Cumbria Partnership
NHS Foundation Trust

Policy Title: Seclusion and Long Term Segregation

Reference	POL/001/004
Version	2.0
Date Ratified	26 September 2018
Next Review Date	30 September 2019
Accountable Director	Director of Quality & Nursing
Policy Author	Ward Manager, Mr Shaun Thomson, Rowanwood

Please note that the Intranet / internet Policy web page version of this document is the only version that is maintained.

Any printed copies or copies held on any other web page should therefore be viewed as "uncontrolled" and as such, may not necessarily contain the latest updates and amendments.

Policy On A Page

SUMMARY & AIM

This Policy defines the use of Seclusion and Long Term Segregation and contains guidance for the use of Seclusion and Long Term Segregation

TARGET AUDIENCE:

Quality and Safety Lead
PICU Ward Manager

TRAINING:

Training through local induction and Prevention and Management of Violence and Aggression Training

KEY REQUIREMENTS

Definition of Seclusion
Undertaking Seclusion
Reviews of Seclusion
Definition of Long Term Segregation
Undertaking Long Term Segregation

TABLE OF CONTENTS

EXECUTIVE SUMMARY

This policy provides assurance to the Trust Board and Trust management that the processes used within the organization for the use of seclusion, reflect best practice and comply with the Department of Health Mental Health Act Code of Practice 2015

DEFINITION OF SECLUSION

Positive and Proactive Care: reducing the need for restrictive interventions April 2014 refers to seclusion as:

'The supervised confinement and isolation of a person, away from other users of services, in an area from which the person is prevented from leaving.' 'Its sole aim is the containment of severely disturbed behaviour which is likely to cause harm to others.'

Only people detained under the MHA should be considered for seclusion. If an emergency situation arises involving an informal patient and, as a last resort, seclusion is necessary to protect others from risk of injury or harm, then it should be used for the shortest possible period to manage the emergency situation and an assessment for detention under the MHA should be undertaken immediately. The MHA Code of Practice11 lays down clear procedures for the use of seclusion including its initiation, ongoing implementation and review and termination.

Seclusion is not the same as 'Time Out'. Alternative terminology such as 'therapeutic isolation', 'single-person wards' and 'enforced segregation' should not be used to deprive patients of the safeguards (code of practice 26.104). All episodes which meet the definition in the MHA Code of Practice must be treated as seclusion regardless of the terminology used and the appropriate review process and documentation completed.

During any period of seclusion it is essential that clinical staff are aware of the need to maintain the patient's privacy and dignity and give due consideration to gender, disability, sensory impairment and cultural needs.

The Code of Practice 2015 defines seclusion as:

The supervised confinement and isolation of a patient, away from other patients, in an area from which the patient is prevented from leaving, where it is of immediate necessity for the purpose of the containment of severe behavioural disturbance which is likely to cause harm to others. Therefore:

- 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.

- 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.

- 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.

- Seclusion should only be used in relation to patients detained under the Mental Health 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 Mental Health Act should be undertaken immediately.

1. INTRODUCTION

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.

This policy identifies Trust requirements on the use of seclusion within mental health inpatient units in the Trust in line with the National code of practice. It clarifies roles and responsibilities and guidance for recording, monitoring and reviewing seclusion episodes. This policy should be read in conjunction with the Trust Rapid Tranquillization, therapeutic management of violence and aggression and personal search policies.

2. PURPOSE

The purpose of this policy is to provide detailed guidance on the use of seclusion. This includes ensuring the physical, emotional safety and wellbeing of the patient, ensuring that the patient receives the care and support rendered necessary by their seclusion both during and after it has taken place, setting out the roles and responsibilities of staff, including requirements for recording, monitoring and reviewing the use of seclusion and any follow-up action. This policy is written in line with the Mental Health Act Code of Practice 2015.

3. POLICY DETAILS:

The aim of this policy is to ensure that within legal and procedural guidelines:

3.1 THE SECLUDED PATIENT, OTHER PATIENTS, AND MEMBERS OF STAFF ARE SAFE.

The patient is cared for and supported, both during and after seclusion.

Seclusion takes place in a suitable environment, and takes account of the patient's dignity and physical well-being.

The continuing need for seclusion is reviewed utilizing the skills and experience of available staff set out the roles and responsibilities of staff.

Set requirements for recording, monitoring and reviewing the use of seclusion and any follow-up action.

Care plans and risk assessments of a secluded patient are updated as required.

3.2 SITUATIONS IN WHICH SECLUSION SHOULD NOT BE USED & SPECIAL CONSIDERATIONS

- Seclusion should not be used as a punishment or a threat, or because of shortage of staff.
- It should not form part of a treatment programme.
- Property being damaged.

Special consideration should be made

- When there is an acute, high risk of suicide
- When there is a known high risk of self-harm

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

- Where Rapid Tranquilisation has been given to the patient
- Where the patient is physically ill
- Where the patient is physically disabled
- Where the patient is heavily intoxicated (drugs, alcohol or psychoactive substances)
- Older adults

When secluding please note the following:

Multi-disciplinary teams should work in collaboration with service users in assessing their history relating to aggression and violence. From this assessment a clear plan of care should take into account issues pertaining to:

- Domestic violence
- Experience of child sexual, physical and emotional abuse, sexual assault/rape.
- Self-harm
- Safety, privacy and dignity
- Experiences within previous accommodation including Mental Health Services

And with females:

- Risk factors associated with pregnancy or recent childbirth (if applicable). Where appropriate advice should be sought from specialist services e.g. Midwives/ PMVA Tutors.

3.3 RAPID TRANQUILISATION

- Rapid tranquillisation includes the use of both intra-muscular injections and oral medication. Oral medication should always be considered before any injections.

- Rapid tranquillisation should be prescribed in accordance with Trust Policy, evidence-based practice guidelines such as those published by NICE 3 and in a manner that is consistent with General Medical Council's good practice in prescribing and managing medicines.

- Staff prescribing rapid tranquilisation must note any physical observations and monitoring needed following administration and make that clear to staff caring for the patient.

- Please refer to the Rapid Tranquillisation policy for further guidance. Link below in associated documents.

- If a patient is placed in seclusion straight after receiving rapid tranquilisation an attempt to do physical observations should be made fifteen minutes after receiving RT, if felt by the team this is safe.

3.4 USE OF SECLUSION

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.

Seclusion should only be undertaken in a designated and approved seclusion room or suite of rooms and which serves no other function on the ward.

Seclusion must only be used in the following situations

- Where patients behaviour is likely to injure others imminently

- Where patient's behaviour is likely to cause significant damage to a ward's environmental infrastructure that is likely to lead to injury to others

- All other interventions have been exhausted or are not feasible and injury to others is highly imminent

INTERVENTIONS SHOULD INCLUDE

- De-escalation techniques
- Diversion techniques
- Reviewing the patient's observation levels
- Obtaining extra staffing resources
- Review of the patients medication-use of oral or IM medication
- A dynamic risk assessment made by staff which indicates that there is an immediate risk of harm to self or others
- Decisions made without prejudice or bias on the part of the nurse or others
- There must be a clear reason for the use of seclusion documented and identifiable in the patient's clinical notes.

Seclusion must NOT be used in the following circumstances

- 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

ENVIRONMENT

- The room should allow for communication with the patient when the patient is in the room and the door is locked, e.g. via an intercom
- Rooms should include limited furnishings which should include a mattress and blanket or covering
- There should be no apparent safety hazards
- Rooms should have robust, reinforced window(s) that provide natural light (where possible the window should be positioned to enable a view outside)
- Rooms should have externally controlled lighting, including a main light and subdued lighting for night time
- Rooms should have robust door(s) which open outwards
- Rooms should have externally controlled heating and/or air conditioning, which enables those observing the patient to monitor the room temperature

- Rooms should not have blind spots and alternate viewing panels should be available where required

    - The room is monitored by CCTV

- A clock should always be visible to the patient from within the room, and

- Rooms should have access to toilet and washing facilities.

3.5 PROCEDURE

The new Mental Health Code of practice provides enhanced guidance in relation to measures to avoid the use of restrictive interventions, as well as establishing a range of procedural safeguards where, as a last resort, they have to be used. These changes serve the purpose of bringing the Code into alignment with 2014 guidance *Positive and Proactive Care: reducing the need for restrictive interventions*

The Mental Health Code of Practice introduces changes to seclusion procedures and practice. Under the 2008 Code a multidisciplinary team (MDT) review was held as soon as practicable after seclusion commenced with subsequent nursing reviews every 2 hours and medical reviews every 4 hours. The MDT had the power to significantly change (and extend) review intervals. Under the new Code: nursing reviews should be completed a minimum of 2 hourly for the entire duration of seclusion; medical reviews should be four hourly until the Independant . The new Code also introduces a standardised content for medical reviews of patients in seclusion and, where these are undertaken by junior doctors, specifies the need for access to, and support from, an approved clinician.

Seclusion may be authorised by either:

- The most senior available ward doctor in hours and the duty doctor out of hours. It is preferable that this will be the RC in hours but this may not always be practicable.

- The professional in charge (e.g. a nurse) of a ward - the most senior doctor available in hours/ duty doctor out of house must be informed straight away. The bronze manager (if out of hours on call manager must be informed)

- An entry must be made in the RiO notes and on the Seclusion Record, detailing the authorisation of seclusion, and (if appropriate) when the responsible clinician or duty doctors was informed

- When an episode of seclusion extends over 24 hours the Network Manager/Clinical Director should be informed.

- When an episode of seclusion extends over 7 days a second opinion by another consultant not involved in the case should be undertaken. The assessment and conclusions should be documented in the notes.

Commencing seclusion

- The staff member authorising seclusion (see procedure section) should have seen the patient immediately prior to commencement of seclusion

- Staff may decide what a patient can take into the seclusion area. The patient's valuables or any other belongings considered to be potentially harmful should be removed from the patient in accordance with the trust search policy. The patient should never be deprived of safe clothing when in seclusion.

- The start time/commencement of seclusion should be recorded in the seclusion record.

Seclusion care plans

- A seclusion management plan must be drawn up immediately, involving the patient where possible

- The plan should set out how the individual care needs of the patient will be met whilst the patient is in seclusion and record the steps that should be taken in order to bring the need for seclusion to an end as quickly as possible. As a minimum the seclusion care plan should include:

- A statement of clinical needs (including any physical or mental health problems), risks and treatment objectives;

- A plan as to how needs are to be met, how de-escalation attempts will continue and how risks will be managed;

- Details of bedding and clothing to be provided;

- Details as to how the patient's dietary needs are to be provided for, and;

- Details of any family or carer contact/communication which will be maintained during the period of seclusion.

- **Deaf services-** Arrangements need to be in place for deaf people so that they are able to communicate, and have equitable experiences of and outcomes from services. There should always an interpreter available on site to explain the seclusion process if required.

Entering seclusion room

- A minimum of three nurses must be present when seclusion room door is opened. However more nurses may be required depending on the risk assessment of the patient.

- All nurses involved in the review process must have up to date Prevention and Management of Violence and Aggression (PMVA).

- Before entering the seclusion room test for compliance by asking the patient to sit down or move to the back of the room.

- In an emergency the observing nurse should activate the alarm and wait for assistance.

- ***Under no circumstances should any staff member enter the seclusion room unaccompanied*.**

Observation during seclusion

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

- A designated nurse must be in attendance at all times immediately outside the seclusion room. He/she must be relieved hourly.

- A record of the patient's behaviour must be made at least every 15 minutes by the observing nurse on the seclusion observation chart/RiO. Observations must include level of alertness, pallor, respiration rate, behaviour, and ability to communicate. If it is not possible to carry out a physical observation, the reason/s why must be detailed in the seclusion observation chart/RiO.

- If the patient has had rapid tranquilisation prior to being placed in seclusion if deemed safe to attempt it physical observations should be done at the 15 minute interval.

- Where the patient appears to be asleep in seclusion, the observing nurse should be alert to and assess the level of consciousness and respirations of the patient as appropriate. This should be recorded in the seclusion observation chart/RiO in accordance with Trust observation policy.

Seclusion reviews

A series of review processes should be instigated when a patient is secluded. These include the multi-disciplinary team (MDT), nursing, medical and independent MDT reviews. All reviews provide an opportunity to determine whether seclusion needs to continue or should be stopped, as well as to review the patient's mental and physical state. Where agreed, family members should be advised of the outcomes of reviews.

The nurse in charge of the ward when seclusion is commenced should ensure that those who will perform the first reviews are aware of when these will be due.

Nursing review

- Nursing reviews of the secluded patient should take place at least every 2 hours by a minimum of 2 registered nurses, one of whom must not have been involved in the original decision to seclude

- Any concerns regarding the patient's condition should be brought to the attention of the most senior available doctor or on call doctor, immediately

- The seclusion care plan may allow the rescheduling of recordings when the patient is asleep, to avoid waking them.

Medical review

- **Nursing/ Medical Review for patients in Seclusion**
  Medical reviews are always undertaken jointly with the nurse in charge of the ward and the ward Doctor (on call Doctor if out of hours) as a minimum.

- **Review within 30 minutes**
  A medical review will need to take place immediately or within 30 minutes of the patient being placed in seclusion. This can be undertaken by the most senior available doctor available at the time – ward doctor, RC or out of hours on call junior Doctor. The Consultant responsible for the patient if not undertaking the review should be informed of the review by the senior doctor available.

- **Review at 4 hours (every 4hrs ongoing) – Medical Review**
  The medical review will be undertaken by the ward doctor or out of hours the on call junior Doctor with Consultant on call Supervision. The review needs to be a face to face. The out of hours junior Doctor would routinely liaise with the out of hours on-call consultant/ RC for any clinical or risk management advice.

- **Review at 8 hours – Independent MDT Review**
  The initial review must be undertaken by senior doctor/RC who was not involved in the decision to seclude, a nurse and other professionals not involved in the decision to seclude – this will involve the Ward Manager as a minimum. (Code of Practice 26.142). It will again be a face to face review. It is good practice to include an Independent Mental Health Advocate (IMHA) in this review if possible. Out of hours the junior Doctor, in consultation with the on call Consultant will perform this review

  Subsequent to the 8 hr Independent MDT review the patient must be reviewed face to face twice by a senior doctor in every 24hr period. One of those reviews must be by the consultant as below, the other can be a specialty doctor.

- **Review at 24 hours (or once in every 24 hours)**
  MDT Review - Consultant
  This review will be undertaken by a Consultant grade Doctor and must be a face to face review.

- **Nights/Weekends:** The reviews can be confined to the out of hours doctor and nurse in charge of the ward. However, even at weekends, the patient must be reviewed in person by the on-call Consultant once in each 24 hours.
  This review will include the Gold Director on call
- The Consultant responsible for the patient has responsibility to ensure that the on call / covering consultant is aware of the seclusion before cover arrangements commence.

  It is the task of the out of hours doctor and the consultant in charge of the patient (RC or covering RC at out of hours) to decide how to manage the review periods within the parameters above

- Medical reviews provide the opportunity to evaluate and amend seclusion care plans, as appropriate. They should be carried out in person and should include, where appropriate:

  - a review of the patient's physical and psychiatric health
  - an assessment of adverse effects of medication
  - a review of the observations required
  - a reassessment 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, and
  - an assessment of the need for continuing seclusion, and whether it is possible for seclusion measures to be applied more flexibly or in a less restrictive manner.

MDT review

- The first internal MDT seclusion review should be held as soon as is practicable, and in particular should be held before midnight rather than in the early hours of the morning for a patient who is secluded during the late evening. If a patient is secluded after 11pm then the MDT review can take place as early as possible the following morning.

- During working hours, the MDT review should include the responsible clinician RC (who may be a covering consultant) the senior nurse on the ward; and ward staff from other disciplines when available, including the psychologist and/or occupational therapist.

- Outside office hours a MDT review should consist of the nurse who was not involved in the decision to seclude and the on call junior Doctor who will liaise with the on call Consultant.

Further MDT reviews should take place once in every 24 hour period of continuous seclusion, and may be combined with one of the further medical reviews (two of which will be held in each 24-hour period as described above).

- If the MDT cannot reach a consensus on whether or not seclusion should continue, the matter should be referred to the Network Manager and the Medical Director. Out of hours, the matter should be referred to the on call manager and the consultant on call.

- Where seclusion continues, these reviews should evaluate and make amendments, as appropriate, to the seclusion care plan.

Independent MDT review

- An independent MDT review should be promptly undertaken where a patient has either been secluded for 8 hours consecutively or for 12 hours intermittently during a 48 hour period. This can happen before 8 hours to avoid unnecessarily waking the patient and if it means a multidisciplinary team is more available.

- Membership should include a senior doctor or out of hours the specialty trainee on call, or, a nurse and other professionals who were not involved in the incident that led to seclusion if possible and an IMHA (independent mental health advocacy worker) where appropriate and accessible. It is good practice for the independent MDT to consult with those involved in the original decision

- If it is agreed that seclusion needs to continue, then the review should evaluate and make recommendations for amendments to the patient's seclusion care plan.

- The patient should be supported to contribute to the seclusion care plan

- Unlike the internal MDT reviews, which continue every 24 hours, there need not be further independent MDT reviews.

- If the patient is secluded for more than 24 hours continuously, the Network Manager or the on call manager should be informed outside office hours (after 5pm and weekends).

- When an episode of seclusion extends over 24 hours the Clinical Director and Network Manager will be informed.

- When an episode of seclusion extends over 7 days a second opinion by another consultant not involved in the case should be undertaken. The assessment and conclusions should be documented in the notes.

Ending seclusion

- Seclusion should immediately end when an MDT review, medical review or independent MDT review determines it is no longer warranted.

- The nurse in charge of the ward may end seclusion at any time following consultation with the responsible clinician or duty doctor, based on a risk assessment. This consultation may take place in person or by telephone

- Seclusion ends when a patient is allowed free and unrestricted access to the normal ward environment. Opening a door for toilet and food breaks or medical review does not constitute the end of a period of seclusion

Debriefing

- A debriefing meeting should be arranged to allow staff involved with the seclusion process to discuss the action and learning during seclusion

- A debriefing meeting should also be arranged for the client to encourage them to speak about any concerns or issues they may have about events surrounding the use of seclusion and their feelings around this. This must be documented on Rio.

3.6 CARERS AND RELATIVES

Once a patient has been placed in seclusion the clinical team should consider the need to inform the nearest relative. Such a decision must however take into account the patient's own confidentiality. Friends and relatives who arrive to visit whilst a patient is in seclusion should be met by the senior nurse on duty and offered an explanation for the patient's seclusion and the possible risk or value of visiting the patient at this time.

By definition it is almost never safe to have visitors in to seclusion area, however, the patient's right to dignity, confidentiality and sensitivity must be adhered to. If the senior nurse on duty feels that a visit should not take place for reasons of safety the consultant must be informed and consulted with if visitation rights are insisted upon. It will be the consultant's responsibility to then make the decision as to whether a visit can take place or not. The senior nurse on duty decides conditions under which any visit takes place.

3.7 DEFINITION OF LONG TERM SEGREGATION (LTS)

26 .150 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.

"This refers to the situation where a person is prevented from mixing freely with other people who use a service. This form of intervention should be rarely used and only ever for hospital service users who present an almost continuous risk of serious harm to others

and for whom it is agreed that they benefit from a period of intensive care and support in a discreet area that minimises their contact with other users of the service." (Positive and Proactive Care 2014).

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, within which the degree of segregation varies dynamically with the service user's mental state and the consequent risk. 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.

Examples of LTS may include:

- If an individual under long-term enhanced observation is also being prevented from having contact with anyone outside the area in which they are confined, then this will amount to either seclusion or long-term segregation

- The use of prolonged restraint resulting degree of immobility preventing patients' ability to leave an area (such as where they are unable to reach or operate door handles) will amount to long-term segregation

- Extended periods of LTS causing delays in transfer to more appropriate levels of security, for want of an available bed may reach the threshold of inhuman and degrading treatment

3.8 Patient's Rights in LTS

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

- To be treated with respect and dignity at all times

- To be fully involved as possible in the development and review of a positive behaviour support plan/seclusion plan.

- To be given the reason(s) for being placed in LTS

- To be told under what conditions LTS will cease

- To be aware of the time of day via a clock viewable from the LTS area or by regular simple orientation being provided for the patient on request. Patients in LTS should have access to a calendar for this reason

- To receive adequate food and fluids at regular intervals

- To be given appropriate access to toilet and washing facilities (where continued observation is required, staff should always attempt to provide a nurse of the same gender

- To be appropriately clothed at all times

- To carry out religious observances with due regard to risk management

- To be visited by and given the opportunity to speak to the staff undertaking the reviews as per policy

- To receive advocacy, legal and family visits with due regard to risk management

A record must be made in LTS documentation of the patient being made aware of their rights, as above. (as per Seclusion Policy)

Complaints arising from the use of LTS must be investigated following the Trust complaints procedure.

3.9 Commencing long-term segregation

Long-term segregation can commence in order to reduce a sustained risk of harm posed by the service user to others, which is a constant feature of their presentation, a multidisciplinary review and a representative from the responsible commissioning authority determines that the service user should not mix freely with other service users on the ward or unit on a long-term basis. In such cases it should be determined that the risk of harm to others could not be ameliorated by a short period of seclusion combined with any other form of treatment. The clinical judgement is that, if the service user were allowed to mix freely in the general ward environment other service users or staff would continue to be exposed to a high likelihood of serious injury or harm over a prolonged period.

Where consideration is given to long-term segregation, wherever appropriate, the views of the service user's family and carers should be taken into account. The MDT review should include the IMHA in cases where the service user has one.

Long-term segregation should never take place outside of hospital setting and should never be used with people not detained under the Mental Health Act. It must only be used in conjunction with safeguards issues in the MHA Code of Practice paragraphs 26.150 to 26.160.

Management of long-term segregation:

During long-term segregation service users should not be segregated from staff, the care plan should aim to end long-term segregation.

The service user must be reviewed by an approved clinician at least once in every 24-hour period. There would be in MDT review at least weekly, consisting of the responsible clinician, nurse in charge of the ward, any other professional substantially involved in the service user's care and an IMHA if they have one.

There must be an independent review of the long-term segregation at least every two weeks by a senior professional not involved in the service user's care. This will normally be a consultant psychiatrist, consultant psychologist or a non-medical consultant.

The responsible commissioning authority Network Quality and Safety Lead will be informed of the outcome of the MDT reviews and the reasons for continued segregation.

Every three months a review of the service user's patients' circumstances in and care should be undertaken by an external hospital body. This should include discussion with the service user's IMHA (where appropriate) and the responsible commissioning authority.

If the service user's behavior requires the service user to be managed in seclusion to a short period of time because of the presenting risk, the usual seclusion procedures and safeguards will apply.

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

• To be treated with respect and dignity at all times

• To be fully involved as possible in the development and review of a positive behaviour support plan/seclusion plan.

• To be given the reason(s) for being placed in LTS

• To be told under what conditions LTS will cease

• To be aware of the time of day via a clock viewable from the LTS area or by regular simple orientation being provided for the patient on request.

Patients in LTS should have access to a calendar for this reason:

• To receive adequate food and fluids at regular intervals.

• To be given appropriate access to toilet and washing facilities (where continued observation is required, staff should always attempt to provide a nurse of the same gender)

• To be appropriately clothed at all times

• To carry out religious observances with due regard to risk management

• To be visited by and given the opportunity to speak to the staff undertaking the reviews as per policy.

• To receive advocacy, legal and family visits with due regard to risk management
A record must be made in LTS documentation of the patient being made aware of their rights, as above. (as per Seclusion Policy)

Complaints arising from the use of seclusion must be investigated following the Trust complaints procedure.

Additional Information Recording of LTS:

In addition to the recording requirements detailed at paragraph …….. of this policy the following must be undertaken for all patients subject to LTS

- Use of LTS should be recorded as an incident on Ulysses and marked for the attention of Safeguarding and Q&S Leads

- A clear rationale, with evidence that it is a necessary 'last resort' of managing disturbed behaviour should be recorded in the patients notes, on commencement of LTS and also at every subsequent LTS review.

- The record must show the determination that the risk of harm to others would not be ameliorated by a short period of seclusion combined with any other.

- The patient's care plan should outline how they are to be made aware of what is required of them so that the period of long-term segregation can be brought to an end.

- Care plans including adequate occupational therapy input, activities, distractions and opportunities for human contact during the time LTS is in place.

- Evidence showing that external reviews are taking place, that any recommendations have considered and if rejected, appropriate reasons are provided.

4. TRAINING AND SUPPORT

In order to ensure the health, safety and well-being of our service users and staff, the Trust aims to address the needs and impact of its corporate, mandatory and statutory training with a comprehensive and robust training needs analysis procedure. To this end, all Trust procedural documents which have risk management training needs for permanent staff are included in the 'Training and Development Policy and Training Needs Analysis' document as managed by the Training and Development Department. This document is available on the Trust intranet, under 'Training and Development'.

Duties within this area are as follows:

Author	Responsible for informing the Training and Development Department of amendments to policy training needs.
Ratification Body	The ratification body is responsible for ensuring all permanent staff are adequately trained as appropriate to the employees duties and work location and to follow up on refresher training needs.
Staff responsibility	To ensure they attend all relevant training as detailed in their induction and annual development review.
Training and Development Department	To provide access to training for all permanent staff. To maintain monitoring, reporting and review systems as per the 'Training and Development Policy and Training Needs Analysis.

5. PROCESS FOR MONITORING COMPLIANCE

The process for monitoring compliance with the effectiveness of this policy is as follows:

Aspect being monitored	Monitoring Methodology	Reporting		
		Presented by	Committee	Frequency
Documentation of seclusion notification incident form	Seclusion Record	Ward Manager	Report to Quality & Safety Manager. Operational manager to share information at Network Governance. Managers, Quality & Safety Manager, lead learning events to share learning points.	Monthly
Implementation of Seclusion care plan	Seclusion Record	Ward Manager	Report to Quality & Safety Manager. Operational manager to share information at Network Governance. Managers, Quality & Safety Manager, lead learning events to share	Monthly

Aspect being monitored	Monitoring Methodology	Reporting		
		Presented by	Committee	Frequency
			learning.	

Wherever the above monitoring has identified deficiencies, the following must be in place:

- Action plan
- Progress of action plan monitored by the *name of relevant committee* minutes
- Risks will be considered for inclusion in the appropriate risk registers

6. REFERENCES:

List any references for example national guidance or literature associated with this policy using Harvard referencing style.

I. The Mental Health Act 1983 as amended by the Mental Health Act 2007 Revised Code of Practice (2008)

II. Challenging behaviour and learning disabilities: prevention and interventions for people with learning disabilities whose behaviour challenges (NG11)

Learning disabilities: challenging behaviour (QS101)

III. Human Rights Act 1998 IV. Independent Enquiry into the Death of David (Rocky) Bennett. Published by the Norfolk Suffolk and Cambridgeshire SHA. December 2003

IV. Positive and Proactive Care: reducing the need for restrictive interventions April 2014

V. Mental Health Act 1983 Code of Practice revised 2015

VI. NICE guidelines [NG10] Violence and aggression: short-term management in mental health, health and community settings Published date: May 2015

VII. No Health Without Mental Health (DoH 2011)

7. ASSOCIATED DOCUMENTATION:

https://cdn.cumbriapartnership.nhs.uk/uploads/policy-documents/Rapid_Tranquillisation_Protocol_POL-001-020.pdf

All necessary documentation in relation to Seclusion can be found on Rio

8. DUTIES (ROLES & RESPONSIBILITIES):

8.1 Chief Executive / Trust Board Responsibilities:

The Chief Executive and Trust Board jointly have overall responsibility for the strategic and operational management of the Trust, including ensuring that Trust policies comply with all legal, statutory and good practice requirements.

8.2 Executive Director Responsibilities:

All policies have a designated Executive Director and it is their responsibility to be involved in the development and sign off of the policies, this should ensure that Trust policies meet statutory legislation and guidance where appropriate. They must ensure the policies are kept up to date by the relevant author and approved at the appropriate committee.

8.3 Managers Responsibilities:

It is the responsibility of all Managers:-

- The Ward Manager is responsible for monitoring and auditing the use of seclusion.
- The Ward Manager is responsible for ensuring the policy is in place and all staff are compliant.
- To ensure that all staff are made aware of their roles and responsibilities in relation to this policy.
- To ensure that all relevant staff have read the policy and are aware of what actions they need to take.
- To identify any additional training and support needs required by their staff to enable them to perform their duties as defined in this policy.
- To monitor and audit periodically staff awareness of their roles in relation to this policy.

8.4 Staff Responsibilities:

All employees (including Bank and Agency staff) and contractors are required to adhere to the policies, procedures and guidelines of the Trust.

8.5 Approving Committee Responsibilities:

The Chair of the approving committee will ensure the policy approval is documented in the final section of the Checklist for Policy Changes. The committee will agree the approval of the final draft of the policy.

9. ABBREVIATIONS / DEFINITION OF TERMS USED

Keep lists in alphabetical order

ABBREVIATION	DEFINITION
PMVA	Prevention and management of violence and aggression
MDT	Multi-Disciplinary Team
RC	Responsible Clinician
CCTV	Close Circuit Television

TERM USED	DEFINITION
RiO	Patient electronic records

DOCUMENT CONTROL

Equality Impact Assessment Date	26/09/18
Sub-Committee & Approval Date	*CPMG 26/9/18*

History of previous published versions of this document:

Version	Ratified Date	Review Date	Date Published	Disposal Date
1	01/03/2017	31/3/2019	15/3/2017	

Statement of changes made from version

Version	Date	Section & Description
1.1	26/9/18	• Addition of Long Term Segregation Policy

List of Stakeholders who have reviewed the document

Name	Job Title	Date
Linda Bennetts	ADN	July 2018
Dave Eldon	Head of MH Legislation	July 2018