

Seclusion Policy, Practice Guidance Note		
Long-term Segregation – V03		
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Author/Designation	Sheree McCartney – Associate Director Helen Percival – Nurse Consultant	
Responsible Officer / Designation	Dave Hatley – Associate Director	
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1 Introduction and Rationale

- 1.1 The Trust is committed to promoting the welfare and well-being of Patients and Staff. As part of this there is often a requirement to balance the need for Patients and Staff safety against the need to ensure maximum freedom of movement for Patients. This in turn reinforces the responsibility of the Trust to establish clear policies on the use of seclusion within clinical areas; see the Trust's CNTW(C) 10 - Seclusion Policy.
- 1.2 The Mental Health Act Code of Practice 2015 (MHA CoP) identifies a small number of patients, who due to the constant feature of their presentation pose a sustained risk of harm to others. In order to reduce the sustained risk of harm posed, which would not be ameliorated by a short period of seclusion combined with any other form of treatment it is necessary for the patient not to mix freely with other patients on the ward or unit on a long-term basis – Long-term segregation does not constitute seclusion.
- 1.3 There are a number of indications for which long-term segregation may be considered; however its use should not be as a default position when a patient is placed within an inappropriate service. It is however acknowledged that, for certain conditions, the use of long-term segregation, whilst primarily necessary to manage and reduce risk, can also have therapeutic benefits
- 1.4 It is recognised that patients in these situations may benefit from a Core Team approach that are extensively trained in clinical issues related to the patient such as management of violence and aggression, sensory integration, immediate life support, communication systems and positive behaviour support. A Core Team will comprise of a number of individuals dedicated to the patient and are trained within the treatment plan.
- 1.5 The use of long-term segregation should only be used in a way that respects human rights.

2 Implementation of Long Term Segregation Process

- 2.1 Long-term segregation refers to a situation where a person is unable to continue to be supported within the ward environment. **This needs to be out of what would be classified as a baseline presentation/ assessment for that person.**
- 2.2 The use of long-term segregation can be verbally requested by a patient stating that they are unable to manage within the environment. It can also be communicated by a patient's behaviour indicating that they are unable to cope with the environment.
- 2.3 Long-term segregation refers to a situation where the sustained risk of harm posed to others is a constant feature of a patient's presentation, as a result of which the patient is unable to mix freely with other patients on the ward or unit on a long-term basis.
- 2.4 It is expected that the Multi-Disciplinary Team involved in the patient's care will have assessed a range of other less restrictive approaches and found them to be ineffective before the decision to implement long term segregation is made. This must be reflected within the Care Plan.
- 2.5 It should have been determined that the risk of harm to others would not be changed by a short period of seclusion 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.

- 2.6 When considering long-term segregation the views of the person's family and carers must be gained and taken into account where possible.
- 2.7 The Multi-Disciplinary Review must include an Independent Mental Health Advocate (IMHA) in cases where a patient has one. If the patient does not have an IMHA then a referral must be made to seek allocation
- 2.8 The environment used to support long term segregation should be no more restrictive than is necessary and the environment can be as homely and personalised as risk assessment allows. The environment needs to be configured to allow patient access to a number of areas including as a minimum bathroom facilities, a bedroom and a relaxing lounge area. Patients should be able to access secure outdoor areas and a range of activities that are of interest and relevance to the person.
- 2.9 Patients should not be isolated from staff and level of observation and interaction needs to be reviewed and agreed within the Multi-Disciplinary Team (MDT) meeting and should be supported through enhanced observation. Treatment Plans should always aim to end long-term segregation or assess for a more appropriate environment.
- 2.10 The Local Safeguarding Team must be made aware of any long-term segregation.
- 2.11 Prior to initiation of long term segregation the relevant Commissioning Authority must be involved in the decision making process and must then be informed on initiation.
- 2.12 There must be authorisation from a Director within the service prior to the initiation of long-term segregation and long term segregation must be reviewed and reauthorized by a Director on a monthly basis.
- 2.13 A web based incident report must be completed upon the initiation of long-term segregation and incident number entered on the initiation of long-term segregation form.

A separate web-based Incident Report should be completed for any other reportable incident (See CNTW (O) 05)

- 2.14 A separate web based incident report must be completed when the episode of long-term segregation ends in order to accurately capture the end date/time and duration of the period of long-term segregation.
- 2.15 All documentation relating to this PGN can be accessed via Trust Intranet and must be stored/ retained in the individuals RIO support file.

3 Review Process

- 3.1 The patient's situation must be formally reviewed by an Approved Clinician who may or not be a Doctor at least once in any 24-hour period using Appendix C Review of long-term segregation PGN. A minimum of three of the daily reviews in any 7 day period must be completed face to face by an Approved Clinician; the remaining reviews may be delegated to a Core Trainee / Senior Trainee or Specialty Doctor. If the review is completed by a Core Trainee / Senior Trainee or Specialty Doctor they must discuss the details of the review with the Responsible Clinician, (or covering Responsible Clinician) and document that it

has occurred, noting the time and contents of the discussion. The formal review (by the Approved Clinician or Delegate) must include a physical face to face review of the patient's presentation, seek an update on presentation from supporting staff and a review of the long term segregation Care Plan. A summary of this formal review must also be documented within patient progress notes alongside long term segregation documentation

- 3.2 The long-term segregation must be reviewed weekly by the full MDT. The MDT review should include the patient's Responsible Clinician / Approved Clinician and an IMHA where appropriate
- 3.3 Staff supporting patients who are in long term segregation should make written records on the person's condition every 15 minutes using the long-term segregation observation documentation (Appendix D). The MHA CoP sets a minimum standard of completion of hourly written records however as means of best practice staff will complete a written record every 15 minutes unless otherwise agreed by the MDT. This must be clearly evidenced in the patients care plan **however as a minimum observations must be recorded at least every 60 minutes**. When observing and reviewing the patient staff should take into account the following:
- General behaviour
 - Engagement in activity
 - Therapeutic interventions
 - Movement
 - Posture
 - Speech / communication ability
 - Expression of ideas
 - Appearance
 - Whether orientated to time, place and person
 - Mood and attitude
 - Interaction with staff
 - Reaction to medication and any side effects and need for any additional medication
 - Level of consciousness
 - Cognitions
 - Whether there are any physical injuries
 - Physical observations. BP, pulse, temperature
 - Anxiety levels
 - Individuals reaction to the review process
 - Verbal requests from the patient
- 3.4 Four hourly reviews must take place on the Ward by 2 Registered Nurses. This review will take place in accordance with the care plan and be recorded in progress notes on RIO and in Appendix C Review of long-term segregation.
- 3.5 Reviews should take place by Senior Professionals not involved with the case on a monthly basis. The outcome of all reviews and the reasons for continued segregation should be recorded in Appendix C Review of long-term segregation and the responsible Commissioning Authority should be informed of the outcome. The frequency of the

communication with the responsible Commissioning Authority must be included within the patient's individual care plan and should be completed each calendar month as a minimum. Communication should also be recorded in the patient's individual progress notes.

- **This monthly review must include 2 Senior Clinicians from outside the service and independent to the case. These Professionals should be asked to join an MDT review**

- 3.6 Where long-term segregation continues for three months or longer, regular three monthly reviews of the patient's circumstances and care should be undertaken in Appendix C Review of long-term segregation by an external hospital. (This can be from another hospital site within the same NHS Trust) These reviews **must be undertaken by 2 or more Professionals from outside this Hospital, Commissioners and IMHA**. This should include discussion with the patient's IMHA (where appropriate) and Commissioner.
- 3.7 Monthly / Three monthly reviews (as per 3.5 and 3.6) should continue to be completed for those patients who are in long-term segregation who have episodes where they are nursed in seclusion. These should take place irrespective of the length of time the individual spent being nursed in seclusion.
- 3.8 The review process will include the assessment of risk to ascertain if ongoing risks have reduced sufficiently to be integrated into the wider ward environment and to check on the person's general health and welfare.
- 3.9 Where successive MDT reviews determine that segregation continues to be required, more information should be available to demonstrate its necessity and explain why the patient cannot be supported in a less restrictive manner. The use of planned, supportive phased returns to the ward should be considered within this process and the successfulness of this intervention will further inform these decisions.
- 3.10 All reviews will be recorded on Appendix C – Review of long-term segregation documentation

4 Care plan

- 4.1 There must be a detailed Care Plan outlining the rationale for the use of long-term segregation, the environment, daily occupation, staff support and aims of use of long-term segregation. This Care Plan will also need to outline what needs to be achieved for long-term segregation to be discontinued.
- 4.2 The Care Plan will outline the review process within the individual management.
- 4.3 The Care Plan should outline how the patient is informed of what is required of them so that the period of long-term segregation can be brought to an end.
- 4.4 The Care Plan will need to be authorised by a Director within the service and reviewed every 28 days.
- 4.5 The Care Plan may include exposure into shared patients areas and also areas outside of the immediate ward environment and also within the local community. For example, a patient may have extensive or regular periods of time outside of the long term segregation identified physical environment under the long term segregation Care Plan.

- 4.6 The long term segregation Care Plan must not be discontinued until an MDT agreement is made that the patient does not need to use the long term segregation area at any point.
- 4.7 Access to other areas of the ward, associations on the ward and access to visit areas may form part of the ongoing development of the Care Plan in working towards discontinuation of long term segregation.
- 4.8 There may be periods within the long term segregation where it is appropriate and therapeutic to increase association with peers and family members. **These periods should be accurately recorded with clear start and end times documented on the Observation Record.**
- 4.9 These periods of association with others and other environments within the ward and outside of this do not automatically indicate the end of long term segregation. These developments should be viewed as a positive strategy in care planning and working towards ending of long term segregation.
- 4.10 At these times outside of the long term segregation area, observations must remain as a minimum of 1:1 support.
- 4.11 The MHA CoP states that local guidance may allow different review arrangements to be applied during the night when the patient is asleep.
- 4.12 A full MDT risk assessment and consideration of the physical health of the person will need to be considered in determining the most appropriate review process for the night time observations. The risk assessment needs to balance the observation and review process against having undisturbed sleep. The rationale for prescribed observation/therapeutic engagement at night must be comprehensively documented within the Care Plan and agreed by the MDT
- 4.13 Where successive MDT reviews determine that segregation should continue more information should be available to demonstrate its necessity and explain why the patient cannot be supported in a less restrictive manner.
- 4.14 The Care Plan should not be discontinued or changed without full MDT agreement.

5 Changes in Presentation

- 5.1 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 restrictive and secure and which has been designed for the purpose of seclusion. In such a situation, the procedure for seclusion should be followed with regards to authorising and commencing seclusion, observation, seclusion reviews and ending seclusion. As outlined in 4.1 a Care Plan should specify needs to be achieved for long term segregation to be discontinued. Therefore an acute episode of seclusion does not mean that the long term segregation is discontinued but must form part of the Care Plan if it is assessed that acute episodes of seclusion may result within the long term segregation period in order for the long term segregation to continue. This would ensure that the long term segregation remained live throughout an acute episode.

6 In cases of emergency

- 6.1 A Care Plan and Prevention and Management of Violence and Aggression (PMVA) Plan including Section 17 leave must be developed in order to plan for the event of any emergency situations, including medical emergency and in the event of a fire. A designated safe area or alternative facilities must be identified and all involved personnel made aware of this. Consideration may be required by the MDT as to the potential need for the use of Emergency Restraint Equipment in any cases of emergency.

7 Audit Process

- 7.1 Documentation should be reviewed to ensure compliance with PGN and Code of Practice. This should be reflected within the audit form (Appendix E). Once per week the Ward Manager/ Clinical Team Lead will carry out a weekly audit of the records and ensure that all reviews have been carried out and are compliant with the PGN. Upon completion this audit form is to be submitted weekly to Clinical Nurse Manager and Seclusion Audit Nurse for Trust- wide audit purposes.
- 7.2. For further support or advice please contact the Seclusion Steering Group Chair or Policy Authors
- 7.3 To be read in conjunction with the following Cumbria, Northumberland, Tyne and Wear NHS Foundation Trust (CNTW/the Trust) Policies:
- **CNTW(C)02 Rapid Tranquilisation Policy**
 - **CNTW(C)16 Positive and Safe - Recognition, PMVA Policy and PGN**
 - **PMVA-PGN-01 Safe Use of Restraint Equipment PGN**
 - **CNTW(C)10 Seclusion Policy**
 - **CNTW(C)19 Observation Policy**