NHS
Cheshire and Wirral Partnership
NHS Foundation Trust

Document level: Trustwide
Code: CP38
Issue number: 9.11

Seclusion and segregation policy

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Authors details	CWP Security Services Manager/Clinical & Social Education Lead

Type of document	Policy
Target audience	All inpatient staff
Document purpose	The policy sets out best practice in supporting service users who require 'supervised confinement' for a period of time. The guidance is based on best practice and guidance from the Mental Health Act Code of Practice [2015] for practices in relation to the seclusion environment, segregation and the needs of the individual for privacy, dignity, nutrition and medication. In addition, the procedures for recording and reviewing seclusion are outlined in the policy along with the appropriate recording proforma.

Approving meeting	Clinical and Practice Standards Sub Committee	Date 18/04/2019
Implementation date	08/05/2019	

CWP documents to be read in conjunction with	
GR1	Incident reporting and management policy
MP10	Violence and aggression: Pharmacological short term management (incorporating Rapid Tranquillisation)
CP6	The management of violence and aggression (incorporating verbal threat to staff and offensive weapons)
CP24	Cardiopulmonary Resuscitation (CPR) policy
CP36	The securing or locking of access doors to inpatient areas
CP19	Advance statements
CP10	Safeguarding adults policy
CP40	Safeguarding children's policy
CP25	Therapeutic observation for in-patients policy
HR14	Guidance on accessing staff support and counselling service
CP35	Physical Health policy
CP74	Intimate examinations and Chaperone Policy

Document change history	
What is different?	Wording 'Electronic patient record' changed to clinical notes throughout document. Use of Person Centered, Trauma Informed Care and co-produced wording. Seclusion & Segregation review forms removed. New Seclusion definition included. 2.1.3 Seclusion clothing wording amended. 2.1.5 Step down planning now includes person centred/coproduced wording. 2.1.7 Post incident support now includes person centred/coproduced wording. 2.1.8 Non-approved seclusion room use now includes environmental safety risk wording. 2.2.2 wording now includes Personal Evacuation Emergency Plan (PEEP) Section 6 Contact Police now includes 'Post incident support procedures'.

	2.8.1 wording added to reflect use of non-approved seclusion room
Review removedAppendices / electronic forms	Part 2 15 minute & two hourly reviews nursing removed Part 3 MDT review removed Part 5 Hourly Segregation review removed Part 6 MDT review removed Part 7 External MDT review removed
What is the impact of change?	Safer practice for all individuals

Training requirements	Yes - Training requirements for this policy are in accordance with the CWP Training Needs Analysis (TNA) with Education CWP.

Document consultation	
Clinical Services	Service Clinical leads
Corporate services	PACE
External agencies	None

Financial resource implications	No

External references
1. Mental Health Act Code of Practice 2015

Equality Impact Assessment (EIA) - Initial assessment	**Yes/No**	**Comments**
Does this document affect one group less or more favourably than another on the basis of:		
- Race	No	
- Ethnic origins (including gypsies and travellers)	No	
- Nationality	No	
- Gender	No	
- Culture	No	
- Religion or belief	No	
- Sexual orientation including lesbian, gay and bisexual people	No	
- Age	No	
- Disability - learning disabilities, physical disability, sensory impairment and mental health problems	No	
Is there any evidence that some groups are affected differently?	No	
If you have identified potential discrimination, are there any exceptions valid, legal and/or justifiable?		
N/A		
Is the impact of the document likely to be negative? - If so can the impact be avoided? - What alternatives are there to achieving the document without the impact? - Can we reduce the impact by taking different action?	No N/A N/A N/A	
Where an adverse or negative impact on equality group(s) has been identified during the initial screening process a full EIA assessment should be conducted. If you have identified a potential discriminatory impact of this procedural document, please refer it to the human resource department together with any suggestions as to the action required to avoid / reduce this impact. For advice in respect of answering the above questions, please contact the human resource department.		
Was a full impact assessment required?	No	
What is the level of impact?	Low	

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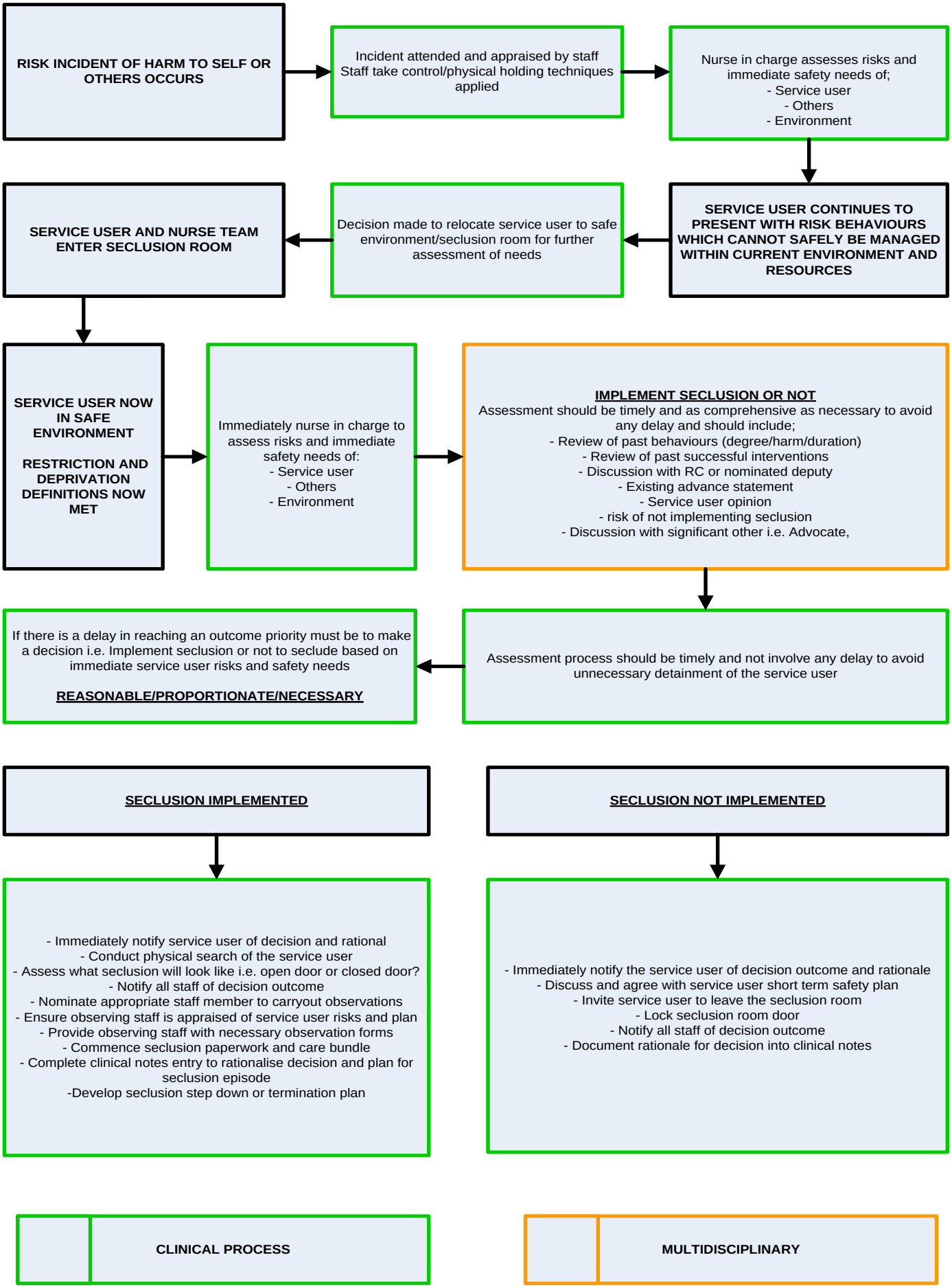
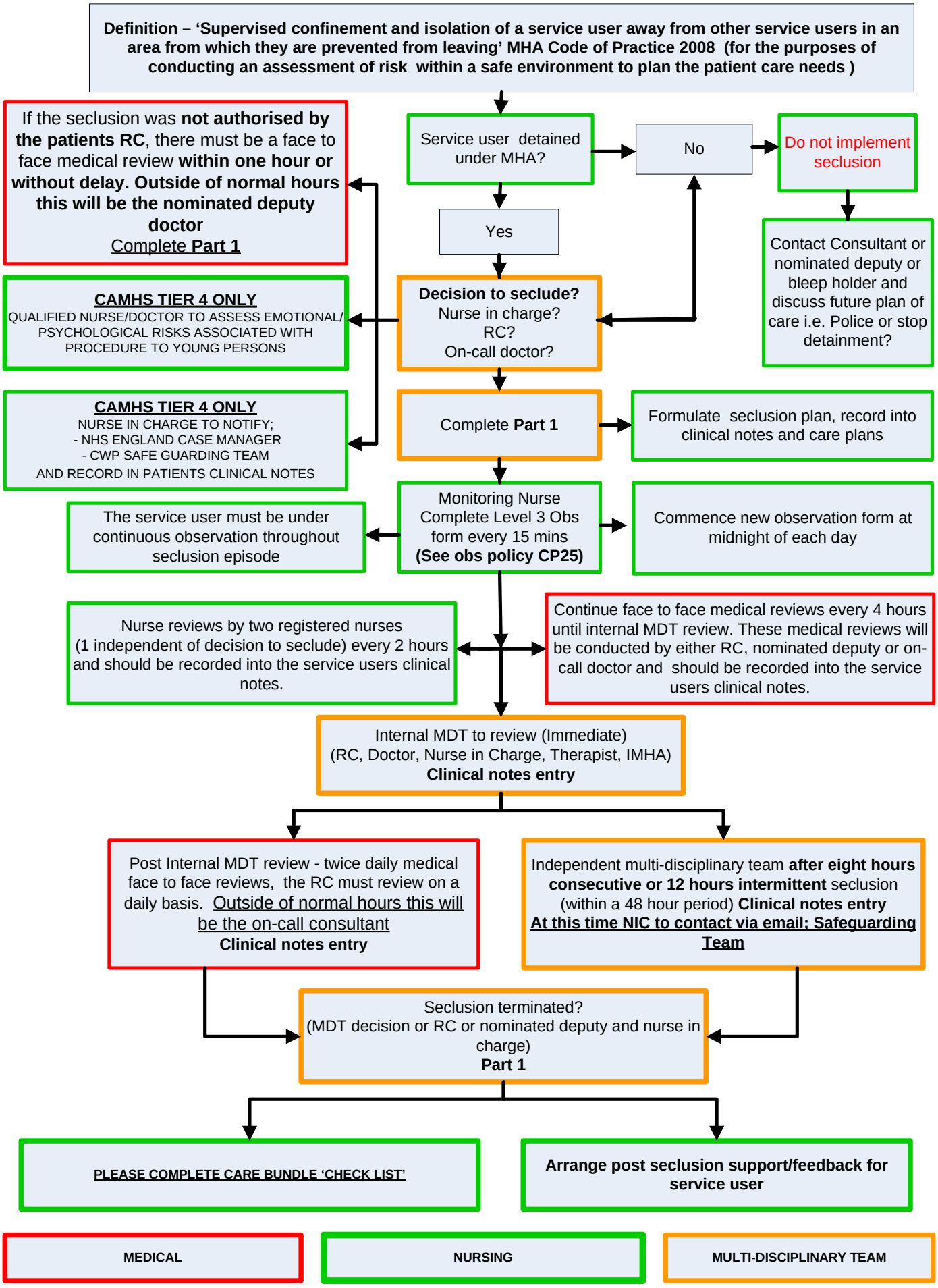
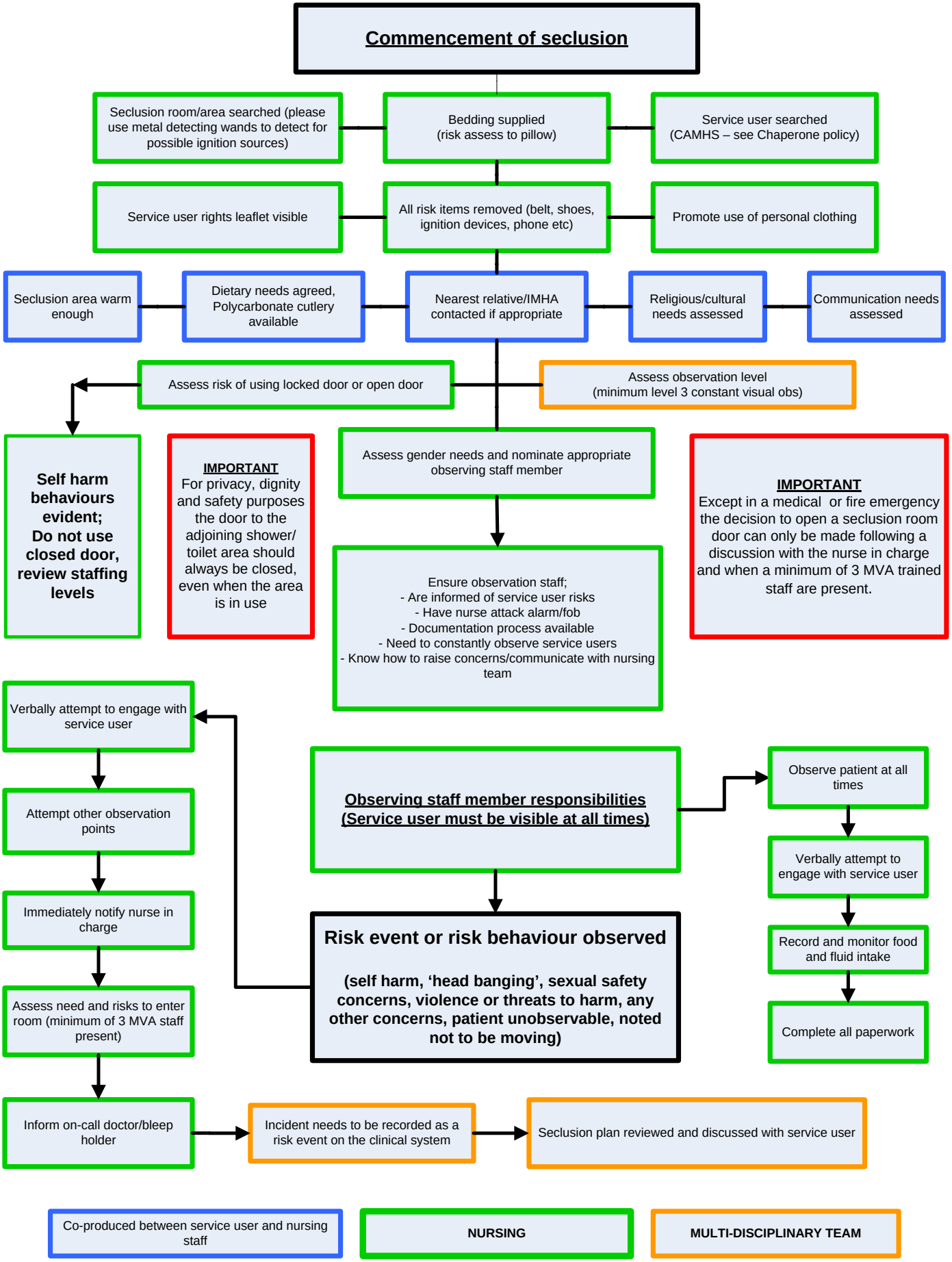
Quick reference flowchart 1 - Seclusion process 'Assessment'



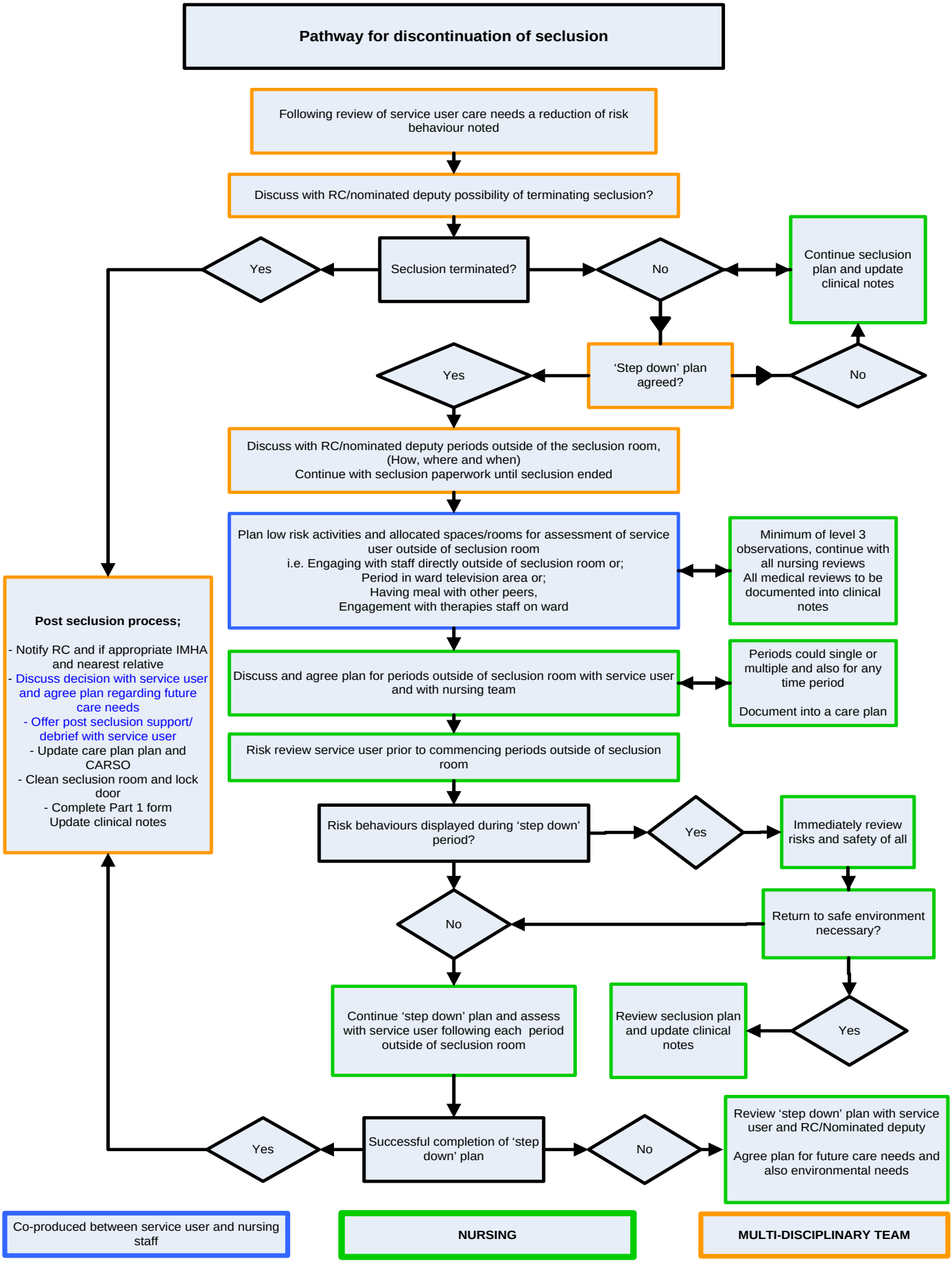
Quick reference flowchart 2 –Seclusion process for Adults and Young People



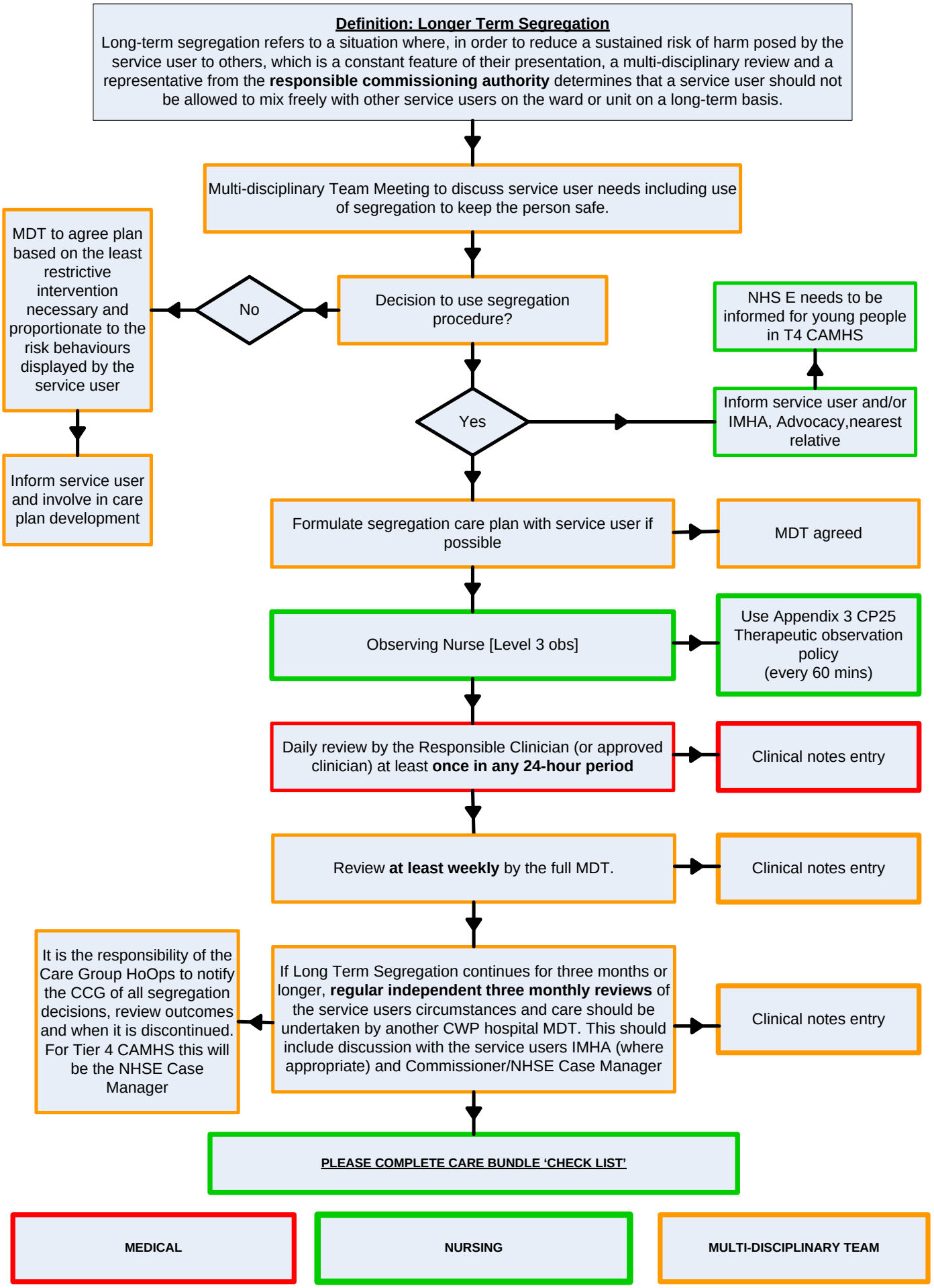
Quick reference flowchart 2(a) - Seclusion process 'Procedural'



Quick reference flowchart 3 - Discontinuation of seclusion and 'step down' process



Quick reference flowchart 4 –Segregation process



1. Introduction

A safe and therapeutic culture should be provided for all people receiving treatment for a mental disorder including those who may present with behavioural disturbance. This policy makes clear those restrictive interventions such as; enhanced observation, physical restraint, rapid tranquillisation, seclusion and long-term segregation, must only be used in a way that respects human rights and ensures these interventions are proportionate, in the best interests of the service user and use least restrictive principles. This policy provides a definition of seclusion and segregation and gives guidance on the particular needs of all vulnerable persons including Young People and people with Learning Disabilities. Where otherwise stated, this guidance also applies to all people receiving assessment and treatment for a mental disorder in a hospital and who are liable to present with behavioural disturbances.

2. Procedure for seclusion

Seclusion is intended as a short term, emergency intervention. The seclusion of a service user(s) should always be used as a last resort when all other interventions have been safely explored and clearly documented within the clinical records. The decision must reflect a balance between positive risk management including impact of other restrictive practices e.g. MVA/Rapid tranqulisation and ensuring service users and staff members are kept safe. In order to ensure that seclusion measures have a minimal impact on a patient's autonomy, seclusion should be for least time possible and considering the service user's circumstances. (see GR1 Incident and management policy)

Definition: Seclusion refers to the supervised confinement and isolation of a patient, away from other patients, in an area from which they are prevented form leaving, where is is of immediate necessity for the purpose of containment of severe behavioural disturbances which are likey to cause harm to others MHA Code of Practice (2015, DH)

2.1 What is a seclusion room?

Seclusion should **only** be used based on outcome of an assessment of risk and in rooms which are recognised as seclusion rooms within the Trust. Rooms used for the purpose of seclusion should be environments which are safe and free of any risks which could harm others. In accordance with the MHA Code of Practice [2015] seclusion should only be undertaken in a room or suite of rooms that have been specifically designed and designated for the purposes of seclusion and which serves no other function on the ward. In exceptional situations, if staff depart from the guidance in the MHA Code and use a bedroom or non-recognised environment for seclusion, the reasons and rational must be clearly recorded in the service user's clinical notes. In each case the room being used for seclusion must be made safe to use and only used for the shortest time possible (see 2.1.8).

CWP currently has eight recognised seclusion rooms / facilities, these are:

- **West** – Willow Ward (PICU), Eastway (LD A&T), Coral (CAMHS), Maple (Adult);
- **Wirral** – Brooklands (PICU);
- **East & Central** – Saddlebridge Recovery Centre, (Adult Low Secure), Alderley Unit (LD Low Secure), Greenways (LD A&T).

2.2 Risk of self-harm

Seclusion should never be used solely as a means of managing self-harming behaviour. Where the patient poses a risk of self-harm as well as harm to others, seclusion should be used only when in the first instance the nurse in charge and Responsible Clinician [or nominated deputy] involved are satisfied that the need to protect other people outweighs any increased risk to the service user's health or safety arising from their own self-harm.

2.3 What is the process of assessment for seclusion? (see quick reference chart 1)

The transfer of a service user to a designated seclusion room must only be done as a last resort/necessary, in the best interest of the service user and for the shortest time possible.

Seclusion **must not** be used:

- As a threat or as a punitive measure;
- As part of a treatment programme;
- Where there is any risk of suicide or self-harm (see Quick reference chart 2(a));
- Because of staff shortages;
- As a first resort.

2.4 How do we document seclusion reviews? (see quick reference chart 2)

For 15 minute staff observation record see CP25 Therapeutic Observation policy - Therapeutic observation record for individual patients (Levels 3 and 4).

2.5 What is the seclusion procedural process? (see quick reference chart 2a)

2.6 What is a seclusion plan?

A seclusion care plan should be developed as soon as the decision to seclude has been made. The plan should set out how the individual care needs of the patient will be met whilst the service user is in seclusion and record the steps that should be taken in order to bring the need for seclusion to an end as quickly as possible. Wherever possible, the service user should be supported to contribute to the seclusion care plan and the steps needed to be taken to ensure that the seclusion comes to an end. if a service user lacks capacity an IMHA should be contacted to provide support. Service User should also be offered an advocate.

As a minimum the seclusion care plan should include:

- A statement of clinical needs (including any physical or mental health problems), risks and treatment objectives;
- A plan as to how needs are to be met, how de-escalation attempts will continue and how risks will be managed;
- Details of bedding and clothing to be provided;
- Details as to how the patient's dietary needs are to be provided for and;
- Details of any family or carer contact/communication which will maintained during the period of seclusion;
- A co-produced person centered 'Step down' plan to include assessment of known trigger behaviours prior to seclusion termination;
- The care plan must be communicated to the service user.

2.7 Advance statements

Service users may set out their wishes about how they want to be cared for in situations where seclusion is used, and can do so by preparing an advance statement, as described in the (see CP19 Advance statements policy).

2.8 What are seclusion reviews? (see quick reference chart 2 and 2a)

Reviews must take place and be documented in the clinical record titled "review of seclusion". These reviews are intended to support by helping to identify any care needs or safety issues. The independent reviews are to ensure that the service user is well cared for and appropriate measures are in place for their continued safety, that steps are being taken to bring the seclusion to an end as quickly as possible. During the review process the service user should be encouraged to raise any personal issues or complaints and these must be directed to the appropriate care team staff for action.

Where it is safe to do so all reviews should be conducted through an open door. Where it is deemed un-safe reviews should be conducted via the observation window and method of review recorded into the service users clinical notes.

2.9 Any dispute or disagreement in the decision to seclude

If there is disagreement in the decision to seclude, the matter must be referred to the Modern Matron and Responsible Clinician for arbitration (where there is dispute with the Consultant's decision, the Clinical Director must be involved); out of hours the bleep holder/senior nurse must contact the on call Consultant.

2.1.0 Service user's expectation whilst in seclusion (see appendix 3)

Service user's expectations whilst in seclusion must be clearly visible and discussed by the observing nurse (and where applicable IMHA). Staff should ensure the Service user can understand the information. The use of a marker board visible from the seclusion room can help support understanding where there may be communication difficulties.

2.1.1 Rapid Tranquillisation

Refer to MP10 Violence and aggression: Pharmacological short term management (incorporating Rapid Tranquillisation) for detail on any medicines to be administered and the monitoring of the administration of such medicines. Further detail is also available within CP35 Physical Health policy and SOP3 Physical observations assessment and the management of altered levels of consciousness.

2.1.2 Privacy & dignity (see CP12 Search policy)

Every effort must be made to maintain service user's privacy and dignity at all times. Safety is also paramount and actions must be taken to ensure that any use of seclusion can be safely provided. Prior to seclusion being implemented a search of the service user must be undertaken by the appropriate gender staff or chaperone.

- Service users should be supported to understand that they may retain as much of their own personal clothing in line with personal safety. Shoes, boots *(and laces),* belts, ties, dressing gown cords and jewellery (plain wedding bands not included), watches which may present dangers maybe removed following an assessment of risk;
- At no time must a service user be deprived of **personal clothing** except where this can be supported via an assessment of risk i.e. risk of ligature. In these circumstances appropriate clothing must be provided by nursing staff and observation levels reviewed by the nurse in charge;
- Appropriate bedding must be supplied, this includes the use of anti-ligature bedding where agreed with the Care Team;
- **Normal diets and fluids** must be provided at appropriate times;
- Access to toilet and shower facilities must be provided with closed door following assessment of risk;
- Access to cultural and religious items must be facilitated following assessment of risk and where applicable discussion with IMHA or other religious lead.

2.1.3 Reinforced clothing and bedding (only where applicable)

The decision to use specialised clothing must only occur in exceptional circumstances, not as a matter of routine and should be authorised by the service users responsible clinician or on-call consultant. Where it is known that a service user is at risk of damaging their clothing and/or bed linen, specialist 'tear proof' clothing and bed linen may be obtained to maintain the services user's safety and dignity. An MDT should undertake an individualised risk assessment before this decision is taken. During out of hours this should be a discussion between the nurse in charge and the Medical Staff on-call.

- Tear-proof clothing should never be a first-line response to such risks and should never be used as a substitute for enhanced levels of support and observation;
- The requirement to wear tear-proof clothing should never be a blanket rule within a service;

- Any tear-proof clothing should fit the service user so as to preserve their dignity. It should not be demeaning or stigmatising, and should, where possible, meet any specific cultural or religious requirements;
- Any requirement that a service user should wear tear-proof clothing should be proportionate to the assessed risk and documented evidence should show that it is used only as long as absolutely necessary;
- As soon as the risk is assessed to have diminished, the service user should be encouraged to wear own clothes.

2.1.4 Visits by friends / family/IMHA or other professionals

The promotion of usual contact with family and friends should be accommodated wherever this is possible. All planned visits to a patient who is in seclusion must be carefully balanced, using clinical judgment and reasoning, alongside the need to safeguard the patient and others.

2.1.5 Periods out of seclusion room (see quick reference chart 3)

A seclusion plan (including 'step down' arrangements) must be formulated to terminate the use of seclusion as soon as practicable. The seclusion plan should be co-produced and person centered with the service user and Care Team. Where this is not possible then the plan should be shared with the service user as soon as possible and or nearest relative/IMHA. Short periods outside the seclusion room can be used to assess a service users(s) mental state and risk in a supportive and safe manner. This may include family visiting times. The service user(s) can be restricted to specific ward areas before allowing access to all areas of the ward. These periods can vary in duration, based on risk and must be incorporated into the care plan. The service user will be on a minimum of level 3 observation during these periods. Seclusion paperwork must be continued during the step down process.

2.1.6 Decision taken to end seclusion period (see quick reference chart 3)

2.1.7 Post seclusion support

A trauma informed care approach should be adopted for all service users who have been involved in an episode of seclusion. Post incident support and feedback throughout the period of seclusion should be an integral part of the agreed support processes. The post incident support should form part of the co-produced 'step down' plan. A reflective review of the seclusion, involving the service user, where appropriate nearest relative/IMHA, should be arranged by the NIC and / or MDT to allow the service user and staff members an opportunity to discuss how care can be changed. The outcome of the review should be recorded into the service users clinical notes and discussed with ward team to mitigate future seclusion episodes through co-produced care planning.

Any member of staff who requests support post incident can access CWP Guidance on accessing staff support and counselling service. Post seclusion reviews must document the following:

- Assess any adverse effects of seclusion;
- Explain why it was necessary to implement seclusion;
- Seek the service user's views *(particularly in terms of possible alternatives to seclusion);*
- Jointly consider future alternative means by which the service users may be supported positively when distressed/demonstrates behaviour that challenges;
- Record into the electronic patient record any comments or complaints that the service users wishes to make;
- Manage constructively/support how an individual will be supported integration back into the ward environment;
- Consider impact on other inpatients and how this may be minimised.

2.1.8 Using non approved areas for seclusion

The use of a non-approved room to confine a service user within must only be taken as an emergency measure, be reasonable and proportionate to the harm it is intended to prevent, for the minimum time necessary and supported by implementation of the seclusion policy.

- The decision to utilise a non-approved room for temporary seclusion must be agreed with the MDT and must only be undertaken whilst awaiting transfer of the individual to a more suitable environment with approved seclusion facilities e.g. PICU.
- In order to identify the most appropriate environment for facilitating temporary seclusion a risk assessment of the environment and the individual's needs must be undertaken. Consideration should include:
    - The proximity of the individual to the identified space to facilitate temporary seclusion at the time of the incident
    - The fixtures and fittings within the environment including type of bed and door locking mechanism.
    - The ability to safely remove furniture and personal possessions from the identified environment
    - The ability to maintain constant observation of the individual at all times for the duration of seclusion. This will require having a clear line of sight and will inform the decision regarding whether the door to the room being utilised for seclusion can be locked.
    - The ability to facilitate safe access to toilet facilities.
- In line with a trauma informed approach the use of an individual's bedroom as a seclusion space should only be undertaken where no other room is deemed appropriate.
- The use of enhanced observation levels (minimum level 3) and increased staffing levels must be part of the measures used to maintain the safety of all concerned.
- Referral to a more secure environment e.g. PICU should be undertaken as soon as the decision is taken to implement seclusion
- Where a vehicle is required to transfer the individual to a more appropriate environment follow the Designated Secure Vehicle protocol in the GR35 Transport Policy
- Any incident of seclusion outside of a designated seclusion room must be recorded as a Grade B Restrictive Practice incident on Datix and an ISAR completed to identify any areas of learning and reflection followed by a debrief for the patient and staff.

2.1.9 Service user transfer using stairs and lifts

If following the outcome of a risk assessment it is decided that transfer to a safer environment would be in the service users best interest and involves traversing a flight of stairs, either going up or down, this must only be attempted where there are minimal risks which can be safely managed without level 3 physical restraint and that this has been agreed with the senior nurse on duty.

2.2.0 Pregnant service users

Special provision should be made for pregnant women in the event that interventions for the short-term management of disturbed / violent behaviour are needed refer to CP6 The management of violence and aggression policy and MP10 Rapid tranquillisation policy for further advice.

2.2.1 Aids to communication and nutrition

All service users should be a) provided with a normal diets and fluids b) allowed to have a choice of diets and fluids. A record of all diets and fluids intake should be recorded on CWP Fluid balance chart. Polycarbonate utensils should be used when facilitating meal times and when affording any fluids. Plastic or paper should not be used unless supported following a risk assessment and then any restriction imposed must be clearly recorded by the care team in the service user's clinical record and communicated to ward team (including handover).

Aids to communication are vital and should not be removed or withheld unless absolutely necessary to protect the service user. Following a risk assessment, spectacles, hearing aids, false teeth or other items can be retained by a service user.

2.2.2 Responding to a /fire within the seclusion suite

Firstly it is imperative that CWP fire procedures are not compromised in any way. If the fire is within the seclusion suite whilst occupied it will be necessary to remove the patient as soon as possible. This should be achieved by using safe procedures and Personal Evacuation Emergency Plan (PEEP) where appropriate and also by assessing all risks whilst prioritising the patient's safety. The fire should be extinguished if safe to do so or the fire door to the room closed.

3. Procedure for use of longer term segregation (Refer to quick reference chart 4)

Long-term segregation refers to a situation where, in order to reduce a sustained risk of harm and support care the person may require longer supervised geographical restriction. A multi-disciplinary review (and a representative from the responsible commissioning authority*) determines that a service user should not be allowed to mix freely with other service users on the ward or unit on a long-term basis.

* The Care Group Head of Operations (HoOps) are responsible for notifying and liaising with the Clinical Commissioning Group Representative on all matters relating to segregation i.e. implementation, reviews and discontinuation. For Tier 4 CAMHS the Care Group HoOps will need to notify NHS England Case Manager.

The following issues must be considered and documented:-

- The risk of harm to self or others would not be ameliorated by a short period of seclusion combined with any other form of treatment;
- The clinical judgement were if the patient were allowed to mix freely in the general ward environment, other service users or staff would be exposed to a high likelihood of serious harm;
- the views of the person's family and carers should be elicited and taken into account. The multi-disciplinary review must include an IMHA and/or Advocate.

3.1 Environment

It is permissible to manage this small number of service users by ensuring that their contact with the general ward population is limited. The environment should be no more restrictive than is necessary. This means it should be as homely and personalised as risk considerations allow. Facilities which are used to accommodate service users in conditions of long-term segregation should be configured to allow the service user to access a number of areas including;

- bathroom facilities;
- a bedroom;
- relaxing lounge area;
- secure outdoor areas;
- a range activities of interest and relevance to the person.

3.2 What is a segregation treatment/care plan?

The use of longer-term segregation **must be** care planned and person centered based on the strengths, needs and aspirations of the individual service user. Treatment/care plans must be developed between the named nurse and service user (or with nearest relative/IMHA/advocate) with the overall aim to end long-term segregation. These plans must not include periods which would meet the definition of seclusion.

Segregation reviews (see CP25 Therapeutic Observation policy)

- Hourly nursing entries must be conducted and recorded onto the Thereapeutic Observation record form appendix 3;
- All segregation plans must be reviewed as a minimum weekly by the MDT and/or following any change in the clinical risk status and documented into the service users clinical notes;
- The RC or Approved Clinician should review the service users and segregation plan on a daily basis. At weekends these reviews can be conducted by a phone call from the on-call Consultant and the outcome documented into the service users clinical notes by the nurse in charge;
- If the segregation period exceeds 3 months there must be an external MDT review documented into the service users clinical notes.

The service user's co-produced, person centered treatment/care plan should clearly state;

- steps taken which reflect a trauma informed care principles;
- the reasons why long-term segregation is required;
- how the plan will be reviewed and communicated with them;
- 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;
- how the segregation can be terminated;
- provision for periods of activities, supervision and periodic multidisciplinary reviews;
- where appropriate when the treatment/care plan has been discussed and shared with the nearest family / carers, IMHA or Advocate.

4. Children and young people (see quick reference flow chart 1 & 2)

The Mental Health Act 1983 and MHA Code set no age limit on the use of seclusion and segregation. The Code is applicable to people of all ages including children and young people. All restrictive practices can be a traumatic experience for any individual but can have particularly adverse implications for the emotional development of a child or young person. The key principles of trauma informed care of should be integral in any decision to seclude and/or segregate a child or young person.

The wellbeing and safety of the child or young person must be a priority and all actions taken to safeguard the individual concerned. CWP does have approved seclusion rooms within CAMHS.

If a decision is made to implement seclusion or it is believed the definition of seclusion has been met within a CAMHS ward, the Consultant/Responsible Clinician (or nominated deputy) and Modern Matron must be consulted immediately and involved in the decision process. Out of hours the on call consultant and Tier 2 manager **must** be notified.

If there are indications that the use of restrictive interventions (particularly physical restraint or seclusion) might become necessary, consideration should be given to whether formal detention under the Act is appropriate. All incidents and action arising following any incident must be fully documented in the electronic patient record. For each new episode of seclusion, at the earliest opportunity the Care Group HoOps or equivalent must notify the NHS England Case Manager.

4.1 Parental consent

A person with parental responsibility can consent to the use of restrictive interventions where a child lacks competence but only if the decision falls within the 'scope of parental responsibility'. Chapter 19 of the Code of Practice advises against using parental consent to authorise the treatment of a child under 16 who is competent to make the decision but who is refusing, this includes seclusion;

- Decisions about seclusion and longer term segregation would usually fall outside the zone of parental control;
- A decision to seclude a child under 16 who is being treated with parental authority or a young person aged 16 or 17 who is informal should be an indicator to assess the child or young person for detention under the MHA;
- If children or young persons under the age of 16 years are secluded staff **must** contact the Safeguarding team for advice and support.

Parents or carers should be informed about decisions to seclude children or young people at the earliest opportunity. Any physical restraint must be in accordance with Trust management of violence and aggression policy and in line with the local *Guidance on Physical Restraint of Young People at the Young People's Centre*. All incidents of restraint must be recorded on the Trust Datix system.

5. Gender, ethnic and cultural diversity (see Intimate examnation and Chaperone policy)

Seclusion or longer-term segregation process can restrict a service user's exposure to normal life and the ability to engage in usual everyday social, recreational, vocational and spiritual activities. Consideration must be given to involving service users in their normal routine at the earliest opportunity and of ensuring that individual cultural and spiritual needs are identified and met throughout the restrictive intervention episode.

- Gender, cultural and ethnic factors must be considered in decision making.
- Dignity and privacy must be included in plans to search any service user;
- Same gender persons (wherever possible) must undertake the observations of a patient where dignity is an issue. If a request is made to have same gender staff present this must be accommodated where possible;
- All cultural requests must be accommodated where safely possible;
- Communication must be optimised. Translators should be used if required, as family should not be routinely asked to act as translators.

6. Contacting the Police

Emergencies - CWP staff have a duty to maintain safe environments and to safeguard the wellbeing of vulnerable people. When a situation arises where it is believed that safety is compromised and control is lost, staff must contact the police. If a situation arises which involves significant threats to others or imminent threat of use of a weapon staff must contact the police immediately. Staff must dial **(9)999**, giving exact location and state that an emergency response is required. Post incident support procedures must be implemented following any Police intervention and fully documented into the service users clinical notes.

Appendix 1 - Care bundle for use of seclusion

To be completed by nurse in charge or equivalent as soon as possible once seclusion has commenced and review by modern matron (accessed via electronic patient records risks/alert)

Initiation of seclusion	**Yes**	**No**
Documentation of reason for use of seclusion and proposed outcomes in clinical notes?		
Responsible Clinician or nominated deputy informed?		
Service user informed of reason for seclusion and documented?		
Information i.e. rights explained and service user given information about access to advocate and documented?		
Family/carers/IMCA/IMHA informed of use of seclusion and documented?		
Medical review within 1 hour if medical staff not involved with initial decision?		
Review of existing risk assessment and care plan?		
Senior nurse review of seclusion?		
Care bundle checklist copied and inserted into service users electronic patient record?		
Search to ensure patient and environment are safe?		
Where the items the service took into the seclusion documented?		
If appropriate IMHA/Nearest relative informed?		
*__Tier 4 CAMHS patients only__ For each new episode of seclusion, at the earliest opportunity the nurse in charge to notify the NHS England Case Manager?		

Monitoring of seclusion	**Yes**	**No**
Nursing reviews recorded in clinical notes every 15 minutes?		
Review by ward nurse and independent nurse every 2 hours?		
Medical review every 4 hours? (RC or nominated deputy once daily)		
Twice daily face to face Medical/RC review?		

Monitoring of seclusion	**Yes**	**No**
Nursing reviews recorded in clinical notes every 15 minutes?		
Review by ward nurse and independent nurse every 2 hours?		
Internal MDT review arranged?		
Internal MDT review carried out?		
Daily MDT reviews carried out [to include Internal MDT review]?		

Independent MDT review	**Yes**	**No**
Independent multidisciplinary team review arranged [if secluded for 8 hrs continuously or intermittently for 12hours in a 48hr period]?		
CWP Safeguarding Team and Clinical Education Lead notified via email [if secluded for 8 hrs continuously or intermittently for 12hours in a 48hr period]??		
Independent multidisciplinary review arranged?		
Independent multidisciplinary review carried out?		

Post seclusion review	**Yes**	**No**
Record of discontinuation of seclusion in clinical notes?		
Datix form completed?		
Reflective review by NIC or MDT arranged (service user included)		
If appropriate IMHA/Nearest relative invited to attend?		
Service user experience/feedback of seclusion recorded in clinical notes?		
Effective ongoing management/behavioural support plan in place?		

Appendix 2 - Care bundle for use of segregation

To be completed by ward manager or equivalent as soon as segregation period has commenced and checked by modern matron.

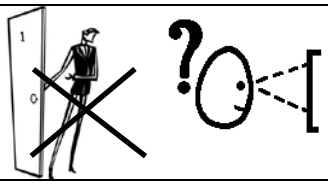
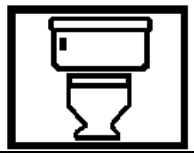
Initiation of longer term segregation	Yes	No
Record of multi-disciplinary decision to use segregation as part of behavioural management plan in clinical notes. Names of staff present recorded?		
Has a person centered treatment plan been developed that aims to end long term segregation?		
Has a treatment plan been agreed by the MDT that aims to end the long term segregation?		
Documentation of reason for use of segregation and proposed outcomes in clinical notes?		
Representative from the commissioning (CCG) authority notified?		
Has the local safeguarding team must be made aware of the service user being supported in longer term segregation.		
For Tier 4 CAMHS has the NHS E been informed?		
Review of existing risk assessment and care plan?		
Review period by RC agreed and documented?		
Notification to responsible Commissioning Group representative?		
Service user informed of reason for segregation and documented?		
Senior nurse review of segregation?		
Family/carers/IMCA/IMHA informed of use of segregation and documented?		
Information re- rights explained and service user given information about access to advocate and documented?		
Care bundle checklist copied and inserted into service users clinical notes?		
Review of environment to ensure patient is safe?		
Any items removed have been recorded into clinical notes?		

Review of use of segregation	Yes	No
Nurse review of use of segregation as part of Care plan daily and documented in clinical notes?		
Daily medical review? (At weekend this can be via phone call discussion with Responsible Clinician by nurse in charge). Outcome recorded into clinical notes?		
Weekly review of segregation care plan and behavioural care plan undertaken by MDT and documented in clinical notes?		
Outcome of weekly review discussed with service user and documented?		
Feedback from service user recorded in clinical notes?		
Family/carer/IMHA invited to attend MDT?		
Outcome of weekly review discussed with family/carer/IMCA/IMHA and documented ?		
Feedback from family recorded in clinical notes?		
Following weekly review has Responsible Commissioning Authority notified?		

Review of segregation after 3 months	Yes	No
Independent external review of care plan, including use of segregation?		
Independent external review outcome documented in clinical notes?		
Independent external review outcome discussed with service user?		
Independent external review outcome discussed with family/carer/IMHA?		
Responsible Commissioning Authority notified?		

Post segregation review	Yes	No
Record discontinuation of segregation in clinical notes?		
Service user experience/feedback of segregation recorded in clinical notes?		
Effective ongoing management/behavioural support plan in place?		
Responsible Commissioning Authority notified?		

Appendix 3 - CWP Service user expectation chart

1.	At times the Seclusion Room may be locked. You will be kept safe; there will be a nurse outside at all times and staff will explain to you why you need to be in seclusion.	
2.	We will make your environment as safe and comfortable as possible. We may be able to provide music or books etc.	
3.	You will be offered food and drink on a regular basis. If you would like any special diets please ask the supervision staff.	
4.	You will be able to use your own clothing however for your safety certain items may be removed and kept safely on the ward and returned to you when safe to do so.	 
5.	Bathroom & shower facilities are available you whilst you are in seclusion.	
6.	You may ask to speak to the Nurse in Charge at any time via the supervising staff.	
7.	There is a clock outside the room, which is clearly visible. If you are unable to tell or are not sure of the time, day and date ask the supervision staff and they will tell you.	
8.	With your help a care plan will be developed which will detail how we can keep you safe and supported. This plan will also detail how we can end this seclusion episode and how you will be supported to return to the main flat / ward area.	 
9.	You have the right to send and make appropriate calls and messages, if you would like someone to help with this please speak to the nurse in charge.	 
10.	Please speak with Doctors, Nurses and other professionals who may visit you. They are trying to end seclusion for you as soon as possible	
11.	If you want to speak to a patient advocate please ask the nurse in charge.	
12.	If you are not happy about how you are looked after you have a right to complain and will be given help to do so if you need it.	

Appendix 4 - Part 1 Seclusion review chart

Service user name		Chart No		Day No	
Service user NHS No.		Person initiating seclusion			
Ward		Date			

Commencement of seclusion						
Date			Time			
Enter below the name, date and time the following personnel were informed of seclusion						
RC / Duty Doctor name		Date		Nurse in Charge	Date	
		Time			Time	

Termination of seclusion					
Date		Time			
Enter below the name, date and time the following personnel were informed of seclusion					
RC / Duty Doctor	Date		Nurse in Charge	Date	
	Time			Time	

Please indicate the reasons for initiating / continuing seclusion* (Summary details – full details to be in service users clinical notes) (*please delete)		
Please indicate when the need for seclusion is disputed by any member of the Multi-Disciplinary Team	Yes	No
Modern Matron or Bleep Holder / RC informed at what time		
Outcome		

Datix incident No:			Care plan development	Yes	No	Nearest relative, carer notified?	Yes	No
Related complaint	Yes*	No	Access to en-suite facility	Yes	No	IMHA notified?	Yes	No
						Care Co-ordinator Informed?	Yes	No
*If **YES**, Datix Number:			Service user 'expectation chart' displayed / explained?			Yes	No	

Internal Multi-Disciplinary review	Notified		MDT	Notified	
Responsible Clinician	Yes	No	IMHA	Yes	No
Senior OT	Yes	No	Duty doctor	Yes	No
Modern Matron/bleep holder	Yes	No	CCO	Yes	No

Appendix 5 - Part 2 - Longer Term Segregation

Service user name			
Service user NHS No.		Responsible Clinician:	
Ward:		Date:	

Commencement of Longer Term Segregation					
Date			Time		
Enter below the name, date and time the following personnel were informed of seclusion					
RC / Duty Doctor	Date		Senior Manager / Clinical Lead	Date	
	Time			Time	
Representative of Clinical Commissioning Group	Date		IMHA/Nearest relative	Date	
	Time			Time	

Termination of Longer Term Segregation					
Date			Time		
Enter below the name, date and time the following personnel were informed of termination of **Longer Term Segregation**					
RC / Duty Doctor	Date		Senior Manager / Clinical Lead	Date	
	Time			Time	
Representative of Clinical Commissioning Group	Date		IMHA/Nearest relative	Date	
	Time			Time	

Please indicate the reasons for initiating / continuing Longer Term Segregation* (Summary details – full details to be in service users clinical notes) (*please delete)		
Please indicate when the need for Longer Term Segregation is disputed by any member of the Multi-Disciplinary Team	**Yes**	**No**
If disputed were Modern Matron or Senior Manager / RC informed at what time?		
Outcome of Modern Matron or Senior Manager / RC review:		

Appendix 6 - Definitions

a) **Approved Clinician** - is a healthcare professional who is competent to become responsible for the treatment of mentally disordered people compulsorily detained under the Mental Health Act and approved by the Secretary of State or a person or body exercising the function of the Secretary of State. A clinician must complete special training and demonstrate competence in their professional portfolio in order to be approved as an AC. Within CWP the term Approved Clinician refers to the medical lead or Responsible Clinician for each service user unless another healthcare professional has been appointed who meets the required criteria under Secretary of State guidance.

b) **'External Hospital'** – this refers to another CWP inpatient hospital for the independent review of a service users care and treatment by mental health professionals/managers. This independent review should include a doctor who is an approved clinician, senior nurse and other mental health professionals and also discussion with the service users IMHA and service commissioner.

c) **Internal Multi-disciplinary Team** – During normal working hours will include the responsible clinician, a doctor who is an approved clinician, or an approved clinician who is not a doctor but who has appropriate expertise, the senior nurse on the ward, IMHA and staff from other disciplines who would normally be involved in patient reviews. At weekends and overnight, membership of the initial MDT review may be limited to medical and nursing staff, in which case the on-call bleep holder must also be involved.

d) **Independent Multidisciplinary Team** - As a minimum should include a doctor who is an approved clinician, or an approved clinician who is not a doctor i.e. Modern Matron/bleep holder, a nurse and other professionals who were not involved in the incident which led to the seclusion and an IMHA (in cases where the patient has one).

e) **Long-term segregation** - refers to *'a situation where, in order to reduce a sustained risk of harm posed by the service user to others, which is a constant feature of their presentation, a multi-disciplinary review and a representative from the responsible commissioning authority determines that a service user should not be allowed to mix freely with other service users on the ward or unit on a long-term basis'.*

f) **Physical restraint -** refers to *'any direct physical contact where the intention is to prevent, restrict, or subdue movement of the body (or part of the body) of another person'. Section of the Mental Capacity Act [2005] 6[4] of the Act states that someone is using restraint if they; use force – or threaten to use force – to make someone do something that they are resisting, or to restrict a person's freedom of movement, whether they are resisting or not'*

g) **Seclusion -** refers to the supervised confinement and isolation of a patient, away from other patients, in an area from which they are prevented form leaving, where is is of immediate necessity for the purpose of containment of severe behavioural disturbances which are likey to cause harm to others MHA Code of Practice (2015, DH)