

Seclusion Policy

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Seclusion Policy

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1.0	Approved	December 2020	Trust Wide Patient Safety and Mortality Review Group	Virtually ratified

REFERENCES

National Institute for Clinical Excellence (2015) Violence and aggression: short-term management in mental health, health and community settings. Nice ng10/ng11
National Institute for Clinical Excellence (2005) The short-term management of disturbed/violent behaviour in patient psychiatric settings.

RELATED POLICIES/PROCEDURES/protocols/forms/leaflets

Long-term Segregation Policy	
Promoting Safe Services policy	
Rapid Tranquilisation policy	
Post Incident Review and Immediate Support policy	
High dose antipsychotic medication guidelines (Appendix U - Medicines Management Policy)	

SUMMARY OF CHANGES

Date	Author	Page	Changes (brief summary)
December 2020			This policy has been separated from and replaces the previous Segregation and Seclusion of Patients Policy (KMPT.CLiG.065.05)

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1 INTRODUCTION

- 1.1 Kent and Medway NHS and Social Care Partnership Trust is committed to establishing a culture within its services which focuses on the early recognition, prevention and de-escalation of potential aggression using techniques and initiatives to minimise the risk of violence occurring.
- 1.2 Within the Trust, the use of seclusion is viewed as a last resort to manage severely disturbed behaviour and is only used as a reasonable, necessary and proportionate response to the risks presented.
- 1.3 This policy takes into account the requirements of the Human Rights Act 1998; the Mental Health Act Code of Practice (2015) and NICE guidance ng10 (2015) and ng11 (2015)

2 WHO DOES THIS POLICY APPLY TO?

- 2.1 This policy applies to all clinical staff employed by Kent and Medway NHS and Social Care Partnership Trust including agency and bank staff who, during the course of their work, may be involved in the seclusion of a patient.
- 2.2 This policy applies to all patients cared for in seclusion at any time, whether they are detained under the Mental Health Act or not.

3 PURPOSE

- 3.1 The Policy sets out detailed guidance on the use of seclusion that is consistent with the guiding principles of the Mental Health Act 1983 (Code of Practice 2015).
- 3.2 Adherence to this policy will:
 - 3.2.1 Limit the use of seclusion to exceptional circumstances and promote alternative approaches to the care and treatment of disturbed behaviour
 - 3.2.2 Ensure that patients' rights are respected and adhered to if seclusion is initiated
 - 3.2.3 Support staff to adhere to the correct process of implementing, monitoring and managing the care of the patient whilst in seclusion, and ensure that accountable decisions and observations are recorded appropriately.
 - 3.2.4 Ensure that when seclusion is used it is terminated at the earliest and safest opportunity
 - 3.2.5 Detail the formal responsibilities of all Trust employees regarding the use, monitoring, recording and review of the use of seclusion both during and post seclusion.
 - 3.2.6 Provide a consistent approach in the use of seclusion
 - 3.2.7 To support the Trust's commitment to reducing the use of restrictive interventions
- 3.3 The policy must not be used as a stand-alone document but in conjunction with all Trust policies and guidelines, in particular the following policies:
 - Promoting Safe Services policy
 - Rapid Tranquilisation policy

- Post Incident Review and Immediate Support policy
- High dose antipsychotic medication guidelines (Appendix U - Medicines Management Policy)
- Long-term Segregation Policy

4 DUTIES

4.1 Board of Directors

4.1.1 The Board of Directors are responsible for ensuring that a policy is in place that governs the safe and appropriate use of seclusion via its governance arrangements and that all staff working within the Trust are aware of and work within the policy.

4.2 Executive Director of Nursing, AHP's and Quality

4.2.1 The Executive Director of Nursing and Governance is responsible for ensuring that mechanisms are in place to ensure all nursing and allied health professionals are aware of and comply with the policy and procedures for the use of seclusion.

4.3 Medical Director

4.3.1 The Medical Director is responsible for making sure all medical staff are made aware of and adhere to the policy.

4.4 Promoting Safe Care Group

4.4.1 This group will have a senior representative from Promoting Safe Services (PSS), Corporate Nursing, Health and Safety, Care Groups and Safeguarding and other relevant parties to oversee actions relating to restrictive practices.

4.4.2 The group will consider themes and trends and ensure these are taken to the Learning from Experience Group and picked up in supervision if needed in the Care Groups.

4.5 Matrons

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

4.6 Ward Managers

4.6.1 Ward Managers should ensure that staff are trained in the safe and appropriate use of seclusion

4.6.2 Ward managers will ensure that observations of seclusion and related processes are carried out by staff that are competent to do so.

4.6.3 Ward manager should ensure that staff are familiar with the policy and procedures related to the use of seclusion.

4.7 Promoting Safe Services Manager

4.7.1 The manager will ensure the policy is inclusive of all legislations and guidance and any associated training is fit for purpose. They will provide assistance in the auditing of seclusions where applicable.

4.8 Nurse in Charge of the Ward

4.8.1 The nurse in charge of the ward is responsible for managing any incident of seclusion in accordance with this policy and procedure.

4.8.2 Staff allocated to observe seclusion are competent to do so

4.8.3 Nurse in Charge will ensure that all required procedures are done as required in a timely manner.

4.9 Patient Flow Team/Designated Senior Nurse (Night)

4.9.1 This team and group of staff are responsible to recording all incidents of seclusion in every 24 hour period and notifying clinical leads, Heads of Nursing, Promoting Safe Services and Deputy Director of Nursing and Practice.

4.10 All Staff

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

4.10.2 Staff should be familiar with the policy and related procedures

4.10.3 Staff to undertake the seclusion observation only if competent to do so

4.10.4 All staff should treat secluded patients with respect and dignity at all times

5 DEFINITIONS AND PRINCIPLES

5.1 The 2015 Code of Practice (CoP) defines seclusion as:

“Seclusion refers to 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. (CoP para. 26.103)

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. It is **essential that they are afforded the procedural safeguards** of the Code. (CoP para. 26.104)

5.2 “Seclusion should only be undertaken in a room or suite of rooms that have been specifically designed and designated for the purposes of seclusion and which serves no other function on the ward” (CoP para. 26.105).

5.3 Seclusion **will apply** therefore if:

- a patient is locked in a seclusion room

- a patient is placed alone in a room and prevented from leaving either by the door being locked, held shut or staff standing in the doorway preventing the patient from leaving.

(Mental Health Data Set definition - NHS England/CQC Briefing, 2019)

5.4 Seclusion **will not apply** if:

- A person is being managed in a specific part of the ward (e.g. ECA) as part of an agreed care plan. As part of the plan there will be active engagement with staff carrying out enhanced observations and potential scheduled time on the wider unit with other patients. This will be termed Long-term segregation. *(Please refer to the Long Term Segregation Policy)*

5.5 Seclusion should be used as a last resort and for the shortest time possible. All other less restrictive interventions must have been exhausted and/or considered before deciding to use seclusion. Seclusion must never be deemed a therapeutic intervention.

5.6 When determining whether to seclude a patient, the following must be taken into account:

5.6.1 Previous trauma and/or abuse

5.6.2 Current physical health

5.6.3 Self-harm or suicide history

5.6.4 Any advance directives relating to restrictive practices

5.7 Seclusion must be a reasonable and proportionate response to the risk posed by the patient.

5.8 The patient must be treated with respect and dignity at all times.

5.9 Human Rights Act 1998 sets out certain rights that must be adhered to, including Article 3 – Prohibition of Torture, Inhuman and degrading treatment or punishment. It is inarguable that the application of seclusion has the potential to amount to inhuman and degrading treatment if:

- It is applied when it is not necessary, either in commencement, continuation and justification
- If it is applied in such a way as to be inhuman or degrading, i.e. extended isolation from any human contact or lack of appropriate activity.

5.10 There is a particular risk that the effect of restrictions such as seclusion can have a cyclical or paradoxical effect of sustaining or increasing the behaviours that led to the decision to use seclusion.

5.11 In order to ensure that seclusion measures have a minimal impact on a patient's autonomy, seclusion should be applied flexibly and in the least restrictive manner possible, considering the patient's circumstances. Where seclusion is used for prolonged periods then, subject to suitable risk assessments, flexibility may include allowing patients to receive visitors, facilitating brief periods of access to secure outside areas or allowing meals to be taken in general areas of the ward.

5.12 The possibility of facilitating such flexibility should be considered during any review of the ongoing need for seclusion. Particularly with prolonged seclusion, it can be difficult to judge when the need for seclusion has ended. This flexibility can provide a means of evaluating the patient's mood and degree of agitation under a lesser degree of restriction, without terminating the seclusion episode.

5.12.1 If applying flexibility during prolonged seclusion, the rights, procedures and documentation for seclusion continue. Seclusion only ends when the patient has unrestricted access to the ward environment again.

5.13 Seclusion should not be used:

- as a punishment or threat;
- as part of a treatment programme;
- because of shortage of staff;
- Where there is an indication of a significant risk of suicide or self-harm (see sec. 8.1)

6 PREVENTATIVE INTERVENTIONS

6.1 The effective nursing of aggressive or severely disturbed patients is one of the most challenging aspects of working in a mental health inpatient setting. It is an area where good interaction and communication skills are required.

6.2 KMPT places emphasis on recognising early warning signs and knowing individual triggers in attempts to prevent situations escalating into aggressive and violent incidents.

6.3 A patient's anger and frustration needs to be treated with an appropriate, measured and reasonable response. Use de-escalation techniques before other interventions.

6.4 De-escalation can be defined as the gradual resolution of a potentially violent or aggressive situation through the use of verbal and physical expressions of empathy and alliance. It should be tailored to individual needs and typically involves establishing rapport and the need for mutual co-operation, demonstrating compassion, negotiating realistic options, asking open questions, demonstrating concern and attentiveness, using empathic and non-judgemental listening, distracting, redirecting the patient into alternate enjoyable activities, removing sources of excessive environmental stimulation and being sensitive to non-verbal communication.

6.4.1 If other interventions are necessary, e.g. physical interventions, then staff must continue to use verbal de-escalation throughout.

6.5 Staff should also consider the use of PRN medication to help calm the patient and alleviate any psychological distress, where appropriate.

6.6 All staff should learn to recognise what generally and specifically upsets and calms the patient. This should be noted in their care plans/Positive Behaviour Support plans and a copy should be given to the patient.

7 USE OF RAPID TRANQUILISATION

- 7.1 Rapid tranquillisation may also be used to manage acute behavioural disturbance, though this should be a very short-term strategy designed solely to reduce immediate risk and is distinct from treating any underlying mental illness.
- 7.2 Rapid tranquillisation should only be used where a patient is highly aroused, agitated, overactive and aggressive, or is making serious threats or gestures towards others, or is being destructive to their surroundings, when other therapeutic interventions have failed to contain the behaviour.
- 7.3 It seeks to reduce psychological suffering and maintain a safe environment for the patient and others. However sudden cardiac death has been associated with the use of antipsychotic medication especially in younger, fit, struggling individuals.
- 7.4 All patients administered Rapid Tranquilisation should have their physical health monitored routinely. This should include visual observations of respiration, skin colour and movements observed if the patient is unwilling to engage with physical health monitoring.
- 7.5 Staff should refer to the Trust's Rapid Tranquilisation policy.

8 ADDITIONAL CARE CONSIDERATIONS

8.1 Self-Harm Risks

- 8.1.1 The Trust recognises that at times patients who may require seclusion also present with risks of self-harm. "Where the patient poses a risk of self-harm as well as harm to others, seclusion should only be used when the professionals are satisfied that the need to protect others 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". (CoP para. 26.108)
- 8.1.2 The rationale for secluding a patient with known self-harm risks must always be documented with the Seclusion record and the patient's clinical notes. The care plan should identify measures to manage any potential self-harming behaviours.

8.2 Specialist Services

- 8.2.1 The Trust does not expect patients within our perinatal services to be secluded. However, in an exceptionally rare circumstance staff would need to consider issues such as arrangements for the care of the baby during this period in addition to the possible implications if the mother is breastfeeding and the physical health of the mother if she has recently given birth.
- 8.2.2 The Trust does not expect seclusion to be used for adolescents.

8.3 Trauma Informed Care

- 8.3.1 Trauma can be defined in many ways. The concept of trauma encompasses experiences of interpersonal violence, such as rape or domestic violence; complex childhood and developmental traumas including community violence (e.g. bullying, gang culture, sexual assault, homicide, war), abuse, neglect, abandonment and family separation. Lesser understood, but equally important, forms of trauma include social trauma, such as inequality,

marginalisation, racism and poverty.

8.3.2 Experiencing trauma can lead to emotional and physiological responses which can result in feelings of despair, hopelessness and helplessness and behaviours associated with harm to self and others.

8.3.3 Staff should be aware of the concept of trauma and the potential risks of re-traumatisation within mental health systems. These include the use of restrictive practices, such as restraint, seclusion and long-term segregation which can all trigger the original event and cause mental distress to the patient.

8.3.4 Staff must consider any previous trauma and the potential impact seclusion could have in their decision making process.

8.4 Careful consideration needs to be given prior to instigating seclusion in the following circumstances:

- Where the patients is heavily medicated
- Physically ill
- Physically disabled
- Heavily intoxicated (drugs or alcohol)
- Older adults

9 SECLUSION ENVIRONMENTAL FACTORS

9.1 Information on the requirements for a seclusion room as stipulated in Mental Health Act Code of Practice (2015) can be found in Appendix B – Design and Requirements of a Seclusion Room

9.2 If a patient is in seclusion during the night then adequate provisions should be available, including a seclusion mattress/bed, pillow and blanket. Each ward with seclusion facilities should keep a stock of items for use.

9.3 Individuals should never be deprived of appropriate clothing with the intention of restricting their freedom of movement; neither should they be deprived of other aids necessary for their daily living. (CoP para. 26.161)

9.4 Alternative clothing should be offered to any patient who removes their clothing in attempts to promote dignity.

9.5 In certain situations, patients who use their personal clothing to attempt self-harm should also be offered anti-tear clothing. This is particularly likely to be the case where the risk of shredded clothing being used to self-harm or attempt suicide has been assessed and is considered to be very high.

9.6 Tear-proof clothing should never be a first-line response to such risks and should never be used as a substitute for enhanced levels of support and observation.

10 COMMENCING SECLUSION

10.1 Decision to Seclude

10.1.1 The decision to seclude a patient is taken after all other less restrictive

interventions have been considered and/or exhausted and the imminent risk of harm to others cannot be managed in any other way

- 10.1.2 The decision to seclude a patient can be made by either the Nurse-in-Charge of the ward, the Responsible Clinician (RC) or another Doctor. If no Doctor was present when the decision was made the nurse in charge of the ward must immediately inform the appropriate ward doctor, or if they are unavailable, the duty doctor should arrange to see the patient within one (1) hour of the seclusion starting.
- 10.1.3 If a Doctor initiated or made the decision to seclude a patient then it is not necessary for another Doctor to see the patient within the first hour.
- 10.1.4 If the seclusion was initiated by the nurse-in-charge and terminated within the first hour, then the Doctor should still see the patient within the first hour.
- 10.1.5 Seclusion should only be used in hospitals and 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. (CoP para. 26.106)

10.2 Clinical Procedure

- 10.2.1 Before the patient is placed in seclusion, the Nurse-in-Charge will ensure potentially dangerous items are removed from the patient. The aim is to ensure the patient does not have in their possession items which they can readily use to harm themselves, or harm staff entering the room. In particular, consideration must be given to articles of clothing which could be used as a ligature.
- 10.2.2 The clothing and pockets of the patient will be checked in accordance with the Trust's Search Policy. Items removed must be documented in the clinical notes with clear rationale of risk.
- 10.2.3 The patient will normally remain dressed in their own clothes as appropriate to the time of day and also retain personal items of religious or cultural significance so long as they do not compromise the safety of themselves or others.
- 10.2.4 On initiating seclusion the patient should be informed of the reason for being placed in seclusion; under what conditions seclusion will cease and how to summon the attention of staff whilst in seclusion.
- 10.2.5 To avoid disorientation the patient should be aware of the date, day and time. A clock should be in view for the patient at all times.
- 10.2.6 A patient in seclusion may be allowed to send messages to any person(s) whom they wish to make contact with where it is feasible and appropriate. Where this is not possible an entry must be made as to why it was not possible or appropriate within the seclusion record.
- 10.2.7 The patient should be given appropriate access to toilet and washing facilities (only staff of the same gender should be present when the patient is using the facilities. For patients identified as transgender then this needs careful consideration based on capacity. Trans people should be accommodated according to their presentation, the way they dress and the names and pronouns they currently use).

10.2.8 Nurse in charge should ensure that the patient is clothed at all times (appropriate to the individual situation)

10.2.9 The nurse in charge should ensure that the patient receives adequate food and fluids at regular intervals. Staff should ensure that appropriate cutlery is used and all utensils taken into seclusion are taken out after use, Staff to ensure that these implements are not used for self-harm or to harm others.

10.3 Notifications

10.3.1 Immediately the service user is placed in seclusion, the nurse in charge will inform the ward manager and the ward doctor (or duty doctor and clinical lead if out of hours).

10.3.2 The doctor will attend the ward immediately or within one hour from the time they were contacted if the decision to seclude was not taken by a medically qualified AC. The doctor will evaluate with the nurse in charge if there is a need for seclusion to continue (CoP para. 26.128).

10.3.3 Family members should be notified of the use of seclusion if previously agreed in either an advanced statement or positive behavioural support plan. This decision must consider the patient's wishes, right to confidentiality and best interests.

10.3.4 All seclusions will be recorded once every 24 hour period by the Patient Flow team in Acute Care Group and Older Adult Care Group and the Designated Senior Nurse in Forensic and Specialist Care Group. Notifications will be disseminated to Heads of Nursing, Deputy Director of Nursing, identified clinical leads and Promoting Safe Services team.

11 SECLUSION OBSERVATIONS AND RECORD KEEPING

11.1 It is important that attempts to engage the patient and use de-escalation techniques are made at regular periods throughout the seclusion period. All observing staff, as well as staff conducting nursing and medical reviews should **attempt to de-escalate** and document attempts and outcomes.

11.2 It is recognised that the patient's level of arousal may not be conducive to de-escalation early in the seclusion period. If it appears that attempts to de-escalate are antagonising the patient than staff must use clinical judgement so as not to cause further distress.

11.3 Ward Manager and Matrons have responsibility to assess their staff team as competent to carry out observations

11.4 A member of the staff team who has been assessed as competent to observe a patient in seclusion in accordance with the Seclusion competency assessment tool must be available within sight and sound of the seclusion area at all times throughout the patient's period of seclusion.

11.4.1 The observing staff should have the means to summon urgent assistance from other staff at any point.

11.4.2 Consideration should be given to whether a male or female person should carry out ongoing observations; this may be informed by consideration of a patient's trauma history and to maintain the dignity of the patient being observed.

- 11.4.3 The aim of observation is to safeguard the patient, monitor their condition and behaviour and to identify the earliest time at which seclusion can end.
- 11.5 For patients who have received rapid tranquilisation, a trained member of staff competent in Immediate Life Support will need to be observing the secluded patient for the first 30 minutes. (Rapid Tranquilisation Policy, section 4.4.1 KMPT.CliG.180)
- 11.6 A record of the patient's behaviour should be made at least every 15 minutes which will continue throughout the whole of the seclusion.
- 11.6.1 The record made should include, where applicable:
- the patient's appearance
 - what they are doing and saying
 - their mood,
 - their level of awareness
 - any evidence of physical ill health especially with regard to their breathing, pallor or cyanosis.
- 11.7 Where a patient appears to be asleep in seclusion, the staff member observing the patient should be alert to and assess the level of consciousness and respirations of the patient as appropriate.
- 11.8 In line with the Trust's Therapeutic Observation and Engagement of Patients Policy observing staff should only continuously observe for one (1) hour; a maximum of two hours in exceptional circumstances.

12 REVIEWS DURING SECLUSION

12.1 Medical Reviews

- 12.1.1 The patient should have a medical review within an hour of seclusion commencing, unless the seclusion was authorised by a Consultant psychiatrist or other Doctor. If authorised by a Consultant psychiatrist or other Doctor, the first review is that done by the Consultant/Doctor immediately before seclusion commenced.
- 12.1.2 For the purposes of medical reviews, where the responsible clinician is not immediately available, e.g. outside of normal working hours, a 'duty doctor' can deputise for the responsible clinician.
- 12.1.3 Medical reviews provide the opportunity to evaluate and amend seclusion care plans, as appropriate. They should be carried out in person and should include, where appropriate:
- a review of the patient's physical and mental health (see section 11.1.4)
 - an assessment of adverse effects of medication
 - a reassessment of medication prescribed
 - an assessment of the risk posed by the patient to others
 - an assessment of any risk to the patient from deliberate or accidental self-harm
 - an assessment of the need for continuing seclusion, and whether it is possible for seclusion measures to be applied more flexibly or in a less restrictive manner.

12.1.4 Every patient that is in seclusion should have a full set of **physical health observations** attempted at every review; these include

- Respirations
- Pulse Oximetry
- Temperature
- Blood Pressure
- Pulse
- Level of Consciousness

12.1.5 All observations must be documented in the eObservations and in the seclusion review documents on RiO.

12.1.6 If there are concerns about the patients physical health the duty doctor should be requested to assess the patient if possible and / or seclusion should be immediately terminated and the patient transferred to A&E.

12.1.7 The patient should then be reviewed every 4 hours by a doctor. At least once every 24hrs it should be a doctor from the treating team (during normal working hours). In the absence of the treating doctors the covering doctor should conduct the review.

12.1.8 4 hourly medical reviews should continue until the first internal MDT review has taken place (see section 12.3). Following the first MDT review, further medical reviews should continue at least 2 times in every 24 hour period. At least one of these should be carried out by the patient's Responsible Clinician. At weekends, public holidays and nights, an on-call Doctor or Duty Doctor is to cover these Responsible Clinician reviews.

12.1.9 One of these two required medical reviews can be in conjunction with the internal MDT review.

12.2 Nursing Reviews

12.2.1 Nursing reviews of the secluded patient should take place at least every two hours following the commencement of seclusion. These should be undertaken by two individuals who are registered nurses, and at least one of whom should not have been involved directly in the decision to seclude.

12.2.2 The Nursing reviews allow for assessment of the patient and should include the areas identified in 11.1.3 -11.1.4 above.

12.2.3 In the event of concerns regarding the patient's condition, this should be immediately brought to the attention of the patient's responsible clinician or duty doctor.

12.2.4 The two-hourly Nursing review must be conducted throughout the duration of seclusion.

12.3 Internal Multi-Disciplinary Team (MDT) Reviews

12.3.1 The first internal MDT seclusion review should be held as soon as is practicable.

12.3.2 Plans for the first internal MDT should be made at the first medical review within an hour of seclusion commencing.

- 12.3.3 Appropriate membership of the internal MDT review would likely include the responsible clinician, a doctor who is an approved clinician, or an approved clinician who is not a doctor but who has appropriate expertise, the senior nurse on the ward, and staff from other disciplines who would normally be involved in patient reviews.
- 12.3.4 At weekends and overnight, membership of the initial MDT review may be limited to medical and nursing staff, in which case the on-call manager should also be involved.
- 12.3.5 Further internal MDT reviews should take place once in every 24-hour period of continuous seclusion.
- 12.3.6 Where seclusion continues, the internal MDT reviews should evaluate and make amendments to the seclusion care plan where appropriate

12.4 Independent MDT Reviews

- 12.4.1 An independent MDT review should be promptly undertaken where a patient has either been secluded for **8 hours consecutively** or for 12 hours intermittently during a 48 hour period. (CoP paragraph 26.141)
- 12.4.2 This independent MDT review must be undertaken by a Consultant/Doctor not involved in the patient's care, a nurse and other professionals not involved in the decision to seclude. (CoP paragraph 26.142). It must be a face to face review. It is good practice to include an Independent Mental Health Advocate (IMHA) in this review if possible.
- 12.4.3 If the seclusion continues, then a second independent MDT review should take place at the end of the **initial 72 hour** period.
- 12.4.4 Good practice is that further independent MDT reviews should continue **every 7 days** thereafter the 72 hour review throughout the entire duration of seclusion.
- 12.4.5 If it is agreed that seclusion needs to continue, the review should evaluate and make recommendations, as appropriate, for amendments to the seclusion care plan.
- 12.4.6 In rare circumstances, if the seclusion period continues for 4 weeks then good practice dictates that an **external (to the Trust) independent MDT** review should be conducted. This review should be led by a Consultant/Doctor from another trust/organisation.

13 ENDING SECLUSION

- 13.1 Seclusion should be terminated immediately when it is determined that is no longer warranted (CoP para. 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)
 - The Nurse-in-Charge when instances of self-harm and/or suicide attempts override the risk of harm to others.
 - Following an internal or independent multi-disciplinary review
 - Following a medical review

- 13.2 Opening a door for short periods (e.g.: 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 (CoP para. 26.146)
- 13.3 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 (CoP para. 26.148)
- 13.4 The nurse in charge must complete the termination section of the Seclusion record and ensure this is reflected in the patient's progress notes.
- 13.5 The nurse in charge must ensure the seclusion room is cleaned and prepared for further use.

14 SECLUDED PATIENT'S RIGHTS AND VISITS

14.1 Patient's Rights

- 14.1.1 All patients, secluded or otherwise have various rights, including freedom of liberty; not to be treated in an inhuman or tortuous way under the Human Rights Act (1998). Additional protections under the mental Health Act 1983 Code of Practice (2015) ensure that patients are always treated with respect and dignity, ensuring confidentiality and protecting individuals from abuse of various kinds.
- 14.1.2 All patients placed in seclusion are guaranteed the following basic rights. These must be explained verbally to them by the nurse in charge or other suitably skilled professional at the commencement of seclusion. These rights must also be displayed in a safe place that the patient can read whilst in the seclusion room (see Appendix E – Patient Rights Poster)

14.2 Visits

- 14.2.1 For the purposes of this policy, the term visitors refers to: carers, family members, next of kin, solicitors, IMHA, CQC Inspectors or anyone else who has relevant input into the patients care.
- 14.2.2 The code of practice recognises that for patients who are in seclusion for a prolonged time visits may be appropriate (CoP para. 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 and in consideration of the patient's wishes.
- 14.2.3 Visitors will not be permitted to visit the patient unless they have the approval of the nurse in charge of the ward, who will seek confirmation from the RC or their nominated deputy before allowing the visit to a secluded patient. Prior to granting approval consideration must be given to whether the visitor or patient will be at risk.
- 14.2.4 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. 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 on duty prior to the visit commencing. The decision of the senior nurse will be final.

14.2.5 Visits will be supervised at all times by a PSS trained team, The team will monitor the safety of the patient and that of others, visits may be terminated at any point if the risk to self or others escalates.

15 SECLUSION CARE PLAN

- 15.1 A seclusion care plan should set out how the individual care needs of the patient will be met whilst the patient is in seclusion and record the steps that should be taken in order to bring the need for seclusion to an end as quickly as possible. As a minimum the seclusion care plan should include:
- a statement of clinical needs (including any physical or mental health problems), risks and treatment objectives
 - a plan as to how needs are to be met, how de-escalation attempts will continue and how risks will be managed
 - details of bedding and clothing to be provided
 - details as to how the patient's dietary needs are to be provided for
 - details of any family or carer contact/communication which will be maintained during the period of seclusion if applicable
- 15.2 Wherever possible, the patient should be supported to contribute to the seclusion care plan and steps should be taken to ensure that the patient is aware of what they need to do for the seclusion to come to an end.
- 15.3 In view of the potentially traumatising effect of seclusion, care plans should provide details of the support that will be provided when the seclusion comes to an end. This should include how the patient will be re-integrated into the full ward community.

16 POST- INCIDENT PROCEDURES

- 16.1 Following any period of seclusion, a post-incident review and debrief should be undertaken so that involved parties, including patients, have appropriate support and there is opportunity for organisational learning. It is important that patients are helped to understand what has happened and why. Patients with limited verbal communication skills may need support to participate in the post incident debriefing.
- 16.2 Where a patient is not able to participate in debriefing, methods for assessing the effects of any intervention on their behaviour, emotions and clinical presentation should be fully explored as part of their assessment(s) and recorded in their positive behaviour support plan (or equivalent). (CoP para. 26.168)
- 16.3 Staff should adhere to the trust's Post-Incident Review and Immediate Support policy for further guidance.
- 16.4 If patients wish to formally raise a concern they should be reminded of how to access the local complaints system and independent advocacy services. Safeguarding teams should be notified of any patient complaint involving a restrictive practice such as seclusion.

- 16.5 Following termination of seclusion, the patient's care plan, risk assessments and positive behaviour support plan, if applicable, should be updated.

17 STAKEHOLDER, CARER AND USER INVOLVEMENT

- 17.1 Key Individuals: Executive Director of Nursing, Deputy Director of Nursing, Heads of Nursing Medical Directorate Lead Nurses, Service Manager/Modern Matrons
- 17.2 Disciplines: Nursing, Allied Health Professions, Medical and Legal Services

18 EQUALITY IMPACT ASSESSMENT SUMMARY

- 18.1 The Equality Act 2010 places a statutory duty on public bodies to have due regard in the exercise of their functions. The duty also requires public bodies to consider how the decisions they make, and the services they deliver, affect people who share equality protected characteristics and those who do not. In KMPT the culture of Equality Impact Assessment will be pursued in order to provide assurance that the Trust has carefully considered any potential negative outcomes that can occur before implementation. The Trust will monitor the implementation of the various functions/policies and refresh them in a timely manner in order to incorporate any positive changes

19 HUMAN RIGHTS

- 19.1 The Human Rights Act 1998 sets out fundamental provisions with respect to the protection of individual human rights. These include maintaining dignity, ensuring confidentiality and protecting individuals from abuse of various kinds. Employees and volunteers of the Trust must ensure that the trust does not breach the human rights of any individual the trust comes into contact with.

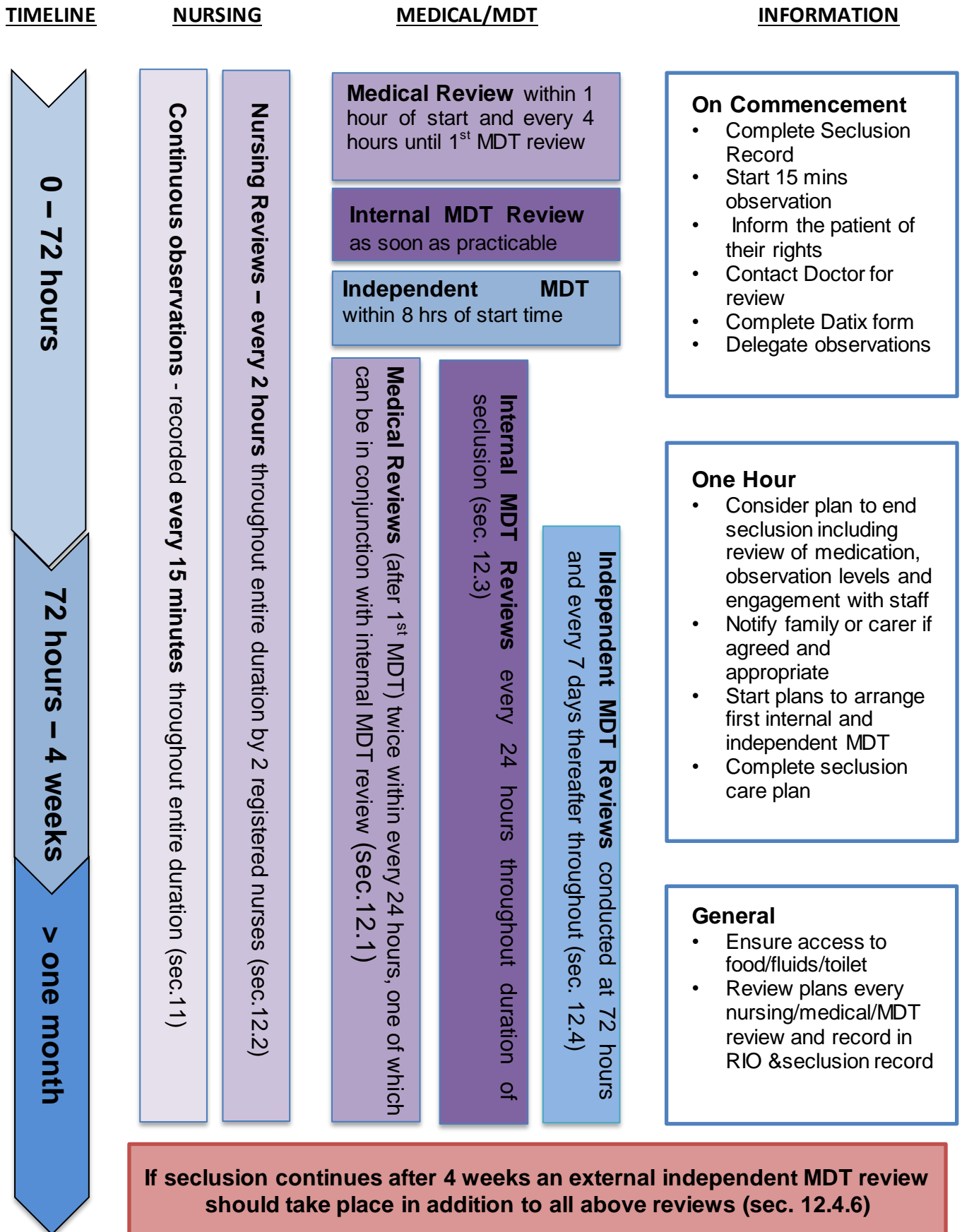
20 MONITORING COMPLIANCE WITH AND EFFECTIVENESS OF THIS DOCUMENT

What will be monitored	How will it be monitored	Who will monitor	Frequency	Evidence to demonstrate monitoring	Action to be taken in event of non-compliance
Daily reporting on seclusion	Daily report	Clinical Leads and Patient Flow	Daily	Daily report from each hospital site	Follow up with the Patient flow by DDON/PSS Manager
IQPR and Quality Digest	Monthly IQPR Report	Information and Performance Team	Monthly and Bi monthly for Quality Digest	IQPR and Quality Digest Reports	DON to follow up
Positive and Safe Care Group: use of restrictive interventions	Governance group on restrictive interventions	DDON to chair the group	Bi-monthly	Reported incidents of seclusion	DON to follow up
Safeguarding reports	Quality Digest	Safeguarding lead	Bi-monthly	Quality Digest reports	Safeguarding team will monitor reports and received daily reports
PSS training	Training compliance on Physical skills and Breakaway	PSS Manager, ward managers, matrons and heads of Service. L&D PSS Group	Monthly	Training Compliance of 85%	Reports on training to be submitted to Workforce Committed by L&D
PBS	Review of electronic records	Ward manager and PSS team	Monitoring as Datix reports are submitted	Case notes review	PSS team will monitor that PBS plan are in place

21 EXCEPTIONS

21.1 There should be no exceptions to this policy. This policy adheres to the Mental Health Act 1983 (amended 2007) Code of Practice (2015) and any departure away from the Code must be for cogent reasons on

APPENDIX A – OVERVIEW OF SECLUSION REVIEWS



Overview of Seclusions Reviews continued

Observations and Reviews factors to consider and document:

Continuous Observations include:

- the patient's appearance
- what they are doing and saying
- their mood,
- their level of awareness
- any evidence of physical ill health especially with regard to their breathing, pallor or cyanosis.

Medical Reviews include:

- a review of the patient's psychiatric health
- an assessment of adverse effects of medication
- a reassessment of medication prescribed
- an assessment of the risk posed by the patient to others
- an assessment of any risk to the patient from deliberate or accidental self-harm
- an assessment of the need for continuing seclusion, and whether it is possible for seclusion measures to be applied more flexibly or in a less restrictive manner.
- Review and amend the seclusion care plan

A review of the **physical condition** of the patient:

- Respirations
- Pulse Oximetry
- Temperature
- Blood Pressure
- Pulse
- Level of Consciousness

Nursing Reviews include:

- a review of the patient's psychiatric health
- an assessment of adverse effects of medication
- an assessment of the risk posed by the patient to others
- an assessment of any risk to the patient from deliberate or accidental self-harm
- an assessment of the need for continuing seclusion, and whether it is possible for seclusion measures to be applied more flexibly or in a less restrictive manner.
- Food and fluid offers and intake
- Toilet and washing offers and use

A review of the physical condition of the patient:

- Respirations
- Pulse Oximetry
- Temperature
- Blood Pressure
- Pulse
- Level of Consciousness

APPENDIX B – REQUIREMENTS OF A SECLUSION ROOM

Design and requirements of a seclusion room

The following factors should be taken into account in the design of rooms or areas where seclusion is to be carried out:

- The room should allow for communication with the patient when the patient is in the room and the door is locked, e.g. via an intercom
- Rooms should include limited furnishings which should include a bed, pillow, mattress and blanket or covering
- There should be no apparent safety hazards
- Rooms should have robust, reinforced window(s) that provide natural light (where possible the window should be positioned to enable a view outside)
- Rooms should have externally controlled lighting, including a main light and subdued lighting for night time
- Rooms should have robust door(s) which open outwards
- Rooms should have externally controlled heating and/or air conditioning, which enables those observing the patient to monitor the room temperature
- Rooms should not have blind spots and alternate viewing panels should be available where required
- A clock should always be visible to the patient from within the room, and
- Rooms should have access to toilet and washing facilities.

(CoP Chapter 26, 2015)

APPENDIX C –SECLUSION RECORD PAPER VERSION (FOR BUSINESS CONTINUITY PLAN)

SECLUSION DOCUMENTATION					
Individual's full name – Print		MHA Status	Ward name	Date	Booklet number
Responsible Clinician (RC) Name		Rio Number	Datix reference number (s)		
Seclusion started	Date	Time	Seclusion ended	Date	Time
Doctor Notified	Time		Doctor Attended	Time	

RATIONALE FOR THE USE OF SECLUSION (include patient presentation/behaviour/risk and what interventions were exhausted prior to making the decision to seclude)					
Last food/fluid intake (including time if known)					
Patients clothing (list clothing patient is wearing at the time the seclusion commenced)					
Print Name	Date	Time	Designation	Signature	

Seclusion observation recording sheets
(Make an entry every 15 minutes of your continuous observations)

Patient's Name		Ward	Continuation sheet no
	Comment on Physical appearance/behaviour – Level of consciousness - nursing/medical interventions – Fluids/Food – Meds – Toilet (please see guidelines)		
Date			Print name & sign
Time			
Date			Print name & sign
Time			
Date			Print name & sign
Time			
Date			Print name & sign
Time			

Nurse in charge to check all entries and countersign

Print Name	Designation	Date	Signature

MEDICAL REVIEWS

(To be carried out every four hours until the first internal MDT review has been carried out.
There after medical reviews can take place at least twice daily.)

Patient's Name	Ward	Responsible Clinician
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Medical Review

If seclusion is to continue this review should establish any new individual care needs and steps that should be taken in order to bring seclusion to an end as quickly as possible.

Print Name	Date	Time	Designation	Signature
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NURSING REVIEWS

(Every two hours by two Nurses to carry out a seclusion review – one of which was not involved in the decision to seclude the individual)

Patient's Name	Ward	Responsible Clinician
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Nursing Review

If seclusion is to continue this review should establish any new individual care needs and steps that should be taken in order to bring seclusion to an end as quickly as possible.

First Nurse: Print Name	Date	Time	Designation	Signature
Second Nurse: Print Name	Date	Time	Designation	Signature

INTERNAL MDT REVIEW

(To be carried out once in every 24 hours)

Patient's Name	Ward	Responsible Clinician		
Name And Designation Of Those In Attendance (including supporting staff)				
Name	Designation			
<i>If seclusion is to continue this review should establish any new individual care needs and steps that should be taken in order to bring seclusion to an end as quickly as possible.</i>				
Print Name	Date	Time	Designation	Signature

APPENDIX D – STAFF COMPETENCIES CHECKLIST

No.	Competency	Staff Sign.	Manager Sign.
1.	Understands that Seclusion: <ul style="list-style-type: none"> • can only be justified when immediate and serious risk of injury to others is present. • can only be initiated by Nurse-in-Charge or by Doctor • can only be initiated when all other methods have been considered and/or exhausted • 		
2.	Comprehends that all reviews: <ul style="list-style-type: none"> • are legal safeguards in the MHA Code of Practice • must be completed and documented as per policy • should assess whether seclusion can be terminated 		
3.	Acknowledges that Observations should: <ul style="list-style-type: none"> • be continuous throughout the entire seclusion episode • be documented every 15 minutes • be based on physical health and well-being; behaviour and identify any risks • be conducted by a registered nurse for the first 30 minutes if rapid tranquilisation is used 		
4.	Demonstrates knowledge of: <ul style="list-style-type: none"> • How to summon immediate help if required • Reasons for immediate help, i.e. self-harm behaviour, physical deterioration of health, and environmental risk 		
5.	Understands that the patient must: <ul style="list-style-type: none"> • Be treated with respect and dignity at all times • Must be informed of reasons seclusion was initiated and under what conditions it will cease. • Be engaged with appropriately and positively 		
6.	Staff member accepts that this policy must be read in conjunction with: <ul style="list-style-type: none"> • Promoting safe Services Policy • Observation and Engagement of Patients (Therapeutic) Policy • Rapid Tranquilisation Policy 		

Staff member has been oriented on the use of seclusion and had any queries answered. They have read related policies. The member of staff has been deemed safe to observe patients in seclusion


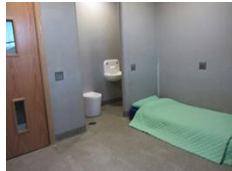




Staff Signature:






Manager Signature:

Date:

Date:

APPENDIX E - PATIENT'S RIGHTS POSTER

<p>The seclusion room door will be locked. You will be looked after at all times. Staff will explain to you why you needed to be nursed in seclusion.</p>	
<p>We will make your environment as comfortable as possible, dependent on risk. This may include newspapers or books.</p>	
<p>You will be offered food and drink on a regular basis. If you have a specific diet, please ask the observing staff.</p>	
<p>For your safety, certain items may be removed and kept safely on the ward and returned to you when safe to do so.</p>	
<p>Bathroom and shower facilities are available when you are in seclusion.</p>	
<p>You may speak to the nurse in charge at any time via the observing nurse.</p>	

<p>There is a clock which will be clearly visible. If you are unsure of the time, day and date you can ask the observing nurse and they will be happy to tell you.</p>	
<p>With your help, a care plan will be developed which will detail how we can keep you safe and supported. This plan will also detail how we can end this seclusion episode and how you will be supported to return to the main ward area.</p>	
<p>You have the right to send and make appropriate calls and messages. If you would like someone to help with this, please speak to the nurse in charge.</p>	
<p>Please speak with doctors, nurses or other professionals who may visit you. They are trying to end seclusion for you as soon as possible.</p>	
<p>If you wish to speak to a patient's advocate, please ask the nurse in charge.</p>	
<p>If you are not happy about how you are being looked after, you have the right to complain and you will be given help to do so if you need it.</p>	