**SECLUSION POLICY**

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| 5.0     | November 2015 | Lorraine Sunduza - Deputy Director of Nursing and Day Njovana Lead Nurse, Shaun Wright – Matron  | Approved | • Policy updated in line with Code of Practice 2015  
• Seclusion records are now electronic throughout the trust. Included relevant codes and guidance.  
• Update seclusion process chart  
• All band 4 and 5 inpatient staff should undertake seclusion training  
• All junior doctors to have seclusion at induction  
• Amended seclusion environment checklist  
• Amended stock equipment  
• Addition of competency checklist for observing staff  
• Segregation procedure now available as a separate policy  
• Restricted access removed  
• Added seclusion audit tool |
| 6.0     | October 2016 | Lorraine Sunduza - Deputy Director of Nursing Rebecca Lingard Matron, Lucy Newman Clinical Nurse Manager.  |         | • Added template for Medical Review  
• Added template for Nursing review  
• Recommendation for SIR – Outside normal working hours DSN to inform duty doctor medical review times. |
| 7.0     | February 2018 | Day Njovana – Head of Nursing Forensics, Rebecca Lingard- Matron  
Asha Sauboora-Domah – Clinical effectiveness coordinator Armstrong-Esther  
Lorraine- Matron |         | • Added introduction  
• Added Use of ELModified – Broset Tool for seclusion reviews  
• Added Life signs monitoring system  
• Added Seclusion debrief Guide  
• Amended to note that all |
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<th>staff carrying out seclusion observations should be undertake seclusion training delivered in their directorate and this should be recorded as core competencies on OLM</th>
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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 person is aggressive and being violent towards other people and all other options have been considered. Seclusion may be the option that presents the lowest risk and is likely to be the most benefit to the person. 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.

1.4. The right to respect for private and family life, home and correspondence for service users whilst in seclusion should always be considered.

1.5. The Mental Health Act does not itself cover seclusion; guidance is however
2.0. Aim of the policy

2.1. This policy has been developed to guide good practice when initiating or managing 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 a secluded patient are updated as required
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 restraint
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

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 placing a patient in seclusion cannot be planned for in advance as part of their care or treatment plan, planning should be made about how to support the patient working 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).
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 be only used when all other interventions have proved unsuccessful and for the shortest possible time.

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 care plan. Where possible, an advance directive agreement should be reached with the patient prior to using seclusion. *See appendix 4 for guidelines*

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. (Physical restraint should be used as a last option and only when absolutely necessary).

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 a 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 be used only when the professionals involved are satisfied that the need to protect other people outweighs any increased risk to the patient’s health or safety and that any such risk can be managed)*
6.0. Prevention

6.1. The effective handling 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 and communication skills are required.

6.2. Certain features may serve as warning signs that a patient may be escalating towards physically violent behaviour. As soon as these early warning signs or known triggers are identified there should be a mental state examination and a MDT review of the patient's treatment care plan. Where possible and appropriate, encourage the patient to understand his or her own triggers.

6.3. In ELFT, a study by Felice Loi & Karl Marlowe (2017), indicated that the use of the East London Modified-Brosset Checklist (ELM-B) can help to support teams in predicting and reducing the likelihood and length of seclusion by 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 7). Training for the ELM-Brosset tool will be imbedded in the directorate seclusion training.

6.4. A patient's anger and frustration needs to be treated with an appropriate, measured and reasonable response. Use de-escalation techniques before other interventions.

6.5. Continue to use verbal de-escalation even if other interventions are necessary.

6.6. All staff should learn to recognise what generally and specifically upsets and calms the patient. This should be noted in their care plans a copy should be given 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. RCODE SECLN00: Seclusion Authorisation – please see Appendix 4 for guidance

7.2. 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 if he or she is unavailable, the duty doctor should arrange to see the patient within one (1) hour. East London Modified-Brosset Checklist (ELM-B) should be completed immediately after Seclusion commences. (If a doctor initiated or made the decision to seclude then it is not necessary for the patient to be seen by another doctor with 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.

7.3. The duty senior nurse must also be informed of all seclusions and attend as soon as possible.
7.4 If a member of staff has been injured they should be supported by having another member of staff escort them to the local hospital Accident and Emergency department. They should be advised that this incident is reportable to the police.

7.5 If any patient has been injured / assaulted the ward or duty doctor will be notified so they can be physically examined. Patients will be advised that they can press charges as well, if they are victims of assault. They should also be advised that staff can assist them to call local advocacy for support.

7.6 Once a patient has been secluded, it is the responsibility of the nurse in charge to ensure that the ‘Seclusion Authorisation (RCODE SECLN00) is initiated along with an incident form detailing events prior to, during and immediately after the seclusion process.

7.7 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 capacity to consent, consideration would have to be given to whether disclosure is in the patient’s best interest. Actions and reasoning must be recorded in the patient’s documentation.

7.8 The nurse authorising seclusions should update the risk assessment when completing the initiation of seclusion documentation by ticking the risk box in their initiation of seclusion entry on Rio.

7.9 Serious incidents related to seclusion should be reported outside hours to the on call Senior Manager, Consultant and Director.

7.10 When secluding women please note the following:

7.10.1 Multi-disciplinary teams should work in collaboration with patients in 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
   f. Risk factors associated with pregnancy or recent childbirth (if applicable)

7.10.2 Where appropriate advice should be sought from specialist services e.g. Labour teams/midwives etc.

7.10.3 These issues are written specifically for women but it should be noted that some may be applicable to male patients.

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 does not expect seclusion to be used for adolescents. If
however in exceptional cases when the clinical team believes that its use is necessary the clinical team would need to seek approval from the child and adolescent Consultant, Service manager or nominated other and a director.

7.12 Careful consideration needs to be given prior to instigating seclusion in the following circumstances:

a. Where the patients 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 Rapid Tranquilisation should have their physical health Monitored routinely this can include visual observations of respiration, skin colour and movement observed if patient is unstable to complete physical health monitoring.

9.0. Risk of self-harm or suicide  
9.1. 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 why the necessity of its use outweighs the risks of self-harm/suicide.  
9.2. It is important to note the risk of self-harm can still be present following when patients is in seclusion. Following 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. Each ward with a seclusion room should have access to anti-ligature clothing, trust designated seclusion cutlery and all physical health equipment as listed in appendix 3.

10.0. Search for potential risk items  
10.1 Clearly some judgement is required here, as almost any article can pose some threat.  
10.2 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.

10.3. Before a patient is placed in seclusion they should be searched and this should be documented in the patient's progress notes including a record of all items that were removed, along with risk related reason as to why the items were removed.

10.4A Patient in seclusion should be clothed (ideally keeping their 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 reason.

11.0. Observation of Seclusion

11.1. The aim of observation is to monitor the condition and behaviour of the patient to assist staff to determine when seclusion can be terminated.

11.2. In line with the Trust observation policy observing staff should only continuously observe for a maximum of one hour. The staff will observe the patient, ensuring that the patient remains in sight and sound at all times.

11.3. 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 should undertake seclusion training delivered in the directorate where they work.

11.4. All seclusions should be observed for the first 2 hours by Registered Nurses or doctors. Anytime Rapid tranquilisation is given, a registered nurse or doctor should carry out observations thereafter.

11.5 Unregistered clinical staff (Band 4) should not hand over to another unregistered band 4 clinical staff. They should always hand over to registered clinical staff.

11.6 It is the observing staff 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 unless it is the nurse in charge documenting that a medical review is not necessary due to the patient being asleep. (appendix 4)

11.7. 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. 
RCODE SECLN01: Seclusion 15 minute observation

11.8. 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.
11.9. 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 patients presentation.

12.0. CCTV Procedures

12.1 The aim of CCTV is to enhance safety of patients and staff within seclusion rooms.

12.2. 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.

12.3 Monitors are situated outside of the seclusion rooms as an additional tool to observe areas that would usually be more difficult to see.

12.4. Staff must refer to policy and local protocols relating to use of CCTV

13.0 Life Signs

13.1. 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, to aid sleep, the lights are dimmed and in certain sleeping positions the staff cannot monitor or detect signs of life. This usually led to staff having to wake patients up in order to be satisfied.

13.2. The detection of life is via infra-red and when this is not picked up they make a noise to alert the staff. The addition of the monitors is not to replace staff taking physical health observation including respirations from outside the seclusion if patients refused nor was it to replace the visual observations.

13.3. Life signs monitoring support and can help in providing a more controlled, safer environment and early warning signs of physical deterioration of patients in seclusion rooms.

13.4. Life signs is part of the seclusion training, each locality will include life signs monitoring training package for all new staff before they complete seclusion observation.

14.0. Medical assessment

14.1. 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.

14.2. Medical reviews should insofar as possible include:

- 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

14.3. 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 their attendance 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.

14.4. 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.

14.5 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 (R CODE SECLN03 4 hour/3 a day medical review) As soon as the patient wakes up arrangements should be made for them to be seen by a doctor within one hour.

15.0. Care for the Patient in seclusion

15.1 The vital signs of patients who have been sedated prior to being placed in seclusion should be monitored at regularly prescribed intervals.

15.2. Meals should be provided as usual, but with seclusion cutlery.

15.3. There should be a ready supply of fresh, clean drinking water available to the patient.

15.4 If the patient requires use of the toilet, steps should be taken to ensure the privacy and dignity of the patient are maintained, according to local procedures and layout of the seclusion areas.

16.0 Review of Patients in seclusion

NB East London Modified-Broset Checklist (ELM-B) should be completed immediately after Seclusion commences and at every review to support decision making. Appendix 7

16.1. 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.

16.2 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
16.3 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, by giving advice to the medical and nursing team, or attending the ward round and CPA or other professionals meetings. Members of the team can communicate with their patient via the panel and intercom whilst carrying out the seclusion observations or during the reviews. This is to ensure that the patient’s care is not solely based on nursing interventions when they are in a crisis.

16.4 Seclusion reviews will be organised by the treating team through the team secretary/ward administrator, who will liaise with the ward Clinical Nurse Manager. Any difficulties in accomplishing this are to be reported to the Consultant and Matron.

16.5 Outside normal working hours, when a patient is secluded the Duty senior nurse must inform the duty doctors of the planned times for medical reviews during their shift.

16.6 There are two types of reviews Ordinary and Extraordinary reviews.

16.7 **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. **All relevant codes must prefix any joint review.**

16.7.1 **Nursing Reviews** \( \text{(RCODE SECLN02: Seclusion 2h nursing review)} \)

16.7.2 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 (one of whom was not involved in the decision to seclude). At least once in the 24 hours this should involve a nurse from the treating team.– **See appendix 4 for guidance**

16.7.3 **Medical Reviews** \( \text{(RCODE SECLN03 4 hour/3 a day medical review)} \)

16.7.4 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, the first review is that done by the consultant immediately before seclusion was authorised.

16.7.5 The patient should then be reviewed every 4 hours by a doctor. At least once every 24hrs it should be a doctor from the treating team (during normal working hours). In the absence of the treating doctors the covering doctor should conduct the review.

16.7.6 4 hourly medical reviews should continue until the first MDT review has taken place (see section 15.7.7-15.7.10). Following the first MDT review, further medical reviews should continue at least 3 times in every 24 hour period. At least one of these should be carried out by the patient’s Responsible Clinician. 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.
16.7.7 Internal MDT Reviews *(RCODE SECLN05: Seclusion 24 hour MDT Review)*

16.7.8 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 staff of the patient’s treating team. Refer to section 16 for details of the conduct and nature of these reviews.

16.7.9 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 such a review medical reviews will be required three times in a 24 hour period rather than four hourly as in 15.7.6 above.

16.7.10 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.

16.7.11 Independent MDT Review

16.7.12 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.

16.7.13 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.

16.8 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. *RCODE SECLN05: Seclusion extraordinary MDT review.*

16.9 One week Elapsed

16.9.1 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.

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

16.10 Two Weeks Elapsed
16.10.1 When an internal second opinion does not lead to the seclusion being discontinued by the end of the second week a request will be made for an opinion from a consultant external to the treating locality/service, but from within the Trust.

16.11. Three weeks elapsed

16.11.1 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 for an opinion and recommendations on the patient’s management. For CAMHS, consideration of referral to specialist adolescent services should be given.

16.11.2 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 about informing the Care Quality Commission about the long-term seclusion.

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

17.0. Role of the Multidisciplinary Review Team (treating team and independent)

17.1. 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.

17.2. 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.

17.3. The team need to also ensure that the patient has appropriate access to:

a. nutrition/fluids,
b. personal hygiene provisions
c. toilet facilities,
d. utensils
e. reading materials
f. medication
g. advocate
h. religious material
i. a clock (within sight of the patient but outside of the seclusion room)
j. a calendar (within sight of the patient but outside of the seclusion room)

17.4 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.

17.5 If the independent MDT review teams believe that the seclusion should be terminated they need to make recommendations to the treating clinical team with ideas of how is 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.

17.6 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.

17.7. A record will be maintained in the patient’s clinical notes of all relevant information that relates to clinical matters for the secluded patient.

17.8 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.

18.0. Termination of Seclusion

18.1. 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) part of the regular review, and allows for a discussion to make the decision to discontinue seclusion.

18.2 The nurse in charge should inform and discuss with the ward/duty doctor when considering terminating.

18.3. The person terminating the seclusion is to ensure that the patient’s care plan is carefully explained to them.

18.4. The nurse in charge will complete the termination seclusion summary in the progress notes. RCODE SECLN08: Seclusion Termination

18.5 Following the termination of seclusion a nurse and/or doctor will meet with the patient to discuss the seclusion and the events which led to it. The debrief should follow a structured guidance (appendix 8). The patient’s overall care plan will be discussed / reviewed. At the earliest opportunity after seclusion has been terminated, the Clinical Nurse Manager, Clinical Practice Lead or the Matron for the ward will carry out a debrief with the patient using the template in appendix 8. RCODE SECLN07: Post Seclusion Senior nurse debrief

18.6. The ward/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. RCODE SECLN06: Post
Seclusion Physical Examination.

18.7. The allocated nurse will update the Risk assessment to reflect the circumstances of seclusion and current mental state.

18.8. The nurse in charge of the ward will ensure that the seclusion room is cleaned and prepared for further use.

19.0 Post Incident Review

19.1. The aim of a post incident review should be to seek to learn lessons, 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.

19.2. 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.

20.0 Informal Patients

20.1 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.

20.2. 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.

21.0. Visits by the Care Quality Commission

21.1. 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.

22.0. Reporting and Monitoring

22.1 The nurse in charge must inform the Matron and consultant when a patient has been secluded as soon as possible.

22.2. For each episode of seclusion an incident form should also be completed.
22.3. All seclusion episodes should be audited and reported at local ward level and directorate governance structures.

22.4. 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, occurrences this should be reviewed at local governance meetings.

23.0. Training

23.1 All staff who undertake seclusion observations should attend at minimum the below training
- local seclusion training.
- Life signs Monitoring
- Trust Physical health training

Venous Thrombosis Embolism

NB: Seclusion training should be part to be part of all in-patient trainee doctors inductions. All seclusion training should be recorded on OLM for clinical staff.

24.0. Local Procedures

24.1. 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  Seclusion Review Flowchart

Seclusion

Doctor informed must be seen within 1 hour

2 hourly nursing reviews

4 hourly medical reviews or 3 times a day after 1st senior medical review

8 hours consecutively or 12 hours over 48 hours

MDT review by people not involved in the incident leading to seclusion every 24 hours

After One week elapsed

Terminate after an hour

Terminate

Terminate

Terminate

Terminate
MDT review by people not involved in the incident leading to seclusion every 24 hours

After Two weeks elapsed

1. Independent review by an external senior clinician within trust

After Three weeks elapsed

1. Independent review by senior clinician outside the Trust
2. Professionals meetings, inviting Security Team (secure services where applicable) and a member of the Directorate Management Team
3. Referral to appropriate services

Repeat cycle

Terminate
### Appendix 2  Seclusion Room Environment Checklist Fit For Use

<table>
<thead>
<tr>
<th></th>
<th>Satisfactory?</th>
<th>Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td>Cleanliness</td>
<td>(Please circle your) Yes / No</td>
<td></td>
</tr>
<tr>
<td>Lighting</td>
<td>Yes / No</td>
<td></td>
</tr>
<tr>
<td>Ventilation</td>
<td>Yes / No</td>
<td></td>
</tr>
<tr>
<td>Heating</td>
<td>Yes / No</td>
<td></td>
</tr>
<tr>
<td>Clock</td>
<td>Yes/No</td>
<td></td>
</tr>
<tr>
<td>Calendar</td>
<td>Yes/No</td>
<td></td>
</tr>
</tbody>
</table>

**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 3  Seclusion Room Stock Equipment

<table>
<thead>
<tr>
<th>Item</th>
<th>Minimum Stock No.</th>
<th>Number Present</th>
<th>Comment/Action Required</th>
</tr>
</thead>
<tbody>
<tr>
<td>Manual sphygmomanometer</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>With small, medium, large and extra-large cuffs</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Stethoscope</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Pulse oximeter</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Gloves</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Small, medium, large and extra large</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Disposable Aprons</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Disposal PPE Suits</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Goggles</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Mouth Mask</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Shoes Protectors</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Seclusion Cutlery Sets</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>XXXL Ligature Suits</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>XXL Ligature Suits</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>XL Ligature Suits</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>L/M/S Ligature Suits</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Seclusion Blankets</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Seclusion Mattress</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

*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

Appendix 4  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.

<table>
<thead>
<tr>
<th>RCODE SECLN00: Seclusion Authorisation</th>
</tr>
</thead>
<tbody>
<tr>
<td>Ward:</td>
</tr>
<tr>
<td>MHA Status:</td>
</tr>
<tr>
<td>Seclusion commenced at (time)</td>
</tr>
<tr>
<td>Decision to seclude by (NIC/doctor)</td>
</tr>
<tr>
<td>DSN informed at (time and name of DSN)</td>
</tr>
<tr>
<td>RC informed at (name, time and if by email)</td>
</tr>
<tr>
<td>Doctor informed at (time and name)</td>
</tr>
<tr>
<td>Time doctor scheduled to attend:</td>
</tr>
<tr>
<td>Patient asked if they want Next Of Kin informed or to see or inform the IMHA (please detail) ....</td>
</tr>
<tr>
<td>Has the risk been updated on Rio ?</td>
</tr>
</tbody>
</table>

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

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 5  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
## Appendix 6  Seclusion Audit Tool

<table>
<thead>
<tr>
<th>Patient Name</th>
<th>Ward</th>
</tr>
</thead>
<tbody>
<tr>
<td>Patient ethnicity</td>
<td>Patient age</td>
</tr>
<tr>
<td>Date &amp; Time Seclusion Initiated</td>
<td>Date &amp; Time Seclusion Terminated</td>
</tr>
<tr>
<td>Standard</td>
<td>Y/N/NA</td>
</tr>
</tbody>
</table>

### Initiation of Seclusion

**SP1**
Authorization 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.

### Actions During Seclusion

- If rapid tranquillisation is used an RMN / doctor completes the observations for the first 2 hours.
- Band 4 staff handover only to registered staff for the duration of the seclusion.
- Written observation notes are recorded in the service users inpatient record on RIO every 15 minutes.
- Staff undertake observations for a maximum of 1 hour at time.
- 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?

### Ordinary Reviews

- [ ]
- [ ]
| 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 responsible clinician |
| 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 |

**Extraordinary Reviews**

| 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 |
### Termination of Seclusion

<p>| | |</p>
<table>
<thead>
<tr>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>SP24</td>
<td>When terminating seclusion the person terminating it discussed the patients care plan with them</td>
</tr>
<tr>
<td>SP25</td>
<td>The Ward Doctor/Duty Doctor completes a physical examination of the patient following the termination of seclusion</td>
</tr>
<tr>
<td>SP28</td>
<td>The patients Risk Assessment is updated</td>
</tr>
<tr>
<td>SP29</td>
<td>Following termination of seclusion a Senior nurse and/or doctor met with the patient to debrief the patient,</td>
</tr>
<tr>
<td>SP30</td>
<td>There is a local system for collating seclusion stats</td>
</tr>
<tr>
<td>SP31</td>
<td>The Seclusion Room Environmental Checklist is completed following the termination of each episode of seclusion over last month</td>
</tr>
</tbody>
</table>

### Additional Comments

<p>| | |</p>
<table>
<thead>
<tr>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Completed by | Date
Appendix 7  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.

<table>
<thead>
<tr>
<th>Hospital</th>
<th>Ward</th>
</tr>
</thead>
<tbody>
<tr>
<td>Assessor/Assessors</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Patient Name</th>
<th>D.O.B</th>
</tr>
</thead>
<tbody>
<tr>
<td>Date of Assessment</td>
<td>Time of Assessment</td>
</tr>
</tbody>
</table>

**Behavioural Descriptor**

Please score only the behavioural elements objectively present.

<table>
<thead>
<tr>
<th>Confused</th>
<th>Item Present?</th>
</tr>
</thead>
<tbody>
<tr>
<td>Item not present: 0</td>
<td>Item present: 1</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Irritable</th>
<th></th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>Boisterous</th>
<th></th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>Verbal Threats</th>
<th></th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>Physical Threats</th>
<th></th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>Attacking Objects</th>
<th></th>
</tr>
</thead>
</table>

**Response to de-escalation**

**PRN Compliance (P.O. /I.M.)**

<table>
<thead>
<tr>
<th>Recorded in Rio- Total Score 0/8</th>
</tr>
</thead>
<tbody>
<tr>
<td>Patient Secluded</td>
</tr>
</tbody>
</table>
### Appendix 8  RCODE SECLN07: Post Seclusion senior nurse debrief Guidance

This engagement should address the following (suggestions but not definitive list)

<table>
<thead>
<tr>
<th>Question</th>
<th>Answer</th>
</tr>
</thead>
<tbody>
<tr>
<td>Tell me about what happened that led you to being secluded/restrained?</td>
<td></td>
</tr>
<tr>
<td>What sort of things were you feeling leading up to that event and why were you feeling that way?</td>
<td></td>
</tr>
<tr>
<td>So you felt...when...? (Confirm feelings and triggers to develop understanding, trust &amp; engagement)</td>
<td></td>
</tr>
<tr>
<td>Has there been a time when you have experienced those sorts of feelings before and you did something that helped ease them? What did you do?</td>
<td></td>
</tr>
<tr>
<td>What sort of things could staff do that would have helped the situation?</td>
<td></td>
</tr>
<tr>
<td>Question</td>
<td></td>
</tr>
<tr>
<td>--------------------------------------------------------------------------------------------------</td>
<td></td>
</tr>
<tr>
<td>Are there any things that we haven’t already talked about that you or staff could have done</td>
<td></td>
</tr>
<tr>
<td>differently to prevent this?</td>
<td></td>
</tr>
<tr>
<td>What can we do to make sure these helpful actions happen in the future? (e.g. explore self-</td>
<td></td>
</tr>
<tr>
<td>soothing options, develop staff and service user skills and strategies, incorporate into</td>
<td></td>
</tr>
<tr>
<td>safety/crisis/WRAP plans)</td>
<td></td>
</tr>
<tr>
<td>Is there anything else you would like to discuss related to what happened or that we can learn</td>
<td></td>
</tr>
<tr>
<td>from the experience to ensure this doesn’t happen again?</td>
<td></td>
</tr>
</tbody>
</table>