Southern Health and Social Care Trust

SOUTHERN HEALTH & SOCIAL CARE TRUST

Policy and Care Pathway on the Management of Seclusion within Rosebrook and Dorsy Units

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1.0 Introduction/Purpose of Policy

The following definition of seclusion has been identified from within the Mental Health Northern Ireland Order (1986) Code of Practice:

Seclusion is the supervised confinement of a patient in a room, which may be locked to protect others from significant harm. Its sole aim is to contain severely disturbed behaviour, which is likely to cause harm to others. Seclusion should only be used as a last resort; for the shortest possible time and as a temporary means of safe confinement until the risk of significant harm which led to its implementation has passed. Seclusion should not be used as a punishment or threat; as part of a treatment programme; because of staff shortages; where there is a risk of suicide or self-harm.

Seclusion must be differentiated and excluded from the purpose of therapeutic engagement with an individual to go to a designated room for the purpose of calming down. Seclusion allows for a period of calming in the patient and should always be managed in a designated room for seclusion, separating the patient from other patients and placing them in a positive milieu. (Cashin 1996).

It has to be recognised that no clinical guidelines can adequately address every situation, and any interventions initiated will depend on the judgement and skill of the medical and nursing staff involved at that time. Any clinical management plan should be proportionate to managing the patient in the least restrictive environment whilst still managing the presenting risk. Staff should be aware of the principles to be applied by those involved in taking decisions about an individual's care or treatment that this may result in the deprivation of that individual's liberty.

Deprivation of liberty considerations are based on the current legislative framework, the Mental Health (Northern Ireland) Order (1986), the European Court of Human Rights in its (2004) judgement in the Bournewood case (HL v UK) and the imminent introduction of new Mental Capacity legislation in Northern Ireland. The Bournewood case (HL v UK) highlighted that additional safeguards are needed for people who

lack capacity and who might be deprived of their liberty. The Bournewood Judgement identified that it would be unlawful for the Trust (without the prior authorisation of the High Court) to arrange or provide care or treatment for a service user who lacks capacity to consent in a way that amounted to deprivation of liberty within the meaning of Article 5 of the Convention unless the patient is detained under the Mental Health (NI) Order 1986. This guidance recognises that in certain circumstances deprivation of liberty may need to be authorised for some people whilst alternative means of providing the care in a less restrictive manner are explored and developed.

It is acknowledged that staff, in fulfilling their responsibilities for the care of patients, will need support and guidance in carrying out their duties. Seclusion should only be used in relation to patients normally detained under the Mental Health Northern Ireland Order (1986). If an emergency situation arises involving a voluntary patient and as a last resort seclusion is necessary to prevent significant harm to themselves or others, then a patient who is assessed as liable to be detained, whether on a Form 5 or Form 6 of the Mental Health Northern Ireland Order (1986) seclusion can be commenced with consultation with the Head of Service/Bluestone Coordinator and the responsible Consultant Psychiatrist/Consultant Psychiatrist on call. This action will be completed under the auspices of common law and will be recorded and reviewed as an untoward event.

All staff should be aware of the principles to be applied by those involved in taking decisions about an individual's care of treatment that may result in the deprivation of that individual's liberty. It is essential to consider the protection of Human Rights of service users as required under the Human Rights Act (1998) which defines the list of human rights that individuals are entitled to. The Trust focuses on seven significant Human Rights in particular, which must be considered when assessing need, developing care and treatment plans and undertaking reviews with service users and they are:

Article 1 – Protection of property

Article 2 – Right to life

Article 3 – Right to freedom from torture, inhumane or degrading treatment

Article 5 – Right to liberty and security

Article 6 - Right to a fair trail

Article 8 – Right to respect for private and family life

Article 14 – Prohibition of discrimination

2.0 Seclusion Environment

Seclusion should be in a safe room which offers maximum opportunity for observation. The door of which cannot be opened from the inside and from which there is no other means of exit.

There may be occasions where an individual is nursed in the Extra Care Suite in Rosebrook and Dorsy which is in the vincity of the seclusion room and a patient may access the seclusion room with the door unlocked, this **does not** meet the definition of seclusion.

Prior to the immediate use of seclusion or the Extra Care Suite, environmental checks and alarm checks will be undertaken to ensure that the seclusion room is so far as reasonably practicable safe. These checks should also be completed immediately after an event of seclusion and weekly when the seclusion room is not in use*. (See Appendix 1).*

It is the ward sister's responsibility to ensure that the weekly and periodic checks are completed.

It is the responsibility of the nursing team to ensure that the weekly and periodic checks are completed and any remedial works required and requested on the backtraq system to ensure that the room is as far as reasonable practicable fit for purpose at all times.

3.0 Authorisation and Notification of Seclusion

Due to the significant restrictive practise of seclusion, alternatives to seclusion should be considered (unless in an emergency) and evidenced in the Paris clinical records and clinical risk assessment. These alternatives should include (list is not exhaustive):

- Review of the prescribed level of continuous observations
- Nursing in a lower stimulus environment
- Review and administration of prescribed medications
- Diversionary/Distraction techniques
- Additional Staffing for support of the patient
- A review of behavioural support plan which has Red, Amber and Green strategies (For Dorsy ward only)

The decision to commence seclusion can be initiated in the first instance by a Registered Mental Health Nurse/Registered Learning Disability Nurse, Medical staff and/or suitable qualified allied health professional who has discussed an individual's presentation and risk and subsequent management plan to include the requirement of seclusion with the nurse in charge of the ward. The nurse in charge is then responsible to inform the following individuals:

With the commencement of seclusion, the nurse in charge of Rosebrook will inform as soon as reasonably practicable the individuals below that an individual patient has been secluded and the rationale for this restrictive intervention:

- The responsible Consultant Psychiatrist for PICU/Dorsy or the Consultant Psychiatrist on call can be made aware of the situation verbally if on the Bluestone site or via telephone/email if off the site or outside of working hours.

- The ward doctor/first on call doctor and they should be requested to assess the patient as soon as it is practicable after the decision to commence seclusion has been initiated. This initial review should take priority over

routine tasks and should be undertaken within 1 hour. If there is an anticipated delay in the meeting, this should be discussed in the first instance with the Bluestone Bed flow Co-ordinator/Nurse holding the bleep which may require further discussion with the Consultant Psychiatrist on call and Directorate Senior Manger on call to ensure that the delay is considered reasonable and appropriate given other competing clinical priorities.

- The Bluestone Bed flow Co-ordinator/Nurse holding the bleep and they should attend the respective ward, to complete the required assessment documentation; this should take priority over routine tasks. They should also provide support and guidance to support the health and wellbeing of the patient and the staff involved and ensure that sufficient staffing is available.

- The next of kin/significant others should be informed in a timely of the necessity for seclusion but in a considerate manner taking into account time of day/night.

4.0 Commencement of Seclusion

- The seclusion procedure, the rationale for commencing seclusion and the patient's individual rights must be clearly explained to the patient through the use of the easy read leaflet (Appendix 5 and 6). If English is not their first language; interpreter services should be asked to visit as soon as possible.
- The full explanation should be given regardless of any perceived inability of the patient to fully understand such information. It is imperative that this process of explanation should be repeated when the patient is more able to fully comprehend the information. For individuals who do not have capacity or full understanding of the process, additional measures should be considered. Details of information provided either verbally or in writing must be recorded in the Paris electronic records.
- Transitioning to Seclusion – The Standard Operating Protocol must be adhered to (Appendix 7).
- A patient in seclusion should keep their clothing and any personal items, including those of religious or cultural significance (such as some items of

jewellery), provided this does not compromise their safety or the safety of other's.

- As far as reasonably practicable and ensuring the safety of staff and patient, the patient should be firstly wanded with the search wand and also searched in accordance with extant searching policy. No intimate searches are allowed.
- Based on their presentation, individual's items of clothing with a potential identifiable ligature risk i.e shoes laces, belts (this list is not exhaustive) should be removed if possible with consent and if not based on the balance of presenting risks and in accordance with MAPA principles if physical interventions are required.
- All patient property removed should be recorded in the patient property booklet
- If there is a specific identified risk, knowledge or intelligence available of item(s) that could pose a significant risk of harm to themselves, then consideration is to be afforded to contacting the PSNI to request their assistance in the searching and management of the individual and potential items that could pose a risk. It is important to note that based on such presenting risks that seclusion can be interrupted for the management of specific risk management interventions.

5.0 Rapid Tranquilisation and Seclusion

Rapid tranquilisation is not absolutely contraindicated, providing that the policy for rapid tranquilisation is adhered to. The discontinuation of seclusion should be considered when rapid tranquilisation has had the desired calming effect and the risk of harm towards self and others has safely reduced.

6.0 Observation

The principles of visual health and welfare observations are:

- To monitor the condition and behaviour of the patient
- To identify the time at which seclusion can he terminated at the earliest opportunity.

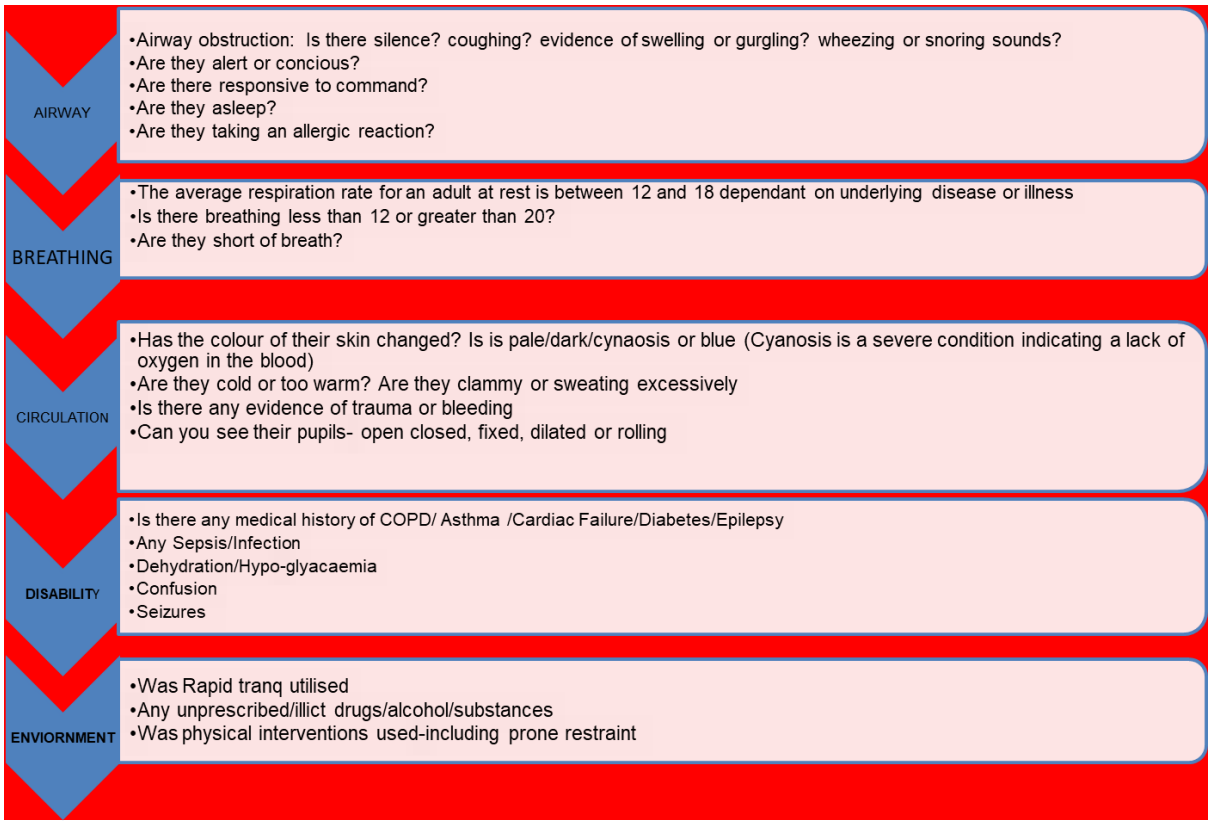
The nurse in charge will delegate the responsibility for the observation of the individual patient in seclusion in cognisance of the patient's gender and cultural beliefs. A minimum of one registered nurse should be delegated the responsibility of initially observing the patient in the seclusion room. This duty can be delegated to an unregistered member of staff if it deemed safe and appropriate to do so. The staff should observe the monitor and visually observe the individuals actions when in the seclusion room. The nursing staff present should also engage verbally with the patient as well as updating the seclusion records. The staff must be guided by the patient's clinical presentation and risk assessment but must record an entry at a minimum of 15 minute intervals.

Staff should ensure that the patient has a means of communicating with staff during the period of seclusion, and a full rationale has been given to the individual during face to face engagement at outset of seclusion and during prescribed reviews thereafter. Staff observing the patient via CCTV should be appropriately skilled to be able to interpret behaviour in the absence of verbal communication; which may indicate the patient's needs e.g. for toilet, drink, food or reassurance, ensuring that dignity is protected at all times. The staff flow to the seclusion room should be kept to a minimum during periods of seclusion to protect the privacy, and dignity of the patient in seclusion. Staff should also monitor the humidity and general warmth of the seclusion room. Any further restricted practise like access to running water to be considered and evidenced.

7.0 Non-Contact Physical Observations

When it is not possible to undertake NEWS monitoring e.g. during seclusion and after restrictive interventions/physical restraint staff should utilise the proforma below as a guide on when to discontinue seclusion and commence NEWS monitoring and/or seek medical staff interventions. This list is not intended to replace clinical experience but to be used as an aide to support staff. If staff have any concerns about a clinically deteriorating patient, then seclusion should be immediately discontinued and clincial observations and assessments should be undertaken by appropriate nursing and medical staff. Defibrilation and oxygen is available within all

wards and assistance can also be obtained from the emergency crash team from the acute hospital by dialing 6666 or an ambulance by dialling 9999.



8.0 Record of Reviews of Patient by Staff while in Seclusion

- If clinically indicated that seclusion needs to continue, prescribed reviews should take place at the following minimal intervals or more often if clinically indicated. A documented report (Appendix 3) should be completed by all staff that has assessed the patient in seclusion and this should include all relevant information on the service user's mental state, behaviour and any requests.
- The initial medical review should take priority over routine tasks and should be undertaken within 1 hour recorded on the Paris medical review section and include the following (this list in not exhaustive):
- *A review of the patient's current physical and mental state including any risk of harm posed by the patient to themselves or others*
- *Assessment of risk or injury from deliberate or accidental self-harm*

- *An assessment of the efficacy of medications administered including any potential adverse effects, extra pyramidal side effects, excessive sedation and orientation to time, place and person*
- *Consideration of withdrawals from illicit substances*
- *A re-assessment of prescribed medications*
- *In conjunction with the nurse in charge the need for and rational for ongoing seclusion*
- Every hour there must be a formal review by the nurse in charge
- Every two (2) hours there must be a formal review by two registered Nurses one of whom must be the nurse in charge
- Every four (4) hours there must be a formal review by two registered Nurses one of whom must be the nurse in charge
- Also every four (4) hours the First on call Doctor/Ward Doctor will also be required to assess and review the patient.
- Also every four (4) hours there must be a formal review by the Bluestone Coordinator/Nurse holding the bleep.
- If an individual remains in seclusion after eight hours, the review at eight (8) hours must be carried out by the ward/first on call doctor and Nurse in Charge of the ward and the Bluestone Coordinator/Nurse holding the bleep. The assessing staff ward may seek to discuss the individual's presentation with the Responsible Consultant Psychiatrist/Duty Consultant Psychiatrist.
- If an individual is in seclusion for a further eight hours, which is 16 hours in total the review at 16 hours must be carried out by the ward/first on call doctor, Nurse in Charge and the Bluestone coordinator/Nurse holding the bleep. The assessing staff ward may seek to discuss the individual's presentation with the Responsible Consultant Psychiatrist/Duty Consultant Psychiatrist. The Bluestone Coordinator/Head of Service/Senior Manager (on call) will be informed should the incident of seclusion extend to 16 hours.
- If an individual is in seclusion for a further eight hours, which is 24 hours in total the review at 24 hours must be carried out by the Responsible Consultant Psychiatrist/On call Consultant Psychiatrist on call.
- The Head of Service, Assistant Director for Inpatients and the Associate Medical Director must be notified in writing of the continued use of seclusion at the 24 hours interval. A multidisciplinary review meeting must be convened and the membership of this review must include the responsible Consultant

Psychiatrist, a registered nurse and another multidisciplinary professional that is independent of the initial incident.

- If one individual incident of seclusion lasts for more than 48 hours then it must be escalated in writing by the Assistant Director of Mental Health and Learning Disability Inpatients to the Director of MHLD and a twice daily multidisciplinary review meeting should be convened and must the responsible Consultant Psychiatrist, a registered nurse and another multidisciplinary professional.

9.0 Care Plan while in Seclusion

The welfare, health and wellbeing of the patient are paramount at all times. To achieve this, the nurse in charge must ensure that the patient is:

- Be advised as to under what conditions that seclusion will cease
- Be made aware of their rights and provided the leaflet if appropriate
- Be treated with respect and dignity and that their privacy is maintained at all times
- Have the ability to view a clock
- Be aware of the restrictions of cutlery, breakable plates and cups etc
- Have meal's and beverages must be provided and their oral and nutritional intake should be recorded on an input/output chart.
- The patient will have access to toilet and showering facilities and during the period of seclusion and the least restrictive principles applied at all times, in relation to the ability of staff to electronically turn off the water to the seclusion room bathroom.

10.0 Staff Welfare

While it is recognised that the welfare, health and wellbeing of the patient is paramount, it is important to also recognise the welfare and safety of staff. To achieve this the nurse in charge must ensure that:

- No member of staff enters the seclusion room alone

- That all interventions which require the seclusion room door to be opened are coordinated through them (excluding a medical emergency)
- That there is a minimum of three appropriately MAPA trained staff available when the seclusion room door is being opened

11.0 Record keeping

The Nurse in Charge is responsible for ensuring that detailed records of any period of seclusion are recorded in the patient's Paris records. The rationale for the use of seclusion and subsequent observations and reviews by nursing staff must also be clearly recorded on the seclusion care pathway.

The medical officer is responsible for completing and updating the Paris medical records and seclusion care pathways during visits/reviews.

The following documents must be properly completed and updated:

- Paris Nursing Notes
- Comprehensive Risk Assessment and Management Plans
- Recovery Care Plan
- Datix Form
- Seclusion Care pathway

12.0 Immediate Post Seclusion Interventions

As soon as the risk of harm towards self and others is sufficiently diminished, seclusion should be discontinued. Seclusion will be deemed as discontinued as soon as the door is opened. This will usually be indicated when the patient becomes verbally / non-verbally calm or falls asleep. However, due regard will be given to the clinical history if it is known that this is not necessarily an accurate indicator. The decision to discontinue seclusion is the responsibility of the Nurse in Charge and may be made in consultation with medical staff. If appropriate and seclusion is discontinued the individual maybe cared for in the Extra Care Suite to assess and ensure that the risk of harm towards self and others is sufficiently diminished. Staff in exceptional circumstances may need to be recommence seclusion if a patient

presents with an increased level of risk to themselves or others and an alternative care plan is not available.

13.0 When Seclusion has been Discontinued:

When seclusion has been discontinued, the Nurse in charge will ensure that:

- The ward doctor/first on call doctor attends the ward to examine the patient as soon as reasonably practicable after the decision to discontinue seclusion has been initiated. This initial review should take priority over routine tasks and should be undertaken within 1 hour. If there is an anticipated delay in the meeting, this should be discussed in the first instance with the Bluestone Bed flow Co-ordinator/Nurse holding the bleep which may require further discussion with the Consultant Psychiatrist on call and Directorate Senior Manger on call to ensure that the delay is considered reasonable and appropriate given other competing clinical priorities.
- This assessment should focus on the physical and mental health of the patient and consider any further risk of harm to themselves or others and the recording of an ongoing care plan and risk management plan. This assessment should also reflect engagement with the patient only (if appropriate to do so) as to the antecedents of the incident and their interpretation of their presentation, behaviour and their appreciation of the necessity of the requirement of seclusion.
- The monitoring of the patients clinical observations as per the NEWS chart and consideration should also be afforded to the potential risks of patients who may be experiencing intoxication or withdrawals from illicit substances.
- Nursing staff will update the body chart
- The outcome of all assessments including clinical observations and body chart will be recorded in the Paris clinical records.
- The First on Call Doctor/ward doctor and the Nurse in Charge should also discuss an alternative management plan and explore whether there are alternatives to seclusion. The clinical decision making and outcomes should be recorded within the Paris clinical records. Any differences in viewpoints should be documented and discussed with the RMO or Consultant Psychiatrist on call.

- The Seclusion care pathway must be fully completed
- The next of kin should be informed in a timely but considerate manner taking into account time of day/night.
- The patient`s advocate should be informed as soon as practical to enable discussion in future multidisciplinary meetings.
- Person centred seclusion documentation i.e. the seclusion record and the record of seclusion times (Appendices 1, 2 and 3) must be retained in the clinical records.
- A copy of the seclusion documentation (Appendix 1) should be completed on the Datix Incident recording system and the safety cross updated to reflect the incident of seclusion

14.0 Review of Seclusion

The primary objective of an incident of seclusion is to maintain the safety of patients and staff. Each episode of seclusion should be reviewed at the next ward MDT meeting and consideration should be afforded to the antecedents of the incidents, potential causative factors, and any future management and contingency plans as an alternative means of intervening with the individual to maintain their safety and the safety of staff. A key element of this review is the post incident debrief and learning with members of the MDT engaging with the patient and staff who were directly involved in the incident to ascertain and potential learning/reflection.

15.0 Debrief with Patient

Whenever the clinical presentation of the patient allows and it has to be considered that this may be some time after the initial event but prior to their discharge or transfer back to an open ward, there should be a debrief with the patient in relation to their experience of the incident of seclusion. The MDT should be cognisant of the potential negative experiences and impact of seclusion and they must be given opportunity to discuss their experience of the seclusion episode and this debrief will be completed with the named nurse/nurse in charge. The patient should be reminded of the availability of the advocacy service to support them through this

process. Where indicated, the Speech and Language Therapist should be involved with individual patients.

15.1 Debrief with Staff

As soon as practicable the ward manager or nominated deputy should engage the debrief process with all of the staff involved in the incident of seclusion. The aim of this is to identify any learning opportunities and to offer additional support if required to the staff involved.

16.0 Audit of Seclusion

- A copy of the Seclusion records (Appendix 1 and 2) should be retained at ward level for audit purposes
- All events of seclusion event must be discussed by the MDT at the following ward round. Where possible the patient should also be encouraged to attend the next MDT meeting to discuss their experience of seclusion to enable their individual views and communication aids or interpreters should be made available to assist with individuals who have deficits in communication or where English is not their first language.
- The outcome of the individual incidents of seclusion for individual patients should be discussed at the MDT meeting to develop appropriate care plans as the MDT should monitor the trend and impact of seclusion on individual patients.
- Incidents of seclusions must be audited at least on a monthly basis which should include the frequency and the length of individual incidents of seclusion and this information will be presented at the units governance fora which is chaired by the Associate Medical Director/Clinical Director and attended by the Assistant Director and Head of Services for Mental Health and Learning Disability Inpatients.
- Incidents of multiple episodes of seclusion for the same patient within their care spell will be monitored and may require an urgent care planning review meetings which will be chaired by Head of Service for Bluestone

17.0 Staff Training and Induction

The necessity of training and induction cannot be underestimated and it is the vision of the inpatient service to co-develop and co-produce with experts by experience and the Recovery College a bespoke training programme around seclusion but in the interim:

- It is the responsibility of the ward managers of Rosebrook and Dorsy wards to ensure that all new staff are informed on employment of the content of the this policy and their individual requirements in adhering to this
- It is the responsibility of the Clinical Directors/Associate Medical Director to ensure that this policy is shared with all new Junior Staff on their Psychiatry/ Learning Disability rotation and their individual requirements in adhering to this.

18.0 Appendices

Appendix 1 Seclusion Room and ECS Environmental check
Appendix 2 Decision to seclude form
Appendix 3 Record of Seclusion Times
Appendix 3 Decision to Discontinue Seclusion
Appendix 5 Easy Read leaflet
Appendix 6 Service User Information Sheet
Appendix 7 Discontinuation of Seclusion
Appendix 8 Seclusion Quick Reference Chart

19.0 Equality Statement

In line with duties under the equality legislation (Section 75 of the Northern Ireland Act 1998), Targeting Social Need Initiative, Disability discrimination and the Human Rights Act 1998, an initial screening exercise to ascertain if this should be subject to a full impact assessment has been carried out.

The outcome of the Equality Screening for this policy is:

Major Impact ☐

Minor Impact ☐

No Impact ☐

Appendix 1

Seclusion Room and Extra Care Suit Environmental Check

Environmental checks will be undertaken and recorded as a minimum on a weekly basis when the seclusion room is not in use. These checks will also be completed as far as reasonable practicable immediately before and always after a seclusion event

Item	Yes	No	Remedial Action Taken
The room is free from objects that could cause harm to the patient or be potentially used as a weapon			
The room is safe and secure, all locks working			
The room has the appropriate bed and bedding in place for proposed use			
The room has adequate lighting, heating, access to a clock and ventilation			
Patient Observation is not hampered in any way, the mirrors are intact, the observation window is clean and in a good state of repair			
Seclusion and ECS CCTV is working			
Alarms in the ECS and seclusion room are working			

properly			

Checks completed by …….. Date …….

Ward Manager/Nurse in Charge…… Date …….

Appendix 2

Decision to Seclude

Datix Number

_____

Patients Details: **Surname:** **First Name:** **Gender:** **Ethnicity:**	**Date of admission**……. **D.O.B**…… **H&C Number**……..
Seclusion Commenced **Date …. /…. /…. Time……..**	**NOK informed:** **Yes** **No** **Not Available** **Comments**
Ward Doctor/First on call Doctor informed/Seclusion agreed **Date …. /…. /…. Time……..** **Name……**	**Senior Nurse/Bed Flow Coordinator Informed** **Date …. /…. /…. Time……..** **Name……**
Service User Expectation Chart **Accepted/Declined**	**Seclusion commenced by** **Name……** **Designation……**

Description of incident: *Reason for Seclusion*

Alternative Measures attempted prior to Seclusion: *De-escalation Engagement to identify possible cause/offered time to talk/offered quiet time in the low stimulus environment/offered possible solutions/Diversional Activities/communication skills/relaxation techniques and PRN/as required medication if indicated.*

Medication Administered (Drug Name, Dose, Route)

Rapid Tranquilisation Yes ☐ No ☐

MAPA/Physical Interventions

Yes ☐ No ☐

RPI form completed Yes ☐ NO ☐

Team Members present:

Name	Designation

Patient searched and search wand used: **Yes** ☐ **No** ☐

List of Personal Property removed and recorded in patient Property book:

Medical Staff Review

Initial Assessment by Ward Doctor/First on Call Doctor:

Name and Designation Print_____ Signature_____

4 Hour Review by Ward Doctor/First on Call Doctor
Name and Designation Print_____ Signature_____

8 Hour review by Ward Doctor/First on Call Doctor
Name and Designation Print_____ Signature_____

12 Hour review by Ward Doctor/First on Call Doctor
Name and Designation Print_____ Signature_____

16 Hour review by Ward Doctor/First on Call Doctor

Name and Designation Print_____ Signature_____

20 Hour review by Ward Doctor/First on Call Doctor
Name and Designation Print_____ Signature_____

24 Hourly Review Consultant Psychiatrist/On Call Consultant Psychiatrist
Name and Designation Print_____ Signature_____

Bed Coordinator/Senior Nurse holding the bleep reviews:

Initial Assessment by Bed Coordinator/Senior Nurse holding the bleep
Name and Designation Print_____ Signature_____

4 Hour Review by Bed Coordinator/Senior Nurse holding the bleep

Name and Designation Print_____ Signature_____

8 Hour Review by Bed Coordinator/Senior Nurse holding the bleep
Name and Designation Print_____ Signature_____

12 Hour Review by Bed Coordinator/Senior Nurse holding the bleep
Name and Designation Print_____ Signature_____

16 Hour Review by Bed Coordinator/Senior Nurse holding the bleep
Name and Designation Print_____ Signature_____

20 Hour Review by Bed Coordinator/Senior Nurse holding the bleep

Name and Designation Print_____ Signature_____

24 Hour Review by Bed Coordinator/Senior Nurse holding the bleep
Name and Designation Print_____ Signature_____

Nursing Staff Reviews

2 Hour Review by 2 Registered Nurses, one who is the Nurse In Charge
Name and Designation Print_____ Signature_____ **Name and Designation** Print_____ Signature_____

4 Hour Review by 2 Registered Nurses, one who is the Nurse In Charge
Name and Designation Print_____ Signature_____ **Name and Designation** Print_____ Signature_____

6 Hour Review by 2 Registered Nurses, one who is the Nurse In Charge

Name and Designation Print_____ Signature_____ **Name and Designation** Print_____ Signature_____

8 Hour Review by 2 Registered Nurses, one who is the Nurse In Charge
Name and Designation Print_____ Signature_____ **Name and Designation** Print_____ Signature_____

10 Hour Review by 2 Registered Nurses, one who is the Nurse In Charge
Name and Designation Print_____ Signature_____ **Name and Designation** Print_____ Signature_____

12 Hour Review by 2 Registered Nurses, one who is the Nurse In Charge
Name and Designation Print_____ Signature_____

Name and Designation Print_____ Signature_____

14 Hour Review by 2 Registered Nurses, one who is the Nurse In Charge

Name and Designation Print_____ Signature_____

Name and Designation Print_____ Signature_____

16 Hour Review by 2 Registered Nurses, one who is the Nurse In Charge

Name and Designation Print_____ Signature_____

Name and Designation Print_____ Signature_____

18 Hour Review by 2 Registered Nurses, one who is the Nurse In Charge

Name and Designation Print_____ Signature_____

Name and Designation Print_____ Signature_____

20 Hour Review by 2 Registered Nurses, one who is the Nurse In Charge

Name and Designation Print_____ Signature_____ **Name and Designation** Print_____ Signature_____

22 Hour Review by 2 Registered Nurses, one who is the Nurse In Charge
Name and Designation Print_____ Signature_____ **Name and Designation** Print_____ Signature_____

24 Hour Review by 2 Registered Nurses, one who is the Nurse In Charge
Name and Designation Print_____ Signature_____ **Name and Designation** Print_____ Signature_____

Appendix 3

RECORD OF SECLUSION TIMES:

Record of face to face contacts **(F)** Record of Observation via CCTV Monitor **(M)**

Ward		Patient Name	Hospital No:
D.O.B.		Named Nurse	Consultant:
Date	**Time**	**Comments**	**Print and Sign Name Signature/Designation**
	08:00		
	08:15		
	08:30		
	08:45		
	09:00		
	Nurse in charge review		
	09:15		
	09:30		
	09:45		
	10:00		
	Nurse in charge review		
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	01:45		
	02:00		
	Nurse in charge review		
	02:15		
	02:30		
	02:45		
	03:00		
	Nurse in charge review		
	03:15		
	03:30		
	03:45		
	04:00		
	Nurse in charge review		
	04:15		
	04:30		
	04:45		
	05:00		
	Nurse in charge review		
	05:15		
	05:30		
	05:45		
	06:00		
	Nurse in charge		

	review		
	06:15		
	06:30		
	06:45		
	07:00		
	Nurse in charge review		
	07:15		
	07:30		
	07:45		
	08:00		
	Nurse in charge handover		

Appendix 4

Decision to Discontinue Seclusion

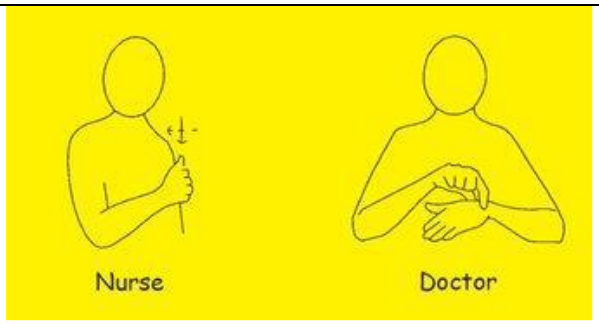
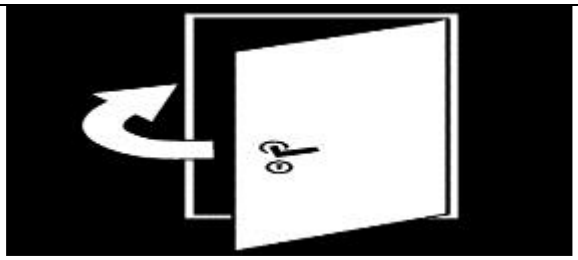
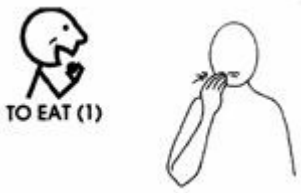
Datix Number
_____

Surname: **First Name:**	**D.O.B**…… **H&C Number**…….. **Duration of seclusion** From_____ To_____
Seclusion Discontinued **Date …. /…. /…. Time…….** **Name…….** **Designation……**	**NOK informed: Yes No**
Ward Doctor informed **Date …. /…. /…. Time……..** **Name…….**	**Senior Nurse/Bed Flow Coordinator Informed** **Date …. /…. /…. Time……..** **Name……**
Clinical Observations and Body Chart Updated Yes ☐ NO ☐ (If not please record why not) **Date …. /…. /…. Time……..**	**Patient Debrief Completed** **Date …. /…. /…. Time……..** **Name……**

Name…….	

- Record of Seclusion Completed YES/NO
- Datix Completed YES/NO
- Quick reference Guide Completed YES/NO

Appendix 5

Service User Expectation Chart **Patient Name** Date…… H&C Number……. Time……	
The seclusion room door will be locked. You will be looked after and monitored at all times via face to face engagement or by CCTV. Staff will explain why you are in seclusion and how you can speak with staff via the intercom.	
You will be offered food and drink on a regular basis. If you have any dietary requirements please advise staff.	
For your safety certain items will be removed and kept safely on the ward and returned to you when it is safe to do so.	

Toilet facilities are available whilst you are in seclusion.	
Please speak with the nurses, doctors and any other professionals who may visit you. We are all trying to end you period in seclusion as quickly as is possible.	
With your help a care plan will be developed which will detail how we can keep you safe and supported. We want seclusion to end at the earliest opportunity and we will support you in returning to the main ward area.	
If you are not happy about how you are looked after you have a right to speak to the peer advocate, make a complaint, speak to Nurse in Charge and we will assist you if you need help with this.	

Service User Information Sheet **Appendix 6**

Seclusion – Your Rights

- Seclusion is the supervised confinement of a service user in a room which may be locked to protect everyone.
- Staff will verbally inform about your rights.

They will tell you:

- Why you have been secluded
- How long it is likely to last
- What you need to do for seclusion to end
- When regular reviews with staff and doctors will occur
- How to call staff if you need to.

Your Safety

- Two members of staff will be allocated to monitor you whilst you are in seclusion.
- If staff need to search you they will tell you why.
- Staff may take items like shoes, belts, hoodies etc. You will get them back when it is safe to return them to you.

Dignity and Respect

- You will be treated with respect.
- You can wear your own clothes
- You can use the toilet and shower in private.

Food and Drink

- You will be offered food at regular intervals.
- You will be offered a drink at regular intervals.
- If you have any specific dietary requirements/allergies please let staff know

Visits and Messages

- Senior staff will visit you regularly. You will be able to speak with them.
- When possible you can speak to your next of kin.

Questions and complaints

- If you have any questions or complaints, raise them with the member of staff dealing with you.
- If you prefer, speak to a senior member of staff when they visit you. If you are still not happy, ask to speak with the ward manager or write to the service manager for the unit/ward you are on.

Appendix 7

Discontinuation of Seclusion Checklist

Checklist	Comment	Signature and designation
Rationale for discontinuation of seclusion recorded on Paris		
Date and time of discontinuation recorded on Paris and Seclusion documentation		
Patient debrief completed if safe and appropriate for do so. (If not indicate time that it may be safe to do so)		
Bed Flow coordinators/Nurse holding the bleep informed/attended		
Ward doctor/First on call doctor informed and attended		
Next of Kin informed		
Care plan and risk assessment reviewed and updated		
LSE documentation commenced (if		

required)		

Checks completed by …….. Date ……

Ward Manager/Nurse in Charge……Date …….

Appendix 8

Seclusion Quick Reference Chart

Decision to commence Seclusion

- The decision is made by the Nurse in Charge to place the patient in seclusion. Evidence must be provided for alternatives considered/utilised.
- The Ward Doctor/First on Call Doctor must attend and assess the patient, record assessment in case notes and complete seclusion care pathway.
- Inform Bed Flow Coordinator/Senior Nurse holding the bleep that must attend and assess the patient, and complete seclusion care pathway.
- Inform the Consultant within working hours or Consultant on call
- Inform the patients next of kin
- Inform advocacy services

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Safeguards for Patient

Staff Should:

- Protect and promote the individual's dignity at all times.
- Explain the reason for the use of seclusion to the patient upon commencement and throughout.
- Explain the CCTV monitoring system to the patient and advise that staff will remain there to support them.
- Ensure that the patient can retain any significant cultural or religious items as long as this does not compromise the safety of the patient or others.

⇩

Observation: The level of observation should be determined on an individual basis, guided by the patients clinical presentation and risk assessment but must take place at a minimum of 15 minute intervals via face to face or CCTV monitoring. This should be completed initially by a registered nurse and can be reviewed thereafter by

the nurse in charge

Seclusion Reviews:

- Every hour there must be a formal review by the nurse in charge
- Every two hours there must be a formal review by two members of the nursing team, one of whom must be a nurse in charge
- Every four hours, there must be a review by the Junior Doctor./ward Doctor/On call Doctor
- Every four hours, there must be a review by Bed Coordinator/Nurse holding the bleep
- If an individual remains in seclusion after eight hours, the review at 8 hours must be carried out by the ward/first on call doctor and Nurse in Charge of the ward and the Bluestone Coordinator/Nurse holding the bleep. The assessing staff ward may seek to discuss the individual's presentation with the Responsible Consultant Psychiatrist/Duty Consultant Psychiatrist.
- If an individual is in seclusion for a further eight hours, which is 16 hours in total the review at 16 hours must be carried out by the ward/first on call doctor, Nurse in Charge and the Bluestone coordinator/Nurse holding the bleep. The assessing staff ward may seek to discuss the individual's presentation with the Responsible Consultant Psychiatrist/Duty Consultant Psychiatrist. The Bluestone Coordinator/Head of Service/Senior Manager (on call) will be informed should the incident of seclusion extend to 16 hours.
- If an individual is in seclusion for a further eight hours, which is 24 hours in total the review at 24 hours must be carried out by the Responsible Consultant Psychiatrist/On call Consultant Psychiatrist on call.
- The Assistant Director and Clinical Director must be notified in writing of the continued use of seclusion at the 24 hours interval.

Commencement of Seclusion Form

- Seclusion Form (Appendix 2) must be completed in its entirety and a copy retained at ward level for audit purposes
- All original documentation must be filed in the patient's notes.

Post Seclusion

- Ensure that all relevant individuals including next of kin are advised of discontinuation of seclusion.
- Discuss with the patient the clinical rationale for seclusion and support given in the reintegration to ward routine and activities.
- Does the patient understand why they were secluded and how does the patient feel now, after the event?
- In collaboration between the nurse and patient, identify strategies as to how the need for any further episodes of seclusion can be avoided in the future?
- Complete all appropriate documentation regarding discontinuation of

seclusion i.e. recovery care plan, Comprehensive risk assessment, nursing records, planned review at next MDT.

- If patient is unwilling to engage post seclusion this must be clearly documented in the Paris nursing notes.
- Complete discontinuation seclusion checklist (Appendix 6)

Appendix 7

The transitioning of a patient to the seclusion suite

*This Protocol **must be utilised** in conjunction with;*

The Policy and Care pathway on the Management of Seclusion within Rosebrook and Dorsy Units

Definition:

Seclusion is the supervised confinement of a patient in a room, which may be locked to protect others from significant harm. Its sole aim is to contain severely disturbed behaviour, which is likely to cause harm to others. Seclusion should only be used as a last resort; for the shortest possible time and as a temporary means of safe confinement until the risk of significant harm which led to its implementation has passed. Seclusion should not be used as a punishment or threat; as part of a treatment programme; because of staff shortages; where there is a risk of suicide or self-harm.

Seclusion suite

1 - Prior to the immediate use of seclusion or the Extra Care Suite, environmental checks and alarm checks will be undertaken to ensure that the seclusion room is reasonably and practicably safe. These checks should also be completed immediately after an event of seclusion and weekly when the seclusion room is not in use.

The seclusion procedure, the rationale for commencing seclusion and the patient's individual rights must be clearly explained to the patient through the use of the easy read leaflet If English is not their first language; interpreter services should be asked to visit as soon as possible.
The full explanation should be given regardless of any perceived inability of the patient to fully understand such information. It is imperative that this process of explanation should be repeated when the patient is more able to fully comprehend the information. For individuals who do not have capacity or full understanding of the process, additional measures should be considered. Details of information provided either verbally or in writing must be recorded in the Paris electronic records.
Staff – A lead must be identified and documented for the purpose of safe transition and commencement of seclusion. This staff lead must have completed the appropriate MAPA training and this training must be 'in-date'
As far as reasonably practicable and ensuring the safety of staff and patient, the patient should be firstly assessed with the search wand and also searched in accordance with extant Search Policy. No intimate searches are allowed.
The identified lead will coordinate the transition to the seclusion area, ensuring, if required, that all utilised safety interventions are aligned to National taught core MAPA skills
Individuals who require seclusion may be exposed to "protected" prone restraint to enable staff to safely exit the seclusion room. This taught skill does not promote the use of routine prone

restraint but may be used to enable safe and timely disengagement by staff and to reduce the likelihood of unforeseen crush injuries or further MAPA interventions when locking the seclusion room door.
All patient property removed should be recorded in the patient property booklet
If there is a specific identified risk, knowledge or intelligence available of item(s) that could pose a significant risk of harm to themselves, then consideration is to be afforded to contacting the PSNI to request their assistance in the searching and management of the individual and potential items that could pose a risk. It is important to note that based on such presenting risks that seclusion can be interrupted for the management of specific risk management interventions.
Disengagement, The identified lead must coordinate the safe disengagement of staff to facilitate the commencement of seclusion. This lead **MUST be the last team member to leave the seclusion suite and the MUST look back and facilitate a check to assess the location and safety of the patient PRIOR to closing the seclusion suite door** **If the patient is within the immediate vicinity of the door THE DOOR MUST NOT BE CLOSED** **Safety intervention procedures must be recommenced as necessary** ***The Seclusion suite door must only be locked closed when THE LEAD assesses the patient location as not being within the immediate vicinity of the door***

A) It is the ward sister's responsibility to ensure that the weekly and periodic checks are completed. B) It is the responsibility of the nursing team to ensure that the weekly and periodic checks are completed and any remedial works required and requested on the backtraq system to ensure that the room is reasonably and practicably fit for purpose at all times.