POLICY TITLE:	**Seclusion and Long-Term Segregation**
Policy Number:	H40
Version Number:	16
Date of Issue:	30/11/2023
Date of Review:	30/11/2026
Policy Owner:	Colin Quick, Chief Quality Officer
Ratified by:	Paul Cowans, Speciality Director
Responsible Signatory:	Colin Quick, Chief Quality Officer
Outcome:	This policy: • Aims to ensure that the use of seclusion as an aid to ensure the safety of the patient and others is in line with the requirements of the Mental Health Act 1983 (as amended in 2007) and the Code of Practice (as revised in 2015) • Provides forms to record the progress of an episode of seclusion • Provides additional specific guidelines and procedures in Appendix 2
Cross Reference:	H35 Clinical Risk Assessment and Management H37 Prevention Management of Behaviour that Communicates Distress in Adults H37.1 Use of Mechanical Restraint and Soft Cuffs H37.3 Prevention and Management of Challenging Distressed Behaviour in Young People H97 Searching Service Users & Their Belongings in a Treatment Environment H119 Safer Clothing H&S45 Prevention and Management of Violence at Work OP04.1 Assessment and Control of Ligature Points, Ligatures and other Self Harm Risks OP05 Mental Capacity OP06 Safeguarding Children OP06.1 Child Protection (Scotland) OP08 Safeguarding Adults OP08.3 Adult Support Protection (Scotland) HR10.1 Nursing Services and Revalidation

EQUALITY AND DIVERSITY STATEMENT

Priory is committed to the fair treatment of all in line with the Equality Act 2010. An equality impact assessment has been completed on this policy to ensure that it can be implemented consistently regardless of any protected characteristics (age, disability, gender identity and expression, marriage or civil partnership, pregnancy or maternity, race, religion or beliefs, sex, sexual orientation), and all will be treated with dignity and respect.

In order to ensure that this policy is relevant and up to date, comments and suggestions for additions or amendments are sought from users of this document. To contribute towards the process of review, email LegalandComplianceHelpdesk@priorygroup.com

SECLUSION AND LONG-TERM SEGREGATION

1 INTRODUCTION

1.1 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.

1.2 For Welsh sites only, 'Intensive Mental Health Care' (IMHC) refers to seclusion use and long term segregation.

1.3 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/practices (such as 'therapeutic isolation, open door seclusion, use of Extra Care Areas (ECA) (see Appendix 3), removal from environment, time out, etc.') or the conditions of the immediate environment, do not change the fact that the patient has been secluded** and must be afforded the same safeguards outlined in this policy in respect to the monitoring, review processes and documentation completed.

1.4 Seclusion will be used:
(a) As a last resort
(b) For the shortest possible time
(c) To manage immediate risk of harm to others.

1.5 Seclusion will not be used:
(a) As a punishment or threat
(b) As part of a treatment programme
(c) Because of staff shortage.

1.6 Patient behaviour should be seen in context. Professionals should not categorise behaviour as disturbed without taking account of the circumstances under which it occurs. While it is an important factor in assessing current risk, they should not assume that a previous history of disturbance means that a patient will necessarily behave in the same way in the immediate future.

1.7 Where a patient poses a risk of self-harm as well as harm to others, seclusion should only be used where the professionals involved, are satisfied that the need to protect others, outweighs any increased risk to the patient's health or safety and that any such risk can be properly managed.

1.8 There may be a need to use physical restraint to move a patient to the seclusion suite. This must always be reasonable and proportionate to the risks presented and carried out in accordance with RRIT practice (See H37 Prevention and Management of Disturbed/Violent Behaviour and H37.3 Prevention and Management of Challenging Distressed Behaviour in Young People).

1.9 Seclusion should only be used in hospitals and in relation to patients detained under Mental Health legislation. 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 Mental Health legislation should be undertaken immediately.

1.10 A debriefing session with the patient and staff must be held following any period of seclusion and recorded on **OP Form: 46D or 46N** as well as being referred to on **H Form: 122** Seclusion Front Sheet or for welsh sites IMHC paperwork. It may not always be suitable to de-brief immediately after a seclusion episode, but should be attempted following suitable risk assessment. Following the debrief, the content should be discussed by the MDT with a view to amend any care and treatment plans.

1.11 Definitions of LTS/IMHC are set out within;

- **England MHA Code of Practice (2015):** 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.
- **Wales MHA Code of Practice (2016):** There may be a small number of patients who exhibit behaviours that challenge that are more sustained and therefore not amenable to short-term seclusion. These patients may benefit from intensive mental healthcare delivered in a discrete clinical area that minimises their contact with the general ward population. Services utilising such intervention must have a local policy in place that sets out when it is appropriate to use such an intervention, and how it is to be implemented and kept under review

1.12 The definitions in statutory guidance and this policy should also be read against the current CQC position. This extends the recognition of LTS/IMHC to include patients who are segregated to protect them from harm or self-harm.

- **CQC Brief Guide (2020):** The key test of whether a patient is segregated is whether they can leave the situation of being separated from others when they want to – that is, are they prevented by staff from leaving? The reference in the Code of Practice to the "need to reduce a sustained risk of harm posed by the patient to others" has led to some services not recognising as long-term segregation the care of some people for their own benefit (for example those with a learning disability or autism or both), even when they are not mixing freely with others on the ward/unit for long periods. Patients segregated to protect them from harm or self-harm are entitled to the same protection as those who pose a risk to staff and other patients. The safeguards set out in the Code should be applied to support the patient and reduce the need for continuing long-term segregation.

1.13 The definitions and required management checks, reviews and scrutiny for LTS/IMHC remain appropriate and required across the vast majority of our healthcare services. With the need to set clear parameters for use and ensure any segregation from other patients and ward areas is seen as a serious intervention, with high risks to people's dignity and autonomy, and should be for the minimum amount necessary

1.14 Due to the serious impact on people rights, any departure from the statutory guidance and Priory policy standards set out within this document must be escalated for review with the Chief Quality Officer.

2 GUIDELINES

2.1 In the event of seclusion staff shall:

(a) Ensure the safety and wellbeing of the patient, including searching the patient as per policy for items that they may use to harm themselves or others (See H97 Searching Patients & Their Belongings in a Treatment Environment)
(b) Ensure the patient receives the care and support rendered necessary by his or her seclusion, both during and after it has taken place
(c) Formulate a care plan, which is individually tailored and where possible includes the patient's involvement, which will be documented in the seclusion record and copied as a clinical entry into CareNotes
(d) Record, monitor and review the use of seclusion and any follow-up action in the patient's health record.

2.2 Seclusion may be authorised by either:

(a) **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 advanced practitioner) must be informed of seclusion as soon as practicable

(b) **An approved clinician who is not a doctor** - the patient's RC or duty doctor (or advanced practitioner) must be informed as soon as practicable
(c) **The nurse in charge of the ward** - the patients RC or duty doctor (or advanced practitioner) must be informed as soon as practicable.

2.2.1 If the decision to seclude was authorised by the Nurse in Charge, an initial medical review of the need for seclusion must be carried out by the RC or duty doctor (or equivalent) within one hour of seclusion commencing and documented on **H Form: 122** or for Welsh sites on the IMHC paperwork. If the patient is newly admitted, not well known to the staff, or there has been a significant change in the patient's physical, mental state and/or behavioural presentation, this medical review should take place without delay. If it is concluded that seclusion needs to continue, the review should establish the individual care needs of the patient while they are in seclusion and the steps that should be taken in order to bring the need for seclusion to an end as soon as appropriate. If seclusion was authorised by a psychiatrist, the review they undertook immediately prior to authorising seclusion is deemed to be the medical review (therefore a medical review after one hour is not necessary).

2.3 If a patient is in a seclusion room alone, a suitably skilled member of the nursing team should, as a minimum, be constantly maintaining visual and aural observation of the patient within the seclusion room (including en-suite) **at all times** throughout the period of the patient's seclusion. Where possible, the observing staff member should be of the same gender, in order to respect privacy and dignity. The staff member must have the means to summon urgent assistance from other staff at any point. i.e. radio and personal alarm.

2.4 Where it has been agreed with the patient in a Positive Behavioural Support (PBS) plan, advanced statement (or equivalent) that family members will be notified of significant behavioural disturbances and the use of restrictive interventions, this should take place as agreed in the plan.

2.5 The aim of observation is to monitor the physical condition and behaviour of the patient and to identify the time at which seclusion can be terminated. Particular attention should be made to breathing, pallor or cyanosis. If the suitably skilled observing staff member feels the seclusion episode can be safely terminated prior to the first two hour nursing review they will ask the Nurse in Charge to arrange a review as soon as possible. The level and duration of observation will be decided on an individual basis. A documented report will be made at least every 15 minutes on **H Form: 122H (for Welsh Sites ONLY*,* use H Form: 122J, 122K and 122L)**.

2.6 For patients who have received sedation, a qualified nurse will conduct the observations of the patient for the first hour.

2.6.1 **NOTE:** If patients have been given rapid tranquilisation, the rapid tranquilisation flow chart should be used.

2.7 Seclusion must be reviewed every two hours by two qualified nurses and the outcome should be documented and signed by both nurses on **H Form: 122B. (for Welsh Sites Only, use H Form: 122J, 122K and 122L** (one of the qualified nurses should be someone who was not involved directly in the original decision to seclude wherever practicable).

2.7.1 Seclusion should be reviewed every four hours by a doctor or suitably qualified approved clinician and documented on **H Form: 122E (for Welsh Sites ONLY*,* use H Form: 122J, 122K and 122L)** (This review may be carried out by an Advanced Practitioner or Physician Associate who has had the required training) up until the first review by the patients internal Multi-Disciplinary Team (MDT). (Please read 2.7.2)

2.7.2 The first internal MDT review should take place as soon as practicable and be documented on form **H Form: 122A**, or for welsh sites IMHC paperwork. In this review it can be determined that further medical reviews can be reduced but must continue at least twice in every 24 hour period, at least one of these should be conducted by the RC (local arrangements for out-of-hours cover

may provide for an alternative RC to cover these RC reviews). Out of hours, the patient's own MDT may not be available, therefore an initial MDT review must take place as soon as practicable, at a minimum, this should include at least medical and senior nursing staff.

2.7.3 Subsequent MDT reviews must take place at least once in 24 hours of continuous seclusion. Out of hours, the membership may be limited, but should include at least on call medical and senior nursing staff.

2.7.4 If the patient appears asleep, different medical review arrangements may be put in place and documented in the patient's Seclusion Care Plan, decided and approved by the MDT. Staff must remain vigilant that the patient's level of consciousness is not related to any sedation that has been given (the nursing reviews must continue every two hours).

2.7.5 An independent multidisciplinary review shall be completed by a senior doctor or suitably qualified approved clinician, nurses or other professionals (including an Independent Mental Health Advocate (IMHA), if the patient has one), who were not involved in the initial seclusion decision. However, it is good practice for those involved in the original decision to be consulted in the review. This must take place promptly following the patient being secluded for:
(a) Eight hours consecutively; or
(b) 12 hours intermittently over a period of 48 hours (in practice this can be the next working day).

2.8 In order to ensure that seclusion measures have a minimal impact on a patient's autonomy, seclusion should be applied flexibly and in the least restrictive manner possible, considering the patient's circumstances. Where seclusion is used for prolonged periods then, subject to suitable risk assessments, flexibility may include allowing patients to receive visitors, facilitating brief periods of access to secure outside areas or allowing meals to be taken in general areas of the ward. The possibility of facilitating such flexibility should be considered during any review of the ongoing need for seclusion. Particularly with prolonged seclusion, it can be difficult to judge when the need for seclusion has ended. This flexibility can provide a means of evaluating the patient's mood and degree of agitation under a lesser degree of restriction, without terminating the seclusion episode (see **Appendix 4** in relation to visitors).

2.9 If the need for seclusion is disputed by any member of the multidisciplinary team, the matter must be referred to the Hospital Director and Medical Director to get prompt resolution.

2.10 For patients who are no longer of immediate risk of harm to others, but continue to pose a sustained risk of harm to others, consideration should be made to the use of long term segregation 26.150 in the Mental Health Act Code of Practice 2015.

2.11 Monitoring Duration of Seclusion Episodes

1. If any patient is in seclusion for more than seven days the Consultant must inform the Clinical Director and Specialist Director for that service.
2. A review call will then be arranged to include the patients MDT, Clinical Director and Specialist Director.
3. If a patient remains in seclusion for 21 days, a 24 Hour Notification must be completed and this will trigger an independent review of the need for seclusion to continue.

Thereafter, if seclusion continues there will be an independent review every four weeks.

2.12 **Terminating Seclusion -** 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

3 CONDITIONS WITHIN A SECLUSION ROOM

3.1 The following factors need to be taken into account:
(a) The room should allow for communication with the patient when the patient is in the room and the door is locked, e.g. via an intercom
(b) Rooms should include limited furnishings which should include a bed, pillow, mattress and blanket or covering
(c) There should be no apparent safety hazards
(d) Rooms should have robust, reinforced window(s) that provide natural light (where possible the window should be positioned to enable a view outside)
(e) Rooms should have externally controlled lighting, including a main light and subdued lighting for night time
(f) Rooms should have robust door(s) which open outwards
(g) Rooms should have externally controlled heating and/or air conditioning, which enables those observing the patient to monitor the room temperature
(h) Alternate viewing panels or CCTV coverage should be available where there may otherwise be areas not visible from outside the room
(i) A clock should always be visible to the patient from within the room
(j) Rooms should have access to toilet and washing facilities.

3.2 In exceptional cases, it may be the case that the room used for seclusion does not meet all of the criteria as outlined above. Where seclusion is used in such circumstances, it is essential that the reasons for deviating from the conditions of 3.1 above are clearly noted and the necessity for placing a patient in seclusion in such circumstances are clearly noted in the patient's records. In addition, a 24 hour notification form (**OP Form: 46B**) is required to be completed immediately in order to alert the healthcare senior management team.

3.3 Staff must be mindful of the risk posed by ligatures, for example tights, laces and cords. If the patient presents with a risk of self-harm/suicide, potential ligatures must be removed from the patient. The severity of the risk may require consideration of the use of safer clothing. (see OP04.1 Assessment and Control of Ligature Points, Ligatures and other Self Harm Risks, and H119 Safer Clothing policy).

3.4 The integrity of the seclusion room needs to be safety checked and cleaned after every use and periodically thereafter – particularly when the seclusion room is not in regular use. This will include:
(a) A search for items that may have been secreted.
(b) A check on the furnishing and whether the flooring is intact.
(c) Are there any hinges or screws that are loose – these can be shaken loose over time (through general room / building vibration) and may need to be glued in place.
(d) Check the door, vision panel and window frame to ensure it is intact – staff should physically test these.
(e) Is the smoke alarm out of reach – could it act as a potential ligature point or can it be damaged and the items used for self-harm.

4 HEALTH AND SAFETY

4.1 For any patient placed in seclusion/LTS, the clinical team should complete a Personal Emergency Evacuation Plan (PEEP) **H&S Form: 70**.

5 RECORD KEEPING

5.1 Sufficiently detailed and contemporaneous records of any use of seclusion will be kept in the patient's health record, the reasons for its use and subsequent activity, which will contain a step-by-step account of the seclusion process (**H Form: 122** and **H Forms 122A-E** form a sequential record).

5.2 Responsibility for the accuracy and completeness of seclusion records should lie with the professional in charge on the ward. Each episode of seclusion should be audited by the ward manager for quality monitoring. The Hospital Director will monitor and regularly review the use of

seclusion and any themes reported to the Hospital Clinical Governance Committee.

5.3 For audit purposes and for regulatory inspections, the completed seclusion records should be kept in hard copy, and archived with the individual patient's health records on discharge.

5.4 Every episode of seclusion should have a report completed on the incident reporting system as well as an entry into the service users care record.

6 COLLATION OF DATA

6.1 An audit of five (or all of them if there are less than five) incidences of seclusion per ward shall be undertaken once a year and recorded on **H Form: 122F** Seclusion Audit Tool. The annual audit will be organised by a member of the Healthcare Informatics Team. An action plan for improvement of the process or lessons learnt will be shared with all staff through the Clinical Governance system.

6.2 A log of the numbers of times seclusion is used will be kept on each ward. The information to be recorded will be who was secluded, when and for how long. **H Form: 122G** Use of Seclusion Log Sheet is available for this purpose. This information will be made available to regulatory inspectors if requested.

7 CAPACITY ISSUES

7.1 Seclusion should only take place in hospitals and in relation to patients detained under Mental Health legislation. The issue of capacity is overridden within the context of the detention and emergency where the danger to others and its safe management is paramount. (see 1.9 regarding informal patients)

8 TRAINING

8.1 All staff who are to be designated to take responsibility for observing a patient in seclusion, should be suitably skilled and competent in doing so. The competency based assessment should be conducted by a qualified nurse, senior healthcare assistant or a site security lead who has also been assessed as being competent in observing a seclusion episode.

8.2 The assessment will comprise of both a practical demonstration and discussion with the assessor and the outcome of each element should be documented on the H122M Seclusion Competency Assessment form. A copy should be retained by the ward manager.

8.3 Sites that use seclusion should ensure that seclusion training and assessment is part of induction. Reassessment of competency should be considered where concerns are raised.

9 REFERENCES

9.1 **Legislation**

Adults with Incapacity (Scotland) Act 2000
Mental Health Act 1983
Mental Health (Care and Treatment) (Scotland) Act 2003

9.2 **Guidance**

DH (2015) Code of Practice: Mental Health Act 1983
Mental Welfare Commission for Scotland (2019) The Use of Seclusion
NAPICU position on the monitoring, regulation and recording of the extra care area, seclusion and long-term segregation use in the context of the Mental Health Act 1983: Code of Practice (2015)
NICE (2015) Violence and Aggression: Short-term management in mental health, health and community settings. NG10

Welsh Assembly Government (2016) Mental Health Act 1983 Code of Practice for Wales

Appendix 1 – Procedure for Use of Long Term Segregation in English/Scottish Sites and Intensive Mental Health Care (Welsh Sites Only)
Appendix 2 – Guidelines for Nursing Staff
Appendix 3 – Procedure for Patients Receiving Visitors Whilst Being Nursed in Seclusion
Appendix 4 – Long-Term Segregation or Intensive Mental Health Care use in Bespoke Therapeutic Placements

Associated Forms:

H Form: 122 Seclusion Front Sheet
H Form: 122A MDT Review
H Form: 122B Record of Nursing Reviews - Seclusion
H Form: 122E Record of Medical Seclusion Reviews
H Form: 122F Seclusion Audit Tool
H Form: 122G Use of Seclusion Log Sheet
H Form: 122H Seclusion Observation Record 15 Minute Documentation
H Form: 122J Intensive Mental Healthcare Pack IMHC (0 - 4 hours) FOR WELSH SITES ONLY
H Form: 122K Intensive Mental Healthcare Pack IMHC (4 - 24 hours) FOR WELSH SITES ONLY
H Form: 122L Intensive Mental Healthcare Pack IMHC (24 – ongoing hours) FOR WELSH SITES ONLY
H Form: 122M Seclusion Competency Assessment
H Form: 122N Long Term Segregation (LTS) Plan
H&S Form: 70 Personal Emergency Evacuation Plan (PEEP)
OP Form 46B Serious Incident Notification (SBAR) Situation, Background, Assessment, Recommendation
OP Form: 46D Service Users Account Following Use of Physical Intervention
OP Form: 46N Debrief - Service User's Account following a Clinical Incident

Appendix 1

PROCEDURE FOR USE OF LONG TERM SEGREGATION IN ENGLISH/SCOTTISH SITES AND INTENSIVE MENTAL HEALTH CARE (WELSH SITES ONLY)

1 INTRODUCTION

1.1 Both the Mental Health Act Code of Practice 2015 and the Welsh Mental Health Act Code of Practice 2016 refer to the fact that there will be a small number of patients who exhibit sustained behaviours that challenge, who are not amenable to short term seclusion, who need to be cared for in a discreet clinical area which minimises their contact with the general ward population. The rationale is to manage sustained risk of harm posed by the patient to others, where it is a constant feature of their presentation.

1.2 The use of Long Term Segregation (LTS) or Intensive Mental Health Care (IMHC) is restrictive in nature and should be afforded the correct safeguards, in order to objectively review its use and for it to be discontinued as soon as the risk has reduced to a more manageable level.

2 DEFINITIONS

2.1 **LTS/IMHC of patients who pose harm to others** - refers to a situation where, in order to reduce a sustained risk of harm posed by patients to others, which is a constant feature of their presentation, access to certain areas of the ward environment will be restricted, to minimise interactions with other patients. The interactions would be reduced as it has been determined that it is clear these interactions exacerbate this risk to other patients and staff.

3 GUIDANCE

3.1 LTS/IMHC of patients who pose harm to others:

3.1.1 When considering the use of LTS or IMHC, patients should have been assessed as being high risk of harm to others, where violence and aggression is a constant feature of their presentation and mixing freely with other patients increases the immediacy of the risk to other patients and staff. In this consideration, other interventions should be explored and the decision to segregate should have a clear rationale, as to why this is the least restrictive option.

3.1.2 If the MDT agrees that long term segregation is required, a representative from the commissioning authority should be contacted and be involved in the decision.

3.1.3 Where appropriate, the views of the patient's family and carers should be sought and taken into account.

3.1.4 If a patient has the involvement of an IMHA, they should also be consulted/informed.

3.1.5 Once the LTS plan has been developed Form: 122N should be completed and submitted to the Service Line Clinical Director for their agreement. Only at this point can LTS commence.

3.1.6 Once LTS has been agreed, with sign off from the Clinical Director, each Weekly MDT review should be forwarded to the Clinical Director to allow them to keep oversite on the progress being made. The Clinical Director should be involved in organising the three-monthly external review if LTS is still in place.

3.1.7 The local safeguarding team should be informed of any patient being supported in LTS/IMHC.

3.1.8 Patients being nursed in LTS/IMHC due to risk of harm to others should be nursed on enhanced observations by at least two members of staff, trained in the management of violence and aggression. An hourly written record should be made by the observing staff on **H Form: 99F***.*

3.1.9 The environment that the patient can have access to should be made as safe as possible, removing items which could be used in order to harm others. Details of the area the patient can have access to, should be detailed in the MDT care plan and discussed with the patient. The environment should be made as homely and personalised as the risk considerations allow. The patient, where possible, should have access to bedroom and bathroom facilities and a relaxing lounge area. Patients should be able to access secure outdoor areas and a range of activities of interest and relevance to the person.

3.1.10 At times of acute behavioural disturbance, where it is necessary to contain an immediate risk of harm to others, it may be appropriate to consider the use of seclusion. In this circumstance, the procedure relating to seclusion should be followed, in relation to commencement, documentation, observation, review and discontinuation. Therefore, if the patient is secluded, then this period of LTS/IMHC would be terminated at this point.

3.1.11 The patient being nursed in conditions of LTS/IMHC should be reviewed by a consultant or their representative (Speciality Doctor/Advanced practitioner/Physician Associate) at least once in every 24 hours and at least weekly by the MDT, members of which at a minimum should be; the RC and the nursing team (where appropriate, the patients IMHA). The reviews should provide a clear rationale as to why the LTS has been terminated or why it continues to be the least restrictive intervention to manage the risk to others. During the review, there should be consideration to allowing a greater access to the ward environment. The patient's general health and welfare should be monitored and referenced in the contemporaneous notes (for Welsh sites, they should use the IMHC pack for documentation).

3.1.12 Patients should have a senior professional, not involved in the case; independently review the requirement for the intervention on a fortnightly basis. This can be a consultant psychiatrist, registered psychologist, or senior nurse. Any recommendations should be immediately communicated to the multidisciplinary team and an entry should be made into the contemporaneous notes.

3.1.13 Patients who have been subject to LTS/IMHC for three months should have a full review by an external hospital MDT. The external hospital review team should discuss the case with the commissioner and IMHA where appropriate. Any recommendations should immediately be communicated to the multidisciplinary team and an entry made into the contemporaneous notes. These reviews should continue to take place every three months if LTS/IMHC continues.

3.1.14 In any instance where the patient becomes an immediate and high risk of harm to others, the use of seclusion should be considered. Any decision made, should include the professionals involved being satisfied that the need to protect other people outweighs any increased risk to the patients' health or safety arising from their own self-harm and that this risk can be properly managed.

3.1.15 Once LTS concludes, the Clinical Director and all external bodies should be informed. The Clinical Director should get a final MDT report on the ending of LTS and on the safe integration of the patient to the ward environment.

Appendix 2

GUIDELINES FOR NURSING STAFF

1 Constant observation within eyesight will be maintained **at all times, including using the en-suite** during an episode of seclusion, which will be by a Qualified nurse for the first hour, post any sedation given. Beyond the first hour, it is a matter for the nurse in charge of the ward to determine responsibility for observations. Nurses will not be expected to conduct constant Within Eyesight observation for consecutive periods exceeding one hour.

2 Any Nurse(s) who has been assaulted, which has led to the seclusion episode, should not undertake the first period of observation following seclusion. Consideration needs to be given to the suitability of the assaulted nurse to undertake any observation during the seclusion period.

3 All wards, where seclusion is used, must have available appropriate seating for the use of nursing staff which permit within eyesight observation through the particular arrangements of the seclusion room door/window as appropriate.

4 The nurse conducting the observations must make a documented and signed record at least every 15 minutes on **H Form: 122H,** or more frequently if a need is identified, in the seclusion record. The nurse should be mindful of the patient's activity especially where the patient is lying beneath a blanket and his/her hands cannot be seen. In these instances, the patient could be injuring him/herself. The nurse should have a low threshold for ensuring there is a proportionate intervention in these circumstances.

5 The nurse in charge should ensure that nurses undertaking observation duties are aware of the requirements of their role, and are competent to undertake it.

6 The observing nurse should always note and record the nature of, and changes to the patient's:
(a) Mental state
(b) Physical state - if there are any changes to respiration or pallor, contact the medical staff to review urgently
(c) Fluid/dietary intake and output-fluid balance charts should be used
(d) Interaction with others
(e) Evidence of change in the attitudes or beliefs which contributed to the circumstances in which the patient was secluded
(f) Evidence of continuing hostility, threat or violence.

7 Any significant changes to the patient's condition should be immediately reported to the nurse in charge who will advise the ward doctor or duty doctor if appropriate.

8 Whilst in seclusion, the patient must be:
(a) Treated with respect and dignity at all times - special consideration needs to be given to women during times of menstruation
(b) Told the reasons for being placed in seclusion
(c) Advised under what conditions seclusion will cease
(d) Informed how to summon the attention of members of staff
(e) Provided with meals and fluids regularly in an appropriate manner which allows the patient's intake to be monitored and recorded
(f) Given access to toilet and washing facilities, which will be supervised by the same gender professionals
(g) Appropriately clothed at all times, unless safe clothing is authorised
(h) Assisted by nursing staff who will relay messages to the patient's legal representatives and the Independent Mental Health Advocate (IMHA), and, subject to their clinical judgement, to relatives and/or significant others
(i) Given their personal mail, access must not be withheld unless the item in question poses a clear risk and this has been agreed with the RC

(j) Have access to a visible clock to ensure the patient is orientated to time and place.
(k) The patient should be encouraged to engage in activities that are not contraindicated to the risks presented.

Appendix 3

PROCEDURE FOR PATIENTS RECEIVING VISITORS WHILST BEING NURSED IN SECLUSION

1 INTRODUCTION

1.1 This procedure has been written to reflect 26.111 of the Mental Health Act Code of Practice 2015, which allows consideration to allowing the patient being nursed in seclusion to receive visitors.

2 DEFINITIONS

2.1 Seclusion

2.1.1 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 (26.103 Mental Health Act Code Of Practice 2015).

2.2 Prolonged Seclusion

2.2.1 The mental health act code of practice 2015 refers to consideration to allow visits during periods of 'prolonged seclusion'.

3 SCOPE

3.1 The scope of this procedure is to:
(a) Provide guidance on when a visit to a patient can be facilitated whilst being nursed in seclusion.
(b) Provide guidance on how to facilitate a visit to a patient being nursed in seclusion.

3.2 Rationale

3.2.1 Every patient in Priory Healthcare, subject to carefully limited exceptions; has the right to maintain contact with family and friends, this can include visits to the seclusion area.

3.2.2 Hospital managers, under certain circumstances, hold the right to restrict or refuse visitors, including requiring them to leave.

3.2.3 The value of visits in maintaining links with family and community networks is recognised as a key element in a patients care, treatment and recovery.

3.2.4 Article 8 of the Human Rights Act (EHCR) protects the right to family life.

3.2.5 'Where seclusion is used for prolonged periods then, subject to suitable risk assessments, flexibility may include allowing patients to receive visitors' (26.111 Mental Health Act Code of Practice 2015).

4 GUIDANCE

4.1 When to consider a patient receiving a visit whilst being nursed in seclusion

4.1.1 In exceptional circumstances, the multidisciplinary team should consider the patients right to receive a visit whilst being nursed in the seclusion room. This can only be considered at the discretion of the RC, at a minimum, if the episode of seclusion becomes 'prolonged'.

4.2 What should be considered when making a decision to allow a visit?

4.2.1 Each individual visit should be considered by the multidisciplinary team before it is authorised.

4.2.2 The multidisciplinary team should consider whether the patient has the capacity to consent to a visit taking place whilst being in seclusion. For patients under 16, Gillick competency should be used. If a patient does not have the capacity to consent to the visit, a best interest decision should be sought and consideration to any previously documented advanced directives given.

4.2.3 The multidisciplinary team should consider whether the patient's dignity can be maintained during the visit.

4.2.4 The multidisciplinary team should consider the nature of the risks involved and how they can be managed safely if a visit was to be facilitated.

4.3 How should the visit be planned, once agreed by the multidisciplinary team?

4.3.1 The hospital senior management team should be informed immediately that a visit to a patient being nursed in seclusion has been agreed.

4.3.2 The visitor should be informed of the outcome of agreement to facilitate the visit.

4.3.3 The visitor should be briefed on how the visit will be facilitated, as per 4.4 (below) guidance.

4.4 How should a visit to the seclusion area be facilitated once authorised?

4.4.1 The visit should be booked in advance, with a minimum of one working days' notice to allow the multidisciplinary team to discuss whether the visit can be facilitated.

4.4.2 The nurse in charge should inform the visitor of the visiting process whilst in seclusion, including:

4.4.2.1 The nature of seclusion, the process of the visit and what to expect.

4.4.2.2 An explanation that the visit would be supervised at all times.

4.4.2.3 The duration of the visit should be agreed prior to the visit and communicated to both the patient and visitor.

4.4.2.4 They may be asked to leave at short notice.

4.4.2.5 Direct physical contact with the patient will be prohibited; this includes the unlocking of the seclusion door.

4.4.2.6 Communication will be via an intercom system.

4.4.3 The nurse in charge should allocate a qualified nurse to escort the visitor throughout the duration of the visit.

4.4.4 The visit should be terminated immediately if any of the following occur:
(a) There is a negative behavioural response to the visitor.
(b) The patient becomes distressed, agitated and/or unwell.
(c) The visitor becomes distressed, agitated and/or unwell.
(d) The fire alarm is activated.

4.5 Actions to take following the visit

4.5.1 The nurse in charge or nominated qualified nurse, following the visit should offer a post visit debrief to the visitor and provide any required reassurances and support.

4.5.2 A clinical entry should be made onto the CareNotes system, detailing how the visit went, whether the visit lasted the full duration of 15 minutes, which colleague supervised seclusion, supervised the visit and provided the post visit debrief with the visitor.

Appendix 4

Long-Term Segregation or Intensive Mental Health Care use in Bespoke Therapeutic Placements
Position on any departure from the Mental Health Act Code of Practice Guidance

1 Introduction

1.1 The Seclusion Policy (H40) establishes Priory's position on Long Term Segregation (LTS) in England and Scotland and for Intensive Mental Health Care (IMHC) in Wales. This follows the guidance of the Mental Health Act (MHA) Codes of Practice in both England and Wales. In Scotland, there are no specific references to the use of restrictions that may amount to segregation in the statute or the Code. However, policy documentation and good practice align their expected approach to the requirements of the Human Rights Act and the guidance available in England and Wales.

1.2 This recognises that the use of LTS or IMHC is restrictive and the correct safeguards must be met for our patients. This includes objective reviews of its use and identifying for it to be discontinued as soon as the risks have reduced.

1.3 Definitions of LTS/IMHC are set out within;

- **H40 Policy: LTS/IMHC of patients who pose harm to others** - refers to a situation where, in order to reduce a sustained risk of harm posed by patients to others, which is a constant feature of their presentation, access to certain areas of the ward environment will be restricted, to minimise interactions with other patients. The interactions would be reduced as it has been determined that it is clear these interactions exacerbate this risk to other patients and staff.

- **England MHA Code of Practice (2015):** 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.

- **Wales MHA Code of Practice (2016):** There may be a small number of patients who exhibit behaviours that challenge that are more sustained and therefore not amenable to short-term seclusion. These patients may benefit from intensive mental healthcare delivered in a discrete clinical area that minimises their contact with the general ward population. Services utilising such intervention must have a local policy in place that sets out when it is appropriate to use such an intervention, and how it is to be implemented and kept under review

1.4 The definitions in statutory guidance and our policy should also be read against the current CQC position. This extends the recognition of LTS/IMHC to include patients who are segregated to protect them from harm or self-harm.

- **CQC Brief Guide (2020):** The key test of whether a patient is segregated is whether they can leave the situation of being separated from others when they want to – that is, are they prevented by staff from leaving? The reference in the Code of Practice to the "need to reduce a sustained risk of harm posed by the patient to others" has led to some services not recognising as long-term segregation the care of some people for their own benefit (for example those with a learning disability or autism or both), even when they are not mixing freely with others on the ward/unit for long periods. Patients segregated to protect them from harm or self-harm are entitled to the same protection as those who

pose a risk to staff and other patients. The safeguards set out in the Code should be applied to support the patient and reduce the need for continuing long-term segregation.

1.5 The definitions and required management checks, reviews and scrutiny for LTS/IMHC remain appropriate and required across the vast majority of our healthcare services. With the need to set clear parameters for use and ensure any segregation from other patients and ward areas is seen as a serious intervention, with high risks to people's dignity and autonomy, and should be for the minimum amount necessary.

2 Application of LTS/IMHC in Bespoke Therapeutic Placements

2.1 The introduction of Bespoke Therapeutic Placements (BTPs) in some services means that we have patients that are admitted to and continue to be in single occupancy areas. This means, patients admitted to BTP are not removed from or awaiting return to a ward environment as set out in the definitions and guidance on LTS/IMHC (see appendix A for detail of our BTP framework).

2.2 The nature of BTPs means that, prior to admission, the benefits of having access to a single occupancy placement within our service has meant a reduction of current or potential restrictions from their previous environment, enabling the individual greater freedoms and increased therapeutic care benefits. With a care and treatment plan tailored and agreed with commissioners and others, to help support their individual needs.

2.3 As people in BTPs will (or may) still be subject to restrictions that amount to the definition of segregation, there is a requirement for consistent and independent reviews against the LTS/IMHC requirements. However, the positive impact and benefits of some of the requirements e.g. daily medical reviews are reduced by the medium to long term nature of the placements. Meeting the requirements of the reviews can feel intrusive and, as the people in BTPs are subject to multiple reviews and assessments by Priory and others, it can be difficult to provide clear justification and purpose to people and their families or others.

2.4 To address this, we want to ensure we are respecting patient's wishes and minimising any unnecessary assessments and reviews. This document sets out our management plan to ensure quality, protection and safeguards are met and offers cogent reasons for any departure from the statutory or good practice guidance or LTS/IMHC in BTPs across our services.

Change in risk or presentation

2.5 While this document sets out the expected approach to LTS/IMHC for our patients in BTPs, if there was any change to the risks or person's presentation and a more restrictive environment was deemed necessary – amounting to seclusion or separation from peers, staff and others – then the Priory Seclusion policy would still apply in full. This departure from the guidance is only where the restrictions have been identified and agreed as part of planned and expected care and provision of service.

3 Guidance for LTS/IMHC in Bespoke Therapeutic Placements in England and Wales

3.1 The checklist and rationale below include the position for BTPs against all required criteria for LTS/IMHC in our services.

Guidance	Standard	Bespoke Therapeutic Placements
1. Rationale and authorisation		
MHA Code (26.150)	There is a clear rationale for LTS, with evidence that it is a necessary 'last resort' of managing disturbed behaviour. The rationale and evidence of this is recorded in the notes, on commencement of LTS and at every subsequent LTS review	The decision for placing a patient in a BTP is based on future longer term planning for a single occupancy community placement. This is fully recorded in notes and records from the point of referral and throughout admission to a BTP.
H40 Seclusion Policy (3.1.1) MHA Code (26.150)	Other interventions should be explored and the decision to segregate should have a clear rationale, as to why this is the least restrictive option. There is evidence that LTS is used only when there is a cogent reason to depart from the Codes procedural safeguards over seclusion and the risk of harm to others would not be ameliorated by a short period of seclusion combined with any other form of treatment	Prior to admission, alternative interventions will have been explored and BTP found to be the most appropriate environment. Following admission, patients have full access to the staff and all living and outdoor areas. There are no alternative interventions and rationale will remain consistent (unless presentation and risk change, in which case this document would not apply).
2. Involving and informing others		
H40 Seclusion Policy (3.1.2)	If the MDT agrees that long term segregation is required, a representative from the commissioning authority should be contacted and be involved in the decision.	All BTPs are referred into from commissioners and care teams identifying the need – this is not identified by site. The commissioning authority remains involved throughout the admission (see reviews below)
H40 Seclusion Policy (3.1.3)	Where appropriate, the views of the patient's family and carers should be sought and taken into account.	All patients and where appropriate/available family are involved and encouraged to come for a site visit before admission
H40 Seclusion Policy (3.1.4)	If a patient has the involvement of an IMHA, they should also be consulted/informed.	All BTP patients are referred to an IMHA by site
H40 Seclusion Policy (3.1.7)	The local safeguarding team should be informed of any patient being supported in LTS/IMHC.	N/A for BTPs -although all are discussed in sites quarterly CQRM meeting which the local Safeguarding team are invited to.
3. Care and Treatment (records and reporting)		

MHA Code (26.152, 26.157-8)	Care and treatment plans have an aim to end long term segregation. They clearly state the reasons why LTS is required and outline how the patient is to be made aware of what is required of them so that the period of LTS can be ended	The decision for placing a patient in a BTP is based on future longer term planning for a single occupancy community placement.
H40 Seclusion Policy (3.1.5)	Once the LTS plan has been developed Form: 122N should be completed and submitted to the Service Line Clinical Director for their agreement. Only at this point can LTS commence.	Medical Director is aware of all BTP admissions
H40 Seclusion Policy (3.1.6)	Once LTS has been agreed, with sign off from the Clinical Director, each Weekly MDT review should be forwarded to the Clinical Director to allow them to keep oversite on the progress being made. The Clinical Director should be involved in organising the three-monthly external review if LTS is still in place.	Medical Director is fully involved in all BTP admission from point of referral and has ongoing oversite.
MHA Code (26.152)	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	BTP patient have full access to staff – the only time this may vary is if they have a care plan that makes staff retreat into the office/ other room so the patient can self-regulate.
MHA Code (26.154) H40 Seclusion Policy (3.1.8)	Patients being nursed in LTS/IMHC due to risk of harm to others should be nursed on enhanced observations by at least two members of staff, trained in the management of violence and aggression. An hourly written record should be made by the observing staff on H Form: 99F.	Observations are assessed per individual need based on risk. Not all BTP patients are on enhanced observations.
MHA Code (26.161)	Individuals should never be deprived of appropriate clothing … neither should they be deprived of other aids necessary for their daily living.	All BTP patient have their own clothing and the environment is as personalised as possible
MHA Code (26.165)	Any requirement that an individual should wear tearproof clothing should be proportionate to the assessed risk and documented evidence should show that it is used only as long as absolutely necessary. As soon as the risk is assessed to have diminished, consideration should be given by nursing staff or the MDT team to a return to usual clothing. This will require ongoing dynamic risk assessment.	N/A in BTPs all patients have own clothing. If safer (tear proof) clothing is required, this would be subject to the same safeguards and requirements as for any patient. Risk assessments would be completed and a return to usual clothing agreed with Responsible Clinician and MDT.
4. Environment		

H40 Seclusion Policy (3.1.9)	The environment that the patient can have access to should be made as safe as possible, removing items which could be used in order to harm others.	All BTPs are assessed and accommodated based on the individual. They are made as personalised as possible.
H40 Seclusion Policy (3.1.9)	Details of the area the patient can have access to, should be detailed in the MDT care plan and discussed with the patient.	Patients have access to the hospital grounds and contact with other patients - accessing site events, the onsite café, tuck shop, OT and therapies provision. (except CAMHS who can only access when no adult patients on the grounds)
MHA Code (26.151) H40 Seclusion Policy (3.1.9)	The environment should be made as homely and personalised as the risk considerations allow.	All BTPs are assessed and accommodated based on the individual. They are made as personalised as possible.
MHA Code (26.151) H40 Seclusion Policy (3.1.9)	The patient, where possible, should have access to bedroom and bathroom facilities and a relaxing lounge area.	All BTP patients have access to a bedroom, bathroom, lounge area, dining area and outside garden.
MHA Code (26.151) H40 Seclusion Policy (3.1.9)	Patients should be able to access secure outdoor areas and a range of activities of interest and relevance to the person.	All BTP have their own designated garden area and access to the hospital grounds.
H40 Seclusion Policy (3.1.10)	At times of acute behavioural disturbance, where it is necessary to contain an immediate risk of harm to others, it may be appropriate to consider the use of seclusion. In this circumstance, the procedure relating to seclusion should be followed, in relation to commencement, documentation, observation, review and discontinuation. Therefore, if the patient is secluded, then this period of LTS/IMHC would be terminated at this point.	None of the BTPs have a designated seclusion. If seclusion is needed for BTP patients the seclusion policy will be adhered to. This would include the requirement for reporting of seclusion in a non-designated area.
5. Reviews		
MHA Code (26.155) H40 Seclusion Policy (3.1.11)	The patient being nursed in conditions of LTS/IMHC should be reviewed by a consultant or their representative (Speciality Doctor/Advanced practitioner/Physician Associate) at least once in every 24 hours	Due to the nature of the admission and care provided, the benefits of daily reviews are limited. There is no alternative (in the service) for them to be 'discharged' from LTS to. Completing daily reviews without clear rationale or purpose can be overwhelming for patients. BTPs explain that reviews can be requested by the patient or any other person at any time and

		offer this information on admission and during weekly care reviews or CPA meetings.

MHA Code (26.155)
H40 Seclusion Policy (3.1.11)
	The patient being nursed in conditions of LTS/IMHC should be reviewed at least weekly by the MDT, members of which at a minimum should be; the RC and the nursing team (where appropriate, the patients IMHA).	• 2 Weekly Care Review (MDT* Reviews/Ward Rounds)
		• CPA Meetings
		  ○ 2 Monthly for CAMHS
		  ○ 3 Monthly for Adults
		8 weekly discharge planning meetings and case manager site visits
		* see Appendix for list of roles that typically form BTP specialist multidisciplinary teams

H40 Seclusion Policy (3.1.11)	The reviews should provide a clear rationale as to why the LTS has been terminated or why it continues to be the least restrictive intervention to manage the risk to others.	Expected discharge from the BTP would only be via community. However, if the persons clinical presentation changed and another setting was required then discharge would follow Priory policy (rather being managed as than an ending of LTS within current setting)
H40 Seclusion Policy (3.1.11)	During the review, there should be consideration to allowing a greater access to the ward environment.	Patients have access to the hospital grounds and contact with other patients - accessing site events, the onsite café, tuck shop, OT and therapies provision. (except CAMHS who can only access when no adult patients on the grounds) All BTP have their own designated garden area and access to the hospital grounds Patients can also have access trips to the community under Section 17 MHA, determined by their Responsible Clinician and in-line with their care plan.
H40 Seclusion Policy (3.1.11)	The patient's general health and welfare should be monitored and referenced in the contemporaneous notes (for Welsh sites, they should use the IMHC pack for documentation).	All patients in BTP have daily running records. They also have weekly reports which are full summary of their week which go to the commissioners and community teams and family if requested.

MHA Code (26.155)
 	
H40 Seclusion Policy (3.1.12)
	Patients should have a senior professional, not involved in the case; independently review the requirement for the intervention on a fortnightly basis. This can be a consultant psychiatrist, registered psychologist, or senior nurse. Any recommendations should be immediately communicated to	Ongoing reviews will be completed via:
		• 2 Weekly Care Review (MDT Reviews/Ward Rounds)
		• CPA Meetings
		  ○ 2 Monthly for CAMHS
		  ○ 3 Monthly for Adults

	the multidisciplinary team and an entry should be made into the contemporaneous notes.	• In additional they have discharge planning meetings and case manager site visits at least every 8 weeks. CPA and discharge meetings include external representatives from community teams and other agencies. The outcome of the reviews that take place will be; • Changes to current care and treatment within the BTP • Identifying support and arrangements needed to plan discharge to a community placement • Identifying any change in presentation or risk that would no longer make BTP or community placement possible and an alternative pathway to be identified

MHA Code (26.156)
H40 Seclusion Policy (3.1.13)
	Patients who have been subject to LTS/IMHC for three months should have a full review by an external hospital MDT.
	
	The external hospital review team should discuss the case with the commissioner and IMHA where appropriate.
	
	Any recommendations should immediately be communicated to the multidisciplinary team and an entry made into the contemporaneous notes. These reviews should continue to take place every three months if LTS/IMHC continues.
		Internal reviews will be completed via:
		• 2 Weekly Care Review (MDT Reviews/Ward Rounds)
		
		Meetings involving external reviewers from commissioning or community teams include;
		
		• CPA Meetings
		  ○ 2 Monthly for CAMHS
		  ○ 3 Monthly for Adults
		
		In additional each patient has a discharge planning meetings and case manager site visits at least every 8 weeks.
		
		The outcome of the reviews that take place will be;
		• Changes to current care and treatment within the BTP
		• Identifying support and arrangements needed to plan discharge to a community placement
		• Identifying any change in presentation or risk that would no longer make BTP or community placement possible and an alternative pathway to be identified
		
		IMHAs are involved for all patients and this includes invitation to meetings.

H40 Seclusion Policy (3.1.15)	Once LTS concludes, the Clinical Director and all external bodies should be informed. The Clinical Director should get a final MDT report on the ending of LTS and on the safe integration of the patient to the ward environment.	From the BTP they will go to the community and the governance of this will be as per our discharge from service policies and procedures. The Clinical Director and external bodies would not need a separate LTS approach to confirm the ending of placement in BTP. However, if the persons clinical presentation changed and another setting was required then discharge would follow Priory policy (rather being managed as than an ending of LTS within current setting)

4 Authorisation and Review Process

4.1 Priory require any departure from statutory guidance to be recognised as exceptional and only possible if the Executive Team agree this is justifiable and kept under close review and monitoring. This includes seeking independent and external challenge to our position from people and their families, regulators and others.

4.2 In reviewing and authorising the departure from guidance in the BTPs, the priority is to avoid any arbitrary or random decision-making, and ensure that our processes are accessible, foreseeable and predictable. Allowing consistent and meaningful engagement with our staff, patients and stakeholders in identifying any unintended consequences to be quickly reported and resolved.

4.3 This document provides the organisational record of the reason for departure from the Code and evidence that this has been authorised by the Executive Team. Site records and governance groups will provide ongoing recording and reporting of the impact of the departure which will be available for auditing and monitoring purposes.

4.4 To ensure the reasons for departure from the statutory guidance is regularly and robustly reviewed, assessing whether there is sufficiently convincing justification for continuing the departure, there will be formal audits and discussions as follows;

- Monthly reviews in BTP site Clinical Governance meetings (reviewing any new information or impact including feedback received from patients, families or representatives, complaints, audits, regulator information)
- Annual audits completed by each BTP service and reported to relevant committees including specific BTP governance groups or forums, the Mental Health Legislation Committee and Quality Assurance Committee

4.5 If any reviews identify a specific challenge that impacts any individual patient adversely, then this will be immediately escalated to the Head of Mental Health Act and Mental Capacity Act Operations and the Chief Quality Officer for review and response.

Authorisation Record			
Name	**Role**	**Changes or comments**	**Date authorised**
Colin Quick	Chief Quality Officer	V2. Strengthen position on Scotland in introduction Change to reflect plans for BTP governance	18 September 2023
Adrian Cree	Chief Medical Officer	V2. No changes	12 September 2023
Dave Hall	General Counsel Company Secretary	Shared V6 2 October	31 October 2023
Paul Cowans Kris Irons	Specialist Director	Review of V0.03 and V0.02. Changes made to review (replaced service line or clinical directors with medical directors), discharge – noting discharge could be to other inpatient placement and not only to community, recognition of use of tear proof clothing or non-designated seclusion areas. PC	25 September 2023

		support for governance proposal. All added to V0.05	
Reuben Evans Gary Stobbs Stephen Baker Sue Harms	Managing Directors	No changes made during consultation period	29 September 2023
Mental Health Legislation Committee		Approved	29 September 2023

Appendix 1: Bespoke Therapeutic Placements

4.6 BTPs are single occupancy placements available for adults and young people with autism and/or learning disabilities. These placements are offered to those who present with complex and challenging needs which might include aggressive behaviours, sensory issues and emotion dysregulation, all of which can make it difficult for these individuals to be supported in a shared environment.

4.7 The core aim of our BTPs is to offer an environment with the least restrictive practices, and one that is completely tailored to the unique needs and preferences of our patients. Our aim is to support our patients to develop their independence skills, enabling them to transition to community living, wherever possible.

4.8 Our BTPs are tailored programmes of care within a safe, secure and purpose-designed environment. This means we take an individual's needs and requirements into consideration when forming a treatment plan and create the most comfortable and supportive environment as possible. Each placement is designed to accommodate a single person's needs. Our BTPs also include:

- Collaborative care from our experienced multidisciplinary team (MDT)
- Dedicated positive behavioural support (PBS) provision
- A least restrictive model of care, with minimal use of restraint
- Time and space for individuals to self-regulate their emotions
- Activities designed around individual needs, interests and abilities
- Family involvement throughout the duration of the programme
- Close liaison with outside agencies to support individuals to attend appointments such as dentistry and hospital appointments

Bespoke Environments

4.9 Our BTPs are designed to accommodate one individual and their needs, allowing us to easily adapt our units as needs and requirements change. Our units can be changed so that they constantly meet the emotional, behavioural and sensory needs of people using them.

4.10 Changes can be made in individual areas such as bedrooms, and communal areas like common rooms and outdoor spaces. We can use individual's favourite colours, patterns and designs to decorate areas, and incorporate images and stickers to help emotional understanding. We can also create low stimulus 'black out' areas, designed to create a safe space if individuals ever feel overwhelmed. For service users who prefer to de-escalate with water, we are able to provide spacious wet rooms and showers.

4.11 Outdoor areas can also be customised and we can create large spaces for individuals to be in, whether that's to run around and reduce energy or to alleviate any sensory issues they may have. Grassy areas can also be created for individuals who like to walk barefoot to regulate sensory stimuli.

Specialist multidisciplinary team

4.12 We ensure that our patients are supported by caring, knowledgeable and engaged teams. Our staff are provided with high levels of support, supervision and training, and we engage in reflective practice in order to ensure continuous improvement. We pride ourselves on delivering dedicated and stable care, while offering consistency and familiarity to our patients, in order to build trust. Our specialist team typically consist of:

- Core nursing team and healthcare assistants
- Experienced psychologists, who work with our patients to develop coping strategies, relaxation techniques and healthy emotional expression
- Consultant psychiatrists, specialising in working with people with autism and/or learning disabilities
- Occupational therapists
- Speech and language therapists
- Dedicated PBS provision, available throughout the duration of the BTP, prior to step-down. This allows us to produce sustainable outcomes
- Child and adolescent mental health services (CAMHS) input, where applicable