Policy Group: Clinical
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Approved by: Charity Executive Committee

Seclusion Policy

1. **Policy Summary / Statement**

St Andrew's intention is to follow the Mental Health Act Code of Practice in relation to the use of Seclusion. Related elements of best practice from NICE guidance 10, and other best practice national guidance will also be incorporated, such as the CQC Brief Guide: Seclusion Rooms (CQC, 2015).

Seclusion is defined in paragraph 26.103 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 severe behavioural disturbance which is likely to cause harm to others'.*

As per the Code of Practice, 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 [Code of Practice 26.104].

Seclusion should only be undertaken in a room or suite of rooms that have been specifically designed and designated for the purposes of seclusion and which serves no other function on the ward [Code of Practice 26.105].

Seclusion should only be used in hospitals and in relation to patients detained under the Act. If an emergency situation arises involving an informal patient and, as a last resort, seclusion is necessary to prevent harm to others, then an assessment for an emergency application for detention under the Act should be undertaken immediately [Code of Practice 26.106].

Seclusion is an emergency management strategy, only used when other approaches to de-escalate the situation have been tried and failed. Seclusion is therefore a last resort intervention and must only be used for the shortest time possible.

All patients will have guidance within individual Positive Behaviour Support care plans on preventing the use of restraint or seclusion (CQC 2012), highlighting less restrictive interventions to be implemented initially for managing aggression and violence.

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

Seclusion is always to be undertaken with the patient's best interests in mind, maintaining dignity and respect at all times, and in accordance with Code of Practice guidance.

Seclusion should never be used solely as a means of managing self-harming behaviour [Code of Practice 26.108].

In order to ensure that seclusion measures have a minimal impact on a patient's autonomy, seclusion should be applied flexibly and in the least restrictive manner possible, considering the patient's circumstances [Code of Practice 26.111].

If a Service User is in seclusion during a Fire alarm activation, a clinical decision needs be made as to whether it is safe to terminate seclusion. If it is deemed clinically appropriate to terminate seclusion encourage the Service User to evacuate the building. If it is not clinically appropriate or the Service User refuses explain the situation calmly and advise them that they will need to stay in seclusion until the Fire and Rescue Services provide the all clear. Please ensure that the Fire Service are aware that there is a service user in the seclusion room. See Fire Policy (available from Policy A-Z Policies - Policies - A-Z (sharepoint.com))

Seclusion must be discontinued when the identified risks are deemed manageable outside of seclusion. As per 26.111 Code of Practice, in situations of prolonged seclusion it can be difficult to judge when the need for seclusion has ended. Flexibility is allowed for periods of access out of the seclusion room e.g. to have visitors, access meals or other ward areas, in order to help form a judgement as to whether seclusion can be ended.

Our policy and procedure will:

- Ensure the physical and emotional safety and wellbeing of the patient
- Ensure that the patient receives the care and support rendered necessary by their seclusion both during and after it has taken place
- Designate a suitable environment that takes account of the patient's dignity and physical wellbeing and is used solely for the purpose of seclusion: (Code of Practice 26.109) :

Seclusion Environment

A seclusion environment should have no apparent safety hazards
A seclusion environment should allow communication with the patient, when the door is locked
It should have robust doors that open outward
A bed/ mattress, pillow and bedding (blanket) should be provided
There should be functioning externally controlled lighting that allows subdued lighting at night time
There should be externally controlled heating and/or air conditioning that allows those observing the patient to monitor the room temperature
There should be no blind spots and alternative viewing panels and/or use of CCTV should be available to ensure the patient can be observed
The room should have natural light via robust, reinforced windows that, where possible, offer a view of the outside.
A clock should be visible to the patient
There should be access to toilet and washing facilities
If the seclusion room has a lock-back door between the seclusion room and the bathroom area, this door must either be in a locked open or locked shut position at all

times: it must never be left unlocked as it can increase the chances of blind spots being created.

- Set out the roles and responsibilities of staff, including who is approved to carry out seclusion reviews. For Responsible Clinician reviews, these should be the patient's Responsible Clinician or an alternative Responsible Clinician. For medical reviews, anyone employed as a doctor by St Andrew's Healthcare, and who has completed their basic induction can carry out a medical review of seclusion. The Code of Practice dictates that nursing reviews must be undertaken by registered nurses only.
- Set requirements for recording, monitoring and reviewing the use of seclusion and any follow-up action including the use of post-incident debrief.

As per the Mental Health Act Code of Practice section 26:109 where "rooms should not have blind spots and alternate viewing panels should be available where required". Blind spots are determined as an obstructed viewing or observation of a service user in seclusion. Blind spots are not deemed as such when staff can see a person through the use of a CCTV monitor and/or through windows or observation lens. The use of one form of viewing media should not be used to determine if a blindspot is in place and both methods of viewing a service user must be used to identify whether there is an obstruction. Any identified blind spots should be reported immediately. NICE guidance 10 1.4.50 states that: ' …allocate a suitably trained member of staff to carry out the observation, which should be within eyesight as a minimum' and the Code of Practice 26.149 refers to 'continuous direct observation'. The CQC brief guide acknowledges the potential impact of this on privacy and dignity when a patient is using the bathroom:

'Any toileting arrangements for patients in seclusion require a balance between ensuring the safety of the person and maintaining their dignity and physical well-being. Total privacy when using the toilet is not always achievable in seclusion. The best practice standard is to have en-suite toilet and washing facilities. This will be an expectation for any new-build service and a requirement of registration for such services, and any refurbishment of seclusion facilities should create en-suite facilities where possible. If the seclusion room is a single room and includes a toilet, the room should as far as is practicable be arranged or adapted to provide elements of privacy afforded by en-suite arrangements'

In order to ensure we have considered and managed this impact, our policy and procedure will require that we document in the seclusion care plan that we have explained to the patient that they will be subject to observation whilst in the seclusion bathroom, either via non recording CCTV or via a viewing window. If there are additional specific reasons why such observation is required e.g. self -harm risk, then this should also be explained to the patient.
If there are doubts about the need for bathroom observations because the patient is not presenting with clinical risk behaviour, then this should lead to an active consideration to end the seclusion episode.

Post Seclusion Debrief

This will adhere to the broader principles outlined in the Least Restrictive Practice policy.

In line with CoP 26.167, after an episode of seclusion, a post-incident review or debrief should be undertaken, so that all parties, including patients, have the appropriatesupport and there is organisational learning.

It is important that patients are appropriately supported to help them understand what has happened and why.

If a patient is able and willing to participate in a review, then their understanding and experience of the incident should be explored (CoP 26.169). What aspects of the intervention helped or did not help, their feelings, anxieties and concerns about the intervention should be explored and documented in the progress notes.

If appropriate, positive behaviour support plans and related care plans and risk assessment and management plans should be updated.

If a patient is unable or unwilling to participate in a review, the team should explore methods for assessing the effect of the intervention on the patient's behaviour, emotions and clinical presentation and adapting the positive behaviour support plan accordingly.

Although most national guidance suggests that a debrief/ review should occur as soon as possible after a restrictive intervention, we recognise that this may not be possible for patients or appropriate in all cases when the seclusion episode is ongoing. Additional learning may also be achieved by the patient reflecting on the overall episode, post seclusion termination. This policy encourages staff to use their judgement, as to when the most appropriate time is to hold a patient debrief, but this should be no later than 72 hours post seclusion termination.
Staff debriefs should be held the same day/ no later than 24 hours after the event and can be recorded as having occurred in DATIX.

Any variations from the Code of Practice must follow the guidance from Munjazvs UK (2012 ECHR) and the variation must be justified with good reason arisingfrom the particular circumstances. The variation must be justified on a case- by-case basis on each and every occasion and be clearly documented in the patients relevant care plan. The variation must have been discussed with the Clinical Director of the Service.

2. **Links to Procedures**
   Seclusion Procedure

   Policies and procedures available via the Policy A-Z:
   Policies - Policies - A-Z (sharepoint.com)

3. **Monitoring and Oversight**
   There is a line of oversight and monitoring from the Board, to the Charity Quality, Safety and Assurance Committee (QSAC), to the QSG (Quality and Safety Group), and the Restrictive Practices Monitoring Group (RPMG), with a line of sight from each Divisional ClinicalGovernance Meeting.

All aspects of the seclusion policy and procedure will be assured at multiple levels:
First Line Assurance- provided by front line staff who have received required induction, training and have access to the policy and procedure

Second Line Assurance – The operations function will conduct an audit process in conjunction with front-line staff and findings will be shared within divisional governance. This data is available via a seclusion audit dashboard.

Third Line Assurance- Quality business partners will undertake random and targeted audits to assure the accuracy of the previous levels of assurance. Seclusion practice is also audited as part of the central Charity Audit and Assurance Programme.

Fourth Line Assurance- we will ensure we share, learn lessons and address any gaps in seclusion practice highlighted by external inspections of the service.

Data on seclusion will form part of the Safety Framework dataset and Integrated Performance Report.

The seclusion environment is checked daily as part of the expected duties of the NIC and by a weekly environment check carried out by senior staff within each division.

4. **Diversity and Inclusion**

St Andrews Healthcare is committed to *Inclusive Healthcare*. This means providing patient outcomes and employment opportunities that embrace diversity and promote equality of opportunity, and not tolerating discrimination for any reason

Our goal is to ensure that *Inclusive Healthcare* is reinforced by our values, and is embedded in our day-to-day working practices. All of our policies and procedures are analysed in line with these principles to ensure fairness and consistency for all those who use them. If you have any questions on inclusion and diversity please email the inclusion team at DiversityAndInclusion@standrew.co.uk.

5. **Training**.

Staff should only use methods of restrictive interventions for which they have received training. All St Andrew's staff with clinical contact will receive de-escalation and physical intervention training and are required to attend 12-month refresher training.

All Doctors and Registered Nurses must complete annual training in Immediate Life Support.

Training records should record precisely the techniques for which a member of staff has received training

An e-learning module on Restrictive Practices and Seclusion is required to be completed by all clinical staff.

Posters derived from the procedure will be placed outside of seclusion rooms to act as a reminder of the ley tasks, roles and responsibilities

6. **References to Legislation and Best Practice**

- DH (2015) Mental Health Act Code of Practice
- DH (2014) Positive and Proactive Care: reducing the need for restrictive interventions. www.gov.uk
- NICE (2015) *Violence and Aggression: Short-term management in mental health, health and community settings. Updated edition* (NICE Guideline 10). London: NICE
- R (on application of Munjaz) v Mersey Care NHS Trust
- Care Quality Commission (2012) *The State of Health Care and Adult Social Care in England 2011/12*. London: The Stationary Office
- Care Quality Commission (2015). Brief Guide: seclusion rooms.

7. **How to change or get an exception to this policy**

Please refer to either the Policy and Procedure Update Application Link
Or the exception process Policy and Procedure Exception Application Link

8. **Key changes**

Version Number	Date	Revisions from previous issue
1.0	January 2018	Replaces Seclusion Policy (CRM21) v16.14. Main changes have been revisions of procedure to create a number of documents that make up a seclusion pack, with the aim that these documents have been simplified and designed to ensure accurate completion.
1.1	August 2019	Additional made to the Seclusion Environment Section and an addition of a Post Seclusion Debrief section
1.3	May 2020	Changed text in Monitoring & Oversight section (v1.2 was draft version).
1.4	May 2020	Additional paragraph on evacuation procedure during fire alarm activation.
1.5	November 2021	Amends to the evacuation procedure during fire alarm
1.6	March 2022	Amends to clarify changes around CCTV in seclusion room, and details on the NICE Guidance NG 10 and CQC own brief guide