Birmingham and Solihull NHS
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, 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.

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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, NICE NG10 and the Mental Health Act Code of Practice 2015.

1.2 Scope (Where, When, Who)

This policy applies to all patients receiving treatment for a mental disorder in a hospital and who are liable to present with behavioural disturbances, regardless of their age and whether or not they are detained under the Mental Health Act. It does not apply to prison healthcare services which are not considered hospitals for the purpose of the Mental Health Act.

Managers and clinical staff are required to follow the guidance in this policy. The policy includes detailed guidance on the use of seclusion and segregation consistent with the guiding principles of the Mental Health Act 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 patient;
- Guidance to ensure that the patient receives the care and support rendered necessary by their seclusion both during and after it has taken place;
- Standards for suitable environments for seclusion and segregation that takes account of the patient's dignity and physical well-being;
- Guidance on the roles and responsibilities;
- 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 is committed to the provision of a positive and therapeutic culture which focuses on preventing behavioural disturbance through individual assessment and treatment, early recognition and de-escalation.

Where patients are at risk of being exposed to restrictive interventions they will have an individualised treatment plan guiding their use. Seclusion and segregation are forms of restrictive interventions that can be effective in managing the risk of violence.

Seclusion will be lawful in principle, provided:

- There is lawful detention as under the Mental Health Act; or
- Seclusion of an informal patient can be justified under common law, to protect from the immediate risk of significant harm; and

- Seclusion and segregation is compatible with the Human Rights Act 1998. When seclusion and segregation complies with the procedural safeguards set out in this policy

'The Trust positively supports individuals with learning disabilities and ensures that no-one 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 in our services. Information is shared appropriately in order to support this.'

2 POLICY

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

2.2 Where seclusion is carried out anywhere else except the designated seclusion suite, the clinician authorising such seclusion must document cogent reasoned justification in the patient's clinical records, being aware that this can be legally challenged and he/she could be called upon to defend their position in authorising such a seclusion.

This will be categorised as an untoward clinical incident and should be recorded as such on the Trust incident reporting system.

3 PROCEDURE

3.1 SECLUSION

Seclusion is defined 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.'**
- Seclusion must be only used to contain severely disturbed behaviour which is likely to cause harm to others. It will never be used as a punishment or threat, or because of shortage of staff or as part of a treatment program. It must never be used solely as a means of managing self-harming behaviour. Where the patient poses a risk of self-harm as well as harm to others, seclusion will only be used when the professionals' are satisfied that the need to protect other people outweighs any increased risk to the patient's health and safety arising from their own self-harm and that any such risk can be properly managed.
- Only patients detained under the Mental Health Act should be considered for seclusion. If an emergency situation arises involving an informal patient, and as a last resort, seclusion is necessary to protect others from risk of injury or harm, then it should be used for the shortest possible period to manage the emergency situation and an assessment for detention under the Mental Health Act must be undertaken.

3.2 COMMENCING SECLUSION

3.2.1 The decision to confine a patient in seclusion is wholly a matter of professional judgement but should be informed by risk assessment and any existing

individualised positive behavioural support plans (or equivalent). Out of hours, the on call Responsible Clinician and Clinical Nurse Manager/Clinical Service Manager outside of secure care must be informed at the earliest opportunity. In exceptional cases where complications arise e.g. where the police are involved, the on-call Consultant Psychiatrist and the Executive must also be informed. In hours (9.00AM – 5.00PM Monday to Friday) the Responsible Clinician, Clinical Nurse Manager, Matron and in exceptional cases commissioners are to be informed and as soon as possible out of hours.

3.2.2 The person authorising seclusion should have seen the patient immediately prior to the commencement of seclusion. The decision to initiate seclusion may be taken by a Consultant Psychiatrist (who has undertaken a medical review of the patient), an Approved Clinician who is not a registered medical practitioner or the professional in charge (i.e. nurse) of a ward. Where seclusion is not authorised by a Consultant Psychiatrist who is the patients' Responsible Clinician, the Responsible Clinician must be informed as soon as practicable. When the seclusion intervention is taking place the responsibility for managing the process will be held by the nurse in charge, which includes any interface with police, ambulance and other non-mental health agencies.

3.2.3 Resuscitation equipment must be readily available in the seclusion suite including an automatic external defibrillator, a bag valve mask, oxygen, cannulas, intravenous fluids, and suction and first-line resuscitation medications. This equipment must be maintained and checked daily.

3.2.4 A doctor should be available to attend to a psychiatric emergency within thirty minutes of an alert by non-medical staff. Where the on-call doctor covering the ward is unable to attend the ward within 30 minutes **a medical management plan must be devised to ensure a medical review is undertaken as soon as is practicable**. The matter will be immediately escalated to the on call consultant who will make arrangements for himself/herself or another on call doctor to immediately attend the ward.

3.2.5 The combined use of rapid tranquillisation and seclusion are to be undertaken with caution. Staff need to be aware of, and be prepared to address, any complications with rapid tranquillisation. The patient will be observed within eye sight by a registered nurse at all times. Consideration to be given to ending seclusion when medication has taken effect, providing the risk to others has reduced to a safe level.

3.2.6 When the decision to seclude a patient has been made, the patient must be taken to the seclusion room as quietly and calmly as possible. Where police assistance is required, the nurse in charge shall retain full responsibility for the patient transfer Staff will ensure that communication is maintained and that patient co-operation is encouraged throughout the process. The use of physical interventions to safely transfer the patient to the seclusion room should be at the minimum required to manage the level of risk present. In terms of the AVERTS programme, this could be lower levels of holding (Level 2) or more robust levels of restriction (level 3) or use of the Emergency Response Belt (ERB) where sanctioned. As always, it will be the presenting high risk behaviours of the person being held that will determine the levels of holding or responses from staff. This is in keeping with all UK national guidance and statute (NICE, 2005, NHS SMS, 2006, Criminal Law Act, 1967).

3.2.7 Each time a patient is secluded, a search (in accordance with BSMHFT policy) will

be carried out on the patient to ensure that they do not have any objects in their possession that could compromise their/others health, safety, or well-being. A clear record of any search and its findings should be included in the Seclusion Record.

3.2.8 All property, belonging to the patient, that is removed must be properly logged in the Seclusion Record and kept safe. The record must specify what was taken, when it was taken, taken by whom, and where placed for safekeeping. The patient should be informed of this information as soon as possible in order to provide reassurance about their belongings.

The following will be removed from the patient and securely stored;

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

3.2.9. A patient in seclusion should 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.

3.2.10 A record of any reported or observable injuries or marks on the patient's body must be made at the commencement of seclusion in the Seclusion Record.

3.2.11 A patient's clothing should never be removed when they are secluded, as long as it compromises neither their safety nor the safety of others. Patients in seclusion will retain as much of their own personal clothing as is compatible with any risk presented and their personal safety needs. What the patient is allowed to take into the seclusion room will be a matter of professional judgement, but they should always be clothed. If any items of clothing are assessed to present a compromise to the patient's safety and/or the safety of others, the specific items should be removed by nurses of the same gender as the patient. Where clothing is removed this should always be replaced with more appropriate clothing dependant on type to maintain the patient's dignity. There are some circumstances whereby special clothing may need to be used to assist in the prevention of risks of self-harm; these are specially designed items of clothing referred to as – 'Anti Rip Clothing.' The decision to use this clothing must take into consideration any existing positive behavioural support plans providing guidance on the safe use of restrictive interventions.

3.2.12 In order to safely end the use of physical interventions and to safely exit the seclusion room:

- The nurse in charge (NIC) of the event must identify and allocate appropriate members of staff to assist in the effective exit from seclusion.

- The exit strategy needs to be clear to all and any decisions made based on the presenting behaviours of the patient.
- The person responsible for monitoring the seclusion room door must control the flow of people going into the seclusion room. Non-essential staff should not be inside the room or loitering in the doorway. The person on the door should manage any potential build-up of people that may impede the safe exit of those in the room.
- It would be appropriate for staff holding onto the patient to take their instruction from the NIC when the decision to leave the room is made. It should be the assessment of the person that determines the decision to exit swiftly or invest time in settling the service user prior to leaving the room.

3.2.13 **All members of the nursing team must be completely clear on the strategy prior to any attempt to leave the seclusion room. Any exit must be in a co-ordinated way and the exit clear as taught on AVERTS training.**

3.3 SECLUSION OTHER THAN IN A SECLUSION SUITE

3.3.1 The Mental Health Act Code of practice 2015 requires that "Seclusion should be in a safe, secure and purpose-specific room that is identified as being for that sole purpose".

3.3.2 There are hospitals sites within BSMHFT which currently have only one seclusion suite and other locations where there are none. Seclusion should occur only in a room or suite of rooms, specifically designed and designated solely for the purpose of seclusion, and serves no other function on the ward. Secluding a service user in another room not specifically designed for the purpose maybe a breach of the COP 2015 (Section 26) unless it can be demonstrated that the action was urgently necessary proportionate and for the minimum safe amount of time, in such circumstances an eclipse form must be completed.

Where seclusion is carried out anywhere else the clinician authorising such seclusion must document cogent reasoned justification in the patient's clinical records. This will be categorised as an untoward clinical incident and should be recorded as such on the Trust incident reporting system, as noted in section 2 – 2.2

3.3.3 The Responsible Clinician or on-call consultant should be informed immediately and there should be an MDT constituted as soon as practicable, The patient in seclusion, if needing continued seclusion, must be moved to a purpose built seclusion suite within the Trust as soon as possible, unless the risks to the patient and/or to others of moving the patient outweigh the risks of remaining in the non-designated seclusion area. There needs to be recognition that movement of patients has its own inherent risks at such times a cogent reasoned justification should be documented by the Responsible Clinician reflecting the views of the MDT, where this is not possible, particularly where a service user might be assessed as requiring a different level of security. In such cases for example, a formal referral must be made to the receiving service (such as a Medium Secure Service) and a bed made available to be admitted to if accepted. The seclusion record must continue between sites as a single seclusion episode.

3.3.4 Where seclusion continues beyond 24 hours in a room not exclusively used for seclusion, the Clinical Director, the Medical Director and the Director of Nursing of

the Trust should be informed by the Responsible Clinician setting out detailed reasoning.

3.3.5 The Medical Director 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.

3.4 THE SECLUSION RECORD AND SECLUSION CARE PLAN

3.4.1 Upon commencement of seclusion it is important that there is on-going consultation between the doctor and nursing staff deciding the initial management of the process and, together with the multi-professional team, establishes a plan of care for the patient which takes account of the necessity for seclusion and care whilst implemented. The care plan should account for the care of the patient whilst in the seclusion room and for occasions when they might temporarily leave the room.

3.4.2 A seclusion record should be completed whenever seclusion is implemented and the episode of seclusion must be recorded on the Trust patient clinical record system RIO

3.4.3 All sections of the seclusion record should be completed contemporaneously during the period of seclusion. It is essential that sections of the seclusion record are completed as soon as practicable on the commencement of seclusion to provide a record of assessment and the authority to seclude a person. If any part of the seclusion record cannot be completed due to the patient's refusal to participate or because it is inappropriate or unsafe (e.g. some physical checks), the reason for not recording the required information is to be noted in the appropriate section of the documentation.

3.4.4 The seclusion record must reflect that the patient has received information about their rights through a verbal explanation by a nurse and also given a patient information leaflet where deemed appropriate and safe, on seclusion and their rights.

3.4.5 After the commencement of seclusion a multidisciplinary seclusion care plan needs to be set as soon as practicable. A seclusion care plan should be the corner stone of patient care during the period of seclusion. It should reflect the patient's views and its aim should be to bring seclusion to an end as soon as practicable. It will set out the steps that should be taken, be reviewed and amended throughout the period of seclusion to reflect the on-going needs of the patient in order to bring seclusion to an end as quickly as possible.

3.4.6 The following sections should be included in a multi-disciplinary seclusion care plan:

- <u>A statement of clinical need including an assessment of risk</u>

  This section provides details of clinical needs including mental health needs, assessment of risk that gave rise to the need for seclusion and treatment objectives.

- <u>Treatment and risk management plan</u>

  This section specifies how the treatment needs will be met and how risks will be managed. This should include the continued use of de-escalation, use of medication, restriction to access to potential weapons, levels of observation and patterns of association. This section should make specific reference to

physical health monitoring (such as B.P, pulse, respiratory rate, Blood Glucose Monitoring).

- Details of bedding and clothing to be provided

  This section specifies the type of clothing and bedding provided to the patient.

- Details of how the patients dietary care is to be provided for

  This section outlines any specific dietary needs and any specific monitoring that is required.

- Activity

  This section identifies and prescribe the activities that should be made available to the patient whilst in seclusion and association. This should include such things as reading materials, entertainment facilities, rehabilitation input, spiritual support, access to physical exercise and specify the conditions under which these are to be facilitated.

- Working towards ending seclusion

  This section includes the specific details of interventions and changes needed for seclusion to end (e.g. length of time for a settled mental state, symptom changes, cessation of threats etc.). The section should also include what pro-active strategies and approaches are to be used to assist this process. This may detail the use of seclusion flexibly to facilitate periods of association on the ward or access to visits which may assist in determining when seclusion can be safely ended.

- Communication with family and carer's.

  This section should include details of any family or carer involvement and how this will be maintained during the period of seclusion.

3.5 OBSERVATION DURING SECLUSION

3.5.1 During seclusion, the role and responsibility of maintaining appropriate observation and communication with the patient will be allocated and undertaken by a Registered Nurse. Arrangements must be in place to ensure that the observing nurse is not isolated when caring for a highly disturbed individual, 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 patient or outside the seclusion room to offer enhanced protection for the patient and staff.

3.5.2 There must be consideration as to the most appropriate gender of the observing staff members(s) taking into consideration a patients clinical needs; for example, trauma history or the presence of disinhibited behaviour. These needs should be identified in the seclusion care plan.

3.5.3 Where CCTV facilities are available within seclusion rooms, their use should never replace direct observation of the patient. However, they may supplement direct observation; for example, where patients have deliberately blocked observation panels. (to record or not to record)

3.5.4 Consistency and stability are significant factors when working with a person who is disturbed and, consequently, it is important to minimise the possibility of adverse effects on the patient by staff changes. However, it is also important that the observing nurse(s) do not undertake this duty for prolonged periods and must take regular breaks, i.e. at least hourly. Wherever there are staff changes with respect to the observation and communication role, there must be a handover between the changing staff and wherever appropriate or possible this should include the patient.

3.5.5 The aim of this observation is to safeguard the patient, monitor their condition and behaviour and to identify the earliest time at which seclusion can be ended. Record of the patient's behaviour must be made every 15 minutes. This is to include, where applicable, the patient's appearance, what they are doing/saying, their mood, awareness and any physical ill health.

3.5.6 Where a person appears to be asleep in seclusion, the person observing the patient must be alert to and assess the level of consciousness and respiratory rate of the patient. The respiration rate must be recorded every 15 minutes as a minimum. If concerned or unable to observe signs of life, a clinical judgement should 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.

3.5.7 A record of fluid and food intake and output should be maintained with the Seclusion Record. All food and drinks should be appropriate to the risk(s) present, e.g. in some situations it might be preferable to offer cold drinks and sandwiches in disposable containers.

3.5.8 At all times there will be at least one member of staff who is the same gender as the patient if staff enter the seclusion room. Prior to entering the seclusion room staff must always communicate their intention to the patient. Each occasion where staff enter the seclusion room must be documented on the Seclusion Record.

3.6 SECLUSION REVIEWS

3.6.1 A series of formal reviews of seclusion are essential to safeguard the rights of the patient, to establish the earliest opportunity to discontinue the episode of seclusion and to review the physical and mental well-being of the patient. These include multi-disciplinary team reviews, nursing reviews and medical reviews.

3.6.2 It is essential that consideration is always given to the use of interpreting services to ensure the service user can participate in these reviews.

3.7 Medical reviews

3.7.1 For the purpose of medical reviews, where the Responsible Clinician is not immediately available, e.g. outside normal working hours the Code Of Practice (paragraph 26.127) allows for "local policies to make provision for a 'duty doctor' (nominated deputy) to deputise for the Responsible Clinician." It requires that the "The policy should also identify which of their doctors is competent to carry out a medical review". For the purpose of this policy a nominated deputy may be a, Senior Trainee, Associate Specialist/Speciality Doctor who has received training in undertaking seclusion reviews. Where the nominated deputy is not a medically Approved Clinician they should be able to discuss the review with a medically Approved Clinician. During working hours this should be the patient's Responsible

Clinician and out of working hours this should be the on call Consultant.

3.7.2 An initial medical review must occur when a patient is secluded. This should ideally be within one hour of seclusion commencing and without delay if the patient is newly admitted, not well known to staff or there has been a significant change in the patient's physical/mental health.

3.7.3 Where seclusion was authorised by a Consultant Psychiatrist the review of the patient prior to their seclusion constitutes the initial medical review. Where seclusion is not authorised by a Consultant Psychiatrist a medical review should be undertaken within one hour. This review should be undertaken by the Responsible Clinician or any medical doctor.

3.7.4 Continuing medical reviews of a secluded patient should be undertaken every four hours following the first medical review until the initial MDT review. Four hourly medical reviews may be undertaken by the Responsible Clinician or any medical doctor.

3.7.5 Following the initial MDT review, further medical reviews should continue at least twice in every 24 hour period and spaced throughout the day. At least one of these needs to be carried out by the patient's Responsible Clinician (or any nominated deputy deputising for the Responsible Clinician, see paragraph 3.7.1).

3.7.6 For the purposes of Responsible Clinician medical reviews, where the Responsible Clinician is not immediately available, e.g. outside of normal working hours or if the Responsible Clinician is off site, a nominated deputy or another Consultant Psychiatrist may carry out the review. Where a nominated deputy, deputises for a Responsible Clinician medical review it should be discussed directly with the Responsible Clinician or another Consultant Psychiatrist.

3.7.7 During weekends and bank holidays it is an expectation that patients in seclusion are seen at least daily by the on call Consultant. However, there may be occasions when this is not possible due to the numbers of patients in seclusion and/or other unplanned urgent work. Under these circumstances it may be necessary for a nominated deputy to deputise for the Responsible Clinician as outlined in paragraph 3.7.1. Or if out of hours a non-consultant doctor may deputise but should discuss the case directly with the supervising medical Approved Clinician and document the discussion in the clinical record.

3.7.8 Medical reviews MUST be carried out in person. They should include, where appropriate:

- A review of physical and mental health of the patient;
- An assessment of any adverse effects of medication;
- A review of the observations required;
- A reassessment of medication prescribed;
- An assessment of the risk posed by the patient to others;
- As assessment of any risk to the patient from deliberate or accidental self-harm;
- An assessment of the need for continuing seclusion and wherever it is possible for seclusion measures to be applied more flexibly or in a less restrictive manner.

3.7.9 Following each medical review there should be a review of the seclusion care plan.

3.8 Nursing reviews

3.8.1 Nursing reviews to be undertaken at least every two hours. These must be undertaken by two registered nurses (Band 5 and above), at least one of whom was not involved in the decision to seclude and should also work on a different ward. In the event of concerns about the patient this will be immediately brought to the attention of the patient's Responsible Clinician or nominated deputy. When a patient in seclusion is asleep reviews may be undertaken in a revised schedule to avoid waking the patient and this should be recorded in the seclusion care plan.

3.9 Multi-disciplinary reviews

3.9.1 Initial MDT review – can be combined with the initial medical review

3.9.2 The initial MDT review to occur as soon as practicable promptly ideally within 1 hour of seclusion commencing. Membership of the MDT should consist of:

- RC (or on-call Consultant out of hours) or an nominated deputy who has been trained in carrying out seclusion reviews and is working under the supervision of a medical Approved Clinician
- The nurse in charge of the ward
- A band 7 nurse if the review is occurring between 09.00hrs and 17.00hrs Monday to Sunday or the designated site senior nurse or link worker outside of these hours
- Another professional where available such as OT, Psychology or Social Worker.
- This MDT will be responsible for formulating the seclusion termination plan

3.9.3 Following commencement of seclusion there should be coordination between clinician's to ensure that if seclusion continues beyond 8 hours, an MDT review MUST occur within the next 24 hours.

3.9.4 However, if for example there are any physical health or risk concerns unscheduled MDT review can be requested by the nurse in charge of the ward at any time and this should be complied with without fail. A medical review could also be requested and this should be complied with promptly without fail

3.10 Subsequent MDT reviews

A multi-disciplinary review should be undertaken where a patient has either been secluded for 8 hours or more consecutively or 12 hours intermittently during a 48 hour period. Flexibility around when the review occurs should be considered to avoid waking a patient at night: however clinical need and risk issues will take priority. This review should also include another professional. The reviewing Team should not have been involved in the original decision to seclude (except the nurse in charge of the ward or RC), and may include an IMHA if available (in cases where the patient has one). Where the patients IMHA is not available to attend the MDT and the seclusion continues, the IMHA is to be invited to attend the next daily MDT. The membership of the daily MDT review during working hours and out of hours should be:

- The medically approved Responsible Clinician or Consultant on-call or nominated deputy;
- A band 7 nurse if the review is occurring 09.00-17.00hrs Monday to Sunday or the designated site senior nurse or link worker outside of these hours
- Another professional who would normally be involved in patient reviews (e.g. Social Worker, Psychologist, Pharmacist or OT);

3.10.1 Thereafter the MDT Review must be conducted daily.

3.10.2 Disagreement at reviews in situations where a review team are unable to unanimously agree about the continuation or discontinuation of seclusion, the reasons for disagreement must be recorded on the review form (NB. the period of seclusion should continue until a 'senior manager' is able to support the review process to establish a consensus review outcome). A member of the review team will contact a 'senior manager' i.e. the Clinical nurse /service manager, Clinical Director or the 'on-call' Trust Executive if none of these are available.

3.10.3 The 'senior manager' will be asked to nominate a senior clinician within the Trust who has not been involved in the decision to commence seclusion, or its periodic reviews, to work with the review team. A member of the review team will then organise a meeting between the review team and appointed senior clinician as soon as possible, but within 2 hours of the disputed review event. The role of the nominated senior clinician is to act as a mediator to address the differences of opinion within the review team, and to gain a consensus / majority decision regarding the continuation or discontinuation of seclusion.

3.10.4 Where seclusion continues for three months or longer, regular three monthly 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 for this purpose another hospital within Birmingham and Solihull Mental Health NHS Foundation Trust.

3.11 ENDING SECLUSION

3.11.1 Seclusion will immediately end when a MDT review, a medical review determines that it is no longer required. Alternatively, where the nurse in charge of the ward determines it is no longer required, seclusion may end following consultation with the Responsible Clinician.

3.11.2 Seclusion ends when a person is allowed both 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.

3.11.3 A record of the decision to discontinue seclusion should be made in the Seclusion Record. Seclusion must always be discontinued when the patient is awake and able to engage with the process. The discontinuation of seclusion must be informed by a thorough risk assessment and following a review of the patients care plan which addresses their subsequent clinical needs and risk management. The 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. The patient's care plan should

identify the observation level and strategy for reintegration of the patient into the unit environment.

3.11.4 A record of any reported or observable injuries or marks on the patient's body must be made at the discontinuation of seclusion in the Seclusion Record.

3.12 Post Incident review

3.12.1 Following the use of seclusion when the risks of harm have been contained, a post-incident review should be undertaken. This should include all involved parties including the patient.

3.12.2 Where a patient is not able to participate, methods for exploring the effects of the seclusion on the patient should be explored as fully as possible. The patient should be given a choice as to who they would like to discuss their experiences with as far as possible. Patient's accounts of their feelings, anxieties or concerns will be fully recorded in the clinical record and should inform subsequent care and care plans updated accordingly.

3.13 SEGREGATION

3.13.1 Definition of segregation

3.13.2 Segregation refers to a situation where, in order to reduce a sustained risk of harm posed by the patient 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 patient should not be allowed to mix freely with other patients on the ward or unit on a long term basis, however patients should not be isolated from contact with staff or deprived of access to therapeutic interventions . In such cases, it should 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.

3.13.3 The clinical judgement is that, if the patient 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.

3.14 Physical environment for segregation

Patients in segregation whose contact from the general ward is limited, should be able to freely 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 allows.

3.15 Authority for segregation

The decision to use segregation should be planned and after careful assessment of the patient's clinical needs and assessment of risk. This would 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 IMHA (where the patient has one). Where appropriate, the views of the patient's family and carers should be taken into account. When a decision is taken to nurse a patient in segregation a safeguarding alert should be raised as soon as possible.

3.16 The segregation care plan

A segregation record must be maintained whenever segregation is implemented. The episode will be recorded on the patient clinical recording system (RiO). In most cases segregation will follow a period of seclusion and the segregation record should be a continuation of the seclusion record.

The care plan should include:

- A statement of clinical need including an assessment of risk

  This section provides details of clinical needs including mental health needs, assessment of risk that gave rise to the need for segregation and treatment objectives.

- Treatment and risk management plan

  This section specifies how the treatment needs will be met and how risks will be managed. This should include the continued use of de-escalation, use of medication, restriction to access to potential weapons, levels of observation and patterns of association. This section should make specific reference to physical health monitoring (such as B.P, pulse, respiratory rate, BM). It should also specify how segregation reviews should be conducted (see below).

- Details of bedding and clothing to be provided

  This section specifies the type of clothing and bedding provided to the patient.

- Details of how the patients dietary needs are to be provided for

  This section outlines any specific dietary needs and any specific monitoring that is required.

- Activity

  This section identifies and prescribe the activities that should be made available to the patient whilst in segregation. This should include such things as reading materials, entertainment facilities, rehabilitation input, spiritual support, access to physical exercise and specify the conditions under which these are to be facilitated.

- Working towards ending segregation

  This section includes the specific details of interventions and changes needed for seclusion to end (e.g. length of time for a settled mental state, symptom changes, cessation of threats etc.). The section should also include what pro-active strategies and approaches are to be used to assist this process. This may detail the use of segregation flexibly to facilitate periods of association on the ward or access to visits which may assist in determining when segregation can be safely ended.

- Communication with family and carer's.

  This section includes details of any family of carer involvement and how this will be maintained during the period of segregation.

3.17 Observation during segregation

Patients who are subject to segregation should be able to freely mix with observing nursing staff. Therefore, it is essential that the number of nursing staff observing the patient is determined according to the patient's assessed level of risk. Patients subject to segregation should never be observed with less than two nursing staff (observation level should be based upon clinical need). This should be recorded in the nursing observation section of the patient electronic record and the segregation care plan.

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

3.18 Reviews of segregation

3.18.1 Patients subject to segregation should be reviewed formally by an approved clinician at least once in every 24 hour hours and at least weekly by the full multi-disciplinary team. Multi-disciplinary reviews should include the patient's Responsible Clinician, the nurse in charge of the ward, another professional (e.g. social worker, psychologist, OT) and an IMHA.

3.18.2 The patient's treatment plan should specify the way the patient's situation should be reviewed and this should reflect the specific nature of the management plan. In some circumstances, e.g. during weekends, the daily formal review by the approved clinician could be undertaken over the telephone in consultation with the Nurse in Charge.

3.18.3 Where segregation continues for three months or longer, regular three monthly 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 for this purpose another hospital within Birmingham and Solihull Mental Health NHS Foundation Trust. The relevant commissioning body should also be informed i.e. Clinical Commissioning Group (CCG) or NHS England

4 RESPONSIBILITIES

Post(s)	Responsibilities	Ref
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	
The Restrictive Intervention Reduction programme and the Trust Clinical Governance teams	Responsible for the monitoring of adherence to this policy through regular audit. Responsible for monitoring training and educational needs to support staff.	

5 DEVELOPMENT AND CONSULTATION PROCESS

Consultation summary		
Date policy issued for consultation		July 2016
Number of versions produced for consultation		8
Committees or meetings where this policy was formally discussed		
Positive and Pro-active Care Group		April 2015
Where else presented	**Summary of feedback**	**Actions / Response**
Trust CGC	Reviewed in July 2016	For further review once policy has been utilised across organisation

6 REFERENCE DOCUMENTS

- Mental Health Act Code of Practice (2015)
- NICE NG10 available at: **https://www.nice.org.uk/guidance/ng10**
- NICE (2005)
- NHS SMS (2006)
- Criminal Law Act (1967)

7 BIBLIOGRAPHY

- Mental Health Act Code of Practice (2015)
- NICE NG10 available at: **https://www.nice.org.uk/guidance/ng10**
- NICE (2005)
- NHS SMS (2006)
- Criminal Law Act (1967)

8 GLOSSARY

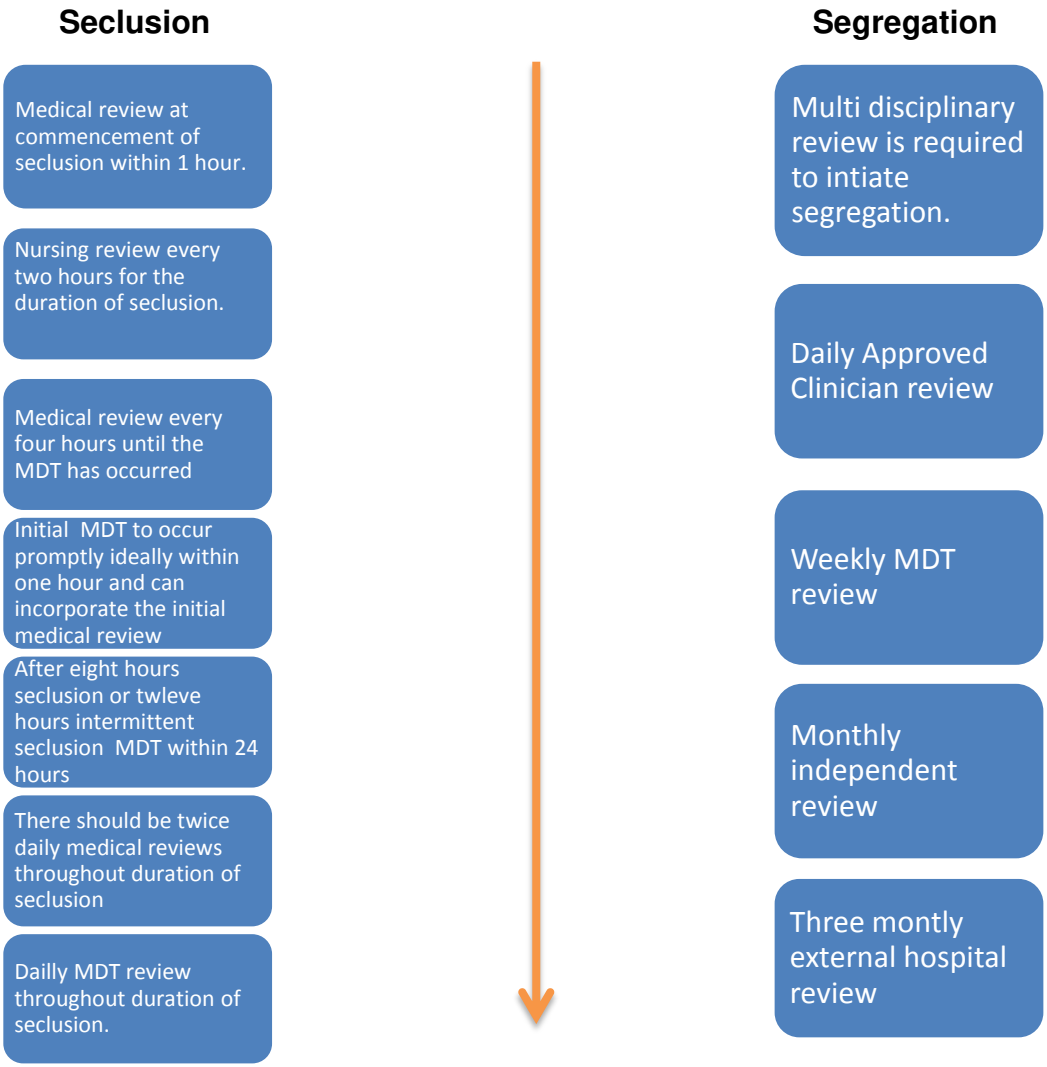
- CNM (Clinical Nurse Manager)
- CSM (Clinical Service Manager)
- IMHA (Independent Mental Health Advocacy)
- MDT (Multi-Disciplinary Team)

9 AUDIT AND ASSURANCE

Element to be monitored	Lead	Tool	Frequency	Reporting Arrangements	Acting on Recommendations and Lead(S)	Change in Practice and Lessons to be shared
Policy implementation	Dave Austen	Audit of episodes of seclusion	Bi Annually	To be reported to CGC	Stuart Wix DDoN	Policy Review date or sooner if required
Ethnicity & Diversity	Stuart Wix	Seclusion check list	Bi Annually	To be reported to CGC	Stuart Wix DDoN	Policy Review date or sooner of required
Seclusion Record	Stuart Wix	Seclusion Records	Random Sampling	To be reported to CGC	Stuart Wix DDoN	Policy Review date or sooner of required

10 APPENDICES

APPENDIX 1 OVERVIEW OF REVIEWS FOR SECLUSION AND SEGREGATION



APPENDIX 2 SUMMARY OF SECLUSION REVIEWS

When	Type of review	By whom	Policy reference
Commencement of seclusion.	There should be a medical review within one hour if seclusion was not authorised by a psychiatrist. This can be combined with the Initial MDT review	The Responsible Clinician or an nominated deputy	3.7.2 – 3.7.3
Every two hours	There should be a review by two nurses throughout seclusion.	Two registered nurses, one of who has not been involved in initiating seclusion and is from a different ward.	3.8.1
Every four hours until the initial MDT	There should be a medical review.	The Responsible Clinician or a nominated deputy.	3.7.4
Promptly, ideally within one hour of commencement	There should be an Initial MDT.	• RC (or on-call Consultant out of hours) or an nominated deputy r who has been trained in carrying out seclusion reviews and is working under the supervision of a medical Approved Clinician • The nurse in charge of the ward • A band 7 nurse if the review is occurring between 09.00hrs and 17.00hrs Monday to Sunday or the designated site senior nurse or link worker outside of these hours • Another professional where available such as OT, Psychology or Social Worker.	3.10.1
After eight hour's consecutive seclusion an MDT MUST take place within 24 hours and daily thereafter	There should be an MDT.	• RC or on-call Consultant out of hours (if, out of hours, it is impractical for the on-call consultant to carry out all necessary reviews, a non-consultant doctor may deputise but should discuss the case directly with the supervising medical Approved Clinician and document the discussion in the case record). • The nurse in charge of the ward • A band 7 nurse if the review is occurring 09.00-17.00hrs Monday to Sunday or the designated site senior nurse or link worker outside of these hours • Another professional such as an OT, Psychologist or Social Worker • An IMHA if available	3.12.1
Twice daily	Medical review	One of these should be undertaken by the Responsible Clinician. Where the Responsible Clinician is not available a nominated deputy may deputise for the RC.	3.7.5

APPENDIX 3 SUMMARY OFSEGREGATION REVIEWS

When	Type of review	By Whom	Policy reference
The decision to initiate segregation	Multi-disciplinary.	Responsible Clinician, other members of the multi-disciplinary team, a representative from the responsible commissioning authority and an IMHA (where one is involved)	3.15.1
Daily	Formal review of patient's situation. The nature of this review (which may not be a face to face review) should be guided by the patients care plan.	An approved clinician/Consultant Psychiatrist	3.20.1
Weekly	Multi-disciplinary.	Responsible Clinician, other members of the multi-disciplinary team.	3.20.1
Monthly	Independent review	Another Consultant Psychiatrist.	3.20.3
Three monthly	External hospital review.	Representative from an external hospital who should liaise with representative from the responsible commissioning authority and an IMHA (where one is involved).	3.20.4

APPENDIX 4 SECLUSION ROOM STANDARDS

1. Seclusion should 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 should:

    - 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 should 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.
    - A clock should be visible to the patient from within the room.

3. There should be arrangements for safe use of a telephone to enable contact with family, carer and legal representatives.

APPENDIX 5 TRAINING

1. Staff must have received appropriate education and training to prepare them to be able to work with patients who may present with disturbed behaviours. This will include how to recognise the early signs of disturbed behaviour, the use of de-escalation and the safe use of seclusion and segregation.

APPENDIX 6 GUIDELINES ON GOOD PRACTICE AND PATIENTS' RIGHTS

1. Patients' rights whilst in seclusion

Patients 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 downloaded from the Trust intranet. 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 patient:

- 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 patient's clinical notes of the patient having been given these rights accordingly.

2. Carers and Relatives

Once a patient has been placed in seclusion the clinical team should consider the need to inform the nearest relative and or significant other /carer. Such a decision must however take into account the patient's own wishes and right to confidentiality. In circumstances where a young person is designated a "looked after child" then the local authority responsible must be notified.

3. **Care Quality Commission**

   Members of the Commission and staff employed by them may request to see a patient in Seclusion.

4. **Independent Mental Health ACT Advocate**,

   Patients should be notified that they are entitled to see an IMHA and this should be facilitated

5. **Visits by Medical Officers and Approved Mental Health Practitioners (AMHP)**

   Medical staff and AMHPs should be allowed to visit patients in Seclusion if they ask to do so, however, the risks associated with this must be communicated to the persons concerned. Visits could be limited to talking to the patient through an open hatch where risks are high.

6. **Meeting spiritual, ethnicity and diversity needs**

   Service users will be provided with support in access to chaplaincy services and support in meeting their spiritual needs. This should include all aspects of Ethnicity and Diversity needs.

7. **Access to legal Representative**

   Patients who are in seclusion who wish to contact their legal representative can do in the following way;

   A patient can access their solicitor or legal representative while they are in seclusion

   A patient will be allowed to send messages via the advocate to their legal representative

   Access to a cordless telephone will be provided and given to the patient following a risk assessment and management plan to reduce any risks.

   Following discontinuation of seclusion the patient will be offered access to make a free phone call to contact their legal representative in privacy.

8. **Legal Status**

   Seclusion may be used on informal patients provided that it is used to protect others from immediate risk or harm, in accordance with paragraph 4 above. Seclusion of an informal patient should be taken as an indicator of the need to consider formal detention, and a Mental Health Act assessment arranged where applicable.

If detention of a Secluded Informal patient is not considered appropriate then discharge of the patient from hospital must be considered and police assistance may need to be requested, with possibly the person being taken into police custody in line with local agreements between the NHS Securities Management Service and West Midlands Police.

Seclusion has recently been confirmed in law as a “medical treatment” under the Mental Health Act (Section 63) and as such, may be imposed upon a detained patient without the need for patients consent.

9. **Human Rights Act Issues**

Seclusion will be lawful in principle, provided:

- There is lawful detention as under the Mental Health Act; or
- Seclusion of an informal patient can be justified under common law, to protect from the immediate risk of significant harm; and in any event.
- Seclusion is defined as medical treatment when reasonably necessary; and
- Seclusion is compatible with the Human Rights Act 1998; and The Seclusion used complies with the procedural safeguards set out in this policy

APPENDIX 7 GUIDELINES ON THE MENTAL HEALTH ACT CODE OF PRACTICE 2015

The Mental Health Act Code of Practice 2015 was produced after consultation which preceded the drawing up of the Code, and received parliamentary sanction. The Code was issued by the Secretary of State as the public officer responsible for the National Health Service. It considers the high importance of protecting detained mentally ill patients, a vulnerable and defenceless sector of society, from any risk of abuse. This currently expressly requires that seclusions occur only in rooms solely used for this purpose.

The issue of compliance with the code with regard to seclusion has been considered by the House of Lords appellate committee in the case of .Regina v. Ashworth Hospital Authority (now Mersey Care National Health Service Trust), (Appellants) ex parte Munjaz (FC) (Respondent) Appellate Committee, Lord Bingham of Cornhill. Lord Steyn.Lord Hope of Craighead. Lord Scott of Foscote. Lord Brown of Eaton-under-Heywood, [2005] UKHL 58.The House of Lords Appellate committee allowed deviation from the code of practise with regard to seclusion by a majority of 3:2 in exceptional circumstances.

LORD BINGHAM OF CORNHILL delivering his judgment in support of allowing Ashworth Hospital to deviate from the code of practice in regard to seclusion noted:

"Code does not have the binding effect which a statutory provision or a statutory instrument would have. It is what it purports to be, guidance and not instruction. But the matters relied on by Mr Munjaz show that the guidance should be given great weight. It is not instruction, but it is much more than mere advice which an addressee is free to follow or not as it chooses. It is guidance which any hospital should consider with great care, and from which it should depart only if it has cogent reasons for doing so". He also held that "If a practice is supported by cogent reasoned justification, the court is not entitled to condemn it as unlawful".

LORD STEYN delivering the dissenting judgment noted:

"*Parliament had authorised a Code with some minimum safeguards and a modicum of centralised protection for vulnerable patients. This is inconsistent with a free-for-all in which hospitals are at liberty to depart from the published Code as they consider right. Indeed, it seems unlikely that Parliament would have authorised a regime in which hospitals may as a matter of policy depart from the Code. After all that would result in mentally disordered patients being treated about seclusion in a discriminatory manner, depending on the policy adopted by the managers and clinicians in particular hospitals."*

APPENDIX 8 SECLUSION RECORD – SERVICE USER WELL BEING & SECLUSION ROOM STANDARDS HOURLY CHECK

Please fill in every hour for the service user in seclusion. For most checks a simple "Yes" or "No" is required. If you are entering "No" into any of the boxes please explain your rationale & action plan in the action box at the bottom.

Service User Name: **DOB:** **RiO No:** **Ethnicity**

Date:	Time(24hr clock):						
The room is:							
Free from dangerous objects and fittings?							
Has natural daylight?							
Has a view of the horizon?							
Has a temperature of (^{0}C):							
Temperature controls are working?							
Has good ventilation?							
Has fresh air into the room?							
Has a mattress in it?							
Has bed linen available?							
The service user:							
Has sight of a clock?							
Has easy access to a bathroom for toilet and washing?							
What is the patient's level of consciousness? (AVPU scale)							
Respirations have been recorded?							
Pulse rate has been recorded?							
Temperature has been recorded?							
Blood pressure has been recorded							
Fluid & food have been offered in the last hour? (add to Fluid/diet record)							
Has used the toilet in the last hour? (record on Bladder/bowel movement chart)							

Has washed in the last hour?						
Is appropriately clothed?						
Action Plan: (*List any actions to correct deficits*)						
Staff Name:						
Staff Signature:						

APPENDIX 9 SECLUSION RECORD: SECLUSION KEY ALLOCATION

Please ensure you are recording the handover of the seclusion room key every hour in the table below.

Date:	Time:	Name of staff:	Signature:

APPENDIX 10 SECLUSION RECORD: DIET AND FLUID RECORDING CHART

Please record any diet/fluid taken by the patient in seclusion in the tables below.

Any allergies/Sensitivities please state:

Any considerations/instructions for taking of diet (e.g. spoon/fork/Finger food only/special cups for fluid etc.) please document below:

Please state specific amounts eaten e.g. 2 spoonful's, ½ a bowl, 200ml fluid.

Date:

Time:	Time:	Time:	Time:	Time:	Total:
Signature:					
Print Name					

Date:

Time:	Time:	Time:	Time:	Time:	Total:
Signature:					
Print Name					

Date:

Time:	Time:	Time:	Time:	Time:	Total:
Signature:					
Print Name					

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Signature:					
Print Name					

Date:

Time:	Time:	Time:	Time:	Time:	Total:
Signature:					
Print Name					

APPENDIX 11 SECLUSION RECORD OF SLEEP ACTIVITY AND RESPIRATIONS

Record sleep activity over an hour and respiration rate every 15 minutes.
It is not enough to assume that because a service user is ambulant that their respiration rate is normal. If a service user is snoring then this may be a sign that their airway is obstructed and an ABCDE assessment should take place.
Sleep Activity Key: S= sleeping R= resting A= awake & alert

Service User Name		DOB		RiO No.	

Date						Date					
Time of Day	Sleep Activity	Respiration Rate (Breaths/min)				Time of Day	Sleep Activity	Respiration Rate (Breaths/min)			
		00 min	15 min	30 min	45 min			00 min	15 min	30 min	45 min
00:00						00:00					
01:00						01:00					
02:00						02:00					
03:00						03:00					
04:00						04:00					
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Once complete file this form in the service user clinical notes.