

## Seclusion Policy

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Name and Job Title of author:	Forensics Lead Nurse & Clinical Effectiveness coordinator Consultant Psychiatrist Interim Modern Matron
Executive Director lead :	Chief Operating Officer
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### Version Control Summary

Version	Date	Author	Status	Comment
4.0	April 2013	Lead Nurse Forensic Services. Lead Nurse Newham MH Services. Lead Nurse Tower Hamlets MH Services.	Approved	Addition of flow chart
5.0	November 2015	Deputy Director of Nursing and Lead Nurse , Matron  Trust wide Restrictive Intervention Reduction QI group	Approved	<ul style="list-style-type: none"> <li>• Policy updated in line with Code of Practice 2015</li> <li>• Seclusion records are now electronic throughout the trust. Included relevant codes and guidance.</li> <li>• Update seclusion process chart</li> <li>• All band 4 and 5 inpatient staff should undertake seclusion training</li> <li>• All junior doctors to have seclusion at induction</li> <li>• Amended seclusion environment checklist</li> <li>• Amended stock equipment</li> <li>• Addition of competency checklist for observing staff</li> <li>• Segregation procedure now available as a separate policy</li> <li>• Restricted access removed</li> <li>• Added seclusion audit tool</li> </ul>
6.0	October 2016	Deputy Director of Nursing 'Matron, Clinical Nurse Manager.  Trust wide Restrictive Intervention Reduction QI group		<ul style="list-style-type: none"> <li>• Added template for Medical Review</li> <li>• Added template for Nursing review</li> <li>• Recommendation for SIR – Outside normal working hours DSN to inform duty doctor medical review times.</li> </ul>
7.0	February 2018	Head of Nursing Forensics  Matron  Clinical effectiveness coordinator  Matron		<ul style="list-style-type: none"> <li>• Added introduction</li> <li>• Added Use of ELM modified – Broset Tool for seclusion reviews</li> <li>• Added Life signs monitoring system</li> <li>• Added Seclusion debrief Guide</li> <li>• Amended to note that all</li> </ul>

				<p>staff carrying out seclusion observations should undertake seclusion training delivered in their directorate and this should be recorded as core competencies on OLM</p> <ul style="list-style-type: none"> <li>Reviewed template for nursing and Medical reviews</li> </ul>
8.0	December 2020	<p>Forensic Lead Nurse</p> <p>Clinical Effectiveness coordinator</p> <p>Consultant Forensic Psychiatrist (Medium Secure Learning Disabilities) and RCPsych Regional Advisor</p> <p>Interim Modern Matron</p>	Approved	<ul style="list-style-type: none"> <li>Policy Updated</li> <li>Added other discipline of MDT to carry out seclusion</li> <li>Template for the Senior Nurse debrief has been removed</li> <li>Small foam cube to be used as a tray for serving food .</li> </ul>
9.0	October 2021	Director Of Nursing		<p>Minor amendment to reference to Venous Thromboembolism Reducing the risk Policy at 2.3</p>
10.0	June 2022	Director of Nursing		<p>Policy updated to include:</p> <ul style="list-style-type: none"> <li>reference to Use of Force and related Policy</li> <li>Oxehealth Life Signs monitoring system</li> <li>Responding to a medical emergency in seclusion</li> </ul>
11.0	March 2024	Director of Nursing		<p>Minor amendment to include:</p> <ul style="list-style-type: none"> <li>- inclusion of patient's in seclusion being discussed in MDT discussions including ward round and safety huddle where they are unable to attend</li> <li>- guidance on the use of Tear Proof Clothing</li> </ul>

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## **1.0. Introduction**

- 1.1 East London NHS Foundation Trust has a duty of care to provide and maintain environments which are safe for all and comply with national and professional guidance. This policy aims to ensure a consistent approach to the management of service users who may need to be nursed in seclusion.
- 1.2 This policy is to give support to trust staff through the process of implementing and managing care of individuals subject to these restrictions. This policy complements the Mental Health Act Code of Practice guidelines on the use of seclusion.
- 1.3 Seclusion should be used only in extreme circumstances where a patient poses an immediate and significant harm to others and all other options of keeping the situation safe have been considered. Seclusion may be the option that presents the lowest risk and is likely to be the most benefit to the person.
- 1.4 In order to ensure that seclusion measures have a minimal impact on a service user's autonomy, seclusion should be applied flexibly and in the least restrictive manner possible, considering the service user's circumstances.
- 1.5 The right to respect for private and family life, home and correspondence for service users whilst in seclusion should always be considered.
- 1.6 The Mental Health Act itself does not cover seclusion; guidance is however given on how Restrictive Practices should be governed.

## **2.0. Aim of the policy**

- 2.1. This policy has been developed to guide good practice when initiating or supporting patients in seclusion.
- 2.2. The aim of this policy is to ensure that:
  - a. The secluded patient, other patients and members of staff are safe
  - b. The patient is cared for and supported, both during and after seclusion
  - c. Seclusion takes place in a suitable environment, and takes account of the patient's dignity and physical well-being
  - d. The continuing need for seclusion is reviewed utilising the skills and experience of available staff.
  - e. Each period of seclusion is recorded completely and contemporaneously
  - f. The care plans and risk assessments of the secluded patient are updated
  - g. Members of staff understand their roles and responsibilities and work within legal and procedural guidelines
  - h. Patients are only secluded in seclusion rooms as identified by the Trust
  - i. All staff are working with the least restrictive options that can be offered to patients based on their presentation and risks.
- 2.3. The policy must not be used as a stand-alone document but in conjunction with all Trust policies and guidelines, in particular the policies listed:
  - a. Policy on the use of physical holding skills
  - b. Medicine policy
  - c. Guidelines for the management of acutely disturbed adults
  - d. Guidelines for PRN medication

- e. High dose antipsychotic medication guidelines
- f. Rapid Tranquillisation Policy for Adults and Older People
- g. Incident policy
- h. Long Term Segregation Policy
- i. Venous Thromboembolism Reducing Risk Policy
- j. Management of a Medical Emergency
- k. Mental Health Units- Use of Force Policy

### **3.0. Scope**

- 3.1. This Policy applies at all times to all staff working within inpatient mental health services provided by East London NHS Foundation Trust. Locality specific protocols must be observed.
- 3.2. The policy applies to all patients cared for in seclusion at any time, whether they are detained under the Mental Health Act or not. The seclusion of an informal patient should be viewed as an indicator to consider the need for formal detention. An assessment must be completed immediately.
- 3.3. Although the act of supporting a patient in seclusion cannot be planned for in advance or as part of their care or treatment plan, planning should be made on how to support the patient towards termination of seclusion once it has started.
- 3.4. Use of seclusion must be strictly monitored and recorded in accordance with the guidance provided in the Mental Health Act 1983 amended 2007 Code of Practice (2015) and the Mental Health Units (Use of Force) Act 2018.

### **4.0. Definition of seclusion**

- 4.1. The 2015 Code of Practice defines seclusion as:

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. Assessment must indicate that if seclusion did not take place the safety of others would be significantly compromised.

Although seclusion falls within the definition of medical treatment in the Mental Health Act (Section 145), seclusion is not a planned treatment technique and should not be used as a part of any planned treatment programme. Seclusion should only be used when all other interventions have proved unsuccessful and for the shortest possible time.

- 4.2. Seclusion constitutes the 'use of force' as defined by the Mental Health Units (Use of Force) Act 2018. As such it should only be used as a last resort and when its use is reasonable under the circumstances to keep people safe. All inpatient services have a legal requirement to have processes in place to monitor the use of seclusion and to avoid and reduce its use as much as possible.
- 4.3. Seclusion should never be used as a punishment. Any use of seclusion must take into account the human rights of the patient. Seclusion should be used for no longer than is necessary to keep people safe; it should be proportionate to the risk posed by the patient; and any use of seclusion should be the least restrictive option given the risk posed by

the patient.

## **5.0. Principles**

- 5.1. When determining whether to seclude a patient, the clinical and safety needs of the patient and other patients should be taken into account.
- 5.2. Previous trauma or abuse and physical health issues should be considered and advanced directives must be in place.
- 5.3. Care plans should always be used in conjunction with any management plan. Where possible, an advance directive agreement should be reached with the patient prior to using seclusion.
- 5.4. Seclusion must be a reasonable and proportionate response to the risk posed by the patient.
- 5.5. Consideration should be given to using seclusion and or rapid tranquillisation as alternatives to prolonged physical intervention.
- 5.6. Where there is a disagreement about continuation of seclusion the relevant managers of that service may be contacted. Outside 9-5 weekday hours the on call system may be used for advice.
- 5.7. Seclusion should not be used:
  - a. As punishment or threat;
  - b. As part of a treatment programme;
  - c. Because of shortage of staff;
  - d. Where there is an indication of a significant risk of suicide or self-harm.

*(Where the patient poses a risk of self-harm as well as harm to others, seclusion should only be used when the professionals involved are satisfied that the need to protect other people outweighs any increased risk to the patient's health or safety and that any such risk can be managed)*

- 5.8. If in the process of secluding a patient, there are injuries to either staff or patients, the relevant medical assistance should be given. The staff member will be accompanied or supported to go to the nearest Accident & Emergency department. Staff (Nursing & Medical) attending to the incident will make the informed decision of whether to treat the patients on site or to go to the nearest Accident & Emergency department. This should be followed up by the Senior Nurse.

## **6.0 Prevention**

- 6.1. The effective and safe support of aggressive patients is one of the most challenging aspects of working in a mental health inpatient setting. It is an area where good interaction, communication skills and risk assessment are required.
- 6.2. In East London Foundation Trust (ELFT), a study by Felice Loi & Karl Marlowe (2017), indicated that the use of the East London Modified-Broset Checklist (ELM-B) can help support teams to predict and reduce the likelihood and length of seclusion. This can be achieved through concentrating on assessment and interventions when behaviours such as attacking objects, physical threats and PRN compliance, response to de-escalation, irritability, boisterousness and verbal threats. It is important that in areas with acute

needs that this tool is used in reducing and supporting seclusion decisions (Appendix 1). Training for the ELM-Broset tool should be embedded in the directorate seclusion training.

- 6.3 When a patient is distressed this needs to be treated with an appropriate, measured and reasonable response. Verbal de-escalation techniques must be used throughout.
- 6.4 The Multi-Disciplinary Team (MDT) should be aware of what generally and specifically upsets and calms the patient. There should be support plans with interventions in place to help prevent the patient from escalating. This should be noted in their care plans. A copy should be provided to the patient.

## **7.0 Decision to seclude a Patient**

- 7.1 The decision to seclude a patient is made by the nurse in charge or the doctor for the relevant clinical area, in liaison with the nursing/multi-disciplinary team.
- 7.2 The East London Modified-Broset Checklist (ELM-B) should be completed Immediately after Seclusion commences.
- 7.3 If there is no doctor present at the time the decision is made to seclude a patient, the nurse in charge of the ward must immediately inform the appropriate ward doctor, or duty doctor and arrange that they review the patient within one (1) hour. If a doctor initiated or made the decision to seclude then it is not necessary for a Doctor's review within an hour.

If the nursing staff terminate the seclusion before the doctor arrives, the doctor should still see the patient. If the doctor is unable to attend local escalation procedures should be initiated.
- 7.4 The duty senior nurse must also be informed of all seclusions and attend as soon as possible.
- 7.5 Once a patient has been secluded, it is the responsibility of the nurse in charge to ensure that the Seclusion Authorisation is completed on the patient's electronic record prefixed by the correct RiO code. An incident form detailing events prior to, during and immediately after the seclusion process to be completed (Appendix 2 and 3).
- 7.6 If the patient wants their next of kin to be informed of their seclusion this should be documented and facilitated. If there are concerns regarding lack of capacity to consent, consideration would have to be given to whether disclosure is in the patient's best interest. Actions and reasoning must be documented in the patient's records.
- 7.8 The nurse authorising seclusion should update the risk assessment when completing the initiation of seclusion documentation. The risk box on the electronic record for the authorisation must be checked/ticked.
- 7.9 Serious incidents related to seclusion should be reported to the on call Senior Nurse and Consultant, out of hours, who will consider their own escalation process.
- 7.10 When secluding patients, please note the following:
  - 7.10.1 Multi-disciplinary teams should work in collaboration with patients and have a trauma informed approach when assessing their history relating to aggression and violence. From this assessment a clear plan of care should take into account issues pertaining to:



- a. Domestic violence
- b. Experience of child sexual, physical and emotional abuse, sexual assault/rape
- c. Self-harm
- d. Safety, privacy and dignity
- e. Experiences within previous accommodation including Mental Health Services

7.10.2 The Multi-Disciplinary team needs to pay attention to risk factors associated with women e.g. pregnancy or recent childbirth applicable. Where appropriate advice should be sought from specialist services e.g. Labour teams/midwives etc.

## **7.11 Specialist Services:**

7.11.1 In **perinatal** cases, staff would need to consider issues such as arrangements for care of the child during this period and possible implications if mother is breastfeeding or physical health of the mother if she has recently given birth.

7.11.2 The Trust has a dedicated seclusion suite for Adolescents which is located in the inpatient **Child and Adolescent Mental Health Services**, as per the PICU specifications set out by NHS England. In exceptional cases should an adolescent require seclusion, the decision to authorise will be made by the Nurse in Charge (NIC) of the shift. Once seclusion is initiated the service manager and the Responsible Clinician will be notified along with the wider Multi-Disciplinary Team. Should seclusion be required out of hours the NIC authorising seclusion will inform the DSN, the manager on –call and duty doctor. Out of hours an email notification will be sent to the service manager and the RC informing them of the authorisation of seclusion.

7.11.3 Careful consideration needs to be given prior to initiation of seclusion in the following circumstances:

- a. Where the patient is heavily medicated
- b. Physically ill
- c. Physically disabled
- d. Heavily intoxicated (drugs or alcohol)
- e. Older adults

## **8.0. Rapid Tranquilisation**

8.1. Rapid tranquilisation aims to calm the patient quickly and thereby control extreme agitation, aggression and potential violence

8.2. It seeks to reduce psychological suffering and maintain a safe environment for the patient and others.

8.3. However sudden cardiac death has been associated with the use of antipsychotic medication especially in young, fit, struggling individuals.

8.4 All patients administered with Rapid Tranquilisation should have their vital signs monitored as per the Rapid Tranquillisation policy.

## **9.0 Tear Proof Clothing (TPC)**

9.1 The instigation by staff of the removal of normal daytime clothing is a highly restrictive intervention. This restriction should only be used when all other interventions have been attempted to support the patient in reducing behavioural disturbance and attempts of self-harm.

9.2 Staff must be aware that removal or restriction of typical daytime clothing does not automatically include the patient's underwear. Specific consideration needs to be given to the removal of underwear especially garments below the waist. Staff must be aware of increased risk of trauma/re-traumatisation in these circumstances.

9.3 The application of the least restrictive option should always be considered. The MHA 1983 Code of Practice (CoP) provides guidance on the use of tear proof clothing (Section 26.161 – 26.167). Key points include:

- Tear proof clothing should never be a first line response or used as a 'blanket rule' within services
- The dignity of patients should be a primary consideration when using tear proof clothing
- The use of tear proof clothing should be proportionate to the risks faced and only used for as long as necessary
- Tear proof clothing should never be used as a substitute for enhanced levels of support and observation

It is recognised that there may be extreme circumstances where a very urgent response to risk and severe behavioural disturbance is required and under these circumstances it may not always be practical to seek the authority of the Responsible Clinician in advance however attempts to do so should still be made and evidenced. If staff are unable to contact the Responsible Clinician, they should contact their Matron or most senior person on duty to notify them of the situation and agree ongoing arrangements for contacting the Responsible Clinician.

9.4 Tear Proof Clothing must be appropriately stored and laundered in line with Infection Control guidance. Clothing should not be made available by services in a range of sizes in order to meet individual requirements.

## **10.0. Risk of self-harm or suicide**

- 10.1. If suicidal ideation or self-harm has been a feature of the patient's illness or condition, but he/she is not felt to pose any immediate risk whilst subject to seclusion it is important to document the assessment of this in the clinical notes. The assessment must be clear and specific as to why seclusion is the only means of managing the patient's behaviour and reasons to why this outweighs the risks of self-harm or suicide.
- 10.2. It is important to note the risk of self-harm can still be present when the patient is in seclusion. Before and during seclusion, the treating team should risk assess the use of equipment by a patient to include clothing, cutlery and other items that might be needed whilst a patient is in seclusion.
- 10.3. Each ward with a seclusion room should have access to anti-ligature clothing, blanket, mattress, Trust designated seclusion cutlery and all physical health equipment (Appendix 4).

## **11.0. Search for potential risk items**

- 11.1 Clearly some judgement is required here, as almost any article can pose some threat.
- 11.2 The goal is to ensure that the patient does not have in his/her possession items which he/she can use readily to harm him/herself, or staff entering the room. In particular, consideration must be given to articles of clothing which could be used as a ligature.

- 11.3. Before a patient is secluded they should be searched and this should be documented in the patient's progress notes. A record of all the removed items should be made along with the risk related reasons.
- 11.4. A patient in seclusion should be clothed (ideally in their own clothing unless anti-ligature suits are needed) and any personal items, including those of religious or cultural significance (such as some items of jewellery), provided this does not compromise their safety or the safety of others. If anti-ligature clothing is needed the team must document the reason.

## **12.0. Observation of Seclusion**

- 12.1. The aim of observation is to monitor the condition and behaviour of the patient to assist staff to determine when seclusion can be terminated.
- 12.2. In line with the Trust observation policy observing staff should only continuously observe a patient in seclusion for a maximum of one hour consecutively. The staff will observe the patient, ensuring that the patient remains within sight at all times and that there are signs of life. In instances where staff undertake observations for more than one hour consecutively, reasons for this need to be documented and a Datix raised.
- 12.3. The observations will be carried out by a suitably qualified clinical member of staff. All clinical staff, band 4 and above staff who observe patients in seclusion must undertake seclusion training delivered in the directorate where they work.
- Other registered professionals within the Multi-disciplinary Team (MDT) may carry out seclusion observations. This is subject to the professionals having completed seclusion training.
- 12.4. All seclusions should be observed by a Registered Nurse or doctor for the first 2 hours and after the administration of Rapid Tranquilisation.
- 12.5. Unregistered clinical staff (Band 4) can only handover seclusion observations to a Nursing Associate or other registered clinical staff.
- 12.6. It is the observing staff's responsibility to enter all electronic record codes and documentation related to the activity during their observing hour **except** the medical review code which is the responsibility of the doctor to use in their clinical notes entry. The exception is if the nurse in charge is documenting that the physical presence of the doctor was not necessary, due to the patient being asleep.
- 12.7. An electronic record of observation, using the correct RiO code must be made every 15 minutes, saved but not validated until the hour is complete. In this way the observations over the hour are recorded as a validated single RiO entry and not as separate entries every 15 minutes. Saving but not validating every 15 minutes allows entries to be checked to ensure records are made every 15 minutes and avoids entries being lost/timed out by the system.
- 12.8. When handing over responsibility for observation the member of staff handing over will make an entry of who they are handing over to and the patient's current state.
- 12.9. Staff who carry out observation should:
- a. Engage positively with the patient;

- b. Be appropriately briefed about the patient's history, background, risk factors and needs;
- c. Be familiar with the ward, ward policy for emergency procedures and potential environmental risks;
- d. Be able to increase or decrease the level of engagement based on their judgement of the patient's presentation.
- e. Be competent on the use of the Oxehealth system to support observations for signs of life

### **13.0. CCTV Procedures**

- 13.1 The aim of CCTV equipment is to enhance safety of patients and staff within seclusion rooms.
- 13.2. The installation of the CCTV does **not** replace the usual observations employed by staff and is to enhance the observation of activity and increase the safety and security of persons within the seclusion area.
- 13.3 Monitors are situated outside of the seclusion rooms as an additional tool to observe areas that would usually be more difficult to see.
- 13.4. Staff must refer to policy and local protocols relating to the use of CCTV

### **14.0 Oxehealth Equipment to monitor signs of life**

- 14.1. Each seclusion room is fitted with life signs monitoring equipment. The equipment is to support members of staff completing seclusion observations particularly at night when the lights are dimmed or when the patient is in a sleeping position that makes it difficult to monitor or detect signs of life.
- 14.2 The addition of the life signs monitors does not replace staff taking physical health observations (including respirations from outside the seclusion if patients refuse) and it does not replace visual observations. The Oxehealth system compliments the Trusts Supportive Observations Policy and does not replace it. The Oxehealth system does not alert to changes in physical observations; this requires continued eyesight observations and staff must remain alert and responsive to any observed changes. The Oxehealth system is best utilised when the patient is uncooperative and is seen as the least restrictive practice to undertake a basic physical health observation.
- 14.2 Within designated Seclusion rooms the Oxehealth system will monitor:
  - Vital Signs – Spot-check measurements of pulse and breathing rate.
  - Activity Detection alert – Real-time alert to when no activity/movement is detected in an occupied room
  - In Bathroom warning – real-time warning to when a patient is in the bathroom

If signs of life are not detected an alarm is sounded to alert the staff. The Oxehealth system does not alert to changes in vital signs.

- 14.3. Training on the use of the Oxehealth equipment will be delivered in each locality. Life signs monitoring training (including use of the Oxehealth system) will be completed for all staff before they can undertake seclusion observation.
- 14.4 The Oxehealth Technology only takes the basic health observations of pulse and respiration. If the patient requires their blood pressure and oxygen saturation taken as well, if the patient is compliant staff would be expected to do this manually as per normal

process. If for example someone is on physical observations every 4 hours, it would be the expectation that the pulse and respiration rates are taken as per normal process with the other physical observations such as temperature, oxygen saturations at the required time.

- 14.5 If for any reason there is a technical failure/malfunction of the Oxehealth system, then staff must revert to the manual taking/recording of observations as detailed in the Trusts Observations Policy and any other linked clinical policies as identified above. This may require staff to enter the seclusion room as a planned intervention.

#### **15.0. Medical assessment**

- 15.1. It is acknowledged that if the patient is displaying violent behaviour, this assessment might be limited and will be based on the current observations as opposed to carrying out an interview and undertaking a physical examination of the patient.
- 15.2. Medical reviews should consider:
- A review of mental and physical health
  - Assessment of adverse effects of medication
  - Review of observations required
  - Reassessment of prescribed medication
  - Assessment of risk posed to others
  - Assessment of risk from deliberate or accidental self-harm
  - Assessment of the continued need for seclusion, and whether less restrictive measures can be applied
- 15.3. This policy recognises that in some instances the duty doctor is based elsewhere out of hours, e.g. Accident and Emergency. Consequently, their immediate attendance on a ward may not be possible and may be when practicable. However, “practicable” in this context does not imply that the doctor attends when convenient. It means that the doctor should regard the situation as urgently requiring their presence at the unit in the shortest possible time.
- 15.4. If it is not possible for the doctor to attend immediately, the nurse in charge is to hand over via the telephone and document in the patient’s case notes, plus remind the doctor as necessary. However, this does not count as a medical review. The doctor must be physically present to review the patient.
- 15.5 At night it is not necessary for the duty doctor to attend if the patient is asleep. The Duty Senior Nurse and one other registered nurse are to confirm that the patient is sleeping and inform the duty doctor. The nurse in charge should document their observations, their discussion with a doctor including names of the two nurses and the doctor. The doctor will also make an entry in the patient’s electronic record. As soon as the patient wakes up arrangements should be made for them to be seen by a doctor within **one** hour.

#### **16.0. Care for the Patient in seclusion**

- 16.1 The vital signs of the patient in seclusion should be monitored at least once a day or more depending on the physical health care plan for the patient. This should include visual observations of respiration, skin colour and movement. The Oxehealth system can be used to undertake pulse and respiration observations where the risk of entering or engaging the service user to carry out manual observations is deemed high by the MDT or the patient refuses; however must still use visual observations to observe for signs of life- the Oxehealth system does not replace this responsibility. In cases where the

decision is made not to enter seclusion or the patient refuses, this needs to be clearly documented and re-attempted at the earliest review.

- 16.2 The team need to also ensure that the patient has appropriate access to:
- a. nutrition/fluids
  - b. Personal hygiene provisions not limited to but including shower gel, toilet paper, towel & oral hygiene items.
  - c. toilet facilities,
  - d. appropriate cutlery for seclusion
  - e. reading materials
  - f. medication
  - g. advocate
  - h. religious material
  - i. a clock (within sight of the patient but outside of the seclusion room), indicating the day / date and year
  - j. A foam cube (covered in seclusion mattress material) to be used as a tray for food.
  - k. Electronic devices such as phone, reading devices & music devices need to be risk assessed before handing over to the patient in seclusion.

This list is not exhaustive and any request made by the patient should be considered by the treating team and a risk assessment made. This should be documented along with the decision taken on whether or not to grant the request.

- 16.3 To ensure the holistic care of the service user remains paramount, patients in seclusion should still be included in ward round MDT discussions or safety huddle discussions as well as the Seclusion Reviews. Treatment planning involving professionals and carers remains relevant to MDT ward rounds when the patient is unable to attend due to being in seclusion.

## **17.0 Responding to the deteriorating patient in seclusion**

- 17.1 Staff undertaking seclusion observations must escalate immediately by raising an alarm and follow the Trust Management of a Medical Emergency Policy if:
- There are observed changes related to breathing, verbal response, respiration rate and skin colour change that indicate a deterioration in physical health or cause concern. Where the Oxhealth monitoring system does not produce a simultaneous alert, staff must raise an alarm based on their observations.
  - If the Oxhealth system creates an alert and indicates a deterioration in physical health
- 17.2 Upon raising the alarm observing staff must continue observation and attempts to verbally engage the patient through the viewing panels. They must not enter the seclusion room on their own.
- 17.3 A team of 4 staff is the minimum number required to enter seclusion in emergency situations. This is to ensure the safety of staff and adequate response to manage the presenting situation.
- 17.4 The MDT will review the need for further seclusion and consider least restrictive options to continue to meet both the mental and physical health needs of the service user. Any decision to terminate seclusion should be undertaken by the MDT and fully documented.

- 17.5 Service users must be offered the opportunity for a post incident debrief once seclusion is terminated and they are able to engage.

## **18.0 Review of Patients in seclusion**

The East London Modified-Broset Checklist (ELM-B) should be completed at every review to support decision making.

The review flowchart explains the process (Appendix 5)

- 18.1. The set times for reviews are the minimum required. Treating teams can increase the frequency of reviews as they see appropriate based on presentation, risk and services available/appropriate. All documentation on the electronic record should be preceded by the appropriate RiO code.
- 18.2 To ensure that a patient remains in seclusion for the minimum time necessary, two registered clinical staff one being the nurse in charge of the ward will carry out a review of the patient within **one** hour from the time seclusion commenced.
- 18.3 When a patient is secluded, members of the MDT will remain involved in the care of the patient. This might be by maintaining direct contact with the secluded person through carrying out observations, attending reviews and other professional meetings. This is to ensure that the patient's care is not solely based on nursing interventions when they are in a crisis.
- 18.4 Outside normal working hours, when a patient is secluded the Duty senior nurse must inform the duty doctor of the planned times for medical reviews during their shift.
- 18.5 Where Tear Proof Clothing is being used, reviews must consider if it is safe and appropriate to discontinue and provide the individual's own clothing for the remainder of their time in seclusion.

## **19.0 There are two types of reviews: Ordinary and Extraordinary reviews.**

- 19.1 Ordinary reviews- These are the minimum required reviews that must be completed throughout the duration of the seclusion. These must include assessment of mental and physical health monitoring. All physical health observations should be recorded in progress notes and on electronic NEWS forms. Some reviews may overlap e.g. joint nursing and medical review or Joint MDT, nursing and medical review.

### **19.2 Nursing Reviews**

The first nursing review is after an hour and if seclusion cannot be terminated within that hour, the need to continue seclusion should be reviewed every 2 hours thereafter by 2 nurses. At least once in the 24 hours this should involve a nurse from the treating team.

### **19.3 Medical Reviews**

The patient should have a medical review within an hour of seclusion commencing, unless the seclusion was authorised by a consultant psychiatrist. If authorised by a consultant psychiatrist this can be recorded as the first medical review.

The patient should then be reviewed every 4 hours by a doctor.

Four (4) hourly medical reviews should continue until the first MDT review has taken place. Following the first MDT review, further medical reviews should continue at least 3 times in a 24-hour period. At least one of these should be carried out by the patient's Responsible Clinician (or designated senior doctor cover). At weekends, public holidays and nights, the local arrangements for out-of-hours cover provide for an alternative Approved Clinician to cover these Responsible Clinician reviews.

Where possible, at least once every 24hrs the medical review should be a doctor from the treating team). In the absence of the treating doctors the covering doctor should conduct the review.

#### 19.4 Internal MDT Reviews

Where the patient remains in seclusion an MDT review should be carried out once in every 24-hour period. The MDT review should consist of a senior doctor (ST4-6 or above), a nurse and one other registered clinical professional. In normal working hours this will usually include members of the patient's treating team. Out of hours, an MDT review is considered to have taken place when the patient has been reviewed together by the Duty Senior Nurse and a senior doctor (ST4-6 or above). No other professional discipline is required to attend. Following these medical reviews will be required three times in a 24-hour period rather than four hourly.

The senior doctor must record a plan of action and treatment in relation to the patient for the following day based on their review of the patient, discussion with staff, the presenting risks and assessment of the patient. If the need for seclusion is disputed by a member of the multi-disciplinary team, the matter should be referred to a second clinical opinion in that same locality/service. It is good practice if the MDT reviews do not always solely comprise members of staff who are part of the treating team.

#### 19.5 Independent MDT Review

**An independent MDT review should take place if seclusion continues for more than 8 hours consecutively, or more than 12 hours intermittently within a 48 hour period.**

This should be completed by a doctor who is an approved clinician, a senior nurse and another health professional, not involved in the incident leading to seclusion. An IMHA (independent mental health advocate) should also be included.

#### 19.6 Extraordinary reviews

These are reviews that are required based on the length of the seclusion. These review frequencies can also be used when patients are frequently secluded for short periods over a short time.

#### 19.7 One week Elapsed

Where the patient has been in seclusion for a week there will be an MDT meeting (outside of ward round) involving those working with the patient, to discuss short and long-term MDT treatment care plans, including medication management, the appropriateness of the placement and potential referral to other appropriate services. This care plan should be recorded in the patient's progress notes. This meeting should be held within 10 days of the date of secluding the patient. In forensic services after seven days of seclusion, the Clinical Team should inform the NHS England commissioners of the continued seclusion episode.



If the seclusion has not been terminated after 7 days there should be an independent review by an MDT team within the locality/service.

#### 19.8 Two Weeks Elapsed

When an internal second opinion does not lead to the seclusion being discontinued by the end of the second week the treating team should consider requesting for an opinion from a consultant external to the treating locality/service, but from within the Trust.

#### 19.9 Three weeks Elapsed

If it is not possible to safely end seclusion after 3 weeks, consideration should be made for referral from Medium Security to High Security (if this has not happened already) or from acute adult services to Medium Security. The prospective referrals would be for an opinion and recommendations on the patient's management.

For CAMHS, consideration of referral to specialist adolescent services should be given.

A minuted professionals' meeting should be held, involving current care team, security department (where appropriate), and a member of the Directorate Management Team. Consideration should be given to inform the Care Quality Commission about the long-term seclusion.

This process will be repeated every three weeks thereafter, with consideration as to the necessity of an external (to the trust) second opinion. If deemed necessary then it is the responsibility of the consultant/RC to ensure that the referral is made.

### **20.0. Role of the Multidisciplinary Review Team (treating team and independent)**

20.1. The two overriding principles are that firstly, seclusion should be a safe procedure which minimises the likelihood of harm befalling the secluded patient and secondly that seclusion should extend no longer than necessary for the safe management of the ward and all patients and staff therein. All reviews of the secluded patient should be informed by these two principles.

20.2. There are four parts to the review of the secluded patient:

1. Consideration of the circumstances of the patient as set out in the case notes and from discussion with staff from the patient's ward.
2. The assessment of mental state and interview with the patient.
3. Monitoring the patient's physical health condition by interview, observation and examination where appropriate.
4. The subsequent liaison with staff from the secluded patient's ward in order to agree a plan for further management.

20.3 If the independent Multi-Disciplinary Team (MDT) review teams believe that the seclusion should be terminated, they need to make recommendations to the treating clinical team with ideas of how this can be achieved safely. They need to record this in the patient's clinical notes and to inform the patients care team of their recommendations.

- 20.4 Where the care team does not agree with the recommendations, the matter will be discussed further with the Clinical Director/Associate Clinical Director. A second opinion can at this point be sought if there continues to be disagreements about the seclusion.
- 20.5 A record will be maintained in the patient's clinical notes of all relevant information that relates to clinical matters for the secluded patient.
- 20.6 Access to the advocacy service should be considered if the patient requires it. Due to presenting risk this cannot be unsupervised access and will be in the room or outside.

#### **21.0. Termination of Seclusion**

- 21.1. The nurse in charge and the observing nurse can terminate seclusion. Outside normal working hours (evenings, weekends and bank holidays) the decision to terminate seclusion should be discussed with the duty nurse. The East London Modified-Broset Checklist (ELM-B) should be part of the regular review, and allows for a discussion to make the decision to discontinue seclusion.
- 21.2 The nurse in charge should inform and discuss with the ward/duty doctor when considering terminating the seclusion period.
- 21.3. The person terminating the seclusion is to ensure that the patient's care plan is carefully explained to them.
- 21.4. The nurse in charge will complete the termination seclusion summary in the patient's electronic record.
- 21.5 The ward/cross cover/duty doctor will complete a physical examination as soon as possible. If the doctor is unavailable, the nurse in charge will complete physical health observations and feedback to the doctor highlighting any concerns. Ideally, the physical health observations should be completed at the review prior to terminating seclusion.
- 21.6 The allocated nurse will update the risk assessment to reflect the circumstances of seclusion and current mental state.
- 21.7. Individuals whose period of seclusion is terminated should not remain in Tear Proof Clothing where this had been used during the period of seclusion.
- 21.8 The nurse in charge of the ward will ensure that the seclusion room is cleaned and prepared for further use. The Seclusion Room Environment Checklist Fit For Use must be completed (Appendix 6).

#### **22.0 Post Incident Review**

- 22.1 Following the termination of seclusion a nurse and/or doctor will meet with the patient to discuss the events which led to the seclusion episode and their experience of it. The debrief should consider the structured guidance. The patient's overall care plan will be discussed / reviewed.
- 22.2 Within 72hrs or at the earliest opportunity after seclusion has been terminated, the Clinical Nurse Manager, or the Matron for the ward will begin a review of the event, in order to process aspects of the experience and learn from it

22.3 The Debrief should include an understanding of the following

- i.Triggers
- ii.Antecedent behaviours
- iii.Alternative behaviours
- iv.Least restrictive or Alternative intervention attempted
- v.De-escalation preferences or safety planning measures identified
- vi.Treatment plan strategies.

22.4 The above process helps identify what went wrong, what knowledge was unknown or missed, and what could have been done differently and how to avoid it in future. This is recorded in the patient's electronic record with the RiO Code.

22.5. In addition, a post incident review should be facilitated by the treating team to identify lessons learnt support staff and patients, and to encourage the therapeutic relationship between staff and patients. A post-incident review should take place as soon as possible after the incident has ended. If possible, a person not directly involved in the incident will lead the review.

22.6. The review should address:

- a. What happened during the incident?
- b. Any trigger factors and early warning signs
- c. Each person's role in the incident
- d. Their feelings at the time of the incident, at the review and how they may feel in the near future, including what can be done to address any concerns.
- e. The (secluded) patient's views about the incident, which should be documented in the patients notes.
- f. A debrief should also be facilitated for all the other patients on the ward who were not involved in the incident.

### **23.0 Informal Patients**

23.1 As with detained patients, seclusion may have to be used with informal patients in an emergency situation in order to ensure the safety of others.

23.2 As a minimum an informal patient should be detained under Section 5/4 (nurse's holding power) before seclusion is commenced and the patient should be informed as such.

23.3 If an emergency situation arises involving an informal patient and, as a last resort, seclusion is necessary to prevent harm to others, then an assessment for an emergency application for detention under the Act should be undertaken immediately.

### **24.0. Visits by the Care Quality Commission**

24.1. Members of the Commission and staff employed by them may request to see a patient in seclusion. However, the risks associated with this will usually preclude the visit occurring.

## **25.0. Reporting and Monitoring**

- 25.1 The nurse in charge must inform the Matron and consultant and the rest of the clinical team when a patient has been secluded as soon as possible.
- 25.2. For each episode of seclusion an incident form should also be completed.
- 25.3. All seclusion episodes should be audited and reported at local ward level and directorate governance structures (Appendix 7).
- 25.4. The Matron must submit seclusion usage statistics at monthly intervals to a designated person in the service/trust. Local areas will have their own arrangements for compilation and collection and review of trends and occurrences, this should be reviewed at local governance meetings.

## **26.0. Training**

- 26.1 All staff who undertake seclusion observations should attend at minimum the below training
  - Local seclusion training. Clinical Nurse Managers and Modern Matrons to complete competency checklist for their teams (Appendix 8). All seclusion training should be recorded on OLM for clinical staff.
  - Seclusion training should be part of all in- patient trainee doctor's inductions.
  - Signs of life monitoring equipment training
  - Trust Physical health training including Venous Thromboembolism management.

## **27.0. Local Procedures**

- 27.1. All staff should be aware of local procedures related to:
  - CCTV use
  - Transfer of patient from area of incident to seclusion facilities including across ward, different floors and secluding males and females (where applicable).
  - Use of lifts to transfer patients
  - Guidance on use of forensic seclusions by other directorates.

## Appendix 1 East London Modified Broset Assessment Tool

- Completed by the MDT after initial seclusion and then after each seclusion review, to aid decision to terminate seclusion. A score of less than 4/8 should trigger review of clinical need to continue with seclusion.

East London Modified-Broset (ELMB)	
Hospital	
Ward	
Assessor/Assessors ..... ....	
Patient Name	D.O.B
Date of Assessment	Time of Assessment
<b><i>Behavioural Descriptor</i></b> Please score only the behavioural elements objectively present.	<b><i>Item Present?</i></b> Item not present: 0 Item present: 1
<b><i>Confused</i></b>	
<b><i>Irritable</i></b>	
<b><i>Boisterous</i></b>	
<b><i>Verbal Threats</i></b>	
<b><i>Physical Threats</i></b>	
<b><i>Attacking Objects</i></b>	
<b><i>Response to de-escalation</i></b>	
<b><i>PRN Compliance (P.O. /I.M.)</i></b>	
Recorded in Rio- Total Score 0/8	
Patient Secluded    Yes <input type="checkbox"/> No <input type="checkbox"/>	

## Appendix 2 Electronic Documentation of Seclusion

All information relating to the seclusion, restricted access or long term segregation of a patient must be recorded in RiO progress notes in conjunction with Datix incident reporting. In RiO seclusion is recorded in **Progress Notes** only.

### Progress Notes

In order to capture all required information into RiO, the format below must be followed. To assist clinicians this can be cut and pasted directly into RiO progress notes as a template to be filled-in.

#### **RCODE SECLN00: Seclusion Authorisation**

**Ward:**  
**MHA Status:**  
**Seclusion commenced at** (time)  
**Decision to seclude by** (NIC/doctor)  
DSN informed at (time and name of DSN)  
RC informed at (name, time and if by email)  
Doctor informed at (time and name)  
Time doctor scheduled to attend:  
Patient asked if they want Next Of Kin informed or to see or inform the IMHA (please detail) ....  
Has the risk been updated on Rio ?

#### **Incident Description**

Datix number:  
Events leading up to incident ....  
What happened and how this was managed (including reason for seclusion being used) ....  
Was rapid tranquilisation used (medication, dose and route) ....  
Has Restraint Debrief Form been completed? ....  
Learning from incident ....  
Search completed by (& comments) ....

#### **RiO Code: RCODE SECLN02: Seclusion 2 hour nursing review**

Name of Duty Nurse Present and Registered Nurse:  
Time of Review:  
Physical Health vital signs/NEWS score: physical health review  
(Consider if the patient has had Rapid Tranquilisation template is completed)  
Current Presentation ( Mental State/presentation over the past 2 hours:  
Food and Fluid chart should be used ( is food and fluid available/offered/intake):  
Identified Risks (risk to self or others):  
(Discussion with service user/Patient needs:  
(e.g Attending to personal care/religious needs/clothing )  
Can the needs be met /considering safety in seclusion)

Administration of medication:  
Physical Intervention applied (Yes/no)  
Reason for intervention: Datix/restraint monitoring form to be entered  
Rationale for Remaining in seclusion:  
Next Nursing Review: (e.g. 1400 hours)  
Next Medical Review: (e.g. 1300 hours)  
Actions/Plans:

#### **RCODE SECLN03: Seclusion 4 hour/3 a day medical review**

Reason for initial decision to seclude: Insert description here

Mental State Examination: Insert description here  
Physical Health Concerns: Yes/No  
Last Physical Health Observations:  
Eating & Drinking: Yes/No  
Changes to medication:  
Timing of next medical review:  
Plan:

**RCODE SECLN08: Seclusion Termination**

Date and time seclusion terminated:  
Name of professional terminating seclusion:  
Time duty nurse is informed:  
Seclusion summary including the condition of the patient at the end of seclusion:

**RCODE SELCN06: Post seclusion physical examination**

Time of physical examination:  
Physical examination completed by:

Reason for seclusion has been explained to the patients  
Condition for ending seclusion explained ....

PHYSH: (i.e. frequency of vitals, urgent medical examination, any other relevant concerns or health conditions, etc.)....

Plan ....

Identified Risks ....

All staff involved in the observation and documentation must familiarise themselves with the Seclusion Standards

### Appendix 3: Rio Codes and documentation standards

All observations and reviews must be recorded in RiO with codes in order to allow audit and to check standards have been met. All RiO codes are accessible using the RiO “?” help button when writing in the progress notes.

It is the observing nurse responsibility to enter all codes except the medical review code which is the responsibility of the doctor to use in their RiO entry. A record of observation must be made every 15 minutes. It must be saved every 15 minutes but not validated until the hour is complete. In this way the observations over the hour are recorded as a validated single RiO entry not as separate entries every 15 minutes. Saving but not validating every 15 minutes allows entries to be checked to ensure records are made every 15 minutes and avoids entries being lost/timed out by the system. Entries can be accessed and examined to confirm the time that notes were saved on RiO.

Rio Codes are as follows and are found on the **Help ICON** of RIO

RCODE SECLN00: Seclusion Authorisation

RCODE SECLN01: Seclusion 15 minute observation

RCODE SECLN02: Seclusion 2 hour nursing review

RCODE SECLN03: Seclusion 4 hour/3 a day medical review

RCODE SECLN04: Seclusion 24 hour MDT review

RCODE SECLN05: Seclusion extraordinary MDT review

RCODE SECLN06: Post Seclusion physical examination

RCODE SECLN07: Post Seclusion senior nurse debrief

RCODE SECLN08: Seclusion Termination

### Recording reviews

Reviews must be recorded in RiO. **The names of all those participating in the actual review must be recorded on RiO**, i.e. the names and grade of the reviewing nurse, doctor, social worker, psychologist or occupational therapist along with the names of each nurse present. It is the responsibility of the professional documenting the interaction or review to gather and enter all staff names present at each review and record in RiO.

#### Seclusion Care Plan

A seclusion care plan should set out how the individual care needs of the patient will be met whilst the patient is in seclusion and record the steps that should be taken in order to bring the need for seclusion to an end as quickly as possible. As a minimum the seclusion care plan should include:

- a statement of clinical needs (including any physical or mental health problems), risks and treatment objectives
- a plan as to how needs are to be met, how de-escalation attempts will continue and how risks will be managed
- details of bedding and clothing to be provided
- details as to how the patient's dietary needs are to be provided for
- details of any family or carer contact/communication which will maintained.



#### Appendix 4 Seclusion Room Stock Equipment

Item	Minimum Stock No.	Number Present	Comment/Action Required
Manual sphygmomanometer With small, medium, large and extra-large cuffs			
Stethoscope			
Pulse oximeter			
Gloves Small, medium, large and extra large			
Disposable Aprons			
Disposal PPE Suits			
Goggles			
Mouth Mask			
Shoes Protectors			
Seclusion Cutlery Sets			
XXXL Ligature Suits			
XXL Ligature Suits			
XL Ligature Suits			
L/M/S Ligature Suits			
Seclusion Blankets			
Seclusion Mattress			
Small Seclusion square/ rectangular mattress used as a table tray			

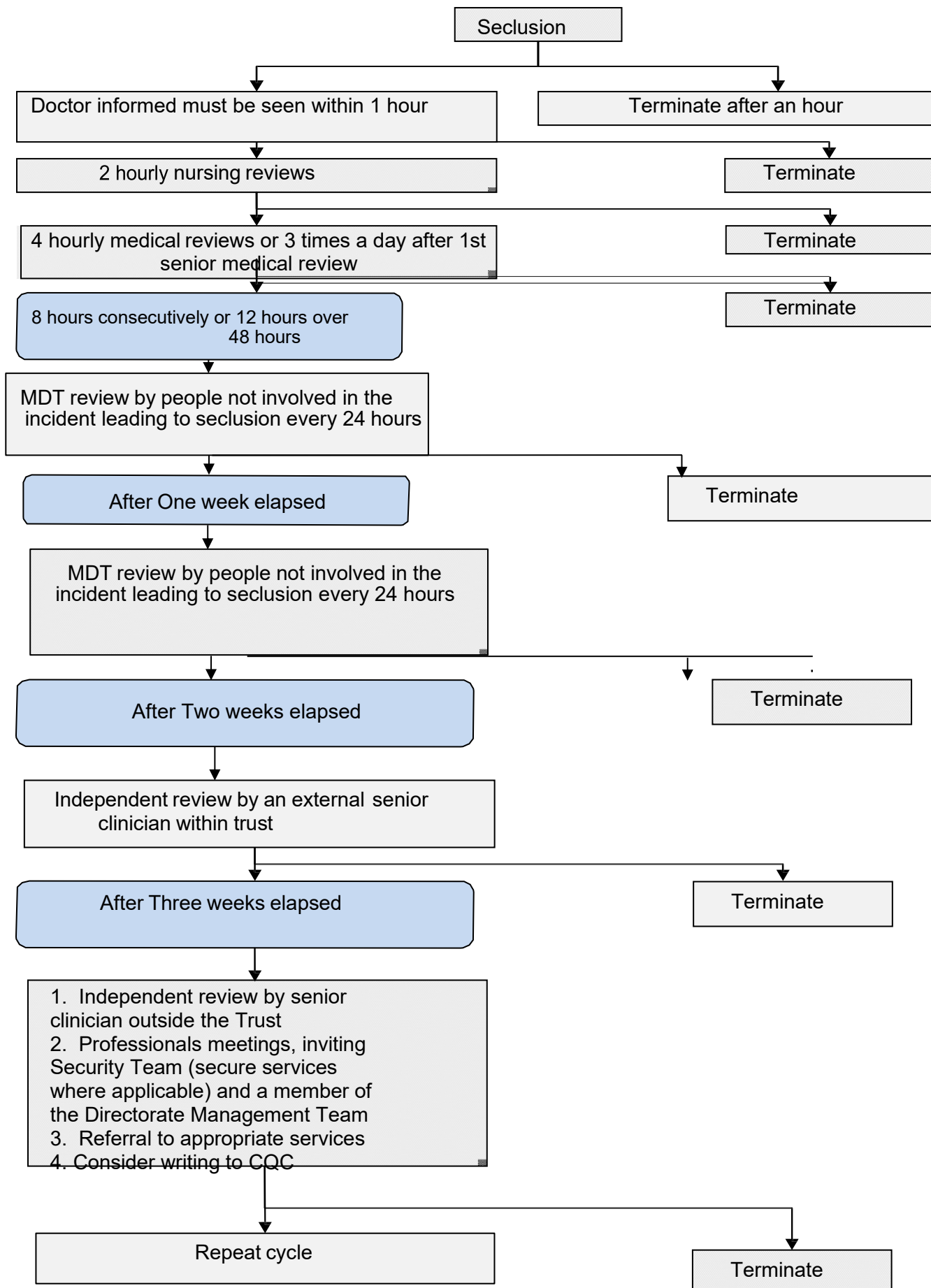
***This form must be filed with the ward environment checks, following the completion of each seclusion episode or weekly during Matrons environment checks***

Each Locality/Service to agree minimum stock levels and frequency of checks.

#### References:

- *Mental Health Act Code of Practice, 2015*
  - Mental Capacity Act 2005 Code of Practice DoH 2007
  - Deprivation of Liberty Safeguards DoH 2008
  - Violence
  - CG 25: The short-term management of disturbed/violent behaviour in in-patient psychiatric settings and emergency departments NICE 2005
  -
- NG10 : Violence and aggression: short-term management in mental health, health and community settings NICE 2015

## Appendix 5 Seclusion Review Flowchart



## Appendix 6 Seclusion Room Environment Checklist Fit For Use

Seclusion Room			
Date:		Time	

Satisfactory?	(Please circle your)	Comments
Cleanliness	Yes / No	
Lighting	Yes / No	
Ventilation	Yes / No	
Heating	Yes / No	
Clock	Yes/No	
Calendar	Yes/No	

### Assessment of –

Door Frame(s)	
Vision Panel(s)	
Skirting	
Flooring	
Windows	

### Any other damage? - Please specify –

--

### Remedial action taken –

--

Signed by (Nurse in Charge)	
Print Name	
Date	

***This form must be filed with the ward environment checks (NOT WITH PATIENTS NOTES), following the completion of each seclusion episode or weekly during Matrons environment checks.***

## Appendix 7 Seclusion Audit Tool

<b>Patient Name</b>		<b>Ward</b>			
<b>Patient ethnicity</b>		<b>Patient age</b>		<b>Gender M/F</b>	
<b>Date &amp; Time Seclusion Initiated</b>		<b>Date &amp; Time Seclusion Terminated</b>			
	<b>Standard</b>		<b>Y/N/NA</b>	<b>Comments</b>	
<b>Initiation of Seclusion</b>					
SP1	Authorisation Record fully completed for initiation of seclusion stating who authorised the seclusion.				
SP2	Ward/Duty Doctor informed of seclusion and service user seen within one hour of seclusion initiation				
SP3	Duty Nurse informed of seclusion and time				
SP4	Incident form completed for seclusion/ Details of seclusion reason noted				
SP5	Restraint debrief form completed if required (forms)				
SP6	Entry made in RIO clinical notes detailing description of events and interventions and de-escalation attempts				
SP7	A pat-down search of the service user was completed during seclusion initiation and documented on Rio?				
SP8	Next of Kin / IMHA informed of seclusion				
<b>Actions During Seclusion</b>					
	If rapid tranquilisation is used an RMN / doctor completes the observations for the first 2 hours				
SP9	Band 4 staff handover only to registered staff for the duration of the seclusion				
SP10	Written observation notes are recorded in the service users inpatient record on RIO every 15 minutes				
SP11	Staff undertake observations for a maximum of 1 hour at time				
SP12	Physical examinations are completed whilst the patient is in seclusion and Rio code used when recording outcome. When patient refuses physical examinations this is documented as such on Rio?				
<b>Ordinary Reviews</b>					

SP13	Patient reviewed by Ward/ Duty doctor within an hour of seclusion		
SP14	Reviews are completed every 2 hours by 2 nurses		
	Reviews are completed every 4 hrs by Doctor. until first MDT review?		
SP15	MDT reviews consisting of 1 doctor, 1 nurse and 1 other health professional (Monday to Friday), are completed approximately every 24 hours, if seclusion continues for 8 hours consecutively or for 12 hours over a period of 48 hours At least one is the responsible clinician (or covering senior doctor)		
SP16	MDT reviews consisting of 1 doctor and 1 nurse (weekends and Bank Holidays), are completed approximately every 24 hours, if seclusion continues for 8 hours consecutively or for 12 hours over a period of 48 hours At least one is approved clinician		
	After first MDT review 3 medical reviews per day		
<b>Extraordinary Reviews</b>			
SP17	Where a patient has been in seclusion for a week, an MDT meeting (outside of ward round) involving those working with the patient is held to discuss the short and long term treatment plans. The care plan must be recorded in the patients clinical notes		
SP18	After a week in seclusion there must be an independent review by an MDT team within the locality/service		
SP19	After 2 weeks in seclusion a request must be made for an opinion from a consultant external to the treating team/service, but from within the Trust		
SP20	After 3 weeks a referral is made to service with a higher level of security, i.e. from Medium Security to High Security and from Low Security to Medium Security for an opinion and recommendations on the patients management		
SP21	After 3 weeks in seclusion a minuted professionals meeting is held involving the current care team, security (where appropriate) and a member of the DMT		
SP22	After 3 weeks in seclusion consideration was given to informing the Care Quality Commission of the long term seclusion		

SP23	Following 3 weeks in seclusion Standards 20, 21 and 22 repeated every 3 weeks		
<b>Termination of Seclusion</b>			
SP24	When terminating seclusion the person terminating it discussed the patients care plan with them		
SP25	The Ward Doctor/Duty Doctor completes a physical examination of the patient following the termination of seclusion		
SP28	The patients Risk Assessment is updated		
SP29	Following termination of seclusion a Senior nurse and/or doctor met with the patient to debrief the patient,		
SP30	There is a local system for collating seclusion stats		
SP31	The Seclusion Room Environmental Checklist is completed following the termination of each episode of seclusion over last month		
<b>Additional Comments</b>			
Completed by		Date	

## Appendix 8 Seclusion Policy Competency Checklist

**The Manager (Band 8a, 7 or 6) will be satisfied that members of staff they line manage is able to undertake seclusion observation and is competent in the following areas:-**

- Seclusion policy read and understood. A - NO ☐ B - YES ☐
- Responsibilities regarding documentation prior to, during and after seclusion observations understood. A - NO ☐ B - YES ☐
- Understanding the rationale for using seclusion (predominantly but not exclusively risk of harm to others) and the risks involved in using such a restrictive interventions. A - NO ☐ B - YES ☐
- Understands the frequency and nature of all nursing/medical reviews and the purpose of these whilst someone is in seclusion. A - NO ☐ B - YES ☐
- Understanding when and how to summon assistance if required when on seclusion observations A - NO ☐ B - YES ☐
- Understanding of the importance of updating and amending a patient's care plan if seclusion is being used. A - NO ☐ B - YES ☐
- Acknowledges the responsibility of the shift coordinators role in ensuring that all staff conducting seclusion observations have had a full handover and have read and understood the policy and completed this checklist. A - NO ☐ B - YES ☐
- Understanding the responsibilities of the observing person in seclusion in the event of an emergency on the ward. A - NO ☐ B - YES ☐
- Understands what is meant by 'restrictive practice and segregation' in line with the Trust policy and the nurses responsibilities when this practice has commenced. A - NO ☐ B - YES ☐
- Has an understanding of the importance of handovers/ prebriefs and debriefs A - NO ☐ B - YES ☐
- Understands the need for regular physical health monitoring and the Trust policy of rapid tranquilisation. A - NO ☐ B - YES ☐

When this document has been read and understood, please sign below:-

Assessor:..... (Print Name)

..... (Signature)

Designation:.....

Staff Member:..... (Print Name)

..... (Signature)

Designation:.....

Able to assess bank staff out of hours Y / N