Seclusion and Long-Term Segregation Policy

Please be aware that this printed version of the Policy may NOT be the latest version. Staff are reminded that they must always refer to the Intranet for the latest version.

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Review Log

Version Number	Review Date	Name of Reviewer	Ratification Process	Reason for Amendments
1	January 2012	RB Seclusion Room Clinical Reference Group AMH Essential Standards Meeting	N/A Document review	Updated sections to ensure Code of Practice Compliance, updated operational considerations, updated links to other policies.
2	February	AMH Essential Standards Meeting	AMH ratification before passing to NHSLA Operational Meeting	Amendments made. Now ready for presentation at the NHSLA Operational Meeting.
3	March 2012	NHSLA Operational Group and Richard Brown	Virtual ratification from group members	Amendments made.
4	March 2012	Mick Tutt, Dr Mustafa Soomro, Richard Brown	Prior to presentation at Assurance Committee	Amendments made.
5	April 2012	Assurance Committee members, Richard Brown	Prior to re-presentation at Assurance Committee and re- tabling at NHSLA Operational	Amendments made.
6	June 2012	Clinical Expert Panel	Prior to re-submission through the Solent policy ratification process	Minor Amendments made. Agreed to progress to NHSLA meeting
7	March 2015	Robert Pollock		Amended in light of the new Code of Practice
8	June 2015	Richard Webb, Richard Murphy and Robert Pollock	Prior to re-submission through the Solent policy ratification process	Amended and updated in light of the new Code of Practice to ensure compliance.
9	August 2015	Mick Tutt	Prior to presentation at Policies Committee	Amendments made

10	June 2019	Robert Pollock	Review of policy	Amendments made.
11	July 2019	Teresa Henry, Cheryl Sullivan, Jo Perry and Nina King	Prior to presentation at Policies Committee	Amendments made.
12	April 2021	Ben Martin-Lihou	Amendment agreed via Policy Steering Group Chairs Action	Appendix 1, Page 32 amended “4 hourly form” to “2 hourly form” to ensure that the correct form is used
13	October 2022	Ben Martin-Lihou, Lorraine Davis, Chantelle Wilde, Jessica Shirley. Additional amend: Dr Tade Thompson, Dr Ian McCafferty	Policy Steering Group, Clinical Executive Group	Standard 3 year review of policy. Additional changes made on day of CEG meeting (approved by PSG and CEG Chair’s action) for: Amendment made to mirror MHA Code of Practice in ending seclusion

SUMMARY OF POLICY

This policy addresses the use of seclusion taking into account the physical and emotional wellbeing of the individual. It also provides guidance to staff to ensure the safety of others from severe behavioural disturbance which is likely to cause harm to others. It ensures the patient receives the care and support rendered necessary by their seclusion both during seclusion and after it has taken place. It describes the need to minimise the frequency and duration of seclusion and prevent any inappropriate use of seclusion. It provides the distinction between seclusion and other restrictive interventions and psychological behaviour therapy interventions, ('time out') and the difference in levels of seclusion, i.e. tertiary and secondary. It distinguishes what would constitute seclusion and what would be described as a clinical intervention in the management of challenging behaviour. It also ensures proper monitoring and reporting of periods of seclusion and to provide a complete record of all periods and audit.

The term 'restrictive interventions' is used here to reflect current terms used by the Department of Health and in order to encompass training systems currently employed by the Trust, namely the Prevention & Management of Violence & Aggression (PMVA). All use of restrictive interventions by employees must be lawful, necessary, reasonable in the circumstances, and undertaken in good faith. The policy details why and when an individual would be managed in seclusion.

The policy offers some context and guidance for staff, and reflects current national guidance relating to the use of seclusion and the prevention & management of violence & aggression when it does occur. It is underpinned by the Mental Health Act Code of Practice Guidelines 2015 and Mental Health Units (Use of Force) Act 2018. Overall, it sets out Solent NHS Trust's approach to minimising the risk of harm to all persons in its mental health inpatient services.

Seclusion and Long-Term Segregation Policy

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Seclusion and Long-Term Segregation Policy

1. INTRODUCTION & PURPOSE

1.1 This policy will outline the use of Seclusion, which is ordinarily facilitated within Maple ward, The Orchards. Maple Ward is an Adult Mental Health (AMH) Psychiatric Intensive Care Unit (PICU) which provides care and treatment for adults experiencing a mental health crisis who require an intensive level of support due to the increased needs and risks of the patients admitted.

1.2 The overriding principle of inpatient care is the provision of effective care within a minimally restrictive environment, in accordance with the Mental Health Act (1983, amended 2007) and Mental Health Units (Use of Force) Act 2018. The decision to utilise more restrictive interventions (such as seclusion) must be based upon an assessment of the patient, their risks and mental state. Seclusion must not be used as a punishment or a threat, or because of a shortage of staff. It must not form part of any treatment programme (Mental Health Act Code of Practice 2015).

1.3 The use of the Seclusion suite must not be common place within modern day mental health inpatient care. The use of seclusion engages a person's right to private and family life and could be deemed a further deprivation of their residual liberty. Its use must never be taken lightly and must occur fully within the law.

1.4 The use of the Seclusion suite must never be considered primary treatment techniques, but instead strategies for the safe management of patients who present with heightened risks to others and only in situations in which the criteria for its use, as set out in this policy, the Reducing Restriction Network (RRN) standards, Mental Health Units (Use of Force) Act 2018 and the Mental Health Act Code of Practice 2015 is met. 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 regardless of whether any local or alternative terms are used (such as 'therapeutic isolation') or the conditions of the immediate environment. If a patient is taken to their own bed area and prevented from leaving on their own free will, then this would constitute seclusion as described above.

1.5 The Seclusion suite has been specifically designed to ensure that it provides an appropriate physical environment to safely manage patients who may be presenting with increased agitation and aggression. The physical environment can have a strong and mitigating effect on the short term management of disturbed or violent behaviour (NICE Guideline, Violence, NG10). If there is a situation whereby seclusion is used outside of the seclusion suite on Maple ward, then this information must immediately be escalated to the Clinical Matron or on-call manager.

1.6 Seclusion must never be used as a means of managing self-harming behaviour. Where the patient poses a risk of self-harm as well as harm to others, seclusion must 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. (Mental Health Act Code of Practice 2015).

1.7 The Seclusion suite on Maple Ward enables distinct clinical practices in 2 separate areas dependent on patient need and risk. The suite consists of :

- A tertiary seclusion room with toilet, shower and communication facilities
- A secondary/tertiary seclusion room with toilet, shower and communication facilities and an adjoining de-escalation room, with an enclosed, secure garden

1.8 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. Its sole aim is the containment of severely disturbed behaviour which is likely to cause harm to others. Seclusion must ordinarily 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. (Mental Health Act Code of Practice Guidelines 2015). However, if a patient is prevented from leaving an area other than the seclusion suite, then this will constitute seclusion and the pathway must be commenced. (see 1.5).

1.9 When making decisions as to the appropriate use of the seclusion suite, practitioners must give due regard and consideration to the Code of Practice, particularly the five guiding principles:

(i) Least restrictive option and maximising independence
Where it is possible to treat a patient safely and lawfully without detaining them under the Act, the patient must not be detained. Wherever possible a patient's independence must be encouraged and supported with a focus on promoting recovery wherever possible.

(ii) Empowerment and involvement
Patients must be fully involved in decisions about care, support and treatment. The views of families, carers and others, if appropriate, must be fully considered when taking decisions. Where decisions are taken which are contradictory to views expressed, professionals must explain the reasons for this.

(iii) Respect and dignity
Patients, their families and carers must be treated with respect and dignity and listened to by professionals.

(iv) Purpose and effectiveness
Decisions about care and treatment must be appropriate to the patient, with clear therapeutic aims, promote recovery and must be performed to current national guidelines and/or current, available best practice guidelines.

(v) Efficiency and equity
Providers, commissioners and other relevant organisations must work together to ensure that the quality of commissioning and provision of mental healthcare services are of high quality and are given equal priority to physical health and social care services. All relevant services must work together to facilitate timely, safe and supportive discharge from detention.

1.10 Regarding informal patients

Seclusion should only be used 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". (Mental Health Act Code of Practice Guidelines 2015).

1.11 The use of the seclusion suite, or the patient's own bed area, must only ever be as a last resort taken by the staff team to safely manage the needs and risks of the patient. All other de-escalation and engagement techniques must, where practicable, be used in the first instance in attempting to safely manage patient's behaviour in the ward environment. Staff must be aware that isolating a patient away from the general ward population constitutes seclusion.

1.12 Whenever a patient is cared for in the seclusion suite, the staff team are responsible for ensuring that the patient is cared for in this way for the shortest time possible and therefore must review the care and treatment being offered to ensure it meets the needs of the patient in a timely fashion to support their recovery. The review procedures are set out in this policy and must be followed.

1.13 The safety and well being of patients being cared for in the seclusion suite, is a significant concern and needs to be considered alongside their rights to autonomy. Through the use of dedicated therapeutic engagement and observation, responsive treatment and positive patient engagement, staff will ensure that patients' needs are met and safety is maintained whilst they are being nursed in these areas.

1.14 The implementation of a therapeutic programme of engagement will provide meaningful activity for all patients and must be considered as a de-escalation tool, with the risks taken into account.

2. SCOPE & DEFINITIONS

SCOPE

2.1 This policy applies to locum, permanent, and fixed term contract employees (including apprentices) who hold a contract of employment or engagement with the Trust, and secondees (including students), volunteers (including Associate Hospital Managers and Patient Safety Partners), bank staff, Non-Executive Directors and those undertaking research working within Solent NHS Trust, in line with Solent NHS Trust's Equality, Diversity and Human Rights Policy. It also applies to external contractors, agency workers, and other workers who are assigned to Solent NHS Trust.

2.2 Solent NHS Trust is committed to the principles of Equality and Diversity and will strive to eliminate unlawful discrimination in all its forms. We will strive towards demonstrating fairness and Equal Opportunities for users of services, carers, the wider community and our staff.

DEFINITIONS

2.3 **Advocacy:** The Advocacy Service ensures that the views, wishes and feelings of those using health and social care services are promoted to service providers. Patients on Maple Ward have access to all advocacy services, including but not limited to Independent Mental Health Advocates (IMHA) and Independent Mental Capacity Advocates (IMCA).

2.4 **Detained Patients:** A detained patient is one whereby the person is detained under the Mental Health Act and the care and treatment provided for this

person has to be in accordance with the parameters of this Act. Engagement with the patient and their views and opinions about the care and treatment they receive must where practicable be sought and built into care planning.

2.5 **Seclusion Suite:** As per point 1.7 above.

2.6 **Informal Patients:** An informal patient is not detained under the mental health act.

2.7 **Mental Health Act (1983, amended 2007):** An Act of Parliament which primarily deals with the detention in hospital of people with mental disorders. It sets out the criteria that must be met before compulsory measures can be taken, along with protections and safeguards for patients.

2.8 **Multidisciplinary Team (MDT):** A group of clinicians from a variety of professional backgrounds who contribute to the care and treatment that a patient receives.

2.9 **Therapeutic Observations:** A routine clinical intervention whereby patients are monitored at regular intervals as per the clinical decision making process. It has two main purposes; firstly to promote therapeutic engagement between staff and patients and secondly, to meet the patients' needs and manage the risks that they pose.

2.10 **Rapid Tranquilisation:** The use of medication to calm patients and thereby reduce the risks to themselves or others by achieving a reduction in agitation and arousal. Medication may be given either orally or via Intramuscular Injection (IM), though the oral route must always be the first line of treatment. Further information can be found in the Managing Violence and Aggression Policy – including Rapid Tranquilisation Policy.

2.11 **Responsible Clinician (RC):** The RC is an approved clinician with overall responsibility for the patients' care and treatment for persons detained under the Mental Health Act. This is usually a Consultant Psychiatrist, though can be persons from other professional groups.

3. PROCESS/REQUIREMENTS

3.1 The Seclusion suite must meet the following requirements:

- To allow for communication with the patient when the patient is in the room and the door is locked
- Limited furnishings
- No apparent safety hazards
- Robust, reinforced window(s) that provide natural light
- Externally controlled lighting, including a main light and subdued lighting for night-time
- Robust door(s) which open outwards
- Externally controlled heating and/or air conditioning,
- No blind spots an
- A clock must always be visible to the patient from within the room
- Access to toilet and washing facilities.

Operational Process for the use of Secondary Level Seclusion Area

3.2. **When the Seclusion Areas are not in Use.**

3.2.1. Whilst the seclusion areas are not in use, its upkeep and security will be maintained via the Environment Check process on Maple Ward. This occurs at the beginning of each shift . Its purpose will be to ensure that the area (including the secure garden area) is fit for use and secure to enable it to be operational at any given time. The checklist for the area will include:

- All doors within the room are locked and without damage
- The ensuite toilet/shower is clean and without damage
- Floors and walls are clean
- Furnishings are clean and without damage
- Window blind is set to partially closed and window is intact

- The door to the secure garden area is locked
- The secure garden area is clean, tidy and without damage.

3.2.2 During the environment check, should any areas within the room be noted to be broken/missing/not at the required standard, this must be reported to the Nurse in Charge immediately who will liaise with relevant personnel to ensure swift remedial action.

3.2.3 The domestic staff will be responsible for cleaning the area on a daily basis according to the cleaning schedule.

3.3 **When the Seclusion Areas are in use**

3.3.1 The door to the main corridor must be locked and disabled from opening by the patient.

3.3.2 There must be staff present at all times. In secondary seclusion, a minimum of 2 staff must be allocated, but following a risk assessment by a senior nurse, this can be increased as required, but should never be decreased to a single staff. Tertiary is one member of staff in the observation suite.

3.4 **Use of the Garden Area**

3.4.1 Whilst in the secondary seclusion area, patients must be risk assessed as to which parts of the area they can have access. This must be done on commencement of seclusion and kept under review throughout the episode.

3.4.2 The private garden area can only be accessed by the patient through the door in secondary seclusion. This door will be locked when not in use. If a patient wishes to access the garden area, staff will unlock the door and staff must enter the garden area with the patient. Under no circumstances must the patient be allowed to be in the garden area alone.

3.4.3 If at any time staff have cause for concern that the patient is using the garden area inappropriately – such as attempting to abscond, damaging property or becoming agitated or aggressive, the patient must be brought back into the seclusion suite immediately.

3.5 Decision to place a Patient in Seclusion

3.5.1 The decision to place a patient into seclusion room must only be made once all other attempts to try to manage the patient's behaviour have been discounted and to manage the patients' risks to others.

3.5.2 Decisions to place a patient into seclusion must be based on clinical judgement made at the time the decision needs to be made, i.e. the decision to start seclusion cannot be pre-planned.

3.5.3 In rare circumstances, patients' may need to remain in tertiary level seclusion for a protracted period of time. It may be that the seclusion is re-graded to Long – term segregation as described in 3.15.

3.5.4 The seclusion suite must not be used to segregate patients with either infectious conditions (such as scabies) or any other physical health needs. If a patient has to be barrier nursed to prevent the risk of infection, this would not constitute seclusion as per this policy, but regarded as a clinical intervention. If the individual refuses to comply with this, this would then constitute seclusion and advice sought from senior management.

3.5.5 The decision to use seclusion must be made in the first instance by the nurse in charge of the ward and they must notify the patients Responsible Clinician, Advanced Clinical Practitioner, or the out of hours doctor.

3.5.6 Although situated in Maple Ward, patients within Hawthorn Ward may be transferred to the seclusion suite on Maple Ward when clinically and legally indicated as the required intervention for the patient. In such circumstances, staff must ensure that they protect the dignity of the patient and ensure Maple Ward staff are aware of the plan.

3.5.7 Staff must remove from the patient any items that they may use to either harm themselves or others following a thorough risk assessment. Staff will search the patient and remove any items which could cause harm either to them, or the staff entering the room. All items removed from the patient will be recorded on the Seclusion Pathway Record within Appendix 1 and stored in the patients' store room or if not risk items, an appropriate place, i.e. their own room.

3.5.8 The person authorising seclusion must have seen the patient immediately prior to the commencement of seclusion.

3.5.9 When a patient is placed in seclusion, the start time of the seclusion must be recorded in the seclusion record and in the electronic notes. The Nurse In Charge of the ward (or delegate) must inform the following people, as a matter of urgency, that a seclusion episode has begun:

- A Doctor (team doctor or cross cover doctor in hours or duty doctor out of hours) who must attend immediately or at the earliest opportunity (if it was not an approved clinician who initiated the seclusion episode) Whenever the duty doctor is not an approved clinician, they must at all times have access to an on-call doctor who is an approved clinician.
- The float or 136 Nurse, who must attend immediately or at the earliest opportunity.
- The inpatient Lead Nurses, Clinical Matron and Physical Intervention Lead

via e-mail.

- The IMHA, and if out of hours, a message can be left.

3.6 Observations during Seclusion

3.6.1 The patient must be observed continuously by a member of staff. The observing staff must have sight of the patient at all times. For the first hour this person must be a suitably skilled registrant. All staff who are assigned to complete the observation must be deemed competent by the nurse in charge to do so and understand the rationale for what they are doing. Physical observations must be carried out on the patient as soon as practicable following risk assessment. If the risk is too high, then the patients breathing, verbal response and skin colour must be observed, (see appendix 6). If the observing member of staff assesses that the patient is in physical distress, then help must be summoned and staff must enter the room.

3.6.2 Any staff taking over responsibility for observing a patient in seclusion must be fully aware of the risks and any other significant information, including details of the incident that resulted in the need for seclusion and subsequent reviews. This handover will be between the staff member leaving their observation duties and the staff member taking over. . Care must be taken that the information shared is not overheard by other patients.

3.6.3 The role of the staff observing the patient must be to offer supportive engagement, to safeguard the patient, monitor their condition and behaviour and to identify the earliest time at which seclusion can be either ended or regraded to secondary level. Staff must individually assess each patient as to their wishes whilst they are in the seclusion area with the intention to support the patient to move towards a less restrictive environment at the earliest opportunity. Staff must give the patient a copy of their rights leaflet upon them entering the tertiary level seclusion room. A copy of this leaflet can be seen in Appendix 2.

3.6.4 Observing staff must be deemed competent to monitor a patient in seclusion. This must include competence to monitor someone who has received rapid tranquilisation. This competence is assessed at induction. Rapid tranquilisation pathway to be followed, and risk asses as to which elements cannot be obtained (for example blood pressure, as per appendix x)

3.6.5 If the person is being managed in the tertiary level seclusion room and it is necessary to enter the room to give the patient medication, this must be done by staff appropriately trained in Prevention and Management of Violence and aggression, (PMVA), with a minimum of 4 staff being present, 1 being responsible for unlocking and locking the door, at all times. Once medication has been given, staff must leave the area as quickly as possible ensuring that all staff leave safely.

3.6.6 During seclusion staff must carefully risk assess any requests by the patient for either food or drink. Patients may be provided water or snack items (no cutlery unless approved seclusion safe cutlery) at meal times and/or regular intervals

3.6.7 Consideration must be given to whether a male or female person should carry out ongoing observations; good practice would dictate same gender, however this may not always be possible due to gender mix of staff on shift. This may

be informed by consideration of a patient's trauma history and if they are exhibiting sexual disinhibition.

3.6.8 A record of the patient's behaviour must be made at least every 15 minutes. The record made must include, where applicable: the patient's appearance, a summary of what they are doing and saying, their mood, their level of awareness, food and fluid input/output (Appendix 6), hostility or aggression, interaction with the staff member, whether asleep and any evidence of physical ill health especially with regard to their breathing, pallor or cyanosis. Staff must remain alert to patient's consciousness and respirations, monitoring for change and taking appropriate action.

3.7 Medical Reviews

3.7.1 If the person making the decision to commence seclusion was not an approved clinician then the first medical review must occur within one hour of seclusion commencing (where practicable, depending on medical teams whereabouts out of hours). If it is agreed that seclusion needs to continue, a seclusion care plan must be agreed and prepared, which must identify how the patient's presenting and ongoing needs whilst in seclusion can continue to be met and record the steps that must be taken in order to bring the need for seclusion to an end as quickly as possible. As a minimum the seclusion care plan must 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.

3.7.2 Wherever possible, the patient should be supported to contribute to the seclusion care plan and steps must be taken to ensure that the patient is aware of what they need to do for the seclusion to come to an end. In view of the potentially traumatising effect of seclusion, care plans must provide details of the support that will be provided when the seclusion comes to an end. This must include a debrief with the patient after the patient has left the seclusion room and is back on the main ward area.

3.7.3 Continuing four-hourly medical reviews of secluded patients must be carried out until the first ward MDT has taken place (which must occur as soon as possible following the commencement of seclusion), including in the evenings, night time, on weekends and bank holidays. Where possible the review must be undertaken by the person's responsible clinician. If this is not possible then the duty doctor or Advanced Clinical Practitioner must undertake the review. If the patient is asleep and it is deemed not in their best interest to wake them then no more than two reviews can be missed in a row.

3.7.4 Following the first MDT review , further medical reviews must continue at least twice in every 24-hour period. At least one of these must be carried out by the patient's responsible clinician. Outside of normal working hours the out of hours SHO will act on behalf of the responsible clinician and may access the on call consultant for advice and support as required.

3.7.5 Medical reviews provide the opportunity to evaluate and amend seclusion care plans, as appropriate. They should be carried out in person (where possible)

and must 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.

3.8 Nursing Reviews

3.8.1 Nursing reviews of the secluded patient must take place at least every two hours following the commencement of seclusion. These must be undertaken by two individuals who are registered nurses, and at least one of whom must not have been involved directly in the decision to seclude. In the event the patient is asleep and it is deemed that it is not in their best interest to wake them then no more than 8 hours can lapse without a review taking place.

3.8.2 In the event of concerns regarding the patient's condition, this must be immediately brought to the attention of the patient's responsible clinician or duty doctor.

3.9 Multi- Disciplinary Team (MDT) Reviews

3.9.1 The first MDT seclusion review must be held as soon as is practicable.

3.9.2 Wherever possible the MDT review must include an approved clinician. If one is not available then it must include a doctor or Advanced Clinical Practioner, who has access to the advice of an approved clinician, the nurse in charge of the ward, and other members of the MDT who can contribute to the patient's care and treatment, including their psychological, physical health and occupational needs.

3.9.3 At weekends and overnight, membership of the initial MDT review may be limited to medical and nursing staff, in which case a Charge Nurse must also be involved.

3.9.4 Further multi-disciplinary seclusion reviews should take place once in every 24 hour period of continuous seclusion.

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

3.10 Independent MDT Review

3.10.1 An independent MDT review must be promptly undertaken where a patient has either been secluded for eight hours consecutively or for 12 hours intermittently during a 48-hour period.

3.10.2 Appropriate membership must as a minimum include a doctor who is an approved clinician, a nurse and other professionals who were not involved in

the incident which led to the seclusion. An IMHA should be involved in cases where the patient has one. It is good practice for the independent MDT to consult those involved in the original decision.

3.10.3 The Code of Practice does not specify the membership of the Independent MDT review at weekends and overnight. The Trust therefore requires the review to be carried out by the on-call Consultant, a nurse as well as a Charge Nurse all of whom were not involved in the incident which led to seclusion

3.10.4 If it is agreed that seclusion needs to continue, the review must evaluate and make recommendations, as appropriate, for amendments to the seclusion care plan.

3.11 Ending Seclusion

3.11.1 Seclusion must immediately end when one of the reviews determines it is no longer warranted. At least one of the professionals must be a Charge Nurse.

3.11.2 If the nurse in charge deems that seclusion is no longer required at nursing review, seclusion may end following consultation with the patient's responsible clinician or duty doctor. This consultation may take place in person or by telephone.

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

3.11.4 If the need for seclusion – or continued seclusion - is disputed by any member of the MDT, the matter must be referred to a senior manager or clinician. Therefore, disputes must be referred to one of the following people depending upon their availability:

- **In hours** – either the Clinical matron, Head of Unplanned Care Mental Health or the Lead Clinician
- **Out of Hours** – escalated as appropriate to on-call.

3.11.5 In order to effectively arbitrate over any disputes, the above people must ensure that they are aware of all the factors and risks relating to the patient. They may choose to attend the ward to interview the patient themselves and any other staff members they feel may help them make an informed decision. Once arbitration has been achieved and a decision has been reached, the clinical team caring for the patient will be expected to adhere to the arbitrator's decision.

3.12 Care Plan and Management

3.12.1 Whilst in seclusion, the patient will only be able to receive visitors if it is risk assessed as suitable. An employee from the Care Quality Commission, a representative from their legal team or their advocate must be enabled to visit if requested and it is safe to do so. Any other visits must only be undertaken with the agreement of the nurse in charge. This engages the patient's right to private and family life and the Mental Health Act Policy on restricting visiting must be followed.

3.12.2 Whilst in seclusion, the gender, cultural and religious needs of the patient must be upheld and facilitated wherever possible.

3.12.3 As well as completion of the Seclusion Pathway Record in Appendix 1, staff must ensure that relevant sections of the patients' electronic record are also updated to provide an accurate reflection of the care and treatment the patient is receiving. On termination of seclusion, the seclusion paperwork must be uploaded to clinical documentation on the electronic patient records.

3.13 Long –term segregation

3.13.1 The processes and safeguards outlined in this policy will, for the vast majority of patients, ensure that their time in any part of the seclusion suite is short. However, a small minority of patients will have needs and risks that will not respond quickly to the treatment and care being offered. Therefore, the review procedures as outlined in this policy must be strictly followed.

3.13.2 If during the multi-disciplinary teams review of seclusion the team determine that the criteria for long term segregation is met then the process to begin long-term segregation should be started by that team. The team should ask themselves, 'Is the review timetable for seclusion no longer serving any useful purpose, and are the less frequent but more exacting reviews, for Long Term Segregation (LTS), now appropriate?'

In answering the question, the team need to be mindful that LTS can only be used for patients in order to reduce a sustained risk of harm posed by the patient to others, which is a constant feature of their presentation. In answering this question, it should have been determined that the risk of harm to others would not be ameliorated by a short period of seclusion combined 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.

Each case must be decided on its own facts by applying the above criteria to them. Reasons why the criteria are met should be clearly recorded. The team should seek the views of any IMHA involved and the patient's family.

It is permissible to manage this small number of patients by ensuring that their contact with the general ward population is limited. In Solent NHS Trust the only ward authorised to practice Long Term Segregation is Maple. The environment should be made no more restrictive than is necessary. This means it should be as comfortable as risk considerations allow. The area used to accommodate the patient in conditions of long-term segregation should be configured to allow the patient to access a number of areas including, as a minimum, bathroom facilities, a bedroom and lounge area. Patients should also be able to access secure outdoor areas and a range of activities of interest and relevance to the person. They must have a clear risk assessment and care plan setting out what areas they can access, the risks and how these will be managed. Patients should not be isolated from contact with staff (indeed it is highly likely they should be supported through enhanced observation) or deprived of access to therapeutic interventions. Treatment plans should aim to end long-term segregation.

Staff supporting patients who are long-term segregated should make written records on their condition on at least an hourly basis. The patient's situation should be formally reviewed by an approved clinician at least once in any 24-hour period and at least weekly by the full Maple ward MDT and it should include IMHA if there is one.

Out of normal working hours, the approved clinician is the on-call consultant psychiatrist. The Head of Quality & Professions for Mental Health Services or a suitably senior deputy will review the use of long-term segregation fortnightly.

The outcome of all reviews and the reasons for continued segregation should be recorded. The view of Solent NHS Trust is that LTS is not appropriate beyond 3 months.

The purpose of a review is to determine whether the on-going risks have reduced sufficiently to allow the patient to be integrated into the wider ward community and to check on their general health and welfare. The decision to end long-term segregation should be taken by the MDT (including consultation with the patient's IMHA where appropriate), following a thorough risk assessment and observations from staff of the patient's presentation during close monitoring of the patient in the company of others.

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. 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 the seclusion area. In such a situation, the procedure for seclusion should be followed with regards to authorising and commencing seclusion, observation, seclusion reviews and ending seclusion.

3.14 Support for Patients Leaving the Seclusion Area

3.14.1 The service recognises that being cared for in the seclusion suite can have a significant effect on the patient. Staff must ensure that time is set aside to re-integrate the patient into their environment and to discuss seclusion episode with the patient to re-establish the therapeutic relationship which may have been affected.

3.14.2 In order to facilitate this process, staff members may consider discussing the following questions with the patients:

- Does the patient understand why he/she was in seclusion?

- How does the patient feel now, after the event?
- How can future episodes of extra care/seclusion be avoided?
- Can they offer any alternative that they feel would work and include this in an advance statement?

3.14.3 The debrief session between the staff and the patient must be recorded within the patients' notes and the patient must be offered a copy of these. This will enable both the patient and the staff team caring for them to learn from this experience and to enable it to inform the future management and care given to the patient.

3.14.4 As soon as is practicably possible following a patient leaving the suite, the patients' MDT must meet to discuss and review the patients time during seclusion. The purpose of this must be to identify precipitating factors that led to the need for seclusion and how care can be planned to avoid this being required in the future. The patient must also be invited to attend this review in order to give their views and feelings.

4. ROLES & RESPONSIBILITIES

4.1 Staff

4.1.1 The Chief Executive has ultimate accountability for the strategic and operational management of the organisation, including ensuring all policies are adhered to.

4.1.2 The Chief Nurse is responsible for ensuring that this policy is clinically appropriate in ensuring that patients' needs and safeguards are met and that best practice is proposed.

4.1.3 The Head of Quality & Professions is responsible for ensuring this policy is reviewed, in line with legislation and best practice. They also hold responsibility for reviewing patients placed in seclusion fortnightly.

4.1.4 The Head of Unplanned Care Mental Health has the responsibility of ensuring that this policy is cascaded down to the Clinical Matron as appropriate for dissemination and implementation within the inpatient environments.

4.1.5 The Clinical Matron is responsible for the dissemination and implementation and monitoring of this policy in the areas that they are accountable for.

4.1.6 Maple Ward Manager is accountable for ensuring that this policy is adhered to and implemented by their staff team. They are responsible for ensuring that staff receive appropriate support on how to follow the guidance within this policy and will monitor for breaches of this policy and take action as appropriate to rectify this. The Maple Ward Manager will review all incidences of seclusion and provide a report, which will be shared with staff.

4.1.7 Inpatient staff are responsible for being aware of and following this policy at all times. Whilst this policy only relates to the use of the seclusion suite on Maple Ward, all MHS Inpatient staff are expected to provide cover across all inpatient areas, therefore all staff need to be aware of what is required of them with regard to this policy. They must raise potential problems that may arise from this policy appropriately. They are also responsible for ensuring new starters to the team and Bank and Agency staff are aware of this policy.

4.1.8 MHS now have a dedicated Physical Intervention Lead who has responsibility for maintaining the standards set out in this policy by ensuring that all staff are trained both in restraint and the use of seclusion. They will also be responsible for reviewing practice and developing strategies that will support both staff and patients.

4.2 Committees/Groups

In order to maintain appropriate governance and monitoring arrangements of the use of seclusion, all episodes of seclusion will be reported to the Mental Health Act Scrutiny Committee, as per point 3.9.3 Explanations will also be provided for patients who are repeatedly placed in seclusion.

5. TRAINING

5.1 Solent NHS Trust recognises the importance of appropriate training for staff. For training requirements and refresher frequencies in relation to this policy

subject matter, please refer to the Training Needs Analysis (TNA) on the intranet.

5.2 In order for staff to provide effective and safe patient care whilst patients are in the seclusion suite, staff must have attended training in the following areas:

- Risk Assessment and Management for all staff
- Deteriorating and Resuscitation Training, (DART), for all staff.
- Prevention of Management of Violence and Aggression for all MHS inpatient clinical staff.

5.3 All staff members must maintain responsibility for not only attending such training sessions but that they remain in date with them to enable them to work to best practice guidelines at all times. The training needs and records of the staff are liable for reporting to the Mental Health Act Scrutiny Committee.

5.4 It is vital that the Clinical Matron, Ward Managers and Charge Nurses accountable for MHS inpatient services can demonstrate that their staff members have attended the above training courses and have the necessary level of competence to nurse patients in the seclusion suite. This will be achieved through reviews and audits of individual and team training records.

5.5 On the job shadowing, mentoring and support will be given to all new starters, Bank and Agency members of staff to ensure that they are aware of this policy and that they can be supported to achieve high standards of providing care for patients within the seclusion suite. Where appropriate competence checklists to support this practice will be utilised

6. SUCCESS CRITERIA / MONITORING EFFECTIVENESS

6.1 The success criteria for this policy would be that the seclusion suite is used appropriately in meeting patients' needs and managing their risks. This will include:

- Patients are only cared for in the suite when clinically indicated
- Patients' Human and Legal rights are protected and supported
- Patients only remain in the suite for as long as they require it, with clear evidence to show the treatment and interventions planned to enable the patient to recover as quickly as possible.

6.2 In order to monitor the effectiveness of this policy and to ascertain that it successfully achieves its aims, a number of auditing and benchmarking standards will be used by managers and matrons. This will include the following:

- All episodes of seclusion will be reviewed in the Incident Reporting Process. Reporting to Mental Health Act Scrutiny Panel, Mental Health Act Monitoring Meeting, Violence & Aggression Sub-Group and Integrated Governance Board ensures that thorough scrutiny into the reasons why seclusion was required can be carried out and to ensure that it was a proportionate response to meet the needs of the patient at that time
- Inclusion of this policy and guidance on its implications for clinical practice in all local induction packs for new staff/students/temporary staff
- Review of incidents that are raised via the online reporting system process

to enable trends to be identified and/or lessons learnt to improve practice. This is discussed at the Mental Health Service Violence & Aggression Sub-Group.

- Feedback and or complaints from people who use the service
- Ongoing audit and spot checks relating to the use of the suite on Maple Ward and regular reviews of documentation pertaining to these areas
- Discussions between individual staff with their line manager through the supervision format.

6.3 A guide to assist in the audit of the standards required when the suite has been used can be seen in Appendix 4. The Clinical Matron for The Orchards (or nominated deputy) will be required to complete this audit monthly.

6.4 Results from ongoing audits and spot checks will be taken to staff team meetings and/or individual staff to raise awareness of good and bad practice that may be occurring. Issues relating to the implementation of this policy must also be taken to the MHS Integrated Governance Board so that these can be addressed accordingly. Furthermore, results from the quarterly audit completed by the Clinical matron will be tabled at the following meetings for information and discussion:

- Monthly Mental Health Act Monitoring Meeting
- Mental Health Act Scrutiny Committee.

6.5 All staff members working for Solent NHS Trust or within inpatient areas run by Solent NHS Trust are expected to comply with the contents of this policy at all times. In rare circumstances, if staff members are **unable** to comply with this policy it must be immediately reported to the Line Manager who must consider what remedial steps will be taken to manage this risk. The Non-Compliance Form (Appendix 6 within the Policy for the Development and Implementation of Procedural Documents (Solent NHST/Policy/GO/01)) must also be completed.

7. REVIEW

7.1 This document may be reviewed at any time at the request of either staff side or management, but will automatically be reviewed twelve months from initial approval and thereafter on a three-yearly basis unless organisational changes, legislation, guidance or non-compliance prompt an earlier review.

8. REFERENCES AND LINKS TO OTHER DOCUMENTS

8.1 REFERENCES

- Department of Health, (1983) "Mental Health Act". HMSO. London.
- Department of Health, (2002) '*Mental Health Policy Implementation Guide: National Minimum Standards for general adult services in Psychiatric Intensive Care Units (PICU) and Low Secure Environments'.* London
- Department of Health, (2015) 'The Code of Practice – The Mental Health Act (1983) TSO London
- Mental Health Chief Psychiatrists Guideline (2002) '*Chief Psychiatrist's guidelines: High Dependency Unit Guidelines*. Accessed at www.health.vic.gov.au/mentalhealth/cpg/hdug_guidelines.pdf
- NICE Guideline [2005, revised in 2006] *'Violence: The short term*

management of disturbed/violent behaviour in psychiatric in-patient settings and emergency departments. NHS. London

- Seclusion Policy (2007) Suffolk Mental Health Partnerships NHS Trust
- Seclusion Policy (2008) West London Mental Health NHS Trust
- Seclusion and Long-Term Segregation Policy (2017) Southern Health Foundation Trust

8.2 LINKS TO RELATED SOLENT NHS TRUST DOCUMENTS

- Deprivation of Liberty Safeguards and Mental Capacity Act Policy
- Information Governance Policy
- Safeguarding Children, Young People and Adults at Risk Policy
- Management of Violence Aggression and Abuse against Staff Policy
- Physical Security policy
- Rapid Tranquilisation policy
- Risk Management Strategy Policy
- Mental Health Act Policy
- Infection Prevention and Control Decontamination Policy
- Psychiatric Observations and Engagement Policy
- Creating a Smoke Free Workplace Policy
- Serious Incident Requiring Investigation (SIRI) Policy

9. GLOSSARY

9.1

PMVA	Prevention of Violence and Aggression
AMH	Adult Mental Health
OOH	Out of Hours
PICU	Psychiatric Intensive Care Unit
NICE	National Institute for Clinical Excellence
MDT	Multi-Disciplinary Team
RC	Responsible Clinician
NRT	Nicotine Replacement Therapy
NIC	Nurse in Charge
IMHA	Independent Mental Health Advocates
IMCA	Independent Mental Capacity Advocates
NHS	National Health Service
TNA	Training Needs Analysis
NHST	National Health Service Trust
CoP	Code of Practice
TMT	Trust Management Team

Appendixes

Appendix	Title
Appendix 1:	Seclusion Pathway Record Paperwork
Appendix 2:	Patient Rights Leaflet whilst in Seclusion
Appendix 3:	Equality Impact Assessment
Appendix 4:	Audit Tool for the use of the Extra Care Area and Seclusion Room
Appendix 5:	Psychiatric Observation Levels
Appendix 6:	Food and Fluid intake/output chart
Appendix 7	Non – contact physical health observations tool

Appendix 1

SECLUSION PATHWAY RECORD

Patient Name:	
Date of Birth:	
NHS Number	
Gender:	
MHA Status:	

Date and time seclusion commenced:	
Level of seclusion, secondary or tertiary.	
Name and designation of person initiating seclusion episode:	
Incident No.	
Care plan commenced Y/N	
Staff de-brief completed Y/N	

Staff Members Involved in placing the patient into Seclusion	
NAME	**DESIGNATION**

PROFESSIONALS NOTIFIED OF SECLUSION EPISODE

	Name	**Date and time**	**Date and time**	**E X**
Doctor				
Senior Nurse on Duty (OOH) and Ward Manager				
Responsible Clinician				
Clinical Matron				
Mental Health Act Admin Team				
Advocacy Services				

Physical Intervention Lead				
Staff de-brief				
Patient de-brief				

Brief Description of events and rationale for seclusion (THIS MUST STATE WHAT WAS THE RISK OF SEVERELY DISTURBED BEHAVIOR WHICH PRESENTED A RISK TO OTHERS AND WHY IT COULD NOT BE MANAGED IN A LESS RESTRICTIVE WAY) / patient response to seclusion / details about medical staff involvement:

Items removed from patient entering seclusion and where these have been Stored

Details of medication given to patient either prior to seclusion episode starting and within the first 30 minutes of seclusion episode starting – rapid tranquilisation pathway started?

Date and Time that 1st 2 hour review is due

Form Completed By:	**Name:**	
	Designation:	
	Date and Time:	

Seclusion Record Nursing Review - (2 Hourly Form)

Patient Name:		**MHA Status**	

Name and Designation of 1st Reviewer	
Name and Designation of 2nd Reviewer	
Date and Time of Review:	

Appearance: (Physical Obs, Behaviour, Food/Fluid Intake, Aggression etc.)

Details of Review: (changes to care plan and reasons for decisions made) THIS MUST STATE HOW THE CRITERIA ARE STILL MET OR NOT

Date and Time of next review (2 hourly form)

Signature of 1st Reviewer		**Date and Time**	
Signature of 2nd Reviewer		**Date and Time**	

Seclusion Record Medical Review -

Patient Name:		**MHA Status**	

Name and Designation of 1st Reviewer	
Name and Designation of 2nd Reviewer	
Date and Time of Review:	

Appearance: (Physical Obs, Behaviour, Food/Fluid Intake, Aggression etc.)

Details of Review: (changes to care plan and reasons for decisions made) THIS MUST STATE HOW THE CRITERIA ARE STILL MET OR NOT

Signature of 1st Reviewer		**Date and Time**	
Signature of 2nd Reviewer		**Date and Time**	

Seclusion Record MDT review

Patient Name:		**MHA Status**	

Date and Time of Review	

INDEPENDENT REVIEW CARE TEAM REVIEW

(delete as appropriate)

Details of Review and ongoing Care Plan THIS MUST STATE HOW THE CRITERIA ARE STILL MET OR NOT

Signature of Doctor	
Print Name and Designation	

Signature of Nurse	
Print Name and Designation	

Signature of the senior nurse out of hours co-ordinator (OOH) or Manager	
Print Name and Designation	

Termination of Seclusion Episode

Patient Name:		**MHA Status**	

Date and Time Seclusion Terminated	

Name and Designation of Staff member terminating seclusion episode	

Reasons for Seclusion Episode being terminated – include risk assessment, behaviour, engagement with staff

Plan for the Patient now that Seclusion has ended – gradual or full termination? Transfer to Enhanced Care or Ward?

Patients' view of time within Seclusion – include date and time that debrief will occur

PROFESSIONALS NOTIFIED OF SECLUSION EPISODE ENDING

	Name	Date and time informed
Doctor		
The senior nurse out of hours co-ordinator (OOH) and Ward Manager		
Clinical Matron		
Responsible Clinician		
Mental Health Act Admin Team		
Advocacy Services		
Physical Intervention Lead		

Appendix 2 **Equality Impact Assessment**

Equality Analysis and Equality Impact Assessment

Equality Analysis is a way of considering the potential impact on different groups protected from discrimination by the Equality Act 2010. It is a legal requirement that places a duty on public sector organisations (The Public Sector Equality Duty) to integrate consideration of Equality, Diversity and Inclusion into their day-to-day business. The Equality Duty has 3 aims, it requires public bodies to have due regard to the need to:

- **eliminate unlawful discrimination**, harassment, victimisation and other conduct prohibited by the Equality Act of 2010;
- **advance equality of opportunity** between people who share a protected characteristic and people who do not;
- **foster good relations** between people who share a protected characteristic and people who do not.

Equality Impact Assessment (EIA) is a tool for examining the main functions and policies of an organisation to see whether they have the potential to affect people differently. Their purpose is to identify and address existing or potential inequalities, resulting from policy and practice development. Ideally, EIAs should cover all the strands of diversity and Inclusion. It will help us better understand its functions and the way decisions are made by:

- **considering the current situation**
- **deciding the aims and intended outcomes of a function or policy**
- **considering what evidence there is to support the decision and identifying any gaps**
- **ensuring it is an informed decision**

You can find further information via the Solent e-learning module:

https://mylearning.solent.nhs.uk/course/view.php?id=170

Equality Impact Assessment (EIA)

Step 1: Scoping and Identifying the Aims

Service Line / Department	Mental Health Service	
Title of Change:	Seclusion and Long-term Segregation Policy	
What are you completing this EIA for? (Please select):	Policy	*(If other please specify here)*
What are the main aims / objectives of the changes	Review of Solent Policy	

Step 2: Assessing the Impact

Please use the drop-down feature to detail any positive or negative impacts of this document /policy on patients in the drop-down box below. If there is no impact, please select "not applicable":

Protected Characteristic	Positive Impact(s)	Negative Impact(s)	Not applicable	Action to address negative impact: *(e.g. adjustment to the policy)*
Sex			X	
Gender reassignment			X	
Disability			X	
Age			X	
Sexual Orientation			X	
Pregnancy and maternity			X	

Marriage and civil partnership			X	
Religion or belief			X	
Race			X	

If you answer yes to any of the following, you MUST complete the evidence column explaining what information you have considered which has led you to reach this decision.

Assessment Questions	Yes / No	Please document evidence / any mitigations
In consideration of your document development, did you consult with others, for example, external organisations, service users, carers or other voluntary sector groups?)	No	
Have you taken into consideration any regulations, professional standards?	Yes	Mental Health Act: Code of Practice (2015) Mental Health Units (Use of Force) Act (2018) National Associate of Psychiatric Intensive Care & Low Secute Units (NAPICU) guidance (2019)

Step 3: Review, Risk and Action Plans

How would you rate the overall level of impact / risk to the organisation if no action taken?	Low	Medium	High
	■	☐	☐
What action needs to be taken to reduce or eliminate the negative impact?			
Who will be responsible for monitoring and regular review of the document / policy?			

Step 4: Authorisation and sign off

I am satisfied that all available evidence has been accurately assessed for any potential impact on patients and groups with protected characteristics in the scope of this project / change / policy / procedure / practice / activity. Mitigation, where appropriate has been identified and dealt with accordingly.

Equality Assessor:	*Ben Martin-Lihou*	*Date:*	*07/10/2022*

Additional guidance

Protected characteristic		Who to Consider	Example issues to consider	Further guidance
1.	**Disability**	A person has a disability if they have a physical or mental impairment which has a substantial and long term effect on that person's ability to carry out normal day today activities. Includes mobility, sight, speech and language, mental health, HIV, multiple sclerosis, cancer	• Accessibility • Communication formats (visual & auditory) • Reasonable adjustments. • Vulnerable to harassment and hate crime.	Further guidance can be sought from: Solent Disability Resource Group
2.	**Sex**	A man or woman	• Caring responsibilities • Domestic Violence • Equal pay • Under (over) representation	Further guidance can be sought from: Solent HR Team
3	**Race**	Refers to an individual or group of people defined by their race, colour, and nationality (including citizenship) ethnic or national origins.	• Communication • Language • Cultural traditions • Customs • Harassment and hate crime • "Romany Gypsies and Irish Travellers", are protected from discrimination under the 'Race' protected characteristic	Further guidance can be sought from: BAME Resource Group
4	**Age**	Refers to a person belonging to a particular age range of ages (eg, 18-30 year olds) Equality Act legislation defines age as 18 years and above	• Assumptions based on the age range • Capabilities & experience • Access to services technology skills/knowledge	Further guidance can be sought from: Solent HR Team
5	**Gender Reassignment**	" The expression of gender characteristics that are not stereotypically associated with ones sex at birth" World Professional Association Transgender Health 2011	• Tran's people should be accommodated according to their presentation, the way they dress, the name or pronouns that they currently use.	Further guidance can be sought from: Solent LGBT+ Resource Group
6	**Sexual Orientation**	Whether a person's attraction is towards their own sex, the opposite sex or both sexes.	• Lifestyle • Family • Partners • Vulnerable to harassment and hate crime	Further guidance can be sought from: Solent LGBT+ Resource Group
7	**Religion and/or belief**	Religion has the meaning usually given to it but belief includes religious and philosophical beliefs, including lack of belief (e.g Atheism). Generally, a belief should affect your life choices or the way you live for it to be included in the definition. (Excludes political beliefs)	• Disrespect and lack of awareness • Religious significance dates/events • Space for worship or reflection	Further guidance can be sought from: Solent Multi-Faith Resource Group Solent Chaplain
8	**Marriage**	Marriage has the same effect in relation to same sex couples as it has in relation to opposite sex couples under English law.	• Pensions • Childcare • Flexible working • Adoption leave	Further guidance can be sought from: Solent HR Team
9	**Pregnancy and Maternity**	Pregnancy is the condition of being pregnant or expecting a baby. Maternity refers to the period after the birth and is linked to maternity leave in the employment context. In non-work context, protection against maternity discrimination is for 26 weeks after giving birth.	• Employment rights during pregnancy and post pregnancy • Treating a woman unfavourably because she is breastfeeding • Childcare responsibilities • Flexibility	Further guidance can be sought from: Solent HR team

Appendix 3

Audit Standards for the use of the Enhanced Care Area Suite on Maple Ward, The Orchards

- Audit to be completed on a quarterly basis by Clinical matron
- Audit to cover Seclusion Pathway Record sheets and SystmOne notes
- A minimum of 5 clinical episodes of either of the areas being used must be audited

Patient Name:		**MHA Status:**	
NHS number		**Date of Audit**	

Area where patient was placed

Extra Care ☐ **Seclusion Room** ☐ **Both** ☐

	Audit Standards	Yes	No	If no, give rationale
1	Was the patient informed of the rationale for the Seclusion suite being used and clearly identified what is expected of them?			
2	Was the ward or duty doctor informed of the decision to place in seclusion suite in the agreed time frame? Is this recorded appropriately?			
3	Was the Lead nurse/Matron/548/RC informed (during working hours) or 548/On Call Manager (out of hours) in the agreed time frame? Is this recorded appropriately?			
4	If the patient was informal at the time of Seclusion being used was consideration given to formal detention under the Act?			
5	Were the patient's valuables or any other belongings considered to be potentially harmful removed before entering Seclusion suite? Is this recorded appropriately?			
6	Were Advocacy Services informed in a timely fashion?			
7	Is the observation records completed correctly? Points to consider: - Are the records timed and dated? - Are the records completed in full and cover the required clinical detail? - Are the records signed and have printed names and designation of the observing member of staff? - Are staff members replaced on observations every hour? - was the first hour of observations completed by a RMN?			
8	Is the 2 hourly – 2 nurse Nursing Review completed on time and in the appropriate format - Seclusion Pathway Record and electronic notes?			
9	Is the 4 hourly joint Medical and Nursing Review completed on time and involving direct contact with the patient, inside the suite?			

	Entries to be made in the Seclusion Pathway Record and S1 notes.			
10	Did the seclusion episode continue for more than 8 hours or 12 hours over a 48 hour period? If so, were the relevant persons informed (e.g. Matron/RC/on call manager/on call SPR/Consultant) and did the required review occur on time?			
11	Is the need for secondary level seclusion assessed and reviewed each shift by nursing staff and each day by medical staff? Is this recorded within the patients' S1 notes?			
12	Names of the staff involved in all reviews are to be clearly written in the Seclusion Pathway Record			
13	Is there clear documentation as to the rationale for the Seclusion episode ending?			
14	If the Seclusion suite was required again, was a new process of documentation started?			
15	Is there evidence that use of the Seclusion suite was discussed at the next Care Planning meeting with the MDT?			
16	Is there evidence that the patient was debriefed at the end of Seclusion episode?			

NON-CONTACT PHYSICAL HEALTH OBSERVATIONS TOOL

NHS Solent NHS Trust

IF A RED BOX STATEMENT IS TRUE: IMMEDIATELY ESCALATE. DO NOT LEAVE THE PATIENT.
DEPENDING ON OUTCOME: CONTACT MEDICAL TEAM USING SBAR OR EMERGENCY AMBULANCE

Document assessment on reverse of this form and also in patients electronic record

Airway clear? • If awake, can they speak? (Not just moans and groans)	**AIRWAY**	• Airway obstructed? Silence? Coughing? Stridor? *(Suggestive of possible swelling)* Gurgling? Wheezing? Snoring? *(Consider: opening airway, back blows, abdominal thrusts, oral suction)* • Is airway unsafe? (Especially if asleep or resting) Are they at risk of vomiting? *(Consider: moving onto their side and carry out constant observations to prevent choking / aspiration)*
Breathing is quiet and regular? • Breathing 12 - 20 respirations per min? • Breathing causes no extra effort or difficulty? • No abnormal breath sounds?	**BREATHING**	• Noisy? Irregular? Shallow? Rapid? Malodourous/unpleasant odour (E.g. pear drops)? • Difficulty breathing, even with open airway? • Rate: more than 20 breaths per min? Or less than 12 breaths per min? *(Consider: COPD, asthma, heart failure, chest infection? Acute illness? Recent rapid tranquilisation? Or restraint? Need for emergency oxygen? Assisted ventilations with bag & valve mask?)*
Warm, comfortable presentation? • Well perfused skin? • "Normal" complexion for them? • Pink mucous membranes inside the mouth? (If easily visible) • If asleep, monitor movement	**CIRCULATION**	• Obvious trauma? Bleeding? Physiological shock? Dehydrated / Malnourished? • Skin: Flushed? Clammy? Sweating? Cold? Pale? Swollen? Ashen (grey)? Mottled (purplish discoloration)? Swollen? Cyanosed (blue tinge, or discoloration of lips, nail beds, tip of nose or ear lobes)? Blue grey tinge to mucous membranes inside the mouth (Dark skin best seen in inner eye lids and lips)? Pallor: white/light coloured skin = skin takes on white hue, especially on face, inside of lips, eyelids & nail beds? Brown skin = yellow/red. Black skin = ashen grey.
Alert? • Responsive to voice? • No other physical health concerns?	**DISABILITY**	• AVPU assessment = Unresponsive? Only responds to verbal or physical stimulus? • Orientation - New or unexplained: Confusion? Disorientation? Sleepy? Drowsy? Fitting? *(Consider: overdose, epilepsy & blood glucose level)* • Temperature: If able to touch - is skin Hot? Cold? Clammy? • Other physical health concern requiring additional interventions / monitoring e.g. Asthma? Diabetes? Epilepsy? Intoxication? Drug / Medication side effects?
Active, walking, steady gait, resting / sleeping NOT unconscious? *(See note on reverse)* • Eating and Drinking? • Presenting as "Normal" for them? • No Patient, Carer, Health / Social Care / Professional concerns	**EXPOSURE**	• Change in ability to mobilise? Inability to stand unaided? • Muscle rigidity? Change in their ability to mobilise? (E.g. weakness in any limbs?) • Not eating & drinking? Signs of dehydration? (Dry cracked lips? Not passing urine?) • Increased: thirst (polydipsia)? And urination (polyuria)? • Signs of Physical Injury / bleeding / bruising / rash / self-harm? • Signs of Infection – Think: Could this Be Sepsis? (Check Sepsis Screening Tool) • Patient, Carer, Health / Social / Professional concerns? (Use clinical judgement

Patient Name **DOB** **NHS No**							**Please** **If ANY "RED" statements are triggered overleaf, tick relevant A, B, C, D or E box below Note your concerns to red trigger in larger box provided** **(Include escalations, support, monitoring & outcomes)**						**Name, Signature & Role**
Date: **Time:**		A	B	C	D	E	A	B	C	D	E		
Date: **Time:**		A	B	C	D	E	A	B	C	D	E		
Date: **Time:**		A	B	C	D	E	A	B	C	D	E		
Date: **Time:**		A	B	C	D	E	A	B	C	D	E		
Date: **Time:**		A	B	C	D	E	A	B	C	D	E		
Date: **Time:**		A	B	C	D	E	A	B	C	D	E		
Date: **Time:**		A	B	C	D	E	A	B	C	D	E		
Date: **Time:**		A	B	C	D	E	A	B	C	D	E		

Important Notes: NEWS (contact physical health observations) is always preferred, in conjunction with an ABCDE assessment. The decision to use only this Non-Contact Physical Health Guidance & Assessment Framework tool is a Registered Nurse decision, on a case by case basis and should be determined each time physical health observations are required. This tool aids assessment, but Registered Nurses should always act on their best professional clinical judgement too. NB: Circumstances why non-contact PHO rather than full NEWS should be summarised on the NEWS chart along with RR and AVPU.

Differentiating between unconsciousness and sleep: Being asleep is not the same as being unconscious. If someone is asleep we would expect them to occasionally change position while sleeping and for them to have a "normal" complexion for them. If you are at all concerned that the patient is not sleeping, and may be unconscious escalate / evoke full AVPU assessment of consciousness immediately.