Birmingham and Solihull Mental Health NHS Foundation Trust

SECLUSION AND LONG-TERM SEGREGATION POLICY

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POLICY CONTEXT

Seclusion (and long term segregation) are forms of restrictive interventions for which The Mental Health Act Code of Practice sets out specific safeguards. The Policy includes detailed guidance on the use of seclusion and long term segregation consistent with the guiding principles of the Mental Health Act 1983 as amended, NICE NG 10 and the Mental Health Act Code of Practice 2015.

POLICY REQUIREMENT

As driven by the Mental Health Act Code of Practice (DH, 2015) this policy promotes and supports the strategy-based approach to managing violence Trust-wide. Its sole aim is to contain severely disturbed behaviour which is likely to cause harm to others." (DoHWO 1999). Seclusion should be in a safe, secure and purpose-specific room that is identified as being for that sole purpose.

C 09 June 2023

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1 INTRODUCTION

1.1 RATIONALE (WHY)

Seclusion (and long-term segregation) (segregation) are forms of restrictive interventions for which The Mental Health Act Code of Practice sets out specific safeguards The Policy includes detailed guidance on the use of seclusion and segregation consistent with the guiding principles of the Mental Health Act 1983 as amended, NICE NG10 and the Mental Health Act Code of Practice 2015. It is also relevant to the Use of Force Act and Appendix 8 sets out the requirements of this Act in relation to seclusion and segregation.

1.2 SCOPE (WHERE, WHEN, WHO)

This policy applies to all service users receiving treatment for a mental disorder in a hospital and who present with behavioural disturbances, regardless of their age. It will primarily relate to service users detained under the Mental Health Act 1983 as amended, however in certain circumstances it may also relate to service users not detained under the Act (see Section 3.1) It does not apply to prison healthcare services, which are not considered hospitals for the purpose of the Mental Health Act 1983 as amended.

Managers and clinical staff are required to follow the guidance in this policy, which is based upon the guiding principles of the Mental Health Act 1983 as amended and the Mental Health Act Code of Practice 2015.

The policy provides:

- Guidance to ensure the physical and emotional safety and well-being of the service user;
- Guidance to ensure that the service user receives the care and support necessitated by their seclusion both during and after the episode
- Standards for suitable environments for seclusion and segregation that takes account of the service user's dignity and physical well-being;
- Guidance on the roles and responsibilities of staff
- Guidance for recording, monitoring, and reviewing the use of seclusion and any follow up action.

1.3 PRINCIPLES (BELIEFS)

Birmingham and Solihull Mental Health NHS Foundation Trust (BSMHFT) is committed to the provision of a positive and therapeutic culture which focuses on preventing behavioural disturbance through individualised assessment and treatment, early recognition and de-escalation.

Where service users are deemed to require the use of a restrictive intervention, an individualised treatment plan will be created regarding the intervention Seclusion and

segregation are forms of restrictive interventions that, if used appropriately, can be effective in managing the risk of violence.

Seclusion will be lawful in principle, provided:

- The service user is lawfully detained under the Mental Health Act 1983 as amended; or
- Seclusion of an informal patient can be justified under common law, to protect from the immediate risk of significant harm; and
- It is used in a manner compatible with the Human Rights Act 1998, ie complies with the procedural safeguards set out in this policy

The Trust positively supports individuals with learning disabilities and ensures that noone is prevented from accessing the full range of mental health services available. Staff will work collaboratively with colleagues from learning disabilities services and other organisations, in order to ensure that service users and carers have a positive episode of care whilst they are in our services. Information is shared appropriately in order to support this.'

2 POLICY

2.1 The decision to confine a service user in seclusion or segregation is ultimately a matter of professional judgement but will be informed by historical and contemporaneous risk assessment and any existing individualised positive behavioural support plans (or equivalent).

2.2 Where seclusion is carried out anywhere other than the designated seclusion suite, the clinician authorising such seclusion must record an explanation of the reasons for this in the service user's clinical records. Any seclusion or segregation occurring outside of a designated seclusion suite must be recorded as an adverse incident via the BSMHFT incident recording system (Eclipse). There should be particular attention to the risk of self-harm where the patient cannot be seen in some parts of the room (eg bathroom) and how this will be managed.

This policy should be read in conjunction with the following BSMHFT policies:

Rapid Tranquilisation Policy

Management of the Deteriorating Patient & Resuscitation Policy

Prevention and Management of Violence Policy

Mechanical Restraint Policy

Blanket Restrictions Policy

Clinical Searching of Service Users in In-Patient Settings Policy

Police Interventions Policy

Safe Use of Force Policy

3 PROCEDURE

The procedure of seclusion and segregation is broken down into the following areas:

- commencement of seclusion , both in a seclusion suite and in a non-purpose built area (eg bedroom) and roles and responsibilities of staff

- The review process of a seclusion episode

- Observations of service user whilst in seclusion

- documentation of seclusion (note that the new policy incorporates electronic forms rather than the paper forms supported by the old policy)

- process of segregation, including documentation and review process

- training of all staff in relation to seclusion and segregation

- Physical health monitoring for both seclusion and segregation

3.1 SECLUSION – definition and decision making

Seclusion is defined in the Mental Health Act Code of Practice 2015 as:

'The supervised confinement and isolation of a person, away from other users of services in an area from which the person is prevented from leaving.'

Decision to seclude – seclusion must be only used to contain severely disturbed behaviour which is likely to cause physical harm to others. It must never be used as a punishment or threat, or because of shortage of staff or as part of a treatment program. It must also never be used solely as a means of managing self-harming behaviour. Where the service user poses a risk of self-harm as well as harm to others, seclusion must only be used when the professionals involved are satisfied that the need to protect other people outweighs any increased risk to the service user's health and safety arising from their own self-harm and that any such risk can be properly managed.

Only service users detained under the Mental Health Act 1983 as amended should usually be considered for seclusion. If an emergency situation arises involving an service user not detained ("informal"), and as a last resort, seclusion is necessary to protect others from risk of injury or harm, then it must be used for the shortest possible period to manage the emergency situation and an assessment of the service user for detention under the Mental Health Act 1983 as amended must be arranged immediately.

3.2 **COMMENCING SECLUSION (see decision flow chart in Appendix 2)** This section includes information regarding:

- Authorising seclusion
- Escorting service user to seclusion area
- Identification of seclusion suite in another area
- Searching
- Physical health monitoring
- Exiting the seclusion room
- Recording the seclusion episode

3.2.1 Authorising a seclusion episode is undertaken by the following staff:

- A psychiatrist (RC or Approved Clinician (AC) who has undertaken a medical review of the patient) OR
- An AC who is not a registered medical practitioner OR - the professional in charge (i.e. nurse, OT) of a ward.
- Where seclusion is not authorised by a Consultant Psychiatrist who is the patients' Responsible Clinician (RC) or AC, the RC must be informed as soon as practicable. If this is out of normal working hours, the RC (on call consultant) must be informed by phone or in person
- responsibility for managing the process will be held by the member of staff in charge of the ward, which includes any interface with police, ambulance and other non-mental health agencies.

3.2.2 Escorting to an area of seclusion - following the decision to commence a seclusion episode, the service user must be escorted to a purpose built seclusion suite. The use of physical interventions to safely transfer the patient to the seclusion room should be at the minimum required to safely manage the level of risk of harm towards others posed by the service user (see Prevention and Management of Violence Policy) (Insert Hyperlink).

Consideration may also be given to:

- the use of the Soft Restraint System (Formerly ERB) in high-risk situations (eg to prevent prolonged prone restraint during the process of conveying the individual to seclusion suite) See Mechanical Restraint Policy
- calling for police assistance if there is a high risk of serious harm towards staff or other service users

- Transfer to another seclusion area: if there is no seclusion suite available in the immediate clinical area, consideration must be given to assessing the risk of the service user being transferred to another unit with seclusion facilities, against the risk of them being secluded in a non- seclusion area in the immediate clinical environment. This will require an oversight of the availability of seclusion suites across BSMHFT and consideration of whether they are appropriate for the service user (eg gender, age). The Responsible Clinician (this is the on-call consultant out of hours) must liaise with operational colleagues in order to identify the most

appropriate environment for the service user and **the rationale of the decision recorded in the clinical notes**. Appendix 9 of this policy outlines key aspects to consider when making these decisions.

- The ward of origin will retain clinical responsibility for the service user, including the Responsible Clinician
- Staff from the ward of origin will be responsible for oversight of seclusion and observations.
- Director on Call or Associate Director of Operations will ensure that any risks arising from this are mitigated, e.g. safe staffing on the ward of or

- A suitable bed must be kept for the service user, in case the seclusion episode is terminated, and the service user needs to return to the ward. This will usually be on the ward from which the service user was admitted to seclusion. There must always be a bed available for the service user to be able to exit seclusion.
- In making the decision to transfer the service user, the risks of transfer (transportation across the city, physical health issues, type of ward being transferred to, safeguarding etc) must be considered against the risks of remaining on the ward, but not in a seclusion suite.

3.2.3 Seclusion not in a seclusion suite

If a seclusion suite is not available, consideration should be given to whether it is safer for the service user to be secluded in their bedroom, or to be transferred to another ward or site with a purpose build seclusion suite (see Section 3.2.3 above). This should be avoided whenever possible and does not follow the Code of Practice guidance, however patient and staff safety must be prioritised. If a non-purpose built seclusion suite is used, an Eclipse form must be completed and reasoning of the decision made must be clearly documented in the clinical records. It is also important to ensure that while the service user is being secluded in the bedroom (being prevented from coming out to mix with others), equipment that is not designed for seclusion must not be used (the door locks must not be altered, barricades not used, for example). Irrespective of where the seclusion episode takes place, the seclusion documentation must be completed, even if the episode is only for a short period. Where seclusion continues beyond 24 hours in a room not exclusively used for seclusion, the Clinical Director, local Head of Nursing/AHP, the Medical Director and the Director of Nursing of BSMHFT must be informed by the Responsible Clinician, setting out detailed reasoning and at least one of these people should attend the ward in person to support staff and ensure that any risks are mitigated. The Clinical Nurse Manager and Clinical Director of the service currently caring for the service user will appoint a team, lead by a senior clinician, to consider all options to terminate such seclusion as soon as practicable taking into consideration safety of others and the well-being of the service user. This will require an oversight of the use of all seclusion suites across BSMHFT and the risks and benefits of transferring the service user from the non-seclusion room to a purpose-built suite. However, it is important to note that service users from non-secure services must not be transferred to seclusion suites within secure services unless in exceptional circumstances, as set out in the on-call Standard Operating Procedures.

3.2.5 Searching- prior to the period of seclusion starting, the service user must be searched, to ensure that they do not have in their possession anything that could cause harm to themselves or to others (See Appendix 3) . This must be logged as completed on the in-patient portal and documented in the electronic seclusion record on the search form. Any property that is removed must be logged and placed in safekeeping on the ward. The service user must be informed of this information as soon as possible in order to provide reassurance about their belongings. If searching is not possible at the start of seclusion, for example due to the high risk of physical harm to staff, this must be documented on the in-patient portal under the searching section and in the RiO record and attempts to search the service user must be made as soon as possible, and documented.

3.2.6 Prior to the seclusion episode starting the area used (seclusion suite or bedroom) must be searched and any items that could be used to cause physical harm must be removed. A record must be kept of any items removed belonging to the service user and these must be placed in safekeeping. For considerations of the event of a fire, in or near to the seclusion area, the local fire procedures should be followed.

3.2.7 Physical health monitoring (see Appendix 5 and Section 3.10 below)- at the commencement of seclusion, the nurse in charge of the episode must document any physical injuries, including marks from self harm, that the service user has sustained, in the seclusion documentation. The initial medical review must also record information about the service user's physical health, including level of consciousness, any medication taken, existing physical health problems and any injuries. Actions addressing these must be included in the seclusion care plan.

3.2.8 If the service user receives rapid tranquilisation prior to the episode of seclusion, physical observations must be recorded according to that policy. If this is not possible, due to a high risk of harm to others that the service user is posing at that time, a record of their level of consciousness and respiratory rate must be clearly documented, and efforts made to take the observations as soon as possible (e.g. with a team of staff). Resuscitation equipment must be readily available in the seclusion suite (see Resuscitation policy), this equipment must be maintained and checked daily.

3.2.9 Exiting- Prior to the service user entering the area used for seclusion, consideration must be given to how staff will safely exit the room (see Prevention and Management of Violence Policy) This should be co-ordinated and done in accordance with the process delivered on AVERTS training.

- The member of staff in charge of the event must identify and allocate appropriate members of staff to assist in the effective exit from seclusion, this must be clearly communicated along with the exit plan .

- The person responsible for monitoring the seclusion/bedroom door must control the flow of people going into the seclusion room. Non-essential staff must not be inside the room or loitering in the doorway. The person on the door must manage any potential build-up of people that may impede the safe exit of those in the room.

- When the decision to leave the room is made, the team must follow instructions of the member of staff in charge regarding when to exit, based upon the presentation of the service user and the risk posed of physical harm.

3.2.10 Documentation of the seclusion episode – the member of staff in charge of the seclusion episode must ensure that all documentation is completed on the appropriate electronic forms including information relating to decision making. The seclusion record must reflect that the service user has received information about their legal rights (in relation to seclusion and the MHA 1983 as amended, see Appendix 4), either via verbal explanation by a qualified member of staff, or a service user information leaflet if deemed appropriate and safe.

3.2.11 A seclusion care plan, setting out the service users needs during seclusion, must be completed with all service users within the first eight hours, in a collaborative way if possible, considering the following areas:

- Risk assessment, including consideration of risk factors leading to seclusion episode, risk of harm to self and to others.

- Treatment plan, including medication, psychological interventions.

- physical health needs, both acute and chronic, frequency of physical observations to be recorded and how (eg if a team is required to enter the room)

- any neurodevelopmental disorders or cognitive impairment that could make the use of seclusion more distressing or disorientating for the service user.

- factors relating to any protected characteristics applicable to the service user.

- consideration of the need for nicotine replacement therapy

- communication needs (use of interpreter, visual or hearing impairment, cognitive impairment, learning disability or neurodiversity) , gender of staff working with service user, in relation to trauma or other issues.

- type of food that service user can access cutlery and crockery.

- clothing while in seclusion (individual risk assessment of the service user and situation may allow use of their own clothing or anti-rip clothing may be required)

- positive behavioural support plan (or equivalent) to support service user to reflect

on the incident leading to the seclusion episode, and how they can progress to exiting seclusion (e.g., time out to access fresh air, gradual re-integration into wards areas)

- mental health team's views regarding exit planning and how service user can be supported to work towards exiting seclusion.

- contact with family or carers (this may be by phone, or family members visiting them in the seclusion area, see below)

- any spiritual care needs, and how these will be met (e.g. contacting the Spiritual Care team)

- personal hygiene needs (access to toiletries, sanitary products etc)

- activities for the service user while they are in seclusion (music, TV, games, other activities)

The care plan must be available for the multi-disciplinary review team to consider, and the care plan must be reviewed daily, with amendments made if required

A post –incident review form must also be completed regarding the seclusion episode, either whilst the service user is still in seclusion or after they exit, in order to document the service user's views (a service user debrief). This must be recorded on the appropriate Post-incident review form within the electronic records and must be taken into account when planning for any future use of a restrictive intervention.

3.3. PROFESSIONAL REVIEW OF SECLUSION EPISODE

3.3.1 During each seclusion episode, there is a MHA Code of Practice requirement for a number of reviews to take place- these allow consideration of whether seclusion is still necessary, and also to review the care plans in place to support the service user. The Code of Practice allows for agreement that the review schedule can be revised when appropriate, to avoid waking the service user. However, any decision to do this should be clearly recorded.

Definitions of the required reviews are as follows (see also table under Section 3.5 below):

- **initial medical review** – within the first hour of seclusion if seclusion not commenced by a doctor (RC or duty doctor). If it was, the medical review that led to seclusion is deemed to be the initial medical review.

- **initial MDT (internal) review** – as soon as is practicable, RC or nominated deputy with nursing staff and other staff if possible.

- **independent MDT review** – after 8 hours of continuous seclusion, or 12 hours of intermittent seclusion with 48-hour period. This includes the RC or nominated deputy, a nurse and staff who were not involved in the original decision

2 hourly nursing reviews – by at least two nurses, one of which was not involved in the original decision to seclude. Every effort should be made to identify a second nurse to be present for the review. If staffing numbers make this difficult, then in consultation with their colleagues, and taking into account the available clinical information about the patient in seclusion, including their current physical and mental health, the nurse in charge may decide that on balance the best option is for one nurse to carry out the review and consult with their colleague by telephone. This departure from usual procedure should be reported through the eclipse system.

Further clarification of terms used is set out below:

Duty doctor - any doctor who is deemed competent in undertaking seclusion medical reviews" (i.e. FY2 doctor, Core Trainee, SAS doctor, Higher Trainee, or above) . This does not include FY1 or Physician Associates

Nominated deputy - a Consultant Psychiatrist; Higher Trainee (ST4 or above); Staff Grade or Associate Specialist – who is deemed competent to carry out MDT Reviews (i.e. can do MDT reviews in place of RC). This is seen as an important training opportunity and can be carried out under supervision of the RC, but there must be discussion with the RC (during hours or on call RC) and this should be documented in the MDT seclusion review record. It is not appropriate for psychiatric core trainees to act as the Nominated Deputy. The nominated deputy can be from a different clinical team.

3.3.2 SECLUSION REVIEW PROCESS (See also Appendix 1)

Following the episode of seclusion starting, the following reviews must take place:

- Initial medical review- within the first hour
- Initial MDT review within first eight hours (ideally, within first hour as well, this can be combined with the initial medical review if in the first hour)
- Two hourly nursing reviews
- Four hourly medical reviews until initial MDT review
- Independent MDT review – after eight continuous hours of seclusion or 12 hours intermittently

Staff overseeing the seclusion episode have responsibility for arranging the reviews and ensuring that staff are aware of the requirement for the review to take place .

The table in Section 3.5 explains the types of reviews, the purpose and who conducts them. In addition, the flow chart in Appendix 1 gives a clear process of which review is required, at what stage. This should be displayed where ward staff can clearly see it.

Consideration must be given to whether seclusion reviews are conducted with the service user through the seclusion door hatch, or whether staff will enter the seclusion room. A careful assessment of the risks and benefits of entering the seclusion room must made

and if a decision is made not to enter, for example during the MDT reviews, the rationale for this must be documented in the MDT review record.

3.4 ESCALATION OF CLINICAL DECISIONS REGARDING SECLUSION

3.4.1 Where there is a clinical disagreement within the multi-disciplinary team regarding the continuation or discontinuation of the seclusion episode, the reasons for disagreement must be recorded in the seclusion MDT electronic form in the designated text box. A member of the multi-disciplinary team must contact a senior manager (Clinical Nurse Manager or equivalent, Clinical Director, or on-call Trust Senior Manager or Executive if out of hours). Consensus must be reached regarding the decision, although this does not need to be unanimous. Any dissenting views need to be clearly recorded with the reasons, and this should be made available to subsequent review teams.

3.4.2 Prolonged seclusion episode

In the case of a seclusion episode being prolonged (more than fourteen consecutive days) the service user's RC must seek a second opinion from another Consultant Psychiatrist, and the outcome of the review documented with reasons as to why the seclusion should be continued. After four weeks of seclusion (28 days), the Clinical Director of the service area caring for the service user in seclusion must arrange a review meeting, which incudes the clinical team and an independent clinician from BSMHFT to review the care and to consider ways to work towards ending the seclusion episode. This discussion must be recorded in the electronic care record and must be available to other multi-disciplinary team reviews.

Where the seclusion episode continues for three months or longer, regular threemonthly reviews of the patient's circumstances should be undertaken by an external hospital. An external hospital should be identified by the Clinical Director for the service and may include another hospital within BSMHFT.

Any seclusion episode where a service user is secluded longer than 14 days must be escalated to the local senior management team within the relevant service area and an eclipse incident form must be completed. The local management team will ensure that relevant additional reviews are completed. Learning from such prolonged seclusion episodes will be reviewed by the Reducing Restrictive Practice Steering Group.

3.5 OBSERVATIONS DURING SECLUSION

The table below provides information regarding each type of review.

Review	When	Who	Tasks	Notes

Constant Observations (ward team)	mental state documented every hour (therapeutic obs, inpatient portal) Respiratory rate and AVPU recorded every 15 mins (inpatient portal)	- Nursing staff, or appropriately trained Health Care Assistants, Nurse Associates, occupational therapists	Monitor changes in physical health and mental state. Alert staff member in charge /Clinical Team if any concerns	All documentation on inpatient portal (seclusion app) except: 2 hourly reviews and room check –record these in the 2 hourly review boxes on Rio.
Nursing Reviews (as stated in the Code of Practice)	Every 2 hours	- Two qualified nurses, ideally one independent from initial seclusion decision	To review physical health and mental state Input into Seclusion Care Plan Consider termination of seclusion/reduction in restrictions	If deemed suitable to terminate seclusion, nursing team to discuss with Responsible Clinician via telephone if required. However, nursing staff can end seclusion episode if deemed appropriate. Room checks included in this
Initial Medical Review	As soon as possible, within 1 hour of commencement of seclusion	- Responsible Clinician or any medical doctor	To review physical health and mental state Input into Seclusion Care Plan Review medication +/- Rapid Tranquilisation Consider termination of seclusion/reduction in restrictions	If seclusion authorised by a Consultant Psychiatrist, the review prior to their seclusion constitutes the initial medical review.

4 hourly Medical Reviews	Every 4 hours until initial MDT completed	- Responsible Clinician or any medical doctor	To review physical health and mental state Input into Seclusion Care Plan Consider termination of seclusion/reduction in restrictions	To be completed in person, face to face (i.e. not on the phone) Following MDT, medical reviews become twice a day (See 'Daily Medical Reviews')

Initial MDT Review	Within 8 hours of seclusion episode commencing or as soon as practicable	- Responsible Clinician or nominated deputy (see notes above) - staff member in charge of ward - Band 7 nurse, or most senior nurse/OT on site - Where possible, other members of the MDT - Advocate if available	To review physical health and mental state Input into & review of Seclusion Care Plan Consider termination of seclusion/reduction in restrictions	Can be combined with initial Medical Review if within the first hour. Nominated Deputy can be: another Consultant, Specialist Psychiatry Trainee or appropriately trained Staff Grade/Associate Specialist (see above).

Daily MDT Review- each day after the independent MDT review (including weekends and bank holidays)	Daily	- Responsible Clinician or nominated deputy (see notes) Staff member in charge of ward - Band 7 nurse, or most senior nurse/OT on site - Where possible, other members of the MDT - Advocate if available	To review physical health and mental state Input into Seclusion Care Plan Consider termination of seclusion/reduction in restrictions	The 'Daily MDT Review' can count as one of the 'Daily Medical Reviews' (see below) If MDT deemed to be independent from decision to seclude (see below), this can be counted as an 'Independent MDT' too. If the Responsible Clinician is not immediately available (e.g. out of hours, or off site), the Responsible Clinician can nominate a suitable deputy (see above). Review should then be discussed with oncall RC and documented.
Independent MDT Review	After 14 days, then after 28 days, then after 3 months	Separate Consultant Psychiatrist , other senior clinical staff independent of clinical team of service user in seclusion	To review reasons for ongoing seclusion episode and to proactively consider all aspects of exit planning from seclusion.	Although independent of the decision to commence seclusion, the 'Independent MDT' should consult the Clinical Team of the patient prior to
			Clear documentation of recommendations and plan in the seclusion record	making recommendations. Timing can be flexible (dependent on risk which takes priority), e.g. so to not wake a patient

Daily Medical Reviews	Twice a day	- At least one review to be carried out by the Responsible Clinician. - Other review can be carried out by any medical doctor	To review physical health and mental state Input into Seclusion Care Plan Consider termination of seclusion/reduction in restrictions	If the Responsible Clinician is not immediately available (e.g. out of hours, or off site), the Responsible Clinician can nominate a suitable deputy (see above). Review should then be discussed with oncall RC and documented.
Post-Seclusion Review	As soon as clinically possible / appropriate	- Service User - Clinical / Nursing Team - Advocate if available	Complete postincident review with Service User Consider changes to care plans / PBS plans Close down seclusion episode	Consider any advance statements – these can be updated on RIO If the service user refuses to engage, this needs to be documented on RIO and a team review to take place.

- During the seclusion episode, the service user will be subject to continuous observations by staff, in addition to the periodic reviews outlined above. Such staff able to do this would include: registered mental health nurse, a registered occupational therapist, registered Nursing Associate, or an appropriately trained health care assistant (HCA). Assistant psychologists who have completed AVERTS training would also be able to do this. A health care assistant undertaking such observations must have received training and be considered by the staff member in charge to be competent to carry out this role. Arrangements must be in place to ensure that the observing staff member is not isolated when conducting these observations, and that they have the ability to directly communicate with other staff at all times whilst performing this duty. It may be necessary to have more than one member of staff with the service user or outside the seclusion room to offer enhanced protection for the service user and staff. The aim of this observation is to safeguard the service user , monitor their condition and behaviour and to identify the earliest time at which seclusion can be ended. **Record of the service user's appearance and mobility must be made every 15 minutes (AVPU score).** Staff rotate each hour, and within a three-hour period, only one health care assistant can observe (i.e., there will

  not be more than one hour where a registered nurse is not observing)

3.5.1 Consideration must be given to the most appropriate gender of the observing staff members(s), taking into account the service user's clinical needs, for example, self-identified gender, trauma history or the presence of disinhibited behaviour. These

needs should be identified in the seclusion care plan. In addition, when staff need to enter the seclusion room, there must be at least one member of staff who is the same gender as the service user (if this is not possible, this must be documented, and a clinical incident recorded on the incident reporting system) . Prior to entering the seclusion room staff must always communicate their intention to the service user. Each occasion where staff enter the seclusion room must be documented in the Seclusion Record.

3.5.2 Where CCTV facilities are available within seclusion rooms, their use must never replace direct observation of the service user in seclusion. However, they may supplement direct observation; for example, where a service user has deliberately blocked the observation panel.

3.5.3 Where a service user appears to be asleep in seclusion, the staff member observing the service user must assess the respiratory rate of the service user, and this must be recorded every 15 minutes as a minimum. If difficulties arise regarding the ability of observing staff to check for breathing or other potentially risks (eg self harm under a blanket), a clinical judgement must be made to enter the seclusion room, to check that the service user is fit and well, with the appropriate resources in place as taught in AVERTS Training.

3.6 SERVICE USER EXPERIENCE DURING SECLUSION and SEGREGATION

Whilst the episode of seclusion or segregation must be as short as possible for the service user, there are a number of aspects of their care to consider while they are in seclusion:

- Visits from family/friends – the clinical team must consider how such visits can be safely facilitated, and this must be recorded in the seclusion care plan. If it considered that such visits cannot be facilitated, a rationale for this must be recorded in the clinical record. The ward should have a plan concerning entry and exit of visitors to the ward.

- Activities- during the seclusion episode, observing staff may be able to engage with the service user in order to support them in working towards ending the need for seclusion. This may include discussion of the episode using the post incident review form , developing a positive behavioural support plan, or other psychological interventions. Other activities such as games, listening to music or drawing may be possible after a careful risk assessment regarding what the service user can safely access

- Personal hygiene . Access to toiletries, sanitary products, hairbrushes, and other personal items must be considered as part of the risk assessment and conclusions regarding access to these items must be recorded in the seclusion care plan.

- Physical health. The clinical team and observing nursing staff must ensure that the service user has access to any interventions required for physical health issues.
- Access to Nicotine Replacement Therapy

- Access to fresh air (in a restricted outside area, if safe to do so)

- Periods of the seclusion door being open to facilitate a re-introduction back to the ward area

3.7 ENDING SECLUSION

3.7.1 Seclusion ends when a service user is allowed free and unrestricted access to the normal ward environment or transfers to conditions of segregation (see section below). Opening a door for toilet breaks, food breaks or medical reviews does not constitute the period of end of seclusion.

3.6.2 .A seclusion episode can be terminated by the member of staff in charge of the ward, a medical review or the multi-disciplinary review. This may be in consultation with the RC for the service user, either by telephone or in person. A post-seclusion care plan (including a risk assessment and risk management component) must be discussed with the service user prior to termination, and in place before they leave the seclusion area.

3.6.3 The clinical risk assessment must indicate that the patient is not likely to cause harm to others and that the reasons for seclusion are no longer evident.

3.6.4 A record of any reported or observable injuries or marks on the service user's body must be made at the discontinuation of seclusion, in the seclusion record.

3.6.5 When the service user has left the seclusion area, the seclusion episode must be closed down in the electronic record, and all documentation from the episode must be complete.

3.6.6 If a post incident review (debrief) form has not been completed with the service user regarding the seclusion episode, then this must now be completed, in order to give the service user an opportunity discuss their views of the episode and to inform management of future incidents- this must link with their care plan, advanced statement or positive behavioural support plan. If the service user cannot engage in this process or chooses not to, the reasons why must be documented and a team review of the episode must be undertaken to inform future care management, and recorded.

.3.7 DOCUMENTATION OF SECLUSION

All aspects of seclusion care must be clearly recorded in the appropriate part of the electronic care record. If this is not possible (e.g. there is no electronic facility to record available), there must be an appropriate paper record of the information. See also Appendix 5 for physical health observations documentation.

3.8. TRAINING

For all staff involved in supporting service users in seclusion, appropriate training must be available and offered by BSMHFT.

At a local level, the following training must be provided to ward staff involved in seclusion processes:

Management of Seclusion (local)- to be facilitated by senior nursing staff

- Key & Door management
- Arranging seclusion reviews
- Completing relevant documentation
- Escalating a concern/raising an alarm
- Maintaining contact with main ward (radio/phone)- A Qualified Nurse should be available to attend seclusion on request at all times.
- Escalation process in the event that the environment is damaged.
- Locating appropriate clothing (Rip-Resistant)
- Access to Care Plan/PBS/Risk assessment
- Local induction completed

3.9 SEGREGATION

3.9.1 Definition of segregation- MHA Code of Practice 2015

Segregation refers to a situation where, in order to reduce a sustained risk of harm posed by a service user to others which is a constant feature of their presentation, a multi-disciplinary review and a representative from the responsible commissioning authority determines that a service user should not be allowed to mix freely with other patients on the ward or unit on a long term basis. In such cases, it must have been determined that the risk of harm to others would not be ameliorated by a short period of seclusion combined with any other form of treatment.

3.9.2 The clinical judgement is that, if the service user were allowed to mix freely in the general ward environment, other patients or staff would continue to be exposed to a high likelihood of serious injury or harm over a prolonged period of time. In contrast to seclusion, segregation is not an emergency response to an acute incident. Rather, it is a planned restriction in response to a chronic presentation of violence and aggression which is used to create the optimal situation in which to provide care and treatment and promote recovery.

3.9.3 Service users must not be isolated from contact from staff (it is likely that they will be supported through enhanced observations) or deprived access to therapeutic interventions. Treatment plans must aim to end segregation. A range of safeguarding considerations must be made by the clinical team, including dignity, proportionality of the intervention and least restrictive principles within the MHA 1983 as amended and the Code of Practice. The clinical team can access support and advice from the BSMHFT safeguarding team if required.

3.9.4 Service users in segregation whose contact from the general ward is limited must be able to access a number of areas, including as a minimum, bathroom facilities, a bedroom and relaxing lounge area and a secure outdoor area. The environment should be as homely and personalised as risk to self or to others allows.

3.9.5 Authority for segregation

The decision to use segregation must be planned and involve a careful assessment of the service user's clinical needs and assessment of risk of harm to themselves or others. This must be a decision taken by a multi-disciplinary review including the patients Responsible Clinician, other members of the multi-disciplinary team, a representative from the responsible commissioning authority (i.e. NHS England Case Manager /CCG Commissioners) and an Independent Mental Health Advocate (IMHA) if the service user has one. Where appropriate, the views of the service user's family and carers should be taken into account. The Safeguarding team should be informed when a service suer is subject to Long Term Segregation and the clinical team will also need to consider other requirements, such as informing NHSE case managers in Forensic Child and Adolescent Mental Health Services.

3.9.6 The segregation care plan

A segregation record must be maintained whenever segregation is implemented. The episode will be recorded on the service user clinical recording system (RiO). In cases where segregation follows a period of seclusion, the segregation record should be a continuation of the seclusion record.

The care plan must include the same features as in the seclusion care plan (see Section 3.2.10), with clear consideration with the service user of how a gradual reintroduction into the ward can be achieved. The care plan must be reviewed on a regular basis (at least weekly) by the clinical team.

3.9.7 Observation during segregation

Service users who are subject to segregation must not be isolated from contact with observing staff. Therefore, it is essential that the number of staff observing the service user is determined according to the service user's assessed level of risk of harm towards themselves and others.. This must be recorded in the observation section of the patient electronic record and the segregation care plan.

Staff supporting service users who are subject to segregation must make written records on their condition on at least an hourly basis.

3.9.8 Reviews of segregation

Service users subject to segregation must be reviewed formally by an approved clinician at least once in every 24 hour hours and at least weekly by the full multidisciplinary team. Multi-disciplinary reviews must include the service user's RC,

the member of staff in charge of the ward, another professional (e.g. social worker, psychologist, OT) and an IMHA where appropriate. During the week, there must be at least three face to face reviews, other reviews can be by telephone. During weekends, the service user's care must be reviewed daily by the on call RC, or by the on call higher trainee in forensic psychiatry, under supervision by the on call RC - this can be via a telephone call with staff if required. The review must include a discussion of the service user's presentation, risk issues, physical health/dietary intake and any other information deemed important by the care team and must be documented in the clinical record.

Where segregation continues for three months or longer, regular three monthly reviews of the service user's circumstances must be undertaken by an external hospital. An external hospital should be identified by the Clinical Director for the service and may include for this purpose another hospital within BSMHFT. The relevant commissioning body must also be informed i.e. Clinical Commissioning Group (CCG) or NHS England

3.10 CONSIDERATION OF PHYSICAL HEALTH CARE DURING SECLUSION EPISODE OR SEGREGATION (see also Section 3.2.7 above)

3.10.1 Physical observations of the service user must be recorded shortly after seclusion is commenced, and if this is not possible due to a high risk of harm towards staff, this must be clearly documented. Further attempts to take physical observations must be attempted at least daily until they have been taken.

3.10.2 If the service user has been admitted from elsewhere straight into a seclusion suite (eg prison, another hospital outside of BSMHFT), routine physical health examination, investigations and documentation must be completed when safe and appropriate to do so, if there is a delay, again the reasons for this must be documented.

3.10.2 If deemed necessary due to safety concerns, a team of professionals may be required to enter the seclusion room in order to take physical observations. This will depend upon the degree of the physical health concerns (eg service user has received rapid tranquilisation, is suspected of using illegal drugs or alcohol, has a pre-existing physical illness or is appearing to be physically unwell). Any decision making regarding this must be clearly recorded in the clinical notes.

3.10.3 Physical observations requiring equipment (blood pressure, pulse, temperature, Pulse oximetry) must not be taken through the hatch in the seclusion door- this can enable the service user to gain access to the equipment, which can be used as a weapon or for the purpose of self harm

4 RESPONSIBILITIES

Post(s)	Responsibilities
All Staff	All incidents of seclusion must be supported by contemporaneous, clear, detailed, and legible formal written records in the Seclusion Record (and any relevant charts), which should be filed in the patient's clinical records.
Service, Clinical and Corporate Directors	To receive notification of when seclusion has commenced and to assist with any staffing issues when on-call
Policy Lead	To oversee and communicate any amendments during consultation and inception
Executive Director	To ensure that policy is circulated across all services with a clear briefing and that all processes regarding ratification are completed.
Nurse-in-charge of the ward	Responsible for ensuring that all relevant documentation is appropriately completed i.e. an incident report (where applicable), clinical entries (including care plans), and seclusion/ segregation forms reviews. Responsible for ensuring that all incidents of seclusion are reported to the relevant parties at the earliest opportunity following commencement and discontinuation of any seclusion event This information should be entered onto the Seclusion Record on RiO
Trust Clinical Governance teams	Responsible for the monitoring of adherence to this policy through regular audit.
Reducing Restrictive Practice Steering Group	Oversight of seclusion data and learning from trends or patterns of episodes of seclusion
Learning and Development department	To ensure that all staff have access to appropriate training to conduct their role to support this policy, in conjunction with AVERTS team and RRP Steering Group

5 DEVELOPMENT AND CONSULTATION PROCESS

Consultation summary	
Date policy issued for consultation	December 2022
Number of versions produced for consultation	1
Committees or meetings where this policy was formally discussed	
Working group for initial seclusion and segregation policy review (subgroup of Positive and Pro-active Care Expert Panel) PPCEP RRP Steering Group Shared with all PICU teams pre-consultation Staff union reps PDMG Acute and secure care PICU consultants, matrons and CNMs, secure care Clinical Leads Safeguarding team L and D	June 2018-Jan 2019 RRP Steering Group Nov 2022

Where else presented	**Summary of feedback**	**Actions / Response**

6 REFERENCE DOCUMENTS

- Mental Health Act Code of Practice (2015)
- **NICE NG10**

7 BIBLIOGRAPHY

- Mental Health Act Code of Practice (2015)
- **NICE NG10**
- **MH Act Code of Practice**

8 GLOSSARY

None

9 AUDIT AND ASSURANCE

Element to be monitored	Lead	Tool	Frequency	Reporting Committee
Service user experience	RRP Steering Group	Annual evaluation report	Annual	QPESC
Seclusion documentation	RRP Steering Group	Quarterly	Quarterly	QPESC
Compliance with Use of Force Act	Mental Health Legislation Committee	NHS Digital submission	Monthly	QPESC

Title of Proposal	**Seclusion and Segregation policy**		
Person Completing this proposal	XXXX XXXX	**Role or title**	Deputy Medical Director for Quality and Safety
Division	Medical Directorate	**Service Area**	All inpatient areas
Date Started	November 2022	**Date completed**	December 2022
Main purpose and aims of the proposal and how it fits in with the wider strategic aims and objectives of the organisation.			
The purpose of the policy is to clearly state the processes required under the Mental Health Act 1983 Code of Practice in relation to the use of seclusion and segregation. It also reflects the Use of Force Act and processes that are required to achieve compliance with all relevant legal requirements			
Who will benefit from the proposal?			
This policy applies to all clinical areas of the organisation and to all staff working in those clinical areas. It is designed so that there will be a consistent approach for all service users experiencing seclusion or segregation, with awareness of individual needs.			
Do the proposals affect service users, employees or the wider community? ***Add any data you have on the groups affected split by Protected characteristic in the boxes below. Highlight how you have used the data to reduce any noted inequalities going forward***			
The policy will affect service users and staff. Data looking at the use of seclusion and segregation, within BSMHF and nationally, does show that there are differences in the ethnicity of service users regarding the use of different restrictive interventions and the policy is designed to support staff to be aware of these differences, and to reduce the impact of unconscious bias and other factors on decision making, in respect of protected characteristics.			

Do the proposals significantly affect service delivery, business processes or policy? *How will these reduce inequality?*

Appendix 1 – Equality Impact Assessment

Equality Analysis Screening Form

A word version of this document can be found on the HR support pages on Connect
http://connect/corporate/humanresources/managementsupport/Pages/default.aspx

The policy does significantly affect service delivery from a restrictive practice and Use of Force perspective. The processes outlined are designed to support staff to make sound clinical decisions, to be aware of how inequalities could arise, for example racial inequality, and how to reduce the risk of this taking place.
Does it involve a significant commitment of resources? *How will these reduce inequality?*
Seclusion and segregation are existing processes and there are no additional resources required.
Do the proposals relate to an area where there are known inequalities? (e.g. seclusion, accessibility, recruitment & progression)
The policy is applicable across the organisation, and as stated above local and national data demonstrates that there are known inequalities within the use of some restrictive interventions.

Impacts on different Personal Protected Characteristics – *Helpful Questions:*	
Does this proposal promote equality of opportunity? *Eliminate discrimination?* *Eliminate harassment?* *Eliminate victimisation?*	*Promote good community relations?* *Promote positive attitudes towards disabled people?* *Consider more favourable treatment of disabled people?* *Promote involvement and consultation?* *Protect and promote human rights?*

Please click in the relevant impact box or leave blank if you feel there is no particular impact.

Personal Protected Characteristic	**No/Minimum Impact**	**Negative Impact**	**Positive Impact**	**Please list details or evidence of why there might be a positive, negative or no impact on protected characteristics.**

Age			√	The policy supports staff to think about the individual needs of the person in seclusion or segregation, including their age and how this affects their needs, and therefore is designed to have a positive impact upon young people in seclusion or segregation
Including children and people over 65				

Is it easy for someone of any age to find out about your service or access your proposal? Are you able to justify the legal or lawful reasons when your service excludes certain age groups				
Disability			√	The policy supports staff to think about the individual needs of the person in seclusion or segregation, including if they have a disability, and how this affects their needs. It is therefore is designed to have a positive impact on people with a disability who are in seclusion or segregation. This may be a physical disability, a sensory or neurodiverse issue or a learning disability.
Including those with physical or sensory impairments, those with learning disabilities and those with mental health issues Do you currently monitor who has a disability so that you know how well your service is being used by people with a disability? Are you making reasonable adjustment to meet the needs of the staff, service users, carers and families?				
Gender			√	The policy supports staff to think about the individual needs of the person in seclusion or segregation, including their gender, and how this affects their needs. It is therefore designed to have a positive impact upon people or all genders who are being nursed in seclusion or segregation

This can include male and female or someone who has completed the gender reassignment process from one sex to another Do you have flexible working arrangements for either sex? Is it easier for either men or women to access your service and proposal?				
Marriage or Civil Partnerships	**√**			Although this is a protected characteristic, the use of this policy will not have an impact upon this characteristic .
People who are in a Civil Partnerships must be treated equally to married couples on a wide range of legal matters Are the documents and information provided for your service reflecting the appropriate terminology for marriage and civil partnerships?				
Pregnancy or Maternity			**√**	The policy supports staff to think about the individual needs of the person in seclusion or segregation, including if they are pregnant or if
				they have recently given birth. It is unlikely that a service user will be secluded if pregnant and additional safeguards for the mother and child will be in place, as well as clinical support from our internal perinatal services.
This includes women having a baby and women just after they have had a baby. This also includes miscarriage, still birth and neo natal deaths and this effects men as well as women. Does your service accommodate the needs of expectant and post natal mothers both as staff and service users? Can your service treat staff and patients with dignity and respect relation in to pregnancy and maternity?				

Race or Ethnicity			**√**	The policy supports staff to think about the individual needs of the person in seclusion or segregation, including their ethnicity, how this affects their needs, and therefore is designed to have a positive impact upon people in seclusion or segregation. There is national and local data to suggest that there are differences in ethnicity in relation to service users experiencing seclusion or segregation and this health inequality is being addressed through the Reducing Restrictive Practice Steering Group within BSMHFT
Including Gypsy or Roma people, Irish people, those of mixed heritage, asylum seekers and refugees What training does staff have to respond to the cultural needs of different ethnic groups? What arrangements are in place to communicate with people who do not have English as a first language to find out about your service or access your proposal?				
Religion or Belief			**√**	The policy supports staff to think about the individual needs of the person in seclusion or segregation, including their religion or belief, and how this affects their needs. It is therefore is designed to have a positive impact for all service users, regardless of their religion or belief, and to ensure that they are supported in the most culturally appropriate way .

Including humanists and non-believers Is there easy access to a prayer or quiet room to your service delivery area? When organising events – Do you take necessary steps to make sure that spiritual requirements are met? Are there any barriers to people of religion or belief to finding out about your service or access your proposal?

Sexual Orientation			**√**	The policy supports staff to think about the individual needs of the person in seclusion or segregation, including their sexual orientation, and how this affects their needs. It is therefore designed to have a positive impact upon people of all sexual orientation, who are being nursed in seclusion or segregation
Including gay men, lesbians and bisexual people Does your service use visual images that could be people from any background or are the images mainly heterosexual couples? Does staff in your workplace feel comfortable about being 'out' or would office culture make them feel this might not be a good idea?				
Transgender or Gender Reassignment			**√**	The policy supports staff to think about the individual needs of the person in seclusion or segregation, including individuals who are transgender, or who are undergoing, or planning, gender reassignment, and how this affects their needs. It is therefore designed to have a positive impact upon all people with this protected characteristic, who are being nursed in seclusion or segregation
This will include people who are in the process of or in a care pathway changing from one gender to another Have you considered the possible needs of transgender staff and service users in the development of your proposal or service?				
Human Rights			**√**	This policy is written to promote equality and remove any discrimination for service users. It is based upon the Mental Health Act 1983 as amended Code of Practice and also the Use of Force Act, both of which support the Human Rights Act

Affecting someone's right to Life, Dignity and Respect? Caring for other people or protecting them from danger? The detention of an individual inadvertently or placing someone in a humiliating situation or position?

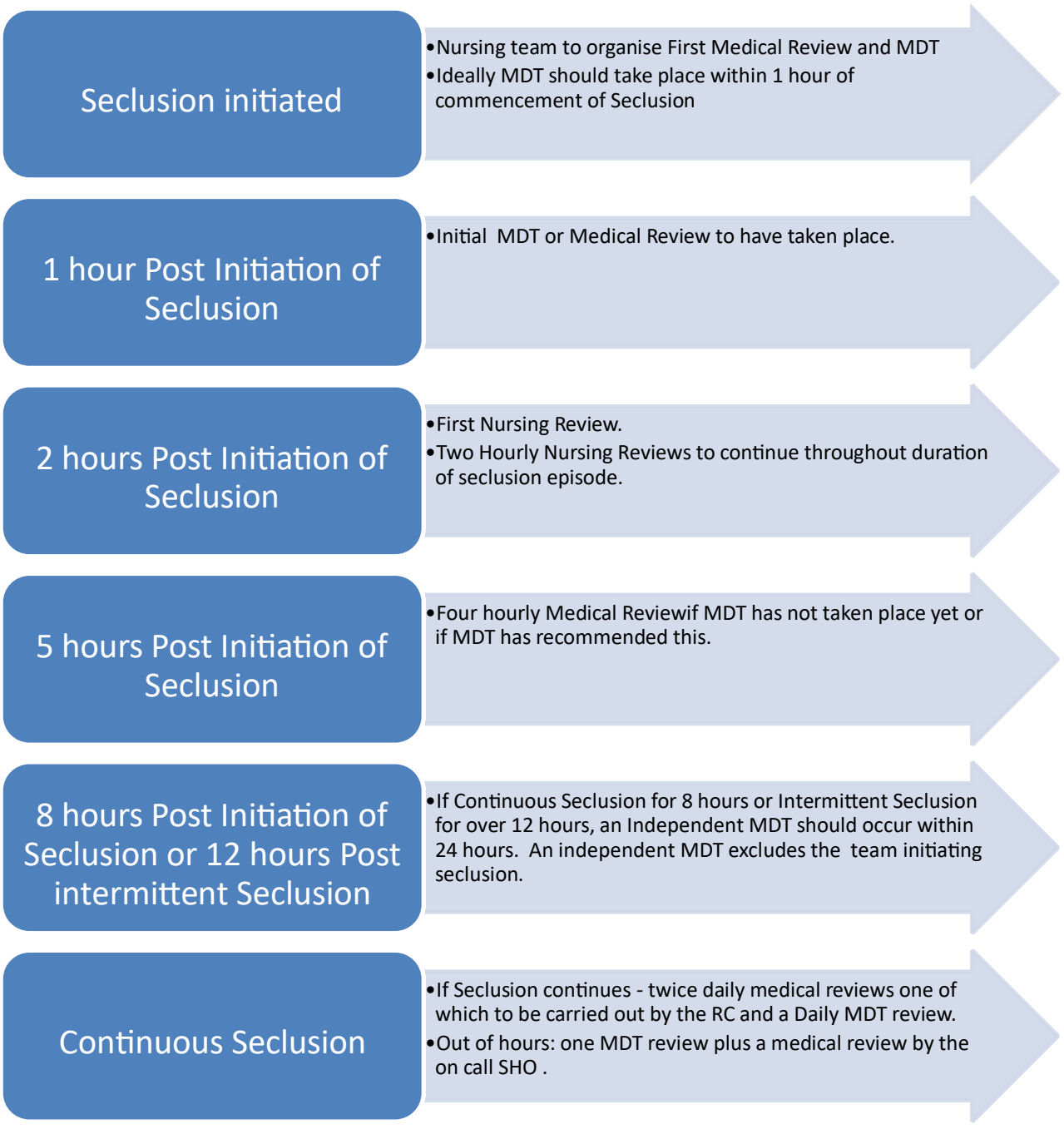
If a negative or disproportionate impact has been identified in any of the key areas would this difference be illegal / unlawful? I.e. Would it be discriminatory under anti-discrimination legislation. (The Equality Act 2010, Human Rights Act 1998)				
	Yes	**No**		
What do you consider the level of negative impact to be?	**High Impact**	**Medium Impact**	**Low Impact**	**No Impact**
If the impact could be discriminatory in law, please contact the **Equality and Diversity Lead** immediately to determine the next course of action. If the negative impact is high a Full Equality Analysis will be required. If you are unsure how to answer the above questions, or if you have assessed the impact as medium, please seek further guidance from the **Equality and Diversity Lead** before proceeding. If the proposal does not have a negative impact or the impact is considered low, reasonable or justifiable, then please complete the rest of the form below with any required redial actions, and forward to the **Equality and Diversity Lead.**				
Action Planning:				
How could you minimise or remove any negative impact identified even if this is of low significance?				
Leads will work with the organisation to reduce impact of any detriment experienced by reports of concerns				
How will any impact or planned actions be monitored and reviewed?				
Feedback from reporters of concerns, escalating concerns through governance routes. Regular audits and policy updates, communication to managers through meetings and committees				
How will you promote equal opportunity and advance equality by sharing good practice to have a positive impact other people as a result of their personal protected characteristic.				

Policy will be trust wide promoted in ways accessible to ALL staff.

Please save and keep one copy and then send a copy with a copy of the proposal to the Senior Equality and Diversity Lead at bsmhft.hr@nhs.net . The results will then be published on the Trust's website. Please ensure that any resulting actions are incorporated into Divisional or Service planning and monitored on a regular basis

Appendix 2 – To be laminated and displayed in all seclusion areas

Summary Flowchart of Seclusion Policy



Notes:

MDT includes the RC/Consultant On-call or On-call SpR deputised by Consultant, Nurse in Charge of ward, Band 7 nurse or Designated Site Senior Nurse, Another Professional: OT/Psychologist/Social Worker and an IMHA if possible.

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Independent MDT is as above, but with the exception of Nurse in Charge, the rest of the professionals should **NOT** have been involved in the original decision for Seclusion.

Medical Reviews – Normally carried out 09:00-17:00 by Team SHO's and RC. Out of Hours On Call SHO can

carry out Medical Reviews. The MDT can count towards a medical review.

Nursing reviews should carry out two hourly. Seclusion Observations should be recorded by nurses every

Summary Flowchart of Segregation Policy

Segregation initialised

- To initiate segregation an MDT needs to take place.
- A segregation care plan needs to be documented in situations where segregation has been initiated.

Nursing Reviews

- The patient should be nursed at an atleast 2:1 level or more, according to risk.
- Documentation should take place at least hourly.

Daily Reviews

- Daily reviews to take place by team doctor which can include SHO, SpR or Consultant Psychiatrist.
- A review doesn't have to be face to face, can occur via telephone in consultation with the Nurse in charge.

Weekly

- MDT review should take place weekly and be guided by the Care Plan.
- After an MDT review, the care plan should be updated.

Monthly Review

- An Independent review should take place every month.
- This review should be carried out by another Consultant Psychiatrist.

•This should be an External Hospital Review.

•A representative from an external hospital should liaise with representative from commisioning authority and an IMHA.

3 Searching of service users in seclusion

The following items must be removed prior to a service use commencing an episode of seclusion:

1. Lighters and Matches, Tobacco etc.
2. Sharp Objects
3. Removable jewellery and valuables such as money, credit cards
4. Footwear dependant on type
5. Dressing gown cords, belts, ties
6. Any other items which might be used as ligatures, for self-harm or harm to others.

A patient in seclusion may be allowed to keep personal items of religious or cultural significance (e.g. some items of jewellery) as long as they do not compromise the safety of the patient or others. If any items are assessed as presenting a compromise to the patient's safety and/or the safety of others, they should be removed.

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4 SECLUSION ROOM STANDARDS

1. Seclusion must usually only be undertaken in a room or suite of rooms that have been specifically designed and designated for the purpose of seclusion and which serves no other purpose on the ward. Wherever seclusion facilities are available, it is important that they are always maintained as 'ready for use' so that they are immediately available in the event of an emergency.

2. Seclusions rooms must:

    - Be safe; secure and contain nothing that could cause harm to patient or others. Be able to withstand attack/ damage.
    - Allow clear observation with no blind spots and alternate viewing panels should be available when required.
    - Be heated, well insulated and ventilated with natural light through a reinforced widow. Lighting and heating must be externally controlled.
    - Have access to toilet/ washing facilities.
    - Be adequately furnished with a bed, pillow, mattress and blanket/covering.
    - Be quiet but not sound proofed with some means of calling for attention.

3. A clock must be visible to the patient from within the room.
4. have arrangements for safe use of a telephone to enable the service user to contact family, carer and legal representatives.

5 GUIDELINES ON GOOD PRACTICE AND PATIENTS' RIGHTS

1. **Patients' rights whilst in seclusion**

Service users in seclusion have the following rights (outlined below) and have the right to have them explained verbally and given a leaflet, a copy can be accessed here:

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The leaflet outlines key information regarding their rights and aspects of care. The nurse in charge of implementing seclusion must ensure the following rights are verbally given at the earliest practical/professionally decided opportunity to the service user:

- To be given the reason for being placed in seclusion.
- To be told under what conditions seclusion will cease.
- To be aware of the time and day.
- To be told how to summon the attention of staff whilst in seclusion.
- To receive adequate food and fluids at regular intervals.
- To be given appropriate access to toilet and washing facilities (where continued observation is required, only staff of the same gender should be present).
- To be clothed at all times .
- To be visited by, and given the opportunity to speak to, a senior staff member at regular intervals during the seclusion period.
- To be allowed to send messages to relatives through the ward nursing team.
- A record must be made in the service user's clinical notes of them having been given these rights
- To see a member of the Care Quality Commission, IMHA, a legal representative or a member of a First Tier Tribunal Panel. A risk assessment must be carried out by staff to ensure that safety of all parties is maintained

6 DOCUMENTATION of PHYSICAL OBSERVATIONS

There is a seclusion dashboard on the inpatient portal which will display all the information below for each service user in seclusion or segregation:

- Therapeutic observations – inpatient portal
- Room checks - recorded in the 2 hourly nursing reviews, in seclusion episode on Rio
- Diet and fluid intake - inpatient portal on the diet and fluid intake chart

APPENDIX

- Sleep Chart- currently on paper but will be on the inpatient portal by the end of 2019
- Respiratory rate - currently on paper but will be on the inpatient portal by the end of 2019

APPENDIX

7 : role of Nursing associates within seclusion process (from Learning and Development , Clinical Nursing Placement team August 2019)

Seclusion and long term segregation (LTS) are forms of restrictive interventions for which, The Mental Health Act Code of Practice sets out specific safeguards. The BSMHFT Policy includes detailed guidance on the use of seclusion and segregation consistent with the guiding principles of the Mental Health Act, NICE NG10 and the Mental Health Act Code of Practice 2015.

Where seclusion is concerned, the a band 5 Registered Nurse or other equivalent qualified mental health professional (eg OT) has to undertake observations. Nursing associates do not currently have professional duties under the MHA (1983).

Despite this, Nursing associates may support a registered nurse or nurse in charge (NIC) with basic delegated seclusion tasks and undertake the hourly observations. However, the registered band 5 staff member remains accountable for such delegated tasks and acting within trust guidelines. **Undertaking nursing reviews solely remains a registered band 5 duty – there is no exception for this.**

The seclusion policy should be read and clearly understood by the nursing associate prior to undertaking any delegated tasks.

APPENDIX 8 Use of Force Act details in relation to seclusion

1) Seclusion Policy

Updated Definition

"Isolation" means any seclusion or segregation that is imposed on a patient.

The Use of Force Act requires that the record of the use of force used on a patient by a member of staff must include the following:

a) the reason for the use of force
b) the place, date and duration of the use of force
c) the type, or types of force used on the patient
d) whether the type or types of force used on the patient formed part of the patient's care plan
e) name of the patient on whom force was used
f) a description of how force was used
g) the patient's consistent identifier
h) the name and job title of any member of staff who used force on the patient
i) the reason any person who was not a member of staff in the mental health unit was involved in the use of force on the patient
j) the patient's mental disorder (if known)
k) the relevant characteristics of the patient (if known)
l) whether the patient has a learning disability or autistic spectrum disorder
m) a description of the outcome of the use of force
n) whether the patient died or suffered any serious injury as a result of the use of force
o) any efforts made to avoid the need for use of force on the patient
p) whether a notification regarding the use of force was sent to the person or persons (if any) to be notified under the patient's care plan

For (k) in the above list the patient's relevant characteristics are:

a) the patient's age
b) whether the patient has a disability, and if so, the nature of that disability
c) the status regarding marriage or civil partnership
d) whether the patient is pregnant
e) the patient's race
f) the patient's religion or belief
g) the patient's sex
h) the patient's sexual orientation
i) gender reassignment – whether the patient is proposing to reassign their gender, is undergoing a process to do so, or has completed that process

- Gender reassignment is a protected characteristic under the Equality Act 2010 and information about whether a patient has transitioned from one gender to another should also be collected.

For (d) and (p) in the list above references to care plans may also include Positive Behavioural Support Plans (or equivalent).

For (k) in the list above proactive steps should be taken to collect data about the patient's protected characteristics in order to comply with the Public Sector Equality Duty.

For (m) in the above list of recording requirements (a description of the outcome of the use of force) the description should include (as a minimum) the views of the patient, any psychological impact, details of any injuries the patient or staff involved may have suffered, whether the outcome of the use of force was segregation or seclusion, and whether the police were called to assist. If the police were called to assist the reason they were called, whether the incident was recorded by their body worn camera, and if not, why not, and who the relevant police contact is should also be recorded.

For (n) in the above list (whether the patient died or suffered any serious injury as a result of the use of force) there is no specific definition of what constitutes a serious injury in NHS settings. Current guidance in the NHS England and Improvement Serious Incident Framework 2015 should be followed to identify a serious incident. What injuries the patient suffered should also be recorded.

Serious injuries to a patient should also be reported to the Care Quality Commission if the patient was seriously injured while a regulated activity was being provided or their injury may have been a result of the regulated activity or how it was provided. The notification form provides detail of what might be considered a serious injury for the purposes of recording under this Act's requirements.

NHS and independent organisations (where providing NHS-funded care) must ensure that any death of a patient detained or liable to be detained under the Mental Health Act 1983 is reported to the Care Quality Commission without delay. The death must also be reported to the local Coroner (including voluntary or informal patients). It is for the Coroner to determine the cause of death. The requirement to record whether the patient died as a result of the use of force will need to be recorded once the Coroner has provided their conclusion. The responsible person must ensure that this is added into the record of the incident. It would also be good practice to notify the Care Quality Commission of the Coroner's conclusion.

For (o) in the above list (any efforts made to avoid the need for use of force on the patient) this should include details of what led to the use of force and provide a record of the deescalation techniques which were employed.

For (p) in the list above (whether a notification regarding the use of force was sent to the person or persons (if any) to be notified under the patient's care plan) this must be with the patient's consent, in relation to adult patients, or with the consent of the person with parental responsibility in the case of a child or young person.

A notification should be sent to the person or persons (families, carers or independent advocates) identified in the patients care plan or positive behavioural support plan (or equivalent) following every use of force. This should occur inline with the guidance in Chapter 26 – 'Safe and therapeutic responses to disturbed behaviour' of the Mental Health Act 1983: Code of Practice on notifications following the use of force.

The Act requires that the responsible person must keep the record of any use of force for 3 years from the date it was made. It is not permitted to record anything which would otherwise breach data protection legislation [footnote 2] or the common law duty of confidence. This is intended to preserve the patient's rights in relation to their information.

BSMHFT records the use of force within its internal incident reporting system Eclipse. It is current good practice to include the record of the use of force within the patient's electronic record. This is satisfied by the eclipse recording system being linked to RIO.

Openness and transparency about the use of force within an organisation is essential, but it is also important to recognise that the data only tells us part of the story. There are many factors which can impact the number of incidents reported such as staff reporting behaviours or the mix of patients which can impact the ward environment and relationships.

Organisations have a responsibility to consider the detail behind the data to evaluate if their wider approaches to minimising the use of force are effective. Success should not be measured on a reduction in the number of reported incidents alone.

BSMHFT will also consider the following:

- when force is used, does it meet the justification threshold of imminent or immediate risk of harm to self or others
- is there a reduction in the average duration when force is used
- was the level of force proportionate in all cases
- is there an overall reduction in the use of physical restraint
- is there a reduction in the use of prone and supine restraint
- is there a reduction in the number of complaints from patients and families or carers following the use of force
- is there a reduction in the number of injuries to patients and staff following the use of force

This data and its analysis will be vital in informing the BSMHFT's plan to reduce the use of force.

APPENDIX 9

Existing BSMHFT patient requires a seclusion suite, but one is only available in secure care

1. Ensure that an MDT seclusion review has taken place, to be clear that seclusion is required. This will include the RC who is considering the use of secure care seclusion.
2. Early discussion between secure and acute consultant psychiatrists, as well as site and ward managers, Clinical Leads or on call managers
3. Read Section 3.2.3 and 3.2.4 of the seclusion and segregation policy when considering the pros and cons of moving the patient (will it be safer for them to remain where they are?): https://bsmhftnhsuk.sharepoint.com/sites/connect-policies/Shared Documents/Forms/AllItems.aspx?id=%2Fsites%2Fconnect-policies%2FShared Documents%2FPolicies%2FClinical Policies%2FSeclusion and Segregation policy%2Epdf&parent=%2Fsites%2Fconnect-policies%2FShared Documents%2FPolicies%2FClinical Policies
4. In addition to the above, consider the following key principles when making the decision about whether or not to move the patient to a secure seclusion suite:
   - Who will carry out nursing observations and complete the 2 hourly nursing reviews
   - Who will be the RC (this needs to be discussed and agreed in writing in the clinical record before transfer is agreed)
   - Which junior doctor will cover the patient during their time in seclusion
   - Who will conduct the MDT reviews from and RC point of view
   - Is there appropriate support to nursing staff who are carrying out the observations, can they access breaks, including comfort breaks
5. If it is considered that the above factors cannot be safely accommodated, then careful consideration of the risks and benefits of the transfer should be clearly documented in the clinical case record by the RC
6. It should be remembered that patients should not be transferred between sites after they have had RT and that there should be at least 2 hours of physical health monitoring after RT before transfer is considered- see RT policy Section 3.7: https://bsmhftnhsuk.sharepoint.com/sites/connect-policies/Shared Documents/Forms/AllItems.aspx?id=%2Fsites%2Fconnect-policies%2FShared Documents%2FPolicies%2FClinical Policies%2FRapid Tranquilisation Policy%2Epdf&parent=%2Fsites%2Fconnect-policies%2FShared Documents%2FPolicies%2FClinical Policies
7. Any transfers should be compliant with the Use of Force Act and the Safe Use of Force Policy.
8. It is good practice to have a brief inter-team discussion between the transferring and the receiving teams, the outcome of which is recorded in the clinical record, so that all relevant people are involved and in agreement with the management plan
9. Removal of the patient must be completed lawfully. This is done using S19(3) of the Mental Health Act 1983. A patient detained in an NHS hospital may, at any time be removed to another hospital managed by the same managers. No Form H4 is required, and there is no special procedure to follow.
10. Prior to any transfer a discussion needs to be held between the consultant psychiatrists covering both the secure care and general adult on-call rotas on call. This discussion needs to be fully documented in the patient notes by the clinician responsible for the patient's care.