Essex Partnership University
NHS Foundation Trust

POLICY FOR THE USE OF SECLUSION & LONG-TERM SEGREGATION

POLICY NUMBER:	CLP41
VERSION NUMBER:	2.2
KEY CHANGES FROM PREVIOUS VERSION:	Amendment: Updates with further guidance from MH CoP. Policy now states patient must be with a member of staff at all times and must not be locked in a seclusion room. 2.2 – review date amended to April 2025 – June 23 review considered majority of Policy & Procedure
AUTHOR:	Consultant Psychiatrist - Forensic
CONSULTATION GROUPS:	Service Management Teams Quality Groups Restrictive Practice Steering Group
IMPLEMENTATION DATE:	November 2017
AMENDMENT DATE(S):	February 2021; June 2023; October 2023
LAST REVIEW DATE:	April 2021
NEXT REVIEW DATE:	April 2025
APPROVAL BY CLINICAL GOVERNANCE & QUALITY SUB-COMMITTEE:	March 2021
RATIFICATION BY QUALITY COMMITTEE	April 2021

POLICY SUMMARY

This policy aims to ensure that all staff are provided with the information required to enable them to adhere to the principles that underpin the use of restrictive practices and the aim to reduce the use of restrictive practices within the Trust. These principles follow safe and therapeutic responses to disturbed behaviour (Code of Practice, 1983) current best practice guidance.

The Trust monitors the implementation of and compliance with this policy in the following ways:

Datix reporting system, Manager's sign off, Restraint and Seclusion Review Group and Restrictive Practice Steering Group as part of the Quality Account.

Services	Applicable	Comments
Trustwide		
Essex MH&LD	✓	
CHS		

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

ESSEX PARTNERSHIP UNIVERSITY NHS FOUNDATION TRUST

POLICY FOR THE USE OF SECLUSION AND LONG-TERM SEGREGATION

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ESSEX PARTNERSHIP UNIVERSITY NHS FOUNDATION TRUST

POLICY FOR THE USE OF SECLUSION AND LONG-TERM SEGREGATION

Assurance Statement

Essex Partnership University NHS Foundation Trust (EPUT) aims to ensure that any patient who presents with behaviour that challenges in-patient services to such an extent that they cause a risk to themselves, or others around them, must be cared for in accordance with guidelines as set out within the Mental Health Act 1983 Code of Practice (Department of Health, 2015).

This policy aims to ensure that all staff are provided with current information and the underlying principles considered by the Trust to be essential regarding the use of Seclusion and Long-Term Segregation.

The principles contained within this policy and associated documents will aim to ensure the physical and emotional safety and wellbeing of the patient by promoting the use of effective communication, respectful and dignified approaches to Restrictive Interventions including Seclusion and Long-Term Segregation.

1.0 INTRODUCTION

1.1 This policy and associated procedure outline the processes for the use of Seclusion and Long-Term Segregation (LTS) within the Trust.

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

1.3 Seclusion and Long-Term Segregation (LTS) are restrictive interventions. The Trust acknowledges this and the associated ethical and practical dilemmas. This policy and the associated procedure titled “Use of Seclusion and Long-Term Segregation Procedure – CPG41” set out circumstances in which such restrictive interventions are to be used and this will be kept under ongoing review.

1.4 Any decision to seclude a patient in accordance with this policy must be for the containment of severe behavioural disturbance which is likely to cause harm to others and where the professionals involved are satisfied the need to protect others outweighs any increased risk to the patient’s health or safety

1.5 Seclusion itself is an emergency measure and should only be used as last resort as directed by the MH Code of Practice. In exceptional circumstances, it would be the case in Child and Adolescent Services that seclusion may be used as part of an actively planned episode of care to manage risks and reduce the need for RT.

1.6 The Mental Capacity Act 2005 (MCA) including the Deprivation of Liberty Safeguards (DOLS) (Liberty Protection Safeguards) cannot be used to authorise seclusion. Seclusion should ordinarily be used on patients who are detained under the MHA 1983. **For emergency situations, please refer to 3.1 of the Seclusion and Long-Term Segregation Procedure.**

1.7 If a patient requests Seclusion or has an Advance Statement which meets the seclusion definition, seclusion processes must be followed and evidenced (COP 26.104)

2.0 DEFINITIONS

2.1 The definition for seclusion and long-term segregation is set out in the MHA COP 2015.

2.2 ***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).

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 (26.104).

2.3 ***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).

The environment should be no more restrictive than is necessary. This means it should be as homely and personalised as risk considerations allow. Facilities which are used to accommodate patients in conditions of long-term segregation should be configured to allow the patient to access a number of areas including, as a minimum, bathroom facilities, a bedroom and relaxing lounge area. Patients should also be able to access secure outdoor areas and a range activities of interest and relevance to the person (COP 26.151).

Patients should not be isolated from contact with staff (indeed it is highly likely they should be supported through enhanced observation) or deprived of access to therapeutic interventions (COP 26.152).

Patients managed under the LTS Framework must not be locked in a seclusion room and must have a member of staff in the room with them at all times.

3.0 DUTIES

3.1 Executive Medical Director for Patient Safety

- Ensure policy and procedures are embedded into clinical practice and that these procedures are implemented and monitored.

3.2 Directors and Senior Management:

- Ensure this policy and accompanying procedure is complied with.
- Monitor the implementation of this policy via clinical audit and supervision.
- Ensure that Trust Risk Management Team is appropriately notified on all incidents of seclusion and long term segregation via the Datix system.
- Be able to evidence that EPUT policies have been followed.

3.3 Team Managers, Clinical Leads, Matrons and other Persons in Charge:

- Ensure policy and procedures are adhered to in accordance with the MHA COP.
- Ensure that all requirements in relation to the seclusion and long-term segregation of a patient are followed and implemented.
- Ensure that all seclusion and long-term segregation incidents are recorded and reported through the Datix Incident Reporting System.
- Ensure staff receives training and are competent in managing seclusion and long term segregation.
- Ensure that risk assessment is reviewed and support plans reflect current risks.
- Ensure that staff wellbeing is maintained following the incident and incident analysis is carried out and takes forward lessons learned.

3.4 Individual Staff Members

- All staff must ensure that they are competent in the seclusion and long term segregation process as set out in the MHA COP.
- All staff must ensure that all required documentation and reporting processes are implemented and adhered to.
- All staff have a responsibility to provide accurate and timely records of Seclusion and or Long-term segregation episode
- Staff must be aware of the rights of a secluded patients' - freedom, choice and autonomy and the rights of others to protection from harm
- Staff must ensure that the patient receive the care and support rendered necessary by their seclusion both during and after it has taken place
- All staff will have a good working knowledge of the risks and care plan requirements of a patient in seclusion or LTS.
- All staff have the duty of care to act on changes to a patient's presentation and mental state whilst in Seclusion or LTS and ensure these are reported and documented.

4.0 MONITORING OF IMPLEMENTATION

4.1 This policy will be made available across the organisation via the Trust Intranet site

4.2 All incidents of Seclusion and LTS must be reported in line with the MHA COP, 2015.

4.3 Screening of staff will be in accordance with Disclosure and Barring Service (DBS) and Recruitment and Retention Policy (HR57).

4.4 Training in relation to the MHA is part of the Mandatory Training portfolio.

4.5 Any additional training needs in relation to Seclusion and LTS will be identified by team managers and should be referred to the Restrictive Practice Trust Steering Group to ensure that they are addressed promptly.

5.0 MONITORING AND COMPLIANCE

5.1 The Executive Medical Director for Patient Safety will be responsible for overall monitoring and review of this policy.

5.2 All incidents of Seclusion and LTS must be recorded on Datix.

5.3 All ward sisters/charge nurses/ ward managers will scrutinise the Seclusion and LTS paperwork and processes as it happens for compliance using Appendix 1g for seclusion and Appendix 2h for LTS. This will be signed off by the relevant services lead (Clinical Lead, Matron, etc.)

5.4 Compliance will be monitored via the local Clinical Governance and Quality Groups and reported into the Restrictive Practice Steering Trust Group for learning and oversight.

5.5 Annually there will be an audit of Seclusion and LTS 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

5.6 This policy will be reviewed every 3 years taking into account emerging research, local audit recommendations and lessons learnt from reports, enquiries and positive practice initiatives.

6.0 POLICY REFERENCES

- Serious Incidents (SI) Policy and Procedure (CP3, CPG3),
- Safeguarding Adults Policy and Procedure (CLP39, CLPG39)
- Safeguarding Children Policy & Procedure (CLP37, CLPG37)
- Clinical Guideline for Engagement and Formal Observation (CLP8)
- Advance Directive (CG6)

7.0 ASSOCIATED DOCUMENTS

- 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

Equality Impact Assessment Template

Section 1: Your details

(1.1) Department / Team: Clinical Governance

(1.2) Locality/Directorate: Brookfield House [Office base]

(1.3) Assessment Lead/person: Gary Bettell-Higgins/jo Paul

(1.4) Contact details:

(1.5) Email:

(1.6) Who else will be involved in the process?

(1.7) Please sign & date this form …… (signed) …… (date)

Guidance Note 1:

For Initial EIA's it is best practice to involve the service /clinical manager, and relevant frontline staff.

For Full EIA's it is best practice to involve the service / clinical manager, relevant frontline staff, service users/ carers, appropriate external agencies, and the voluntary and community sector.

Section 2: What is to be assessed? Seclusion

(2.1) Name of service / function / project / strategy / policy to be assessed (see guidance note 2)

(2.2) Is this a new or existing service / function / project /strategy / policy? (please state)

(2.3) Has it been assessed before and if so please attach the existing assessment.

Guidance Note 2:

Service = your department / service area and its employees

Functions = your department / service area's activities

Projects = your department / service area's work programmes

Strategy = a plan of action intended to accomplish a specific goal

Policy = a plan of action to influence and determine decisions, actions and other matters

Procedure = a series of steps taken to implement a policy

Section 3: Let's do the Initial Equality Impact Assessment (Screening)

3.1 Could a particular group of people be affected differently in either a negative or positive way by the service / function / project / strategy / policy?

Equality Group	**Positive Impact (benefits)** **Please number each one**	**Negative Impact (disadvantage) or potential negative impact** **Please number each one and provide evidence**	**Please rate each negative impact 'low', 'medium' or 'high'** **See guidance note 3**
Disabled People	Managing extreme levels of violence in isolation from others for the protection of others. The individuals wellbeing who has been secluded is the fundamental priority of the staff Trust policy and procedure needs to be followed (Mental health Act code of practice 1983 (2015)	No aids or adaptations appropriate for this procedure Possible some level of trauma The clinical procedure and physical techniques are standard. Following the management of violence and seclusion and long term segregation policies	Low- high as aim to manage high level violence individual in the clinical setting Secluding an individual away from all for the minimum amount of time following Code of Practice guidance Physical techniques to exit seclusion needs to be adapted
Lesbian, Gay & Bisexual People	Managing extreme levels of violence in isolation from others for the protection of others.	Possible some level of trauma The clinical procedure and physical techniques are standard. Following	Low- high as aim to manage high level violence individual in the clinical setting

	The individuals wellbeing who has been secluded is the fundamental priority of the staff Trust policy and procedure needs to be followed (Mental health Act code of practice 1983 (2015)	the management of violence and seclusion and long term segregation policies	Secluding an individual away from all for the minimum amount of time following Code of Practice guidance
Women	Managing extreme levels of violence in isolation from others for the protection of others. The individuals wellbeing who has been secluded is the fundamental priority of the staff Trust policy and procedure needs to be followed (Mental health Act code of practice 1983 (2015)	Possible some level of trauma The clinical procedure and physical techniques are standard. Following the management of violence and seclusion and long term segregation policies	Low- high as aim to manage high level violence individual in the clinical setting Secluding an individual away from all for the minimum amount of time following Code of Practice guidance
Men	Managing extreme levels of violence in isolation from others for the protection of others. The individuals wellbeing who has been secluded is the fundamental priority of the staff Trust policy and procedure needs to be followed (Mental health Act code of practice 1983 (2015)	Possible some level of trauma The clinical procedure and physical techniques are standard. Following the management of violence and seclusion and long term segregation policies	Low- high as aim to manage high level violence individual in the clinical setting Secluding an individual away from all for the minimum amount of time following Code of Practice guidance

Equality Group	Positive Impact (benefits) Please number each one	Negative Impact (disadvantage) or potential negative impact Please number each one and provide evidence	Please rate each negative impact 'low', 'medium' or 'high' See guidance note 3
Transgendered People	Managing extreme levels of violence in isolation from others for the protection of others. The individuals wellbeing who has been secluded is the fundamental priority of the staff Trust policy and procedure needs to be followed (Mental health Act code of practice 1983 (2015)	Possible some level of trauma The clinical procedure and physical techniques are standard. Following the management of violence and seclusion and long term segregation policies	Low- high as aim to manage high level violence individual in the clinical setting Secluding an individual away from all for the minimum amount of time following Code of Practice guidance
Black & Racial Minority People (please state which group)	Managing extreme levels of violence in isolation from others for the protection of others. The individuals wellbeing who has been secluded is the fundamental priority of the staff Trust policy and procedure needs to be followed (Mental health Act code of practice 1983 (2015)	Possible some level of trauma The clinical procedure and physical techniques are standard. Following the management of violence and seclusion and long term segregation policies	Low- high as aim to manage high level violence individual in the clinical setting Secluding an individual away from all for the minimum amount of time following Code of Practice guidance
Older People (60+)	Managing extreme levels of violence in isolation from others for the protection of others. The individuals wellbeing who has been secluded is the fundamental priority of the staff	Possible some level of trauma The clinical procedure and physical techniques are standard. Following the management of violence and seclusion	Low- high as aim to manage high level violence individual in the clinical setting Secluding an individual away from all for the minimum amount of time

	Trust policy and procedure needs to be followed (Mental health Act code of practice 1983 (2015)	and long term segregation policies	following Code of Practice guidance
Younger People (17-25) and Children Please state male or female	Managing extreme levels of violence in isolation from others for the protection of others. The individuals wellbeing who has been secluded is the fundamental priority of the staff Trust policy and procedure needs to be followed (Mental health Act code of practice 1983 (2015)	Possible some level of trauma The clinical procedure and physical techniques are standard. Following the management of violence and seclusion and long term segregation policies	Low- high as aim to manage high level violence individual in the clinical setting Secluding an individual away from all for the minimum amount of time following Code of Practice guidance
Religious / Faith Groups	Managing extreme levels of violence in isolation from others for the protection of others. The individuals wellbeing who has been secluded is the fundamental priority of the staff Trust policy and procedure needs to be followed (Mental health Act code of practice 1983 (2015)	Possible some level of trauma The clinical procedure and physical techniques are standard. Following the management of violence and seclusion and long term segregation policies	Low- high as aim to manage high level violence individual in the clinical setting Secluding an individual away from all for the minimum amount of time following Code of Practice guidance
Pregnancy and maternity	Managing extreme levels of violence in isolation from others for the protection of others. The individuals wellbeing who has been secluded is the fundamental priority of the staff Trust policy and procedure needs to be followed (Mental health Act code of practice 1983 (2015)	Possible some level of trauma The clinical procedure and physical techniques are standard. Following the management of violence and seclusion and long term segregation policies	Low- high as aim to manage high level violence individual in the clinical setting Secluding an individual away from all for the minimum amount of time following Code of Practice guidance

			Physical techniques to exit seclusion needs to be adapted
Marriage and civil partnership		N/A	
Deprived Groups		N/A	

If you have rated any negative impact(s) as 'High' please go straight to Section 4 to complete a full assessment.

If you have rated any negative impact as 'Low' or 'Medium please complete the rest of this section on pages 5 and 6.

Guidance Note 3: How to assess negative impacts

Low = It is not discriminatory according to current legislation. However, it might not be seen as being in line with best practice.

Medium = It is not discriminatory according to current legislation. However, it is not in line with the Trust or Department Equality Policy and/or Strategy and requires attention

High = It is discriminatory according to current anti-discrimination legislation (i.e. it is unlawful), and therefore requires immediate action.

3.2 Please list below any actions that you plan to take as a result of any negative impact

EIA Action plan

Low or medium negative impact	Action required to remove or minimise the impact	Lead person	Timescale	Resource implications	Any other comments

3.3 Could you improve the positive impact(s)? Please explain how

3.4 If you have identified no negative impact, then please explain how you reached that decision and provide reference to evidence (for example reviews undertaken, surveys, feedback, patient data verified etc)

Thank you for completing the initial assessment (please email a copy of this report to the compliance function.

Please note that the lead assessment person is responsible for ensuring the actions on pages 9 and 10 are incorporated into your departmental plan.

Section 4: Full Equality Impact Assessment

4.1 Looking back at pages 2 & 3, in which equality areas are there concerns?

- ☐ Disability
- ☐ Sexual Orientation
- ☐ Gender
- ☐ Race
- ☐ Age
- ☐ Religion & Faith
- ☐ Deprivation
- ☐ Marital status
- ☐ Pregnancy and maternity

4.2 Please summarise the negative impact (s) or potential negative impacts

4.3 What consultation has taken place with local people / patient groups in order to complete this full EIA?

4.4 What consultation has taken place with EPUT staff / stakeholders / those we work in partnership with / those we contract with in order to complete this full EIA?

4.5 What equality research / studies / reports have you referred to in order to complete this full EIA?

4.6 What monitoring / evaluation process do you use to collect equality group data (quantitative and qualitative)?

4.7 Please list below any actions that you plan to take as a result of this full equality impact assessment

EIA Action plan

Negative Impact	Action to be taken	Lead person	Timescale	Resource implications	Any other comments

Thank you for completing the full assessment.
Now email a copy of this report to compliance function

Please note that the lead assessment person is responsible for ensuring the above actions are incorporated into your departmental plan or organisation-wide plan

Essex Partnership University
NHS Foundation Trust

PROCEDURE FOR THE USE OF SECLUSION & LONG-TERM SEGREGATION

PROCEDURE NUMBER:	CLGP41
VERSION NUMBER:	2.3
KEY CHANGES FROM PREVIOUS VERSION:	Amendment: Procedure: definitions updated with further guidance from the (MH) CoP. Appendices 1d-e updated with number of reviews required Appendix 1g replaced with new scrutiny form for Seclusion Appendix 2a updated with patient must not be locked in a seclusion room and staff member having to remain with a patient at all times in LTS Appendix 2h replaced with new scrutiny form for LTS Appendix 3a replaced with updated and completely revised Seclusion flow chart Appendix 3b replaced with updated and completely revised LTS flow chart Seclusion LTS Flowchart PDF (00) rescinded 2.2 – review date amended to April 2025 – June 23 review considered majority of Policy & Procedure 2.3 – new guidance regarding observations & Oxevision in s3.8 & 4.4
AUTHOR:	Consultant Psychiatrist - Forensic
CONSULTATION GROUPS:	Service Management Teams Quality Groups Trust Solicitor Seclusion & LTS Task and Finish Group
IMPLEMENTATION DATE:	November 2017
AMENDMENT DATE(S):	July 2019 (Chair's Action CGQSC); February 2021; June 2023; October 2023 November 2023
LAST REVIEW DATE:	April 2021
NEXT REVIEW DATE:	April 2025
APPROVAL BY CLINICAL GOVERNANCE & QUALITY SUB-COMMITTEE:	March 2021
RATIFICATION BY QUALITY COMMITTEE	April 2021
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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

ESSEX PARTNERSHIP UNIVERSITY NHS FOUNDATION TRUST

PROCEDURE FOR THE USE OF SECLUSION AND LONG-TERM SEGREGATION

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LONG-TERM SEGREGATION FORMS

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APPENDIX 2h Monitoring/Scrutiny Form

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ESSEX PARTNERSHIP UNIVERSITY NHS FOUNDATION TRUST

PROCEDURE FOR THE USE OF SECLUSION AND LONG-TERM SEGREGATION

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 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.

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).

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. Seclusion does not include locking people in their rooms at night (COP 26.105).

Seclusion should not be used as a punishment or a threat, or because of a shortage of staff. It should not form part of a treatment programme (COP 26.107).

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.

3.3 Authorising Seclusion

Seclusion may be authorised by either:	**Additional considerations**
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.

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	• 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	• Two registered nurses (i.e. RMN/RNLD) • One of whom was not involved directly in the decision to seclude.
Every four hours	• 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 Clinician. • 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.
First internal MDT review i.e. Responsible Clinician; Approved Clinician; Senior Nurse; Psychologist; Occupational Therapist; Integrated Clinical Lead/Matron	As soon as practicable
Twice daily following internal MDT review	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.
Subsequent Independent MDT review	• If the patient is secluded for more than 8 hours consecutively; or 12 hours over a period of 48 hours 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 1a.

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 observed 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.

Where Oxevision is in place, the Oxevision equipped seclusion rooms are enabled to capture patient vitals (breathing and pulse rates) through the Oxevision system. Oxevision is a supportive tool for taking vital signs when it is unsafe for staff to enter the seclusion room or when it is unnecessary to disturb the patients sleep. Staff must continue to observe the patient as prescribed in section 3.8 above. Instead of recording the observations on Appendix 1b the observations should be recorded on the Oxevision tablet. An icon (tile) on the Oxevision tablet enables the vitals to be recorded by pressing the icon, 'take vitals'.

Seclusion rooms without Oxevision activated or in instances where Oxevision is authorised to be turned off, staff must revert to recording on Appendix 2b.

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
- 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 (COP 25.150).

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 (COP 26.152).

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). This means that patients should not be locked in a seclusion room.

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 it 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.

4.4 Level of Observations

Appendix 2b must be completed hourly to record the continuous observations of the patient in LTS. ***Where Oxevision is in place,*** Staff must continue to observe the patient as prescribed in section 3.8 above. Instead of recording the observations on Appendix 1b the observations should be recorded on the Oxevision tablet. An icon (tile) on the Oxevision tablet enables the vitals to be recorded by pressing the icon, 'take vitals'.

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. Staff must be in the same room with the patient.

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

When	By Whom
Hourly record Appendix 2b	Observing staff
At least once in every 24 hour period Appendix 2c	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 **Appendix 2d**	MDT (Should include patients RC and IMHA where appropriate)
Periodic reviews **Appendix 2e**	Senior professional who is not involved with the case
3 months or longer **Appendix 2f**	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.

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 l 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.
- 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)
- Therapeutic 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)
- 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

Last Name		**First Name**			
NHS No.		**Date of Birth**		**Unit / Ward**	

SECLUSION - COMMENCEMENT FORM

RESPONSIBLE CLINICIAN

Name: …… ……
(Block Capitals)

NURSE IN CHARGE

Name……Signature……
(Block Capitals)

SECLUSION DETAILS

DATE OF SECLUSION…….. TIME COMMENCED……..

Area of Seclusion
☐ Designated Seclusion Room ☐ Bedroom
☐ Intensive Care Suite ☐ Other

Date and time of change to Area of Seclusion:

REASONS FOR SECLUSION (including patient's mental state, details of incident)

……..

……..

……..

AUTHORISING DOCTOR (where decision is taken to seclude by a senior nurse, doctor must attend within the first hour to authorise it. The person authorising seclusion should have seen the patient immediately prior to authorising the seclusion)

Name……Signature……
(Block Capitals)
Role/ Grade: (On-call doctor, RC etc.): ……

Time Notified……...Time of Arrival……

If delayed please comment: ……..

REASONS FOR AGREEING SECLUSION

……..

Last Name		**First Name**			
NHS No.		**Date of Birth**		**Unit / Ward**	

.....

Consultant informed Date and Time:

- The patient must be continually monitored at all times throughout the period of seclusion and a record made of the patients behaviour every fifteen (15) minutes by a suitably skilled nurse. This should include the patients appearance; what they are doing and saying; their mood; level of awareness and any evidence of physical ill health, especially with regard to their breathing, pallor or cyanosis
- Two (2) hourly reviews by two RMN's/RNLD's (one not involved in the decision to seclude)
- Four (4) hourly reviews by a Doctor (either the ward or duty doctor)
- Out of hours and weekends continuation of the four hourly medical reviews should be carried out until the first MDT has taken place. Different review arrangements can be agreed and applied locally when patients in seclusion are asleep the Doctor must be informed and visit as soon as possible after the patient has woken and the detail of the revised review recorded in the care plan
- 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 patient's responsible clinician.
- If the Seclusion continues for more than eight (8) hours consecutively or for more than twelve (12) hours intermittently over a period of forty eight (48) hours, an independent review must take place by an MDT not involved in the decision to seclude.
- A Datix must be completed for each episode of seclusion
- Family members should be notified as per what has been agreed in the patient's positive behaviour support plan (or equivalent) with the agreement/consent of the patient to share information

Date Family Informed :

CARE PLANNING	
Mental Health Needs	
Managing Risks	
Physical Health Needs	
Clothing	
Bedding	
Dietary Needs	
Verbal De-escalation	
Other	

Last Name		**First Name**			
NHS No.		**Date of Birth**		**Unit / Ward**	

☐ Patient's Views Date: ……
Comments:

☐ IMHA Informed Date: ……
☐ Safeguarding Team Informed Date: ……
☐ Commissioner Date: ……
(Please speak to service lead or commissioners contact details)

FAMILY INVOLVEMENT

:
Name of the Family member / Carer informed /Contacted
Date Family Informed/contacted: Time:

Comments:

MONITORING

UNIT MANAGER'S Clinical Lead /Matron/ Ward Sister / Charge Nurse / Nurse in Charge

NAME: ……
(Block Capitals)
SIGNATURE……DATE……
Responsible Clinician ……
Signature:……Date

OUT OF HOURS

NAME OF SENIOR MANAGER INFORMED: ……

Date……..Time:……

NAME OF CONSULTANT ON CALL INFORMED: ……..

Date……..Time……

Last Name		First Name			
NHS No.		Date of Birth		Unit / Ward	

SECLUSION – RECORD OF OBSERVATIONS

DATE: …….. **Tear- resistant clothing in use yes /no (please circle) If so time commenced ……..**

TIME (Every 15mins)	CLINICAL OBSERVATIONS (i.e. Physical Condition, Mental State, Mood and Behaviour)	DETAILS OF CARE PROVIDED (i.e. drinks/food offered, bedding, books, engagement)	NAME AND STATUS	SIGNATURE
(15)				
(30)				
(45)				
(1 hour)				
(1hr 15)				
(1hr 30)				

Last Name		**First Name**			
NHS No.		**Date of Birth**		**Unit / Ward**	

(1hr 45)				
(2hr 00)				

Last Name		**First Name**			
NHS No.		**Date of Birth**		**Unit / Ward**	

SECLUSION - NURSING REVIEWS

Date and Time of Review (e.g. this must be 2 hourly)	**CLINICAL OBSERVATIONS AND CARE GIVEN**	**DETAILS OF REASONS TO CONTINUE OR DISCONTINUE SECLUSION, INCLUDING RISK MANAGEMENT AND/OR CARE PLAN**	**SECLUSION CONTINUED/ DISCONTINUED (Please state)**
EXPLAINED TO PATIENT		**YES/NO**	

Last Name		**First Name**			
NHS No.		**Date of Birth**		**Unit / Ward**	

Patient's Views
Comments:

IMHA
Comments:

NAME AND ROLE OF 1st RMN/RNLD		**SIGNATURE**
NAME AND ROLE OF 2nd RMN/RNLD		**SIGNATURE**
NAME AND ROLE OF INDEPENDENT MDT PROFESSIONAL (8 hourly review)		**SIGNATURE**

Last Name		**First Name**			
NHS No.		**Date of Birth**		**Unit / Ward**	

SECLUSION - DOCTORS REVIEW FORM

Date and Time of Review (e.g. 4, 8 and 12 hourly)	**CLINICAL OBSERVATIONS CARE GIVEN**	**DETAILS OF REASONS TO CONTINUE OR DISCONTINUE SECLUSION, INCLUDING RISK MANAGEMENT AND/OR CARE PLAN**	**SECLUSION CONTINUED/ DISCONTINUED (Please state)**
EXPLAINED TO PATIENT		**YES/NO**	

Last Name		**First Name**			
NHS No.		**Date of Birth**		**Unit / Ward**	

Patient Views
Comments:

IMHA
Comments:

NAME AND ROLE OF DOCTOR		**SIGNATURE**
NAME AND ROLE OF INDEPENDENT MDT PROFESSIONAL (8 hourly review)		**SIGNATURE**

Last Name		**First Name**			
NHS No.		**Date of Birth**		**Unit / Ward**	

SECLUSION - MDT REVIEWS

If the patient is secluded for more than 8 hours consecutively or 12 hours over a period of 48 hours Independent MDT Review is required

Date and Time of Review (first review to be held as soon as practicable and then minimum once every 24hrs)	**DISCUSSION AND REASSESSMENT OF SECLUSION**	**DETAILS OF REASONS TO CONTINUE OR DISCONTINUE SECLUSION, INCLUDING RISK MANAGEMENT AND/OR CARE PLAN**	**OUTCOME OF REVIEW SECLUSION CONTINUED/DISCONTINUED (Please state)**
EXPLAINED TO PATIENT		**YES/NO**	

Last Name		**First Name**			
NHS No.		**Date of Birth**		**Unit / Ward**	

Patient Views Comments:
IMHA Comments:

NAME OF SENIOR NURSE IN CHARGE/WARD SISTER		**SIGNATURE**
NAME OF DOCTOR		**SIGNATURE**
NAME OF RESPONSIBLE CLINICIAN		**SIGNATURE**
NAME OF MATRON/ICL		**SIGNATURE**
NAME AND ROLE OF OTHER PROFESSIONALS (i.e. OT/Psychology/Social Work)		**SIGNATURE**

(Where agreed by the patient family members should be informed of the review outcome)

Last Name		**First Name**			
NHS No.		**Date of Birth**		**Unit / Ward**	

SECLUSION - DISCONTINUATION FORM

RESPONSIBLE CLINICIAN

Name: .....
(Block Capitals)

NURSE IN CHARGE

Name.....Signature.....
(Block Capitals)

SECLUSION DETAILS

DATE: ..... TIME: .....

REASON FOR DISCONTINUING:

.....

.....

.....

.....

.....

.....

Is patient now being managed under long-term segregation Yes/No
(if yes please complete appendix 2a)

PATIENT Views:
Comments:

IMHA Views:
Comments:

Last Name		**First Name**			
NHS No.		**Date of Birth**		**Unit / Ward**	

RISK MANAGEMENT PLAN: (i.e. level of observation, care plan)

Person Authorising Discontinuation of Seclusion

Name :..... Role/ Grade .....

Signature: ..... Date:.....

CLPG41 - USE OF SECLUSION AND LONG-TERM SEGREGATION PROCEDURE
Appendix 1g (March 2023)

Clinical Lead/Charge Nurse/Sister must review records of each episode of seclusion using this monitoring form to ensure the seclusion process has been completed in line with the Trust Policy and Procedure.

Once completed this form must be scrutiny checked by the Matron/Integrated Clinical Lead and scanned onto electronic records in legal document section.

Seclusion Scrutiny

Scrutiny completed by:	
Ward/Team:	
Speciality:	
Date of scrutiny:	

General Patient Information	1.1	Patients Initials		
General Patient Information	1.2	Patient ID - Paris / Mobius ID		
General Patient Information	1.3	Using M (Male) or F (Female) or O (for any other gender identity		
General Patient Information	1.4	Please Enter Ethnic Origin (Refer to the list of Ethnicity at the end of the questions)		
General Patient Information	1.5	Is there a diagnosis of learning disability or autism for the patient secluded?	**Y / N**	**COMMENTS ↓**
Initiation/ commencement	2.1	Is there a completed Commencement of Seclusion Form Appendix 1a?	**Y / N**	**If no, please explain:**
Initiation/ commencement	2.2	Date of commencement form:	**/ /20**	
Initiation/ commencement	2.3	Time on commencement form:	**:**	
Initiation/ commencement	2.4	Was NIC, AC or Doctor on call contacted to complete authorisation of seclusion as soon as practicable? (Note the authorising person must have seen patient immediately prior to seclusion)	**Y / N**	**If no, please explain:**
Initiation/ commencement	2.4.1	If the seclusion was not initiated by a doctor, was this authorised by a doctor within one hour of commencement of seclusion?	**Y / N**	**If no, please explain:**

Initiation/ commencement	2.5	Was the Out of Hours Senior Manager on Call contacted? (where applicable)	**Y / N / NA**	
Initiation/ commencement	2.6	Was the reason to commence seclusion recorded?	**Y / N**	**If no, please explain**
Initiation/ commencement	2.7	If the psychiatrist who authorises seclusion is neither the patient's RC nor an Approved Clinician (AC), then has the patient's RC or duty doctor (or equivalent) been informed?	**Y / N**	**If no, please explain**
Initiation/ commencement	2.8	Has the care plan section of the commencement form been completed?	**Y / N**	**If no, please explain**
Initiation/ commencement	2.8.1	If not, when will this be completed?		
Initiation/ commencement	2.9	Does care plan include the views of the patient?	**Y / N**	**If no, please explain**
Initiation/ commencement	2.10	Does the care plan section of the commencement form include: Clinical needs, risks and treatment objectives	**Y / N**	**If no, please explain**
Initiation/ commencement	2.10.1	Is it clear what the patient needs to do to end seclusion?	**Y / N**	**If no, please explain**
Initiation/ commencement	2.10.2	Is it clear what staff need to do to support the patient to end seclusion?		**If no, please explain**
Initiation/ commencement	2.10.3	Does the care plan section of the commencement form include: Bedding and clothing	**Y / N**	**If no, please explain**
Initiation/ commencement	2.10.4	Does the care plan section of the commencement form include: Dietary needs	**Y / N**	**If no, please explain**
Initiation/ commencement	2.11	Was the next of kin notified of the seclusion? (where patient has agreed/consented)	**Y / N**	**If no, please explain**
Review Process During Seclusion Episode	3.1	Was the patient observed continuously whilst in seclusion?	**Y / N**	**If no, please explain**
Review Process During Seclusion Episode	3.2	Are there entries for observations for every 15 minutes? Appendix 1b	**Y / N**	**If no, please explain**
Review Process During Seclusion Episode	3.3	Were the vital signs (respiration and alertness) monitored and recorded every 15 minutes?	**Y / N**	**If no, please explain**
Review Process During Seclusion Episode	3.4	Was the nursing review completed using designated seclusion form Appendix 1c every two hours?	**Y / N**	**If no, please explain**

Review Process During Seclusion Episode	3.5	Was the nursing review completed using designated seclusion form Appendix 1c by 2 nurses?	**Y / N**	**If no, please explain**
Review Process During Seclusion Episode	3.6	Was one of the nurses in Q3.5 not involved in the original seclusion decision?	**Y / N**	**If no, please explain**
Review Process During Seclusion Episode	3.7	Is there a Doctors Review completed every 4 hours by a Doctor until the first MDT review?	**Y / N**	**If no, please explain**
Review Process During Seclusion Episode	3.8	Were further medical reviews completed twice in 24 hours following the first MDT review?	**Y / N**	**If no, please explain**
Review Process During Seclusion Episode	3.9	Are the doctors reviews completed using designated seclusion form Appendix 1d?	**Y / N**	**If no, please explain**
Review Process During Seclusion Episode	3.10	Was an independent MDT review undertaken promptly where the patient has either been secluded 8 hours consecutively or for 12 hours intermittently during a 48 hour period? Independent from those who were not part of the decision to seclude (Appendix 1e)	**Y / N**	**If no, please explain**
Review Process During Seclusion Episode	3.10.1	For question 3.10, was there a clinician present who was not involved in the original decision to seclude the patient?	**Y / N**	**If no, please explain**
Review Process During Seclusion Episode	3.10.2	Did the independent MDT consult with those involved in the original decision?	**Y / N**	**If no, please explain**
Review Process During Seclusion Episode	3.10.3	Did the independent MDT involve the patient's IMHA?	**Y / N**	**If no, please explain**
During Seclusion Episode	3.11	Has appendix 1e been completed for all MDT reviews?	**Y / N**	**If no, please explain**
Review Process During Seclusion Episode	3.12	Looking through review documentation, are there notes to show conversations with the patient that reflects their views?	**Y / N**	**If no, please explain**
Only answer the questions below if seclusion ended at the time of review				
Ending seclusion	4.1	Did the seclusion immediately end when a MDT review or NIC determined that it was no longer warranted?	**Y / N**	**If no, please explain**
Ending seclusion	4.2	Was the designated seclusion discontinuation form Appendix 1f used when seclusion was discontinued?	**Y / N**	**If no, please explain**
Ending seclusion	4.3	Was an entry made in the patient notes?	**Y / N**	**If no, please explain**

Ethnicity List:

White British	Black African
White Irish	Black Other
White Other	White and Black Caribbean
Indian	White and Black African
Pakistani	White and Asian
Bangladeshi	Other mixed race
Other Asian	Not stated
Chinese	Unknown
Black Caribbean	Black African

Reviewed by:		**Date reviewed:**	

Last Name		First Name			
NHS No.		Date of Birth		Unit / Ward	

LONG-TERM SEGREGATION (LTS) - COMMENCEMENT FORM

AUTHORISING RESPONSIBLE CLINICIAN

Name: ..... Signature.....
(Block Capitals)

NURSE IN CHARGE

Name.....Signature.....
(Block Capitals)

LONG-TERM SEGREGATION DETAILS

DATE OF LTS: ..... TIME COMMENCED: .....

Area of LTS
☐ Intensive Care Suite
☐ Bedroom
☐ Other (please name area) .....

Reasons for LTS (including patient's mental state, details of incident):
.....
.....
.....
.....
.....
.....
.....
.....

- The patient must be continually monitored at all times throughout the period of LTS and a record made of the patients behaviour hourly by a suitably skilled professional.
- The patient must not be locked in the seclusion room.
- A member of staff must be in the same room with the patient at all times.
- The patients must be reviewed at least once every 24hours by RC or Approved Clinician.
- There should be an MDT review at least weekly and include RC and IMHA where appropriate.
- Arrangements should be made for a Senior professional not involved in the case to review.
- Where LTS continues or 3 month and longer reviews of the patient's circumstances and care should be undertaken by an external hospital, this should include discussions with the patient's IMHA and commissioner.
- The local Safeguarding team should be made aware of any patient being supported in LTS.
- A Datix must be completed for each episode of LTS.
- The views of the patient's family should be elicited and taken into account with the consent of the patient.

Last Name		**First Name**			
NHS No.		**Date of Birth**		**Unit / Ward**	

CARE PLANNING

Care Plan & Socialisation Plan: (Physical and mental health needs, managing risks, utilising verbal de-escalation, clothing and bedding provided, dietary needs)

☐ Patient's Views Date: ……
Comments:

☐ IMHA Informed Date: ……
Comments:

☐ Safeguarding Team Informed Date: ……
☐ Commissioner Date: ……
(Please speak to service lead or commissioners contact details)

FAMILY INVOLVEMENT

Family Informed/contacted :

Date Time:

Comments:

MONITORING

Unit Manager's Clinical Lead /Matron/ Ward Sister / Charge Nurse / Nurse in Charge

Name: ……
(Block Capitals)

Signature……..Date……..

OUT OF HOURS

Name of Senior Manager informed:

Date…… Time……

Name of Consultant On Call Informed……..

Date……..Time……

Last Name		**First Name**			
NHS No.		**Date of Birth**		**Unit / Ward**	

LONG-TERM SEGREGATION (LTS) - RECORD OF OBSERVATIONS

DATE: ……Tear- resistant clothing in use yes /no (please circle) If so time commenced ……..Time terminated ……

TIME (Hourly)	CLINICAL OBSERVATIONS (i.e. Physical Condition, Mental State, Mood and Behaviour)	DETAILS OF CARE PROVIDED (i.e. drinks/food offered, bedding, books, engagement)	NAME AND STATUS	SIGNATURE

Last Name		**First Name**			
NHS No.		**Date of Birth**		**Unit / Ward**	

Last Name		**First Name**			
NHS No.		**Date of Birth**		**Unit / Ward**	

Last Name		**First Name**			
NHS No.		**Date of Birth**		**Unit / Ward**	

Last Name		**First Name**			
NHS No.		**Date of Birth**		**Unit / Ward**	

LONG-TERM SEGREGATION (LTS) - RC/APPROVED CLINICIAN REVIEWS

Date and Time of Review (e.g. once every 24 hours)	**CLINICAL OBSERVATIONS AND CARE GIVEN**	**DETAILS OF REASONS TO CONTINUE OR DISCONTINUE LTS, INCLUDING RISK MANAGEMENT AND/OR CARE PLAN**	**LTS CONTINUED/ DISCONTINUED (Please state)**

Last Name		**First Name**			
NHS No.		**Date of Birth**		**Unit / Ward**	

Patient's Views

Comments:

IMHA
Comments:

PRINT NAME (RC/Approved Clinician)		**DATE:**
SIGNATURE:		**TIME:**

Last Name		**First Name**			
NHS No.		**Date of Birth**		**Unit / Ward**	

LONG-TERM SEGREGATION (LTS) - MDT WEEKLY REVIEW

Date and Time of Review (at least weekly)	**DISCUSSION AND REASSESSMENT OF LTS**	**DETAILS OF REASONS TO CONTINUE OR DISCONTINUE LTS, INCLUDING RISK MANAGEMENT AND/OR CARE PLAN**	**OUTCOME OF REVIEW LTS CONTINUED/DISCONTINUED (Please state)**
EXPLAINED TO PATIENT		**YES/NO**	

(Where agreed by the patient family members should be informed of the review outcome)

Last Name		**First Name**			
NHS No.		**Date of Birth**		**Unit / Ward**	

Patient's Views

Comments:

IMHA
Comments:

PRINT NAME: RESPONSIBBLE CLINICIAN		**SIGNATURE**	**DATE:**
PRINT NAME: NURSE		**SIGNATURE**	**DATE:**
PRINT NAME: OTHER PROFESSIONALS (i.e. Psychology)		**SIGNATURE**	**DATE:**
PRINT NAME: OTHER PROFESSIONALS (i.e. Occupational therapist)			
PRINT NAME: OTHER PROFESSIONALS (i.e. Social Work)			

(Where agreed by the patient family members should be informed of the review outcome)

Last Name		First Name			
NHS No.		Date of Birth		Unit / Ward	

LONG-TERM SEGREGATION (LTS) – PERIODIC REVIEW FORM

RESPONSIBLE CLINICIAN

Name: ..... Signature.....
(Block Capitals)

NURSE IN CHARGE

Name.....Signature.....
(Block Capitals)

LONG-TERM SEGREGATION DETAILS

DATE OF LTS: ..... TIME COMMENCED: .....

Area of LTS
☐ Intensive Care Suite
☐ Bedroom
☐ Other (please name area) .....

SENIOR PROFESSIONAL (not involved with the case)

Name.....Signature.....
(Block Capitals)

Designation: .....

Address:
.....
.....

CONSULTED WITH

☐ Discussed with patient

Comments:

☐ Discussed with family

Comments:

☐ Other

Comments:

Last Name		**First Name**			
NHS No.		**Date of Birth**		**Unit / Ward**	

RECOMMENDATIONS

Last Name		First Name			
NHS No.		Date of Birth		Unit / Ward	

LONG-TERM SEGREGATION (LTS) – EXTERNAL REVIEW FORM

RESPONSIBLE CLINICIAN

Name: ……
(Block Capitals)

NURSE IN CHARGE

Name……
(Block Capitals)

LONG-TERM SEGREGATION DETAILS

DATE OF LTS: …….. TIME COMMENCED: ……..

Area of LTS
☐ Intensive Care Suite
☐ Bedroom
☐ Other (please name area) ……

EXTERNAL REVIEWING TEAM

Name/s……
(Block Capitals)

Designation: ……

Address:
……
……

CONSULTED WITH

☐ Discussed with Patient

Comments:

☐ Discussed with IMHA

Comments:

☐ Discussed with Family

Comments:

☐ Discussed with Commissioner

Comments

Last Name		**First Name**			
NHS No.		**Date of Birth**		**Unit / Ward**	

RECOMMENDATIONS

Review Team

Name: .....Signature:.....Date:.....

Name:.....Signature:.....Date:.....

Last Name		**First Name**			
NHS No.		**Date of Birth**		**Unit / Ward**	

LONG-TERM SEGREGATION (LTS) - DISCONTINUATION FORM

RESPONSIBLE CLINICIAN

Name: ..... Signature.....
(Block Capitals)

NURSE IN CHARGE

Name.....Signature.....
(Block Capitals)

LONG-TERM SEGREGATION DETAILS

DATE: ..... TIME: .....

REASON FOR DISCONTINUING:

.....

.....

.....

.....

.....

.....

.....

(If patients requires seclusion, please complete appendix 1a)

RISK MANAGEMENT PLAN (e.g. level of observation, care plan)

CLPG41 - USE OF SECLUSION AND LONG-TERM SEGREGATION PROCEDURE
Appendix 2h (March 2023)

Clinical Lead/Charge Nurse/Sister must review records of each episode of Long Term Segregation (LTS) using this monitoring form to ensure the LTS process has been completed in line with the Trust Policy and Procedure.

Once completed this form must be scrutiny checked by the Matron/Integrated Clinical Lead and scanned onto electronic records in legal document section.

Long Term Segregation Scrutiny

Scrutiny completed by:	
Ward/Team:	
Speciality:	
Date of scrutiny:	

General Patient Information	1.1	Patient's Initials		
General Patient Information	1.2	Patient ID - Mobius and Paris ID		
General Patient Information	1.3	Using M (Male) or F (Female) or O (for any other gender identity		
General Patient Information	1.4	Please Enter Ethnic Origin (Refer to the list of Ethnicity at the end of the questions)		
General Patient Information	1.5	Is there a diagnosis of learning disability or autism for the patient in LTS?	**Y / N**	**COMMENTS ↓**
Initiation/ commencement	2.1	Date of commencement form:	**/ /20**	
Initiation/ commencement	2.2	Is there evidence of clear clinical judgement indicating the decision to implement LTS? (Appendix 2a)	**Y / N**	**If no, please explain:**
Initiation/ commencement	2.3	Was the decision to implement LTS as an MDT communicated with the Responsible Commissioning Authority? (Appendix 2a)	**Y / N**	**If no, please explain:**
Initiation/ commencement	2.4	Were the views of relevant family/carers sought (Appendix 2a)?	**Y / N**	**If no, please explain:**

Initiation/ commencement	2.5	Were the views of IMHA sought? (Appendix 2a)?	**Y / N**	**If no, please explain:**
Initiation/ commencement	2.6	Was the local Safeguarding Team made aware of patient being supported in LTS? (Appendix 2a)	**Y / N**	**If no, please explain:**
Initiation/ commencement	2.7	Has a care plan for LTS been developed? (Appendix 2a)	**Y / N**	**If no, please explain:**
Initiation/ commencement	2.8	Does the care plan include the views of the patient? (Appendix 2a)?	**Y / N**	**If no, please explain:**
Initiation/ commencement	2.9	Is there a PBS in place?	**Y / N**	
Monitoring and review	3.1	Have hourly observations been carried out?	**Y / N**	**If no, please explain:**
Monitoring and review	3.2	Have hourly observations been recorded in the patient records? (Appendix 2b)	**Y / N**	**If no, please explain:**
Monitoring and review	3.3	Has a review been carried out at least once every 24 hours by Approved Clinician (may not be a Doctor (Appendix 2c)	**Y / N**	**If no, please explain:**
Monitoring and review	3.4	Have the outcomes of each review been clearly documented within the patient's records?	**Y / N**	**If no, please explain:**
Monitoring and review	3.5	Does the outcome of each review reflect the views of the patient?	**Y / N**	**If no, please explain:**
Monitoring and review	3.6	Is it clear in the care plan what the patient needs to do to end LTS? (Appendix 2a)	**Y / N**	**If no, please explain:**
Monitoring and review	3.7	Is it clear in care plan what the staff need to do to support the patient to end LTS? (Appendix 2a)	**Y / N**	**If no, please explain:**
Monitoring and review	3.8	Has there been daily access to fresh air?	**Y / N**	**If no, please explain:**
Monitoring and review	3.9	Has the patient had access to daily activities?	**Y / N**	**If no, please explain:**
Monitoring and review	3.10	Has there been contact with friends / family / carers?	**Y / N**	**If no, please explain:**
Monitoring and review	3.11	Has the patient been supported with daily living activities? (food, fluid, hygiene)	**Y / N**	**If no, please provide further detail where required:**

Monitoring and review	3.12	Has the patient been supported to contact advocacy?	**Y / N**	**If no, please provide further detail where required:**
Monitoring and review	3.13	Do records show daily physical health monitoring?	**Y / N**	**If no, please explain:**
Monitoring and review	3.14	Has a review been carried out at least weekly by MDT including RC and IMHA (where appropriate) (Appendix 2d) **NA = where LTS is less than a week at the time of scrutiny**	**Y / N / NA**	
Monitoring and review	3.15	Where successive MDT reviews determined that LTS continues to be required; is there evidence to explain why the patient cannot be supported in a less restrictive manner?	**Y / N**	**If no, please explain:**
Monitoring and review	3.16	Have periodic monthly reviews been carried out by a senior professional (Appendix 2e) Where patient has been in LTS for more than a month. **NA = where LTS is less than a month at the time of scrutiny**	**Y / N / NA**	
Monitoring and review	3.17	Has a review been carried out if LTS is for longer than 3 monthly by an External Hospital? (Appendix 2f) **NA = where LTS is less than 3 months at the time of scrutiny**	**Y / N / NA**	
Monitoring and review	3.17.1	If yes to question 3.17, was this completed within the identified date period?	**Y / N**	**If no, please explain:**
Only answer the questions below if LTS ended at the time of review				
Discontinuation of LTS	4.1	Has the care plan and risk assessment been updated since LTS has ended?	**Y / N**	**If no, please explain:**
Discontinuation of LTS	4.2	Was an entry made in the patient's notes clearly documenting that LTS has ended?	**Y / N**	**If no, please explain:**

Ethnicity List:

White British	Black African
White Irish	Black Other
White Other	White and Black Caribbean
Indian	White and Black African
Pakistani	White and Asian
Bangladeshi	Other mixed race
Other Asian	Not stated
Chinese	Unknown
Black Caribbean	Black African

Reviewed by:		**Date reviewed:**	

SECLUSION FLOW CHART

Seclusion should be used as a last resort and for the least possible time.

SECLUSION PATHWAY MUST BE FOLLOWED ANY TIME A PATIENT IS ISOLATED BEHIND A DOOR AND PREVENTED FROM LEAVING (DOOR LOCKED OR OTHERWISE BARRED)

Decision to commence Seclusion. Appendix 1a	**On Appendix 1a ensure:-** Reason for seclusion 9s clear and highlights how less restrictive interventions were explored Care plan completed including what is required for seclusion to end. Patient views completed and they are informed of reason for seclusion Family Involvement – if not applicable, state why. If seclusion not authorised by RC or duty doctor, they must be notified as soon as practicable Commissioner, IMHA, and safeguarding team to be informed
Commence seclusion observations. Appendix 1b	Continuous visual observations without delay Record every 15 minutes, observation and engagement **DO NOT** use terms such as 'Level 3 observations maintained' If RT been used first hour obs to be completed by qualified staff
With first hour of seclusion episode. Appendix 1a	To be reviewed without delay if seclusion not authorised by a doctor and if patient not known or has significant change from usual presentation If not authorised by RC the consultant psychiatrist, ward doctor or duty doctor should undertake the first medical review. A consultant psychiatrist review prior to seclusion can satisfy requirement of first hour medical review Ensure 'Authorising Doctor' section is completed on Appendix 1a
Two hourly nursing reviews. Appendix 1c	This will be undertaken by two registered nurse, one of who was not involved directly in the decision to seclude The review should consider the last 2 hours of engagement and observation and if less restrictive intervention would be appropriate. Following review, care plan should be updated if required, patient's views are captured and rationale for continuing seclusion explained Physical observations should be completed if appropriate
Four hourly Doctor reviews. Appendix 1d	Review by RC. Where RC is not immediately available, a "duty doctor" can deputise for RC. 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 Clinician. If seclusion is continued the rationale should be explained to the patient
Internal MDT Review. Appendix 1e	This should take place as soon as practicable and should include as many of the MDT as possible including a medic and senior nurse. Further MDT reviews should take place once in every 24-hour period. If the 4 hourly Doctor reviews are ended, the rationale should be clearly stated on Appendix 1e and seclusion care plan.
Continuous Medical Reviews. Appendix 1d	Medical reviews continue with daily MDT reviews The minimum requirement for the medical reviews is twice within a 24 hour period, one of which should be completed by RC or alternative approved clinician. Frequency of medical reviews can be increased by the MDT if required.

- **Subsequent Independent MDT Review** If the patient is secluded for more than 8 hours consecutively; or 12 hours over a period of 48 hours 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.

Seclusion should immediately end when an MDT review, a medical review or the independent MDT review determines it is no longer warranted. Alternatively where 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 or duty doctor. This consultation may take place in person or by telephone. Appendix 1f should be fully completed, including a risk management plan to support the patient being safely cared for outside of the seclusion environment.

LONG TERM SEGREGATION FLOW CHART

Patients in LTS should not be isolated from contact with staff. Staff must be in the room with the patient at all times. The patient must have access to bathroom facilities, a bedroom, relaxing lounge area, secure outdoor areas and a range of activities of interest and relevance to the person. The patient must not be deprived of access to therapeutic interventions. The patient must not be locked in the seclusion room.

Decision to commence LTS. Appendix 2a

On Appendix 2a ensure:-
Reason for LTS – this is clear and highlights how less restrictive interventions were explored
Care plan completed – including what is required for LTS to end.
Patient views completed – they are informed of reason for LTS and how they can work with staff to end LTS.
Family Involvement – if not applicable, state why.
Commissioner, IMHA, safeguarding team to be informed

Commence LTS observations. Appendix 2b

Continuous visual observations (staff must be in same room as patient)
Record every 1 hour, observation and engagement with patient referring to care plan. Refrain from using terms such as 'Level 3 observations maintained'
Clinical risk assessment will determine how many staff are required to support the patient safely whilst in LTS.

Daily 24 hour review. Appendix 2c

The patient should be formally reviewed by an approved clinician who may or not be a doctor at least once in any 24-hour period.
Ideally, this will be patient's RC, however ward or duty doctor can complete this role.
The outcome of the review should clearly state the reasons why long-term segregation is required to continue. This must be reflected in the patient's treatment plan.

Weekly MDT and periodic review. Appendix 2d / 2e

The composition of the MDT should include the patient's responsible clinician, an IMHA where appropriate and a senior professional who is not involved with the case. The outcome of all reviews and the reasons for continued segregation should be recorded and the responsible commissioning authority should be informed of the outcome.
Where successive MDT reviews determine that segregation 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

External Review. Appendix 2f

Where long-term segregation continues for three months or longer, regular three monthly reviews of the patient's circumstances and care should be undertaken by an external hospital. This should include discussion with the patient's IMHA (where appropriate) and commissioner.
The patient's treatment plan should clearly state the reasons why long-term segregation is required. In these cases, the way that the patient's situation is reviewed needs to reflect the specific nature of their management plan.

The decision to end long-term segregation 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. Appendix 2f should be fully completed, including a risk management plan to support the patient being safely cared for outside of the LTS environment.

Guidance for use of Special tear-resistant clothing

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. using special tear-resistant clothing. The guidance for the use of special tear-resistant clothing within EPUT services is provided below.

- **The use of special tear-resistant clothing is a restrictive intervention and should only be used for immediate management of self-harm**

- To ensure privacy and dignity special tear-resistant clothing must only be used when a patient is either in Seclusion or being nursed in Long Term Segregation.

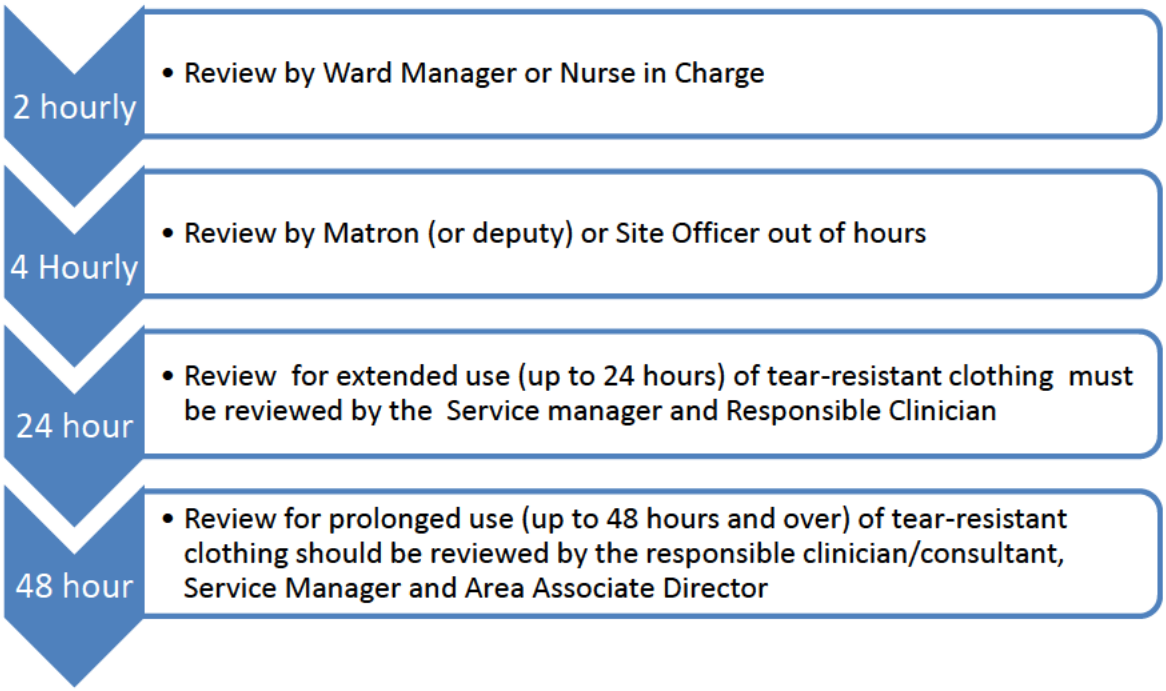
- Use of special tear-resistant clothing must be agreed by the multi-disciplinary team including the responsible clinician and documented in both the care plan and risk assessment. The care plan should outline the rationale for use, including the criteria for its use (under what circumstances) and criteria for discontinuation. The care plan also must detail less restrictive alternative strategies e.g. positive behaviour support plans, which should be employed prior to considering the use of special tear-resistant clothing.

- Where the use of special tear-resistant clothing is implemented, a rationale for this must be recorded in the clinical records and implementation time recorded on Appendix 1b / 2b of the Seclusion & Long Term Segregation policy. The patient must be informed of reasons why the clothing is being used and under what circumstances it will be discontinued.

- The ward manager or nurse in charge and Responsible Clinician will make the decision to terminate the use of specialist tear-resistant clothing and the return of normal clothing. Rational for termination must be recorded in the clinical notes and time of termination recorded on Appendix 1b / 2b of the Use of Seclusion & Long Term Segregation policy

- The responsible clinician (or deputy), Ward Manager and Service manager must be informed when the use of special tear-resistant clothing is implemented and discontinued.

- The use of special tear-resistant clothing must be monitored and reviewed regularly as below. All reviews must be recorded in the clinical notes and make reference to the continued level of risk. If the review concludes that the use of special tear-resistant clothing is still required to manage risk, details must be included as to why less restrictive alternative strategies are not appropriate to manage the risk.



- Where the use of special tear-resistant clothing is being considered for an informal patient, consideration must be given to whether the patient requires an assessment under the Mental Health Act 1983.