Humber Teaching
NHS Foundation Trust

Use of Seclusion or Segregation Policy (M-008)

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Table of Contents

1. INTRODUCTION 3
2. SCOPE 4
3. POLICY STATEMENT 5
4. DUTIES AND RESPONSIBILITIES 5
5. DEFINITIONS 6
   5.1. Seclusion – Definition 6
   5.2. Long-term Segregation – Definition 6
   5.3. Care Away From Others (CAFO) – Definition 7
6. PROCEDURES FOR THE SAFE USE OF SECLUSION 8
   6.1. Use of Seclusion 8
   6.2. Seclusion Environment 8
   6.3. Seclusion Management Plan 11
   6.4. Authorising Seclusion 11
   6.5. Commencing Seclusion 11
   6.6. Observation during Seclusion 13
   6.7. Seclusion Reviews 14
   6.8. Medical Reviews 15
   6.9. Nursing Reviews 17
   6.10. MDT Review 18
   6.11. Independent MDT Review 19
   6.12. Night Time/Patient Sleeping Review Schedule 19
   6.13. Emergency Care of the Secluded Patient 21
   6.14. Ending Seclusion 21
   6.15. Extended Seclusion 22
   6.16. Seclusion of Children and Young People Under 18 22
   6.17. Seclusion of people with Learning Disabilities and Autistic people 24
   6.18. Deprivation of Access to Normal Daytime Clothing 24
   6.19. Documentation 25
7. USE OF LONG-TERM SEGREGATION 25
   7.1. Initiating Long-term Segregation 25
   7.2. Environment of Care 26
   7.3. Long Term Segregation Management Plan 26
   7.4. Segregation Reviews 27
   7.5. Termination of Long-term Segregation 28
   7.6. Documentation 29
   7.7. MANAGEMENT OF INFECTIOUS DISEASE 29
8. CARE AWAY FROM OTHERS (CAFO) 33
   8.1. Reason for Use of CAFO 33
   8.2. Authority to Initiate Care Away From Others 34
   8.3. Review and ending of Care Away From Others 34
   8.4. Characteristics of the Care Away From Others Area 35
   8.5. Care of the Patient 36
   8.6. Documentation Requirements 36
9. POST-INCIDENT REVIEW FOLLOWING USE OF RESTRICTIVE INTERVENTIONS 37
   9.1. Duty of Candour 37
10. EQUALITY AND DIVERSITY 38
11. IMPLEMENTATION/TRAINING 38
12. MONITORING AND AUDIT 39
13. REFERENCES/EVIDENCE/GLOSSARY/DEFINITIONS 39
14. RELEVANT TRUST POLICIES/PROCEDURES/PROTOCOLS/GUIDELINES 40

Appendix 1: Management of Patients in Seclusion with External Bathroom Facilities 41
Appendix 2: Designated Seclusion Suites 42
Appendix 3: Escalation Procedure for Medical Reviews 43
Appendix 4: Escalation AND CONTINGENCIES Procedure for Nursing Reviews 44
Appendix 5: De Facto Seclusion 45
Appendix 6: Flowchart - Responsibilities for Reviews of Patients Secluded on Host Ward 46
Appendix 7: Document Control Sheet 47
Appendix 8: Equality and Health Inequalities Impact Assessment (EHIIA) Toolkit 49

1. INTRODUCTION

Many people who need the support of mental health and learning disabilities services require on occasions to be cared for under special conditions that are viewed as restrictive interventions. Even when restrictive interventions are used as an appropriate response to maintain safety, it is accepted that the potential negative outcomes, including physical and psychosocial trauma, can lead to fragmented therapeutic relationships and inequalities of care and support.

Humber Teaching NHS Foundation Trust is committed to reducing the use of restrictive interventions. Where restrictive interventions are used to prevent harm to the patient or others, services will ensure that they are used:

- Safely and effectively
- As a last resort
- With the least possible force; and
- For the shortest possible duration

These commitments are met by staff training, working collaboratively with patients and their families, ensuring good leadership of services, maintaining appropriate environments, availability of meaningful therapies and activities, individualised care (which includes crisis and risk management plans), support and engagement, and the involvement and empowerment of patients.

This overarching policy outlines the statutory responsibilities of all staff in relation to the seclusion or long-term segregation of patients under our care.

The associated procedures, review requirements and documentation for Seclusion or long-term segregation of patients are addressed separately and described more fully within respective appendices to this Policy.

The Mental Health Act – Code of Practice 2015 (referred to as the Code) defines seclusion as being “the supervised confinement and isolation of a patient away from other patients in an area from which the patient is prevented from leaving, where it is of immediate necessity for the purpose of the containment of severe behavioural disturbance which is likely to cause harm to others”.

The Code goes on to define long-term segregation as “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 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 policy should be read in conjunction with Chapter 26 of the MHA 1983 Code of Practice (2015) on safe and therapeutic responses to disturbed behaviour.

The guiding principles related to the Mental Health Act are:

> ***Least restrictive option and maximising independence:*** Where it is possible to treat a patient safely and lawfully without detaining them under the Act, the patient should not be detained. Wherever possible a patient’s independence should be encouraged and supported with a focus on promoting recovery.

Empowerment and involvement: Patients should be fully 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 the 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.

The Code recognises restrictive interventions may be required in health and social care settings as part of a broader therapeutic programme.

When they are required, they should be planned, evidence based, lawful, in the patient's interests, proportionate and dignified. Restrictive interventions should never be employed to deliberately punish or humiliate, and staff should not cause deliberate pain to a person in an attempt to force compliance with their instructions except in the most exceptional circumstances to mitigate an immediate risk to life.

Staff should only use methods of restrictive interventions for which they have received training; the nature of the technique used must be proportionate to the risk of harm and seriousness of harm, and should only ever be used as a last resort.

These procedures will set out clearly how specific restrictive interventions – **seclusion or long-term segregation** will be initiated, applied, reviewed and discontinued. Approved associated documentation can be found in the appendices to this policy.

2. SCOPE

Areas apply to all staff employed in clinical roles who work within mental health inpatient units.

This Policy does not address Management of Violence and aggression including restrictive interventions of restraint; please read in conjunction with Humber Teaching NHS Foundation Trust's Managing Violence and Aggressive Behaviour Policy.

With regards to any seclusion or segregation to be considered which are outside the scope of this policy guidance should be sought from the Positive Engagement Team/Mental Health Legislation. If urgent and in relation to potential crime then the police should be contacted immediately.

3. POLICY STATEMENT

All staff have a statutory obligation to follow the standards and processes set out within the Mental Health Act (1983) Code of Practice 2015. The procedures outlined in this Policy are in line with the requirements of the Code. There must be no exceptions.

The policy aims to:

- ensure the physical and emotional safety and wellbeing of the patient
- ensure that the patient receives the care and support rendered necessary by their seclusion both during and after it has taken place
- designate a suitable environment that takes account of the patient's dignity and physical wellbeing
- set out the roles and responsibilities of staff, and
- set requirements for recording, monitoring and reviewing the use of seclusion and any follow-up action

4. DUTIES AND RESPONSIBILITIES

Chief Executive
The chief executive has overall responsibility to ensure that policies and processes are in place for the treatment of the patients subject to seclusion.

Medical Director
The medical director as lead director is responsible for ensuring that this policy is understood and adhered to by all staff involved in the implementation of this intervention and that all the processes are in place to ensure the policy is fully implemented.

Chief Operating Officer
The chief operating officer is responsible for ensuring the MHA/CoP legislation/standards are followed by all staff involved in the implementation of this policy.

Director of Nursing, Allied Health and Social Care Professionals/Caldicott Guardian
The director of nursing/Caldicott Guardian has responsibility to ensure that this policy is understood and adhered to by nursing staff.

Clinical Director
Has responsibility for ensuring that all clinical staff within the Trust are familiar with the requirements of the policy and are able to implement them.

General Managers and Clinical Leads
Have responsibility for ensuring that all clinical staff within their division are familiar with the requirements of the policy and are able to implement them.

Modern Matrons
The modern matrons have the responsibility to ensure that all nursing staff working within in-patient areas comply with the policy and ensure it is implemented effectively and safely.

Responsible Clinician (RC)/Approved Clinician (AC)
Has specific responsibilities for the commencement, review and termination of seclusion and long-term segregation, and has ultimate responsibility for the care and treatment of the patient.

Charge Nurses/Registered clinical staff/other clinical staff
Must be aware of and comply with their responsibilities to implement the policy.

Observing Clinician
Will ensure that the requirements of the Seclusion Management Plan are met during their period of observation, specifically including:

- 15-minute summaries of eyesight observations in the Seclusion Communication Record
- Maintaining **eyesight observations at all times** whilst the patient is in seclusion
- Responding to requests from the patient in line with the management plan
- Calling for assistance from colleagues as required
- Escalating concerns about the patient immediately if any concerns arise

5. DEFINITIONS

5.1. Seclusion – Definition

Seclusion refers to the supervised confinement and isolation of a patient, away from other patients, in an area from which the patient is prevented from leaving where it is of immediate necessity for the purpose of the containment of severe behavioural disturbance which is likely to cause harm to others (Code of Practice 2015 26.103).

Within Humber Teaching NHS Foundation Trust if a patient is **confined** in **any way** that meets the definition above, even if they have **agreed** to or **requested** such confinement, they have been secluded and the use of any local or alternative terms (such as “therapeutic isolation”) or the conditions of the immediate environment do not change the fact that the patient has been secluded. It is essential that they are afforded the procedural safeguards of the Code (Code of Practice 2015 26.104).

The following practices should be recorded as seclusion:

1. a patient is locked in a seclusion room
2. a patient is locked in a bedroom
3. a patient is placed alone in a room and prevented from leaving either by the door being locked, held shut or staff standing in the doorway preventing the patient from leaving
4. Where a patient asks to be isolated from others and is then prevented from leaving the area in which they are isolated

The following practices should **not** be recorded as seclusion:

1. If a patient is being restrained by staff, they are not being secluded.
2. If a patient is told to go to a particular area but is free to leave that area, they are not being secluded.
3. If a patient requests to take time in a particular area and is supported to do so (with staff remaining in the area with them) but is free to leave that area, they are not being secluded.

(Mental Health Data Set: Restrictive Intervention guidance notes for definitions with working examples.)

5.2. Long-term Segregation – Definition

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

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 serious injury or harm over a prolonged period of time. Where 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. The multi-disciplinary review should include an IMHA in cases where a patient has one (Code of Practice 2015 26.150).

Nursing or caring for a person in enforced isolation, excluding isolation to prevent the spread of infection, regardless of: (1) whether the procedures and requirements of the MHA code of practice 2015 for long-term segregation are met; and/or (2) the user of services has periods of interaction with staff and or peers (Mental Health Data Set: Restrictive Intervention guidance notes for definitions with working examples).

"Isolation" means any seclusion or segregation that is imposed on a patient (Use of Force Act 2018).

The CQC Position

The key test of whether a patient is segregated is ***whether they can leave the situation of being separated from others when they want to – that is, are they prevented by staff from leaving*****?** The reference in the Code of Practice to the "need to reduce a sustained risk of harm posed by the patient to others" has led to some services not recognising as long term segregation the care of some people **for their own benefit** (for example those with a learning disability or autism or both), even when they are not mixing freely with others on the ward/unit for long periods. Patients segregated to protect **them** from harm or self-harm are entitled to the same protection as those who pose a risk to staff and other patients. The safeguards set out in the Code should be applied to support the patient and reduce the need for continuing long-term segregation (Care Quality commission. Brief Guide BG010: Long-Term Segregation V4, August 2020).

5.3. Care Away From Others (CAFO) – Definition

This addition to the policy is for use within Mental Health and Learning Disability Inpatient Services with a clear emphasis on supporting those individuals who require a bespoke environment in the community. CAFO must only be used if the MDT determines that the patient is not deemed suitable to be reintegrated back onto the ward due to their presentation meaning they will require a single person placement upon discharge.

As part of a patient's individualised care plan it may be identified that an individual may require a care package provided in an alternative environment that provides a safe, secure and bespoke area for this to be delivered whilst in the care of inpatient services.

The purpose of the policy is not to seclude nor segregate any individual but to offer an alternative safe care environment that meets the needs of the patient, recognising the need for community leave and activities, whilst acknowledging that living within a communal space with other individuals is not appropriate.

Most, if not all, of these individuals, will require a single service placement on discharge, which reflects their specific diagnostic requirements for instance, severe autism with a need for reduced stimulus.

This policy addition does not replace the restrictions relating to management of violence and aggression which are determined within other areas of this Policy.

Nursing or caring for a person in enforced isolation, excluding isolation to prevent the spread of infection, regardless of: (1) whether the procedures and requirements of the MHA code of practice 2015 for long-term segregation are met; and/or (2) the user of services has periods of interaction with staff and or peers (Mental Health Data Set: Restrictive Intervention guidance notes for definitions with working examples).

"Isolation" means any seclusion or segregation that is imposed on a patient (Use of Force Act 2018).

6. PROCEDURES FOR THE SAFE USE OF SECLUSION

6.1. Use of Seclusion

Seclusion should only be used in hospitals of Humber Teaching NHS Foundation Trust 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. The principles of the Mental Capacity Act should also be considered at this time (Code of Practice 2015 26.106).

Seclusion should not be used as a punishment or a threat, or because of a shortage of staff. It should not form part of a treatment programme (Code of Practice 2015 26.107).

Seclusion should never be used solely as a means of managing self-harming behaviour. Where the patient poses a risk of self-harm as well as harm to others, seclusion should be used only when the professionals involved are satisfied that the need to protect other people outweighs any increased risk to the patient's health or safety arising from their own self-harm and that any such risk can be properly managed (Code of Practice 2015 26.108).

In order to ensure that seclusion measures have a minimal impact on a patient's autonomy, seclusion should be applied flexibly and in the least restrictive manner possible, considering the patient's circumstances. Where seclusion is used for prolonged periods then, subject to suitable risk assessments, flexibility may include allowing patients to receive visitors, facilitating brief periods of access to secure outside areas or allowing meals to be taken in general areas of the ward. The possibility of facilitating such flexibility should be considered during any review of the ongoing need for seclusion. Particularly with prolonged seclusion, it can be difficult to judge when the need for seclusion has ended. This flexibility can provide a means of evaluating the patient's mood and degree of agitation under a lesser degree of restriction, without terminating the seclusion episode (Code of Practice 2015 26.111).

Advanced Positive Behavioural Support Planning:
All patients should have the opportunity to be involved in their plan of care and treatment. This should include the short-term management of disturbed and violent behaviour. All patients whose history indicates a potential risk of disturbed and violent behaviour should be identified on admission and a Positive Behaviour Support Plan should be devised. This should make specific reference to the potential need for seclusion and aim to recognise the patient's viewpoint/preferences in relation to managing potential or actual violence.

6.2. Seclusion Environment

Seclusion should only be undertaken in a room or suite of rooms that have been specifically designed and designated for the purposes of seclusion and which serves no other function on the ward (Code of Practice 2015 26.105). The factors in the guidance in the MHA Code of Practice 2015 (26.109) describe what should be taken into account in the design of rooms or areas where seclusion is to be carried out.

The Trust has designated seclusion suites (see Appendix 2 for full details).

In units where CCTV is available for observation whilst patients are in seclusion, staff must follow the local standard operating procedures for CCTV.

Appendix 1 outlines the safeguards to manage seclusion rooms with external toilet and shower facilities.

Infection control principles must be adhered to for the use of seclusion rooms in accordance with the NHS England » National infection prevention and control manual (NIPCM) for England

Any concerns raised in relation to environment and maintenance of requirements, i.e. locks/windows and covering/heating/viewing panels must be notified to estates department and urgent rectification requested as a Priority 1.

Facilities without Access to Seclusion
In extreme circumstances, where the designated room or suite is unavailable or there is no designated seclusion facility and there is immediate necessity for the purpose of the containment of severe behavioural disturbance, which is likely to cause harm to others, or give rise to a safeguarding issue then staff should follow the following guidance.

There may be circumstances that arise within a ward when a patient becomes distressed and this manifests as an acute behavioural disturbance. In considering the proportionate response, a period of isolation away from other patients in an area that the patient is prevented from leaving; may become necessary.

This definition meets the criteria for seclusion.

This would then require the use of the seclusion room in line with the Code of Practice as outlined in this policy.

It is acknowledged within mental health services that there are times when the isolation and segregation of a patient to manage an acute behavioural disturbance or safeguarding risk is required, yet the use of seclusion as defined in the code does not/cannot be applied. Work is currently being discussed with the Department of Health and Social Care and the Positive and Safe Champions working group to understand this area of practice.

The following guidance is to support staff in Humber Teaching NHS Foundation Trust to manage the situation and to seek to work within the Code of Practice and NICE guidance as quickly as possible, whilst ensuring safeguards are in place for the patient.

Should a situation occur where the professional in charge deems that the proportionate and least restrictive option to manage a patient is to isolate them away from other patients and prevent them leaving (where a seclusion room or suite is not available) the following must take place: -

- Immediately that the patient is segregated away from other patients, with or without the use of physical restraint, the nurse in charge must make a decision with the clinical team about their intentions to manage the patient.
- If the patient is restrained for the least restrictive period of time with the intention to release the holds, following de-escalation and to allow them to leave the room, this is not classed as seclusion. It must be recorded as an incident of restraint.
- If a patient is restrained and de-escalation is not reducing the risk and the patient is not going to be allowed to leave the area, or the patient goes with staff into an area without restraint but is not allowed to leave, the policy and documentation for seclusion must commence.

- If the patient is managed in an area other than a designated seclusion room and is not allowed to leave, you must follow the seclusion procedure, even if you have no access to a seclusion room.
- You must alert the unit manager and matron (out of Hours the on-call manager). The clinical decision to seclude outside of an approved seclusion room/suite must be discussed and preparations made to transfer to an approved seclusion room, this may include PICU.
- Should transfer to another ward be required this should be facilitated by contacting the appropriate approved provider of secure transport. All wards will have a copy of the approved providers and contact numbers/invoice numbers on their ward.
- The police have no legal powers to transfer detained patients between units. The power to transfer lies with MH providers. The police do have powers to intervene or assist where a criminal act is highly likely, in progress or has taken place. If clinical staff and transport staff believe that a patient will commit a criminal act during the transfer period, then the matter should be discussed with the police. The professional contacting the police should clearly articulate the potential criminal act that they believe will take place if police assistance is not given.
- An agreement should be reached between the professional in charge and the police officer in charge about which party has the lead responsibility for the transfer and welfare of the patient. It is unlikely that the police will take this responsibility as a detained patient is the responsibility of the Trust and all care decisions must be made by the professional in charge. Should the police discharge any of their powers and methods during the transfer, these must be documented in the health record, e.g. Taser, restraint with pain application, CS spray.
- During transfers it is an absolute priority that the patient's physical health is monitored throughout. 15-minute observations must continue as per policy and be documented. Where possible respirations must be taken as a minimum to monitor respiratory function. If the patient is too disturbed to allow pulse rate to be taken, the accompanying health professional must make a note of the patient's pallor, communication, physical presentation.
- If no wards within Humber Teaching NHS Foundation Trust have a seclusion room that can be used consideration should be given as to the use of an out of area bed. All other internal options should be considered before the patient is transferred out of area.
- The Seclusion Policy and monitoring must continue until the patient care episode is ended or transferred to another party.
- Children and Young People: If the seclusion suite at Inspire is in use or out of action for any reason and there is a need to support young people admitted to Inspire in seclusion, Staff should, in the first instance, seek support from the Adult Inpatient wards identified as being appropriate to support young people (Westlands-Female and New Bridges-Male).In hours this will be agreed by the RC and the Service Manager/Matron, out of hours by the CAMHS On-call Consultant and the On-call Manager. Transfer and reviews will be supported as per the policy and must involve a member of the Inspire Inpatient Team. Every effort must be made for the young person to return to Inspire at the earliest opportunity.
- Whilst in the adult mental health seclusion suite the young person will remain an inpatient at Inspire and does not require to be admitted to the adult ward.
- A member of the Inspire Team will support the young person at all times with support from the adult ward in order to provide appropriate breaks.

(Also please refer to the De Facto Practice Note at Appendix 5).

6.3. Seclusion Management Plan

A seclusion management plan should set out how the individual care needs of the patient will be met whilst the patient is in seclusion and record the steps that should be taken in order to bring the need for seclusion to an end as quickly as possible. This is identified in the Exit Criteria.

As a minimum the seclusion management plan should include:

- A statement of clinical needs (including any physical or mental health problems), risks and treatment objectives
- The criteria for the patient to exit seclusion as soon as possible
- How observation can be carried out in a way that respects the individual's privacy as far as practicable and minimises any distress
- Details of consideration as to the gender of staff carrying out engagement, with particular consideration of the patients trauma history; In particular how an individual's dignity can be maximised without compromising safety when individuals are in a state of undress, such as when using the toilet, showering, dressing
- 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 – normal bedding should be provided unless individual risk assessment suggests seclusion blanket should be used instead.
- Details as to how the patient's dietary needs are to be provided for; and
- Details of any family or carer contact/communication which will maintain during the period of seclusion
- Details of the patient's individualised personal evacuation needs

The Seclusion Management Plan must be reviewed on at least a monthly basis for those in extended seclusion.

6.4. Authorising Seclusion

Seclusion is a serious decision and should be regarded accordingly. It can be authorised by Humber Teaching NHS Foundation Trust staff, (including locum staff, agency and bank staff) that hold the roles and responsibilities outlined in the table below as define by the Code of Practice 2015.

Seclusion may be authorised by either:	**Additional considerations**
A psychiatrist	If the psychiatrist who authorises the seclusion is not the patient's responsible clinician (RC) nor an approved clinician (AC), the RC or duty doctor (or equivalent) should be informed of the seclusion as soon as practicable
An AC who is not a doctor	An AC, who is not a doctor, can authorise seclusion, however the patient's RC or duty doctor (or equivalent) should be informed of seclusion as soon as practicable.
The professional in charge of a ward (i.e. a nurse)	The patient's RC or duty doctor (or equivalent) should be informed of seclusion as soon as practicable.

6.5. Commencing Seclusion

Staff may decide what a patient can take into the seclusion area. Necessary consideration should be given to any object or item that may be used to harm self or others and be removed, for example belts/shoes. Staff to consider the necessity for carrying out a search of the patient prior to the commencement of seclusion and the potential risk to staff and patient if search is not carried out (please refer to search policy). The patient should never be deprived of clothing when in seclusion. There may be occasions, following individual risk assessment, when a

patient may need to be provided with some form of tear resistant clothing (see 6.18 Seclusion of people with Learning Disabilities and Autistic people
Seclusion can be a traumatic experience for any individual but can have particularly adverse implications on emotional wellbeing for people with learning disabilities and autistic people. This should be taken into consideration in any decision to seclude a person with any such condition.

If there are indications that the use of restrictive interventions (particularly physical restraint or seclusion) might become necessary, consideration should be given to the management of violence of aggression in people with a learning disability and autistic people, and staff will follow this policy whilst taking into account:

- The person's diagnosis and / or any comorbid physical / mental health problems
- The person's level of social or adaptive functioning and ability to understand new or complex information
- Potential for diagnostic overshadowing - This occurs when the symptoms of physical ill health are incorrectly either attributed to a mental health/behavioural problem or considered inherent to the person's learning disability or autism diagnosis
- The person's past experiences of use of force in any environment
- The person's communication skills and the staff ability to communicate in ways that they understand and is meaningful to them
- The person's sensory needs and as documented in sensory assessments if available / completed
- Making reasonable adjustments in the immediate environment to meet individual sensory needs where possible to do so
- All positive behavioural support plans should be co-produced with individuals where possible and with their family / carers (where appropriate and with consent) and will have specific regard to include person's views and wishes detailing when and how to use physical restraint

All Mental Health and Learning Disability staff should be familiar with the Mental Health Act 1983, Mental Capacity Act 2005, the Human Rights Act 1998 and Equality Act 2010.

All patient leaflets and information regarding the use of force and seclusion, and personal plans will be provided in easy read documents.

Deprivation of Access to Normal Daytime Clothing). The member of staff authorising seclusion should have seen the patient immediately prior to commencement of seclusion.

When a patient is placed in seclusion, the start time of the seclusion **must** be recorded on the Seclusion Management Plan and in the adverse incident form in the restrictive intervention tab in the patient's EPR to ensure real time monitoring of seclusion. It must also be recorded in Datix within the shift. Use of restraint must be recorded.

When seclusion of an individual commences there must be a formal review of all care plans and the existing supportive engagement care plan should be suspended. The Seclusion documentation should be initiated, completing the Seclusion management plan.

If seclusion is authorised by the professional in charge of the ward, the responsible clinician or duty doctor (or equivalent) must attend to undertake the first medical review **within one hour** of the beginning of seclusion.

If the patient is newly admitted, not well known to the staff, or there has been a significant change in the patient's physical, mental state and/or behavioural presentation, this medical review should take place without delay.

Where seclusion has been authorised by a psychiatrist, whether or not they are the patient's responsible clinician, the first medical review will be the review that they undertook immediately before authorising seclusion (meaning that a medical review within one hour of seclusion is not necessary).

Staff should be fully aware of the review requirements when seclusion is authorised and begin the process of notifying professionals required for the reviews. The nurse in charge should prepare staffing availability for two-hourly reviews.

Where it has been agreed in an individual behaviour support plan (or equivalent) that family members will be notified of significant behavioural disturbances and the use of restrictive interventions, this should take place as agreed in the plan.

Rapid Tranquillisation (RT)
If a patient has received RT, the observing nurse must monitor the patient in line with RT policy and guidance.

6.6. Observation during Seclusion

Supportive engagement/observation schedules should be reviewed and discontinued at the point an episode of seclusion was initiated. Continuing requirements for engagement and observation should be clearly recorded in the patients Seclusion management plan as part of a holistic plan of care for the duration of the seclusion episode.

A suitably-skilled professional (this can be an unregistered member of staff who has completed the training in relation to supportive engagement and observation policy) should as a minimum be readily available within sight and sound of the seclusion area at all times throughout the patient's period of Seclusion.
The professional should have the means to summon urgent assistance from others if required. These arrangements will vary from ward to ward and information about their location and use should be an integral part of the local induction process; usually this will be by personal alarm systems.

Consideration should be given to gender of patient and gender of staff carrying out observations; this may be informed by consideration of patient history, cultural requirements, gender identity issues and any history of trauma or abuse.

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. The observing member of staff can request a review to end seclusion with the nurse in charge in consultation with the RC at any time and does not need to wait until a prescribed review, specifically if a patient has met the requirements of their exit criteria.

A record of the patient's behaviour should be made at least every 15 minutes on the seclusion review and communication record.

The record made should include, where applicable: the patient's appearance, what they are doing and saying, their mood, their level of awareness and any evidence of physical ill health especially with regard to their breathing, pallor or cyanosis. Monitoring of fluid balance, physical observations and other requirements must be taken as directed by the seclusion management plan. Where necessary monitoring cannot be carried out due to the patient's presentation, the Responsible Clinician (RC)/on call Doctor should be informed and their advice obtained.

Where a patient appears to be asleep in seclusion, the person observing the patient must be alert to and assess the level of consciousness and record hourly respirations of the patient (see 6.12 Night Time/Patient Sleeping Review Schedule).

The person observing should as a minimum be readily available within sight and sound of the seclusion area at all times throughout the patient's period of seclusion (Code of Practice 2015 26.118).

6.7. Seclusion Reviews

Supportive engagement/observation schedules should be reviewed and continued at the point an episode of seclusion were initiated. Continuing requirements for engagement and observation should be clearly recorded in the patients individual behaviour support plan as part of a holistic plan of care for the duration of the seclusion episode.

All reviews MUST be recorded on the seclusion record, not in separate electronic or paper files. If the attending staff wish to make corresponding entries in additional patient records, they must ensure accurate transcribing of information.

Schedule of review requirements	
Constant Review	The patient remains in constant sight and sound of a staff member.
First Medical Review	• **WHEN?** Within one hour **maximum** after the commencement of seclusion • **WHO?** Any medical doctor at any grade, e.g. medical RC, medical AC, duty doctor • If patient is newly admitted, not well known to services, or there has been a significant change from their usual presentation this medical review should take place without delay. • If a medical doctor made the decision to seclude, that face to face review they undertook immediately before seclusion was authorised will serve as the first medical review (no need for additional Medical Review). • All reviews must be recorded on the seclusion record – medical entry in adverse incident
Nursing reviews	• **WHEN?** At least every two hours following the commencement of seclusion • **WHO?** Two registered nurses and at least one of whom should not have been involved directly in the decision to seclude. • Secluded patient to be reviewed every 2 hours throughout period of seclusion.
Ongoing Medical reviews	• **WHEN? 4** hourly (unless a decision has been made in the Internal MDT or the independent MDT to alter frequency) including evenings, overnight, weekends and Bank Holiday • **WHO**? Any medical doctor at any grade, e.g. medical RC, medical AC, duty doctor (if not an AC, should have access to a medical AC) *refer to section 6.12 for reviews at night.
First Internal MDT review	• **WHEN?** As soon as practicable but within 24 hours and must be face to face. • **WHO?**

	• In hours - RC, any medical doctor if RC non-medical, Senior Nurse on the ward and staff from other professional disciplines who would normally be involved in patient reviews. • Out of hours – on call AC, any medical doctor if AC non- medical, a qualified nurse and the manager on site/call (who can be on the phone). • The periodicity of further Medical Reviews can be decided in this meeting.
Further medical reviews	• **WHEN?** Following the first internal MDT review, medical reviews should continue at least **twice in every 24 hour period.** • **WHO?** At least one of these should be carried out by the patient's RC or on-call medical AC; the other can be any medical doctor at any grade.
Independent MDT Review	• **WHEN?** If secluded for eight hours continuously (or 12 hours intermittently, during a 48-hour period). Unless exceptional circumstances this would be the next morning at 09.00 or as close to that time as possible. • **WHO?** An AC, any medical doctor if AC non-medical, a qualified nurse, other registered professionals who were not involved in the incident which led to the seclusion, and the patient's IMHA (where appointed) • This cannot involve professionals who made the decision to seclude, however, it is good practice to consult these people •
Subsequent MDT reviews **Weekly MDT Review**	• **WHEN?** Once in every 24-hour period of continuous seclusion • **WHO?** • In hours – RC, any medical doctor if RC non-medical, senior nurse on the ward and staff from other professional disciplines who would normally be involved in patient reviews • Out of hours – on-call medical AC, qualified nurse and the manager on site/call (who can be on the phone). • In the event of seclusion continuing for more than a week, the daily MDT review should be extended once in every 7-day period to include additional participants (see MDT Review below, 6.10)

6.8. Medical Reviews

Following the first medical review, as detailed above, subsequent medical reviews should be undertaken by the responsible clinician, an approved clinician or a duty doctor. Continuing four-hourly medical reviews of secluded patients should be carried out unless a decision has been made in the internal MDT or the independent MDT to alter frequency. This policy provides guidance on review arrangements to be applied when patients are asleep in seclusion (section 6.12 Night Time/Patient Sleeping Review Schedule.)

Medical reviews provide the opportunity to evaluate and amend seclusion management.

Plans and medical management plan.

They should be carried out in person and should include, where appropriate:

- A review of patients physical and psychiatric health
- An assessment of adverse effects of medication
- A review of observations required
- A review 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 need for continuing seclusion, and whether it is possible for seclusion measures to be applied more flexibly, or in a less restrictive manner

For the purpose of medical reviews, where the responsible clinician is not immediately available, e.g. outside of normal working hours, the on call ‘duty doctor’ will deputise for the responsible clinician and cover required reviews. With exception to the reviews where a medical review must be carried out by an approved clinician (as indicated in the ‘schedule of review requirements’ table) whenever the duty doctor is not an approved clinician, they should at all times have access to an on-call doctor who is an approved clinician.

The patient should be consulted during the review process and updated on the outcome.

In the event of a medic not being available to undertake the medical review of a patient in seclusion, either within one hour or for the ongoing reviews, the Standard Operating Procedure for escalating seclusion reviews by medics as detailed in Appendix 3 should be followed.

Any failure to meet the requirements of the medical seclusion review detailed in this policy must be recorded on the Datix system with the level of harm decided by the reporter and confirmed by the daily huddle, and with details of the steps taken by the clinical team to escalate the matter. For late medical reviews a datix is only required if the review is more than 10 minutes late.

6.9. Nursing Reviews

Nursing reviews of the secluded patient should take place at least every two hours following the commencement of seclusion.

These should be undertaken by two individuals who are registered nurses, and at least one of whom should **not have been** involved directly in the decision to seclude.

Please note: Band 4 Nursing Associates are NOT permitted to be counted as one of the registered Nurses who carry out the 2 hourly nursing reviews of seclusion.

In exceptional circumstances where the criteria for nursing reviews is not being met, the matter should be escalated to the unit manager/matron for resolution and the guidance should be followed **as detailed in Appendix 4**. Out of hours the on-call manager/clinician should be contacted for support. The on-call manager should consider Trust-wide solutions to ensuring the Nursing Reviews are undertaken in line with Trust Policy/Code of Practice.

Any failure to meet the requirements of the nursing seclusion review detailed in this policy must be recorded on the Datix system with the level of harm decided by the reporter and confirmed by the daily huddle, and with details of the steps taken by the clinical team to escalate the matter. For late nursing reviews a datix is only required if the review is more than 10 minutes late.

In the event of concerns regarding the patient's condition, this should be immediately brought to the attention of the patient's responsible clinician or duty doctor and the nature of concerns and actions taken documented in clinical notes.

The nurses involved in the review should refer to management plan and consider whether the patient can exit seclusion. If the exit criteria has been met, the nurse in charge should contact the Responsible Clinician (RC) or duty doctor in person or by telephone) to consult on the agreement for the patient to exit seclusion. The nurse in charge must have agreement from the RC or deputy before ending seclusion. Where a dispute occurs, the nurse in charge can escalate to the manager on call.

Where this is not deemed appropriate, clear documented evidence should be given to continue seclusion. The nurses should then review the seclusion plan and ensure that all the requirements are being met, documenting the evidence for each area.

The patient should be informed of the outcome of the review and views sought on how they can be supported to meet the exit criteria. The patient response should be clearly documented in the seclusion record. Verbatim quotes should be captured where possible from the patient.

Staff must look at how the risks associated with restrictive interventions can be minimised; in particular an assessment of their potential to cause harm to the physical, emotional and psychological wellbeing of patients. Staff must also take in account a patient's individual vulnerability to harm (such as unique needs associated with physical/emotional immaturity, older age, disability, poor physical health, pregnancy, past history of traumatic abuse etc.).

The Seclusion management plan should be updated with any new needs that arise during the review process.

6.10. MDT Review

The first internal MDT seclusion review should be held as soon as practicable (within 24 hours). Membership would likely include the responsible clinician, a doctor who is an approved clinician, the senior nurse on the ward, and staff from other disciplines who would normally be involved in patient reviews.

At weekends and overnight, membership of the initial MDT review may be limited to medical and nursing staff, in which case the on-call manager or senior on-call clinician should also be involved.
Further MDT reviews should take place once in every 24-hour period of continuous seclusion. The occurrence of these should be recorded on the Seclusion 24hr Internal MDT Review questionnaire on SystmOne.

Where seclusion continues, these MDT reviews should inform evaluation and any changes as appropriate to the Seclusion care plan.

In the event of seclusion continuing for more than a week, the daily MDT review should be extended once in every 7-day period to include additional participants including Safeguarding, MH Legislation Lead, IMHA and Pharmacy. At least one of which must attend the review, in order to include an independent viewpoint, otherwise a datix will be required. Also in attendance should be the usual MDT members who weren't involved in the initiation of seclusion.

The weekly MDT review will also be attended by an AC other than the patient's usual RC and who was not involved in the initiation of the seclusion episode. However, if the review takes place on a Monday and it is not possible to acquire the attendance of an independent AC, if the patient was seen by an AC (other than the usual RC) over the previous weekend then the narrative from that review can be used to contribute to the weekly MDT review (providing the information is sufficient enough to provide an independent medical viewpoint).This narrative must be added to the independent seclusion review form as part of that review. Likewise if the review is occurring on the Friday and it is not possible to acquire the attendance of an independent AC, the review will still take place with the other independent clinical staff. However, the assessment by the independent AC the following day (Saturday) can be used to inform the independent MDT review the previous day (Friday). Again, this narrative must be added to the independent seclusion review form as part of that review. Other than reviews held on a Monday or a Friday, due to the possible changes in presentation of the patient, attendance of an independent AC must be sought.

It is the responsibility of the ward staff to organise these independent MDT Reviews.

The first weekly MDT Review should be held during normal working hours at the earliest opportunity after the first week of initiation of seclusion then weekly thereafter if seclusion continues.

The weekly MDT review must be recorded on the Seclusion 8hr and Weekly Independent MDT Review questionnaire and should be saved (print to PDF then save) and forwarded to the Incident Reporting Team (HNF-TR.IncidentReporting@nhs.net) for oversight at the CRMG.

The weekly MDT Reviews can be held via MS Teams but the independent AC will carry out a face to face review with the patient**.**

The weekly Independent MDT review can be forfeited when it is due at same time as the monthly independent seclusion review, which takes priority.

6.11. Independent MDT Review

A patient in continuous seclusion for a period of eight hours, or 12 hours intermittently in any 48-hour period, is subject to an independent multidisciplinary team review by at a minimum an approved clinician, a nurse and other healthcare professionals not directly involved in the incident which led to seclusion. An independent mental health advocate (IMHA) should be involved if possible, when the service user has one.

In the best interests of the patient, planning is essential to facilitate a full and complete review and the patient should be invited to participate fully in the review. The review should provisionally be planned at the onset of the seclusion episode and agreed by the RC or on-call consultant and the ward manager or delegate. The arrangements are to be documented clearly in the seclusion records. The patient should be kept informed if at all possible of the arrangement for an independent review, in addition to the four hourly medical review and the daily MDT reviews.

It is good practice, where possible for the independent MDT to consult those involved in the original decision. If it is agreed that seclusion needs to continue, the independent MDT review should inform evaluation and any changes as appropriate to the seclusion care plan.

At the 8 or 12-hour point, whichever is applicable, a note must be entered in the seclusion records of the agreed arrangements for scheduled independent review.

The planned independent MDT review should take place during normal waking hours seven days per week. On Saturdays, Sundays and bank holidays, the on-call manager can contribute to this review by telephone, as the other professional not involved in the seclusion incident, however the nurse and RC on-call must visit the unit and review the patient. Unless exceptional circumstances this would be the next morning after 9am and as close to that time as possible.

The occurrence of these should be recorded on the Seclusion 8hr and Weekly Independent MDT Review questionnaire.

Wherever possible, the independent MDT review should be carried out by an RC who is not the patient's usual inpatient RC.

In the event of an RC not being available to undertake the independent MDT review of a patient in seclusion, the following morning this should be escalated to the director on call.

Humber Teaching NHS Foundation Trust internal governance arrangements require that **in the event of seclusion continuing over seven days, additional independent reviews must be arranged and documented every seven days and each completed Seclusion 8hr and Weekly Independent MDT Review questionnaire (from the first 7 day review) should be saved (print to PDF then save) and forwarded to the Incident Reporting Team (HNF-TR.IncidentReporting@nhs.net) for oversight at the CRMG.**

It is the responsibility of the ward staff to organise these independent MDT Reviews.

The patient should be kept informed of the next planned review.

6.12. Night Time/Patient Sleeping Review Schedule

The Code of Practice states "Ongoing Medical Reviews: A provider's policy may allow different review arrangements to be applied when patients in seclusion are asleep".

The following guidance is given for a MDT to agree that Medical Reviews will not be carried out at night if the patient is asleep. **It does not authorise a reduced schedule for nursing reviews.**

During the first night of seclusion prior to an MDT review being held it is acceptable for the RC / AC on call to participate in a review via discussion (after the patient has been seen by a Junior Doctor) in order to decide on stopping night time medical reviews when the patient is asleep, until the Internal or Independent MDT review can be held the following morning (which the RC / AC on call will attend in person).

On patient's waking nurses to contact on call doctor to attend to carry out medical review but this should not deviate from the planned timetable of medical reviews.

The patient's risk assessment, care plan and seclusion management plan should be used to inform decision making and reviewed as necessary. Consideration should also be made to the impact of mental ill health on sleep patterns and that many patients experience greater levels of anxiety, fears and level of arousal at night.

When a patient in seclusion appears asleep the member of staff carrying out the supportive engagement must monitor their physical health noting changes in body position, breathing, etc. **Safety takes priority over privacy.**
If a patient has received Rapid Tranquillisation (RT) as part of a current restrictive intervention plan, the observing nurse must monitor the patient in line with RT policy and guidance.

Staff must not assume that patients are sleeping and/or that they should not be woken. The consequences of safe practices will need to be explained and discussed with the patient who may be disturbed by staff entering the room.

If the member of staff has not observed the patient moving or cannot observe the patient breathing, they **must take the following steps to ensure the patient is alive.**

Call for assistance from the nurse in charge/registered nurse in the unit to support the assessment of physical wellbeing and for entry to the seclusion if warranted.

Increase lighting in the room to improve visual acuity/stimulate a patient response.

Staff should respond promptly but with their safety in mind to an unresponsive patient. Staff are cautioned against entering the room alone due to the risk of a patient demonstrating unresponsiveness in order to gain a lone worker response, which leaves the worker vulnerable to assault/hostage.

If the patient is not responsive and breathing cannot be observed, the assembled staff team should enter seclusion and check the patient for signs of life. Once satisfied the patient is alive, the registered nurse should make a clinical assessment to determine if further intervention or assessment is required.

The registered nurse may require further clinical observations to be undertaken, urgent review by a medic or in an emergency situation follow the procedure for management of a deteriorating patient/Immediate life support.

All interventions and decisions must be recorded in the continuation record for seclusion. The Seclusion Management Plan should be updated to reflect the assessment and outcomes.

6.13. Emergency Care of the Secluded Patient

In the event of an emergency situation arising that requires a patient to attend A&E or other urgent care setting, the requirement for seclusion should be paused and a risk management plan agreed and documented to ensure the safe transfer and care of the patient to receive urgent care.

Once urgent care has been provided and the ongoing care agreed; a clinical assessment and decision regarding place of ongoing care which includes the clinician who has provided emergency/urgent care, the RC (or on-call RC), senior nurse from the ward and Matron (or on call manager) should be made. This may include ongoing support to remain within alternative health care provision, transfer back to Humber Teaching NHS Foundation Trust premises and **following re assessment** the cessation of seclusion **or** return to seclusion.

The senior nurse in charge of the ward is responsible for ensuring all assessments, actions and clinical decisions are documented in the seclusion record and care records for the patient. Staffing support and reviews should also be agreed and implemented to support the patient's care needs.

Given the need for urgent care, if the decision is made to return patient to seclusion, 4 hourly medic reviews should be resumed until a decision can be made at the internal MDT to change to 2 in every 24-hour period if appropriate to do so.

NB: For transferring between seclusion suites there is no need to end the current episode of seclusion.

6.14. Ending Seclusion

Seclusion ends when a patient is allowed free and unrestricted access to the normal ward environment or transfers or returns to conditions of long-term segregation.

Seclusion should immediately end when an MDT review, a medical review or the independent MDT review determines it is no longer warranted, alternatively where the professional in charge of the ward feels that seclusion is no longer warranted, seclusion may end following consultation with the patient's responsible clinician or duty doctor. This consultation may take place in person or by telephone.

Opening a door for toilet and food breaks or medical review does not constitute the end of a period of seclusion.

The patient must be offered the opportunity to engage in a post seclusion review by a member of the professional team in addition to support from an IMHA.

When seclusion is terminated, a registered professional must ensure that seclusion documentation is discontinued and supportive engagement and an individual care plan is resumed or re-prescribed.

Following the termination of seclusion the patient must be reviewed by a member of the medical team, out of hours by the on-call doctor, to ensure there are no physical injuries or concerns for the patient's physical health. This could be in relation to previous use of restraint, use of medications/rapid tranquilisation and self-injurious behaviours that have not been able to be assessed fully whilst the patient was in seclusion. This must be recorded in the patient's notes and any actions required clearly outlined.

6.15. Extended Seclusion

In exceptional circumstances a period of seclusion may be prolonged, Trust policy determines Extended Seclusion as a period of more than 14 days.

In these circumstances the clinical team must:

- Ensure that the rationale for extended seclusion and the management plan are detailed and take account of the impact of extended seclusion with specific reference to impact of solitary secluded status, potential for psychological trauma and impact on physical exercise and access to outside space.
- Update the psychological formulation to support the extended seclusion management plan.
- Ensure the weekly MDT review (recorded on independent MDT review template) is forwarded (print to PDF then save) to the Incident Reporting Team (HNF-TR.IncidentReporting@nhs.net) for oversight at the CRMG.

The appropriate commissioning body or case manager must be informed and sent weekly MDT reviews. The CQC relationship manager should also be informed via the Governance CQC Team by notifying the Humber CQC internal email address: hnf-tr.cqc@nhs.net

The outcome of reviews and the reasons for continued seclusion should be recorded on the standard Extended Seclusion Review record documentation, in order to demonstrate its necessity and explain why the patient cannot be supported in a less restrictive manner.

Where extended seclusion links to alternative placement, details of the referral progress, any delays or blocks in progressing assessment or placement must be included in the weekly independent review template.

An independent review team should be set up to review the patient after 4 weeks of continuous seclusion. Please follow exactly the same process as for monthly long term segregation reviews at section 7.4.1. Please note that if a patient transfers to segregation during the 4 week period the monthly independent review will still take place at the 4 week point which can result in the monthly review taking place before the patient has been in LTS for a month. However, the patient has still experienced a 4 week continues period of ‘isolation’ either in seclusion or segregation. This independent overview ensures the patient’s rights are upheld in terms of being subject to these additional restrictions for over 4 weeks.

Arrange for external review after each three-month period of continuous seclusion. Please follow exactly the same process as for external long term segregation reviews at section 7.4.2.

6.16. Seclusion of Children and Young People Under 18

Seclusion can be a traumatic experience for any individual but can have particularly adverse implications for the emotional development of a child or young person. This should be taken into consideration in any decision to seclude a child or young person. Careful assessment of the potential effects of seclusion by a trained child and adolescent clinician is required, especially for those children and adolescents with histories of trauma and abuse, where other strategies to de-escalate behaviours may be more appropriate than the use of seclusion (Code of Practice 2015 26.57).

Restrictive interventions must only be used with great caution on children and young people who are not detained under the Act. As noted in paragraphs 26.73 and 26.106, if there are indications that the use of restrictive interventions (particularly physical restraint or seclusion) might become necessary, consideration should be given to whether formal detention under the Act is appropriate. A person with parental responsibility can consent to the use of restrictive interventions where only if the decision falls within the ‘scope of parental responsibility’ (see paragraphs 19.38-19.43) (Code of Practice 2015 26.59).

For young people aged 16 or 17 who are not detained under the Act and who lack capacity to consent to the proposed interventions, the use of restrictive interventions in the young person's best interests will not be unlawful if they meet the requirements in section 6 of the MCA and do not amount to a deprivation of liberty (see paragraph 26.49) (Code of Practice 2015 26.60).

Staff having care of children and young people should be aware that under section 3(5) of the Children Act 1989 they may do 'what is reasonable in all the circumstances of the case for the purpose of safeguarding or promoting the child's welfare'. Whether an intervention is reasonable or not will depend, among other things, upon the urgency and gravity of what is required. This might allow action to be taken to prevent a child from harming him/herself, however it would not allow restrictive interventions that are not proportionate and would not authorise actions that amounted to a deprivation of liberty (Code of Practice 2015 26.61).

The CAMHS Inpatient service at Inspire has a designated seclusion suite. Seclusion reviews of the CYP in locked door seclusion must take place in line with this policy. Exceptional circumstances may result in the need for a child or young person to be admitted to an adult inpatient bed on a temporary basis whilst appropriate provision for their care is being sought.

Under the **Procedure for Emergency and Atypical Admissions of Young People to Adult Mental Health Wards Standard Operating Procedure** the service will be working in collaboration with the safeguarding and CAMHS teams to formulate and deliver an appropriate safety and clinical care until such the CYP is transferred to an appropriate unit.

In the event that a young person requires seclusion whilst being supported on an adult inpatient ward. This should be agreed by the CAMHS Consultant (On-call if out of hours). Reviews will take place as per this policy and should include a CAMHS Clinician. Nursing reviews will be undertaken by Nurses from the admitting ward and will be supported by Nurses from CAMHS Crisis or Inspire Inpatient Team. Staff supporting reviews will be identified in the Management care plan.

All staff on inpatient units that receive CYP under these circumstances should be aware that NICE guideline NG10 (2015) states *"Do not seclude a child in a locked room, including their own bedroom"*. This policy permits open door seclusion in line with NICE guidance for Children and Young People only.

Careful assessment of the potential effects of open door seclusion by a trained CAMHS clinician is required, especially for those CYP with histories of trauma and abuse. In addition to the safeguarding alert for a child admission, a further direct contact with the Trust safeguarding team is required to alert that open door seclusion is being considered/has been instigated for a CYP. As soon as is practicable, a member of the child safeguarding team will attend to review the CYP in seclusion.

In extreme circumstances, if the clinical team authorise the use of **locked door seclusion**, an immediate escalation must take place through the management structure. This must escalate to the chief operating officer and director of nursing. Out of hours this must be escalated to the on-call director via the on-call manager.

Seclusion reviews of the CYP in locked door seclusion must take place in line with policy, if seclusion review schedules cannot be met for a CYP in seclusion this must be escalated to the Director on call.

As soon as is practical, a senior operational manager and senior representative of the nursing directorate must attend the unit to review the child/young person in locked seclusion, with a view to offering additional support or resources.

6.17. Seclusion of people with Learning Disabilities and Autistic people

Seclusion can be a traumatic experience for any individual but can have particularly adverse implications on emotional wellbeing for people with learning disabilities and autistic people. This should be taken into consideration in any decision to seclude a person with any such condition.

If there are indications that the use of restrictive interventions (particularly physical restraint or seclusion) might become necessary, consideration should be given to the management of violence of aggression in people with a learning disability and autistic people, and staff will follow this policy whilst taking into account:

- The person's diagnosis and / or any comorbid physical / mental health problems
- The person's level of social or adaptive functioning and ability to understand new or complex information
- Potential for diagnostic overshadowing - This occurs when the symptoms of physical ill health are incorrectly either attributed to a mental health/behavioural problem or considered inherent to the person's learning disability or autism diagnosis
- The person's past experiences of use of force in any environment
- The person's communication skills and the staff ability to communicate in ways that they understand and is meaningful to them
- The person's sensory needs and as documented in sensory assessments if available / completed
- Making reasonable adjustments in the immediate environment to meet individual sensory needs where possible to do so
- All positive behavioural support plans should be co-produced with individuals where possible and with their family / carers (where appropriate and with consent) and will have specific regard to include person's views and wishes detailing when and how to use physical restraint

All Mental Health and Learning Disability staff should be familiar with the Mental Health Act 1983, Mental Capacity Act 2005, the Human Rights Act 1998 and Equality Act 2010.

All patient leaflets and information regarding the use of force and seclusion, and personal plans will be provided in easy read documents.

6.18. Deprivation of Access to Normal Daytime Clothing

Individuals should never be deprived of appropriate clothing with the intention of restricting their freedom of movement; neither should they be deprived of other aids necessary for their daily living.

It may be appropriate, in a small number of instances, for individuals to be asked to wear special tear-proof clothing; such a decision should be authorised by the patient's responsible clinician. The unit MDT (nurse and medic as a minimum) should undertake an individualised risk assessment before this decision is taken. This is particularly likely to be the case where the risk of shredded clothing being used to self-harm or attempt suicide has been assessed and is considered to be very high.

Tear-proof clothing should never be a first-line response to such risks and should never be used as a substitute for enhanced levels of support and observation. The requirement to wear tear-proof clothing should never be a blanket rule within a service.

Any tear-proof clothing should fit the person so as to preserve their dignity. It should not be demeaning or stigmatising, and should, where possible, meet any specific cultural or religious requirements.

Any requirement that an individual should wear tear-proof clothing should be proportionate to the assessed risk and documented evidence should show that it is used only as long as absolutely necessary. As soon as the risk is assessed to have diminished, consideration should be given by nursing staff or the MDT team to a return to usual clothing. This will require ongoing dynamic risk assessment.

Positive behaviour support plans (or equivalents) should detail primary prevention strategies that will aim to avoid the ongoing need for such restrictions. The patients should be told what they need to do so that they can wear their usual and preferred clothing.

6.19. Documentation

Specific forms in relation to the use of seclusion are available on the EPR.

7. USE OF LONG-TERM SEGREGATION

It is permissible to manage this small number of patients by ensuring that their contact with the general ward population is limited. The environment should be no more restrictive than is necessary. This means it should be as homely and personalised as risk considerations allow.

Patients should not be isolated from contact with staff (indeed it is highly likely they should be supported through enhanced observation) or deprived of access to therapeutic interventions. Treatment plans should aim to end long-term segregation.

The Trust safeguarding team and the Mental Health Legislation Team must be made aware of any patient being supported in long-term segregation and an adverse incident record must be completed in the restrictive intervention section of the EPR.

7.1. Initiating Long-term Segregation

LTS is not an emergency response to an acute incident. It is a planned restriction, decided upon by multi-disciplinary review involving the responsible clinician, the clinical lead, an Independent Mental Health Advocate (IMHA) where a patient has one, and a **representative from the responsible commissioning authority** in response to a chronic presentation of violence and aggression.

The Trust safeguarding team and the Mental Health Legislation Team should, where possible be included in the discussion and planning for LTS. Best practice would require a safeguarding practitioner and a Mental Health Legislation Manager to attend the MDT to discuss the implementation of long-term segregation. As a minimum telephone contact should be made with each team.

The discussion and decision to use LTS should be recorded as part of the ongoing MDT review process.

Where consideration is being given to the implementation of LTS, wherever appropriate, the views of the person’s family and carers should be asked for and taken into account.

The safeguarding team in the relevant Local Authority should be made aware of any patient being supported in longer term segregation (MHA Code of Practice 26.153).

7.2. Environment of Care

The environment should be no more restrictive than is necessary. This means it should be as homely and personalised as risk considerations allow.

Facilities which are used to accommodate patients in LTS should be configured to allow the patient to access a number of areas including, as a minimum, bathroom facilities, a bedroom and relaxing lounge area.

Patients should also be able to access secure outdoor areas and range of activities of interest and relevance to the person.

At times of acute behavioural disturbance where there is a need to contain an immediate risk of harm to others, there may be a need to transfer the person, for a short period of time, to a physical area that is more secure and restrictive and which has been designed for the purpose of seclusion. In such a situation, the procedure for seclusion in the Code should be followed with regards to authorising and commencing seclusion, observation, seclusion reviews and ending seclusion.

Consideration should be given to whether the patient is in the least restrictive environment, whether it is possible to continue managing high levels of risk posed by the patient in the LTS area, and the likelihood that it would not be beneficial to place these additional restrictions on the patient; conversely it may be likely to have a detrimental impact on their wellbeing.

Best practice would suggest completion of the barriers to change document and interventions as described within “A Guide to the Barriers to Change Checklist to Reduce Long Term Segregation in Secure Care” (Mersey Care NHS Trust).

LTS management plan must be updated to ensure it clearly specifies the expectations of staff to offer maximum engagement with the patient, where possible, and whilst acknowledging the levels of risk posed to staff.

7.3. Long Term Segregation Management Plan

The patient’s individual behaviour support plan should clearly state the reasons why long-term segregation is required. In these cases, the way that the patient’s situation is reviewed needs to reflect the specific nature of their segregation management plan.

Comprehensive individual behaviour support plan (care plan) should be prescribed detailing the rationale for LTS, aims and objectives, positive support actions by staff, details of schedule of regular review, as agreed in the MDT and in line with the requirements set out below, and outline how information will be shared with the patient as to what is expected of them in order for LTS to be brought to an end.

The LTS Management Plan must be reviewed on at least a monthly basis.

Use of LTS must not deprive patients of access to therapeutic interventions or isolate patients from contact with staff. It is highly likely that in delivering intensive mental health care, the patient would be supported by enhanced engagement and observation.

LTS does not always mean constant separation from other service users. It may sometimes be used flexibly, as part of a graded therapeutic risk management plan where the degree of segregation varies dynamically with the service user’s mental state and the risks perceived by clinical teams. This may allow nursing within the setting of least restrictive practice but provides sufficient risk management to prevent rapid transition back into more restrictive settings of seclusion (Care Quality commission. Brief Guide BG010: Long-Term Segregation V4, August 2020).

For people with LD/autism diagnosis who are in LTS there is a requirement for a HOPES assessment.

During a period of Long-term Segregation, the individual should be supported to remain engaged with their active treatment plans as much as is reasonably possible, which may include the continued use or consideration of Section 17 Leave. The potential risks of undertaking leave whilst being managed under the conditions of long-term segregation will need to be balanced up with the positive benefits of these activities, and these considerations must be documented on a relevant care plan.

Staff supporting patients who are in LTS should make written records on their condition on **at least** an hourly basis using approved supportive engagement documentation.

7.4. Segregation Reviews

The purpose of all reviews is to determine whether the ongoing risks have reduced sufficiently to allow the patient to be integrated into the wider ward community and to check on their general health and welfare.

The outcome of all reviews and the reasons for continued segregation should be recorded on the standard LTS review record documentation, in order to demonstrate its necessity and explain why the patient cannot be supported in a less restrictive manner. The responsible commissioning authority should be informed of the outcome.

The patient's situation should be formally reviewed by:

- An approved or responsible clinician at least once in any 24-hour period (it is permitted for this to be via telephone at weekends and bank holidays)
- At least weekly by the full MDT. The MDT should comprise of the responsible clinician, a senior nurse for the unit, a senior allied health professional or psychologist known to the unit and the patient's IMHA where appropriate.

Monthly Reviews

The Code of Practice (2015) states that "*Periodic reviews should be completed by a senior professional not involved in the case*". The Trust defines periodic as one month. The Trust requires an independent monthly review to involve the following professionals:

- A clinical lead **or** a matron from an alternative division to that providing LTS
  and
- A senior practitioner from the Nursing and Quality Directorate (including safeguarding clinicians)
- Where possible the MHA clinical manager will take part in the review.

One reviewer will take the lead and write up the report (to be agreed by the reviewing team prior to the review). The author of the report will send the completed report to the Mental Health Legislation Team within 10 days of the review however any concerns arising from the review must be escalated to the MHA Clinical Manager or the Mental Health Legislation Team immediately.

The independent review must be completed with the MDT in attendance, which as a minimum must include (separate to the reviewing panel) a doctor, a nurse and any other relevant professional involved with the patient, with a good knowledge and understanding of the patient's current care and treatment plan.

The IMHA should also be invited to attend. The MDT should explore the necessity and rationale for maintaining long-term segregation and the patient must be seen by a member of the review team as part of the process, unless this would have a detrimental impact on the patient's mental wellbeing; the reasons for this must be clearly documented.

It is permissible for independent long term segregation reviews to be held via MS Teams however at least one of the reviewers must personally visit the patient (if restrictions permit) around the date of the review in order to gain their wishes, feelings and understanding about their period of seclusion / segregation.

The MHA Clinical Manager will arrange the reviews and send out MS Teams invites to all relevant parties. The reviewer/s will access the Teams invite at the specified date and time. Where possible the team will try to ensure the availability of the full MDT in the MS Teams meeting.

Please note that if a patient transfers to segregation from seclusion during the month period (or indeed vice versa), and there is no break in terms of reintegrating back onto the ward, the monthly independent review will still take place at the 4 week point which can result in the monthly review taking place before the patient has been in either LTS or seclusion for a month. However, the patient has still experienced a 4 week continuous period of 'isolation' either in seclusion or segregation. This independent overview ensures the patient's rights are upheld in terms of being subject to these additional restrictions for over 4 weeks.

External Reviews
Where LTS continues for **three months or longer (in a cumulative 12-month period)**, regular three monthly reviews of the patient's circumstances and care should be undertaken by an external hospital. This should include discussion with the patient's IMHA (where appropriate) and commissioner. The mechanism for these discussions should be arranged by the ward staff.

The external review must be completed with the MDT in attendance, which at a minimum must include (separate to the reviewing panel), a doctor, a nurse and any other relevant professional involved with the patient. The MDT should explore the necessity and rationale for maintaining long-term segregation and the patient must be seen by a member of the review team as part of the process, unless this would have a detrimental impact on the patient's mental wellbeing; the reasons for this must be clearly documented.

Where a patient in long-term segregation has intermittent periods in seclusion this will not delay the process of reviewing monthly; the independent and external reviews will continue each month as planned.

PLEASE NOTE – where an external review is taking place, the monthly independent review is not required in that particular calendar month; however, a representative from Humber Teaching NHS Foundation Trust (independent of the division in which the patient is detained) should be present at the external review.

Any delays in identifying external reviewers should be shared with the CQC.

7.5. Termination of Long-term Segregation

The decision to end long-term segregation should be taken by the MDT, informing the clinical lead (including consultation with the patient's IMHA where appropriate), following a thorough risk assessment and observations from staff of the patient's presentation during close monitoring of the patient in the company of others.

A clear re-integration plan must be formulated and closely monitored during the first two weeks of reintegration back into the ward population.

7.6. Documentation

Specific forms in relation to the use of long-term segregation are available on the EPR.

7.7. MANAGEMENT OF INFECTIOUS DISEASE

The decision to isolate or segregate a resident or patient with regards to infectious disease should be considered using the following principles:

- Always seek consent to isolation
- Assess capacity and act in the patient's best interests if deemed not to have capacity (capacity should be assumed unless assessed otherwise and must be documented on relevant paperwork in patient's record)
- Thorough risk assessment and care planning should be completed on an individual basis. Patients should be encouraged to participate in the development of such plans if capable and willing to do so.
- Plans should be reasonable, necessary and proportionate balancing risks to the patient and others.
- Patients should be encouraged to make an advanced statement with respect to the use of isolation with regards to infectious disease if capable and willing to do so.
- Ward environments should be adapted to the person rather than the person to the environment where feasible.

Legal basis of any restrictions imposed

Deciding which legal framework to use in relation to restriction of patients' movements and deprivation of liberty should be driven by the **primary purpose of the intervention** and **the patient's need for mental and physical health treatment**.

If an informal patient is not cooperating with the local recommendations an MDT meeting should be held to determine the level of risk the patient may pose to themself and others. Options considered may include the discharge of the individual or, where the criteria is met for the MHA, the use of detention as appropriate.

Mental Capacity Act 2005/DoLS

- The MCA is used when an individual lacks the mental capacity to make a specific decision. Staff can make a best interest decision on behalf of their patient unless there is a Health and Welfare Lasting Power of Attorney or Court Appointed Deputy who can be contacted to make the decision.
- Proportionate restriction or restraint, which does not amount to a "deprivation of liberty", is permitted under the Mental Capacity Act for the protection of the individual.
- The Mental Capacity Act **cannot be used for the protection of others**. Where the patient lacks mental capacity in regards to specific decisions around self-isolation for infectious disease purposes, the decision must be made on their behalf and in their best interest.
- The capacity assessment should be thoroughly documented and decision specific as above. The best interests process as detailed in the Trust's MCA and DoLS policy must be followed.
- An IMCA should be appointed where necessary.
- If any proposed restrictions amount to a deprivation of liberty, ensure that an authorisation for the deprivation of liberty safeguards is submitted immediately (if not already protected under the safeguards of the MHA).

Mental Health Act 1983

Infectious diseases are physical health conditions but relevant steps may need to be taken using the Mental Health Act to prevent the spread of the virus.

MHA powers must not be used to enforce treatment or isolation for any reason unrelated to the management of a person's mental health, such as detaining inpatients whose refusal to be tested/isolated is unrelated to their mental disorder. For currently detained patients, blanket restrictions should not be imposed, but the use of the MHA may offer authority for enforcing social distancing and isolation of symptomatic patients. It is vital these powers are used with regard to the principles of the MHA Code of Practice.

Any restrictions should be the minimum necessary to safely provide the care or treatment required, having regard to whether the purpose for the restriction can be achieved in a way that is less restrictive of the persons rights and freedom of action (MHA CoP, 1.5).

Mental Health Act Code of Practice (MHA COP 2015)

- Chapter 26 of the Mental Health Act Code of Practice (2015) governs the use of restrictive interventions.
- Where the patient is detained under the Mental Health Act 1983, adherence to the Code should be maintained. Only where there is a cogent reason should there be a departure from the code.
- Where a cogent reason can be documented to depart from the Mental Health Act Code of Practice 2015 this can be acceptable.

Children Act 1989

In relation to children it may be that the Children Act is the more relevant framework in some situations.

Specific Considerations Children and Young People:

In children (under 16) lacking competence, consideration could be given to authorising confinement not amounting to a deprivation of liberty under the scope of parental responsibility. For non-capacitous 16 to 17-year olds, where the care plan amounts to a deprivation of liberty, parental responsibility and consent cannot be relied on. If a deprivation of liberty was needed and the criteria for the MHA were not met, there should be consideration of seeking the authorisation of the court. In young people (16 -17), DoLS are not available, but a deprivation of liberty can be authorised by the Court of Protection.

Isolation

The expectation is isolation would occur in a patient's bedroom or an area of a ward; not a seclusion room. This does not constitute seclusion under the MHA, and the seclusion policy and procedures do not apply. Patients are not to be kept in their rooms with the door locked.

Staff are reminded to contact the Infection Control Team when they have a new confirmed infectious disease positive patient /or a patient who is awaiting the results from their swab.

Any Infected patients on the **same ward as other non-infected patients** will be advised to self-isolate. Although the door will not be locked, movement in and out of bedroom and around the ward environment will not be allowed. An example will be a patient **who has consented to being barrier nursed and who is amenable to follow staff instructions**. Reviews for isolation – for patients who are conforming to isolation and amenable to staff instruction and advice, review times as indicated in the MHA CoP (2015) do not apply.

- If a patient does not meet the criteria for / is not detained under the MHA and lacks capacity to consent to being isolated, but is compliant, MCA/DoLS will apply. NB: A patient who lacks capacity to consent to their admission and treatment cannot be admitted informally. Remember the MCA is decision specific.
- If patients detained under the MHA are objecting to being isolated (which is due to their mental disorder) but not behaviourally disturbed then segregation might be a consideration

and an MDT meeting should be held to discuss this.
- For patients who are violent and disturbed, and detained under the MHA then the seclusion pathway should be followed and the Code of Practice Guidelines followed with regards to reviews. NB: In this situation the decision to seclude the patient would be because they are an immediate risk to others due to their acute behavioural disturbance, and not because they need to isolate for infectious disease purposes.
- Rationale needs to be really strong and there should be full defensible documentation and robust justification through use of the MDT.

Segregation
Segregation for preventing the spread of infection in line with any current government guidance will only considered after all other less restrictive options have been ruled out. For example, use of appropriate PPE, keeping distance, appropriate ventilation of rooms etc.
Staff should always try to use skilled intervention and encourage isolation to reduce the use of restrictive practices.

- While all effort should be made to avoid the need for tertiary interventions, it is preferable to use segregation in circumstances where close physical contact such as extended holds (restraint) are the only alternative.
- Segregation may need to continue throughout the period of time that the person with the infectious disease presents with behaviour that is a significant risk to others.
- It is of the utmost importance that an ethical balance is maintained safeguarding the patient and others. This will require careful thought in difficult circumstances on a case by case basis.
- Where infection control is a major concern for any segregated patient, account should be taken of the infection period duration during the reviews.
- As soon as possible, segregation should be discontinued in favour of lesser restrictive isolation where infection risk remains.
- Methods of segregation may vary between units depending on the format of intensive nursing suites and extra care areas.
- It is possible that there may be no alternative to using bedrooms or locking off areas of a unit or ward.
- For a patient representing risk of infection, an individual care plan should be developed with the aim of maintaining cooperation with isolation and diminishing the need for physical intervention or other restrictive practices.
- All effort should be made to achieve agreement and cooperation.
- The care plan supporting segregation should have provision for recognising and dealing with any physical deterioration related to the known course of infectious disease, or for other reasons.

Initiating infectious disease Segregation under the MHA 1983
Once there are reasonable grounds to believe that the patient is, or may be, infected or contaminated with infectious disease and there are valid reasons to believe that they **will not be amenable to staff instructions / advice to adhere to isolation protocol due to their mental disorder**, then it may be appropriate for segregation to commence.

Consideration of segregation and authorisation will be discussed in an MDT meeting with attendance from the patient's Responsible Clinician or a nominated deputy, other members of the nursing team, the patient's IMHA, IPC Nurse, a Safeguarding representative and a Mental Health Legislation Team representative, where possible. Views of patient's family / carer should also be sought. There should be MDT agreement of how the segregation will be managed, including environment, engagements, reviews, etc.

An urgent decision out of normal working hours could be made via MDT discussion without attendance from the patient's IMHA, IPC Nurse, Safeguarding representative and Mental Health Legislation Team representative however they should all be informed / consulted at the earliest opportunity during normal working hours.

Environment
Whilst it is recognised it may not always be possible in urgent circumstances specific to the risks from infectious disease, every effort should be made to ensure the environment of the segregation area meets the required criteria for Long Term Segregation in the Trust's Seclusion and Segregation Policy:

- Facilities which are used to accommodate patients in segregation should be configured to allow the patient to access a number of areas including, as a minimum, bathroom facilities, a bedroom and relaxing lounge area.
- Patients should also be able to access secure outdoor areas and range of activities of interest and relevance to the person.
- The environment should be no more restrictive than is necessary. This means it should be as homely and personalised as risk considerations allow.

Engagements
There must be a mechanism for patients to summon staff in case they become unwell; this should be discussed and agreed at initial MDT discussion.

Additional engagements might be necessary dependent to the presentation of the individual.

Review of patient in infectious disease Segregation
- Keeping a patient apart from other patients for the purposes of quarantine during the infection period does not need to be identified as, or subject to the procedural safeguards for, seclusion or long-term segregation under the terms of the MHA Code of Practice.
- Such reviews in the case of infectious disease isolation would serve no purpose, as the effective question is simply the presence or absence of communicable disease.
- Medic reviews to take place at least daily during the week– frequency to be agreed in MDT – with daily access to medic reviews on a weekend. The purpose of the daily medical review is to check the patient is not becoming physically ill, but this could involve discussion with nursing staff and/or talking to the patient through a door or via an intercom, or even by phone/laptop (where allowed/possible). Only if the ward staff thought the patient required physically examining, would a Doctor (or nurse) need to enter and physically touch the patient.
- Regular nursing reviews to be carried out - frequency to be agreed in MDT.

Transitioning from Segregation to Self-Isolation
- All effort should be made to achieve cooperation and removal of the need for segregation
- Disturbed, uncooperative or aggressive behaviour that may also represent an infection risk, should form part of the process of review of the need for continuing segregation
- As soon as possible, segregation should be discontinued in favour of lesser restrictive isolation where infection risk remains.
- The decision to terminate segregation (before risk of infection is confirmed) and commence self-isolation should be made by the MDT and approved by the Responsible Clinician (RC) or a nominated deputy.

Recording of Segregation
- Clear and robust multi-disciplinary documentation should be completed to include a

rationale, justification and management plan.
- Staff should record the segregation in the adverse incident tab and should add into the reasons for restriction (because of infectious disease).
- Staff should also review the patient's Infection Prevention and Control Risk Assessment Documentation within the EPR.
- Staff supporting patients who are in segregation should make written records on their condition on **at least** an hourly basis via the adverse incident tab in the clinical chart.

Post Isolation Support – (post incident review)
Following any self - isolation or segregation, the patient should be supported and given the opportunity to participate in a post incident review process to help them understand what has happened and why (MHA CoP 26.167). The patient's account of the reasons giving rise to the use of segregation, including feelings, anxieties or concerns, should be documented on the EPR in the patient debrief record (MHA CoP 26.170).

If a patient is not able or willing to participate in a post incident review process then assessments of the effects of the use of isolation or segregation on behaviour, emotions and clinical presentation should be undertaken and recorded in the patient's record.

Seclusion
Infectious disease is in itself **not** a valid justification for use of seclusion as described under the MHA and as we commonly understand it within the Trust.

If a patient who is suspected or positive for infectious disease **becomes violent or aggressive as a consequence of their mental disorder** and poses an immediate risk to others they may need to be secluded under MHA to uphold the safety of others on the ward. In such circumstances the following guidance applies. NB: In this situation the decision to seclude the patient would be because they are an immediate risk to others due to their acute behavioural disturbance, and not because they need to isolate for infectious disease purposes.

8. CARE AWAY FROM OTHERS (CAFO)

8.1. Reason for Use of CAFO

The purpose of this procedure is to ensure the safe management of patients who require a period of care in an area away from other patients and not to seclude nor segregate.

The care required must be led by the patient's needs and be appropriate to maintain privacy, dignity and safety for those who are acutely distressed, disinhibited or have difficulty with living within busy ward environments, e.g. individuals with conditions such as autism, sensory processing disorders or other individual diagnosed needs.

CAFO must only be used if the patient is not deemed suitable to be reintegrated back onto the ward due to them requiring a single person placement upon discharge. CAFO is for patients who present as a risk to others or for their own vulnerability. Any such arrangements made must be the least restrictive option, must be for the least possible period of time, and must be proportionate in response for each individual.

An individual should only be nursed separately from other patients when absolutely necessary and agreed through a documented MDT meeting including family/carer/advocacy involvement whenever appropriate. All incidences where the plan is for a patient to be nursed under CAFO must be logged within the Clinical Risk Management Group (CRMG) so as to have oversight through an external structure.

Every effort should be made to facilitate the patient accessing activities off the unit if safe to do so and wherever possible the patient will be allowed access to communal areas, i.e. during

quieter periods when there are fewer patients in these areas following clear and documented risk assessment(s) agreed by the multi-disciplinary team. Patients in CAFO wishing to mix with others should be allowed to do so unless their current presentation suggests that this would not be in their best interest or others at that time.

8.2. Authority to Initiate Care Away From Others

There should be the legal framework of the MHA in place first in order to nurse someone in a CAFO environment. The MCA does not allow restrictions if it is to protect others.

The plan to nurse the patient away from other patients should ordinarily only be made by the MDT collectively, which will comprise minimally of the responsible clinician (or delegated deputy), nurse in charge and one other professional involved in the care of the patient. The patient, next of kin/nearest relative/carer, IMHA and the responsible commissioning authority should be involved in the decision making where possible and be clearly documented that this consultation, with agreed outcomes, has occurred. The individual plan must then be referred to the Clinical Risk Management Group (CRMG) for oversight.

The Trust safeguarding team and the Mental Health Legislation Team should, where possible be included in the discussion and planning for LTS. Best practice would require a safeguarding practitioner and a Mental Health Legislation Manager to attend the MDT to discuss the implementation of CAFO. As a minimum telephone contact should be made with each team.

Where urgent action is required to safeguard a patient and an MDT as indicated above cannot be convened, i.e. a weekend or during the night, and the Nurse in Charge believes that CAFO is the least restrictive and proportionate action, this must be indicated in the patient clinical notes. The on-call manager and on-call consultant will be contacted to inform them of the implementation of CAFO.

The Trust Safeguarding Team and the Mental Health Legislation Team must be advised of the implementation of CAFO outside of office hours as soon as practicable and where appropriate may request further information and actions to be taken to support safeguarding of vulnerable patients.

The usual decision making and authorisation process must be initiated as soon as practicable following the implementation of CAFO outside of office hours.

Steps must be taken to inform the next of kin/nearest relative and/or carer as soon as is possible.

8.3. Review and ending of Care Away From Others

The next of kin/nearest relative/carer and IMHA must be involved in all reviews where appropriate.

Daily

The continuing need to nurse any patient separately from other patients should be reviewed each shift by the nurse in charge in line with the outlined criteria for termination of CAFO (which may include the patient's request to end procedure).

Weekly

Patient MDT Review

Undertaken weekly comprising of responsible clinician/consultant psychiatrist (or delegated deputy), nurse in charge and one other professional involved in the care of the patient.

Independent/External Reviews

Three-monthly

Independent MDT Review
An MDT Review will be undertaken every three months, comprising of responsible clinician (or delegated deputy), nurse in charge, one other professional involved in the care of the patient, a representative from the Trust's Safeguarding Team, IMHA and one of the executives (director of nursing, the medical director or the chief operating officer).

It is permissible for independent CAFO reviews to be held via MS Teams however at least one of the reviewers must personally visit the patient (if restrictions permit) around the date of the review in order to gain their wishes, feelings and understanding about their period of seclusion / segregation.

The MHA Clinical Manager will arrange the reviews and send out MS Teams invites to all relevant parties. The reviewer/s will access the Teams invite at the specified date and time. Where possible the team will try to ensure the availability of the full MDT in the MS Teams meeting but there should at least be a doctor and a nurse in attendance, or a professional with a good knowledge and understanding of the patient's current care and treatment plan.

Six-monthly
Learning Disability Services
Independent/External reviews will be facilitated through Care and Treatment Reviews (CTR – Transforming Care) and scheduled and arranged by appropriate responsible Clinical Commissioning Groups.

CTRs will be conducted by external independent chairperson, and will include patient by experience (and/or independent carer), IMHA and representation from CCG.

First CTR Community CTR prior to admission or within seven days of admission
Second CTR Six months following admission or earlier as requested by MDT

All other inpatient services
External reviews will be facilitated on a six monthly basis via the weekly clinical review and in addition to the required attendance (as stated above) a representative of the commissioners and an IMHA will be in attendance to ensure a fully independent view.

8.4. Characteristics of the Care Away From Others Area
Patients should not be isolated from contact with staff (indeed it is highly likely they should be supported through enhanced observation) or deprived of access to therapeutic interventions. The environment should be no more restrictive than is necessary. This means it should be as homely and personalised as risk considerations allow.

Facilities which are used to accommodate patients in CAFO should be configured to allow the patient to access a number of areas including, as a minimum, bathroom facilities, a bedroom and relaxing lounge area. Patients should also be able to access secure outdoor areas and range of activities of interest and relevance to the person.

The following must be considered in all cases:
- Alarm system
- Proximity to other staff
- Hazards within the room
- Ease of observation

At times of acute behavioural disturbance where there is a need to contain an immediate risk of harm to others, there may be a need to transfer the person, for a short period of time, to a physical area that is more secure and restrictive and which has been designed for the purpose

of seclusion. In such a situation, the procedure for seclusion in the Code should be followed with regards to authorising and commencing seclusion, observation, seclusion reviews and ending seclusion.

Consideration should be given to whether the patient is in the least restrictive environment, whether it is possible to continue managing high levels of risk posed by the patient in the CAFO area, and the likelihood that it would not be beneficial to place these additional restrictions on the patient; conversely it may be likely to have a detrimental impact on their wellbeing.

Best practice would suggest completion of the barriers to change document and interventions as described within “A Guide to the Barriers to Change Checklist to Reduce Long Term Segregation in Secure Care” (Mersey Care NHS Trust).

LTS management plan must be updated to ensure it clearly specifies the expectations of staff to offer maximum engagement with the patient, where possible, and whilst acknowledging the levels of risk posed to staff.

8.5. Care of the Patient

The patient (and relatives/carers/advocate) should be informed of the reason why nursing care is being provided away from other patients.

A care away from others management plan must be formulated that specifies the care to be provided and the goals of care – this plan will be supported by the patient’s Positive Behaviour Support Plan. The care away from others management plan must include clear rationale for the implementation and criteria to be met or risks to be mitigated in order to terminate the CAFO procedure.

The care away from others management plan must be reviewed on at least a monthly basis.

For people with LD/autism diagnosis who are in CAFO there is a requirement for a HOPES assessment.

An agreed observation and engagement plan will be in place for the patient with written documentation to support engagements evident in accordance with the Trust’s Supportive Engagement Policy.
The patient should have access to TV/audio/internet facilities and a telephone on request in line with agreed risk and management plan.

Following risk assessment of the patient and environment there should be arrangements for regular exercise and fresh air, whilst ensuring safety of the patient and others.

Therapeutic activities should be provided as agreed through MDT care planning.

The patient should be given access to drinks, food and snacks regularly.

The MDT must document how support with family and friends will be maintained developed (as appropriate) whilst CAFO is in place. Any restriction on visitors during this period must be documented in the patient’s notes giving reasons for the decision.

8.6. Documentation Requirements

The decision to use CAFO must be recorded in the MDT notes and clear authorisation by the Responsible Clinician and oversight by the CRMG must be evident.

There must be evidence of:

- All Clinical Review Meetings.

- Care and Treatment Review/independent review outcomes with action plans and completed actions.

Contact with next of kin/nearest relative/carers must be documented along with any Trust safeguarding contacts.

Records must be made available for inspection by the Care Quality Commission.

9. POST-INCIDENT REVIEW FOLLOWING USE OF RESTRICTIVE INTERVENTIONS

Following any episode of acute behavioural disturbance that has led to the use of a restrictive intervention, a post-incident review/analysis or debrief should be undertaken so that involved parties, including patients, have appropriate support and there is opportunity for organisational learning. It is important that patients are helped to understand what has happened and why and that staff review whether, if similar circumstances recur, an alternative approach may be feasible. Patients with limited verbal communication skills may need support to participate in the post incident review or debriefing.

Where a patient is not able to participate in debriefing, methods for assessing the effects of any intervention on their behaviour, emotions and clinical presentation should be fully explored as part of their assessment(s) and recorded in their positive behaviour support plan (or equivalent).

If the patient is able and agrees to discuss the incident which led to the use of a restrictive intervention, their understanding and experience of the incident should be explored. The patient should be given a choice as to who they would like to discuss their experience with, wherever possible. Attempts by staff to simply justify decisions to use a restrictive intervention may be counterproductive; the aim is to use empathic therapeutic relationships to explore what aspects of the intervention helped, didn't help and might be done differently in future.

Patients' accounts of the incident and their feelings, anxieties or concerns following the restrictive intervention should be recorded in the debrief record in the adverse incident tab in clinical charts Positive behaviour support plans (or equivalent) should be reviewed and updated as necessary. Patients should be reminded that they can record their future wishes and feelings about which restrictive interventions (or any other aspect of treatment and care that has been raised by the incident) they would or would not like to be used in an advance statement.

If patients wish to formally raise a concern they should be reminded of how to access the Trust complaints system, PALS and independent advocacy services. Patients who need alternative support (e.g. alternative format, additional explanation) should be offered this support to access the use of the complaints procedure.

If a patient raises a concern about a restrictive intervention, a Datix should be completed and the Trust Safeguarding team informed. This may lead to further investigation with the patient and team. Patients who have suffered a serious assault whilst in hospital should be offered police involvement and a safeguarding alert should be completed.

Staff should also hold a post incident review for any restrictive practice, this encourages reflection and learning within the team and will assist with future planning and development for the team. Where possible inviting the matron/unit manager to the review may help with providing clinical challenge and looking at alternative approaches.

9.1. Duty of Candour

The Trust's Duty of Candour Policy and Procedure; Communicating with Patients and/or their Relatives/Carers Following a Patient Safety Incident is based on the National Patient Safety

Agency's (NPSA) Being Open Policy, the principles of which are fully supported by a wide range of Royal Colleges and professional organisations and, is consistent with the Department of Health (2003) "Making Amends" consultation document, which states, "The individual who has suffered harm as a result of the healthcare they have received must get an apology". This should be regardless of whether the patient goes on to complain or claim. A duty of candour (to be open with patients about harm caused) is now also included as a statutory obligation in the NHS Standard Contract. The contract requires NHS Trusts to ensure that "patients/their families are told about patient safety incidents that affect them, receive appropriate apologies, are kept informed of investigations and are supported to deal with the consequences". The duty applies to patient safety incidents that occur during care provided under the NHS Standard Contract and that result in moderate, prolonged psychological, severe harm or death (refer to the Duty of Candour Policy and Procedure).

10. EQUALITY AND DIVERSITY

An Equality and Diversity Impact Assessment has been carried out on this document using the Trust-approved EIA.

This policy, procedures and guidelines ensure that all people are in receipt of services that are safe, effective and led by the needs of the person. The standards within the policy will be applied equally to all patients irrespective of the protected characteristics of the Equality Act 2010. Where individuals are being detained or receiving treatment under the terms of the Act no community group will be treated less favourably.

The impact assessment has identified that the trends in the use of the Mental Health Act will be monitored by the Mental Health Act Legislation Committee against National Equality and Diversity data to identify any impacts on the target groups.

Where patients' legal status is affected, we have a clear duty to inform them of their rights regardless of their main language or communication difficulties. DVDs are available in 28 languages (other than English) with the rights of detained patients.

When patients are detained with any impairment to understanding, clinical staff must identify this need as soon as possible and access appropriate interpreter support (e.g. Language specialist, BSL interpreter, Independent Mental Health Advocate). All staff will ensure that patients are repeatedly advised of their rights using these methods of interpretation.

Religious beliefs will be respected, and the Trust chaplain will support access to relevant faith leaders and information. All clinical settings (wherever possible) should accommodate individual prayer/meditation space with appropriate access facilities.

11. IMPLEMENTATION/TRAINING

This policy will be disseminated by the method described in the Document Control Policy.

All staff must receive appropriate and relevant induction and knowledge of seclusion policy in areas where seclusion is used. This will be via the restrictive interventions training facilitated by the Matrons / Band 7s on a 3 yearly basis; this requirement is on each inpatient staff members ESR.

The restrictive interventions training includes training associated with the observation of a patient post Rapid Tranquillisation as per guidance within the RT policy.

Junior medics receive training at induction on seclusion on a six-monthly basis by one of the Trust's Consultant Psychiatrists.

All staff must complete training associated with the supportive engagement policy to ensure they are competent to undertake the supportive engagement of patients while in seclusion as the suitably skilled professional. Training facilitated by the Matrons / Band 7s to all newly appointed inpatient staff. On Inspire this is facilitated via staff induction - the staff will complete supportive engagement competencies which includes answering questions as well as being shadowed by senior staff to then be signed off. All staff must complete this before being able to complete the supportive engagements independently.

12. MONITORING AND AUDIT

Compliance against the requirements of this policy will be monitored by the Modern Matrons / Band 7 Clinical leads via individual audit of all episodes of seclusion, long-term segregation and CAFO which will be completed via InPhase and via the regular independent and external reviews of long-term segregation and CAFO. Long Term Segregation and CAFO audits should be completed on a monthly basis, and audits of extended seclusion at each 2 week period.

Incidences of seclusion, segregation and CAFO, duration and patient demographics are collected and collated by the Mental Health Act Legislation Team and circulated to the Executive team and CQC on a weekly basis.

Seclusion is monitored quarterly through the Reducing Restrictive Interventions Group as part of an overarching reducing restrictive interventions plan.

This information is reported to the Mental Health Legislation Committee within its quarterly reporting cycle, and where required associated actions should be agreed as part of the quarterly committee meeting.

13. REFERENCES/EVIDENCE/GLOSSARY/DEFINITIONS

Care Quality commission. Brief Guide BG010: Long-Term Segregation V4, August 2020

Department of Health (2014) Positive and proactive care: reducing the need for restrictive interventions London DH.

DH (2015) The Code of Practice, Mental Health Act 1983 London, TSO.

"A Guide to the Barriers to Change Checklist to Reduce Long Term Segregation in Secure Care" (Mersey Care NHS Trust).

NICE (2015) Violence and aggression: short-term management in mental health, health and community settings, London, NICE.

Department of Health Mental Health Units (Use of Force) Act 2018

(Mental Health Data Set: Restrictive Intervention guidance notes for definitions with working examples).

14. RELEVANT TRUST POLICIES/PROCEDURES/PROTOCOLS/GUIDELINES

Managing Violence and Aggressive behaviour Policy
Mental Health Act Policy
Supportive Engagement and Observation Policy
Mental Capacity Policy
Being Open and Duty of Candour Policy and Procedure
Rapid Tranquilisation Policy
Physical Intervention Policy

Appendix 1: Management of Patients in Seclusion with External Bathroom Facilities

The separation of en suite facilities from the seclusion room introduces a number of risks that require careful management for patients who are being cared for in the seclusion room.

It is fundamental that patients have access to toilet and shower facilities when in seclusion (Code of Practice 2015). Seclusion suites built prior to 2013 were not required to have integrated en suite facilities. Humber Inpatient Services were built prior to the new estates specification (Health Building Note 03-01).

Where washroom facilities are external to the seclusion room, patients will have to leave the seclusion room and be escorted into the toilet/shower area on request/prompting. The following procedures must be adhered to for staff managing patients in these situations; as denial of access to toilet/shower facilities even when proposing alternative methods can be classed as a breach of Human Rights, as set out in Article 3.

This procedure will enable the Trust to identify the risks to patients and staff of managing seclusion on these units, reporting through Datix occasions when patients have been denied access to the toilet or shower and meet our duty of candour requirements.

- The team must ensure that the seclusion management plan includes the staffing numbers necessary to support access to the toilet/shower facilities. This may need to specify the gender of the staff to be involved in the process.
- If the patient asks to go to the toilet or to use the shower you must support this request immediately in line with the risk assessment and agreed staffing numbers.
- If the staff member supervising seclusion believes that the presentation of the patient moving from seclusion to the toilet/shower poses a significant risk and has changed from the current management plan, the following procedures must be followed rapidly:
  a) Raise their concerns with the nurse in charge and jointly undertake a new risk assessment immediately and update the management plan.
  b) Clearly articulate the risk that prevents the patient from being allowed supervised access from seclusion to the toilet/shower.
  c) If this is directly related to not having enough available staff the registered nurse on duty **must** inform the charge nurse, or out of hours contact the on call-manager, to highlight the breach of human rights due to low staffing.
  d) Where the risk is deemed too high due to patient factors and staffing is not an issue, this must be documented in the seclusion record and management plan.
  e) All appropriate interventions should be used to ensure that the privacy and dignity of the patient is maintained as far as possible when they are not able to leave the seclusion room to access the toilet.
  f) When a receptacle is provided to a patient being nursed in seclusion for bodily fluids and is ready for disposal; the receptacle is to be physically collected by clinical staff from the seclusion room when safe to do so, based on a clinical risk assessment. Receptacles containing bodily fluids are **not** to be passed through the hatch.
  g) At the first opportunity the single use urinal/bowl will be removed and disposed of appropriately.
  h) All areas to ensure when receptacles are provided and collected this is documented within the seclusion communication record.
  i) In all instances where the patient has not been able to access shower/toilet facilities due to staffing or clinical presentation a Datix must be completed.

Appendix 2: Designated Seclusion Suites

The Trust has designated seclusion suites in the following inpatient units:

Medium and Low secure (Humber Centre)

- Swale
- Derwent
- Ullswater (2 suites)
- Pine View

Adult Mental Health

- Miranda House:–
  - PICU
  - Avondale
- New Bridges
- Westlands

Learning Disability

- Willow (Townend Court)

Child and Adolescent Mental Health (CAMHS)

- Shared Seclusion Suite for:
  - Nova - PICU
  - Orion – General Adolescent Unit

Appendix 3: Escalation Procedure for Medical Reviews

Out of Hours

- Ward/unit staff will contact the duty doctor to undertake seclusion review as stipulated in policy.
- If the duty doctor is not able to undertake the seclusion review within the stipulated timescale, then the duty doctor is required to contact the on-call consultant. The on-call consultant should support and advise the duty doctor to facilitate a timely review of seclusion and if necessary to attend the ward/unit to undertake the seclusion review if the delay in the duty doctor attending is unacceptable.
- The duty doctor is required to inform the ward if the seclusion review cannot be undertaken in the stipulated timescale.
- Any failure to meet the requirements of seclusion review must be recorded by the ward on the Datix system with the level of harm decided by the reporter and confirmed by the daily huddle. The delay in seclusion review should be escalated to the on-call manager. For late medical or nursing reviews a datix is required if the review is more than 10 minutes late.

In Hours

- Ward staff will contact the duty doctor to undertake seclusion review as stipulated in policy.
- If the duty doctor is not able to undertake the seclusion review within the stipulated timescale, then the duty doctor is required to contact the responsible clinician or the responsible clinician cover. The responsible clinician is required to support and advise the duty doctor to facilitate a timely review of seclusion, and if the delay in the duty doctor attending to review the seclusion is unacceptable, the responsible clinician should attend to undertake the seclusion review.
- The duty doctor is required to inform the ward if the seclusion review cannot be undertaken in the stipulated timescale.
- Any failure to meet the requirements of seclusion review must be recorded by the ward on the Datix system with the level of harm decided by the reporter and confirmed by the daily huddle.. For late medical or nursing reviews a datix is required if the review is more than 10 minutes late.

Appendix 4: Escalation AND CONTINGENCIES Procedure for Nursing Reviews

The nurse in charge who initiated seclusion must check the duty roster at the earliest opportunity to consider the implications for nursing reviews.

Two registered nurses must undertake the review, of which one should not have been involved in the decision to seclude. If a second RN is on duty and was not part of the secluding response team, they can undertake the nursing review as the independent nurse.

In the event where only one registered nurse is available on the unit to carry out the review, every effort should be made to acquire a nurse from another unit to attend in person, given the purpose of the nursing review is to observe the patient's condition. If this is not possible consideration should be given to the use of technology so that the second nurse can be involved remotely in the seclusion review via use of video link. It is recognised that this option might not be appropriate for all patients depending on clinical presentation so each incidence would need to be individually assessed for appropriateness.
When all options have been exhausted to ensure presence of a second nurse the following actions should be taken:
As a minimum in the absence of a physically present second nurse, in order to safeguard the patient and make sure reviews aren't taking place completely in isolation, a second registered nurse will take part in the review over the telephone.

In Hours

- Ward staff will contact the unit manager or matron to plan for appropriate RN cover for seclusion.
- If the appropriate RN cover is not available to undertake the seclusion review within the stipulated timescale, then the unit manager or matron is required to contact the service manager in the first instance to escalate the requirements. It would be expected that the Matron attend the unit to ensure the initial two-hourly nursing review takes place whilst arrangements for ongoing reviews are made.
- The service manager can escalate through the operational management structure to gain appropriate RN cover for the seclusion review.

Out of Hours

- Ward/unit staff will contact the on call manager to alert them to the nursing review requirements and the shortfall requiring attention.
- The on-call manager will utilise the on call managers' pack to identify the appropriate RN cover for the reviews. The ward staff in conjunction with the on call manager should plan at least 24 hours in advance to ensure cover is available. This can be cancelled as soon as seclusion ends, but enables smooth operational planning to meet the patient safety and safeguarding requirements of Seclusion.

Any failure to meet the requirements of seclusion review must be recorded by the ward on the Datix system with the level of harm decided by the reporter and confirmed by the daily huddle. The delay in seclusion review should be escalated to the service manager or clinical lead. For late medical or nursing reviews a datix is required if the review is more than 10 minutes late.
All nursing reviews where only one nurse is physically present (including via video link) must be reported via the datix system; it is permitted for one datix to be completed at the end of each shift indicating the times of each review where only one nurse was physically present.

Appendix 5: De Facto Seclusion

TO: All Humber Teaching NHS Foundation Trust Staff working within mental health/learning disability inpatient settings.

FROM: Clinical Risk Management Group (E-mail: Patient Safety Team)

DATE SENT: 17/02/2025 **DATE RECEIVED**:

Ref: PN 2025-01 **AUTHORISED BY:** Dr Kwame Fofie – Medical Director

ALL INPATIENT STAFF ARE REQUIRED TO BE AWARE OF SITUATIONS THAT MAY SUGGEST A DE FACTO SECLUSION.

NATURE OF CONCERN: Staff used the wrong terminology for a recent episode of seclusion in a non-designated seclusion area, which was reported as a 'de facto seclusion'.

Please note:

- Defacto seclusion is an episode of seclusion that is **not** reported and managed as seclusion in line with the Trust Policy for the use of Seclusion or Segregation.
- In extreme circumstances the policy allows for patients to be secluded in a non-designated seclusion area however they should be moved to a designated area at the first available opportunity; as long as the Trust Seclusion and Segregation Policy is followed this would **not** be classed as a defacto seclusion.
- Seclusion outside of a designated seclusion room needs to be escalated to the Matron in hours and the on-call manager out of hours.

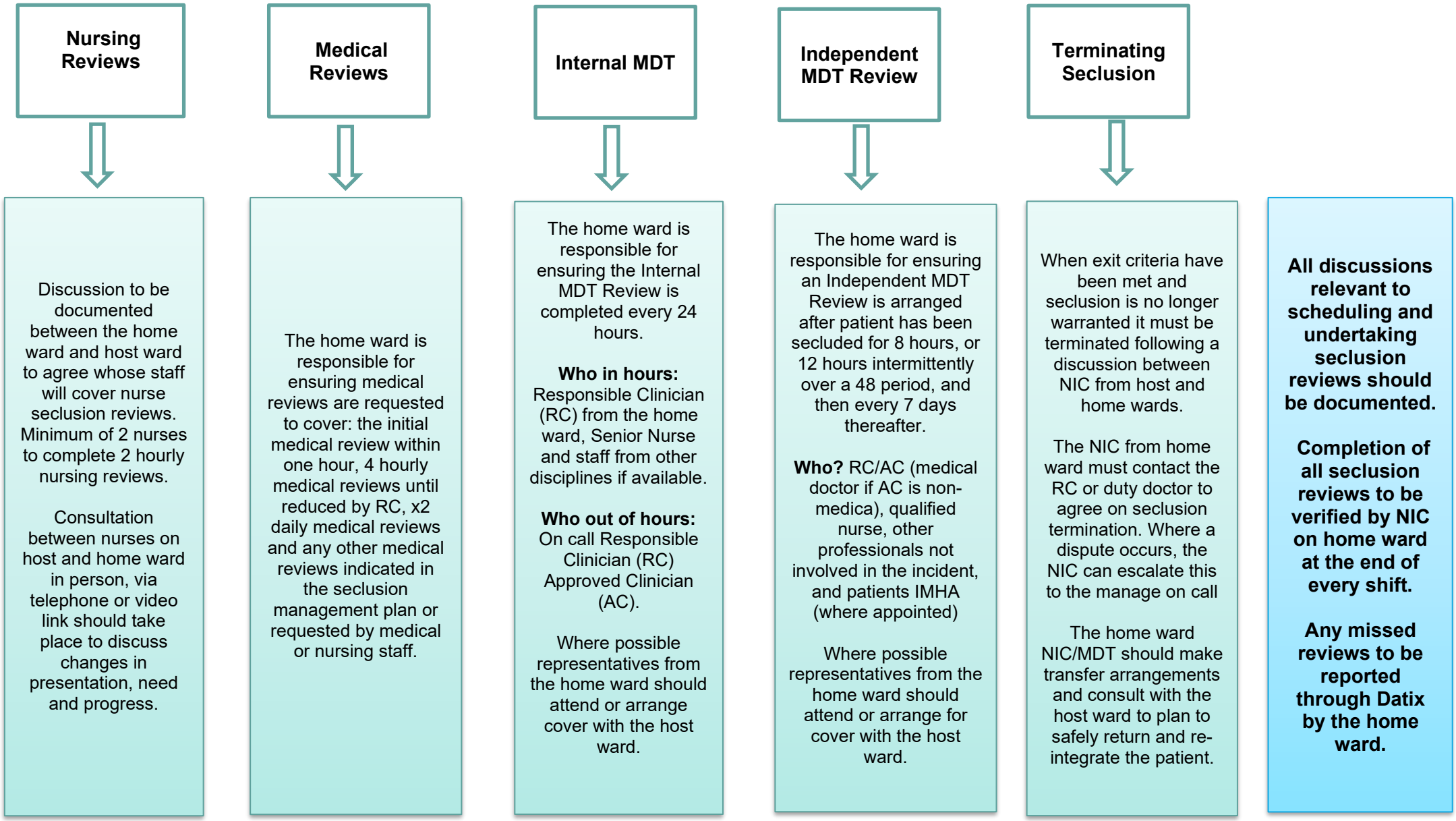
ACTIONS TO BE TAKEN:

1. If you prevent a person leaving an area due to your concerns about their presentation and risk of harm to others, you are secluding that patient. You must therefore apply the safeguards of the policy and immediately escalate to a manager to enable plans to be made to deal with the situation.
2. All episodes of seclusion must be reported via Datix and the restrictive intervention tab in SystmOne.
3. Content of this Practice Note to be discussed within team meetings and / or Supervision and shared with any new inpatient staff who join the Trust via the ward induction pack.

Please ensure the Practice Note is shared in your Team meeting and that the sharing of the Practice Note is noted in the meetings minutes.



Appendix 6: Flowchart - Responsibilities for Reviews of Patients Secluded on Host Ward



Please refer to the policy and help guides in the seclusion folder for more details

Appendix 7: Document Control Sheet

This document control sheet, when presented for approval/ratification must be completed in full to provide assurance. The master copy of the document is to be held by the Policy Management Team.

Document Type	Policy		
Document Purpose	The policy aims to: • ensure physical and emotional safety and wellbeing of patient • ensure that the patient receives the care and support rendered necessary both during and after restrictive interventions • designate a suitable environment that takes account of the patient's dignity and physical wellbeing • set out the roles and responsibilities of staff, and set requirements for recording, monitoring and reviewing the use of seclusion and any follow-up action		
Consultation:	Date:	Group / Individual	
list in right hand columns consultation groups and dates -	20 September 2023	Mental Health Legislation Steering Group	
	19 October 2023	QPAS	
	16.04.25	Mental Health Legislation Steering Group	
	13.05.25	Reducing Restrictive Interventions Group	
	15.05.25	QPAS	
	18.06.25	Mental Health Legislation Steering Group	
	24.07.25	QPAS	
	26.08.25	EMT	
	27.08.25	Mental Health Legislation Committee	
Approving Body:	EMT	Date of Approval:	26 August 2025
Date of Board Ratification:	24 September 2025		
Training Impact Analysis:	None [x]	Minor [ ]	Significant [ ]
Financial Impact Analysis:	None [x]	Minor [ ]	Significant [ ]
Capacity Impact Analysis:	None [x]	Minor [ ]	Significant [ ]
Equality and Health Inequalities Impact Assessment (EHIIA) undertaken?	Yes [x]	No [ ]	N/A [ ] Rationale:

Document Change History:			
Version Number	*Type of Change (full/interim review, minor or significant change(s))*	*Date*	*Details of Change and approving group or Executive Director* ***(if very minor changes as per the document control policy)***
5.0	*Major Review*	*28/01/2016*	*Policy rewritten*
6.0	*Review*	*16/06/2016*	*Minor review – Post CQC visit.*
6.1	*Review*	*11/11/16*	*Minor revisions to support monitoring arrangements*
6.2	*Review*	*Dec 16*	*Minor revisions following consultation*
6.3	*Addition*	*Jan 17*	*Addition of template plans for long-term segregation*
6.4	*Amendment*	*June 17*	*Amendment to Independent Review Process for Seclusion*
6.5	*Addition*	*May 2018*	*Additions made: section 5.18 Extended seclusion, Appendix 12 Extended Seclusion briefing report, section 7 Care Away From Others (CAFO), section 6.4 in relation to S17 Leave. Medical Director Sign off 11-6-18*
7.0	*Full review*	*May 2019*	*Approved by MHLC 9-May-19 and ratified at Trust Board 22-May-19*
7.1	*Amendment*	*July 2020*	*Removed involvement of PET team in professionals meeting (page 13)*
7.2	*Amendment*	*August 2020*	*Removed reference to commissioning of CAMHS inpatient beds (page 19). Addition to monitoring and audit section on page 29 and Seclusion definition (p7).*
7.3	*Amendment*	*November 2020*	*Amendments to LTS and CAFO definitions (page 8 and pages 22 – 26). LA safeguarding team to be made aware of LTS (Page 21)*
7.4	*Amendment*	*January 2021*	*Change to frequency of extended seclusion independent reviews (Page 18). Addition of use of seclusion in adult inpateint units for CAMHS patients and seclusion review arrangements (Page 20). Paragraph deleted in relation to CAMHS open door seclusion (page 21). Appendix 1 (page 40) addition of Inspire in designated seclusion suites. Appendix 2 (page 42) added process to follow if seclusion suite at Inspire is occupied.*

7.5	*Amendment*	*July 2021*	*Change to frequency of independent MDT review (Page 14)*
7.6	*Amendment*	*September 2021*	*Paragraph added to page 16 with regards to the ceasing of night time medical reviews when patients are asleep. Amends made to requirements for completion of datix following late seclusion medic or nursing reviews.* *Approved MHL Steering Group 16-Nov-21*
7.7	*Amendment*	*February 2022*	*Removed reference to briefing report as this has been replaced by sending independent MDT review to CRMG.* *Added link to Restrictive Practice Guidance in relation to segregation due to infection control (Pages 8 and 22)* *Approved at MHL Steeering Group – 16-Feb-22* *Expiry date remains July-24*
7.8	*Amendment*	*April 2022*	*Change to requirement for incident reporting in respect of attendance at the weekly independent MDT review (Page 14, 16 and 17).* *Change to frequency of Independent extended seclusion reviews (page 19).* *Added the option for remote reviews with stipulation that patient is visited around the date of the review (pages 19, 25 and 27).*
7.9	*Amendment*	*May 2022*	*Addition of sub-section regarding Seclusion of people with Learning Disabilities and Neurodiverse conditions (Page 22) in response to action from S42 safeguarding adults enquiry.*
7.10	*Review*	*April 2023*	*Addition to MDT attendees for initiation of LTS (page 24) and of CAFO (page 28). Added option for weekly Independent MDT review to be forfeited when it is due at same time as the monthly independent seclusion review, which takes priority (page 16). Added 'or the independent MDT' as option for altering frequency of 4 hourly medical reviews (page 14). Amends to 6.13 Emergency Care of the Secluded Patient (Page 18). Amends to level of harm decision for missed reviews (page 15). Clarified that Band 4 Nursing Associates are NOT permitted to be counted as one of the registered Nurses who carry out the 2 hourly nursing reviews of seclusion (page 15). Added requirement for HOPES assessment for people with LD/autism diagnosis who are in LTS or CAFO (page 26 and 31). Changes to requirement for independent AC to be in attendance at independent seclusion reviews (Page 16). Amends to allow for RC/AC review of LTS by telephone on a weekend/bank holiday (Page 26). Approved by Director sign-off (19/04/23).*
7.11	*Addition*	*December 2023*	*Restrictive Practice Guidance archived and narrative for the management of infectious disease added to this policy at 7.7 (page 28). Added the requirement for monthly review of management plans at 6.3 (p10), 7.3 (p25), and 8.5 (p35). Following QPAS (October 2023) amends made in relation to: deletion of cleaning appendices and national requirements manual link added at 6.2 (p10), inclusion of Appendix 4 in main body of document at 6.2 (p10), deletion of repeated review narrative at 6.15 (p20), and clarity about training requirements (page 37).* *Removal of appendices no longer required.* **Approved at QPaS 1-Dec-23 with minor amendments.**
8.0	*Full review*	*August 2025*	*Full review with amends. 6.3 Seclusion management plan – addition to bedding requirements (page 11/12)* *6.9 Nursing review – arrangements for when only one nurse available (Appendix 4 - page 44)* *6.11 Independent MDT Review – clarified RC should be different to usual inpatient RC (page 18/19)* *6.15 Extended seclusion – clarified about monthly independent reviews when seclusion / segregation transfer during the month (page 21/22)* *7.4.1 Monthly LTS reviews - clarified about monthly independent reviews when seclusion / segregation transfer during the month (page 27)* *12 Monitoring and Audit - amendment (page 39)* *Lorenzo changed to EPR throughout policy.* *Deleted 'time out' paragraph on page 23* *Approved at EMT (26 August 2025) and ratified at Board (24 September 2025).*
8.1	*Very minor amendment*	*July 2026*	*Addition of Appendix 6: Flowchart - Responsibilities for Reviews of Patients Secluded on Host Ward. Approved by Exec Lead Sign- off (Dr Kwame Fofie – 3 July 2026). Review deadline kept the same.*

Appendix 8: Equality and Health Inequalities Impact Assessment (EHIIA) Toolkit

For strategies, policies, procedures, processes, guidelines, protocols, tenders, services

1. Document or Process or Service Name: **Use of Seclusion or Long-term Segregation Policy**
2. EIA Reviewer (name, job title, base and contact details): **Michelle Nolan, Mental Health Legislation Lead**
3. Is it a Policy, Strategy, Procedure, Process, Tender, Service or Other? **Policy**

Main Aims of the Document, Process or Service
The policy aims to: • ensure the physical and emotional safety and wellbeing of the patient • ensure that the patient receives the care and support rendered necessary both during and after restrictive interventions • designate a suitable environment that takes account of the patient's dignity and physical wellbeing set out the roles and responsibilities of staff, and set requirements for recording, monitoring and reviewing the use of seclusion and any follow-up action
Please indicate in the table that follows whether the document or process has the potential to impact adversely, intentionally or unwittingly on the equality target groups contained in the proforma

Equality Target Groups	Is the document or process likely to have a potential or actual differential impact with regards to the equality target groups listed?	How have you arrived at the equality impact score?
This toolkit asks services to consider the impact on people with protected characteristics under the Equality Act 2010 as well as the impact on additional groups who may be at risk of experiencing inequalities in access, outcomes and experiences of health and care.	Equality Impact Score Positive = evidence of positive impact Neutral = little or no evidence of concern (Green) Moderate negative = some evidence of concern (Amber) High negative = significant evidence of concern (Red)	• who have you consulted with? • what have they said? • what information or data have you used? • where are the gaps in your analysis? • how will your document/process or service promote equality and diversity good practice?

Equality Target Group	Definitions (Source: Equality and Human Rights Commission, 2024)	Equality Impact Score	Evidence to support Equality Impact Score
Age	A person belonging to a particular age (for example 32-year-olds) or range of ages (for example 18- to 30-year-olds).	Neutral	Applicable across the lifespan, to all ages who are admitted to our inpatient units. The MHA specifies who the Law relates to and the legal age thresholds where they exist. Staff should always ensure that any restrictive intervention is used only after having due regard to the individual's age and having taken full account of their physical, emotional and psychological maturity.
Disability	A person has a disability if she or he has a physical or mental impairment which has a substantial and long-term adverse effect on that person's ability to carry out normal day-to-day activities.	Neutral	This policy is consistent in its approach regardless of disability. The MHA Code of Practice details the need for non-discriminatory practice and application of the Act as well as highlighting the requirement for awareness of, sensitivity to any special needs or requirements relating to any form of disability. The Trust is committed to protect human rights and freedoms, and to reduce the disproportionate use of force and discrimination against people sharing particular protected characteristics under the Equality Act 2010, including disabled people. For patients who have a communication need or have English as their second language consideration must be given to providing information in an accessible format.

Sex	Man/Male, Woman/Female.	Neutral	The MHA Code of Practice details the need for non-discriminatory practice and application of the MHA as well as highlighting the requirement for awareness of and sensitivity to any gender related preferences, needs or requirements. The Trust is committed to protect human rights and freedoms, and to reduce the disproportionate use of force and discrimination against people sharing particular protected characteristics under the Equality Act 2010
Marriage / Civil Partnership	Marriage is a union between a man and a woman or between a same-sex couple. Same-sex couples can also have their relationships legally recognised as 'civil partnerships'. Civil partners must not be treated less favourably than married couples.	Neutral	The policy applies equally regardless of marriage or civil partnership status.
Pregnancy / Maternity	Pregnancy is the condition of being pregnant or expecting a baby. Maternity refers to the period after the birth and is linked to maternity leave in the employment context. In the non-work context, protection against maternity discrimination is for 26 weeks after giving birth, and this includes treating a person unfavourably because they are breastfeeding.	Neutral	Staff should always ensure that any use of force is used only after having due regard to the individual's maternity status and having taken full account of their physical, emotional and psychological wellbeing.
Race	A race is a group of people defined by their colour, nationality (including citizenship) ethnicity or national origins. A racial group can be made up of more than one distinct racial group, such as Black British.	Neutral	This policy is consistent in its approach regardless of race. It is acknowledged however that for any patient whose first language is not English, as information needs to be provided and understood, staff will follow the Trust interpretation procedure.
Religion or Belief	Religion refers to any religion, including a lack of religion. Belief refers to any religious or philosophical belief and includes a lack of belief. Generally, a belief should affect your life choices or the way you live for it to be included in the definition.	Neutral	The MHA Code of Practice details the need for non-discriminatory practice and application of the MHA as well as highlighting the requirement for awareness of, sensitivity to and appropriate accommodation of any preferences, needs or requirements related to religious or other belief systems.
Sexual Orientation	Whether a person's sexual attraction is towards their own sex, the opposite sex or to both sexes.	Neutral	The MHA Code of Practice details the need for non-discriminatory practice and application of the MHA as well as highlighting the requirement for awareness of, sensitivity to and appropriate accommodation of any preferences, needs or requirements related to sexual orientation.
Gender Re-assignment	Where people are proposing to undergo, or have undergone a process (or part of a process) for the purpose of reassigning the person's sex by changing physiological or other attribute of sex	Neutral	This policy is consistent in its approach regardless of the gender identity.
Poverty	People on welfare benefits, unemployed/low-income, fuel poverty, migrants with no recourse to public funds	Neutral	This policy is consistent in its approach regardless of income or living standards.
Literacy	Low literacy levels, including includes poor understanding of health and health services (health literacy) as well as poor written language skills	Neutral	The policy applies regardless of literacy level. There is no identified impact on people with low literacy levels.
People with English as an additional language	People who may have limited understanding and/or ability to communicate in written or spoken English	Neutral	This policy is consistent in its approach regardless of language. It is acknowledged however that for any patient whose first language is not English, as information needs to be provided and understood, staff will follow the Trust interpretation procedure.
Digital exclusion	People who can't or don't want to use digital technology due to cost, access to connectivity or devices, digital skills or lack of confidence or trust in digital systems	Neutral	This policy is consistent in its approach regardless of digital skills or access.

Inclusion health groups	People who are socially excluded, who typically experience multiple overlapping risk factors for poor health, such as poverty, violence and complex trauma. This includes:	Neutral	This policy is consistent in its approach regardless of inclusion health group. Taking a trauma informed approach to handing the need for seclusion or segregation will support people from this group, many of whom will have histories of complex trauma.
	• People who experience homelessness	Neutral	This policy is consistent in its approach regardless of housing status.
	• Drug and alcohol dependence	Neutral	This policy is consistent in its approach regardless of drug / alcohol dependence.
	• Vulnerable migrants	Neutral	This policy is consistent in its approach regardless of the person's country of origin/migration status.
	• Gypsy, Roma and Traveller communities	Neutral	This policy is consistent in its approach regardless of ethnic background or community.
	• Sex workers	Neutral	This policy is consistent in its approach regardless of the person's occupation.
	• People in contact with the justice system	Neutral	This policy is consistent in its approach regardless of the person's with the justice system.
	• Victims of modern slavery	Neutral	This policy is consistent in its approach regardless of the person's experience with modern slavery.
Rurality	People who live in remote or rural locations who may have poor access to services.	Neutral	This policy is consistent in its approach regardless of geographical location.
Coastal communities	People who live in coastal communities which may experience unemployment, low educational attainment, poor social mobility, poor health outcomes and poorer access to services.	Neutral	This policy is consistent in its approach regardless of geographical location.
Carers	Carers and families of patients and service users, including unpaid carers and paid carers	Neutral	This policy is consistent in its approach regardless of any identified involvement of carer / family of the patient.
Looked after children	A child or young person who is being cared for by their local authority. They might be living in a children's home, or with foster parents, or in some other family arrangement.	Neutral	The policy applies regardless of looked after status.
Veterans	Anyone who has served for at least one day in Her Majesty's Armed Forces (Regular or Reserve) or Merchant Mariners who have seen duty on legally defined military operations.	Neutral	This policy is consistent in its approach regardless of veteran status.
Neurodivergence	People with alternative thinking styles such as autism, attention deficit hyperactivity disorder, dyslexia, developmental co-ordination disorder (dyspraxia), dyscalculia.	Neutral	The policy applies regardless of Neurodivergence.
Other	Any other groups not specified in this toolkit who may be positively or negatively impacted	Neutral	N/A

Summary

Please describe the main points/actions arising from your assessment that supports your decision above

The standards and principles described within the policy prompt the clinician to have regard to individual holistic needs of the patient in relation to use of seclusion or long-term segregation.

All staff will be trained in restrictive interventions to support the implementation of the policy. Staff must carry out mandatory Equality, Diversity and Human Rights training via e-learning.

It is felt that this policy and any associated documentation would seek to uphold principles of individualised planning and arrangements for ongoing care needs.

Any audit/monitoring outcomes of related policy would continue to inform any changes to the EHIIA in relation to any of the equality target group characteristics and impact of use of seclusion/long-term segregation.

There are statutory requirements and obligations built into existing related legislation (MHA 1983) and its supplementary Code of Practice as well as local systems in place for assurance of the monitoring of compliance with these requirements and reporting through related committees.

EIA Review: Michelle Nolan	
Date Completed: 19.03.25	**Signature:** M.M.M.