Seclusion and Long-term Segregation Policy
Version 8

<table>
<thead>
<tr>
<th>Summary:</th>
<th>The aims of the policy are:</th>
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<tr>
<td></td>
<td>1) To ensure the physical and emotional safety and wellbeing of the patient.</td>
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<td>2) To ensure the safety of others from severe behavioural disturbance which likely to cause harm to others;</td>
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<td>3) To ensure the patient receives the care and support rendered necessary by their seclusion both during seclusion and after it has taken place.</td>
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<td>4) To minimise the frequency and duration of seclusion and prevent any inappropriate use of seclusion.</td>
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<td>5) To distinguish between seclusion and other restrictive practices and psychological behaviour therapy interventions (such as ‘time out’);</td>
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<td>6) To ensure proper monitoring of periods of seclusion and to provide a complete record of all periods of seclusion and audit.</td>
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<th>Keywords (minimum of 5):</th>
<th>Seclusion, Long-term segregation</th>
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<td>(To assist policy search engine)</td>
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| Target Audience: | All clinical and medical staff employed by Southern Health NHS Foundation Trust. |

| Next Review Date: | October 2019 |

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<th>Approved and Ratified by:</th>
<th>Management of Violence and Aggression Committee</th>
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<td>AMH Quality and Safety Forum</td>
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| Date issued: | January 2017 |

| Author: | Dr Mayura Deshpande, Interim Associate Medical Director (Quality, Governance & Patient Safety) |

| Sponsor: | Dr Lesley Stevens, Medical Director |
Seclusion and Long-term Segregation Policy

Author: Dr Mayura Deshpande
Version: 8
May 2019

Table: Version Control

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<td>Feedback re: Seclusion terminology and long-term segregation procedure. Need to place greater emphasis on medical involvement in seclusion practice</td>
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<td>Further feedback on clarifying the role of Doctors in the Seclusion review process. Simplified documentation.</td>
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<td>Louise Hartland</td>
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<td>Updated TNA (Appendix 2)</td>
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<td>Dr Mayura Deshpande</td>
<td>6</td>
<td>8</td>
<td>Specific section on children and young people Seclusion flowchart of reviews added to suite of documents</td>
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<td>Dr Mayura Deshpande</td>
<td>7</td>
<td>Various</td>
<td>Change from paper-based documentation to electronic patient record system; new section added on seclusion reviews at times of major disruptions</td>
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<td>21/05/19</td>
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<td>Removal of reference to track and trigger. Addition of reference to NEWS 2/PEWS/Non-Contact Physical Health Observations Guidance and Assessment framework</td>
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Table: Reviewers/contributors

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<th>Name</th>
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1. **Introduction**

1.1 Southern Health NHS Foundation Trust (“the Trust”) recognises that it has a legal duty so far as is reasonably practicable to protect its patients and staff. The Trust is committed to supporting staff, patients, cares and visitors in the event of adverse situations and recognises that providing a safe environment is paramount to success.

1.2. The Trust will ensure the physical and emotional safety and wellbeing of the services user remains a priority for all staff at all times. Staff will ensure that services users receive the care and support rendered necessary both during and after seclusion has taken place.

1.3. However, the Trust will not tolerate violent, aggressive, antisocial or abusive behaviour towards its staff during the course of their duty. Decisive action will be taken to protect staff.

1.4. This policy stems from a framework to balance the needs of patients to receive care with the need to protect staff and others from violence and aggression by the containment of severe behavioural disturbance which is likely to cause harm to others.

1.5. This policy takes into account the requirements of the Human Rights Act 1998, the Mental Capacity Act 2005, Mental Health Act 1983 (as amended 2007), the Mental Health Act Code of Practice (2015), and relevant NICE guidelines.

2. **Scope**

2.1 This policy applies to all clinical and medical staff employed by Southern Health NHS Foundation Trust.

3. **SHFT Practice Principles shaping this policy**

3.1 Mental ill health, learning disabilities and behaviours which challenge are not inevitably life-defeating, and our services will not work on that basis. The three tenets of recovery – hope, agency and opportunity – are core to our values as a mental health service provider and positive behaviour support in learning disabilities services. We aspire to ensure that every interaction is experienced in the relevant appropriate way. Our clinicians will work with dignity and respect for every individual, recognise each personal narrative and embrace it within care planning, include the people who are important in the individual’s life, and offer information which supports personal decision-making and choice.

3.2. Recovery-oriented practice is the ‘golden thread’ that runs through our services. It is not abandoned if the person experiences an acute period of illness or difficulty, or if his/her capacity is compromised. There may be times when the balance of control between the individual and the service shifts, according to need, yet the principle of sharing the responsibility for managing risk will remain. This will include effective advance planning (e.g. use of collaborative crisis plans).

3.3. The person using services will be supported to take control of the way in which services are used, exercising choice through personalisation of his/her own care.
The level of support needed to manage these choices will vary over time and according to need.

3.4. Services will work on the principle of ‘nothing about me, without me’. All aspects of the Care Programme Approach (CPA) and care planning will be undertaken in collaboration with the individual. That includes assessing, planning, implementing and reviewing care. A shared responsibility, which places demands on both parties, will exist between the clinician and the individual to ensure this occurs.

3.5. Both the CPA and care planning are about the way in which the person using our services is supported to maximise their quality of life, and not about what you get (in terms of services).

3.6. These principles are drawn from the Trust’s Mental Health Strategy (2014), ‘Valuing People’ (2008) and the Green Light Toolkit used for implementing Reasonable Adjustments for those with a Learning Disability.

3.7 The MHA Code of Practice (2015) also introduces the following principles which we must implement when looking after our patients:

- Least restrictive options and maximising independence

  Wherever possible, a patient’s independence should be encouraged and supported with a focus on promoting recovery

- Empowerment and involvement

  Patients should be involved in decisions about care, support and treatment. The views of families, carers and others, if appropriate, should be fully considered when taking decisions. Where decisions are taken which are contradictory to views expressed, professionals should explain reasons for this.

- Respect and dignity

  Patients, their families and carers should be treated with respect and dignity and listened to by professionals.

- Purpose and effectiveness

  Decisions about care and treatment should be appropriate to the patient, with clear therapeutic aims, promote recovery and should be performed to current national guidelines and/or current, available best practice guidelines.

- Efficiency and equity

  Providers, commissioners and other relevant organisations should work together to ensure that the quality of commissioning and provision of mental healthcare services are of high quality and are given equal priority to physical health and social care services. All relevant services should work together to facilitate timely, safe and supportive discharge from detention.
4 GENERAL PRINCIPLES: LOOKING AFTER THE PERSON IN SECLUSION & LONG-TERM SEGREGATION

4.1 Patients in seclusion and long-term segregation (LTS) are guaranteed the following rights and have the right to have them explained verbally and in written / pictorial form as appropriate:

- To be treated with respect and dignity at all times
- To be fully involved as possible in the development and review of a positive behaviour support plan/seclusion plan.
- To be given the reason(s) for being placed in seclusion or LTS
- To be told under what conditions seclusion or LTS will cease
- To be aware of the time of day via a clock viewable from the seclusion or LTS room or by regular simple orientation being provided for the patient on request. Patients in LTS should have access to a calendar for this reason
- To be told how to summon the attention of staff whilst in seclusion. A patient in LTS is likely to be on enhanced observations
- To receive adequate food and fluids at regular intervals
- To be given appropriate access to toilet and washing facilities (where continued observation is required, staff should always attempt to provide a nurse of the same gender)
- To be appropriately clothed at all times
- To carry out religious observances with due regard to risk management
- To be visited by and given the opportunity to speak to the staff undertaking the reviews as per policy.
- To receive advocacy, legal and family visits with due regard to risk management

4.2 A record must be made in the seclusion or LTS documentation of the patient being made aware of their rights, as above.

4.3 Complaints arising from the use of seclusion must be investigated following the Trust Complaints Procedure.

5. GENERAL PRINCIPLES: CODE OF PRACTICE DEFINITION OF SECLUSION

5.1 Definition

5.1.1 The Mental Health Act Code of Practice (CoP) 2015 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 containment of severe behavioural disturbance which is likely to cause harm to others.” (MHA CoP, para 26.103)

5.1.2 If a patient is confined in any way which meets this definition, “…even if they have agreed to or requested such confinement…” the patient has been secluded and must be afforded the procedural safeguards of the Code. The use of local or alternative
terms, such as therapeutic isolation, or the conditions of the immediate environment do not change the fact that the patient is secluded (MHA CoP, para 26.104).

5.2 Other terms for seclusion

5.2.1 All instances of care or intervention e.g. transfer to ‘High Care’ or ‘Therapeutic Isolation’ ‘time out’ that meet the definition of seclusion must be treated as seclusion and the required reviews put in place.

5.3 When seclusion can be used

5.3.1 Seclusion may only be used for the containment of severe behavioural disturbance that is likely to cause harm to others. It may not be used solely as a means of managing self-harming behaviour (MHA CoP, para 26.108). When a 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 arising from their own self-harm and that any such risk can be properly managed.

5.3.2 Seclusion should not be used as a punishment or a threat, or because of shortage of staff. It must never form part of a treatment programme (MHA CoP, para 26.107).

5.3.3 As seclusion may only be used to contain the severe behavioural disturbance that may cause harm to others, it is the responsibility to staff to assess the risk that a patient poses to others due to their challenging behaviour. In placing a patient in seclusion, staff must be able to demonstrate the decision-making which evidences that seclusion was used a) to manage severe behavioural disturbance which is likely to cause harm to others, and b) as a measure of last resort.

5.4 Seclusion and informal patients

5.4.1 Seclusion should only be used in hospitals and in relation to patients detained under the Act. 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 (MHA CoP, para 26.106)

5.5 Seclusion and Advance Statements

5.5.1 Patients must have the opportunity to complete an advance statement that expresses their preference on how an episode of severe behavioural disturbance should be dealt with. The purpose of this is to minimise the use of restraint, seclusion and long-term segregation. Nevertheless, the Trust recognises that some patients may indicate, as part of their advance statements, that they would choose seclusion over restraint as a way of managing their behaviour. In such circumstances, it must be explained to the patient that the Trust is obliged to attempt de-escalation in the first instance, that seclusion is a measure of last resort to be used only for managing behaviour that may harm others, and that its use cannot be included in a care plan.

5.6 Advance Care Planning/ Positive Behavioural Support Planning

5.6.1 All patients who may be at risk of engaging in severe behavioural disturbance likely to cause harm to others should have a Care Plan (some services use the term Positive Behaviour Support Plan). Input should be sought from the patient in developing this plan, and where appropriate, from family members and carers. This
plan should be clearly entitled and should describe the interventions that effectively manage incidents of severe behavioural disturbance for that patient.

5.6.2 Where it has been agreed in a Care Plan/ Positive Behaviour Support Plan with the patient that family member’s carers or Independent Mental Health advocates (IMHA) will be notified of significant behavioural disturbances and the use of restrictive interventions, this should be done as agreed in the plan. For patients under the age of 16 years, persons with parental responsibility (parents, family members or local authority children’s services for looked after children) must be informed each time seclusion is employed. For patients between the age of 16 and 18 years, information may be shared with those with parental responsibility with the patient’s consent.

5.6.3 A well-drafted Care Plan/Positive Behaviour Support Plan focused on understanding the patient’s behaviour in the context of their needs may help to minimise the use of seclusion.

5.7 Additional Considerations for Children and Young People

5.7.1 Restrictive interventions such as seclusion and long term segregation should only be applied to children and young people after taking into account their physical, emotional and psychological maturity.

5.7.2 Staff must be mindful that seclusion or long term segregation, whilst traumatic for any individual may have particularly adverse implications for the emotional development of children and young people and should take this into account before making a decision to seclusion or long term segregation. A child and adolescent trained clinician should make a careful assessment of the potential effects of seclusion, especially if the child or young person has a history of trauma or abuse. Seclusion or long term segregation should only be used when other strategies to de-escalate behaviours and manage risks have been exhausted.

5.7.3 Seclusion should only be used in hospitals and for children and young people who are detained under the Act (see 5.4.1).

5.8 Seclusion Environment

5.8.1 Seclusion should only be undertaken in a room or suite of rooms that have been specifically designed and designated for the purpose of seclusion and which serves no other function on the ward (MHA CoP, para 26.105).

5.8.2 The seclusion room or suite should (MHA CoP, para 26.109):

- Allow for communication for the patient when the patient is in the room and the door is locked, e.g. via an intercom
- Include limited furnishings which should include a bed, pillow, mattress and blanket or covering
- Have no safety hazards
- Have robust, reinforced window(s) that provide natural light (where possible the window should be positioned to enable a view outside)
- Have externally controlled lighting, including a main light and subdued lighting for night time
• Have robust door(s) which open outwards
• Have externally controlled heating and/or air conditioning, which enables those observing the patient to monitor the room temperature
• Have no blind spots, and alternate viewing panels should be available when required
• Have a clock that is always visible to the patient from the room
• Have access to toilet and washing facilities

5.8.3 Any intervention that meets the definition of seclusion, including such interventions that occur outside of designated seclusion rooms, must be treated as seclusion and the safeguards implemented.

5.9 Location of the Trust’s Seclusion Facilities

5.9.1 The Trust has designated seclusion rooms for Mental Health at:
• Antelope House PICU
• Bluebird House adolescent medium secure unit
• Parklands Hospital PICU
• Ravenswood House medium secure unit
• Southfield low secure unit

5.9.2 The Trust has designated seclusion rooms for Learning Disability at:
• Ashford Unit
• Evenlode Unit

5.10 Monitoring for Seclusion and Long-term Segregation Practice

5.10.1 Each episode of Seclusion and LTS requires an incident (Ulysses) report

5.10.2 Each ward must have arrangements in place to scrutinise completion of documents used in Seclusion and LTS.

5.10.3 Recording of seclusion and long term segregation will take place, from Jan 2017 onwards, in the Trust Electronic Patient Record (EPR). System “downtime” forms will be available for completion when the EPR is unavailable. When the EPR is available again, the information contained in those forms should be added to the relevant seclusion/long-term segregation forms on the EPR, and the paper forms destroyed.

5.10.4 The MHA team audit all seclusion documentation as part of the MHA annual audit cycle

5.10.5 A themed report of Seclusion and LTS practice is provided on an annual basis for the Trust Board and periodic reports when requested.

5.10.6 If seclusion takes place outside of designated seclusion facilities, e.g. if a restrictive intervention meets the definition of seclusion, this is a breach of the Code. The safeguards of this policy should be implemented for such incidents of seclusion AND
both the Associate Director for Nursing, AHP and Quality – Mental Health Division, LD and Social Care, and the Mental Health Act Manager should be informed.

5.11 **NHS England Reporting Requirements**

5.11.1 All episode of seclusion in specialised services must be notified to the NHS England Case Managers, at the earliest opportunity, and within 24 hours of commencement of seclusion.

5.11.2 All episodes of seclusion must be recorded on the attached template ('NHS England Seclusion Notification') and sent to:

   [hp-tr.SpecialisedServices@nhs.net](mailto:hp-tr.SpecialisedServices@nhs.net)

following commencement of seclusion. An estimated length of seclusion is to be recorded where possible, or if difficult to predict, ‘unknown’.
The Seclusion Care Pathway

Procedure

6. INITIATION OF SECLUSION

6.1 Staff must complete the form “Seclusion – Commencement” on the EPR.

6.2 Responsibilities of Professional in Charge

6.2.1 In addition to completing the form “Seclusion – Commencement” on the EPR, the person in charge should:

- Complete the Seclusion & Long-Term Segregation Book (this will remain paper-based in each seclusion suite)

- Draw up an observation roster so that a member of staff trained to carry out such observations is observing the patient in seclusion at all times and inform staff of the existence of such roster

- Inform the care team of the seclusion and delegate responsibility for other patients to members of the care staff

- At each review point (see section 8), assess and decide whether it is appropriate to end seclusion.

- Complete a seclusion care plan on the EPR if seclusion continues beyond the first medical review

- Ensure that the patient’s vital signs are identified and recorded accurately in accordance with NICE guidelines. Further specific NICE guidance on monitoring vital signs is given with regards manual restraint, rapid tranquillisation, delirium and head injury. For further information, please see the Trust’s Restrictive Interventions Policy (SH NCP 23); Rapid Tranquillisation: Policy and Guidance for use in Mentally Ill Patients Displaying Acutely Disturbed or Violent Behaviour (SH CP 48); and the Patient Safety Alert on ‘The importance of vital signs during and after restrictive interventions/manual restraint’ (NHS/PSAW/201/011).

  o NICE (2010). Delirium: Diagnosis, prevention and management. [https://www.nice.org.uk/guidance/cg103]
• Make a brief entry in the progress notes section of the EPR during each shift to indicate that the patient remains in seclusion

6.3 Who can authorise seclusion?

6.3.1 Seclusion may be authorised only by the following:
• A psychiatrist
• An approved clinician who is not a doctor
• The professional in charge of a ward (e.g. lead nurse)

6.3.2 All attempts must be made to manage the patient’s severe behavioural disturbance by other means. Seclusion should be used only when all other means have been exhausted

6.3.3 The person authorising seclusion should have seen the patient immediately prior to the commencement of seclusion.

6.4 Who needs to be informed?

6.4.1 When the decision to initiate seclusion is made by the professional in charge, by a psychiatrist who is neither the patient’s Responsible Clinician nor an approved clinician, or by an approved clinician who is not a doctor, he/she should immediately inform the following personnel that the patient has been secluded:

a) The patient’s Responsible Clinician or if unavailable, the duty doctor (this can be the trainee psychiatrist on-call)
   AND
b) The senior nurse on duty with site responsibility

6.4.2 The Trust considers best practice for communicating with the personnel listed above to be within 30 minutes of the initiation of seclusion or as soon as is practicable.

6.4.3 If seclusion is authorised by a psychiatrist, the first medical review will be the one they undertook immediately before authorising seclusion.

6.5 Searching the patient prior to seclusion

6.5.1 A member of the care team shall carry out a visual search of the patient to reduce availability of objects that could be used as a weapon, i.e. shoes, belts, lighters/matches, keys.

6.5.2 If staff members feel that a physical search is required, the policy on search of patients and their property must be adhered to and their rights incorporated under the HRA 1998 taken into account.

Refer to SH HS 07 Search of Patients (detained and informal), visitors and their property

6.6 Privacy and Dignity of the person using seclusion

6.6.1 Staff may decide what the patient may take into the seclusion room or suite, but patients should wear their personal clothing and retain other personal items such as those of cultural or religious significance, if this does not compromise the safety of
the patient or other people. It may be necessary to remove articles of clothing from
the patient, if those clothes are deemed a risk to his/her safety. Should this occur, the
privacy and dignity of the patient will be respected while alternative, safer clothing is
provided (e.g. disposable clothing).

6.7 Who else needs to be informed when initiating seclusion?

6.7.1 Family members, carers or Independent Mental Health Advocates (IMHA) should be
informed, as agreed in the Advance Care Plan/Positive Behaviour Support Plan. For
young people under 18 years, see section 5.6

7. CARE OF THE PATIENT IN SECLUSION

7.1 Who should be observing the person in seclusion?

7.1.1 A suitably skilled practitioner should as a minimum be readily available within sight
and sound of the seclusion area at all times throughout the period of seclusion. A
trained practitioner should be readily available and contactable at all times throughout
the period of seclusion.

7.1.2 Staff should only carry out constant observation for periods not exceeding 1 hour
before handing over to another staff member except in exceptional circumstances. Records must be contemporaneous.

7.1.3 The observing practitioner must have access to a personal alarm or know how to
raise an alarm if a personal alarm system is not in place, and they must retain the
keys to the seclusion door.

7.1.4 Consideration should be given to whether a male or female person should carry out
ongoing observations; this may be informed by the consideration of a patient's
trauma history.

7.2 Observation practice

7.2.1 The aim of observation is to safeguard the patient, monitor their condition and
behaviour and to identify the earliest time at which seclusion can end.

7.2.2 The patient’s behaviour, mental state and physical condition should be constantly
observed using High Observation – Within Eyesight (Southern Health NHS
Foundation Trust Observation & Engagement Policy SH CP 107) by a member of
staff trained to carry out such observations throughout the period of seclusion.

7.3 How often should observations be recorded?

7.3.1 Staff must complete the Seclusion Care Pathway ‘Observation Record’ (Seclusion
Toolkit). This will remain paper-based.

7.3.2 Observations should be recorded at least every 15 minutes (MHA CoP para 26.123).

7.3.3 As a minimum, a record should be made of the patient’s appearance, what they are
doing and saying, their mood, their level of awareness and any evidence of physical
ill-health especially with regard to their breathing, pallor or cyanosis.
7.3.4 Where a patient appears to be asleep in seclusion, the person observing the patient should be alert to and assess the level of consciousness and respirations of the patient as appropriate.

7.4 Observation following rapid tranquillisation

7.4.1 For patients who have received sedation, a skilled professional will need to be outside the door at all times (MHA CoP, para 26.122). They must observe respiratory rate, bodily movements etc. The rapid tranquillisation pathway (SH CP 48- RT Policy & Guidance for use in mentally ill patients displaying acutely disturbed or violent behaviour) must be followed and observations recorded on a NEWS 2/PEWS tool (if appropriate and safe to do so). If it is unsafe to approach the service user to obtain physical observations using NEWS 2/PEWS, the Non-Contact Physical Health Observations Guidance and Assessment Framework can be utilised. Respiratory rate and ACVPU (alert, new confusion, voice, pain unresponsive) must still be documented on the NEWS 2/PEWS tool. The length of time for this additional observation should be care planned in discussion with the staff taking into account the rapid tranquillisation pathway.

8. REVIEWS DURING SECLUSION

8.1 The need to continue seclusion should be reviewed in accordance with the procedure laid out in the Code of Practice (MHA CoP, para 26.112). The following principles apply:

- If not authorised by a psychiatrist, **there must be a medical review within one hour** or without delay if the patient is not known or there is a significant change from their usual presentation.

- Seclusion area to be within constant sight and sound of staff member

- Documented review by person monitoring at least every 15 minutes

- **Nursing reviews by two nurses every two hours throughout seclusion**

- Continuing **medical reviews every four hours** until first (internal) MDT

- First (internal) MDT as soon as is practicable

- **Independent MDT after 8 hours consecutive** or 12 hours intermittent seclusion (within a 48 hour period)

- Following first (internal) MDT, continuing medical reviews at least twice daily (One by Responsible Clinician)

- Following the Independent MDT, continuing (internal) MDT review at least once daily
8.2 Who should undertake the medical review?

8.2.1 If seclusion is authorised by a consultant psychiatrist, then the consultant psychiatrist will have seen the patient immediately prior to authorising seclusion. Their assessment may be the first medical review for the purpose of this policy.

8.2.2 If seclusion is authorised by an approved clinician who is not a doctor, or the professional in charge of the ward, or a psychiatrist who is not a consultant, the first medical review should be undertaken by the patient’s Responsible Clinician or the duty doctor within an hour of the commencement of seclusion.

8.2.3 Overnight and on weekends, when the patient’s own Responsible Clinician may not be available, the duty doctor must have access to an on-call doctor who is an approved clinician.

8.3 What needs to be included in the first medical review?

8.3.1 The doctor who completes the first medical review must:

- Undertake a medical assessment of the patient’s mental and physical state.
- Record any obvious injuries
- Enter the assessment and action plan into the patient’s medical notes/electronic patient record
- Review the form “Seclusion – Commencement” on the EPR
- Complete the form “Seclusion – Periodic Review” on the EPR, choosing the appropriate review type on the form
- If it is agreed that seclusion should continue, a seclusion care plan should be agreed and prepared by the professional in charge (see section 9) and completed on the EPR.

8.3.2 At each review, if it is agreed that seclusion will continue appropriate amendments should be made to the seclusion care plan.

8.3.3 All subsequent medical reviews should be undertaken by the Responsible Clinician, a doctor who is an approved clinician, or the duty doctor.

8.4 What further reviews are required?

8.4.1 At each review staff should complete the form “Seclusion – Periodic Review” on the EPR, choosing the appropriate review type on the form.

8.5 Nursing reviews

8.5.1 Two registered nurses should review the patient every two hours from the commencement of seclusion. At least one of these two nurses should not have been involved directly in the decision to seclude.

8.5.2 Nursing observations should be documented every 15 minutes by a skilled professional who is within sight and sound of the seclusion area at all times.
8.5.3 At any time nurses should raise any concerns about the patient’s condition with the Responsible Clinician or duty doctor

8.6 Medical Reviews

8.6.1 Medical reviews must take place every four hours until the first (internal) MDT review has taken place, including in the evenings, night-time, on weekends and on bank holidays. See section 8.10 for when the patient in seclusion is asleep.

8.6.2 Medical reviews will include the following:
- A review of the patient’s physical and psychiatric health
- An assessment of the adverse effects of medication
- A review of the observations required (the minimum prescribed in this policy must be adhered to)
- A re-assessment of medication prescribed
- An assessment of the risk posed by the patient to others
- An assessment of any risk to the patient from deliberate or accidental self-harm
- An assessment of the need to continue seclusion, and whether it is possible for seclusion measures to be applied more flexibly or in a less restrictive manner

8.7 MDT Reviews

8.7.1 First (Internal) MDT Review: This should be held as soon as is practicable. Membership should include:
- the Responsible Clinician/a doctor who is an approved clinician or an approved clinician who is not a doctor but has appropriate expertise;
- a senior nurse on the ward;
- staff from other disciplines who would normally be involved in patient reviews

8.8 Further reviews required

8.8.1 Medical review - After the First (internal) MDT, further medical reviews will take place at least twice daily in every 24 hour period. At least one will be carried out by the patient’s Responsible Clinician, or an alternative approved clinician out of hours.

8.8.2 One of the two medical reviews should be an MDT review, involving staff from other disciplines who would normally be involved in patient reviews, in addition to a doctor and a nurse.

8.9 Independent MDT reviews

8.9.1 This should be held when a patient has been secluded for eight hours consecutively or for 12 hours intermittently in a 48 hour period. Minimum membership will include:
- a doctor who is an approved clinician or an approved clinician who is not a doctor;
- a nurse;
- other professionals not involved in the incident which led to seclusion, and an Independent Mental Health Advocate (IMHA) if possible

8.9.2 The CoP does not specify the membership of the Independent MDT Review at weekends and overnight. The Trust therefore requires the review to be carried out by the on-call Approved Clinician, a nurse as well as a senior nurse all of whom were not in the incident which led to seclusion.
8.9.3 If it is agreed by the Independent MDT review that seclusion needs to continue, the review should evaluate and make recommendations, as appropriate, for amendments to the seclusion care plan.

8.10 What happens if a review is required and the patient is asleep?

8.10.1 When the patient in seclusion is asleep, the Code of Practice (MHA CoP 26.136) allows Trusts to make different review arrangements in order to avoid waking the patient. Therefore, between 2300 hours and 0700 hours, medical and nursing reviews, First (internal) MDT review and Independent MDT reviews may be suspended if the patient is asleep. At other times, if the patient is asleep, attempts should be made by professionals to wake the patient up, if appropriate.

8.11 MDT reviews required at weekends

8.11.1 At weekends and overnight, membership of the MDT reviews is likely to be limited to medical and nursing staff, therefore the on-call senior site manager should be involved and an on call Approved Clinician.

8.12 Resolving disputes about ongoing seclusion

8.12.1 If any member of the multi-disciplinary team attending any review disputes the continued need for seclusion, the matter must be referred to either the Modern Matron or lead nurse. Furthermore, the opinion of another approved clinician should be sought. For out of hours, as well as referring the matter to the senior nurse on-call, an opinion should be sought from the on-call consultant, and the on-call local manager advised of the outcome of the review.

9. SECLUSION CARE PLAN

9.1 Staff should complete the form “Seclusion – Care Plan” on the EPR.

9.2 What should be in a seclusion care plan?

9.2.1 A seclusion care plan should set out how the individual needs of the patient will be met whilst in seclusion and record the steps that should be taken to terminate seclusion as soon as possible. It will include the following:

- A statement of clinical needs, including physical and mental health problems
- 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 of how the patient’s dietary needs will be met
- Details of any family or carer contact/communication as per agreement in the Positive Behaviour Support Plan
- Details of the support that will be provided to the patient when seclusion ends.

9.2.2 The patient should be encouraged to contribute to the seclusion care plan and steps should be taken to ensure that the patient is aware of what they need to do for seclusion to end.
10. **EXTENDED SECLUSION PERIODS**

10.1 If the period of seclusion exceeds 24 hours (ignoring any periods out of seclusion for six hours or less) the Modern Matron (nominated deputy) must be informed by the person-in-charge of the ward.

10.2 The Modern Matron or senior nurse on-call should be updated every 24 hours by the person-in-charge of the ward.

11. **ENDING SECLUSION**

11.1 Seclusion should immediately end when an MDT review, a medical review or the independent MDT review determined that it is no longer warranted. Alternatively, when the professional in charge of the ward considers that seclusion is no longer warranted, it may be terminated following consultation with the patient’s Responsible Clinician or the duty doctor, either in person or the telephone (MHA CoP, para 26.144).

11.2 The Trust requires the person-in-charge to regularly assess and decide, in consultation with the senior nurse on duty, whether it is appropriate to end seclusion.

11.3 Seclusion ends when the patient is allowed free and unrestricted access to the normal ward environment or transfers or returns to conditions of long-term segregation (MHA CoP, para 26.145)

11.4 Opening a door for toilet or food breaks or medical reviews do not, in themselves, constitute the end of seclusion.

11.5 The Code of Practice recommends that in order to minimise the impact on a patient’s autonomy, seclusion should be applied flexibly and in the least restrictive manner possible. Where seclusion is used for prolonged periods, subject to suitable risk assessments, flexibility may include allowing the patient to receive visitors, facilitating brief periods of access to secure outdoor areas or allowing meals to be taken in general areas of the ward. Such flexibility should be considered during any review, and it may provide a means of evaluating the patient’s mood and degree of agitation under a lesser degree of restriction, without termination the seclusion episode (MHA CoP, para 26.111).

11.6 Staff should complete the form “Seclusion – Discontinuation” on the EPR and update the Seclusion Book/ Record to confirm when Seclusion ended (Seclusion Toolkit)

12. **DEBRIEFING & RE-INTEGRATION TO WARD**

12.1 Following a period of seclusion the clinical rational should be explored with the patient, and they should be supported in the process of re-integration to normal unit activities. Nursing time should be set aside to facilitate this process.

12.2 This discussion will include the following:

- Does the patient understand why they were secluded?
- How does the patient feel about the necessity, reasonableness and appropriateness of the use of seclusion?
• How does the patient feel now, after the event?

• How can the need for any further episodes of seclusion be avoided in the future?

12.3 Ongoing care planning

12.3.1 The above discussion will feed into a review of the patient’s ongoing Care Plan or Behaviour Support Plan.

12.4 Debrief

12.4.1 Post-incident debrief should be available to both staff and patients. Staff should be aware of Trust facilities for debriefing and should access this as required.

13. REPORTING AND MONITORING

13.1 In addition to Incident ‘Ulysses’ reporting, the following people must be informed at commencement of seclusion:
  • Modern Matron
  • Associate Director of Service or nominated Area Manager

14. SECLUSION REVIEWS AT TIMES OF MAJOR DISRUPTION

14.1 In the rare event of major disruptions (such as severe adverse weather or transport disruptions) which prevent access to or from inpatient sites over many hours, it may not be possible for doctors to attend in order to carry out seclusion reviews in person, as prescribed by this policy.

14.2 If no doctor is available, the senior nursing team in the inpatient unit should make telephone contact with the required doctor, discuss the patient’s presentation, make a decision about whether seclusion is to continue, and record this in the appropriate review form in the EPR.

14.3 If seclusion continues, the patient should be reviewed by a doctor as soon as one is next available.

14.4 This is to be done only in the event of major disruptions which prevent physical access to the inpatient units. It is otherwise the expectation that all reviews will be completed as prescribed in this policy.
15. **CODE OF PRACTICE DEFINITION OF LONG-TERM SEGREGATION & GENERAL PRINCIPLES**

15.1 The Mental Health Act Code of Practice (CoP) 2015 defines **long-term segregation** as follows. “Long-term segregation refers to a situation where, in order to reduce a sustained risk of harm posed by the patient to others, which is a constant feature of their presentation, a multi-disciplinary review and a representative from the responsible commissioning authority determine that a patient should not be allowed to mix freely with other patients on the ward or unit on a long-term basis. In such cases, it should have been determined that the risk of harm to others would not be ameliorated by a short period of seclusion combined with any other form of treatment. The clinical judgement is that: If the patient were allowed to mix freely in the general ward environment, other patients or staff would continue to be exposed to a high likelihood of harm over a prolonged period of time.” (MHA CoP, para 26.150)

15.2 The Code of Practice further states that “…it is permissible to manage this small number of patients by ensuring that their contact with the general ward population is limited…” (MHA CoP, para 26.151)

15.3 **When should LTS be considered?**

15.3.1 LTS may only be considered when:

- All other forms of treatment and management have been considered as ineffective/ inappropriate (e.g. Behavioural Management plans including those to tackle incidents of violence and aggression, rapid tranquilisation and seclusion).

- It is in the best interests of the patient

- It is proportionate to the likelihood and seriousness of the harm threatened.

- There is no less restrictive alternative

- A patient may be felt to require LTS after a period in seclusion, when attempts to end seclusion have failed repeatedly due to ongoing high risk of harm towards others. In such cases, a decision should be made by the patient’s Responsible Clinician about whether the use of LTS may be more appropriate than long periods in seclusion.

15.3.2 LTS may only be considered for patients detained under the MHA 1983.

15.4 **Who needs to be involved in decisions relating to LTS?**

15.4.1 Discussion must take place with the patient and their relatives or carers or advocate. The Code of Practice states that “…when consideration is being given to long-term segregation, wherever appropriate, the views of the person’s family and carers should be elicited and taken into account…” (MHA CoP, para 26.150)
16. **LONG-TERM SEGREGATION ENVIRONMENT**

16.1 The CoP states “…the environment should be no more restrictive than necessary. This means that it should be as homely and personalised as risk considerations allow…” (MHA CoP, para 26.151)

16.2 The minimum facilities required are:
   - Bathroom facilities
   - A bedroom
   - Relaxing lounge area
   - Access to secure outdoor areas
   - Range of activities of interest and relevance to the patient

17. **INITIATION OF LONG-TERM SEGREGATION**

17.1 The patient’s RC must complete form “Long-term Segregation – Commencement” on the EPR.

17.2 The Trust places the decision to consider a patient as long-term dangerous and requiring management under a long-term segregation regime with the patient’s multi-disciplinary team.

17.3 The CoP requires a representative from the responsible commissioning authority to be involved in the decision to initiate LTS (MHA CoP, para 26.150).

17.4 **Who else must be consulted when initiating LTS?**

   17.4.1 A decision to place a patient in LTS may only be made by the patient’s Responsible Clinician and the multi-disciplinary team. Others who must be consulted:
   - The views of the patient and his/her family/carers should be sought and taken into account.
   - The patient’s Independent Mental Health Advocate (IMHA) should be consulted. A representative from the responsible commissioning authority should be consulted.
   - If it is felt that the patient may lack capacity to understand the rationale for LTS, a capacity assessment must be carried out. If the patient does lack capacity, all decisions made in his/her best interests should be documented.
   - The local safeguarding team should be informed.

18. **CARE OF THE PERSON IN LTS**

18.1 The CoP states that “…patients should not be isolated from contact with staff or deprived of access to therapeutic interventions…” and “…it is highly likely they should be supported through enhanced observations…” (MHA CoP, para 26.152)

18.2 Services must make an assessment of the appropriate enhanced observations required for supporting the patient and for the safe management of the patient’s sustained risk of harm to others. This will generally be a minimum of 2:1.

18.3 **Staff supporting the patient in LTS should make written records of the patient’s condition at least every hour.**
18.4 It may become necessary for a patient to be placed in seclusion while they are in LTS, if there is acute behavioural disturbance where there is a need to contain an immediate risk of harm to others. At such times, the procedure for seclusion as laid out in this policy should be followed. When seclusion is terminated, the patient will return to LTS.

19. **REVIEWS DURING LTS**

19.1 Every formal review should attempt to determine if the risks have reduced sufficiently to allow the patient to be integrated into the wider ward community and to check on their health and welfare.

19.2 Less restrictive means of managing the patient’s risks towards others must be considered at every stage.

19.3 LTS will be reviewed as follows:

<table>
<thead>
<tr>
<th>Overview of LTS and Monitoring Process</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Written record every hour by person supporting the patient in LTS</td>
</tr>
<tr>
<td>• Daily review by an approved clinician, (who need not be a doctor)</td>
</tr>
<tr>
<td>• At least weekly review by the full MDT (including patient’s Responsible Clinician or deputy, ward manager or deputy, and IMHA)</td>
</tr>
<tr>
<td>• Weekly review by a consultant psychiatrist not involved with the patient</td>
</tr>
<tr>
<td>• If LTS continues beyond 3 months, review by an external hospital, and discussion with IMHA and commissioner</td>
</tr>
</tbody>
</table>

19.4 **Hourly Observation**

19.4.1 Staff supporting the patient in LTS should make a record of the patient’s mental state, communication, behaviour and risks to self and to others on at least an hourly basis.

19.4.2 Staff must complete Part 2- Long-term Segregation Pathway ‘observation record (Seclusion Toolkit)’

18.5 **Daily Reviews**

19.5.1 There must be a daily review by an approved clinician, who need not be a doctor. This should be recorded in the electronic progress notes

19.5.2 The approved clinician must complete the form “Long-term Segregation – Periodic Review” on the EPR, and choose the appropriate review type on the form.

19.5.3 On weekends, the review may be conducted by telephone with nursing staff contacting the on-call consultant. Nursing staff will then complete the form “Long-term Segregation – Periodic Review” on the EPR, and choose the appropriate review type on the form, recording the name and designation of the on-call consultant contacted.

19.6 **Weekly Reviews**

19.6.1 The weekly review by the MDT should be carried out by the patient’s Responsible Clinician or deputy, the ward manager or deputy, other members of the MDT who would normally be involved in the patient’s care, and the patient’s IMHA.
Consideration should be given to whether less restrictive alternatives of managing the patient’s risk to others are appropriate, and to provision of a full therapeutic programme, including, where appropriate, access to visitors.

19.6.2 Staff must complete the form “Long-term Segregation – Periodic Review” on the EPR, and choose the appropriate review type on the form.

19.6.3 Where successive MDT reviews determine that LTS continues to be required, more information should be available to demonstrate its necessity and explain why the patient cannot be supported in a less restrictive manner (MHA CoP, para 26.159).

19.6.4 The Code also requires periodic review of LTS by a senior professional not involved with the case (para 26.155). To meet this requirement, a weekly review of the patient and the treatment plan must be undertaken by a consultant psychiatrist who is not otherwise involved in that patient’s care. The psychiatrist should complete the form “Long-term Segregation – Periodic Review” on the EPR, and choose the appropriate review type on the form.

19.7 Review of Extended Long-term segregation

19.7.1 If LTS continues beyond three months, a comprehensive review must be undertaken by an external hospital. The clinicians involved in this review must discuss the care of the patient with the patient’s family, IMHA and the responsible commissioners. A written report should be provided to the detaining authority. This review must be repeated every 3 months as long as LTS continues. This must be documented in the electronic progress notes in the form “Long-term Segregation – Periodic Review” on the EPR, choosing the appropriate review type on the form.

20. LTS CARE PLAN

20.1 Staff must complete a LTS Care Plan on the EPR, within the Long-term Segregation section.

20.2 What should be in the Care Plan?

20.2.1 Every patient in LTS must have a specific LTS treatment plan. This should be prepared with input from the patient, where possible.

20.2.2 The aim of the treatment plan should be to end LTS (MHA CoP, para 26.152).

20.2.3 The LTS treatment plan should clearly state why LTS is necessary and should be supported by a comprehensive risk assessment and therapeutic plan.

19.2.4 The LTS treatment plan must detail the steps and therapeutic goals to be achieved in order for LTS to be terminated.

20.3 Who should we share the LTS care plan with?

20.3.1 The patient should have access to a copy of the LTS treatment plan, where possible. If this is not appropriate or possible, the patient must be informed of the steps and therapeutic goals they should achieve in order for LTS to be terminated.

20.3.2 Patients in LTS, and their relatives/carers should be given information by the Ward Manager or Responsible Clinician about:
• the visiting arrangements based on risk assessment;
• Emergency procedures e.g. Panic alarms, staff response etc.

20.3.3 The information given to the patient must meet the individual’s communication needs, for example people with additional needs such as physical, sensory or learning disabilities, and people who do not speak or read English.

21. TERMINATION OF LTS

21.1 The RC and ward manager should complete the form “Long-term Segregation – Discontinuation” on the EPR.

21.2 LTS must be terminated when it is determined that the patient’s risks have reduced sufficiently to allow them to be re-integrated into the ward.

21.3 The decision to terminate LTS should be taken by the MDT, following a thorough risk assessment and taking into account observations from staff of the patient’s presentation during close monitoring of the patient’s presentation in the company of others.

21.4 The MDT should consist of, as a minimum, the patient’s Responsible Clinician and the ward manager. The patient’s IMHA should be consulted.

22. DEBRIEFING & RE-INTEGRATION TO WARD

22.1 The patient’s LTS Care Plan and Discontinuation plan should include a detailed account of all the steps to be taken to bring about LTS to an end. There should be a section detailing how the patient will be re-integrated back into the wider ward. It is expected that this will take place over a period of time, allowing the patient to gradually re-acclimatise to being in the company of other patients and staff.

22.2 Following the termination of LTS and complete re-integration into the ward, the patient should have a de-briefing session to explore their experience of LTS, their understanding of the rationale for it, and their current risks towards others.

23. REPORTING & MONITORING

23.1 In addition to Incident ‘Ulysses’ reporting, the following people must be informed at commencement of LTS, weekly reviews, and at termination:
• Director of MH, LD & Social Care
• Associate Director of Nursing, AHP & Quality
• Associate Director of the Service (MH/SS/LD)
• Safeguarding Team

24. SUPPORTING REFERENCES

• Human Rights Act 1998
• Mental Capacity Act 2005
• Mental Health Act 1983 (as amended 2007)
• Mental Health Act Code of Practice 2015
• Patient Safety Alert on ‘The importance of vital signs during and after restrictive interventions/manual restraint’ (NHS/PSA/W/201/011).
• Positive and Proactive Care: Reducing the need for restrictive interventions, April 2014, Department of Health
• Southern Health NHS Foundation Trust Policy SH NCP 23 – Restrictive Interventions Policy
Appendix 1

Addresses of current designated seclusion rooms

<table>
<thead>
<tr>
<th>Hospital</th>
<th>Address</th>
<th>Number/Wards</th>
</tr>
</thead>
<tbody>
<tr>
<td>Antelope House</td>
<td>Brintons Terrace, Southampton SO14 0YG</td>
<td>PICU</td>
</tr>
<tr>
<td>Ashford Unit</td>
<td>Woodhaven, Loperwood, Calmore, Southampton, SO40 2TA</td>
<td></td>
</tr>
<tr>
<td>Bluebird House</td>
<td>Tatchbury Mount, Horseshoe Drive, Calmore, SO40 2RZ</td>
<td>3 – Hill, Moss, Stewart</td>
</tr>
<tr>
<td>Evenlode</td>
<td>Littlemore Mental Health Centre Sandford Road</td>
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<td></td>
<td>Littlemore Oxford</td>
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<tr>
<td></td>
<td>Oxfordshire OX4 4XN</td>
<td></td>
</tr>
<tr>
<td>Parklands Hospital</td>
<td>Aldermaston Road, Basingstoke RG24 9RH</td>
<td>PICU</td>
</tr>
<tr>
<td>Ravenswood House</td>
<td>Knowle, Fareham PO17 5NA</td>
<td></td>
</tr>
<tr>
<td>Southfield</td>
<td>Tatchbury Mount, Horseshoe Drive, Calmore, SO40 2RZ</td>
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</tbody>
</table>
### Training Needs Analysis

If there are any training implications in your policy, please complete the form below and make an appointment with the LEaD department (Louise Hartland, Quality, Governance and Compliance on 02380 874091) before the policy goes through the Trust policy approval process.

<table>
<thead>
<tr>
<th>Topic/Subject</th>
<th>Frequency</th>
<th>Course Length</th>
<th>Delivery Method</th>
<th>Facilitators</th>
<th>Recording</th>
<th>Strategic &amp; Operational Responsibility</th>
</tr>
</thead>
</table>
| Conflict Resolution Training | Once followed by refresher every 3 years | Initial and Refresher – 3.5 hours | Face to face | LEaD | LEaD | Strategic - Medical Director  
Operational - Head of Nursing, AHP and Quality for MH. |

<table>
<thead>
<tr>
<th>Service</th>
<th>Target Audience</th>
</tr>
</thead>
<tbody>
<tr>
<td>MH/LD</td>
<td>All staff who are not required to complete Supporting Safer Services (sSs) training</td>
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</table>

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<tr>
<th>ISD</th>
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<tbody>
<tr>
<td>Adults</td>
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<tr>
<td>Children Services &amp; Quit for Life</td>
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</tbody>
</table>

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<tr>
<th>Corporate</th>
<th></th>
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<tbody>
<tr>
<td>Director of Nursing</td>
<td></td>
</tr>
<tr>
<td>Medical Director</td>
<td></td>
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<tr>
<td>Chief Executive</td>
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<td>Chief Financial Officer</td>
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<td>Development Director</td>
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<td>People of Communications</td>
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<td>Property and Estates</td>
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## Supporting Safer Services (sSs)

<table>
<thead>
<tr>
<th>Topic/Subject</th>
<th>Frequency</th>
<th>Course Length</th>
<th>Delivery Method</th>
<th>Facilitators</th>
<th>Recording Attendance</th>
<th>Strategic &amp; Operational Responsibility</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Full programme once only followed by annual Refresher</td>
<td>Full programme – 30 hours Refresher – 15 hours</td>
<td>Face to face</td>
<td>LEaD</td>
<td>LEaD</td>
<td>Strategic - Medical Director</td>
</tr>
<tr>
<td></td>
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<td></td>
<td>Operational - Head of Nursing, AHP and Quality for MH.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Service</th>
<th>Target Audience</th>
</tr>
</thead>
<tbody>
<tr>
<td>MH/LD</td>
<td></td>
</tr>
<tr>
<td>Adult Mental Health</td>
<td>All registered nurses, mental health practitioners, trainee practitioners and health care support workers who work in the following services; Elmleigh (Elmleigh Inpatients, Elmleigh FM); Antelope House (Hamtun, Trinity &amp; Saxon wards); Parklands Hospital (Hawthorns Inpatients, Hawthorns MOD &amp; Hawthorns PICU); Melbury Lodge (Kingsley Ward &amp; Mother &amp; Baby Unit).</td>
</tr>
<tr>
<td>Specialised Services</td>
<td>All registered nurses, mental health practitioners, trainee practitioners and health care support workers who work in the following services; Leigh House All registered nurses, mental health practitioners, occupational therapists, OT technicians, trainee practitioners and health care support workers who work in the following services; Ashford Unit, Ravenswood House (RSU Clinical Management, RSU Ashurst, RSU Lyndhurst, RSU Malcolm Faulk Ward, RSU Mary Graham Ward, Meon Valley Ward, RSU Therapies, RSU Clinical Risk &amp; Security Liaison, RSU Support Services); Southfield (Cedar, Oak and Beech wards, Southfield OT &amp; Southfield Reception and Security); Bluebird House (Bluebird Nursing &amp; Security, Hill Ward, Moss Ward &amp; Stewart wards, Bluebird House Site Services, Bluebird House OT, Bluebird Staff Dummy) and Specialised Services Management.</td>
</tr>
<tr>
<td>Learning Disability Services</td>
<td>All registered nurses, assistant/associate practitioners, and health care support workers who work in the following services; Willow Assessment &amp; Treatment Unit;</td>
</tr>
<tr>
<td>Older Persons Mental Health</td>
<td>All registered nurses, mental health practitioners, trainee practitioners and health care support workers who work in the following services; Gosport War Memorial Hospital (Dryad &amp; Daedalus wards); Melbury Lodge (Stefano Oliveri ward); Parklands Hospital (Beechwood &amp; Elmwood wards) and Western Community Hospital (Beaulieu &amp; Berrywood). All inpatient modern matrons (OPMH Western Management).</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>ISD</th>
<th>Adults</th>
</tr>
</thead>
<tbody>
<tr>
<td>Childrens Services &amp; Quit for Life</td>
<td>Not Applicable</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Corporate</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Director of Nursing</td>
<td></td>
</tr>
<tr>
<td>Medical Director</td>
<td></td>
</tr>
<tr>
<td>Chief Executive</td>
<td></td>
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<tr>
<td>Chief Financial Officer</td>
<td></td>
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<tr>
<td>Development Director</td>
<td></td>
</tr>
<tr>
<td>People and Communications</td>
<td></td>
</tr>
<tr>
<td>Property and Estates</td>
<td></td>
</tr>
<tr>
<td>Strategy Director</td>
<td>Not Applicable</td>
</tr>
<tr>
<td>Topic/Subject</td>
<td>Frequency</td>
</tr>
<tr>
<td>--------------------------------------</td>
<td>-------------</td>
</tr>
<tr>
<td>Seclusion and Long Term Segregation</td>
<td>Once only</td>
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<td><strong>Specialised Services</strong></td>
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</tr>
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<td>ISD</td>
<td><strong>Adults</strong></td>
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<tr>
<td></td>
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</tr>
</tbody>
</table>
Equality Impact Assessment (or ‘Equality Analysis’) is a process of systematically analysing a new or existing policy/practice or service to identify what impact or likely impact it will have on protected groups.

It involves using equality information, and the results of engagement with protected groups and others, to understand the actual effect or the potential effect of your functions, policies or decisions. The form is a written record that demonstrates that you have shown due regard to the need to eliminate unlawful discrimination, advance equality of opportunity and foster good relations with respect to the characteristics protected by equality law.

For guidance and support in completing this form please contact a member of the Equality and Diversity team

<table>
<thead>
<tr>
<th>Name of policy/service/project/plan:</th>
<th>Seclusion and Long-term Segregation Policy</th>
</tr>
</thead>
<tbody>
<tr>
<td>Policy Number:</td>
<td>SH CP 107</td>
</tr>
<tr>
<td>Department:</td>
<td></td>
</tr>
<tr>
<td>Lead officer for assessment:</td>
<td>Tim Coupland, Head of Nursing, AHP and Quality</td>
</tr>
<tr>
<td>Date Assessment Carried Out:</td>
<td>31.03.2015</td>
</tr>
</tbody>
</table>

1. Identify the aims of the policy and how it is implemented.

<table>
<thead>
<tr>
<th>Key questions</th>
<th>Answers / Notes</th>
</tr>
</thead>
<tbody>
<tr>
<td>Briefly describe purpose of the policy including</td>
<td>Creating and maintaining a safe and secure environment for service users, the staff it employs, visitors, contractors and all persons who visiting Mental Health in-patient units. This policy has been written to support the organisational framework for promoting equality and eliminating discrimination (Equality Delivery System):</td>
</tr>
<tr>
<td>▪ How the policy is delivered and by whom</td>
<td>✓ Service users and their carers should be made aware of the policy and its procedures</td>
</tr>
<tr>
<td>▪ Intended outcomes</td>
<td>✓ Service users and their carers should be involved in shared decision-making about the management of violent/aggressive behaviour through the use of seclusion.</td>
</tr>
</tbody>
</table>

**Person-centred care**
In order to create a genuinely service user-centred service several processes should be created to
enable users to contribute to the design and delivery of care. The aim is to promote a non-judgemental and collaborative approach to care (Department of Health, Mental health policy implementation guide 2002, p14).

**United Kingdom Central Council for Nursing, Midwifery and Health Visiting**

Violence directed to staff, service users or visitors is completely unacceptable. We should start from a position of Zero Tolerance, but then recognise that some service users, because of their illness, may behave in a violent (physical and non-physical manner) and that this condition may need special consideration.

### 2. Consideration of available data, research and information

Monitoring data and other information involves using equality information, and the results of engagement with protected groups and others, to understand the actual effect or the potential effect of your functions, policies or decisions. It can help you to identify practical steps to tackle any negative effects or discrimination, to advance equality and to foster good relations.

Please consider the availability of the following as potential sources:

- **Demographic** data and other statistics, including census findings
- Recent **research** findings (local and national)
- Results from **consultation or engagement** you have undertaken
- Service user **monitoring data**
- Information from **relevant groups** or agencies, for example trade unions and voluntary/community organisations
- Analysis of records of enquiries about your service, or **complaints** or **compliments** about them
- Recommendations of **external inspections** or audit reports

<table>
<thead>
<tr>
<th>Key questions</th>
<th>Data, research and information that you can refer to</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>2.1</strong> What is the equalities profile of the team delivering the service/policy?</td>
<td>The policy is relevant to all Trust staff. The Equality and Diversity team will report on Workforce data on an annual basis.</td>
</tr>
<tr>
<td><strong>2.2</strong> What equalities training have staff received?</td>
<td>All Trust staff undertake Equality and Diversity training as part of Corporate Induction (Respect and Values) and E-Learning. LEaD provides training in the management of violence and aggression.</td>
</tr>
<tr>
<td><strong>2.3</strong> What is the equalities profile of service users?</td>
<td>The Equality and Diversity team will report on service user data on an</td>
</tr>
<tr>
<td>Section</td>
<td>Question</td>
</tr>
<tr>
<td>---------</td>
<td>----------</td>
</tr>
</tbody>
</table>
| 2.4 | What other data do you have in terms of service users or staff? (e.g. results of customer satisfaction surveys, consultation findings). Are there any gaps? | The effectiveness of this policy will be reviewed on an annual basis and assessed by reviewing its implementation and application across the organisation in line with the requirements of the NHSLA minimum data set for Standard 4 – Safe Environment review will be led by the LSMS and approved by the MOVA and Health & Safety Committee. The Trust is aware and acknowledges the following resources:  
- Department of Health (1999) Homicides and Suicides Inquiry  
- Department of Health (1999) Zero Tolerance  
- Mental Health Act (1983) Code of Practice  
- United Kingdom Central Council (2002) The recognition, prevention and therapeutic management of violence and aggression  
- NICE (2005) Short term management of violent behaviour |
| 2.5 | What internal engagement or consultation has been undertaken as part of this EIA and with whom? What were the results? Service users/carers/Staff | ✓ Management of Violence and aggression Committee (MOVA)  
✓ Quality & Safety Committee  
✓ Trust Equality and Diversity Lead |
| 2.6 | What external engagement or consultation has been undertaken as part of this EIA and with whom? What were the results? General Public/Commissioners/Local Authority/Voluntary Organisations | Seclusion policies from similar Mental Health and Community Trusts have been reviewed. |
In the table below, please describe how the proposals will have a positive impact on service users or staff. Please also record any potential negative impact on equality of opportunity for the target:

In the case of negative impact, please indicate any measures planned to mitigate against this:

<table>
<thead>
<tr>
<th>Positive impact (including examples of what the policy/service has done to promote equality)</th>
<th>Negative Impact</th>
<th>Action Plan to address negative impact</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Age</strong></td>
<td><strong>Applied to all Protected Characteristics:</strong> Everyone has a duty to behave in an acceptable and appropriate manner. Staff have a right to work, as service users have a right to be treated, free from fear of assault and abuse in an environment that is safe and secure.</td>
<td><strong>Unqualified and junior staff are at greater risk than more senior, experienced staff (United Kingdom Central Council (2002))</strong></td>
</tr>
<tr>
<td></td>
<td>Incidents not considered serious enough (Beale et al 1999) - although serious incidents are not always reported (Owen et al 1998)</td>
<td>✓ Number of incidents being reported; ✓ Number of incidents passed onward to the Security Management team; ✓ The uptake of training programmes; ✓ Information</td>
</tr>
<tr>
<td></td>
<td>Monitoring data will be used to inform any changes</td>
<td>On-going: EqIA will be reviewed at Policy Review stage and monitoring data will be used to inform any changes</td>
</tr>
</tbody>
</table>
Staff exit interviews; 

**Employees** can expect that the Trust will: 
Uphold the principles of the Human Rights Act that all individuals should be treated with fairness, respect, equality, dignity and autonomy

Investigate all reported incidents of violence and aggression

Undertake continual monitoring and evaluation of such incidents

Provide advice, support and counselling to any employee involved in a violent or aggressive incident
<table>
<thead>
<tr>
<th>Category</th>
<th>Description</th>
<th>Responsible Party</th>
<th>Frequency</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Disability</strong></td>
<td>The Trust will ensure that all its facilities and estates are accessible and safe through: Disability Access Audits and the design of service areas and personal alarms</td>
<td>Service users with a dual diagnosis (co-existing mental illness and substance misuse) are much more likely to perpetrate a violent act than people with mental illness alone (United Kingdom Central Council 2002)</td>
<td>Estates and Facilities Management Local Security Management Specialist AMH Modern Matron/Area Lead Nurse</td>
</tr>
<tr>
<td><strong>Gender Reassignment</strong></td>
<td>The ethical framework used by the Trust will ensure each staff member and service user privacy and confidentiality are preserved</td>
<td>Transgender people may require seclusion in the event of violent and aggressive behaviour.</td>
<td>AMH Modern Matron/Area Lead Nurse</td>
</tr>
<tr>
<td><strong>Marriage and Civil Partnership</strong></td>
<td>The ethical framework used by the Trust will ensure each staff member and service user privacy and</td>
<td>All seclusion rooms are sole occupancy and provide appropriate single sex accommodation</td>
<td></td>
</tr>
<tr>
<td>Seclusion and Long-term Segregation Policy</td>
<td>Author: Dr Mayura Deshpande</td>
<td>Version: 8</td>
<td>May 2019</td>
</tr>
<tr>
<td>-----------------------------------------</td>
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</table>

| **Pregnancy and Maternity** | As above | Some community staff workplace may be service user’s home | Trust Lone Worker and individual staff risk assessments | Conflict Resolution Training | Local Security Management Specialist | On-going: EqIA will be reviewed at Policy Review stage and monitoring data will be used to inform any changes |

| **Race** | The David Bennett Inquiry (2004) highlighted the importance of considering the needs of black and minority ethnic groups when managing disturbed/violent behaviour in the short-term. | Discrimination based upon race affecting staff and service users. The effects of violence and aggression are wide-ranging and include not only physical injury, sometimes necessitating medical treatment, but also the emotional consequences which sometimes amount to post traumatic stress disorder | Policy and procedure will support staff in dealing with racist incidents | Local Security Management Specialist AMH Modern Matron/Area Lead Nurse | On-going: EqIA will be reviewed at Policy Review stage and monitoring data will be used to inform any changes |

<p>| <strong>Religion or Belief</strong> | The ethical framework used by the Trust will ensure each staff member and service user privacy and | | | | On-going: EqIA will be reviewed at Policy Review stage and monitoring data will be |</p>
<table>
<thead>
<tr>
<th><strong>Sex</strong></th>
<th>In terms of managing violent/aggressive behaviour in psychiatric in-patient settings, the main concern raised in <em>The women and mental health strategy</em> has been to identify gender specific needs, such as single-sex facilities, and to ensure that both male and female service users feel safe, listened to and involved in identifying and meeting gender related needs (<em>Mainstreaming gender and women’s mental health implementation guide</em> 2003).</th>
<th>All seclusion rooms are sole occupancy and provide appropriate single sex accommodation.</th>
<th>On-going: EqIA will be reviewed at Policy Review stage and monitoring data will be used to inform any changes</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Sexual Orientation</strong></td>
<td>The ethical framework used by the Trust will ensure each staff member and service user privacy and confidentiality are preserved. Gay, lesbian and bisexual individuals are likely to face additional concerns around homophobia and gender discrimination.</td>
<td>It is important that staff are trained to be aware of the specific requirements of the Equality Act 2010 and Human Rights Act.</td>
<td>Equality and Diversity Lead</td>
</tr>
</tbody>
</table>
Human rights will therefore be reflected where it is appropriate to do so in general training within SHFT. This includes Corporate Induction Training, Respect and Values and E-Learning.