CARE OF PATIENTS IN SECLUSION AND LONGER TERM SEGREGATION (ENGLAND)

1. INTRODUCTION

Caring for patients in seclusion or longer term segregation can be complex and requires clear guidance to promote good practice. This policy makes direct reference to the Mental Health Act Code of Practice *(MHA CoP)* and sets out the context and framework within which PiC staff will practice. Should any conflict arise between this policy and the Code of Practice, the Code of Practice takes precedence. Seclusion of an informal patient should only be undertaken as a last resort and is an indication of the need to immediately consider formal detention[1] *(MHA CoP 26.106[2]).*

Patients' 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.

On admission, all patients should be assessed for immediate and potential risks of behavioural disturbance. Assessments should take into account of the person's history of such behaviours, their history of experiencing personal trauma, their presenting mental and physical state and their current social circumstances. Individual care plans should be developed including actions to be taken should any of these occur *(MHA CoP 26.8).*

Seclusion should be used where it is considered that the patient's clinical presenting condition makes this necessary in all the circumstances of the case. It should only be used as a last resort and for the shortest possible time. 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.

Seclusion should 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 should be used only when the professionals involved are satisfied that the need to protect other people outweighs any increased risk to the patient's health or safety arising from their own self harm and that any such risk can be properly managed *(MHA CoP 26.108*).

Any such intervention should be used for no longer than necessary to prevent harm to the person or to others, be a proportionate response to that harm and be the least restrictive option (*MHA Cop 26.37*).

[1] An informal patient who is secluded without consent is likely to require an urgent application to be made by the hospital under the Deprivation of Liberty Safeguards (DOLS)

[2] References to MHA CoP are to the Mental Health Act Code of Practice published in 2015

This policy should be read in conjunction with the MHA Code of Practice - England and the following PiC policies:

- PiC Operational Policy – *Safe and Supportive Observations*
- PiC Operational Policy – *Managing Incidents and Untoward Occurrences*
- PiC Operational Policy – *Guidelines for the Use of Rapid Tranquilisation*
- PiC Operational Policy – *Health Record Content & Management*
- PiC Operational Policy – *The Safe and Therapeutic Management of Violence And Aggression*
- PiC Health & Safety Policy – *Fire Precautions and Fire Safety*

This policy should be implemented within the context of the PiC Values:

- Valuing people – respecting our staff, patients, their families and communities
- Caring safely – for ourselves, our patients, our customers and communities
- Working together with everyone
- Uncompromising integrity, respect and honesty
- Taking quality to the highest level

2. DEFINITION

Seclusion is the supervised confinement and isolation of a patient, away from other patients, in an area which the patient is prevented from leaving where it is of immediate necessity for the purposes of the containment of severe behavioural disturbance which is likely to cause harm to others (*MHA 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. It is essential that they are afforded the procedural safeguards of the Mental Health Code of Practice. It should be noted that the definition of seclusion is therefore perhaps wider than anticipated and staff should ensure that a care regime which meets the definition of seclusion is only undertaken in accordance with this policy in a seclusion room / suite.

Expectation
Seclusion can only be considered when there is an imminent risk that the patient's severely behavioural disturbance is likely to cause harm to others.

2.1 Conditions of Seclusion

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 (*MHA CoP 26.105*).

The room used for seclusion should:

- Allow for communication with the patient when the patient is in the room and the door is locked;

- Include limited furnishings which should include a bed, pillow, mattress and blanket or covering;
- Be quiet but not soundproofed and should have some means of calling for attention (operation of which should be explained to the patient);
- There should be no apparent safety hazards;
- Rooms should have robust, reinforced window(s) that provide natural light
- Rooms should have externally controlled lighting, including a main light and subdued lighting for night time;
- Rooms should have robust door(s) which open outwards;
- Rooms should have externally controlled heating and/or air conditioning, which enables those observing the patient to monitor the room temperature;
- Rooms should not have blind spots and alternate viewing panels should be available where required;
- A clock should always be visible to the patient within the room, and;
- Rooms should have access to toilet and washing facilities (MH Cop 26.109)
- Provide privacy for the patient in accordance with the need to respect the patient's dignity

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 Code of Practice are clearly noted and the necessity of placing a patient in seclusion in such circumstances are clearly noted in the patient's records.

Staff may decide what a patient may take into the seclusion area, but the patient should always be clothed *(MHA CoP 26.113).* Patients should never be deprived of appropriate clothing at any time of the day or night with the intention of restricting their freedom of movement. They should not be deprived of other aids necessary for their daily living *(MHA CoP 26.161).*

Expectation
Services should identify rooms that can be used for the purpose of seclusion. Safe clothing may be used if a patient is using their clothing in a manner that may endanger others or themselves. This decision should be authorised by the patient's RC.

Any property removed must be documented and kept in a safe place and the patient informed of its location.

2.2 Initiating Seclusion

The decision to use seclusion can be made in the first instance by a doctor, an approved clinician (as defined by the Mental Health Act), or the professional in charge of the ward. Where the decision to use seclusion is made by someone other than a doctor, the Responsible clinician or duty doctor (or equivalent) should be notified as soon as practicable and should attend to undertake the first medical review within one hour of the beginning of seclusion. *(MHA CoP 26.116)*. The person authorising seclusion should have seen the patient immediately prior to the commencement of seclusion *(MHA CoP 26.114).*

Expectation
Local policies should make provision for a duty doctor to deputise when the Responsible Clinician is not immediately available e.g. outside of normal working hours. The policy should also identify which doctors are competent to carry out a medical review. When 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 (MHA CoP 26.127).

The start time of any seclusion should be recorded. Follow the seclusion recording process flowchart on the front of the seclusion pack and commence formulation of a seclusion care plan – ***Appendix A – Seclusion Process & Recording Guide***.

The seclusion care plan will evidence that risks of self-harm are considered and minimized and how the privacy and dignity of the patient is maintained in seclusion.

2.3 Seclusion Reviews

Overview of seclusion and monitoring process:

- If not authorised by a psychiatrist, there must be a medical review within one hour or without delay if the individual is not known or there is a significant change from their usual presentation
- Seclusion area to be within constant sight and sound of staff member
- Documented report by a person monitoring the patient every 15 minutes
- Nursing reviews by two nurses every two hours throughout seclusion
- Continuing face-to-face medical reviews every four hours until the first internal multidisciplinary team meeting
- The first internal MDT meeting to take place as soon as is practicable
- An independent MDT meeting to take place after 8 hours consecutive seclusion or 12 hours intermittent seclusion within a 48 hour period
- Following the first internal MDT meeting, continuing medical reviews to take place at least twice daily (one by the patient's Responsible Clinician)

Detailed procedure

A series of review processes should be instigated when a patient is secluded. All reviews provide an opportunity to determine whether seclusion needs to continue or should be stopped, as well as to review the patient's mental and physical state. Where agreed, family members should be advised of the outcomes of reviews *(MHA CoP 26.126)*.

The first medical review should:

- If seclusion was authorised either by an approved clinician, who is not a doctor or the professional in charge of the ward, be undertaken by the Responsible Clinician or duty doctor within one hour of commencement of the patient's seclusion; or
- If seclusion was authorised by a consultant psychiatrist (whether or not the

patient's Responsible Clinician or Approved Clinician), be the review that s/he undertook immediately before seclusion was authorised. If this is the case, a further review within one hour of the seclusion commencing is not required.

Expectation
If seclusion was authorised by a Consultant Psychiatrist, this review will be regarded as the first medical review. If it was not, the Responsible Clinician or Duty Doctor will be required to carry out a review within one hour of seclusion commencing.

Subsequent medical reviews should be undertaken by the Responsible Clinician, a doctor who is an Approved Clinician, or a duty doctor.

Reviews must take place face-to-face.

Four hourly medical reviews of secluded patients should be carried out until the first internal MDT has taken place; these four hourly reviews need to be continued throughout the night and at weekends and bank holidays.

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.

The medical review should be carried out in person and is an opportunity to evaluate and amend seclusion care plans and an assessment should be made as to whether continued seclusion remains necessary.

Nursing reviews of the secluded patient should take place by the nurse in charge of the ward at least every 2 hours following the commencement of seclusion (26.134) and should be recorded in the seclusion record.

An initial multi-disciplinary review of the need for seclusion should be carried out as soon as practicable after the seclusion begins involving the Responsible Clinician, or a doctor who is an approved clinician, the senior nurse on the ward, and staff from other disciplines who would normally be involved in patient reviews *(MH CoP 26.138).* At weekends and overnight, membership of the initial MDT review may be limited to medical and nursing staff, in which case the on-call senior site manager (or equivalent) should also be involved *(MH CoP 26.139)*. Further reviews should take place once in every 24 hour period of continuous seclusion (*MH CoP 26.140*). Unless the initial multi-disciplinary review concludes that more regular arrangements are appropriate, the need to continue seclusion should be reviewed:

- Every two hours by two Registered Nurses (one of whom was not involved directly in the decision to seclude); and
- At least twice in every 24 hour period. At least one of these should be carried out by the patient's Responsible Clinician, the other can be carried out by a doctor who is an approved clinician or a duty doctor.

However, local policies[3] may allow different review arrangements to be applied during

[3] The phrase "local policies" is a direct quote from MHA CoP. PiC does not allow variation to policy. However, it is recognised that local arrangements for effective implementation of the policy may vary.

the night when patients in seclusion are asleep *(MHA CoP 26.131).*

If the patient is secluded for more than:

- 8 hours consecutively; or
- 12 hours intermittently over a period of 48 hours

An independent multi-disciplinary review should be promptly undertaken by a doctor who is an approved clinician, or an approved clinician who is not a doctor, a nurse and other professionals who were not involved in the incident which led to the seclusion and an IMHA (in cases where the patient has one). Where an independent multi-disciplinary review takes place it is good practice for those involved in the original decision to be consulted in the independent MDT review *(MHA CoP 26.142).*

If the need for seclusion is disputed by any member of the multi-disciplinary team, the local policy[4] should set out arrangements for the matter to be referred to a senior manager or clinician.

Case Managers / Commissioners should be notified (by email) of all episodes of seclusion (start and end) within 1 working day of the episode commencing / ending. Should seclusion commence / end on a weekend, this would be reportable immediately the following Monday. The notification should also include any specific and relevant information relating to the episode of seclusion.

Expectation
A medical review should usually be undertaken within one hour of the commencement of seclusion (see above). An initial multi-disciplinary review of the need for seclusion should be carried out as soon as practicable after the seclusion begins. Further reviews, including independent MDT reviews where applicable, should be carried out as outlined above. The RC or duty doctor (if the duty doctor is not a Consultant then they should refer to the duty Consultant) may decide that there need not be a review by a doctor between 10pm and 8am if:

- *The patient is asleep at the last review of the day i.e. at around 10pm, and*
- *Remains asleep, and*
- *The patient has not received any parenteral medication other than their usual depot that day, and*
- *The patient has not received oral medication which they have not previously received, and*
- *The patient has not received any additional oral medication which takes their aggregate prescription to a level in excess of BNF limits, and*
- *The patient has no current physical condition which necessitates closer medical supervision*

In this event the Nurse in charge must ensure the RC's instructions are communicated to observing staff and inform both the Senior Nurse on-call and the Senior Manager

[4] If the need for seclusion is disputed by any member of the multi-disciplinary team the matter should be referred immediately to the Senior Manager on Call.

on-call. Changes to reviews by a doctor must be recorded along with the rationale in the seclusion care plan (in the seclusion pack) as well as the patient's health record.

2.4 Reviews and Exceptional Circumstances

In very exceptional circumstances it may not be possible for the RC or duty doctor to attend within an hour or in person to review the patient.

Expectation
Exceptional circumstances are not routine practice – they will be very rare and should only occur if absolutely unavoidable. In exceptional circumstances, the initial review following seclusion of a patient will be conducted by the Senior Nurse of the service who was not involved in the decision to seclude the patient (this could be the Night Coordinator or Senior Nurse on-Call or a Charge Nurse from another ward). The Senior Nurse will discuss the review with the RC or duty doctor over the telephone and document this in the seclusion pack and patient's health record along with the reasons why the RC / duty doctor could not attend. The RC or duty doctor will conduct their review in person as soon as they are able. The RC or duty doctor will document their review and why they were unable to attend at the correct time in the seclusion pack and the patient's health record. The Registered Manager should be informed at the earliest opportunity.

2.5 Observations

A suitably skilled professional should as a minimum be readily available within sight and sound of the seclusion room at all times throughout the period of the patient's seclusion *(MHA CoP 26.118).* The aim of this observation is to safeguard the patient, monitor the condition and behaviour of the patient and to identify the time at which seclusion can be ended. The regularity of observation should be decided on an individual basis. A documented report must be made at least every 15 minutes (*MHA CoP 26.149*).

Any professional taking over responsibility for observing a patient in seclusion should have a full handover, including details of the incident that resulted in the need for seclusion, the risks posed by the patient underlying the seclusion decision and subsequent reviews*.*

Expectation
The Nurse in Charge is responsible for identifying the staff members on shift that are suitably skilled to observe a patient in seclusion. Consideration should also be given to whether a male or female person should undertake the observations; this may be informed by consideration of the patient's trauma history. A suitably skilled professional should be readily available within sight and sound of the seclusion room at all times throughout the period of the patient's seclusion (MHA CoP 26.118). The observing staff must record observations of the patient every 15 minutes in the seclusion pack (MHA CoP 26.123).

The Registered Nurse involved in the seclusion review must also make an entry summarising their view which includes that they have considered the content and

quality of the observer team's 15 minute observations and their relevance to the seclusion care plan.

2.6 Seclusion and Rapid Tranquilisation

Rapid tranquilisation should only be used to manage acute behavioural disturbance on a short term basis with the sole intention of reducing immediate risk.

For patients who have received sedation a Registered Nurse will need to be outside the door at all times with adequate call facilities available to them (*MHA CoP 26.122).* The National Institute for Health and Clinical Excellence (NICE) guidelines on rapid tranquilisation do not ban the use of seclusion after rapid tranquilisation.

Expectation
Medical advice should be sought as to the level of observations required and whether it is safe to continue seclusion after rapid tranquilisation. If seclusion is used following rapid tranquilisation physical observations should be conducted when safe to do so and documented within the seclusion care plan. If rapid tranquilisation has been used observations must be conducted by a Registered Nurse and vital signs should be recorded until assessed by the Nurse in Charge, and vital signs are normal (ref: PiC Guidelines for use of Rapid Tranquilisation).

In hospitals where this is used, the nurse undertaking physiological observations must adhere to National Early Warning Score (NEWS) protocols. In summary, the nurse should consult a doctor for urgent review if the NEW score is 5 or above or one of the physiological parameters gives a Red score. 999 should be considered for scores of 7 or above.

Where it is not considered safe to continue seclusion after rapid tranquilisation, seclusion should be immediately terminated and medical / nursing input obtained about other precautionary steps to be put in place to protect staff or others who might be at risk from the patient.

2.7 Record Keeping

Detailed and contemporaneous records should be kept in the patient's case notes of any use of seclusion. The record made should include 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 *(MH CoP 26.124)*. Records should also be kept in a special seclusion recording system which should contain a step-by-step account of the seclusion procedure in every instance. A seclusion care plan as required by paragraph 26.147 of the Code of Practice must be completed. Responsibility for the accuracy and completeness of these records should lie with the professional in charge of the ward. Local policies[5] should require the records of each episode of seclusion to be reviewed by a more senior professional.

[5] *In the seclusion documentation pack, a checklist is available for completion at the end of each episode of seclusion. This should be completed by the Nurse-in-Charge signed and dated.*

Documentation and continuation packs can be found by following these links:

0 – 4 hours documentation pack ***(Appendix B)***
Over 4 hours continuation pack ***(Appendix C)***

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.

Expectation
All seclusion events must be logged in the ward seclusion register in addition to the seclusion documentation pack. For each seclusion event, a full account of the reasons and details of the actual incident must be entered into the seclusion pack ***and*** *the patient's clinical record. The Nurse in Charge must ensure that the entry in the seclusion documentation pack and patient's clinical record gives a detailed account of the reasons for seclusion and the implementation of any temporary care plan. The Nurse in Charge will ensure an incident report (IRIS) is completed for each incident of seclusion. Upon termination of the seclusion episode the documentation checklist included in the seclusion documentation pack should be completed by the nurse in charge signed and dated.*

2.8 Terminating Seclusion

Expectation
This should be done as soon as possible by either MDT following a review; a review by a RC or nurse in charge of the ward. Seclusion should be used for no longer than is necessary to achieve the intended aim of preventing harm to others and should be terminated when a medical review / the RC determines it is no longer warranted (MHA CoP 26.144). All decisions taken to terminate seclusion should be in line with the reintegration care plan. The patient experience of the seclusion should be sought and recorded following termination by a Registered Nurse who was not involved in the decision to seclude the patient using the questionnaire at the back of the main seclusion pack. The MDT will review the care plans for the patient in response to the seclusion episode.

2.9 Longer Term Segregation (LTS)

There are a smaller number of patients under the care of PiC who present a risk of harm to others that is a constant feature of their presentation and is not subject to amelioration by a short period of seclusion combined with any other form of treatment. These patients may require separation from the ward community to maintain the safety of patients and staff, and this separation may need to continue for long periods.

The clinical judgment in these cases must determine 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 *(MHA CoP 26.150).*

It is PiC's position that the difference between seclusion and LTS lies in the aim of the intervention.

Seclusion is always an unplanned intervention that is intended solely to contain seriously disturbed behaviour, which is likely to cause harm to others.

LTS is an intervention that is planned by the clinical team, to manage continuing and longer-term risk to others, presented by a patient who is no longer severely disturbed.

It should be noted that segregation is not necessarily seclusion, and in most cases will not be seclusion. See above for the definition of seclusion. However, it should also be noted that during a period of segregation the need for seclusion may arise to contain an episode of seriously disturbed behaviour, and in that situation, the review and observation processes applicable to seclusion must be adopted.

The Criteria for the use of LTS

1. The patient concerned is no longer acutely and severely disturbed.

2. The patient continues to present a significant risk to other patients or members of staff, and this risk will be manifest if the patient is in the ward community.

3. The risk that the patient presents can only be managed by separating the patient from the ward community.

4. This separation is the least restrictive means of managing the risk and providing the patient with the care and treatment that they need.

5. The risk that the patient presents is likely to be present for a considerable period of time, despite other care and treatment.

PiC recognise the importance of clinical judgment in such cases and acknowledge the difficulty in assessing and managing the clinical risk. The decision to use LTS in the first instance rests with the multi-disciplinary team responsible for the patient. It must be approved by the patient's Commissioner. The relevant Case Managers / Commissioners should be notified (by email) of all episodes of segregation (start and end) within 1 working day of the episode commencing / ending. Should segregation commence / end on a weekend, this would be reportable immediately the following Monday. The notification should also include any specific and relevant information relating to the episode of segregation. Adult safeguarding must also be notified. However, the decision will be supported by the senior management team of the hospital involved, and endorsed by PiC on receipt of relevant medical information explaining the reason for LTS.

In these cases, the patient’s situation should be formally reviewed by an approved clinician which may or may not be a doctor at least once in any 24 hour period and at least weekly by the full MDT. The full MDT should include the Responsible Clinician, a Senior Nurse and an IMHA where appropriate.

Where LTS 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 *(MH CoP 26.156).*

Expectation
The MDT may agree to adopt an LTS care plan based on the assessed needs of the patient following consultation with the local Senior Management Team.

Appendix D – LTS Care Plan *(which includes prompts to ensure that the relevant persons are consulted about any such plan)*.

LTS Care Plans must be shared with and approved by the PiC Legal Department as soon as possible. The PiC Executive Medical Director and PiC Director of Policy and Regulation must also be informed, within one working day of the segregation being commenced, of any patient who is subject to LTS Care Plan. A MHA Commissioner will be invited to attend the MDT review of the patient's management care plan. Consideration should be given as to whether it is appropriate to share LTS Care Plans with any other relevant persons such as the Commissioning Case Manager. Where possible the patient's consent should be sought. The Nurse in Charge is required to initiate a LTS documentation care pack and deploy suitably skilled staff to provide care for the patient.

The LTS Care Plans should include arrangements for review of the patients' mental state, physical health including an appropriate diet, personal hygiene, clothing, exercise, access to fresh air, engaging the patient in a therapeutic manner, a procedure for reintegration back into the ward and the steps that should be taken in order to bring longer term segregation to an end. The care plan should be with those staff undertaking observations at all times.

Once the LTS care plan is adopted the Nurse in Charge must initiate the LTS documentation pack and deploy suitably skilled staff to provide care for the patient.

3. HEALTH AND SAFETY

For any patient placed in seclusion / LTS, the clinical team should complete a Personal Emergency Evacuation Plan (PEEP). Please see attached template at ***Appendix E – Personal Emergency Evacuation Plan***.

Local health and safety audits will capture how Infection Prevention Control Standards are maintained in seclusion rooms.

4. CLINICAL GOVERNANCE ARRANGEMENTS

Expectation
All seclusion episodes will be reviewed daily by the Senior Management Team / Senior Manager-on-Call. The Charge Nurse will conduct a monthly audit of seclusion for their ward using ***Appendix F – Monthly Seclusion Audit****. Seclusion audits will routinely be reviewed by local unit Clinical Governance Group.*

Following Episodes of Acute Behavioural Disturbance

Following an episode of acute behavioural disturbance that has led to seclusion, a post-incident review or debrief should be undertaken so that involved parties, including patients, have appropriate support and there is an opportunity for learning within PiC / the hospital. It is important that patients are helped to understand what has happened and why. Patients with limited verbal communication skills may need support to participate in the post incident review / debriefing (*MHA CoP 26.167*).

Where a patient is not able to participate in a debriefing, methods for assessing the effects of the seclusion on their behaviour, emotions and clinical presentation should be fully explored as part of their assessment(s) and recorded in their Seclusion Pack and in their records / treatment plan.