Pennine Care
NHS Foundation Trust

DOCUMENT CONTROL	
Title:	**Restrictive Interventions, Seclusion Policy**
Version:	**7**
Reference Number:	**CL026**

Scope:

This policy applies to:

- All inpatients including young people, adults of working age and older people.
- All Pennine Care NHS Foundation Trust staff providing direct patient care, in mental health inpatient wards.
- All Temporary and Bank Staff working in the above clinical areas.

Purpose:

To provide clear guidance on the use of Seclusion incorporating high standards of practice.

Keywords:

Seclusion, Time out, Restrictive, Patients, Movements, looking after

Supersedes:

Version 6

Description of Amendment(s):

Review of terminology in relation to 'Nursing away from others'
Review of guidance for use of seclusion for children and young people.
Information added regarding visitors to people in seclusion.
Change in seclusion documentation.

Owner:

Managing Director for Mental Health Services

Individual(s) & group(s) involved in the Development:

This document has been developed in collaboration with the following interested parties:

- Mental Health Service Manager
- Violence Reduction Manager, CEST Manager

Individual(s) & group(s) involved in the Consultation:

The document has been circulated for consultation and comments have been taken into consideration and the document amended accordingly:

- User and Carer Group
- Acute Care Forum

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Other Trust documentation to which this guideline relates (and when appropriate should be read in conjunction with):	
CL003	Care Programme Approach (CPA) Policy
CL002	Consent to Examination & Treatment Policy
CO010	Incident Reporting Policy
CL005	Observation and Engagement Policy
CL009	Resuscitation Policy
CL014	Policy for Rapid Tranquillisation
CO038	Violence Reduction Policy
CL058	Policy on Treatment of patients subject to the Mental Health Act 1983 – Part 4 and Part 4A
CL061	Admission Entry and Exit Policy
CL035	Search Policy
Policy Associated Documents	
TAD_CL026_01	Seclusion Toolkit
TAD_CL026_02	Seclusion Log Sheet
TAD_CL026_03	Food & Fluid Record Chart

TAD_CL026_04	The Medical Early Warning Score (MEWS)
TAD_CL026_05	Seclusion Rights Leaflet
TAD_CL026_06	Seclusion information for Young People
CQC Regulations **This guideline supports the following CQC regulations:**	
Regulation 9	Person centred care
Regulation 10	Dignity and respect
Regulation 11	Consent
Regulation 12	Safe care and treatment

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1. INTRODUCTION

Pennine Care NHS Foundation Trust is committed to providing the highest standard of care for people across the footprint. The Trust recognises that admission to hospital can be a distressing experience for service users, especially if the person's liberty is restricted by compulsory admission. It is therefore essential that any further restriction on the individual is avoided wherever possible, and interaction with others in the hospital environment is positively promoted. The Trust will ensure the physical and emotional safety and wellbeing of the service user remains a priority for all staff at all times.

Pennine Care has undertaken a commitment to reduce all forms of restrictive intervention and has developed a Violence Reduction Strategy, along with a restrictive intervention reduction approach. Both have a high level sponsorship and ownership via the Associate Director of Nursing and Health Care Professionals with overarching review responsibilities for the approach resting with the Trust Executive Team.

This policy stems from a framework to balance the needs of patients to receive care with the need to protect staff and others from violence and aggression by the containment of severe behavioural disturbance which is likely to cause harm to others.

Staff will ensure that service users receive the care and support rendered necessary both during and after seclusion has taken place.

Any limitations which are implemented by the Care Team, should be the least restrictive, and for the minimum length of time. This Policy describes a range of care processes, which can be used to maintain safety and dignity based on individual need. It also identifies the standards and safeguards, which must accompany any restriction of an individual's movement within the inpatient environment.

The Policy is one component of the Trust's efforts to provide safe and individualised care in the inpatient environment. It should be viewed within this wider context, and implemented in conjunction with all other relevant Pennine Care Policies.

2. PURPOSE

To ensure restrictive practices remain proportionate, least restrictive, last for no longer than is necessary, and take account of patient preference wherever possible [NICE NG10, 2015] and based on the individual need and risk of the service user.

Protect the patient from deliberate or accidental self-harm.

Protect others from harm by the patient (deliberate or accidental).Ensure the safety of others from severe behavioural disturbance which likely to cause harm to others.

3. RESPONSIBILITIES, ACCOUNTABILITIES AND DUTIES

To meet and uphold the guiding principles of the Mental Health Act Code of Practice (2015) and to:

- Ensure the physical and emotional safety and wellbeing of the patient
- Ensure that the patient receives the care and support rendered necessary their seclusion both during and after it has taken place
- Designate a suitable environment that takes account of the patient's dignity and physical wellbeing.
- Set requirements for the recording, monitoring and reviewing of the use of seclusion and any follow-up action.
- Ensure the patient receives the care and support rendered necessary by their seclusion both during seclusion and after it has taken place.
- Minimise the frequency and duration of seclusion and prevent any inappropriate use of seclusion.
- Distinguish between seclusion and other restrictive practices and psychological behaviour therapy interventions (such as 'time out').
- To ensure inpatient areas have open and transparent governance processes that support, monitor, advise and report on the use of the restrictive practices of seclusion.
- Ensure proper monitoring of periods of seclusion and to provide a complete record of all periods of seclusion and audit.
- Ensure patients are aware of their rights when there is any form of restriction on their movement within the inpatient ward.

4. DEFINITIONS

Member of nursing staff	A person considered to be part of the nursing team, irrespective of qualification or professional status. A student nurse is not classed as a member of nursing staff in respect of this policy.
Professional in charge of the ward	The senior healthcare professional (usually a nurse) designated as 'in charge' of the ward in which seclusion facilities exist. It may be possible that other more senior healthcare professionals are present, but they should not independently authorised to use or end seclusion.

Bleep holder/senior on-call manager	The senior nurse or other professional who has responsibility for co-ordinating site/unit/area. Where there is no bleep holder out of hours, senior on call manager should participate in review as required. This may be by telephone.
Potentially injurious item	Almost any item potentially poses some threat. The goal is to **ensure** that the service user does not have in his/her possession items which he/she can use readily to harm him/herself, or others entering the room. In particular consideration must be given to articles of clothing which could be used as a ligature or weapon. Should a potentially injurious item be observed in seclusion with the service user, this should be removed as soon as possible. If the service user is threatening with the item they should be asked to leave the item by the door and sit at the back of the room. If the service user continues to refuse, safety of staff entering the room must be considered and an assessment made as to whether police support to remove the item is required.
Registered nurse	All nurses holding a registrable qualification with the Nursing and Midwifery Council (NMC) in one of the following categories: • Mental Health Nurse (first level nurses trained in the nursing of persons suffering from mental illness) RN3 or RNMH. • Mental Health Nurse (second level nurses trained in the nursing of persons suffering from mental illness) RN4 • Learning Disabilities Nurse (first level nurses trained in the nursing of persons suffering from learning disabilities) RN5, RNLD.
Suitably qualified professional	Registered healthcare professional who has the appropriate experience to be able to contribute to the assessment and management of service users in seclusion.
Personal search	This is the least invasive type of personal search and involves a nurse of the same sex as the service user patting his/her hands over the service user's clothed body. His purpose is to collect items which the service user may have in his/her possession which could be used to self-harm, or as a weapon. This type of search will only detect relatively bulky items. If the professional in charge has good reason to suspect that the service user has small but dangerous items concealed on his/her person (such as a razor blade) the use of a full search must be considered. For information relating to personal search please refer to the Searching Service users and their Property Policy.

Medical officers responsibilities	The decision to seclude is described in section of this policy. Wherever possible this decision is taken following consultation with other members of the MDT. Medical staff alone should not instigate or terminate seclusion as a uni-disciplinary decision. Where there is a disagreement about continuation of seclusion the service manager or on-call manager should be contacted for advice. The duty medical officer's primary role is to provide support and advice regarding the medical management of the individual in seclusion. This may include the use of rapid tranquillisation.
Medical assessment	The doctor must attempt to undertake assessments of both the service user's mental and physical state. It is acknowledged that if the service user is behaving in such a way as to make face to face assessment unacceptably risky, this assessment might be limited and based upon those observations that can be carried out without direct access to the service user.
Constant attendance – direct view of the service user	This means that a member of staff must be positioned directly outside the seclusion room and is able to maintain visual contact with the service user. The member of staff must be assessed as competent to take this role before being delegated to task by the professional in charge.
Practicable	This policy recognises that in some instances the local medical officer is required to cover hospital sites that are a considerable distance from each other. Consequently their immediate attendance on the ward may not be possible. However, "practicable' in this context does not imply that the doctor attends when convenient. It means that the doctor should regard the situation as urgently requiring their presence at the unit in the shortest possible time.
Approved clinician	Section 145 (1) of the Mental Health Act 1983 defines an approved clinician as "a person approved by the Secretary of State to act as an approved clinician for the purposes of the Mental Health Act 1983".
Responsible Clinician	"Responsible clinician" is defined in section 34) of the Mental Health Act 1983 as: (a) in relation to a patient liable to be detained by virtue of an application for admission for assessment or an application for admission for treatment, or a community patient, the approved clinician with overall responsibility for the patient's case; (b) in relation to a patient subject to guardianship, the approved clinician authorised by the responsible local social services authority to act (either generally or in any particular case or for any particular purpose) as the responsible clinician.

4.1 Seclusion

Seclusion in this policy is as defined in Chapter 26.103 of the Code of Practice and is held to be "*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*"

Chapter 26.104 of the Code of Practice also states that "*if a patient is confined in any way that meets the definition above, even if they have agreed to or requested such confinement, they have been secluded and the use of any local or alternative terms such as 'therapeutic isolation') or the conditions of the immediate environment do not change the fact that the patient has been secluded"*. The use of any local or alternative terms (such as nursing away from others') the conditions of the immediate environment do not change the fact that the service user has been secluded and therefore it is essential that they are afforded the procedural safeguards of the Mental Health Act Code of Practice.

"If the circumstances of a person's care resemble seclusion, it is seclusion whatever it is called locally." (Positive and Proactive Care 2014).

Staff must be aware that the following situations should be viewed and managed as an incident of seclusion, even when a designated seclusion room has not been used:

Placing a service user in a room with the door locked

Placing a service user in a room with the door held shut

Placing a service user in a room which his or her ability to leave is somehow restricted e.g. by suggesting that any attempt to leave the room will result in physical restraint or compulsory medication or other means.

Seclusion is a tertiary restrictive intervention which includes formal use of a seclusion area and separation from other patients; and through behavioural support planning, clinical teams are required to demonstrate lower level collaborative interventions, where possible, to avoid seclusion use as the highest level or restriction.

Seclusion is neither punitive, nor solely used to manage self-harm or set as part of a treatment plan. However, it may be requested or used as part of a behavioural support plan when there is no other safe alternative to the management of severe behavioural arousal. Service users who are placed in this type of seclusion are afforded specific extra monitoring, review and audit procedures.

Long Term Segregation – Currently NOT supported by our commissioned service pathways and therefore Pennine Care does not utilise long term segregation of service users. It does not currently have the required estate to provide long term segregation as defined by the Code of Practice. Service users who present an almost continuous risk of

serious harm to others and for whom it is agreed that they would benefit from a period of intensive care and support in a discreet area should be supported by referral to the mental health higher secure estate, external to the Trust.

There may be situations where a referral to higher secure services is necessary and a decision is reached by the clinical MDT to utilise seclusion as the only safe alternative to support and manage the service user. Least restriction continues to apply along with the seclusion monitoring requirements whilst a referral takes place and with a continued emphasis on reducing the seclusion restriction, utilising intensive nursing support, outside of a seclusion room/suite where possible. Even where the patient is supported outside of a seclusion room/suite, the conditions of seclusion as laid out by the Mental Health Act Code of practice could have been met and the formal procedural safeguards of seclusion monitoring would need to continue.

4.2 Restrictive Interventions

Restrictive interventions are defined as deliberate acts on the part of other person(s) that restrict a patient's movement, liberty and/or freedom to act independently in order to:

- take immediate control of a dangerous situation where there is a real possibility of harm to the person or others if no action is undertaken, and
- end or reduce significantly the danger to the patient or others.

Restrictive interventions should be used in a way that minimises any risk to the patient's health and safety and that causes the minimum interference to their autonomy, privacy and dignity, while being sufficient to protect the patient and other people. The patient's freedom should be contained or limited for no longer than is necessary.

4.3 Human Rights Act 1998

Any use of restrictive interventions must be compliant with the Human Rights Act 1998 (HRA), which gives effect in the UK to certain rights and freedoms guaranteed under the European Convention on Human Rights (ECHR).

No restrictive intervention should be used unless it is medically necessary to do so in all the circumstances of the case. Action that is not medically necessary may well breach a patient's rights under article 3 of the ECHR, which prohibits inhuman or degrading treatment.

Article 8 of the ECHR protects the right to respect for private and family life. A restrictive intervention that does not meet the minimum level of severity for article 3 may nevertheless breach a patient's article 8 rights if it has a sufficiently adverse effect on the patient's private life, including their moral and physical integrity.

Restrictions that alone, or in combination, deprive a patient of their liberty without lawful authority will breach article 5 of the ECHR (the right to liberty). There is a deprivation of liberty in circumstances where a person is under continuous control and/or supervision (the term continuous control and/or supervision should be liberally interpreted) and is not free to leave and lacks capacity to consent to the proposed interventions giving rise to the deprivation of liberty[1].

Unless a patient is detained under the Mental Health Act or is subject to a deprivation of liberty authorisation or Court of Protection order under the MCA, staff must be careful to ensure that the use of restrictive interventions[2] does not impose restrictions which amount to a deprivation of liberty. For further advice around the interface between the MHA/MCA/DoLS please refer to the Trust's Admission, Entry and Exit policy (CL061), chapter 13 of the MHA Code of Practice 2015 (mental capacity and deprivation of liberty) and or contact your local Mental Health Law office for additional support regarding any applications for DoLS.

Services and their staff should help all patients to understand the legal authority for any proposed action and their rights (especially their right to leave a hospital if they are not detained there). Informal patients should, in particular, be informed of the existence of holding powers.

[1] MHA Code of Practice (2015) 26.49 the precise scope of the term 'deprivation of liberty' is not fixed and develops over time in accordance with European Court of Human Rights case law and UK case law on article 5.

[2] Examples of restrictions that could indicate there is a deprivation of liberty include:

- informal patients being prevented from leaving a hospital
- informal patients being told that they will be detained under the Act if they do not comply with requests of staff, or
- informal patients being kept in circumstances amounting to seclusion without their consent.

4.4 Time Out

Time Out is a specific behaviour change strategy which can be used for children and young people for a period of no more than 15 minutes, which should be delivered as part of a behavioural programme (see also paragraph 6.3). If Time Out processes have the features of seclusion, for example the patient is prevented from leaving their bedroom, this should be treated as seclusion and comply with the requirements of the Code of Practice.

Time out might include:

- Preventing a child or young person from being involved in activities which reinforce a behaviour or concern until the behaviour stops;
- Asking them to leave an activity and return when they feel ready to be involved and stop the behaviour;

- Accompanying the child or young person to another setting and preventing them from engaging in the activity for a set period of time.

If Time Out involves the patient spending time alone in a quiet room or bedroom, the door must NOT be locked. If the presentation of the patient requires that they be nursed behind a locked door or if they are prevented from leaving the room for this period of time out that must be classed as seclusion.

5. PROCEDURE FOR SECLUSION

5.1 Seclusion Room

Seclusion should only take place in a room or suite of rooms that have been specifically designed and designated for the purposes of seclusion and which serve no other function on the ward. [Chapter 26.105]. (See section Designated seclusion rooms should meet the criteria identified within the Code [Chapter 26.109] in that they will:

- Allow for communication with the patient when they are in the room and the door is locked.
- Have limited furnishings which should include a bed, pillow, mattress and blanket or covering.
- Not have any apparent safety hazards.
- Have robust and reinforced windows that provide natural light (and where possible the window should be positioned to enable a view outside).
- Should have external controllable lighting, including a main light and subdued lighting for night time.
- Have robust doors which open outward.
- Have externally controlled heating and / or air conditioning, which enables those observing the patient to monitor the room temperature.
- Not have any blind spots.
- Have a clock visible to the patient from within the room
- Have access to toilet and washing facilities

The seclusion room should:

- Allow clear observation.
- Be well heated and ventilated
- Have access to toilet and washing facilities
- Be able to withstand attack and damage.

The seclusion of the service user in a locked room should only be undertaken in appropriate facilities for this purpose, those being identified on the following units:

- Cobden (Psychiatric Intensive Care Unit) [PICU]
- Hope
- Horizon
- Prospect Place
- Tatton

In areas that do not have designated seclusion rooms but where it is clinically indicated that supervised seclusion is necessary, the seclusion process should still be followed. In exceptional circumstances it may be considered more therapeutic and less restrictive to manage a patient requiring isolation in their own bedroom. This should only be considered if the multi-disciplinary team believe there are cogent clinical reasons for doing so and that any risks presented by the environment can be safely managed. Assessment of these risks should be kept under regular review. The risks of using a Non Designated Seclusion Room must be clearly documented, the risks minimised.

Where a patient requires care and treatment in a designated seclusion room they should be referred to a unit that has this facility as soon as possible.

5.2 Decision to initiate Seclusion

The decision to use seclusion may be made in the first instance by a doctor, a suitably qualified approved clinician (AC) or the professional in charge of the ward, ideally in consultation with other member of the MDT.

Seclusion should be used:

- As a last resort
- To prevent harm to others
- For the shortest possible time.

5.3 Seclusion of informal service users

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 (including the possible use of Section 5(2) or Section 5(4) in the interim until an application under section 2 or 3 of the MHA can be considered and applied).

Restrictions on the use of Seclusion

Seclusion must not be used in the following circumstances:

- Because of staff shortages
- Because equipment or property is being damaged but no one is at risk
- As a punishment or threat
- As part of a treatment programme

5.4 Risk of self-harm or suicide

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

If suicide ideation or self-harm has been a feature of the service users illness or condition, but is not felt to prose any immediate risk whilst subject to seclusion it is important to document the assessment of this in the clinical record.

The assessment must be clear and specific as to why seclusion is the only means of managing the service user's behaviour and why the necessity for seclusion outweighs the risk of self-harm or suicide. Service users must be under constant observation and a plan of action to manage any self-harm is required.

5.5 Procedure prior to and during seclusion

- An incident has occurred and a decision made that the only method of safely managing the situation is to initiate seclusion.
- The procedure for physical restraint has been followed as described in the CO038 Violence Reduction Policy and the service user is taken to the designated area for seclusion.
- The service user is informed why seclusion is being initiated and told that he/she will be able to leave the room as soon as a risk assessment indicates that he/she no longer poses a risk to others. The service user is given clear simple statements about what is required for the seclusion to end.
- A service user should not be placed in seclusion with potentially injurious items in his / her possession; therefore the service user is made subject to a personal search in accordance with the Search Policy CL035.
- Service users will not have either ordinary clothing removed in response to disturbed behaviour or when being secluded. Normal day and night clothing should be worn unless there is a particular overriding reason such as risk of self-harm. However footwear, bets, ties, jewellery which may be a hazard either to the service user or to staff whilst in seclusion will normally be removed. Special consideration must be given to items of religious or cultural significance (including some items of jewellery). Any property removed should be recorded in the patient property book and kept in a safe place.
- The person authorising seclusion must have seen the service user immediately prior to authorisation and complete the **Decision to Seclude (Part 1)** form.
- **Where the decision to use seclusion is taken by someone other than the doctor, the responsible clinician (RC) or their nominated deputy or duty doctor should be notified at once and should attend within an hour.**

- The attending doctor's responsibilities are to consider alternative management strategies including any adjustments to medication including the use of rapid tranquilization and to ensure where possible, that the medical assessment including the physical and mental state of the service user is carried out.
- The **Medical Review Form (Part 2)** should be completed by the attending doctor and arrangements made for the First Internal MDT Review to take place as soon as it is practicable
- The **Seclusion Care Plan (Part 3)** should be completed by the nurse in charge after discussion with the attending doctor. A seclusion Care 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.
- Wherever possible and feasible, the patient should be supported to contribute to the seclusion care plan and steps should be taken to ensure that the patient is aware of what they need to do for the seclusion to come to an end. Patients should be fully involved in the reviews and be given reasons for decisions.

  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 (see MHA Code of Practice (2015) paragraph 26.16).

- All assessments completed during an episode of seclusion must be recorded in the service user's clinical notes.
- A suitably skilled member of nursing staff will remain in constant attendance and maintain a direct view of the secluded service user. They will be supervised by and have immediate access to a suitably skilled professional.
- The professional in charge should ensure that members of staff delegate observation duties are aware of the requirements of their role and are competent to carry out duties of the observer.
- For service users who have received sedation, a suitably skilled professional will be outside the door at all times.
- The aim of this observation is to monitor the condition and behaviour of the service user and to identify the earliest opportunity that the seclusion can be ended. An entry must be made on the observation recording form.
- Any person taking over responsibility for observing a service user in seclusion should have a full handover, including details of the incident that resulted in the need for seclusion and subsequent reviews.

- The observer should always note and record the nature of and changes to service users:
    - Appearance
    - What they are saying and doing
    - Their mood
    - Their level of awareness
    - Any evidence of physical ill-health, especially with regard to their breathing, pallor or cyanosis. Where the service user appears to be asleep, the person observing the service user should assess and record their level of consciousness and respiration.
    - Mental state (or presentation)
    - Physical state
    - Fluid and dietary intake and output
    - Interaction with others
    - Evidence of change in the circumstances which led to seclusion
    - Evidence of continuing hostility, threat or violence
    - Significant changes to the service user's condition should be reported to the professional in charge, who will advise the ward doctor or duty doctor if appropriate.
- It is the responsibility of the professional in charge of the ward to ensure that following the use of rapid tranquillisation the following physical observations are undertaken as soon as practicable:
    - Temperature
    - Pulse
    - Blood Pressure
    - Respiration Rate.
- Taking physical observations may be difficult in the case of the service user requiring seclusion. Staff must aim to obtain physical observations soon as it is safe to do so. Please refer to the trust guidelines for rapid tranquillisation (CL014).

5.6 Safeguards for Service Users in Seclusion

The service user will be

- Made aware of his / her rights and where appropriate given a copy of the Mental Health Act Service User's rights / Care Quality Commission leaflets and the Service User Information sheet on Seclusion
- Informed of why he / she is in seclusion.
- Made aware that the need to continue seclusion will be under ongoing review and reviewed formally at least every two hours.
- Provided with food and fluids at regular intervals
- Given access to toilet and washing facilities
- Treated with dignity and respect
- Told how to summon a member of staff
- Provided with daytime clothing

- Informed of what is required for seclusion to terminate
- Arrangement for regular exercise and fresh air should be made, when considering safe by the care team.

6. REVIEWS

6.1 Seclusion Reviews

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.

6.2 Conducting a review

All reviews focus primarily on the need to continue or terminate seclusion. All reviews should take place in the seclusion room, face to face, unless there are cogent reasons why this is not possible. If it is deemed to be unsafe to enter the room, the reasons should be documented in the review forms.

Before entering a seclusion room, there should be a thorough review of any documentation and assessments and a handover from the observing staff member. The reviewers should decide what information they wish to gather and who is primarily going to lead the assessment to avoid confusion. Once the assessment has taken place the reviewers should leave the seclusion room and discuss whether the seclusion should continue or be terminated and the decision clearly documented. Changes to the care plan can be made. Arrangement for the next review should be made.

6.3 Two hourly review

Two registered nurses, one of whom was not involved in the decision to seclude, will formally review the plan of care at least every two hours. This review is recorded in the appropriate section of the seclusion documentation.

6.4 Medical review

For the purposes of medical reviews, where the responsible clinician is not immediately available e.g. outside of normal working hours, a 'duty doctor' can deputise for the responsible clinician. Whenever the duty doctor is not an approved clinician, they should at all times have access to an on-call doctor who is an approved clinician.

The first medical review should take place within one hour of the commencement of seclusion.

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

A medical review will take place every four hours of continuous seclusion until the first (internal) MDT has taken place. The outcome of the review will be recorded. The medical review can be carried out by any doctor, although where possible this should be a doctor that is familiar with the service user. Alternative review arrangements for when the service user is sleeping will be identified in the care plan.

Following the first (internal) MDT review further medical reviews should continue at least twice in every 24 hour period. At least one of these should be carried out by the service user's responsible clinician, or if it is out of hours by an on-call approved clinician. The review by the approved clinician can be undertaken during a MDT Review.

6.5 Internal MDT Review

A first (internal) MDT review should be held as soon as practicable. Membership of the review should include the Responsible clinician or an approved clinician if the RC is not available, senior nurse on the ward and other professionals who are substantially involved in service user's care. At weekends or overnight the internal MDT review can be undertaken by a duty doctor, senior nurse on the ward and any other professional involved in the Service Users care who is available. If only medical and nursing staff are available the bleep holder / senior on call manager for the service must be involved, this may be by telephone. This review should take place before the independent review.

Further MDT reviews should take place once in every 24 hour period of continuous seclusion.

6.6 Independent MDT Review

A service user in continuous seclusion for the period of eight hours, or 12 hours intermittently in any 48 hour period, is subject to an Independent Multidisciplinary team review by an approved clinician, a nurse and other healthcare professionals not directly involved in the incident which led to seclusion. An Independent Mental Health Advocate (IMHA) should be involved if possible when the service user has one.

At weekends or overnight the independent review can be undertaken by an on-call approved clinician, a nurse and any other healthcare professionals not directly involved in the incident which led to seclusion. If only medical and nursing staff are available, the bleep holder / senior on-call manager for the service must be involved, this may be by telephone.

Although the independent MDT review must be held at a time promptly after continuous seclusion for 8 hours or 12 hours intermittently in any 48 hour period, from a clinical perspective it may be impractical and of limited clinical value to undertake an independent MDT review in the middle of the night. It is important that these reviews support effective clinical decision making and in some instances it may be more appropriate to conduct the review the following morning, particularly if the service user is asleep. (See below for further guidance on service users sleeping).

6.7 Service user sleeping whilst secluded

It will not usually be appropriate to wake the service user in order to undertake a review of the necessity for seclusion to continue. Clearly, much of the immediate assessment of the mental state to discontinue seclusion is impractical when the service user is asleep. However, some issues should be taken into account:

- Is it appropriate to be sleeping at this time of day or night? If the service user has recently fallen asleep after a period of very disturbed behaviour, it may not be appropriate to wake them.
- Has the service user reportedly been asleep for more than eight hours? Waking for the review may be appropriate.
- Are medical and nursing staff confident that the service user has not lost consciousness? Observation of respiratory rate and continence may be relevant.
- Has the service user received any oral or intramuscular medication that day?
- Has the service user received medication which he/she has not previously received?
- Has the service user received medication to a level in excess of British National Formulary limits?
- Has the service user any physical condition that necessitates closer medical supervision?

Though a degree of discretion is indicated, the reasons for any review not taking place due to the service user being asleep should be agreed by the MDT and must be clearly documented.

6.8 Ending Seclusion

When the professional in charge or the MDT is satisfied that the criteria for ending seclusion have been met, seclusion is discontinued immediately.

In the event of disagreement regarding whether seclusion is continued or not, the matter will be referred to the Clinical Lead for the service. Out of hours the on-call manager should be contacted. The outcome will be recorded.

6.9 Post Seclusion Evaluation

At the end of a seclusion episode the professional in charge will complete the evaluation section of the seclusion documentation.

At the earliest possible opportunity the service user is afforded an opportunity to review, discuss and record events leading to seclusion and the seclusion period itself, with the clinical team.

This review is documented and includes:

- An assessment of any adverse effects of seclusion (distress, trauma, increasing psychological suffering).
- An explanation of why seclusion was the only feasible way of managing his/her behaviour.
- Seeking the service users views about alternatives to seclusion.
- Any written comments which the service user may wish to make.
- Considering future alternative means through which the service user may express anger without recourse to violence.

7. MAINTENANCE OF THE SECLUSION ROOM

- It is the responsibility of the professional in charge to ensure that the room is kept up to acceptable standards of cleanliness.
- Contamination with body fluids or wastes, surfaces and furnishings must be cleaned according to the trust's infection control procedures or be replaced.
- The room must be included in the domestic cleaning schedule in addition to post seclusion cleaning.
- The room must be kept prepared for a seclusion and not used for any other purpose.

8. USE OF QUIET AREAS FOR THE PURPOSE OF SUPERVISED SECLUSION

Clinical need may dictate the use of quiet areas to allow individuals to have closely supervised care, with staff in constant attendance. This level of care may be appropriate to maintain safety and dignity of service users who may be acutely distressed, overactive, disinhibited or have other challenging behaviours, or who may be actively seeking to self-harm.

This might involve using a designated area or room to reduce emotional arousal or agitation and support the service user to become calm.

Staff must be aware that the following situations should be viewed as an incident of seclusion, even when a designated seclusion room has not been used:

- **Placing a service user in a room with the door locked**
- **Placing a service user in a room with the door held shut**
- **Placing a service user in a room which his or her ability to leave is somehow restricted e.g. by suggesting that any attempt to leave the room will result in physical restraint or compulsory medication or other means.**

Seclusion can have particularly adverse implications for the emotional development of a child or young person, and should be taken into consideration in any decision to seclude a child or young person. Careful assessment of the potential effects of seclusion by a trained child and adolescent clinician is required, especially for those children and adolescents with histories of trauma and abuse, where other strategies to de-escalate behaviours may be more appropriate. (MHA, Code of Practice, p293, 26.57) Safeguarding children advisors should also be contacted on admission of a child/young person and as soon as practicable after any period of seclusion.

9. CHILDREN AND YOUNG PEOPLE

In the case of children and young people under the age of 18, the use of restrictive interventions (including Time Out – see section 5.4) may require modification to take account of their developmental status. The legal context within which restrictive interventions are used with children and young people is different from adults. **For further information on children and young people more generally, see chapter 19 of the MHA Code of Practice.**

The Mental Health Act 1983 and MHA Code set no age limit on the use of seclusion. The Code is applicable to people of all ages including children and young people. If a decision is made to implement seclusion on CAMHS wards, the Responsible Clinician must be involved in the decision process unless it is an emergency situation. Careful assessment of the potential effects of seclusion by a trained child and adolescent clinician is required, especially for those children and adolescents with histories of trauma and abuse, where other strategies to de-escalate behaviours may be more appropriate than the use of seclusion.

Staff involved in the care of children and young people who exhibit behavioural disturbance are able to employ a variety of skills and strategies that enable them to provide appropriate help and support. In most cases restrictive interventions will only be used if they form part of the positive behaviour support plan (or equivalent) and have therefore been developed with input from the child or young person and their family.

Staff should always ensure that restrictive interventions are used only after having due regard to the individual's age and having taken full account of their physical, emotional and psychological maturity.

When antipsychotic medication is used to sedate a child or young person, special consideration should be given to risks relating to their developing central nervous system, especially when the medication is given to children or adolescents who do not have a diagnosed psychosis. Restrictive interventions must only be used with great caution on children and young people who are not detained under the Act. If there are indications that the use of restrictive interventions (particularly physical restraint or seclusion) might become necessary, consideration must be given to whether formal detention under the Act is appropriate.

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

If children or young persons under the age of 16 years are secluded, staff **must** contact the Service Manager immediately to inform them about the authorisation/initiation and for advice and support. If out of hours, contact the senior manager on call.

Parents or carers should be informed about decisions to seclude children or young people at the earliest opportunity.

Any physical restraint must be in accordance with Trust Violence reduction Policy. All incidents of restraint or seclusion must be recorded on the Trust Safeguard system.

10 VISITS

Whilst a patient is in seclusion consideration will be given to Contact with professionals and family and carers. Where this has been deemed appropriate and following a comprehensive risk assessment visits will be carried out in accordance with the visiting policy for that service.

The circumstances in which a visit may take place should be determined by the nurse in charge of the ward and in consultation with the Responsible Clinician and the Manager.

Before the visit commences, the visitor should be briefed by the nurse in charge regarding the circumstances and conditions placed upon the visit and the rationale for those restrictions being present.

If a visitor is unhappy with the proposed conditions of the visit, nursing staff should immediately liaise with the manager / senior nurse prior to the visit commencing. The decision of the senior nurse / manager will be final

11. MONITORING THE USE OF SECLUSION

The use of Seclusion within the Trust will be monitored by the Trustwide Acute Care Forum and the Specialist Services Division Governance Team.

Any new episode of seclusion must be notified to the NHS England Case Managers, at the earliest opportunity

12. PROCEDURE FOR TIME OUT (UNDER 18'S ONLY)

12.1 Reason for Use

Time Out is a behaviour modification technique. It should form part of a planned approach to manage difficult or disturbed behaviour, in order to achieve positive goals and reduce unwanted behaviour. This should be part of the patient's previously agreed care plan, and "At no time should it be used as a spontaneous reaction to a particular type of behaviour".

Time Out should be consistently applied according to the care plan. The specific behaviours which would indicate the use of Time Out should be clearly defined in the patient's care plan.

12.2 Consent

Time out is a form of behaviour modification. As with any other treatment, the patient's consent should be obtained, if the patient is able to consent for themselves. The patient should be involved in the formulation of the care plan, asked to sign the care plan, and given a copy.

In general any form of behaviour modification usually requires consent and engagement by the patient if it is to be successful. However there may be a rare exception when a care team feels that Time Out would be beneficial to a patient who lacks the capacity to consent.

If the patient is not detained under the Mental Health Act consideration must be given as to whether formal detention is appropriate. It may also be possible to proceed using Section 5 and 6 of the MCA for patients who are aged 16 and over as long as the patient

was assessed as lacking capacity and the person applying the restrictive intervention of Time Out considered this to be in the patient's best interest if the intervention was considered necessary and proportionate response to the likelihood of the person suffering harm and the seriousness of that harm.

In the case of an incapacitated patient, consideration of an authorisation under the Deprivation of Liberty Safeguards must be sought by the Court of Protection / High Court for patients under the age of 18 if Time Out was being used and the patient does not meet the criteria for detention under the MHA.

If the patient is detained under the Mental Health Act then the use of Time Out as a behavioural treatment would fall within Section 63 of the MHA as a treatment not requiring the patients consent although you should still seek the patients consent before proceeding.

12.3 Authority to initiate

Where time out has been agreed and documented as part of the patient's treatment the decision to initiate a period of Time Out may be taken by the nurse in charge of the ward or other members of staff as designated in the patient's care plan.

12.4 Characteristics of the Area

The area used for Time Out from positive reinforcement should be designated in the patient's care plan. It should not be conducted in a seclusion room, and the patient should be able exit the room at any time.

12.5 Care of the Patient

The patient should be informed of the reason for the use of Time Out and an assessment must be made of environmental risks, such as allowing the patient to have matches, lighters, ties, jewellery etc. in their possession.

12.6 Observation of the Patient

The level of Observation needed during Time Out should be documented in the Nursing Care Plan. However staff must be mindful that risks can change. The patient should be assessed before Time Out is initiated to ensure that the risks have not changed since the Time Out plan was agreed.

12.7 Recording of Time Out

Each episode of Time Out must be recorded in the patient's notes, including the precipitating behaviour, the patient's behaviour during the period of Time Out, the duration, and the outcome.

The care plan must be regularly evaluated by the multidisciplinary team, using these records.

Any enhanced observation undertaken during Time Out should be completed according to the Observation and engagement Policy.

12.8 Ending Time Out

Time Out must not continue beyond 15 minutes, (The actual time should be stated in the patient's care plan). If the behaviour which precipitated the use of Time Out continues beyond the time stated in the care plan, staff should review their options for safely managing the behaviour. Alternative care processes contained in this Policy may be considered, and the Trust Policy for Prevention and Management of Aggression and Violence should be consulted.

If the patient chooses to remain in the environment in which Time Out was conducted after 15 minutes, Time Out will be deemed to have ended.

13. PROCEDURE FOR RESTRICTING ACCESS TO COMMUNAL AREAS IN INPATIENT ENVIRONMENT FOR PENNINE CARE NHS FOUNDATION TRUST.

13.1 Reasons for Use

This refers to occasions when a patient's access to some, but not all, communal areas of the ward is restricted.

This may be necessary when some areas which are normally accessible to patients, are felt to be unsafe for the individual patient (e.g. kitchen area). Also in some instances the patient's inappropriate behaviour may be targeted at certain individuals or groups, and it is necessary to keep the patient apart from this group.

Restricted access to communal areas should be for the least possible amount of time. Wherever possible these restrictions should be used intermittently, and the patient allowed access to all communal areas (e.g. during quiet periods when there are fewer patients on the ward).

Every effort should be made to facilitate the patient returning to the shared activities of the ward as soon as possible.

An informal patient should give informed consent to any restrictions as part of their agreed care plan. If an informal patient refuses to accept restrictions, which are felt to be necessary for reasons of safety, the patient's ability to co-operate with inpatient care on an informal basis should be reviewed under the Mental Health Act 1983.

13.2 Authority to Initiate

The decision to restrict access to some communal areas may be taken by the Nurse in Charge of the shift

13.3 Care of the Patient

The patient should be informed of the reason why they have restricted access to some communal areas.

Wherever possible, the restrictions should not prevent the patient's access to TV/audio facilities, a telephone, and meals and drinks. It may be necessary to arrange alternative provision for the patient.

The patients need to access fresh air and exercise should be considered and arranged, wherever possible.

The Care team should be aware of the feeling of exclusion and isolation which these restrictions may cause for the patient. The patient should be encouraged to discuss these feelings, and helped to work towards reducing the behaviours which have caused these restrictions. This should be identified within the care plan.

13.4 Observation

Each individual patients need for observation should be assessed and implemented as detailed in the Trust Observation and Engagement Policy.

13.5 Recording of Restricted Access to Communal Areas

If a patient has restricted access to some communal areas of the ward, a Care Plan should be formulated specifying the reason for these restrictions and any alternative provisions required.

The patient's notes should provide details of when the restrictions were commenced and discontinued.

13.6 Review and Ending Restricted Access to Communal Areas

The need to continue restricted access to communal areas should be monitored daily by the patients Primary or Named Nurse.

This should be discussed within the Multi-disciplinary Team review

The Nurse in Charge of the Ward may discontinue this procedure, following discussion with the patients Primary or allocated Nurse.

13.7 Monitoring of Restricted Access to Communal Areas

This procedure will be monitored on behalf of Pennine Care NHS Foundation Trust by the Trust Wide Acute Care Forum.

14. TRAINING & INDUCTION

This Policy will be supported by a programme of existing training and induction for all inpatient staff. This will comprise of:

- Risk management training/ MVA Training Level 4 (every 12 months)
- Violence Reduction: MVA 4 Team Interventions
- Violence Reduction: Use of seclusion room Training
- Clinical Risk Formulation training
- Basic Life Support Training
- Local induction for new staff and bank/Agency staff ILS Training

15. REPORTING INCIDENTS

Any untoward events relating to restriction of a patient movement must be reported through the Trust Incident Reporting System (see Pennine Care NHS Foundation Trust: Incident Reporting, Management and Investigation Policy Ref CO10).

16. AUDIT

Adherence to the Policy will be monitored through Incident Reviews within the Trustwide Acute Care Forum and the Mental Health Law Scrutiny Group.

17 EQUALITY IMPACT ANALYSIS

As part of its development, this document was analysed to consider / challenge and address any detrimental impact the policy may have on individuals and or groups protected by the Equality Act 2010. This analysis has been undertaken and recorded using the Trust's analysis tool, and appropriate measures will be taken to remove barriers and advance equality of opportunity in the delivery of this policy / procedure

18 FREEDOM OF INFORMATION EXEMPTION ASSESSMENT

Under the Freedom of Information Act (2000) we are obliged to publish our policies on the Trust's website, unless an exemption from disclosure applies. As part of its development, this policy was assessed to establish if it was suitable for publication under this legislation. The assessment aims to establish if disclosure of the policy could cause prejudice or harm to the Trust, or its staff, patients, or partners. This assessment has been undertaken using the Trust's Freedom of Information Exemption Guide, and will be reviewed upon each policy review.

19 INFORMATION GOVERNANCE ASSESSMENT

This Policy has been analysed to ensure it is compliant with relevant information law and standards as in place at the time of approval, and are consistent with the Trust's interpretation and implementation of information governance components such as data protection, confidentiality, consent, information risk, and records management.

Compliance will be reviewed against any changes to legislation / standards or at the next review of this document.

20 SAFEGUARDING

All staff have a responsibility to promote the welfare of any child, young person or vulnerable adult they come into come into contact with and in cases where there are safeguarding concerns, to act upon them and protect the individual from harm.

All staff should refer any safeguarding issues to their manager and escalate accordingly in line with the Trust Safeguarding Families Policy and Local Safeguarding Children/Adult Board processes.

21 MONITORING

The effective application of this policy / guideline, including adherence to any standards identified within will be subject to monitoring using an appropriate methodology and design, such as clinical audit.

Monitoring will take place on a biannual basis and will be reportable to the Quality Group via the Clinical Effectiveness and Quality Improvement Team.

22 REVIEW

The Policy will be subject to regular review by the Trust Acute Care Forum. This will take account of new Good practice guidance, outcomes of Audits, and any recommendations for improvement arising from Trust Incident investigations

This policy / guideline will be reviewed three-yearly unless there is a need to do so prior to this; e.g. change in national guidance.

REFERENCES