Mersey Care NHS
NHS Trust

TRUST-WIDE CLINICAL POLICY

POLICY AND PROCEDURE FOR THE USE OF SECLUSION AND LONG TERM SEGREGATION

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TRUST-WIDE CLINICAL POLICY

v3

Quality, recovery and wellbeing at the heart of everything we do

Mersey Care NHS Trust

TRUST-WIDE POLICY

POLICY AND PROCEDURE FOR THE USE OF SECLUSION AND LONG TERM SEGREGATION

Further information about this document:

Document name	**Policy and procedure for the use of seclusion and long term segregation – SD28**
Document summary	**This policy and procedure provides clear guidance on the use of seclusion and long-term segregation within Mersey Care NHS Trust.** **It allows the Trust to demonstrate that the use of restrictive practices meet and uphold the guiding principles of the Mental Health Act Code of Practice (2015) and that they remain proportionate, least restrictive, last for no longer than is necessary, and take account of patient preference wherever possible.**
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Published by Copies of this document are available from the Author(s) and via the trust's website	**Mersey Care NHS Trust** **8 Princes Parade** **Princes Dock** **St Nicholas Place** **Liverpool** **L3 1DL** **Your Space Extranet: http://nww.portal.merseycare.nhs.uk** **Trust's Website www.merseycare.nhs.uk**
To be read in conjunction with	**Mental Health Act 1983 Code of Practice (2015)** **NICE Guidance NG10 (May 2015)** **SD04 - Management of clinical risk through supportive observation** **SD11 - Policy on use of Rapid Tranquilisation**
This document can be made available in a range of alternative formats including various languages, large print and braille etc	

Version Control:

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SD28 v2	Ratified by Corporate Document Review Group	April 2014
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SUPPORTING STATEMENTS – this document should be read in conjunction with the following statements:

SAFEGUARDING IS EVERYBODY'S BUSINESS

All Mersey Care NHS Trust employees have a statutory duty to safeguard and promote the welfare of children and vulnerable adults, including:

- being alert to the possibility of child/vulnerable adult abuse and neglect through their observation of abuse, or by professional judgement made as a result of information gathered about the child/vulnerable adult;
- knowing how to deal with a disclosure or allegation of child/adult abuse;
- undertaking training as appropriate for their role and keeping themselves updated;
- being aware of and following the local policies and procedures they need to follow if they have a child/vulnerable adult concern;
- ensuring appropriate advice and support is accessed either from managers, *Safeguarding Ambassadors* or the trust's safeguarding team;
- participating in multi-agency working to safeguard the child or vulnerable adult (if appropriate to your role);
- ensuring contemporaneous records are kept at all times and record keeping is in strict adherence to Mersey Care NHS Trust policy and procedures and professional guidelines. Roles, responsibilities and accountabilities, will differ depending on the post you hold within the organisation;
- ensuring that all staff and their managers discuss and record any safeguarding issues that arise at each supervision session

EQUALITY AND HUMAN RIGHTS

Mersey Care NHS Trust recognises that some sections of society experience prejudice and discrimination. The Equality Act 2010 specifically recognises the *protected characteristics* of age, disability, gender, race, religion or belief, sexual orientation and transgender. The Equality Act also requires regard to socio-economic factors including pregnancy /maternity and marriage/civil partnership.

The trust is committed to equality of opportunity and anti-discriminatory practice both in the provision of services and in our role as a major employer. The trust believes that all people have the right to be treated with dignity and respect and is committed to the elimination of unfair and unlawful discriminatory practices.

Mersey Care NHS Trust also is aware of its legal duties under the Human Rights Act 1998. Section 6 of the Human Rights Act requires all public authorities to uphold and promote Human Rights in everything they do. It is unlawful for a public authority to perform any act which contravenes the Human Rights Act.

Mersey Care NHS Trust is committed to carrying out its functions and service delivery in line the with a Human Rights based approach and the FREDA principles of **F**airness, **R**espect, **E**quality **D**ignity, and **A**utonomy

CONTENTS

1 PURPOSE AND RATIONALE

1.1 Mersey Care NHS Trust is one of three Trusts in England that incorporates a range of high secure, medium secure, low secure and psychiatric intensive care mental health services, in addition to a range of adult, older peoples and learning disability services. Mersey Care NHS Trust comprises of two clinical divisions; namely the secure division and the local division. This policy applies to all inpatient areas of the Trust.

1.2 The Mental Health Act 1983 requires that anybody working within the framework of mental health 'shall have due regard for the Code (of Practice)' (s.118(2D)). Consequently, in relation to seclusion and long-term segregation, departure from the Code is only authorised under exceptional, justifiable circumstances, and only where there are cogent reasons for doing so. The statutory scheme, while providing for the Secretary of State to give guidance, deliberately left the power and responsibility of final decision-making to those who bear the legal and practical responsibility for detaining, treating, nursing and caring for the patients. The Trust's policy defines a procedure for seclusion and long-term segregation which does not permit arbitrary or random decision-making and, furthermore, ensures that the rules are accessible, foreseeable and predictable.

1.3 The Trust recognizes the importance of the Code and has incorporated its principles into this policy. It is the responsibility of all members of the Patient Care Team and their managers to ensure that seclusion and long-term segregation is used as described within this policy. They are also responsible for ensuring that they record, monitor and review their use of seclusion and long-term segregation and collaborate with the managerial arrangements for monitoring these within their services.

1.4 Unless otherwise stated, all references to the '*Code'* or '*Code of Practice'* given throughout this policy refer to the 2015 edition of the Mental Health Act 1983 Code of Practice, with all references to 'Chapter xx.xxx' relating to the specific chapter and section of the Code.

1.5 It is recognized that different areas of the trust use differing terminology when it comes to patients/service users. For the purpose of this policy the term 'patient' has been used for no other reason that this is the term used within the Mental Health Act (1983) and throughout the Code of Practice (2015)

2 AIMS and OBJECTIVES

2.1 To provide clear guidance on the use of seclusion and long-term segregation

2.2 To ensure restrictive practices remain proportionate, least restrictive, last for no longer than is necessary, and take account of patient preference wherever possible [NICE NG10, 2015]

2.3 To ensure inpatient areas have robust and transparent governance processes that support, monitor, advise and report on the use of the restrictive practices of seclusion and long-term segregation

2.4 To meet and uphold the guiding principles of the Mental Health Act Code of Practice as highlighted in Chapter 26.110. These are to

- ensure the physical and emotional safety and wellbeing of the patient
- ensure that the patient receives the care and support rendered necessary by their seclusion both during and after it ahs taken place
- designate a suitable environment that takes account of the patient's dignity and physical wellbeing
- set out the roles and responsibilities of staff
- set requirements for the recording, monitoring and reviewing of the use of seclusion and any follow-up action

2.5 To support the Trust commitment to reducing restrictive interventions [Chapter 26.6] and its strive for perfect care.

3 SCOPE

3.1 This policy applies to all staff employed in Mersey Care NHS Trust.

4 DEFINITION OF SECLUSION and LONG-TERM SEGREGATION

4.1 Seclusion in this policy is as defined in Chapter 26.103 of the Code of Practice and is held to be

"the supervised confinement and isolation of a patient, away from other patients, in an area from which the patient is prevented from leaving, where it is of immediate necessity for the purpose of the containment of severe behavioural disturbance which is likely to cause harm to others"

The Trust also notes Chapter 26.104 of the Code of Practice which states that

"if a patient is confined in any way that meets the definition above, even if they have agreed to or requested such confinement, they have been secluded and the use of any local or alternative terms (such as 'therapeutic

isolation') or the conditions of the immediate environment do not change the fact that the patient has been secluded".

4.2 Long-Term segregation in this policy is as defined in Chapter 26.150 of the Code of Practice and is held to be where

"a patient should not be allowed to mix freely with other patients on the ward or unit on a long-term basis. 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. The clinical judgment 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"

5 DUTIES and RESPONSIBILITIES

Trust Board. The trust board is responsible for ensuring that a policy is in place that governs the safe and appropriate use of seclusion and long-term segregation via its governance arrangements and that all staff working in the trust are aware of, and operate within the policy.

Medical Director. The Medical Director is responsible for ensuring that all medical staff are aware of, and operate within the policy and procedure for the use of seclusion and long-term segregation.

Executive Director of Nursing. The Executive Director of Nursing is responsible for ensuring mechanisms are put in place to ensure nursing and allied health professionals within the services are aware of and comply with the requirements of the policy and procedure for the use of seclusion and long-term segregation.

Seclusion Monitoring Group. The Seclusion Monitoring Groups within the Divisional governance structures of the Trust have the responsibility to ensure that the use of seclusion and long-term segregation is reported on to their governance boards in line with agreed governance structures. They also have the responsibility to support and advise on the use of seclusion and long-term segregation within their Division, and to ensure compliance with the Code of Practice, relevant guidance and best practice.

Divisional Directors. The Divisional Directors are responsible for ensuring that all managed staff members are aware of and operate within the policy and procedure for the use of seclusion and long-term segregation, whilst also ensuring that staff members attend any mandatory training and that there is appropriate performance monitoring

Modern Matrons. Modern Matrons have the responsibility for monitoring the adherence to the policy and procedure for the use of seclusion and long-term segregation within their service on a daily basis. There is responsibility for ensuring that any appropriate training associated with the use of seclusion and long-term segregation within the Trust is undertaken by nursing staff within their service

Multi-Disciplinary Teams. It is an essential duty of the multi-disciplinary team that the use of seclusion and long-term segregation within their areas of responsibility is managed in accordance with this policy and procedure, and that they participate fully in the monitoring and review arrangements contained within it.

Nurse in Charge of the Ward. The nurse in charge of the ward is responsible for managing any incident of seclusion or long-term segregation in accordance with this policy and procedure.

All staff. All staff within the Trust with front-line exposure to patients have a responsibility to provide care in accordance with this policy and procedure.

6 PROCEDURE FOR SECLUSION

This section covers the following areas

- Principles of Seclusion
- Commencement of Seclusion
- Observations and Record Keeping
- Needs and Risk Management
- Reviews of Seclusion
- Termination of Seclusion
- Patient Engagement and Experience
- Medication
- Self-Harm
- Visits
- Appeal
- Voluntary Confinement
- Specific Short-Term Confinement/Restrictions
- Monitoring Arrangements

6.1 PRINCIPLES OF SECLUSION

6.1.1 The Code of Practice requires providers to have procedures which provide clear written guidance on “how restrictive interventions which are used should be authorised, initiated, applied, reviewed and discontinued, as well as how

the patient should be supported throughout the duration of the application of the restrictive intervention" [Chapter 26.7]

6.1.2 The nature and manner in which seclusion is used, the reason for its use, and the consequences or outcome should be recorded in an open and transparent manner [Chapter 26.64]

6.1.3 In order to ensure that seclusion measures have a minimal impact upon a patient's autonomy, seclusion should be applied flexibly and in the least restrictive manner possible, considering the patient's circumstances. In cases of prolonged seclusion such flexibility, following risk assessment, may include allowing patients to receive visits, provide access to secure outside areas, or to have meals in the general areas of the ward [Chapter 26.111]

6.1.4 Seclusion should be used as a last resort and for the shortest length of time possible

6.1.5 Seclusion should not be used as either a punishment or a threat, or because of a shortage of staff. Nor should it form part of a treatment programme [Chapter26.107]

6.1.6 Seclusion should only take place in a room or suite of rooms that have been specifically designed and designated for the purposes of seclusion and which serve no other function on the ward. [Chapter 26.105]. However, in exceptional circumstances and for cogent clinical reasons it may be considered more therapeutic and less restrictive to manage a patient requiring isolating from peers and/or staff in their own bedroom (see section 6.4.10)

6.1.7 The Trust is committed to working towards ensuring that designated seclusion rooms meet the criteria identified within the Code [Chapter 26.109] in that they will

- allow for communication with the patient when they are in the room and the door is locked
- have limited furnishings which should include a bed, pillow, mattress, and blanket or covering
- not have any apparent safety hazards
- have robust and reinforced windows that provide natural light (and where possible the window should be positioned to enable a view outside)
- should have externally controllable lighting, including a main light and subdued lighting for night time
- have robust doors which open outward
- have externally controlled heating and/or air conditioning, which enables those observing the patient to monitor the room temperature
- not have any blind spots
- have a clock visible to the patient from within the room
- have access to toilet and washing facilities

6.1.8 Seclusion should never be used solely as a means of managing self harming behaviour. [Chapter 26.108] (See section 6.9)

6.1.9 The locking of patients in their rooms at night in high secure services in accordance with the High Security Psychiatric Services Directions (DoH, 2013) does not constitute seclusion. [Chapter 26.105]

6.1.10 In high secure services where it is considered necessary to seclude a patient at night who is normally managed under the High Secure Policy for Night Time Confinement, then such patients must be managed in accordance with this seclusion policy.

6.1.11 Seclusion should only be used in relation to patients detained under the Act. "If an emergency situation arises involving an informal patient and, as a last resort, seclusion is necessary to prevent harm to others, then an assessment for an emergency application for detention under the Act should be undertaken immediately". [Chapter 26.106]

6.2 COMMENCEMENT OF SECLUSION

6.2.1 Authorisation for the decision to implement seclusion can be made by either the nurse in charge of the ward, a psychiatrist, or an approved clinician [Chapter 26.112]

6.2.2 The person authorising seclusion should have seen the patient immediately prior to the commencement of seclusion [Chapter 26.114]

6.2.3 If the decision to seclude was not made by the patient's Responsible Clinician (RC) then the patient's RC or duty doctor should be informed as soon as practicable [Chapter 26.112]

6.2.4 On commencement of seclusion the nurse in charge of the ward will immediately notify

- The appropriate doctor who should attend for a medical review within one hour or without delay if the patient is newly admitted, or not well known, or there is a significant change in their usual presentation [Chapter 26.116]

- The senior nurse on duty (to be locally determined) who will attend the ward.

6.2.5 If the seclusion was authorised by a psychiatrist the first medical review will be that undertaken immediately prior to the commencement of seclusion. Therefore there will be no need for a further review within one hour [Chapter 26.116]

6.2.6 On being informed of the need to attend for an initial assessment/review of seclusion the doctor must make every effort to attend within an hour. This initial review should take priority over routine tasks and any potential or anticipated delay in meeting the hour deadline should be discussed with the Consultant on-call and Silver on-call. This is to ensure that the delay is

considered reasonable and appropriate given other competing clinical priorities.

6.2.7 Any occasion where a doctor fails to arrive for an initial assessment/review of seclusion within an hour will result in the nurse in charge completing a DATIX incident form that will be reviewed by senior managers. (This should be recorded as a Category C - Service provision failure).

6.2.8 The nurse in charge should decide what the patent can take into the seclusion area/room; noting that the patient should never be deprived of clothing. [Chapter 26.113]

6.2.9 It is considered good practice that there should normally be a minimum of three staff present before the seclusion room door is opened to a secluded patient.

6.2.10 If safe to do so (taking into account the clinical presentation of the patient and the risks identified) the doctor attending for the first review following the commencement of seclusion should physically examine the patient in the seclusion room.

6.2.11 A clinical assessment of risk must be undertaken for all patients in seclusion and if the decision following the initial medical review is that seclusion should continue, then a seclusion care plan should be developed [Chapter 26.129] and placed in the patient's healthcare record. As a minimum the care plan must include

- Assessment and management of risks presented
- Steps to be taken towards the safe termination of seclusion as soon as is practicable.
- The patient's communication needs
- Clothing/bedding needs
- Any reviews of medication required
- Details of access to personal hygiene/toileting facilities
- Details of access to or restrictions to eating utensils and reading materials
- Assessment of fluid and nutritional needs. Note that fluids should be offered to the patient every hour and recorded on a fluid chart if fluid input is considered a specific physical need or concern
- The monitoring of a patient's physical condition when parenteral medication (either deport or emergency medication or rapid tranquilisation) has been, or is due to be administered
- The minimum number of staff that are required to enter the seclusion room (see 6.2.9 above)
- Reference to a positive behavioural support plan or advanced statement
- The patients views regarding his/her being secluded
- Information about how relatives or carers are to be kept informed (dependent upon previously agreed positive behavioral plans or advanced statements)

6.2.12 Attempts should be made to include the patient in the development of the seclusion care plan at the earliest opportunity [Chapter 26.148]. These attempts should be documented in the patient's healthcare record. If the patient is unwilling or not able to contribute to the development of the plan then the plan should be explained to them.

6.2.13 The patient should be provided with a copy of the care plan unless clinically contra-indicated. Such decisions to withhold care plans should be documented in the patient healthcare record.

6.2.14 The nurse in charge of the ward is responsible for ensuring the seclusion room is of an acceptable standard with respects to cleanliness, ventilation, lighting, heating and safety before a patient is secluded within it.

6.2.15 The nurse in charge of the ward is responsible for ensuring that any potential hazards or risks identified within the environment are brought to the attention of the Responsible Clinician or duty doctor and senior nurse on duty immediately, so that risk management strategies can be identified to ensure the continued safety of the patient during seclusion.

6.2.16 The nurse in charge of the ward is responsible for ensuring that all documentation and observation forms/records have been completed correctly.

6.2.17 Family members should be notified of the use of seclusion if previously agreed in either a positive behavioral support plan or advanced statement.

6.2.18 Each division will ensure that all records pertaining to seclusion will be kept as part of an identified seclusion reporting system

6.2.19 The nurse in charge of the ward, or ward manager as appropriate, must ensure there is provision for staff/patient support and de-brief after an incident resulting in the use of seclusion in the form of individual/group discussion and/or clinical supervision.

6.3 OBSERVATIONS AND RECORD KEEPING

6.3.1 Immediately after the commencement of seclusion, the Nurse in Charge will place the patient on a minimum of continuous eyesight observation (Level 3 as defined in SD04 – Management of Clinical Risk through Supportive Observations). These observations must be undertaken by a qualified nurse. A collaborative decision will then be made between the Doctor and the Nurse in charge of the ward as to the appropriate level of observations required.

6.3.2 Throughout the period of seclusion there must be a suitably skilled professional readily available within sight and sound of the seclusion area at

all times [Chapter 26.118] and who has the means of summoning urgent assistance if required [Chapter 26.119]

6.3.3 The level of observation of the patient is to be decided on an individual basis but must be at intervals of no longer than 15 minutes and recorded on the seclusion observation form.

6.3.4 The aim of these observations is to safeguard the patient, monitor and report on their condition and behaviour, and to help identify the earliest time at which seclusion can end [Chapter 26.121].

6.3.5 In recording these observations, the staff should remain mindful of recording relevant issues such as patient appearance, mood, level of awareness, activity, verbal interactions and any physical concerns or issues such as breathing, pallor or evidence of cyanosis [Chapter 26.124]

6.3.6 Where the patient appears asleep the observing staff "should be alert to and assess the level of consciousness and respirations of the patient as appropriate" [Chapter 26.125]

6.3.7 Consideration should be given to the gender of the staff observing the patient; noting consideration of the patient's previous trauma history [Chapter 26.120] and issues of dignity and privacy.

6.3.8 The seclusion record must identify the time at which seclusion commenced [Chapter 26.115], with the principle entry being made by a qualified nurse. A record of the commencement should also be made in the patient's healthcare record.

6.3.9 In line with the Trust policy for the Management of Clinical Risk through Supportive Observations (SD04) the nurse in charge will ensure that wherever practicable an individual does not undertake a period of observation within eyesight observations (Level 3) for an uninterrupted period of longer than two hours.

6.3.10 The format of the seclusion record may be either electronic or paper based depending upon the needs of each service. However as a minimum the seclusion record should include

- details of who authorized the seclusion
- the date and time of commencement and reason(s) for seclusion
- details of items taken into the seclusion room/area
- If/ when a relative/carer and/or advocate was informed of the commencement
- recorded observations at 15 minute intervals
- who undertook nursing reviews and what was observed
- who undertook medical, internal MDT and independent MDT reviews and what was observed and recommended
- date and time seclusion was terminated, and who authorised this

6.4 NEEDS AND RISK MANAGEMENT

6.4.1 Patients in seclusion will be treated with respect and dignity at all times

6.4.2 Needs and risks will be identified and recorded in the seclusion care plan.

6.4.3 Access to bathing and hygiene facilities must be assessed and recorded in the seclusion care plan. The ability of the patient to safely attend to personal hygiene out with of a seclusion room does not necessarily mean that seclusion can be safely terminated.

6.4.4 A patient in seclusion should always remain clothed.

6.4.5 The use of strong clothing or bedding should not be the first choice and should only be used if there is a case where normal attire or bedding may present a risk to the patient or others. The authorisation for the use of strong clothing or bedding will be by the patient's RC, or other RC if unavailable, following assessment by an MDT. Out of hours this MDT assessment may consist of the duty doctor and Nurse in charge of the ward who should then consult with the RC on call to authorise. [Chapter 26.162]

6.4.6 Any use of strong attire or bedding should be proportionate to the perceived risk and last no longer than necessary. The nurse in charge of the ward or an MDT can authorise a return to normal clothing or bedding following an assessment of the continuing risks. These risks will require ongoing assessment and review. [Chapter 26.165]

6.4.7 The use of positive behavioural support plans should identify strategies that may help avoid the use of strong clothing or bedding and provide the patient with guidance on what is required of them to have normal clothing and bedding [Chapter 26.166]

6.4.8 Any clothing or personal items taken from a patient must be stored in a safe place. The reasons for their removal must be clearly explained to the patient and recorded in the patient's healthcare record.

6.4.9 The nurse in charge of the ward must endeavor, where reasonably practicable, to ensure that any patient placed in seclusion does not retain items that may foreseeably cause injury

6.4.10 In exceptional circumstances it may be considered more therapeutic and less restrictive to manage a patient requiring isolation in their own bedroom. This should only be considered if the multi-disciplinary team believe there are cogent clinical reasons for doing so and that any risks presented by the environment can be safely managed. Assessment of these risks should be kept under regular review.

6.4.11 The decision to use a patient's bedroom for the purpose of seclusion or other isolation should be based on clinical rationale and not due to a lack of suitable designated seclusion facilities

6.4.12 En-suite facilities (where available) should be routinely accessible by the patient in seclusion unless, following risk assessment, there are specific concerns raised about potential self harm or risk to others.

6.4.13 Whilst in seclusion, the patient will be

- Advised of the reasons for being placed in seclusion. This should be repeated at subsequent reviews if required
- Advised under what conditions seclusion will be terminated
- Informed of how to summon the attention of staff
- Told that their fluid and food intake (balance) may be monitored and recorded if required
- Provided with food and drinks regularly (same to be recorded on seclusion observation form)
- Given access to toilet and washing facilities and will, if supervision is required, be supervised by a staff of the same gender.
- Be advised that nursing staff will relay messages to legal representatives, CQC and advocacy as required.
- Advised that consideration may be given to visits if considered safe to do so.
- Able to have sight of a clock at all times.
- Able to have access to radio/reading material where clinically appropriate and where safe to do so.
- Encouraged to discuss with staff issues affecting their psychological presentation.
- Informed that their family or carers will be informed of their situation if previously agreed in a positive behavioural support plan or advanced statement, or crisis intervention plan. It is the responsibility of the Responsible Clinician to ensure the family/carers are informed.
- Access to a telephone if considered safe and clinically appropriate.

6.4.14 In all cases where a patient in seclusion needs to be relocated to another ward this must be discussed by the nurse in charge of the ward with the senior nurse/manager on duty.

6.5 REVIEWS OF SECLUSION

For the purpose of this policy the reviews of patients in seclusion have been divided into

- Nursing reviews
- Medical reviews
- Internal Multi-disciplinary Team reviews
- Independent MDT reviews
- Reviews during the night
- Senior Manager reviews (High secure services only)

6.5.1 General principles for seclusion reviews are that

- Every effort should be made undertake the review within the seclusion room/area, but only when it is considered therapeutic and/or safe to do so.
- The names and designations of all staff entering the seclusion room will be recorded in the seclusion record.
- Reviews will remain as per Code of Practice

6.5.2 The purpose of reviews are to "provide an opportunity to determine whether seclusion needs to continue or should be stopped, as well as to review the patient's mental and physical state" [Chapter 26.126]

6.5.3 NURSING REVIEWS

6.5.3.1 Nursing reviews should take place at least every two hours by two registered nurses, one of whom was not directly involved in the decision to seclude [Chapter 26.134]

6.5.3.2 The outcome of these nursing reviews should be recorded in the patient's healthcare record.

6.5.3.3 Any concerns regarding the patient's physical or mental condition should be brought to the immediate attention of the patient's Responsible Clinician or duty doctor [Chapter 26.135]

6.5.3.4 For nursing reviews during the night see section 6.5.7 below

6.5.4 MEDICAL REVIEWS

6.5.4.1 Unless seclusion was authorised by a psychiatrist, a seclusion review will be undertaken by a doctor within the first hour of seclusion commencing, or without delay if the patient is newly admitted, not well known, or if there is a significant change in their usual presentation. [Chapter 26.116]

6.5.4.2 If after the first medical review the decision is that seclusion should continue then a seclusion care plan should be developed in collaboration with nursing staff.

6.5.4.3 The Trust has determined that all medical doctors, irrespective of grade, or level of registration will be considered competent to undertake medical reviews on the provision that they meet the following criteria

- Have read this policy
- Have access to senior medical (consultant) advice at all times
- Have access to senior nursing advice at all times

6.5.4.4 Medical reviews will take place every four hours from the commencement of seclusion until the first Internal Multi-disciplinary Team review takes place [Chapter 26.131]

6.5.4.5 Following this first Internal Multi-Disciplinary Team review further medical reviews should continue at least twice in every 24hr period [Chapter 26.132].

6.5.4.6 At least one of these twice daily reviews should be by the patient's Responsible Clinician, or other consultant out-of-hours [Chapter 26.132]

6.5.4.7 The outcome of the medical reviews should be recorded in the patient's healthcare record.

6.5.4.8 Medical reviews should be carried out in person (for medical reviews during the night see section 6.5.7) and provide the opportunity to evaluate and amend the seclusion care plan [Chapter 26.133]. Such reviews should

- review the patient's physical and psychiatric health
- assess any adverse effects of medication
- review the level of observations required
- reassess prescribed medication
- assess the level of risk to others
- assess risk of deliberate or accidental self harm
- assess the need for the continuation of seclusion
- assess potential measures to allow greater flexibility in seclusion to reduce the restrictive nature of the seclusion episode

6.5.5 INTERNAL MULTI-DISCIPLINARY TEAM REVIEWS

6.5.5.1 The Internal Multi-Disciplinary Team should review the patient as soon as is practicable [Chapter 26.137]. This should be within 24 hours of seclusion commencing.

6.5.5.2 Internal MDT reviews will take place within every 24hrs throughout the seclusion episode [Chapter 26.139].

6.5.5.3 Membership of this Internal MDT will include a Responsible Clinician, the senior nurse on the ward, and staff from other disciplines normally involved in the patient's care

6.5.5.4 At weekends or public holidays the membership of this review team can be limited to a Responsible Clinician and the senior nurse on duty, However, the RC and senior nurse must hold a joint review.

6.5.5.5 These reviews should “evaluate and make amendments” to the seclusion care plan [Chapter 26.140]

6.5.5.6 The outcome of the internal MDT reviews should be recorded in the patient’s healthcare record.

6.5.6 INDEPENDENT MULTI-DISCIPINLARY TEAM REVIEWS

6.5.6.1 If the period of seclusion continues for longer than 8hrs consecutively or 12hrs intermittently during a 48hr period then an independent MDT review should be undertaken [Chapter 26.141]

6.5.6.2 This review should be undertaken by end of next working day after commencement of seclusion

6.5.6.3 Membership of this independent MDT will include a Responsible Clinician, a senior nurse, other professionals not involved in the decision to seclude and an IMHA if available and if the patient has one.

6.5.6.4 It is good practice for this team to consult with staff involved in the decision to authorise seclusion wherever possible [Chapter 26.142]

6.5.6.5 These reviews should “evaluate and make recommendations, as appropriate, for amendments” to the seclusion care plan [Chapter 26.143]

6.5.6.6 The outcome of the independent MDT reviews should be recorded in the patient’s healthcare record.

6.5.7 NIGHT TIME REVIEWS

6.5.7.1 Chapter 26.136 of the Code of Practice allows for alternative review arrangements during the night. The Trust recognises the value in allowing patients periods of uninterrupted sleep and the potentially disturbing nature of reviews during the night

6.5.7.2 Where a patient appears to be sleeping, a clinical judgement needs to be made on whether it is appropriate to wake them for a medical review. In such instances the doctor's attendance for the medical review may be replaced by a telephone review with the nurse in charge of the ward. (see section 6.5.7.3 below)

6.5.7.3 The decision to hold a telephone review needs to be agreed jointly by the doctor and nurse in charge of the ward and may only be agreed on an

individual basis subject to the patient being asleep at the time the review is due. In the absence of a positive decision to have a telephone review, the default position will be that the doctor attends for the medical review.

6.5.7.4 When there are specific concerns around the physical health of the patient, the default position of the doctor attending for medical reviews should continue during the night. If the patient is asleep these reviews should be carried out in such a way that the doctor can satisfy themselves that the patient is safe and that any concerns for physical health and wellbeing can be addressed safely.

6.5.7.5 When the patient is asleep, the two hour nursing reviews should be carried out in such a way that the registered nurse can satisfy themselves that the patient is safe and there are signs of life.

6.5.8 SENIOR MANAGER REVIEWS (HIGH SECURE SERVICES ONLY)

6.5.8.1 The trust recognises the potential complexity of patient presentations within the high secure service and the need to ensure that potential extremes of risk are managed appropriately.

6.5.8.2 Senior Managers within high secure services will review patients in seclusion 4hrly during the day for the duration of the seclusion episode.

6.5.8.3 In line with Section 6.5.7 above, these will be suspended between the hours of 9pm-9am.

6.5.8.4 The purpose of these senior manager reviews will be to

- Provide assurance that the seclusion remains appropriate.
- Ensure appropriate support is provided to ward staff to allow for the safe management of the patient.
- To assist in the re-socialisation of the patient through the authorisation and allocation of additional resources if considered appropriate.
- To assess the patient's wellbeing and address any concerns.
- To speak with the patient and ascertain their perceptions on the seclusion episode
- To assess the physical environment and to ensure appropriate care is being given safely
- To review care plans to ensure they remain appropriate to need and risk
- To provide feedback to the managers of the service on all matters relating to the use of seclusion.
- To monitor that all reviews have been completed as per policy

6.5.8.5 A record of each Senior Manager review will be entered into the patient's healthcare record.

6.6 TERMINATION OF SECLUSION

6.6.1 Seclusion should be terminated immediately when it is determined that is is no longer warranted [Chapter 26.144]. It can be ended by

- The nurse in charge of the ward in consultation with the patient's Responsible Clinician or duty doctor (either in person or by telephone)
- Following an internal or independent multi-disciplinary review
- Following a medical review

6.6.2. Opening a door for short periods (eg: to access toilet or bathing facilities, food breaks, access to secure outside space, or medical, nursing or MDT reviews) does not constitute an end to seclusion [Chapter 26.146]

6.6.3 The nurse in charge of the ward should ensure that there is a care plan in place, informed by a risk assessment, for the safe management and support of the patient on the ending of seclusion [Chapter 26.148]

6.6.4 Following all episodes of seclusion there should be a post-incident review/de-brief to ensure organizational learning and support for all parties involved, including patients. [Chapter 26.167]

6.7 PATIENT ENGAGEMENT AND EXPERIENCE

6.7.1 All patients should have a positive behavioural support plan and be encouraged to participate in the development of such plans if capable and willing to do so.

6.7.2 Patients should be encouraged to make an advanced statement with respect to the use of restrictive practices if capable and willing to do so.

6.7.3 A copy of this policy should be readily available to patients on request.

6.7.4 The safeguarding lead for the clinical divisions should be informed whenever a patient makes a complaint about the use of seclusion or long-term segregation [Chapter 26.171]

6.7.5 Whenever possible patients should be encouraged to participate in the development of the seclusion care plan. This should be evidenced in the patient's healthcare record.

6.7.6 Unless clinically contra-indicated, the patient should be given a copy of the seclusion care plan. If contra-indicated, the reasons for same must be clearly recorded in the patient's healthcare record.

6.7.7 Following the use of seclusion the patient should be supported and given the opportunity to participate in a de-brief process to help them understand what has happened and why [Chapter 26.167]. If the patient is able and willing then this should be undertaken by someone of the patient's choice [Chapter 26.169]

6.7.8 If willing or able, the patient's account of the incident giving rise to the use of seclusion, including feelings, anxieties or concerns, should be documented in their healthcare record [Chapter 26.170]

6.7.9 If a patient is not able or willing to participate in a de-brief process then assessments of the effects of the use of seclusion on behaviour, emotions and clinical presentation should be undertaken and recorded in the patient's positive behavioural support plan [Chapter 26.168]

6.8 MEDICATION

6.8.1 There is no expectation that additional medication will be given whilst a patient is in seclusion. However, where the administration of additional medication is required then oral medication should be offered before parenteral medication.

6.8.2 If additional oral or parenteral medication has been administered within approximately 30 minutes prior to seclusion it must be brought to the attention of the attending doctor and senior nurse attending and the details recorded clearly.

6.8.3 Where it is necessary to prescribe and/or administer emergency oral or parenteral medication, or in exceptional circumstances intravenous medication, to patients in seclusion, this will be considered a medical emergency requiring the presence of a doctor and senior nurse/manager on duty.

6.8.4 If the patient is detained under the Mental Health Act 1983, any prescribed medication must be administered within the legal framework of that Act (with

specific reference to Part 4,sections 58 and 62) and in line with the Trust 'Policy and procedure for the use of rapid tranquillisation' (SD11).

Note that if the patient is **not** eligible for treatment under Part 4 of the Mental Health Act, authority to treat ***may*** be granted either under the common law or the Mental Capacity Act, dependent upon the circumstances. In such circumstances where the patient is not detained under the Mental Health Act, medical staff are advised to seek legal guidance regarding treatment prior to medication being prescribed or administered.

6.8.5 Emergency equipment must be immediately to hand whenever it is deemed necessary to administer emergency parenteral (or IV) medication to a patient in seclusion.

6.8.6 If a patient in seclusion has been sedated or received emergency parenteral (or IV) medication then a care plan will be formulated to monitor the physical condition of the patient. This should be in accordance with the Trust 'Policy and procedure for the use of rapid tranquillisation' (SD11) and include

- The monitoring of the patient's blood pressure, temperature, pulse, respiration, degree of movement and response to verbal or tactile simulation
- Attempts, whether successful or not, to measure the patient's vital signs must be recorded on a BP/TPR chart and in the patient's healthcare record
- A pulse Oximeter should be available

6.8.7 If a patient has been sedated then they should be monitored 'within eyesight' observation (Level 3 of SD04 – Management of Clinical Risk through Supportive Observations) by a qualified nurse, until such time as a medical review indicates otherwise [see Chapter 26.122]

6.8.8 There is no requirement to have a doctor present at the time of, or post administration of a pre-prescribed/regular parenteral depot preparation to a patient in seclusion. However, to ensure the highest standards of care in the administering of parenteral depot medications to seclusion patients all patients who require this should have a care plan that specifically addresses physical care needs during and post administration of the depot. This care plan should make specific reference to

- requirements for the post administration monitoring of the patients physical condition.
- identification of any known physical risks or potential adverse reactions, and the control measures to be employed to minimise and manage these.
- identification of personnel required to be present both during and post administration of the depot to manage any potential adverse physical

reactions, active patient resistance, or increased arousal or agitation at the time of administration.

6.9 SELF HARM

6.9.1 The Trust recognizes that at times patients who may require seclusion also present with risks of self harm. On such occasions patient management will be in accordance with Chapter 26.108 of the Code of Practice which states that “where the patient poses a risk of self harm as well as harm to others, seclusion should be used only when the professionals involved are satisfied that the need to protect other people outweighs any increased risk to the patient’s health or safety arising from their own self-harm and that any such risk can be properly managed”.

6.9.2 The decision and rationale for secluding a patient with a known risk of self harm should always be fully recorded within a care plan that identifies measures to manage any potential self-harming behaviours.

6.10 VISITS

6.10.1 The code of practice recognizes that for patients who are in seclusion for a prolonged time visits may be appropriate [Chapter 26.111] following an assessment of risk. In such cases the visit will be in accordance with the appropriate visiting policy for the particular service

6.10.2 Official visitors should consult with the nurse in charge of the ward before visiting a secluded patient. It would be prudent, in cases of concerns for the visitor, for the nurse in charge of the ward to consult with the Responsible Clinician or their nominated deputy, or the senior nurse on duty if there is concern that that visitor may be at risk.

6.10.3 The conditions under which visits take place for patients in seclusion will be determined by the nurse in charge of the ward in consultation with the Responsible Clinician or deputy, and/or the senior nurse on duty.

6.10.4 Prior to any visit taking place the nurse in charge will ensure that the visitor is made aware of the conditions under which the visit will take place and the reasons for any restrictions placed upon it.

6.10.5 If a visitor is not satisfied with the conditions under which the proposed visit will be facilitated then the nurse in charge should liaise with the senior nurse/manager on duty prior to the visit commencing. The decision of the senior nurse/manager will be final.

6.11 APPEAL

6.11.1 If a patient or patient's representative wants to make any representation regarding the use of seclusion it should be made to the Medical Director, or the Medical Director's nominated deputy, who will conduct a formal review, taking into account all representations as well as all the circumstances before making a decision.

6.12 VOLUNTARY CONFINEMENT

6.12.1 On occasion patients may wish to be voluntarily confined to either their own room or a designated seclusion room as a means of self regulating and managing their own risks to others. Such occasions will be rare, but on those occasions where the patient requests such confinement, there needs to be robust monitoring and governance arrangements to ensure appropriate safeguards are in place.

6.12.2 Such occasions should not be confused with 'advanced statements' which are primarily a means of informing professionals of the patients' preferred care when they lack capacity to understand or communicate their wishes. If a patient is deemed to lack capacity and requests to be confined then this should be considered to be seclusion (as the onus is clearly on the service to manage the risk in the absence of capacity) and management should be as per this policy.

6.12.3 However, when patients are deemed to have capacity, and are considered able to make decisions for themselves, an expressed wish to be confined in either their own room or seclusion room may not be considered seclusion as long as the following criteria has been met

- There is a Positive Behavioural Support Plan previously agreed that has been collaboratively formulated and signed by the patient and subsequently endorsed by the care team.
- That the patient retains a means of summoning the attention of staff at all times
- That the patient retains the right to have the confinement curtailed at a time of his choosing.
- That the nurse in charge of the ward is satisfied that the conditions of confinement/environment do not present undue risk to the patient or others.

6.12.4 The overarching principle for voluntary confinement is that the patient has the ability to have their confinement or isolation ended at a time of their choosing. It is this distinction that separates voluntary confinement from the definition of seclusion, which is "the supervised confinement and isolation of a patient,

away from other patients, **in an area from which the patient is prevented from leaving**" [Chapter 26.103].

6.12.5 All instances of patients enacting voluntary confinement or isolation from their peer group will be recorded in the patient's healthcare record and reported to the division's seclusion monitoring group.

6.12.6 To ensure the physical and psychological wellbeing of patients utilising voluntary confinement, and to ensure that all episodes of using such are voluntarily implemented by the patient, the following must be adhered to

- Evidence in the Positive Behavioural Support Plan that consideration has been given to the need for a review by a doctor (a) within an hour and (b) every four hours
- Evidence in the crisis plan that consideration has been given to the need for continuous eyesight observations by a qualified nurse until reviewed by a doctor and nurse in charge, who have made the decision that such observation levels are no longer deemed necessary

6.12.7 In all cases where patients voluntarily confine themselves there will be

- Nursing observations maintained and recorded at intervals no longer than 15 minutes
- Nursing reviews maintained and recorded every two hours Patient to be seen by Responsible Clinician or deputy if the period of use exceeds 24hrs continuously or 48hrs in any 72hr period.

6.12.8 Should a patient voluntarily confined as part of a crisis intervention plan **not** have their confinement curtailed on request for **any** reason then this amounts to seclusion and will be managed as such.

6.13 SITUATION SPECIFIC SHORT TERM CONFINEMENT/RESTRICTIONS

6.13.1 On rare occasions it may be necessary to consider temporary restrictions upon patients at specific times and for very specific identified risks. These restrictions reflect risks presented in specific situations that, whilst at times may be long term in nature, do not require the formal implementation of a seclusion or long term segregation regime. Such restrictions will be rare, but still require managing to prevent harm.

6.13.2 The imposition of such restrictions should be voluntary and recorded in the patients Positive Behavioural Support Plan.

6.13.3 Examples of such restrictions may be the need to ensure the safe use of cutlery at meal times.

6.13.4 Individual care teams will need to identify on an individual basis whether any of their patients require such forms of specific management. To provide robust governance arrangements and safeguards for patients any plans to introduce any such restrictions will be reported to the Divisional Seclusion Monitoring Group for monitoring and reporting on.

6.13.5 The management of such situations should not automatically be considered seclusion if the response to the risk remains proportionate, reasonable and transparent, and where the patient has the option of having the short term confinement/isolation ended at a time of their choice.

6.13.6 The care team may consider that on such occasions the risk presented by the patient cannot be safely managed in any other way than by placing a physical barrier between the patient and others. On such rare occasions it will be permissible to confine the patient to a room or area for the duration in which the specific risk exists and **only** if the following criteria have been met

- There is a Positive Behavioural Support Plan previously agreed and endorsed by the care team.
- The patient is willing and able to agree to the restrictions
- The patient retains a means of summoning the attention of staff at all times
- The patient retains the right not to have the restrictions placed upon them
- The patient retains the right to have the confinement curtailed on request as soon as the specific conditions giving rise to the risk have abated
- The nurse in charge of the ward is satisfied that the conditions of confinement/environment do not present undue risk to the patient or others.

6.13.7 Should a patient confined to manage specific risks as part of a Positive Behavioural Support Plan **not** have their confinement curtailed on request when the conditions giving rise to the specific risk have abated, then this amounts to seclusion and will be managed as such.

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6.14 SECLUSION MONITORING ARRANGEMENTS

6.14.1 Each division will have a robust seclusion monitoring process in order to ensure that their governance arrangements “enable them to demonstrate that they have taken all reasonable steps to prevent the misuse and misapplication of restrictive interventions”.[Chapter 26.5]

6.14.2 This process will be overseen by a group, whose membership will be determined by the division, and chaired by the Associate Medical Director or nominated deputy.

6.14.3 The role of this group will be to

- Monitor the adherence of seclusion to the Code of Practice and any departures from such
- Receive and analyse data relating to, and monitor overall trends in, the use of seclusion
- Monitor and report on other areas of restrictive practice as determined appropriate by each clinical division
- Submit reports to clinical teams and management teams as required
- Review documentation for the collection of information about the use of seclusion and alternative management strategies
- Consider any staff training and education issues and make recommendations to the management team/committee
- Monitor the use of protective bedding/clothing
- Monitor the use of seclusion for race, gender and age
- Review difficult cases through case presentations with the teams
- Share and disseminate good practice
- To report 6-monthly to the divisional Equality and Human Rights Task Group
- In the Secure Division this should also include the monitoring of Pips and Response Team Activity

6.14.4 The Care Quality Commission will have a standing invitation to attend the group

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6.14.5 Management team members/committees will receive regular reports on the above through the governance arrangements for the division.

7. PROCEDURE FOR LONG-TERM SEGREGATION

7.1 The definition of long-term seclusion is given in section 4.2

7.2 The use of long term segregation will primarily, but not exclusively, be within high secure services due to the nature and presentation of the patients it provides care for.

7.3 The Trust recognizes that on rare occasions, and for cogent clinical reasons, a patient within an inpatient area other than high secure may need isolating from his peer group, staff or the wider ward community for a prolonged period due to the intractable or resistant nature of their presentation.

7.4 For a patient to be considered for long-term segregation a multi-disciplinary team must consider it necessary, and agreement must be been obtained from

- the responsible commissioning authority [Chapter 26.150]
- Associate Medical Director for the respective division
- Director of Patient Safety (Local Division only)

7.5 The multi-disciplinary review that considers the use of long-term segregation should include an IMHA if the patient has one [Chapter 26.150]

7.6 Wherever long-term segregation is considered, the views of family/carers should be elicited where appropriate and where indicated in the patient's Positive Behavioural Support Plan. This is the responsibility of the Responsible Clinician.

7.7 Patients in long-term segregation should be cared for in conditions of least restriction necessary to maintain safety [Chapter 26.151]

7.8 Patients managed under long-term segregation should have access to the following, away from the wider ward community [Chapter 26.152]

- a bedroom
- bathroom facilities (toilet/washing facilities)
- relaxing lounge area
- secure outdoor area
- range of activities of interest and relevance to the patient

7.9 Patients should continue to have contact with staff, and should not automatically be deprived of access to therapeutic interventions [Chapter 26.152]

7.10 Long-term segregation plans should aim to end patient isolation as soon as practicable and re-integrate the patient back into the wider ward community [Chapter 26.152] and outline how patients are to be made aware of what is expected of them so that the segregation can be terminated [Chapter 26.158]

7.11 The local safeguarding team for the clinical divisions should be kept informed of any patient being cared for in long-term segregation [Chapter 26.153]

7.12 It is the responsibility of the care team to determine the level of enhanced observations the patient should be subject to, remaining mindful that Chapter 26.154 states that as a minimum there should be a written observation record made by a supervising staff on at least an hourly basis.

7.13 It is noted that in high secure services there is a requirement to observe patients within bedrooms (either locked or otherwise) at least every 30 minutes. Therefore in high secure services observations and written records of patients in long-term segregation will be at intervals of no longer than 30 minutes.

7.14 The level of enhanced observations should be clearly documented in the long-term segregation care plan.

7.15 Patients in long-term segregation will be seen by the nurse in charge of the ward at each shift handover. The aim of this is to ensure that the patient's health and wellbeing are evaluated and that the current presentation and mental state are assessed to ensure their needs are being met. A written entry will be made into the healthcare record by the nurse in charge on each occasion.

7.16 The long-term segregation care plan must

- identify risks and articulate why long-term segregation is necessary
- summarise the planned treatment/care/activity
- specify the observation levels required. Minimum of 30 minutes in HSS and 1 hr in other clinical areas.
- the conditions under which long-term segregation may be terminated
- any chronic medical conditions presented by the patient
- patient involvement and views
- views and involvement of family/carers where appropriate
- potential use of a crisis intervention plan

7.17 Patients on longer-term segregation should be managed in an appropriate environment commensurate to the risk presented. This may include the patient's own bedroom. The patient must have access to a staff call system.

7.18 Patients in long-term segregation will have their situation formally reviewed by a Responsible Clinician at least once in any 24hr period [Chapter 26.155]

7.19 Patients in long term segregation will have at least three face to face medical reviews each week. If the review is performed by a CT/ST or Specialty Doctor who is not an AC they will need to discuss the situation with the RC, (or covering RC) and document that this has occurred.

7.20 Patients in long term segregation will be reviewed weekly by their multi-disciplinary care team. This review should include an IMHA where appropriate. [Chapter 26.155]

7.21 There is a need for periodic reviews of patients in long-term segregation by a senior professional not involved in the case [Chapter 26.155]. This function will be provided by the Divisional Seclusion Monitoring Groups, with reviews being at periods of no longer than monthly.

7.22 The responsible commissioning authority will be kept informed of the outcomes of these monthly reviews. [Chapter 26.155]

7.23 Whenever long-term segregation lasts longer than 3 months there should be regular three monthly independent reviews by an external hospital, which should include a discussion with the patient's IMHA (if they have one) and representative of the local commissioning authority [Chapter 26.156]

7.24 The purpose of reviews for patients in long-term segregation is to determine whether the ongoing risks have reduced sufficiently to allow the patient to be re-integrated into the wider ward community, and to check on their physical and psychiatric wellbeing [Chapter 26.157]

7.25 The decision to terminate long-term segregation should be made by the patient's multi-disciplinary care team following risk assessment. The patient's IMHA should be involved in this process where available [Chapter 26.157]

7.26 Should a patient in long-term segregation require temporary transfer to a seclusion room from a normal bedroom as a result of an acute behavioural disturbance then the procedure for seclusion should be followed [Chapter 26.150] until such time as the behavioural disturbance is over and the care team consider it appropriate to reinstate long-term segregation.

8 DEVELOPMENT and CONSULTATION

This policy has been developed by the Seclusion Monitoring Group in High Secure Services in consultation with senior colleagues within the Local Division of the Trust. Legal advice was also sought to ensure compliance with the MHA Code of Practice.

9 REFERENCE DOCUMENTS

Mental Health Act 1983
Code of Practice, Mental Health Act 1983 (2015)
Human Rights Act, 1998
NICE Guidance NG10 – May 2015
Mersey Care NHS Trust Policy for the Use of Rapid Tranquillisation (SD11)
Mersey Care NHS Trust Policy for the management of clinical risk through supportive observations (SD04)
Race Relations Amendment Act (2000)
Mental Capacity Act (2005)

10 GLOSSARY

Approved Clinician - A mental health professional approved by the Secretary of State or a person or body exercising the approved function of the Secretary of State, or by the Welsh ministers, to act as an approved clinician for the purposes of

the act. Some decisions under the Act can only be taken by people who are approved clinicians. All responsible clinicians must be approved clinicians.

Association – this refers to any time when the patient is escorted outside the seclusion room/area, possible in the company of other patients, as part of an assessment of whether or not seclusion should end.

Multi-disciplinary Team – a professional team including staff from a range of different professions.

Patient Care Team – the multi-disciplinary team normally responsible for providing and prescribing individual care.to the patient

Positive Behavioural Support Plans – individualized care plans, which should be available to staff, kept up to date, and should include primary preventative strategies, secondary preventative strategies and tertiary strategies

Responsible Clinician – the approved clinician with overall responsibility for a patient's case. Certain decisions (such as renewing a patient's detention or placing a patient on a community treatment order) can only be taken by the responsible clinician.

Senior Nurse/Senior Manager/Duty Manager – these terms may be used interchangeably and be locally determined. It is expected that this would be a qualified nurse of Band 7 or above.

Advanced Statement – a statement made by a person, when they have capacity, setting out the person's wishes about medical treatment. The statement must be taken into account at a future time when that person lacks capacity to be involved in discussions about the8ir care and treatment. Advanced statements are not legally binding although health professionals should take them into account when making decisions about care and treatment.

Sight and sound – there must be a staff positioned within eyesight of the seclusion room. The positioning of the staff must be such that they would be likely to hear the patient should they attempt to summon staff attention

Suitably skilled professional - a member of clinical staff who has a knowledge of the seclusion policy, the specific clinical environment, and the specific needs of patients whilst in seclusion. They need not hold a formal disciplinary or academic qualification but must be aware of the specific risks and care needs of the patient they are providing care for.

Appendix A

MEDICAL REVIEW FLOWCHART FOR SECLUSION

Seclusion

First Medical Review of seclusion by duty doctor within 1 hour of commencement
(Responsible Clinician (RC) to be notified) ***this is not required if seclusion initiated by a doctor***

Remain on 4 hrly medical reviews until MDT directs otherwise

The first **Internal Multidisciplinary Team (MDT)** **** this is the patient's own care team***
Within 24 hours of commencement of seclusion

Subsequent medical reviews should continue - twice within a 24 hour period and at least once by the Responsible Clinician (or covering RC)

Independent Multidisciplinary Team (MDT) Review
Within 24 hours of commencement of seclusion or next working day if seclusion occurs at weekend

Where seclusion is to continue, reviews should evaluate and make recommendations, as appropriate to the seclusion care plan

Ending Seclusion
Immediately when a (MDT) Review, a Medical Review or the Independent Multidisciplinary Team determines it is no longer warranted

OR

If the professional in charge of the ward feels that seclusion is no longer warranted, seclusion may end following consultation with the patient's Responsible Clinician (RC) or duty doctor; in person or by telephone

Appendix B

MEDICAL REVIEWS FOR LONG TERM SEGREGATION

The decision to move from seclusion to segregation is based on the clinical judgement of the Multidisciplinary Team (MDT).

There is no specified time frame. This decision will be informed by the view on long-term risk and in consideration of the definition of long-term segregation as outlined in the CoP (see 26.150)

At this point;

1) **The local Safeguarding Team are notified,**
2) **Approval is sought from the relevant Commissioners**
3) **Approval is sought from the Associate Medical Director for the division**
4) **Approval is sought from Director of Patient safety (local division only)**

The patient's situation should be reviewed by the Responsible Clinician (RC) daily.

The purpose of this review is to determine whether the risks have reduced sufficiently to allow the patient to be integrated into the wider community

A minimum of 3 medical reviews weekly will be in person

At least one of these reviews will be by the Responsible Clinician (RC) or duty RC.
The remainder by medical staff who may not be Approved Clinicians (AC)

All other reviews will be facilitated by consultation with the professional in charge of the ward and documented

A full multidisciplinary review of Long Term Segregation (LTS) will be held weekly

Additional Safeguarding Reviews will include:

i. Monthly independent reviews by the Seclusion Monitoring Group (SMG)
ii. Monthly peer review of all LTS cases by the RC group
iii. Three-monthly external hospital reviews of the patients' circumstances and care
iv. A full clinical review should be sought via the relevant gatekeepers and/or alternatively from peers from other similar services, in the event that LTS exceeds 12 months

The decision to end Long Term Segregation (LTS) should be taken by the Multidisciplinary Team (MDT) including, where appropriate, the patient's Independent Mental Health Advocate (IMHA)

SAMPLE SECLUSION OBSERVATION FORM

Patient Name		RC	Ward	Time/Date Seclusion Commenced
		Observation Form _____ of _____		
TIME		OBSERVATIONS/REVIEW		SIGNATURE
Delete as Required				
0000	1215			
0015	1230			
0030	1245			
0045	1300			
0100	1315			
0115	1330			
0130	1345			
0145	1400			
0200	1415			
0215	1430			
0230	1445			
0245	1500			
0300	1515			
0315	1530			
0330	1545			
0345	1600			
0400	1615			
0415	1630			
0430	1645			
0445	1700			
0500	1715			
0515	1730			
0530	1745			
0545	1800			
0600	1815			
0615	1830			
0630	1845			
0645	1900			
0700	1915			
0715	1930			
0730	1945			
0745	2000			
0800	2015			
0815	2030			
0830	2045			
0845	2100			
0900	2115			
0915	2130			
0930	2145			
0945	2200			
1000	2215			
1015	2230			
1030	2245			
1045	2300			
1100	2315			
1115	2330			
1130	2345			
1200	2400			

Mersey Care NHS
NHS Trust

Equality and Human Rights Analysis

Title: Policy and procedure for the use of seclusion and long term segregation – SD28
Area covered: Trust Wide

What are the intended outcomes of this work **This is a review of a policy that was equality assessed in April 2014.** **Part of the process in this assessment will be to consider the previous equality and human rights analysis .** **This policy and procedure provides clear guidance on the use of seclusion and long-term segregation within Mersey Care NHS Trust.** **It allows the Trust to demonstrate that the use of restrictive practices meet and uphold the guiding principles of the Mental Health Act Code of Practice (2015) and that they remain proportionate, least restrictive, last for no longer than is necessary, and take account of patient preference wherever possible.**
Who will be affected? *e.g. staff, patients, service users etc* **Service users**

Evidence
What evidence have you considered? **The policy** **The previous impact assessment**
Disability including learning disability **Should be monitored within the seclusion monitoring group.** **Need to ensure that with patient care plans that they are available in a format as required (easy read).**
Sex **Should be monitored within the seclusion monitoring group.**
Race **Should be monitored within the seclusion monitoring group.**

Age

Should be monitored within the seclusion monitoring group.
Gender reassignment (including transgender) **Should be monitored within the seclusion monitoring group.**
Sexual orientation **Should be monitored within the seclusion monitoring group.**
Religion or belief **Should be monitored within the seclusion monitoring group.**
Pregnancy and maternity **Should be monitored within the seclusion monitoring group.**
Carers **No issues identified**
Cross Cutting **Equality monitoring needs to be completed within the seclusion monitoring group for the secure and non secure divisions. See action plan below.**

Human Rights	**Is there an impact?** **How this right could be protected?**
This section must not be left blank. If the Article is not engaged then this must be stated.	
Right to life (Article 2)	**Human Rights based Approach supported.**
Right of freedom from inhuman and degrading treatment (Article 3)	**Human Rights Based Approach supported** **The sole aim of Seclusion is to contain severely disturbed behaviour which is likely to cause harm to others.** **States /seclusion to be as short a time as possible.**
Right to liberty (Article 5)	**Human Rights Based Approach supported**
Right to a fair trial (Article 6)	**Human Rights Based Approach supported** **States that seclusion should not be used s a punishment**
Right to private and family life (Article 8)	**Human Rights Based Approach supported**

Right of freedom of religion or belief **(Article 9)**	**Human Rights Based Approach supported** **Consideration is given to sensitivity to cultural and spiritual needs.**
Right to freedom of expression **Note: this does not include insulting language such as racism (Article 10)**	**No issues identified within discussions.**
Right freedom from discrimination **(Article 14)**	**Equality and human rights statement included.**

Engagement and involvement
This policy has been developed by the Seclusion Monitoring Group in High Secure Services in consultation with senior colleagues within the Local Division of the Trust. Legal advice was also sought to ensure compliance with the MHA Code of Practice.
All ward based staff will be made aware of this policy via ward managers and matrons.

Summary of Analysis
Eliminate discrimination, harassment and victimisation **Equality monitoring to be included in the seclusion monitoring reviews meeting (Race and gender and age).**
Advance equality of opportunity
Promote good relations between groups

What is the overall impact? **Intended to have low negative impact**

Addressing the impact on equalities
Following monitoring within seclusion monitoring group improvement action plan to be developed.
Reporting to the Trust equality and human rights steering group twice a year.

Action planning for improvement
Please see below

For the record
Name of persons who carried out this assessment:
George Sullivan (Equality and Human Rights Advisor)
Des Johnson (Service Manager, Secure Division)

Date assessment completed: 30th October 2015

Name of responsible Director/Lead Trust Officer
Medical Director, Mersey Care NHS Trust

Date assessment was signed:
30th October 2015

Action plan

Category	Actions	Target date	Person responsible and their Division
Involvement and consultation	**This Policy was originally assessed with service user and carer input.**		
Monitoring, evaluating and reviewing	**Seclusion monitoring groups need to ensure that there is on going monitoring of patients in relation to the protected characteristics. Full analysis of the data should be completed.**	Feb 2016	Chairs of Divisional Seclusion Monitoring Groups
Reporting data above	**A copy of the analysis of the data should be provided to the Trust Equality steering group twice a year (April and October).**	Apr 2016	Chairs of Divisional Seclusion Monitoring Groups
Transparency (including publication)	**The equality and human rights analysis is to be placed next to the policy on the Trust website.**	Nov 2015	Policy Author