

PROCEDURE FOR THE USE OF SECLUSION & LONG-TERM SEGREGATION

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PROCEDURE SUMMARY		
This procedure aims to provide staff with guidance and practices for seclusion and long term segregation following the changes to the Mental Health Code of Practice in 2015. This procedure applies to all members of staff working within Mental Health, Learning Disability, Child and Adolescent and Secure Services for EPUT whether on a temporary or permanent basis.		
The Trust monitors the implementation of and compliance with this procedure in the following ways:		
Datix reporting system, Manager's sign off, and Restrictive Practice Steering Group		
Services	Applicable	Comments
Trustwide		
Essex MH&LD	✓	
CHS		

**The Director responsible for monitoring and reviewing this policy is
Executive Medical Director**

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Assurance Statement

This procedure sets out the arrangements for the management of Seclusion and Long-Term Segregation for inpatients within EPUT.

The purpose of this procedure is to ensure that all staff take appropriate steps to promote the physical and emotional well-being and the health and safety of patients where the clinical presentation of the patient indicates that the use of seclusion or long-term segregation is warranted. These procedures are intended to be supported by a safe and therapeutic culture that is focussed on individualised, positive and proactive care approaches in the management of disturbed behaviour.

1.0 INTRODUCTION

- 1.1 The 2015 revised MHA Code of Practice (COP) identifies changes to the safe and therapeutic responses to disturbed behaviour. This has required the Trust to review the historic terms of “segregation & restricted access” as. These terms no longer exist within the COP and are covered by the terms “Seclusion” and “Long-Term Segregation” (LTS).

2.0 DEFINITIONS

- 2.1 **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 26.103)
- 2.2 **Long-Term Segregation** refers to a situation where, in order to reduce a sustained risk of harm posed by the patient to others, which is a constant feature of their presentation, a multi-disciplinary review and a representative from the responsible commissioning authority determines that a patient should not be allowed to mix freely with other patients on the ward or unit on a long-term basis. (COP 26.150)
- 2.3 **Time Out** is an intervention used in children and young people’s mental health services ONLY.

Time-out is a specific behaviour change strategy which is delivered as part of a behavioural programme and this may prevent a child or young person from being involved in activities which reinforce a behaviour of concern until the

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behaviour stops; asking them to leave an activity and return when they feel ready to be involved and stop the behaviour; or accompanying the child or young person to another setting and preventing them from engaging in the activity they were participating in for a set period of time.

If at any time “time-out processes” have the features of seclusion, this should be treated as seclusion and comply with the requirements of seclusion processes and the Code. (COP 26.58)

3.0 SECLUSION

3.1 Introduction to Seclusion

Seclusion must only be used as a **last resort** and for the shortest possible time.

Seclusion must never be used solely as a means of **managing self-harming behaviour**. Where the patient poses a risk of self-harm as well as harm to others, seclusion must 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 and that any such risk can be properly managed.

In order to ensure that seclusion measures have a minimal impact on a patient’s autonomy, it 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.

Seclusion should only be used in hospitals and in relation to patients detained under the Mental Health Act. (COP 26.106)

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 26.106). – I.e. holding powers under S.5 (2) or S.5 (4) must be considered as an immediate response whilst MHA assessment is coordinated.

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3.2 Seclusion Environments

If a patient is confined in any way that meets the definition for seclusion (point 1.2) even if they have agreed to or requested such confinement (i.e. they have requested or agreed to be nursed in an area away from other patients), **if they have been prevented from leaving** it is seclusion.

Despite the use of any alternative local terminology or the condition of the immediate environment it does not change the fact that the patient has been secluded and as such the seclusion process must be followed (COP 26.104)

The following factors should be taken into account in the design of rooms or areas in which the patient is secluded to, must (COP 26.109):

- Allow for clear observation with no blind spots
- Have no apparent safety hazards and be ligature free
- Have clear vision of a clock for the patient to identify the time of day
- Have a bed area with pillow, mattress and blanket or covering
- Be fit for purpose and be able to withstand attack/damage
- Have robust doors which open outwards
- Provide privacy from other patients
- Not contain anything which could cause harm to the patient or others
- Be appropriately furnished, heated, lit (and externally controlled where possible), well insulated and ventilated with natural light.
- Have externally controlled temperature that those observing patient can monitor and maintain
- Be quiet, but not sound proofed and will contain some means of calling for attention and allow for communication with the patient; the means of operation will be explained to the patient
- Access to toilet/washing facilities available within the intensive care area

The Trust expects suitable mitigation to be in place where it is not possible to fully meet standards.

Staff may decide what a patient may take into the seclusion room, but the patient must always be clothed.

Patients will be searched before being placed in Seclusion to ensure they have nothing harmful to themselves to others on entry.

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3.3 Authorising Seclusion

<u>Seclusion may be authorised by either:</u>	<u>Additional considerations</u>
A psychiatrist	If the psychiatrist who authorises seclusion is neither the patient's responsible clinician (RC) nor an Approved Clinician (AC), the RC or duty doctor (or equivalent) must be informed of seclusion as soon as practicable.
The professional in charge of ward (i.e. nurse in charge of the ward, RMN)	The patient's RC or duty doctor (or equivalent) must be informed of seclusion as soon as practicable.
An Approved Clinician (AC) who is not a doctor	The patient's RC or duty doctor (or equivalent) must be informed of seclusion as soon as practicable.

The person authorising Seclusion should have seen the patient immediately prior to the commencement of seclusion.

Family members should be notified as per what has been agreed in the patient's positive behaviour support plan (or equivalent).

3.4 Level of Observation

Patients in seclusion requires monitoring on level 3 observation which is "within eyesight" and sound throughout the period of seclusion by a suitably skilled and competent staff member utilising therapeutic engagement to aid in resolving the situation.

In this instance "suitably skilled" and "competent staff member" can include any band 2 Health Care Assistant/Support Worker or above who is TASID trained and have completed the Engagement and Observation competency checklist.

Where a patient identifies as being transgender, where possible staff caring for this patient should be of the same gender the patient identifies as. Any care arrangements will be care planned as required.

The observing staff member should have the means to summon urgent assistance from other staff at any point during the observation

Where a patient appears to be asleep in Seclusion, the person observing the patient should be alert to and assess the level of consciousness and respirations of the patient as appropriate.

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Different review arrangements can be applied **during the night** when **patients in seclusion are asleep**. These arrangements must be agreed by the professional in charge of the ward and/or a doctor and the revised schedule should be recorded in the seclusion care plan and appropriate appendices.

The allocation of the observing staff must take into account patients' gender and consider cultural background.

The aim of observation and engagement is to safeguard the patient, monitor their condition and behaviour and identify the earliest time at which seclusion can come to an end.

3.5 Seclusion Review Process

A series of review processes must be undertaken when a patient is secluded.

WHEN	BY WHOM
Without delay	If the seclusion was not authorised by a doctor and the individual is not known or has a significant change from usual presentation, the patient should be reviewed by a doctor without delay (26.116).
First hour	<ul style="list-style-type: none"> • If the seclusion is not authorised by a consultant psychiatrist, the Responsible Clinician or duty doctor (or equivalent) should attend to undertake the first medical review. • This can be the doctor authorising seclusion • If a consultant psychiatrist authorised the seclusion, their medical review immediately prior to the seclusion satisfies this requirement and no further medical review within the first hour is required.
Every two hours Guidance to Stand alone units	<ul style="list-style-type: none"> • Two registered nurses (i.e. RMN/RNLD) • One of whom was not involved directly in the decision to seclude.
Every four hours	<ul style="list-style-type: none"> • These will be undertaken by the Responsible Clinician. • Where the Responsible Clinician is not immediately available for whatever reason, a "duty doctor" can deputise for the Responsible Clinician. Where the duty doctor is not an Approved Clinician, they should at all times have access to an on call doctor who is an Approved

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	<p>Clinician.</p> <ul style="list-style-type: none"> • During the night if the patient is asleep different medical review arrangements should be agreed and recorded in the patient's records/seclusion care plan.
<p>First internal MDT review i.e. Responsible Clinician; Approved Clinician; Senior Nurse; Psychologist; Occupational Therapist; Integrated Clinical Lead/Matron</p>	<p>As soon as practicable</p>
<p>Twice daily following internal MDT review</p>	<p>Following the first internal MDT review, further medical reviews should continue at least twice in every 24 hour period. At least one of these should be carried out by the patients RC or an alternative approved clinician.</p>
<p>Subsequent Independent MDT review</p>	<ul style="list-style-type: none"> • If the patient is secluded for more than <u>8 hours consecutively</u>; or <u>12 hours over a period of 48 hours</u> an independent multi-disciplinary review must be undertaken by clinicians who were not involved in the original decision to seclude the patient. This process should involve the patient's IMHA where there is one in place. • The independent MDT should consult with those involved in the original decision.

3.6 Seclusion Reviews OUT OF HOURS and WEEKENDS

The on-call Senior Manager and Consultant must be notified of any periods of seclusion and details of this should be recorded on Appendix 1 a.

Nursing reviews will continue at least every 2 hours.

Medical reviews can be designated / delegated to the "Duty Doctor/Consultant on call"; however this must be pre-arranged.

MDT review may be limited to medical and nursing staff, in which case the on-call Senior Site Manager/Unit Coordinator (or equivalent) must also be involved. Further MDT reviews should take place once in every 24-hour period of continuous seclusion.

**3.7 Pharmacological Management of Acutely Disturbed Behaviour (CG52)
(Rapid Tranquilisation COP 26.91 – 26.102) whilst in Seclusion (**

Any patients secluded will have staff present all the time and physical health observation monitoring must be undertaken and recorded on Modified Early Warning System (MEWS).

Where patients have received pharmacological intervention to manage the disturbed behaviour a skilled professional positioned outside of the door is to monitor and record physical health signs for any adverse reaction to medication for at least the first hour after administration or until the effect of the sedation has entirely worn off, whichever is the later.

A skilled professional can be a qualified nurse or suitably experienced Associate Practitioner (Band 4).

3.8 Record Keeping

On commencement of seclusion Appendix 1a must be completed.

The observing staff must observe the patients continuously and document a summary of the patient's mental and physical state and behaviour every 15 minutes, on Appendix 1b. This will include details of any care interventions given and, where applicable:

- The patient's appearance;
- What they are doing and saying
- Their mood
- Their level of awareness; and
- Any evidence of physical ill health especially with regard to their breathing, pallor or cyanosis.

Nursing reviews – will be recorded on Appendix 1c

Medical reviews - will be recorded on Appendix 1d

MDT reviews – will be recorded on Appendix 1e

Care Planning for any seclusion should set out how the individual care needs of the patient will be met whilst in seclusion and the steps that will be taken to bring the need for seclusion to an end as quickly as possible. As a minimum the seclusion care plan (Appendix 1a) must 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

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- 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
- details of the support that will be provided when the seclusion comes to an end

Food, fluid and body charts must be completed for patients

3.9 Discontinuation of Seclusion

Termination of seclusion must be recorded on Appendix 1f.

Seclusion should immediately end when:

- A MDT review, a medical review or the independent MDT review determines it is no longer warranted
- Where the professional in charge of the ward feels that seclusion is no longer warranted
- Following consultation with the patient's responsible clinician or duty doctor (this consultation may take place in person or by telephone)
- A patient is allowed free and unrestricted access to the normal ward environment

Staff should be aware that opening a door for toilet and food breaks or medical review does not constitute the end of a period of seclusion. The period of seclusion only ends when this decision is made by the team.

3.10 Where seclusion must not be used

- Where increased staffing could deal with the problem
- Where managing the risk of suicide or self-harm is the priority
- Where the risk presented is towards property and not towards people. However, if in the view of the nurse in charge, the situation is escalating to a degree where harm to others could easily be caused then seclusion could be considered.
- Where it is seen as a punishment or threat
- As part of a treatment programme (however this can be part of an Advance Decision)
- A pregnant woman must not be secluded after rapid tranquillisation
- Any patient who is heavily sedated or using illicit drugs/alcohol must not be secluded

4.0 LONG-TERM SEGREGATION

4.1 Introduction to Long-Term Segregation

The MHA COP 2015 acknowledges that for a small number of patients it may be necessary to initiate periods of LTS in order to reduce the sustained risk of harm posed by the patient to others and the risk would not be ameliorated by a short period of seclusion combined with any other form of treatment.

The clinical judgement is that, if the patient were allowed to mix freely in the general ward environment, other patients or staff would continue to be exposed to a high likelihood of serious injury or harm over a prolonged period of time.(COP 26.150)

Although isolated from the general ward population for reasons of safety, patients must not be isolated from contact with general ward staff or deprived access to therapeutic interventions.

4.2 Long-Term Segregation Environment

The environment should be no more restrictive than is necessary. This means it should be as homely and personalised as risks considerations allow. (COP 26.151)

Patients in LTS must have access to bathroom facilities, a bedroom, relaxing lounge area, secure outdoor area and a range of activities of interest and relevance to the person. (COP 26.151)

4.3 Authorising Long-Term Segregation

It may be the case that following a period of seclusion, the use of LTS is considered.

The decision to care for a patient under conditions of LTS must be taken by the MDT in conjunction with the responsible commissioning authority representative.

Where is agreed to use LTS, Appendix 2a must be completed.

The patient's views and that of relevant family or carers will be sought in addition to the views of the patient's IMHA if this is appropriate.

The local Safeguarding Team should be made aware of any patient being supported in LTS.

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4.4 Level of Observations

Appendix 2b must be completed hourly to record the continuous observations of the patient in LTS.

As a minimum the patient must be monitored on level 3 observations “within eyesight” by suitably skilled and competent staff utilising therapeutic engagement to aid in resolving the episode.

Allocation of the observing staff must take into account patients’ gender and cultural consider cultural background.

Where a patient identifies as being transgender, where possible staff observing this patient should be of the same gender the patient identifies as. Any care arrangements will be care planned as required.

The aim of engagement and observation is to safeguard the patient, monitor their condition and behaviour and to identify the earliest time at which LTS can come to an end.

4.5 Long Term-Segregation Review Process

<u>When</u>	<u>By Whom</u>
Hourly record <u>Appendix 2b</u>	Observing staff
At least once in every 24 hour period <u>Appendix 2c</u>	Approved Clinician (May or may not be a doctor). Out of hours/weekends the delegated duty doctor for this review would be the on call Approved Clinician/Consultant on call.
At least weekly <u>Appendix 2d</u>	MDT (Should include patients RC and IMHA where appropriate)
Periodic reviews <u>Appendix 2e</u>	Senior professional who is not involved with the case
3 months or longer <u>Appendix 2f</u>	Regular three monthly reviews of the patients circumstances and care to be undertaken by an external hospital. This should include discussion with the patients IMHA and commissioner

These should all be recorded within the patient’s records.

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4.6 Record Keeping

Written records should be made on at least an hourly basis (COP 26.154) within the patient's records.

The outcome of all reviews and the reasons for continued LTS must be recorded on the designated form and within the patient's records and the responsible commissioning authority should be informed of the outcome.

Where successive MDT reviews determine that LTS continues to be required, more information should be available to demonstrate its necessity and explain why the patient cannot be supported in a less restrictive manner.

Care Planning for any episode of LTS must clearly state the reasons why LTS is required and should outline how they are to be made aware of what is required of them so that the period of LTS can be brought to an end. Food, fluid and body charts must be completed for patients

4.7 Discontinuation of Long-Term Segregation

Appendix 2g must be completed for discontinuation of LTS.

The decision to end LTS should be taken by the MDT (including consultation with the patient's IMHA where appropriate), following a thorough risk assessment and observations from staff of the patient's presentation during close monitoring of the patient in the company of others (COP 26.157).

The decision to discontinue long-term segregation must be clearly recorded within the patient's records and care plans.

5.0 DEPRIVATION OF ACCESS TO NORMAL DAYTIME CLOTHING WHILST IN SECLUSION AND LONG-TERM SEGREGATION

Individuals must 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 26.161).

However there are circumstances where it will be appropriate and necessary to use restrictive clothing in order to prevent risks to self-i.e. safe suit/ safe clothing. Where this is implemented, a rationale for this must be recorded, the patient must be informed of reasons, reviews must be evidence (including least restrictive alternative strategies) and the use must be for the shortest amount of time.

For guidance on the use of safe suit/safe clothing please refer to Appendix 3c.

6.0 POST INCIDENT REVIEWS/ DEBRIEFING (Psychology direction)

- 6.1 Following use of seclusion or LTS, a post-incident review or debrief should be undertaken so that all involved parties, including patients, have appropriate support and there is opportunity for learning. It is important that patients are helped to understand what has happened and why.
- 6.2 Methods should be put in place to assess the effect of the seclusion or long-term segregation on the patient.

This should all be recorded within the patient's positive behaviour support plan.

- 6.3 Discussion with the patient about the experience should be used in the future to determine what did and did not help and what could be done differently in the future. The patient's accounts of the incident and their feelings following it should be recorded in the patient's notes.
- 6.4 Patients should be reminded that they can record their future wishes and feelings about which restrictive interventions they would or would not like to be used in an advance statement.

7.0 AUDITING & GOVERNANCE

- 7.1 All incidents of seclusion and LTS must be recorded on Datix.
- 7.2 All ward sisters/charge nurses will scrutinise the seclusion and LTS paperwork and processes as it happens for compliance using Appendix 1g for seclusion and Appendix 2h for LTS. A. This will be signed off by the relevant services lead (Clinical Leads, matron, etc.) and filed in the electronic record.
- 7.3 Compliance will be monitored via the restraint/seclusion review group with a monthly report from the reviewers re process compliance and standard of reporting in line with the MHA code of practice 2015. This will be reported into the Restrictive Practice Steering Group for learning and oversight.
- 7.4 Annually there will be an audit of seclusion and LTS paperwork and processes to provide assurances to the wider Trust. The Clinical Audit Department will ensure that annual audits are carried out as part of the annual audit programme and learning is shared across the Trust.
- 7.5 If patients wish to formally raise a concern
- They will be reminded of how to access the local complaints process and independent advocacy services.
 - They will also be made aware of how to request an accessible version of the Trust policy on restrictive interventions.

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- The safeguarding team will be informed whenever a patient raises concerns about restrictive interventions.
- Patients who need alternative support will be offered this support to access and use the complaints procedure.

8.0 TRAINING

- 8.1 The Trust have a policy on workforce development and training for staff who may be exposed to aggression or violence in their work or who may need to become involved in the application of restrictive interventions.
- 8.2 All Trust staff that support people who are liable to present with acute behavioural disturbance will be competent in physical monitoring and emergency resuscitation techniques to ensure the safety of patients following administration of rapid tranquillisation and during periods of physical restraint or seclusion.
- 8.3 All clinical staff undertaking training in the recognition, prevention and management of violence and aggression and associated physical restraint must attend annual refresher training.

9.0 POLICY REFERENCES/

- Therapeutic and Safety Interventions and De-escalation Policy (RM05)
- Engagement and Supportive Observation Policy and Procedure (Inpatients) (CLP8, CLPG8)
- Pharmacological Management of Acutely Disturbed Behaviour Guideline (CG52)
- Safeguarding Adults Policy and Procedure (CLP39, CLPG39)
- Safeguarding Children Policy & Procedure (CLP37, CLPG37)
- Clinical Guideline for Engagement and Formal Observation (CLP8)
- Advanced Decisions and Directives (CLP6 and CLPG6)

10.0 ASSOCIATED DOCUMENTATION

- Mental Health Act 1983 (amended 2007)
- Mental Health Act Code of Practice, 2015
- Mental Capacity Act, 2005
- Children Act 2004
- Positive and Proactive Care: reducing the need for restrictive interventions. DH (2014)

END