Seclusion Policy

Policy Number:	609	Supersedes:		Classification	Clinical

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Brief Summary of Document:	The aim of the policy is to ensure that the decision to seclude and the seclusion is carried out in accordance with the Mental Health Act 1983 Code of Practice for Wales Review (Revised 2016) and that relevant safeguards are put in place to protect the patient, the staff and the organisation.
Scope:	This policy applies to both formal and informal patients (children, young people and adults) who present with behaviours which pose actual and/or potential harm to others and where the patient has not responded to other de-escalation strategies or identified therapeutic interventions. The policy also applies to patients where a decision to seclude has been deemed necessary. This policy applies to nursing and medical staff who work within the Mental Health and Learning Disabilities inpatient and residential settings.
To be read in conjunction with:	514 - Management & Investigation of Incidents Policy 177 – Engagement & Observation Policy 374 – Mental Capacity Act (2005) Policy

Owning Group	Written Control Document Group – MHLD Directorate

Executive Director:	Joe Teape	Job Title	Deputy Chief Executive

Reviews and updates		
Version no:	Summary of Amendments:	Date Approved:
1	Complete review of MH & LD Division - Policy for Seclusion code of Practice. Pembrokeshire & Derwen NHS Trust.	3/10/2018

Glossary of Terms

Term	Definition
MHLD	Mental Health and Learning Disabilities
PICU	Psychiatric Intensive Care Unit
MH	Mental Health
LD	Learning Disability
MHA	Mental Health Act
QSEASC	Quality Safety Experience Assurance Sub Committee
MHLAC	Mental Health Legislation Assurance Committee
WAG	Welsh Assembly Government
IMCA	Independent Mental Capacity Advocate
IMHA	Independent Mental Health Advocate
Formal IMCA	Patients detained under the Independent Mental Health Act 1983 Capacity Advocate
Informal NAPICU	In patients who have not been detained under the Mental Health Act National Association of Psychiatric Intensive Care & Low Secure Units
Responsible Clinician (RC)	This is the approved clinician who will have overall responsibility got the patient's care.
Approved Clinician	A mental health professional approved by the Welsh Ministers to act as an approved clinician for the purposes of the Act. Some decisions under the Act can only be taken by people who are approved clinicians. All responsible clinicians must be approved clinicians.
De-escalation techniques	A set of non-physical interventions intended to reduce a person's heightened state of arousal and the risk of harm to self, others and the environment.
Advance Statement / Crisis Management Plan	A plan that has been previously agreed with the patient and care team that outlines potential courses of intervention should the patient express a wish to be confined at a time when he maintains capacity to make that decision
Clinical Observation	The practice of maintaining knowledge of the patient's location in the clinical area by use of visual contact and is a therapeutic intervention that can be used intensively to increase safety for patients at risk and should be an integral part of clinical risk management. Clinical observation can be used with different levels of intensity dependent upon the clinical risks and the clinical needs presented by the patient. There are 4 x levels of observation:- • Level 1 = General

	• Level 2 = Intermittent • Level 3 = Constant within eyesight • Level 4 = Constant at arms' length

Key words
Seclusion; segregation; RPI, de-escalation, violence & aggression, assault, human rights, time out.

1. INTRODUCTION

Hywel Dda University Health Board ("the Health Board") recognises that it has a legal duty in line with Health and Safety legislation, so far as is reasonably practicable, to protect its patients, staff and visitors. The Health Board is committed to supporting staff, patients, carers and visitors in the event of adverse situations and recognises that providing a safe environment is paramount to its success.

The Health Board will ensure that the physical safety and emotional wellbeing of its patients remain a priority for all staff at all times. However, the Health Board recognises that there may be times when a patient needs to be removed from the ward environment and secluded away from others for the safety of all. During that circumstance staff will ensure that the patient receives the care and support rendered necessary both during and after seclusion has taken place.

2. POLICY STATEMENT

The Health Board is committed to implementing The Mental Health Act 1983 Code of Practice for Wales Review (Revised 2016), referred to hereafter as The Code, guiding principles which form the foundations of services that excel in the delivery of evidenced-based, effective and humane care and treatment in relation to seclusion.

3. SCOPE

This policy applies to both formal and informal patients (children, young people and adults) who present with behaviours which pose actual and/or potential harm to others and where the patient has not responded to other de-escalation strategies or identified therapeutic interventions. The policy also applies to patients where a decision to seclude has been deemed necessary.

The term patient refers to patients, clients, service users or residents who have been admitted to a Mental Health or Learning Disabilities Unit.

This policy applies to nursing and medical staff who work within the Mental Health and Learning Disabilities inpatient and residential settings.

4. AIM

The aim of the policy is to ensure that the decision to seclude and the seclusion is carried out in accordance with The Code and that relevant safeguards are put in place to protect the patients, the staff and the organisation.

5. OBJECTIVES

The aim of this policy will be achieved by the following objectives:

- Ensuring that staff are clear about the procedure to follow and that the procedure is readily available
- Ensuring inpatient clinical staff understand their roles and responsibilities in relation to the use of seclusion and longer term seclusion and work within legal and procedural guidance
- Ensuring that seclusion or longer term seclusion takes place in a suitable environment and takes account of the patient dignity and physical and mental well-being
- Promoting best practice principles and ensure consistency across the Health Board
- Safeguarding a patient's rights and maintain their welfare throughout any episode of seclusion or longer term seclusion
- Recording each period of seclusion or longer term seclusion completely and contemporaneously.

6. PROCEDURE

6.1 Definitions:

6.1.1.Seclusion

The Code (2016) defines seclusion as the supervised confinement of a patient in a room, which may be locked. However, good practice recommends that services that use seclusion should have a designated seclusion room.

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.

At all times, the use of seclusion should be based on patient need, used as a last resort and employed for the shortest possible time. Seclusion should never be used as a punishment or threat, a routine part of a treatment programme or because of a shortage of staff. A suitably skilled practitioner should be readily available within sight and sound of the seclusion room at all times throughout the period of the patient's seclusion.

Seclusion may also be referred to as:

- High Care
- Time Out
- Extra care
- Therapeutic isolation

The above is not an exhaustive list of alternative terms for seclusion.

6.1.2 Long Periods in Seclusion

On occasions it may be appropriate for a patient, with very specific needs, to be in seclusion for longer periods. In contrast to seclusion, longer term seclusion is not an emergency response to an acute incident, rather it is a planned restriction in response to a chronic presentation of violence and aggression which is used to create the optimal situation in which to provide care and treatment and promote recovery. The Code replaces the previous term ‘long term segregation’ with ‘longer term seclusion’. This should only be undertaken following a multidisciplinary assessment.

If the individual lacks capacity the appropriate use of an IMCA is recommended in line with Hywel Dda UHB Policy 374 – Mental Capacity Act (2005).

The approach to any longer term seclusion must be the least restrictive possible in the circumstance, with a care and treatment plan that gradually enables the patient to begin to reintegrate, for example; receiving visits, access to the main ward area for meals and to a safe outside space. The regime must be subject to regular review in line with locally agreed safeguards.

6.2 General Care Planning

Patients who are in need of care and treatment may present a risk to themselves or others. Such risks are usually associated with behaviours that challenge others, which might include hyperactivity, absconding, self-harming, sexual disinhibition, sexually inappropriate behaviour towards others, aggressive and threatening behaviour towards others and physical violence.

When working with a patient who exhibit such behaviour, staff should support the patient in a therapeutic manner, and in ways that ensure patient safety and optimise their privacy and dignity.

As part of the ongoing assessment, staff should discuss with the patient, whenever possible, any immediate and potential risks they may present to themselves or others. Where such risks are identified, staff and the patient should seek to agree how these risks can be minimised and the care and treatment plans should include the necessary interventions. A WARRN risk assessment should be used to develop a positive behaviour support plan which can include an advance statement that expresses patients' preference on how an episode of severe behavioural disturbance should be dealt with. The WARRN risk assessment is available on the electronic patient record and is used within HDdUHB Mental Health and Learning Disabilities directorate (Appendix 5). Where appropriate, input should be sought from family members/carers and/or the Independent Mental Health Advocate (IMHA) or Independent Mental Capacity Advocate (IMCA) Services.

Interventions to manage the risks associated with challenging behaviour should always be carried out in a way that minimises patient distress and discomfort, promotes dignity and never in a way that intentionally subjects a patient to physical pain. Interventions may however, be perceived as punitive, the patient must be as involved as much as practicable in managing their own behaviour and be given a rationale for the use of the interventions if agreement cannot be reached.

Where it has been agreed in a Positive Behaviour Support Plan (Appendix 6) with the patient that family members, carers or Advocates will be notified of significant behavioural disturbances and the use of restrictive interventions, this must be carried out as agreed in the plan. The Positive Behaviour Support Plan is available on the electronic patient record and is used within HDdUHB Mental Health and Learning Disabilities directorate (Appendix 6).

6.3 Patients' Rights

Patients in seclusion are guaranteed the following rights:

- To have their rights explained verbally and in written/pictorial form as appropriate
- To be treated with dignity and respect and have their views listened to, recorded, valued and taken into account
- For patients' families and carers to be treated with dignity and respect and have their views listened to, recorded, valued and taken into account
- To be cared for by the most appropriate members of staff as identified by the multi-disciplinary team assessment
- To be as fully involved as possible in the development and review of a positive behaviour support
- To be given the reason(s) for being placed in seclusion
- To be told under what conditions seclusion will start and end
- To be aware of the day of the week and the time of day from the seclusion room or by regular simple orientation being provided for the patient on request. Patients in seclusion for longer periods should have access to a clock and a calendar for this reason
- To know how to summon the attention of staff whilst in seclusion.
- To receive adequate food and fluids at regular intervals
- To be given appropriate access to toilet and washing facilities
- To be appropriately clothed at all times
- To practice their religious observance following a risk assessment
- To be visited by and given the opportunity to speak to the staff undertaking the reviews
- To receive advocacy, legal and family/carer visits following risk assessment

An entry must be made in patient's care record confirming that the rights have been communicated with the patient and where appropriate their family/carer(s).

6.4 When Can Seclusion Be Used

Seclusion can only be used for the containment of severe behavioural disturbance that is likely to cause harm to others and where the patient has not responded to other de- escalation strategies or identified therapeutic interventions.
When a patient poses a risk of harm to others as well as themselves, 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.

NICE guidance states that:
Seclusion should only be considered where there is a clear and identified risk that the person who is to be secluded presents a significant degree of danger to other people; and that the situation cannot be managed more safely or appropriately by any other means. It should only take place in the context of a clear care plan, with a concern for the safety of the individual and ensuring that the restriction is not perceived as a punishment.

Seclusion can be used for both and an informal as well as formal patient. However, in the case of an informal patient this policy must be enacted concurrently with an immediate application of either a Doctor's Holding Power section 5(2) or a Nurses Holding Power section 5(4). This must be followed by an immediate Mental Health Assessment.

When deciding to place a patient in seclusion, a clear rationale must be detailed in the patient's care record (see Appendix 1 for seclusion documentation and flowchart) evidencing 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.

6.5 When Seclusion Must Not Be Used

- It must not be used solely as a means of managing self-harming behaviour
- It must not be used as a punishment or a threat
- It must not be used because of shortage of staff
- It must never form part of a routine treatment programme
- It must not be identified as first line of intervention on any advance statement

7. ADDITIONAL CONSIDERATIONS FOR CHILDREN AND YOUNG PEOPLE

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

Staff must be mindful that seclusion, 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 seclude. 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 longer term seclusion should only be used when other strategies to de-escalate behaviours and manage risks have been exhausted.

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.

8. DESIGNATED SECLUSION ROOM

Seclusion is the supervised confinement of a patient in a room, which may be locked.
Services that use seclusion should have a designated seclusion room that:

- Provides privacy from other patients, but enable staff to observe and communicate with the patient in seclusion at all times;
- Is safe and secure, and does not contain anything which could cause harm to the patient or others;
- Is quiet, but not soundproofed, and with some means of calling for attention;
- Is well insulated and ventilated, with temperature controls outside the room;
- Has access to toilet and washing facilities;
- Has furniture which should include a bed, pillow, mattress and blanket or covering, window(s) and door(s) that can withstand damage.
- Has externally controlled lighting, including a main light and subdued lighting for night time
- has no blind spots, and alternate viewing panels should be available when required
- Has a clock that is always visible to the patient from the room.

In addition to the above the NAPICU minimum standards (2014) require that:

- The seclusion room should be located in an area away from the main patient areas and bedrooms.
- The seclusion room door must open outwards.
- The seclusion room should be no less than 15 m_2.
- It should not be possible to reach any fixtures and fittings (including lighting), even from standing on the bed.
- The bed within the seclusion room should not be moveable and should have padding which cannot be removed, is robust and easily cleaned.

9. SECLUSION PROCEDURE

The seclusion process can be separated into 3 distinct parts:

- Starting (initiating)
- Reviewing
- Ending (termination)

The procedure is set out in appendix 1 which is to be followed.

Relative, Carer and/or Advocate

Relatives, carers and/or advocates should, as a routine, be invited to be involved with the care of the patient consents to this or when it is assessed as being in the patient best interest.

When seclusion is assessed as being required, explanations to the patient and the relatives, carers or advocate about why the additional support is required must be provided sensitively by the Nurse in Charge. Co-production of all care plans are best practice and integral to a successful outcome for the patient.

10. MONITORING

10.1 Incident reporting

Each time a patient is secluded an incident report is made in line with Hywel Dda UHB Policy 514 – Management and Investigations of Incidents.
All episodes of seclusion must be reported through the incident reporting system (Datix) which includes notification to Service Management, Directorate management team and Executive Leads.

10.2 Review

Each time a patient is secluded the care team requires to review the documentation used to support the seclusion (see appendices) for timeliness, completeness and robustness of evidence and rationale for decision making.

Once a patient's seclusion episode has come to an end:
Copies should be retained in a separate seclusion folder. The purpose of this folder is to retain 12 months' worth of seclusion records for audit and inspection purposes.

10.3 Audit

The Mental Health Act Administration Team audit all seclusion paperwork as part of the Mental Health Act annual audit cycle.

10.4 Reporting

A themed report of seclusion is provided on a quarterly basis and provided to the Mental Health & Learning Disabilities Quality Safety Experience Sub Committee (MH&LD QSESC) with additional reports when requested.

10.5 Escalation

If seclusion takes place outside of designated seclusion facilities, e.g. if a restrictive intervention meets the definition of seclusion, this constitutes a breach of The Code. The safeguards of this policy should be implemented for such incidents of seclusion AND the Director for Nursing, Quality and Patient Experience, Clinical Director MH&LD, Operational Director MH&LD, Head of Nursing MH&LD, relevant operational managers and the Mental Health Act Manager must be informed.

11. SECLUSION FOR LONGER PERIODS

11.1 Definition

Under the Code of Practice for Wales (2016) para 26.49 it is stated that:

"There may be occasions where it is appropriate for an individual, with very specific needs, to be in seclusion for longer periods. This should only be undertaken following a multidisciplinary assessment and if the individual lacks capacity the appropriate use of an IMCA is recommended. The approach to any longer term seclusion must be the least restrictive possible in the circumstance with a care and treatment plan that gradually enables the patient to begin to reintegrate, for example; receiving visits, access to the main ward area for meals and to a safe outside space. The regime **must** be subject to regular review in line with locally agreed safeguards".

'…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 commission authority determines that a patient should not be allowed to mix freely with other patients on the ward or unit on a long-term basis. 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.'

11.2 The Procedure for Longer Term Seclusion (LTS)

The procedure for longer term seclusion requires a Multi-Disciplinary Team discussion as part of Positive Behavioural Support plan (Appendix 6).

Longer term seclusion of a patient must only be considered where:

- All other forms of treatment and management have been considered as ineffective/ inappropriate (e.g. behavioural management plans including those to manage 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 require LTS when attempts to end seclusion have been repeatedly unsuccessful due to ongoing high risk of harm towards others. In all cases, a decision should be made by the patient's Responsible Clinician in conjunction with the MDT.

Longer term seclusion may only be considered for patients detained under the MHA 1983.

The Health Board places the decision to consider a patient as long-term dangerous and requiring management under a longer term seclusion regime with the patient's multidisciplinary team.

Longer term seclusion therefore does not need to be restricted to take place in a designated seclusion room.

The procedure is set out in appendix 1 which is to be followed.

12. RESPONSIBILITIES

12.1 Chief Executive Officer

The Chief Executive Officer has ultimate responsibility for supporting the development of initiatives to support patient safety; this includes the safe management of seclusion.

12.2 Clinical Directors and Operational Senior Managers

Clinical Directors and operational senior managers are responsible for the policy implementation and compliance within their respective locality and speciality.

12.3 Professional Leads/Ward Managers

Professional leads/ ward managers are responsible to ensure members of their teams are familiar with this policy and understand their responsibilities in relation to the implementation of this policy and procedure.

12.4 Staff

Staff are responsible for the implementation of this policy and procedure in their area of responsibility. This extends to the supervision of unregistered/support staff when tasks are delegated. Staff are also responsible to ensure that they have undertaken continuing professional development and maintain the required competencies to implement this policy and procedure.

13. REFERENCES

- Department of Health (2015). *Mental Health Act 1983*. London, HMSO. (http://www.legislation.gov.uk/ukpga/1983/20/contents)
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- Hywel Dda Health Board 2011. *Policy 106 - Therapeutic Management of Acutely Disturbed Patients in Adult In- patient Mental Health Settings Protocol* (Revised 2015) (http://howis.wales.nhs.uk/sitesplus/862/document/244742)
- Hywel Dda Health Board 2011. *Policy 177 – Engagement & Observation Policy* (Revised 2011) (http://howis.wales.nhs.uk/sitesplus/862/document/281617)

14. APPENDIX 1 - SECLUSION CARE PATHWAY

Timeline	Type of review	What records to complete. Who should be involved
0 hours	**Seclusion started** (section 6) informing others (section13)	• Part 1 – seclusion pathway 'initiation record' • Seclusion book • Progress note • Inform relevant people
0 hours and **throughout seclusion**	**Seclusion observations** (section 7)	Constant observations with a record made at a minimum of every 15 minutes. • Seclusion care Pathway 'Observation record' • Use trick & trigger for observations following rapid tranquilisation (if appropriate)
Within 1 hour And **every 4 hours** until First MDT review	**Medical review** (section 8.1 & 8.2) **Care Planning** (section 9)	First medical review. Review by doctor or suitably qualified approved clinician. • Review Seclusion Care Pathway Part 1 • Complete part 2 Seclusion Care Pathway • If seclusion continues complete Part 3 and 5.
Every 2 hours throughout seclusion	**Nursing review** (section 8.4)	Two registered nurses (or one registered nurse with one suitably skilled practitioner) • Seclusion Care Pathway 'Observation record' • Seclusion Pathway part 4 'Nursing review'
As soon as practicable after seclusion starts and then once every 24 hours	**MDT review** (section 8.4)	Review by RC or medical AC and senior nurse plus staff from other disciplines (out of hours) • Seclusion Pathway part 6 – MDT review • Progress note
Twice in 24 hour period after internal MDT review	**Medical review** (section 8.5)	Twice in 24 hours – one by RC (or AC) and one by other doctor after 24 hours the internal MDT review can count as a medical review. • Seclusion pathway part 5 'medical review' • Progress note.
If secluded 8 hours continuously or 12 hours intermittently over a 48 hour period	**Independent MDT review** (section 8.8)	Review by AC or medical AC and senior nurse plus staff from other disciplines (not involved in initial seclusion) or senior site manager, involve IMHA if available. • Seclusion pathway part 7 – 'independent review' • Progress note
End of seclusion At review or if practitioner in charge assesses seclusion not required.	**End of seclusion review** (section 11 & 12)	• Seclusion care pathway part 4 'Review' • Progress note • Seclusion book • Debrief for patient and update care plans • Debrief for staff to be arranged.

Part 1: INITIATION RECORD

Complete this at start of seclusion and upload to Patient Electronic Record.

Patient's name	**DOB**
NHS No	**MHA Status**
Date of commencement of seclusion	
Time of commencement of seclusion (24 hr clock)	
Name and designation of practitioner initiating seclusion:	

Interventions used prior to seclusion (please describe)	
De-escalation	
Medication (drug name, dose and route of administration)	
Restraint (duration, type)	
Reason for seclusion (to be completed by nurse in charge)	
Has patient been advised of rights as detailed in Section 6.3 of 609 - Seclusion Policy? Yes ☐ No ☐ State why	
Datix incident report completed? ☐	DATIX number:
Seclusion Book completed? ☐	
Practitioner allocated to continuously observe? ☐ Name: Role: 177 - Engagement and Observation Policy	
Senior nurse on duty informed? ☐	RC/Duty doctor informed? ☐

PART 2: FIRST MEDICAL REVIEW

(Within 60 minutes of commencement of seclusion)

Vital Signs If unable to enter the seclusion room and record vital signs, record observation of respiration, alertness and responsiveness.
Behaviour & Verbal Interaction
Review of Observations (minimum required every 15 minutes)
Effects of Medication & Review of Further Medication
Risk to Others
Risks to Self
Should seclusion continue? If so, document why. Consider if seclusion may be applied flexibly.
If seclusion ends, was the patient offered a debrief? Yes ☐ No ☐ **Did the patient accept the debrief? Yes ☐ No ☐** **If the patient is not offered a debrief, or declines, please record the reason here; otherwise, please give a summary of the debrief on the patient's electronic records.**
Name & Post of Doctor

Signature	**Date & Time**

Part 3 – INTERIM SECLUSION CARE PLAN

To be completed by professional in charge

Patient's name	**DOB**
NHS No	**MHA Status**
Date of commencement of seclusion	
Time of commencement of seclusion (24 hr clock)	

CONSIDER THE FOLLOWING:

How will you meet with patient's following needs:	Action	Time required by	Patient responsible
Personal Care (toilet, washing, clothing etc)			
Nutrition and hydration (consider dietary requirements)			
Medication (consider both physical and mental health needs)			
Sleep (consider environment comfort, temperature, lighting, bedding etc)			
Carer/advocate involvement Consider when you will contact, how you will contact, frequency of updates and visiting.			
Other Are there any additional needs that have not been identified above?			
De-escalation Consider how de-escalation attempts will continue and how risks will be managed			
Post seclusion support Consider support, debrief, physical health check and appropriate timeliness of these interventions.			

How will you assess the need to terminate seclusion?

- What will the patient's presentation be in order to safely terminate seclusion?
- Verbal and non verbal communication.
- Triggers indicating escalation

PART 4 – TWO HOURLY NURSING REVIEW

To continue until end of seclusion

Patient's name	**DOB**
NHS No	**MHA Status**
Date of commencement of seclusion	**Time of commencement of seclusion (24 hr)**
Date	**Time**
Mental state	
Effects of Medication including side-effects	
Risk to others	
Risk to self	
Is seclusion to continue? Yes ☐ State why **No ☐** ***(include what attempts have been made to deescalate behaviour)***	
If seclusion ends, was the patient offered a debrief? Yes ☐ No ☐ **Did the patient accept the debrief? Yes ☐ No ☐** **If the patient is not offered a debrief, or declines, please record the reason here; otherwise, please give a summary of the debrief on the patient's RiO progress notes.**	
Has the patient's MHA status changed? Yes ☐ No ☐	
1) Name & designation of practitioner in charge: **Signature:**	**2) Name & designation of practitioner in charge:** **Signature:**

PART 5 – MEDICAL REVIEW

Every four hours until First (internal) MDT Review & twice daily after 24 hours

Patient's name	**DOB**
NHS No	**MHA Status**
Date of commencement of seclusion	**Time of commencement of seclusion (24 hr)**
Date	**Time**
Mental state	
Effects of Medication including side-effects	
Risk to others	
Risk to self	
Is seclusion to continue? **Yes** ☐ State why **No** ☐	
If seclusion ends, was the patient offered a debrief? **Yes** ☐ **No** ☐ **Did the patient accept the debrief? Yes** ☐ **No** ☐ **If the patient is not offered a debrief, or declines, please record the reason here; otherwise, please give a summary of the debrief on the patient's RiO progress notes.**	
Has the patient's MHA status changed? **Yes** ☐ **No** ☐	
Name & designation of practitioner in charge:	**Signature:**
Name & designation of doctor:	**Signature:**

PART 6 – INTERNAL MDT REVIEW

To be conducted as soon as possible after seclusion commences and once a day after 24 hours

Patient's name	**DOB**
NHS No	**MHA Status**
Date of commencement of seclusion	**Time of commencement of seclusion (24 hr)**
Date	**Time**
Mental state	
Effects of medication including side-effects	
Risk to others	
Risk to self	
Is seclusion to continue? Yes ☐ State why **No ☐**	
If seclusion ends, was the patient offered a debrief? Yes ☐ No ☐ **Did the patient accept the debrief? Yes ☐ No ☐** **If the patient is not offered a debrief, or declines, please record the reason here; otherwise, please give a summary of the debrief on the patient's RiO progress notes.**	
Changes to seclusion care plan	
Has the patient's MHA status changed? Yes ☐ No ☐	
Name & designation of practitioner in charge:	**Signature:**
Name & designation of Approved Clinician:	**Signature:**
Names of professionals who participated in review	

PART 7 – INDEPENDENT MDT REVIEW

To be conducted after 8 hours of continuous seclusion

Patient's name	**DOB**
NHS No	**MHA Status**
Date of commencement of seclusion	**Time of commencement of seclusion (24 hr)**
Date	**Time**
Mental state	
Effects of medication including side-effects	
Risk to others	
Risk to self	
Is seclusion to continue? Yes ☐ State why **No ☐**	
If seclusion ends, was the patient offered a debrief? Yes ☐ No ☐ **Did the patient accept the debrief? Yes ☐ No ☐** **If the patient is not offered a debrief, or declines, please record the reason here; otherwise, please give a summary of the debrief on the patient's RiO progress notes.**	
Changes to seclusion care plan	
Has the patient's MHA status changed? Yes ☐	**No ☐**
Name & designation of practitioner in charge:	**Signature:**
Name & designation of Approved Clinician:	**Signature:**
Names of professionals who participated in review	

PART 8 – Patient in Charge Decision to End Seclusion

To be used if Patient in Charge decides that seclusion is no longer required. Please use the boxes to below to describe why the patient no longer requires seclusion

Patient's name	**DOB**
NHS No	**MHA Status**
Date of commencement of seclusion	**Time of commencement of seclusion (24 hr)**
Date	**Time**
Mental state	
Effects of Medication including side-effects	
Risk to others	
Risk to self	
If seclusion ends, was the patient offered a debrief? Yes ☐ No ☐ **Did the patient accept the debrief? Yes ☐ No ☐** **If the patient is not offered a debrief, or declines, please record the reason here; otherwise, please give a summary of the debrief on the patient's RiO progress notes.**	
Has the patient's MHA status changed? Yes ☐ No ☐	
Name and designation of Responsible Clinician or duty doctor consulted	
Name & designation of practitioner in charge:	**Signature of practitioner in charge**

15. APPENDIX 2: LONGER TERM SECLUSION PATHWAY

Part 1: INITIATION OF LTS

To be completed by patient's Responsible Clinician

Patient's name	**DOB**
NHS No	**MHA Status**
Date of commencement of LTS	
Time of commencement of LTS (24 hr clock)	

REASON FOR LTS	
Have the following been consulted? All consultation and notifications must be recorded in the patients electronic records.	
Date IMHA consulted	
Date Family/carers consulted	
Date Care Coordinator consulted	
Datix number (reporting of LTS initiation): Have you notified the Health Board Safeguarding Team? **Safeguarding team Yes** ☐ **No** ☐ State why	
Name of Responsible Clinician	**Signature of Responsible Clinician**

PART 2: LTS OBSERVATION RECORD

Nurse allocated to observe the person in LTS must complete every hour.

Patient's name	**DOB**
NHS No	**MHA Status**
Date of commencement of LTS	

DATE & TIME	DESCRIPTION OF THE PATIENT'S BEHAVIOUR	PRACTITIONER'S NAME AND DESIGNATION	PRACTITIONER SIGNATURE

PART 3: DAILY REVIEWS

A medical review by an AC and a nursing review by two nurses are required each day.

Patient's name	**DOB**
NHS No	**MHA Status**
Date of commencement of LTS	
Date of review	

Mental State & Medication	
Physical Health	
Risks to Others	
Can less restrictive interventions be used?	
Name and designation of professional	**Signature**

PART 4: WEEKLY MDT REVIEW

Person's name	**DOB**
NHS No	**MHA Status**
Date of commencement of LTS	
Date of review	

Mental State & Medication	
Physical Health	
Risks to Others	
Therapeutic Programme	
Can less restrictive interventions be used? If not, explain why.	
Can LTS be terminated? If so, is de-briefing and re-integration plan in place?	
Name of RC or deputy	**Signature**
Name of Ward Manager or deputy	**Signature**
Please list all professionals who took part in this review	

PART 5: WEEKLY PERIODIC REVIEW BY CONSULTANT PSYCHIATRIST NOT INVOLVED IN THE CASE

Person's name	**DOB**
NHS No	**MHA Status**
Date of commencement of LTS	
Date of review	

Mental State & Medication	
Physical Health	
Risks to Others	
Can less restrictive interventions be used? If not, explain why.	
Can LTS be terminated? Please give reasons for decision.	
Name of consultant psychiatrist	**Signature**

16. APPENDIX 3: SECLUSION/LTS BOOK

Name of Patient	Seclusion or LTS	Ward/Unit	Legal Status under MHA at time of Seclusion/LTS	Time and Date of Entry into Seclusion /LTS	Full Reason and Rationale for Seclusion/LTS (frequency of observations)	Full Name and Job Title of Decision Maker(s) to Seclude or LTS	Time and Date of Seclusion/LTS end	Total Time in Seclusion/LTS (HH:MM)

17. APPENDIX 4: SECLUSION TOOLKIT

DECIDING TO SECLUDE A PATIENT AND STARTING SECLUSION

Initiating Seclusion

Authorisation of secluding a patient can only be done by:

- A Psychiatrist or;
- Approved clinician under the MHA or;
- The healthcare professional in charge of the unit.

However, if the professional authorising the seclusion is not the patient's responsible clinician or the approved clinician is not a doctor, the following staff members should be informed within 30 minutes of the initiation of the seclusion process or as soon as practicable possible:

- The patient's responsible clinician or if unavailable, the duty doctor (this can be the trainee psychiatrist on-call)
- The senior nurse on duty with service (e.g. service manager on-call, if out of hours)

Deciding to seclude:

Is the patient displaying severely disturbed behaviour?

↓

Is this behaviour likely to cause harm to others?

↓

Have other practicable methods of intervention / de-escalation been considered or tired?

↓

Decision to seclude may be made by a Doctor, suitably qualified AC or person in charge.
The following must be completed:

- An Incident Form (DATIX)
- The unit's seclusion log book
- Initiating seclusion part of the Seclusion Care Pathway

↓

First internal MDT must be held as soon as is practicable

** If out of hours, the Duty Doctor must be contacted and take part in MDT**

.

REVIEWING SECLUSION

The Code of Practice sets out the timings and requirements for reviewing seclusion:

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) documented 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.

The Seclusion Care Pathway (SCP)

Each patient who is placed in seclusion will have SCP. A new SCP will be started for each period of seclusion: one seclusion period is indicated by the starting and ending of seclusion.

The seclusion log book:

The seclusion log book of your unit or ward to capture each use of seclusion.

TERMINATING SECLUSION

The professional in charge decides, in consultation with the patient's RC or duty doctor, whether it is appropriate to end seclusion
OR
A medical review, internal MDT or Independent MDT determines that seclusion is no longer warranted.

↓

Bringing the patient back on to the Unit (Re-Integration)
Nursing time should be allocated to re-integrate the patient back on to the ward
A de-brief / discussion with the patient should be held and should include:

- Does the patient understand why they were secluded?
- How does the patient feel about the need to seclude?
- How does the patient feel now after the event?
- How can we avoid further episodes of seclusion?

↓

Staff debrief should also be available.

Terminating seclusion

Seclusion should immediately end when an MDT review, a medical review or the independent MDT review determined that 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 by telephone.
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 seclusion.

DECIDING TO USE LONGER TERM SECLUSION

RC and MDT decides that patient requires long-term seclusion
Representative from commissioning body must be involved in the decision, the views of the patient, family / carers and IMHA must also be considered. The Safeguarding Team should be informed.

↓

LTS should be reviewed as follows:

- Written observation notes at least every hour
- Daily review by approved clinician (who need not be a doctor)
- At least weekly review by the full MDT (including the patient's Responsible Clinician or deputy, ward manager or deputy and IMHA)
- Weekly review by a consultant psychiatrist not involved with the patient
- If LTS continues beyond 3 months, review by an external hospital and discussion with IMHA and commissioner.

↓

Termination of LTS:

LTS may be terminated by the decision of an MDT. The MDT should consist of, as a minimum, the patients Responsible Clinician and the ward manager. The patient's IMHA should be consulted.
LTS must be terminated if it is determined that the patient's risks have reduced sufficiently to allow them to be re-integrated into the ward. This will include a thorough risk assessment and take into account observations from staff of the patient's presentation in the company of others.

↓

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

The process for longer-term seclusion

The process for longer-term seclusion would require a full Multi Disciplinary Team discussion as part of a full behavioural plan.

Long-term seclusion of a patient must only be considered where:

- 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.

LTS may only be considered for patients detained under the MHA 1983.
The patient's RC must complete Long-term Seclusion Pathway Part 1:
'Initiation of LTS' (Seclusion Toolkit)
The Health Board places the decision to consider a patient as long-term dangerous and requiring management under a long-term seclusion regime with the patient's multidisciplinary team.

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

Who else must be consulted when initiating LTS?

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 considered 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 their best interests must be documented in the patients electronic care record.
- When capacity is assessed the IMCA must be involved.
- The local safeguarding team should be informed and a referral made.

REVIEWING LONGER TERM SECLUSION

Overview of LTS and Monitoring Process
Written record every hour by person supporting the patient in LTS followed by observations
Daily review by an approved clinician, who need not be a doctor, form needed for review.
Weekly review by the full MDT (including patient's Responsible Clinician or deputy, ward manager or deputy, and IMHA)
Weekly review by a consultant psychiatrist not involved with the patient
If LTS continues beyond 3 months, review by an external hospital, and discussion with IMHA and commissioner

Observation during LTS

Staff should make a record of the patient's mental state, communication, behaviour and risks to self and to others on an hourly basis. Records should be made at least every hour.

LTS environment

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

TERMINATING LONGER TERM SECLUSION

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. 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.

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

Monitoring seclusion and LTS documentation

- Each episode of seclusion and LTS requires an incident report.
- Each ward must have arrangements in place to scrutinise completion of documents used in seclusion and LTS
- The MHA team will audit all seclusion paperwork as part of the MHA annual audit cycle

18. APPENDIX 5 – WARRN

WARRN

Name: _____

Assessors name:…… **Date:……**
Signature:……

Surname:_____
___
First Name(s):_____
Address:_____
___
Postcode:_____

RISK FORMULATION

5 Ws

WHAT:

What is the nature of the risk (describe). Remember there can be more than one risk area. Please put as many details as possible.

WHO:

Who are the likely victims, either specifically or the type or nature of the likely victims, if this can be specified. Remember risks to other children/ vulnerable adults. Do not forget risk to self.

WHY:

What causes or mediates the risk(s), what are the likely trigger situations for risk related behaviour (e.g. a response to feeling threatened, arguments with others, command hallucinations, drug and alcohol abuse, etc).

WHERE:

Where is the risk posed (in which context is it most likely to occur – e.g. home, school, community, hospital, etc). Are there any protective environments (e.g. a grandparent's house, school/college, foster care, etc)?

WHEN:

When is the risk most likely to occur, are there any dates that indicate a particular vulnerability (e.g. Christmas, anniversary of a death or of trauma, etc)? Is there any time of day when risk is increased (e.g. night-time)?

KEY RISK INDICATORS: *those factors most associated with the risk increasing e.g. drug/alcohol use, being in confined space (ward), command hallucinations, lack of insight into illness.*

RISK REDUCING FACTORS: *those factors that can decrease the risk (e.g. being at home/in school, being with a family member, good relationship with a teacher, involvement of Social Services, compliance with medication).*

Please give as much detail as possible. Circle the appropriate category.

Probability:

Risk Category: very low / low / medium / high / very high

Severity:

Risk Category: very low / low / medium / high / very high / catastrophic

Imminence:

Risk Category: No evidence of current imminence (no current active risk indicators) / Possible risk over medium term (some risk indicators present but not severe) / Currently imminent (may happen at any time and many risk indicators present)

Summary of Risk Formulation

CLINICAL FORMULATION

4 Ps

PREDISPOSING FACTORS:

Things that make a person vulnerable to developing psychological problems (e.g. childhood trauma, physical health problems, or family history of mental illness).

PRECIPITATING FACTORS:

Things that happened in a person's life that seems to trigger an episode of illness/change in functioning (e.g. significant life changes, bereavement or loss of job).

PERPETUATING FACTORS:

Things that seem to keep a person in their current state of distress (e.g. pervasive negative thinking, lack of close relationships, or lack of adherence to medication).

PROTECTIVE FACTORS:

Things which seem to keep a person well and if maintained or strengthened decreases the likelihood of the problem reoccurring e.g. strong relationships, a skill/strength in a specific area, or good sense of humour (personality traits).

Risk Management Plan:

- *Clearly highlight the measures that you feel are necessary to manage the identified risks.*
- *Consider what you need to do now, as well as longer term options.*
- *Include contingencies (e.g. what if mental state changes?)*
- *Who do you need to inform of your formulation/plan? Consider your responsibilities to inform external agencies (e.g. If children have been identified as at risk inform Child and Family Social Services and/or the police).*
- *Remember "What I Can Do (WICD)"*

Review

- *What signs/symptoms/circumstances/events would prompt an urgent review before the planned review date?*

Date of next planned review

19. APPENDIX 6 - POSITIVE BEHAVIOUR SUPPORT PLAN

Brief PBS Plan

Photograph

This plan has been written to help people know the best ways to support me. It helps people know what to do when I am happy or when I am upset.

Although this plan is written as though I've said it, it has actually been written by others who know me really well. It's written in this way to make it more person centred and easier to remember.

Contents page

Welcome to my PBS Plan

Pen Portrait

My name is

My Health Needs

Physical Health

Mental Health

Understanding my behaviours

My best day

Primary Prevention

Important things you need to do so that I feel happy and safe

Slow Triggers (something that makes it more like that I will engage in challenging behaviour, these can occur sometime before an incident of challenging behaviour)

Fast triggers (something that happens immediately before I engage in challenging behaviour)

Secondary Prevention

Important things you need to do when I feel upset, angry, worried

Clear description of early indicators that I am feeling upset, angry or worried:

Strategies for diverting and distracting:

How to interact with me when I have moved away from baseline:

Positioning:

Timely use of as required medication:

Reactive Strategies

Important things you need to do when I am very upset and angry

Evaluation and Review

Keeping my PBS plan up to date

This plan was written on by
It needs to be looked at again in to make sure that it is still meeting my needs in the best way. It's really important to me that I keep working towards my goals so don't forget to look at how my skills are developing.

The things needed to review my PBS plan include:

- Daily Reports
- The reports to the MDT
- BMF/ABC analysis
- Participation Summaries