Policy: S2

Seclusion Policy

Version: S2/10

Ratified by: Trust Management Team

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Title of responsible Director: Director of Nursing and Patient Experience

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EIA / Sustainability

EIA Approved

Implementation Plan

Other related Procedure or Documents: Policies V2, O1, H4, P11, D13, M2 and C27
### Equality & Diversity statement
The Trust strives to ensure its policies are accessible, appropriate and inclusive for all. Therefore all policies will be required to undergo an Equality Impact Assessment and will only be approved once this process has been completed.

### Sustainable Development Statement
The Trust aims to ensure its policies consider and minimise the sustainable development impacts of its activities. All policies are therefore required to undergo a Sustainable Development Impact Assessment to ensure that the financial, environmental and social implications have been considered. Policies will only be approved once this process has been completed.
## S2: Seclusion Policy

### Version Control Sheet

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1.0 SECLUSION PROCESS CHART – TIME LINE

On Initiating Seclusion

- After initiating seclusion the nurse in Charge of the ward will immediately notify (6.1);
  - The Ward Doctor or first On Call Doctor who will contact the clinical area (ward) and attend to assess the patient immediately (must be within first hour).
  - The Site Manager (Broadmoor) Unit Co-ordinator (Ealing, Hammersmith & Fulham, Hounslow), Duty Senior Nurse (West London Forensic).
  - The Responsible Clinician (or deputy) – 09:00 to 17:00, Monday to Friday.
  - The Senior Nurse/Clinical Manager for the area
- If seclusion is initiated after 17:00 but before 23:00 or on a weekend/Bank Holiday, following notification by the nurse in charge, Site Management (Broadmoor) the Unit Co-ordinator (Ealing, Hammersmith and Fulham and Hounslow sites), Senior Nurse on call (West London Forensic) will inform the Duty Consultant. (6.1)
- If seclusion is initiated after 23:00, the nurse in charge of the ward will inform the patient’s Responsible Clinician/Consultant Psychiatrist at 09:00 the next working day (or the Duty Consultant if the next working day is a weekend or Bank Holiday). (6.1)

The Senior Nurse/Clinical Manager for the area will attend the ward as soon as possible. (6.2)

Initiate seclusion care plan (7.1)
Initiate eyesight observation (First hour by registered nurse) (9.1)
 Undertake 2 hourly nursing reviews and 4 hourly medical reviews. (9.6)
Other members of the Clinical Team actively involved in the patient’s care should be informed as soon as possible by the Responsible Clinician’s/team’s Personal Assistant. (6.3)

Up to 24 Hours

- Continue 2 hourly nursing reviews and 4 hourly medical reviews. (9.6)
- When seclusion continues for more than 8 hours consecutively or for more than 12 hours intermittently over a period of 48 hours, a multi-disciplinary review will be undertaken by the patient’s Clinical Team. (9.6)

Up to 48 Hours

- Exception from night time 4 hourly medical reviews may only be agreed on an individual named basis. This should be agreed by the RC (or deputy) or Duty Doctor following discussion with the Nurse In Charge of the ward. The exception must be recorded in the clinical record. (9.6)

7 Days

- An independent review must be undertaken on or before the 7th day of a seclusion episode. (9.7)
- The RC is responsible for inviting another RC and a senior nurse (band 7 and above) to carry out a review (other MDT members may participate).

LTs Broadmoor Hospital Only. 7 Days and Over

- Following consideration of this independent review the MDT may place the patient on LTS (on day 8) if, in their opinion, the patient requires longer term management of their behaviour. (17.2)
- The Responsible Clinician, on behalf of the MDT, will have the authority to implement LTS. (17.2)
- The MDT will develop an initial management plan for the patient and provide a copy of the plan to the CD and the Deputy Director of Nursing (or deputies) for review and comment. (17.2)
- The agreed management plan will be presented by the RC and Ward Manager/Team Leader/primary nurse (or deputies) at the next Directorate Seclusion Monitoring Review Group (SMARG), a standing agenda item for Directorate Clinical Improvement Groups (17.2)
- The RC or the nurse in Charge of the ward will advise the CD and Site Management that LTS has commenced.

Patients on LTS will be subject to;
- Daily reviews by the nurse in Charge of the ward (18.3)
- Daily reviews by a doctor (18.4)
- Three reviews per week by the RC (over 7 days) (18.5)
- Weekly reviews at MDT meeting
- 3 monthly MDT case review involving CD and DDN (Option to invite independent senior clinician) (18.7)
- LTS use is subject to monitoring and review via Directorate and CSU SMARG arrangements.
- LTS use is subject to Directorate and CSU level performance review and is reported to CSU senior management teams and Trust board via governance structures
- The Clinical Director will provide an annual report based on SMARG on the use of seclusion within each CSU to
2.0 INTRODUCTION

2.1 The Seclusion Policy defines the practices and responsibilities of staff employed by West London mental healthcare NHS Trust. Some sections of the Policy only apply to High Secure Services; this is indicated where appropriate.

2.2 Seclusion should only be used as a last resort and for the shortest time possible. Seclusion should not be used as a punishment or threat or because of a shortage of staff (see WLMHT Policy V2 - Violence Reduction & Management).

2.3 Seclusion should not form part of a treatment programme.

2.4 The Code of Practice Mental Health Act 1983 (DoH 2008) states: [15.45] "Where the patient poses a risk of self-harm as well as harm to others, seclusion should be used only when the professionals involved are satisfied that the need to protect other people outweighs any increased risk to the patient’s health or safety and that any such risk can be properly managed".

2.5 Seclusion should normally take place in a specially designated seclusion room.

2.6 The Code of Practice states: [15.60] the room used for seclusion should:
   - provide privacy from other patients, but enable staff to observe the patient at all times;
   - be safe and secure and should not contain anything which could cause harm to the patient or others;
   - be adequately furnished, heated, lit and ventilated; and
   - be quiet but not soundproofed and should have some means of calling for attention (operation of which should be explained to the patient).

3.0 SCOPE

3.1 This policy applies to all West London Mental Health Trust services that use seclusion.

3.2 **Broadmoor Hospital only** - patients who present as “High Risk” and who are confined in their rooms at night as part of their treatment plan, are managed in accordance with High Risk Policy which covers Broadmoor Hospital (see Policy H4 High Risk Patients, Their Management in Broadmoor Hospital). Broadmoor Hospital also has patients who may be subject to night time confinement for operational security reasons.

   Where it is considered necessary to seclude a patient under the terms of Policy H4, the seclusion episode must be managed in accordance with this Seclusion Policy.
4.0 DEFINITIONS

4.1 Seclusion for the purpose of this procedure is defined as “the supervised confinement of a patient in a room, which may be locked. Its sole aim is to contain severely disturbed behaviour which is likely to cause harm to others.” (The Code of Practice Mental Health Act 1983: 15.43. DoH 2008).

4.2 Seclusion and “Time Out:” – the distinction

The term “Time Out” describes a behaviour modification technique which denies the patient, for a period of no more than fifteen minutes, opportunities to participate in an activity or to obtain positive reinforcers immediately following an incident of unacceptable behaviour. The patient is then returned to his or her original environment. “Time Out” should never include the use of a locked room and should be clearly distinguished from seclusion which is for use in an emergency only and should never form part of a behavioural programme. The use of ‘time out’, unless prescribed is illegal.

5.0 DUTIES

5.1 Chief Executive
The Chief Executive is responsible for ensuring that the Trust has a policy in place for seclusion and that systems exist for monitoring and ensuring the Trust meets the Code of Practice.

5.2 Accountable Director
The Director of Nursing & Patient Experience is the Accountable Director for overseeing the development, approval and implementation of this policy.

5.3 Managers
Managers are responsible for overseeing implementation and compliance with the policy.

5.4 Policy Author
The Policy Author is responsible for writing the policy, ensuring it meets Code of Practice Standards and that the policy is consulted on.

5.5 Local Policy Leads
Local Policy Leads to follow implementation plan and ensure policy is widely communicated within the service.

5.6 Specific Staff for Policy implementation
Clinical Directors have a responsibility for ensuring the policy is implemented within their service.

5.7 All Staff
All staff to follow policy and report any non-compliance with the policy.
6.0 SYSTEMS & RECORDING

6.1 Start of seclusion
Where recorded: RiO - MDT file – seclusion system
What is recorded: risk assessment / care plan
Who records: Primary nurse/Medical staff
When recorded: Start of seclusion

Incident recording
Where recorded: IR1 on Exchange
What is recorded: Details of incident + check box if secluded
Who records: Nurse in charge
When recorded: At commencement of seclusion and any subsequent incident

During seclusion
Where recorded: RiO - MDT file – seclusion system
What is recorded: Seclusion review (medical), nursing and MDT / physical and mental state including patient’s view / care plan / engagement and observation levels
Who records: Member of clinical team
When recorded: At regular intervals – not less than every 2 hours

Medical Examination
Where recorded: RiO - MDT file – seclusion system
What is recorded: review / physical health check / medication
Who records: Medical staff
When recorded: At regular intervals – not less than every 4 hours (for regular seclusion)

Long Term Segregation
Where recorded: RiO – MDT file – seclusion system and SMARG
What is recorded: Authorisation and reviews
Who records: Medical and nursing staff
When recorded: At regular intervals, not less than daily nursing reviews
7.0 AUTHORISATION OF SECLUSION

7.1 The decision to implement seclusion can be made by either:

a) The Nurse in Charge of the ward.
b) Responsible Clinician, Non Consultant Medical Staff.
c) Senior nurse on duty for the site in consultation with nurse in charge of the ward.

8.0 NOTIFICATION OF SECLUSION

8.1 After initiating seclusion the Nurse in Charge of the ward will immediately notify:

a) The Ward Doctor or first On Call Doctor who will contact the clinical area (ward) and attend to assess the patient immediately (must be within first hour).

b) The Site Manager (Broadmoor) Unit Co-ordinator (Ealing, Hammersmith & Fulham, Hounslow), Duty Senior Nurse (West London Forensic).

c) The Responsible Clinician (or deputy) – 09:00 to 17:00, Monday to Friday.

d) If seclusion is initiated after 17:00 but before 23:00 or on a weekend/Bank Holiday, following notification by the nurse in charge, Site Management (Broadmoor) the Unit Co-ordinator (Ealing, Hammersmith and Fulham and Hounslow sites), Senior Nurse on Call (West London Forensic) will inform the Duty Consultant.

e) If seclusion is initiated after 23:00, the nurse in charge of the ward will inform the patient’s Responsible Clinician/Consultant Psychiatrist at 09:00 the next working day (or the Duty Consultant if the next working day is a weekend or Bank Holiday).

8.2 The Senior Nurse/Clinical Manager for the area will attend the ward as soon as possible.

8.3 Other members of the Clinical Team actively involved in the patient’s care should be informed as soon as possible by the Responsible Clinician’s/team’s Personal Assistant.

9.0 PATIENTS NEEDS – START OF SECLUSION

9.1 A clinical assessment of risk must be completed and a seclusion care plan will be developed by the Primary Nurse (or associate/named nurse) at the commencement of the seclusion episode, in consultation with MDT colleagues if available. The risk assessment and care plan must be documented in the patients’ records and should be considered as part of subsequent MDT reviews. The care plan will address the aim of safe termination of seclusion as soon as possible.
9.2 Clinical Teams will complete full assessment of the individual patient’s communication needs. If required, translation and sign language will be provided for by the Clinical Team as required.

9.3 Patients in seclusion will be offered appropriate clothing, bedding and access to personal hygiene and toileting facilities. Eating utensils and reading materials should be available subject to risk assessment. In exceptional circumstances one or more of these may not be possible and this decision must be documented within the Risk Assessment/notes by the most senior clinician available who has made the clinical judgement. Patients’ nutrition needs must be considered and met. If patients are awake they will be offered fluids at regular intervals throughout every shift, and this will be recorded on a fluid chart/healthcare record.

9.4 Broadmoor Hospital/Women’s Enhanced Medium Secure (WEMS) Services only In exceptional and prescribed circumstances reinforced bedding and clothing can be used (this is clothing and bedding which is difficult to tear/rip). This should be authorised by a member of the medical staff/nurse in charge of the ward at the time. The reason must be clearly recorded on the Seclusion Care Plan and healthcare record, reviewed at every seclusion review and discontinued when agreed clinically safe nurse in charge of the ward or by a member of the medical staff. (see WLMHT Protective Bedding and Clothing (Broadmoor Hospital only) Policy P11).

10.0 RECORDING AND POLICY COMPLIANCE

10.1 The Nurse in Charge of the ward is responsible for ensuring that all documentation and enhanced engagement and observation forms are being correctly completed and that Enhanced Engagement & Observation Policy (O1) is complied with.

11.0 SUPERVISION OF THE PATIENT IN SECLUSION

11.1 Enhanced Engagement and Observation

11.1.1 Immediately after initiating the seclusion of a patient; the patient must be placed within eyesight engagement and observations (until reviewed by medical staff and nurse in charge of the ward).

11.1.2 The first hour of seclusion enhanced engagement and observations must be undertaken by a Registered Nurse.

11.1.3 Beyond the first hour the nurse in charge of the ward will determine responsibility for who undertakes enhanced engagement and observations. The nurse in charge will develop a rota to allocate staff to undertake enhanced engagement and observation and consider staff interaction with the individual patient.
11.1.4 Clinical staff\(^1\) will not be expected to conduct continual eye sight engagement and observations on a patient for periods exceeding 2 hours.

11.1.5 Ongoing Enhanced Engagement and Observation for patients in seclusion will be agreed by the Nurse in Charge and the RC or Deputy. The enhanced engagement and observations will be outlined in the patient’s Seclusion Care Plan and documented in the patients records.

11.1.6 **Individuals in seclusion should be observed either:**

- Within eyesight (constant engagement and observations) or via
- Planned, intermittent, enhanced engagement and observations every 15 minutes

\(\text{NB}\) At all times throughout the period of seclusion a suitably skilled professional will be readily available within sight and sound of the seclusion room.

11.1.7 The nurse undertaking the enhanced engagement and observations must record patient activity every 15 minutes.

11.2 **Seclusion Record Keeping**

11.2.1 The Code of Practice states [15.62] – “*Detailed and contemporaneous records should be kept in the patient’s case notes of any use of seclusion, the reasons for its use, and subsequent activity. Records should also be kept in a special seclusion recording system which should contain a step-by-step account of the seclusion procedure in every instance. Responsibility for the accuracy and completeness of these records should lie with the professional in charge of the ward. Local policies should require the records of each episode of seclusion to be reviewed by a more senior professional*”.

11.2.2 Commencement of the seclusion is documented on the seclusion record and patient’s records. The principal entry should be made by a Registered Nurse. Documentation of enhanced engagement and observations will be entered on the seclusion enhanced engagement and observation record at the minimum of every fifteen minutes by the Nurse/Nursing Assistant or other competent professional carrying out the enhanced engagement and observations.

11.3 **Medical Examination Whilst in Seclusion**

11.3.1 Taking account of the clinical presentation of the patient from a risk perspective, the attending doctor should physically examine the patient in the seclusion room as soon as possible. If it is not possible to enter the seclusion room due to the patients risk presentation, this must be recorded in the patients’ records. If more staff are required to safely enter the room the Site Manager/Senior Manager/Senior Nurse for the area will be consulted.
11.3.2 In such instances a strategy to enable the doctor to examine the patient as soon as possible will be agreed and documented in the patient’s clinical records.

11.4 Care Planning Whilst in Seclusion

11.4.1 Following the medical assessment a seclusion care plan will be written by the Nurse in Charge of the ward in consultation with the attending Medical Staff. The plan will include -

a) Objectives to end seclusion safely.

b) Medication review (teams may consult with the pharmacist).

c) Patient access to fluids and nutrition - a fluid balance sheet will be commenced and must be completed when drinks / food are offered and detail consumption.

d) An assessment of the patient’s likely response to staff entering the room for reviews, etc.

e) Minimum staff in attendance to enter seclusion room.

f) Consideration of safety of bedding and clothing.

g) The patients’ views should be considered and any advance directives put in place as appropriate.

This care plan will be retained in the patient’s clinical records.

11.5 Medication

11.5.1 Any prescribed medication should be administered within the legal framework of the Mental Health Act. (ref Section 58-62).

Oral medication should be offered before parenteral medication (e.g. injection, rapid tranquilisation) (NICE 1.8.4.7, Page 50).

Where it is necessary to prescribe and/or administer emergency parenteral medication to patients in seclusion this will be considered a medical emergency requiring the presence of medical staff and Site Manager/Senior Nurse on Duty/Senior Manager. Any prescribed medication should be administered within the legal framework of the Mental Health Act, with specific reference to Section 58 and Section 62.

11.5.2 Emergency equipment must be present whenever it is deemed necessary to administer emergency parenteral medication in seclusion (a Pulse Oximeter should be available, see NICE 1.8.4.33, Page 55). Attempts should be made to take the patient’s blood pressure and temperature, pulse and respiration following the administration of emergency parenteral medication. Attempts, whether successful or not, to measure the patients’
vital signs, **must** be recorded in the patients' records and on a BP/TPR chart. The patient should be monitored ‘within eyesight’ enhanced engagement and observation by an appropriately trained individual (NICE 1.8.3.6, Page 47).

11.5.3 Once any parenteral medication has taken effect seclusion should be terminated (but the patient monitored ‘within eyesight’ [NICE 1.8.3.6, Page 47]). Any termination of the seclusion will be dependent on the risk assessment at the time. This decision should be made by medical and nursing staff.

11.6 **Reviews**

Unless the initial multi-disciplinary review concludes that different arrangements are appropriate, the need to continue seclusion should be at least reviewed:

- Every two hours by two nurses or other suitably skilled professionals (one of whom was not involved directly in the decision to seclude); and

- Every four hours by a doctor or a suitably qualified approved clinician” (15.51 Code of Practice Mental Health Act 1983)

**NB:** It is good practice for seclusion reviews to be undertaken within the room by opening the door, but recognise that this should only be done when considered therapeutic/and safe to do so.

11.6.1 **Nursing**

11.6.1.1 A nursing review will take place **every 2 hours** by a minimum of two nurses (one of whom is registered). The nurses should enter the seclusion room (if safe to do so) and assess the patient, regarding the need to, discontinue or continue seclusion. It should take a minimum of three people to safely enter a seclusion room. One of those nursing staff will not have been involved in the initial decision to seclude the patient. The outcome of the assessment must be recorded in the healthcare record (and any seclusion record).

11.6.1.2 If it is not safe to enter the seclusion room due to the patient’s presentation, this must be recorded in the healthcare records. If the ward requires more staff to enter the seclusion room, they must contact the Site Manager/Senior Nurse/Service Manager who will organise resources so that a review/assessment can be undertaken as soon as possible. The names and designations of all staff entering the seclusion room will be sequentially recorded in the seclusion/healthcare record.

11.6.1.3 The Nurse in Charge will terminate seclusion when it has become apparent that it is no longer necessary.

11.6.1.4 The purpose of this review is to ensure that the patient’s basic care needs are being met e.g. hygiene, nutrition and sleep. If this is not the case then more senior support/advice should be sought immediately. This is particularly so in the case of female patients who may be menstruating.
11.6.2   **Medical**

11.6.2.1 The purpose of a medical review is to establish the well-being of the patient and to consider the continuing need for seclusion. Medical reviews will take place (as per Code of Practice) every **4 hours**, (however see 9.6) The patient must be seen by the Ward Doctor or first On-Call Doctor by entering the seclusion room, and assessing the patient. The outcome must be recorded in the healthcare record.

11.6.2.2 If it is not safe to enter the seclusion room due to the patient’s presentation, this must be recorded in the healthcare records. If the ward requires more staff to enter the seclusion room, they must contact the Site Manager/Senior Nurse/Service Manager who will organise resources so that a review/assessment can be undertaken as soon as possible. The names and designations of all staff entering the seclusion room will be sequentially recorded in the seclusion/healthcare record.

11.6.3   **RC/ Senior Medical Reviews  Broadmoor Hospital Only**

11.6.3.1 At Broadmoor Hospital, all patients subject to short-term seclusion will be seen and reviewed by their own RC/Consultant Psychiatrist/nominated deputy (a senior trainee doctor ST4-6) on a daily basis. These reviews may be counted as one of the 4 hr reviews (see 11.6.2). However, ‘normal’ 4hrs reviews by junior doctors as (11.6.2) can’t replace these RC/ Senior Medical reviews.

11.6.3.2 At weekends (and Bank Holidays), the responsibility for the daily reviews falls to the duty RC/Consultant Psychiatrist (or deputy ST4-6). It will be for the duty Consultant Psychiatrist/ RC to ensure these reviews take place.

11.6.4   **Site Manager/Night Co-ordinator**

11.6.4.1 The respective Site Manager or Unit Co-ordinator (or Ward Manager) should attend each medical review if undertaken during the night.

11.6.5   **Medical and Nursing Reviews When Patient is Asleep**

11.6.5.1 Where a patient appears to be sleeping, a clinical judgement needs to be made on whether it is appropriate to wake him/her for a medical or nursing review. In such instances medical reviews may be suspended, nursing reviews will continue 2 hourly. This needs to be jointly agreed by both a Doctor and the Nurse in Charge of the ward.

11.6.5.2 However, the nature of the nursing review will be such that the patient should not be woken subject to providing assurance that the patient’s vital signs are observed to be normal. A doctor will be on call to carry out a medical review during the night, should the need arise. The Nurse in Charge of the ward will be responsible for contacting the doctor.
11.6.5.3 The ‘exception’ from night time 4 hourly medical reviews may only be agreed on an individual named basis. This should be agreed by the RC (or deputy) or Duty Doctor following discussion with the Nurse in Charge of the ward. The exception must be recorded in the clinical record.

11.6.6 Multi-Disciplinary Clinical Team Reviews

11.6.6.1 When seclusion continues for more than 8 hours consecutively or for more than 12 hours intermittently over a period of 48 hours, a multi-disciplinary review will be undertaken by the patient’s Clinical Team. Usually this will be the patients RC or deputy and Nurse in Charge of the ward at the time, however other team members should be encouraged to participate. This review must take place the day after the patient has been placed in seclusion and be repeated every 48 hours.

11.6.6.2 During normal office hours (Monday to Friday, 09:00 to 17:00) these will be arranged by the Personal Assistant to the Responsible Clinician, following a request from the Nurse in Charge of the Ward.

11.6.6.3 Out of hours - If the first MDT review falls on a weekend or a Bank Holiday, then the review will be carried out by the Duty Responsible Clinician and the Senior Nurse on Site.

11.6.6.4 The Site Manager/Senior Nurse on site will contact the Duty Responsible Clinician to initiate the Seclusion Review and a suitable arrangement made for the Senior Nurse on site to participate in any review.

11.6.6.5 The purpose of a Multi-Disciplinary Clinical Team Review (usually RC or deputy and Nurse in Charge of the ward) is to review the appropriateness of continuing seclusion, assess the well-being of the patient and to formulate plans to allow seclusion to be discontinued as soon as possible. The Multi-Disciplinary Clinical Team Review should consist of a medical representative, a registered nurse and one other MDT member if possible.

11.6.6.6 If the patient’s Responsible Clinician is not physically on site to participate in such a review, he/she should be contacted by the Ward Doctor/First On-Call Doctor to discuss the seclusion and the further management of the patient.

11.6.6.7 The Ward Doctor/First On-Call Doctor should then relay this discussion to the Multi-Disciplinary Review Team.

11.6.6.8 If the patient’s Responsible Clinician cannot be contacted then the covering Responsible Clinician or the On-Call Responsible Clinician should be contacted regarding participating in the Multi-Disciplinary Review.

11.6.6.9 If a member of the Clinical Team cannot take part in such a review, because, for example, they were involved in the original decision to seclude the patient, then the obligation rests upon that team member to identify an appropriate person.
11.6.6.10 As stated in the Code of Practice [Para 15.59] if the need for seclusion is disputed by any member of the Multi-Disciplinary Team, the matter should be referred to the Clinical Lead for the area. If agreement on a way forward cannot be reached, the Clinical Lead for the area may refer/consult with the Clinical Director/Deputy Director of Nursing.

11.7 **Independent Seclusion Review**

11.7.1 If the period of seclusion continues for longer than 7 days (from commencement of seclusion), there should then be an independent review. The RC will invite another RC and senior nurse (band 7 and above) to carry out a review (other MDT members may participate). The purpose of the review is to monitor the well-being of the patient, to ensure that seclusion remains appropriate and clear plans exist to facilitate the discontinuation of seclusion.

11.7.2 The Nurse in Charge of the Ward should check whether a seclusion review is required and contact the appropriate Responsible Clinician’s Personal Assistant before 10:00. The review will be arranged by the Personal Assistant to the On-call Responsible Clinician. The Personal Assistant will also advise the Senior Manager On-Call.

11.7.3 The Independent Seclusion Review Team should see the patient. The Independent Seclusion Review should document their advice in the patient record and feedback to Responsible Clinician.

11.7.4 The Independent Seclusion Review has an advisory role. It may make recommendations to the Multi-Disciplinary Clinical Team, including a recommendation to end seclusion. The Multi-Disciplinary Clinical Team must actively consider recommendations made by the Independent Seclusion Review at each subsequent Multi-Disciplinary Clinical Team Review.

11.8 Should the independent review fall on the same day as the Multi-Disciplinary Clinical Team Review then it would be good practice for the Consultant on the Independent Review to liaise with the Responsible Clinician of the Multi-Disciplinary Clinical Review Team to consider whether it would be appropriate for the reviews to take place simultaneously.

**12.0 SITE MANAGER/SENIOR NURSE ON DUTY/SENIOR MANAGER**

(for the area)

12.1 The Site Manager/Senior Nurse on Duty/Senior Manger will report all incidents of seclusion at respective communication meetings.

12.2 The Site Manager/Senior Nurse on Duty/Senior Manger will be required to:

   a)  Attend the Independent Review if required.
   b)  Review the documentation relating to seclusion if required.

Such visits will be recorded in the ward seclusion record information sheet.
13.0 TERMINATION OF SECLUSION

13.1 Seclusion should be terminated when a patient’s risk of harm to others can be safely managed within the ward environment. This should include the consideration of patient’s needs and wishes which may be recorded an advanced directive.

13.2 Seclusion may be terminated at the discretion of:

a) The Nurse in Charge of the ward.

b) Ward Doctor.

c) The patient’s Responsible Clinician or Duty Responsible Clinician.

d) The Site Manager.

_{NB} It is good practice that the decision to terminate seclusion be made following a discussion with other clinical team members._

13.3 The clinicians who agree to end seclusion must ensure that they have planned and documented the patients care needs immediately post seclusion, this will include outlining risk assessment and the level of enhanced engagement and observations required.

14.0 PATIENT NEEDS DURING SECLUSION

14.1 These needs will be clearly assessed as to risk and set out in the seclusion nursing care plan. (Access to bathing and hygiene etc must be recorded). The ability of a patient to attend to personal hygiene does not necessarily mean seclusion can be terminated. Patient’s views should be included in the Care Plan.

14.2 A patient in seclusion should retain their clothing as long as it does not compromise their safety or the safety of others (NICE 1.8.3.4). The Nurse in Charge of the ward must endeavour where reasonably practicable to ensure any patient placed in seclusion does not retain items that may cause injury. Clothing and other items taken from a patient must be placed in a safe place. The reasons for their removal being clearly explained to the patient and recorded in the patient’s healthcare record. (NICE 1.8.3.5, Page 46).

14.3 En-suite facilities where available should be routinely accessible to patients in seclusion unless following a risk assessment specific concerns are raised about self harm, suicide or violence. Showering facilities should be made available to those in seclusion rooms without showering facilities, if and when it is safe to do so.

14.4 The team should consider any user views or instructions that a service user has expressed about their management in any advanced directives/recovery plan, and use as appropriate to situation.

14.5 Whilst in seclusion, the patient will be:
• treated with respect and dignity at all times.
• advised of the reasons for being placed in seclusion (this should be explained at each and every review as necessary).
• advised under what conditions seclusion will cease.
• informed how to summon the attention of staff.
• provided with food and drinks regularly in an appropriate manner.
• told that their fluid intake (balance) will be monitored and recorded.
• given access to toilet and washing facilities, which should be supervised by the same gender staff.
• appropriately clothed at all times, (also see 9.3).
• assisted by nursing staff who will relay messages to the patient’s legal representatives, the CQC (MHAC) and Advocacy as necessary.
• patients may have visits from legal, the CQC (MHAC) and Advocacy if safe to do so.
• have access/sight of a clock at all times.
• have access to radio/reading materials where clinically appropriate.
• be encouraged to discuss with staff issues affecting their psychological presentation.
• asked if their family or carers can be informed of their situation and in case of new admissions this would be considered normal practice to make relatives aware of the patients’ current distress and how they are being supported. This should be the responsibility of the RC to organise this.

14.6 A risk assessment will enable the Nurse In Charge to consider providing access to the following:

• reading materials such as books and magazines.
• “piped” music of the patient’s choice (Where available).
• where available a television
• fresh air (which may include garden areas under supervision.)

14.7 A risk assessment must be undertaken, including physical health care risks. Plans of care must be implemented to ensure physical health needs of patients are met. If patient’s refuse to have physical observations (pulse, blood pressure

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2 This must be provided in a safe manner e.g. television behind a fixed Perspex screen, free standing televisions must not be used unless agreed by the Clinical Team and approved by Clinical Lead.
etc.) taken, the Team will outline an agreed process for the management of the patients’ physical health care in the care plan.

14.8 Patients in seclusion will be offered the opportunity to have access to CQC (MHAC), patient’s advocates, chaplaincy, and the patient’s legal representatives; this will be subject to risk assessment at the time of any visit. If it is deemed unsafe to enter the seclusion room, then access should be provided (e.g. discussion through window, etc).

14.9 A patient should not normally be transferred to another ward whilst in seclusion. However, should such circumstances arise, the Site Manager (Senior Nurse on Duty/Senior Manager) and the patient’s Responsible Clinician (or out of hours the Duty Responsible Clinician) will be involved at the earliest opportunity to discuss the clinical justification for this. The Site Manager (or equivalent) should be on hand to ensure the safe transfer of the patient.

14.10 **Broadmoor** - In circumstances where strong bedding/clothing is issued, due to concerns of self harm/suicide, a Care Plan should be included as part of managing the secluded patient. This care plan will reflect areas of concern and the actions and interventions to be taken to minimise the risk. This should all be documented in the patients records and reviewed by the Clinical Team.

15.0 **POST INCIDENT REVIEWS**

15.1 It is good practice to review the incident(s) that led up to use of seclusion. Normally such a review would take place at the next appropriate Clinical Team Meeting.

16.0 **DOCUMENTATION**

16.1 The Nurse in Charge of the ward is responsible for ensuring that all documentation/records and enhanced engagement and observation records have been correctly completed. All such documentation should be filed in patient records to ensure easy access to information for clinical staff and members of the Care Quality Commission. All documents must be signed and dated (including seclusion form, enhanced engagement and observation form, care plan and fluid charts).

16.2 All records pertaining to seclusion should be kept as part of an identified seclusion recording system.

16.3 After the seclusion has ended patients should be given the opportunity to document their assessment of the interventions in their notes [NICE: 1.4.1.5].

17.0 **STAFF SUPPORT**

17.1 The Nurse in Charge of the ward or the Clinical Nurse Manager, as appropriate, must ensure there is provision for staff/patient support after an incident of seclusion in the form of individual/group discussion and clinical supervision.
18.0 SECLUSION MONITORING ARRANGEMENTS

18.1 All seclusion used across WLMHT will be reviewed by a multi-disciplinary group known as the Seclusion Monitoring and Review Group (SMARG). All Clinical Service Units (CSU’s) must have Seclusion Monitoring and Review arrangements in place. The functions of SMARG are:

- to monitor the adherence of seclusion to the Code of Practice and any departures from the Code of Practice;
- to receive and analyse data relating to seclusion and to monitor overall trends in the use of seclusion;
- to submit reports to Trust and CSU Management/governance meetings.
- to review documentation for the collection of information about the use of seclusion and alternative management strategies;
- to consider any staff training and educational issues that arise and make recommendations to the CSU Management Committee;
- to provide a form for peer review of seclusion practice and case reviews.
- to share and disseminate good practice hospital wide.
- in cases of long term segregation the patient’s Clinical Team may be invited to discuss the issues contributing to the long term use of seclusion at the SMARG.

18.2 The SMARG will be chaired by the Clinical Director/Clinical lead (or nominated Deputy) and will have representation from other clinical disciplines in the hospital.

18.3 The Care Quality Commission will have a standing invitation to attend. The SMARG will report to the CSU Management Committee through the Clinical Governance Meeting.

18.4 The Clinical Director will submit an annual report to Trust Patient Safety subcommittee which reports to the Quality Committee which is a committee of the Board on the use of seclusion within their service. The Clinical Director will provide responsive updates on the use of seclusion at the request of the chairs to the following fora: Broadmoor Senior Management Team, The Trust Patient Safety Committee, The Quality Committee and the Trust Board.

19.0 LONG TERM SEGREGATION (LTS)- (BROADMOOR HOSPITAL ONLY)

19.1 Long Term Segregation -Use

19.1.1 Broadmoor Hospital provides care for a number of patients who are not responsive to the short term management of their violence and aggression.
19.1.2 These individual patients present a persistent risk to others over a lengthy period and do not respond to a short period of seclusion designed to safely manage their immediate level of violence and aggression.

19.1.3 The MDT may judge in these cases that if the patient were to mix freely in a general ward environment other patients or staff would continuously be open to the potential of serious injury or harm. Patients who are subject to LTS may be managed in their own room following a risk assessment.

19.2 **Authorisation and Commencement of LTS**

19.2.1 Any patient who has been secluded continuously for **7 days** will have an independent seclusion review (see 11.7). If day seven falls outside of the normal working week, the team will review on the next working day. The independent review has the following purposes:

- To review the continued need for seclusion.
- To offer advice/input to the patient’s team.
- To seek the patient’s view.

19.2.2 Following consideration of this independent review the MDT may place the patient on LTS (on day 8) if, in their opinion, the patient requires longer term management of their behaviour.

19.2.3 The Responsible Clinician, on behalf of the MDT, will have the authority to implement LTS providing that:

- The patient has been subject to 7 days of ongoing continuous seclusion.
- The independent review of seclusion at 7 days has been completed and considered by the team.
- The RC discusses the planned use of LTS with the Clinical Director (CD) or deputy.
- The patient has been consulted and made aware of the clinical management plan.
- A LTS care/management plan has been developed and agreed/shared with the patient.

19.2.4 It will be the responsibility of the RC to ensure any documentation/records are completed, and to inform the patient that LTS is to be used and reasons why.

19.2.5 The CD and Site Management will be informed that LTS has commenced by the RC or the nurse in Charge of the ward. Site Management and the CD will maintain an active ‘register’ of all patients on long term segregation.

19.2.6 The MDT will develop an initial management plan for the patient and provide a copy of the plan to the CD and the Deputy Director of Nursing (or deputies) for review and comment. **(The management plan will provide a summary of the planned treatment and care to be provided whilst being**)
managed in longer term segregation). The agreed management plan will be presented by the RC and Ward Manager/Team Leader/primary nurse (or deputies) at the next Directorate Seclusion Monitoring and Review Group (SMARG), a standing agenda item for Directorate Clinical Improvement groups.

19.2.7 For some patients who have previously been subject to LTS arrangements there may be clear clinical benefits to implementing a LTS arrangement without the need to spend 7 days in seclusion. In these cases the following process must be followed:

- The patient’s RC will seek authority from the Clinical Director (CD) to commence LTS arrangements.
- The CD will consider the case, in consultation with the Deputy Director of Nursing or Deputy.
- The CD will inform The RC of the outcome.
- If the CD agrees to the request, the RC will follow the process outlined in 19.2.3-19.2.6.

19.2.8 If the CD declines the request, the CD will inform the RC of the outcome and the patient will remain on short term seclusion management until the team review at 7 days (see 21.2.1).

19.3 Enhanced Engagement and Observation of patients in LTS

19.3.1 Individuals in LTS should be observed either:

- Within eyesight (constant enhanced engagement and observations)
  or via
- Planned, intermittent, enhanced engagement and observation every 15 minutes

NB At all times throughout the period of LTS a suitably skilled staff will be readily available within sight and sound of the LTS room.

19.3.2 The nurse undertaking the enhanced engagement and observations must record patient activity every 15 minutes.

20.0 MONITORING OF LONG TERM SEGREGATION

20.1 Seclusion Monitoring Review Group (SMARG)
The respective Clinical Team will submit an initial management plan to the first Directorate SMARG after the patient has been subject to LTS arrangements.

20.2 Each patient subject to LTS will be reviewed at a monthly Directorate SMARG (Standing agenda item for Directorate Clinical Improvement groups) chaired by the directorate clinical lead. A summary report together with evidence of scrutiny at Directorate clinical improvement groups will be presented at the bi-monthly CSU safety and safeguarding governance group chaired by the CD (or deputy). Both meetings have an open invite to representatives from the Care Quality Commission.
20.3 **Daily Reviews - Nursing**
Any patient subject to LTS will be seen (face to face) and reviewed each shift by the nurse in charge of the ward. Where it is considered safe to do so the nurse in charge should enter the patient's room to complete their review; an entry detailing the review is made in the patient's clinical record and any separate seclusion records.

20.4 **This review aims to ensure the patient’s health and wellbeing are evaluated and that the current presentation and mental state are assessed to ensure their needs are being met.**

20.5 **Medical Reviews**
All patients on LTS must be seen at least daily by a doctor, this review should be taken face to face (inside patient room). These reviews are aimed at ensuring the patients’ health and wellbeing is maintained, and that mental state assessment is continuous. These reviews, alongside the nursing reviews, will provide the Clinical team with ongoing assessment. The purpose of medical and nursing reviews is not to immediately end LTS, but to inform the Clinical Team so that the team can make any necessary decisions about discontinuation of LTS. The doctor undertaking the review will record their findings in the patients' clinical record and any separate seclusion records.

20.6 **Responsible Clinician Reviews**
Any patient subject to long term segregation will be seen by their own RC/Consultant Psychiatrist at least three times per week (over the course of a period of 7 days). The purpose of this review is to undertake a mental state examination, ensure patients’ needs are being met, and review the need for continuing LTS. These reviews are additional to the daily reviews by a doctor (see 18.4) **NB:** A senior trainee doctor (ST4-6) may deputise for the RC/Consultant Psychiatrist if the RC is on leave (or is out of the hospital for the week). Following these reviews, an entry will be made in the patients’ clinical record and any separate seclusion record by the reviewer.

20.7 **Clinical Team Reviews (MDT)**
The Clinical Team must review any patient subject to long term segregation at the weekly MDT meeting. This review must include information from the nursing and medical assessments over the preceding week. Following this review, a note of the discussion and outcome should be made in the patient’s records. It is good practice for the team to review the care plan at this meeting.

20.8 **Three Month Review**
Any longer term segregation lasting for **3 months** will trigger a full ward based review of the clinical case, led by the Multi Professional Team and includes the Clinical Director and Deputy Director of Nursing (or deputies). The Clinical Director or RC may invite another senior clinician from another team to participate as a peer reviewer. Three month reviews will continue for the duration of LTS.

20.9 **Termination Of LTS**
LTS will be terminated by the RC on behalf of the Clinical Team at any time the Team feel that LTS is no longer required. The termination of LTS will be discussed and agreed with the patient. The termination of LTS will be reported to Site Management and the CD and also reported at the next Directorate SMARG.
20.10 Performance Reporting
All LTS cases will be formally reported as part of High Secure Key Performance Indicators and to any relevant CSU Performance meetings. The monitoring of LTS, use, duration and reason is recorded and reported to Mental Illness (MI) and Personality Disorder (PD) Directorate Governance meetings.

20.11 Monitoring Of LTS Hours
The time (and activity) that each patient spends outside (and inside) the seclusion room will be logged and reported to Directorate SMARG and Hospital Safety and Safeguarding Governance meeting.

21.0 IMPLEMENTATION AND EVALUATION

21.1 As this policy has been amended a policy review will be undertaken within 24 months from implementation date.

21.2 The Clinical Director will provide an annual report based on the use of seclusion within each CSU to The Trust Patient Safety meeting.

22.0 TRAINING

22.1 It is the responsibility of managers to ensure that their staff are adequately trained to ensure that seclusion is carried out within the terms of this Trust policy and any policy based local procedures.

23.0 FRAUD STATEMENT
N/A

24.0 TARGET AUDIENCE

24.1 This procedure is relevant to all staff who provide clinical care for patients.

25.0 RELEVANT TRUST POLICIES AND PROCEDURES

- O1 - Enhanced Engagement and Observation
- H4 - High Risk patients and their Management at Broadmoor Hospital.
- V2 - Violence Reduction and Management Policy
- P11 - Protective bedding and Clothing (Broadmoor Hospital)
- D13 - Dirty protest and decontamination of equipment.
- M2 – medicines policy
- C27 - Clinical risk

26.0 REFERENCES / SOURCE DOCUMENTS

- Department of Health. HMSO
### CURRENT BNF MAXIMA OF COMMONLY USED DRUGS

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<th>Anxiolytics</th>
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<td>Zuclopenthixol acetate</td>
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<td>Time:</td>
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<table>
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<table>
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<th>Reasons why seclusion is still necessary:</th>
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<tr>
<td>Question</td>
<td>Answer</td>
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<tr>
<td>--------------------------------------------------------------------------</td>
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</tr>
<tr>
<td>Why could the patient not be managed using within arms length enhanced engagement and observation?</td>
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<td>Is patient at risk of suicide or self-harm?</td>
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<td>Is patient eating and drinking?</td>
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<td>(If no – who has been informed and what is being done).</td>
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<tr>
<td>Is patient taking medication?</td>
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<tr>
<td>(If no – who has been informed and what is being done).</td>
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<tr>
<td>When was patient last reviewed by Duty MO?</td>
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<tr>
<td>What needs to happen before seclusion can be terminated?</td>
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<tr>
<td>What is the proposed management plan for when seclusion is terminated?</td>
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Signed on behalf of Clinical Team Date:
<table>
<thead>
<tr>
<th>Review Type:</th>
<th>Multi-Disciplinary Clinical Team or Independent Review Team</th>
</tr>
</thead>
<tbody>
<tr>
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<td>(Delete as appropriate)</td>
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**Review Team Members:**

<table>
<thead>
<tr>
<th>Review Team Summary:</th>
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<table>
<thead>
<tr>
<th>Signatures and Designation:</th>
<th>Date:</th>
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APPENDIX 3
SECLUSION NURSING CARE PLAN (example)

Patients will require individual care plans that reflect their needs. This is an example of what may be considered.

<table>
<thead>
<tr>
<th>Patient’s Name:</th>
<th>Responsible Clinician:</th>
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<tbody>
<tr>
<td>Named Nurse:</td>
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<table>
<thead>
<tr>
<th>Date:</th>
<th>Commenced ..................hrs</th>
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<tbody>
<tr>
<td>Date:</td>
<td>Terminated ....................hrs</td>
</tr>
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**PRESENTING BEHAVIOUR / RISK**

........................................................................................................................................... has displayed behaviours which have placed the safety of others at risk. It has been necessary to remove him/her from the company of others and place him/her in an isolated environment.

**DE-ESCALATION TECHNIQUES**

Prior to ................................................ going into seclusion, the following interventions / strategies were used to reduce the level of risk to try and prevent this seclusion episode.

<table>
<thead>
<tr>
<th>INTERVENTION</th>
<th>FACILITATED BY</th>
<th>OUTCOME</th>
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</thead>
<tbody>
<tr>
<td>1.</td>
<td></td>
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<tr>
<td>2.</td>
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<tr>
<td>3.</td>
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</table>
OBJECTIVES

1. ……………………………will be secluded for the minimum period necessary to allow him/her to regain his/her composure sufficiently to be reintegrated into the main ward environment.

2. ……………………………’s dignity will be maintained.

3. ……………………………’s nutritional and hydration needs will be met.

4. ……………………………risk to staff and fellow patients will be minimised.

NURSING INTERVENTIONS

1. Nursing reviews will take place at 2 hourly intervals. A minimum of two staff will make an assessment of ……………………………’s mental state and level of dangerousness using the following criteria:

   a. Likelihood of further serious attack / assault without obvious trigger.
   b. Likelihood of further serious attack / assault with obvious trigger.
   c. Presence of non-verbal indicators of further intent to harm others.
   d. Presence of verbal indicators of further intent to harm others.
   e. Presence of delusional ideation appertaining to intent to harm others.
   f. Presence of high levels of over arousal, elations, irritability, dis-inhibition, anger.

   If the assessment indicates that it is too dangerous to enter the room, this will be recorded on the seclusion record information sheet (Appendix 1).

2. …………………………… will be offered beverages hourly to minimise the likelihood of dehydration.

3. …………………………… will be offered food at set meal times. Finger food will be offered if indications exist which make the issue of cutlery hazardous.

4. The temperature of the room and ventilation will be monitored and adjusted by use of the fan cooling system.

5. Bedding, clothing and opportunities for personal hygiene will be offered in accordance with the time of day and the patient’s mental state. Should strong bedding be issued, the need for its continuance will be assessed at hourly intervals.

6. Nursing staff will request that …………………………… either sits or lies on the bed prior to them entering the room.

7. Where it is necessary to prescribe and/or administer intramuscular or intravenous RT to patients in seclusion, this will be considered a medical emergency requiring the presence of a Medical Officer and Site Manager.

8. Nursing staff will maintain a regular programme of visual and verbal communication with …………………………… In order to reduce sensory deprivation.
ADDITIONAL INTERVENTION (IF REQUIRED)

SIGNED: .............................................................. DAY STAFF

SIGNED: .............................................................. NIGHT STAFF
APPENDIX 4

GUIDELINES TO ADDRESS ISSUES OF PRIVACY AND DIGNITY
FOR PATIENTS IN SECLUSION

1. Wherever possible patients should be allowed to retain clothing. Exceptions should be commensurate with individual risk. If strong clothing is required, the patient should be offered privacy in which to disrobe. If mental state or behaviour makes this difficult, members of staff of the appropriate gender must be present.

   Staff must maintain the privacy and dignity of the patient throughout any interventions that may involve the presence of a member of staff of the opposite gender to the patient.

2. Medical intervention and/or giving of parenteral/intra-muscular injections should be undertaken by staff of the same gender, but where this is not possible such staff must be in attendance, during the procedure.

3. Paper underwear should be offered and be made freely available to the patient to maintain their privacy and dignity. This should be recorded.

4. Female patients should be offered sanitary protection (as required, from a range of products, commensurate with individualised identified risk (i.e. self-harm). Risk assessment, action taken, product given/or not should be recorded in the continuous nursing record.

5. At the termination of seclusion staff should use discrete enhanced engagement and observation when watching the patient removing strong clothing to dress in own clothes. If continuous enhanced engagement and observation is implemented, privacy and dignity of the patient should be of concern.

6. Consideration needs to be given to the gender of the member of staff when observing patients in seclusion.

7. A post incident analysis should take place with the patient, discussing antecedents and reason(s) for seclusion in order to reduce/alleviate the probability of future use of seclusion. This should be discussed by the Clinical Team and recorded in the Single Healthcare Record (RiO).
APPENDIX 5

GLOSSARY

LTS    Long Term Seclusion
MDT    Multi-Disciplinary Team
DDN    Deputy Director of Nursing
CSU    Clinical Service Units
SMARG  Seclusion Monitoring and Review Group
RC     Responsible Clinician
CQC    Care Quality Commission
BNF    British National Formulary
NICE   National Institute of Clinical Excellence
BP/TPR Blood Pressure/Temperature, Pulse, Respiratory
WEMS   Women's Enhanced Medium Security
MHAC   Mental Health Act Commission
MI     Mental Illness
PD     Personality Disorder
KPI's  Key Performance Indicators
WLMHT  West London Mental Health Trust
DSPD   Dangerous Severe Personality Disorder
CTM    Clinical Team Meeting
IC     In Charge
SPR    Specialist Registrar
CD     Clinical Director
IM     Intra Muscular
MO     Medical Officer (Doctor)
RT     Rapid Tranquilisation
RiO    Records in Operation (electronic system)
APPENDIX 6

EMPLOYEE RECORD OF HAVING READ THE POLICY

Title of Procedure: SECLUSION

I have read and understand the principles contained in the named procedure.

<table>
<thead>
<tr>
<th>PRINT FULL NAME</th>
<th>SIGNATURE</th>
<th>DATE</th>
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### MONITORING

<table>
<thead>
<tr>
<th>Minimum Requirement to be Monitored</th>
<th>Where described in policy</th>
<th>WHO (which staff / team / dept)</th>
<th>HOW MONITORED (Audit / process / report / scorecard) - list details</th>
<th>HOW MANY RECORDS (No of records / % records)</th>
<th>FREQUENCY (monthly / quarterly / annual)</th>
<th>REVIEW GROUP (which meeting / committee)</th>
<th>OUTCOME OF REVIEW / ACTION TAKEN (Action plan / escalate to higher meeting)</th>
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<tr>
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<td>Section 7</td>
<td>Audit dept</td>
<td>audit / report</td>
<td>All</td>
<td>Annual</td>
<td>SMARG</td>
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<td>audit / report</td>
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<td>Annual</td>
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<td>audit / report</td>
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<td>Annual</td>
<td>SMARG</td>
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<tr>
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<td>Section 18</td>
<td>CSU</td>
<td>Report</td>
<td>All</td>
<td>Monthly</td>
<td>SMARG</td>
<td>TMT if required</td>
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<tr>
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<td>Section 19</td>
<td>Broadmoor</td>
<td>Report</td>
<td>All</td>
<td>Monthly</td>
<td>SMARG</td>
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<td>Section 19</td>
<td>Clinical Director, Broadmoor</td>
<td>MDT Reviews with senior clinicians</td>
<td>All</td>
<td>3 Monthly</td>
<td>Safety &amp; Safeguarding and Directorate SMARG</td>
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