1.0 INTRODUCTION / PURPOSE OF POLICY

1.1 Background

Seclusion is an emergency intervention.

Seclusion should only be used for acute, severe behavioural disturbance that is likely to cause harm to others and where all other interventions have failed.

Seclusion should not be used to manage self harm.

Seclusion should lead to a review of the patient's legal status if required.

Seclusion should only occur in a designated seclusion room.

Seclusion should NEVER be used as a threat or a punishment.

Seclusion should not be included in a treatment plan, seclusion is not a treatment

Staff must always use the least restrictive alternative and that seclusion should be used as a last resort and for the shortest possible time and be in the best interest of the patient.

The use of seclusion should be subject to regular review.

Caution should be exercised in using seclusion for those with physical health conditions.

1.2 Purpose

The purpose of this policy is to provide staff working within Adult Learning Disability services within BHSCT with clear directives in the use of seclusion.

BHSCT is one of three trusts within NI providing inpatient Learning Disability services. It is the only Trust to have a commissioned regional remit for such provision. This provision is provided onsite at Muckamore Abbey Hospital.

It is recognised that different areas of the trust use different terminology when it comes to patients/service users.

For the purpose of this policy the term 'patient' has been used for no other reason than that is the term used within the Mental Health (Northern Ireland) Order 1986 and throughout the associated Code of Practice.

All staff who may have occasion to use seclusion must receive Seclusion Awareness Training and Human Rights Training as part of their induction and ongoing training, this will will include appropriate monitoring arrangements for

patients placed in seclusion and awareness of the legal framework that authorises seclusion.

This training will be provided by the Ward Manager and supported by the Site Nursing Development Lead (NDL).

1.3 Objectives

To ensure the physical, psychological and emotional safety and wellbeing of patients

To ensure that restrictive practices remain proportionate, least restrictive, last for no more than necessary and take account of patient preference whenever possible (NICE NG 10, 2015)

To ensure that inpatient areas have robust and transparent governance processes that support, monitor, advise and report on the use of restrictive practice of seclusion.

To ensure that patients receive the necessary care and support before, during and after seclusion

To designate a suitable environment that takes account of patients' dignity and physical and psychological safety and wellbeing

To set out roles and responsibilities of staff

To ensure processes are followed for monitoring, recording and reviewing the use of seclusion and that learning is identified and shared.

To promote person centred practices by working in partnership with the patient and their carer (as appropriate) to review available options to minimise the potential for harm

To minimise the frequency and duration of seclusion and prevent any inappropriate use of seclusion with an aim to support the Trust commitment to reduce restrictive interventions.

2.0 SCOPE OF THE POLICY

This policy applies to all staff working with adults within Adult Learning Disability Inpatient Services within the BHSCT. It is the responsibility of all staff within Inpatient Learning Disability services to follow the policy.

3.0 ROLES AND RESPONSIBILITIES

3.1 Trust Board

The trust board is responsible for ensuring that a policy is in place that governs the safe and appropriate use of seclusion via its governance arrangements and that all staff working in the trust are aware of, and operate within the policy.

3.2 Medical Director

The Medical Director is responsible for ensuring that all medical staff are aware of, and operate within the policy and procedure for the use of seclusion.

3.3 Director of Nursing

The Executive Director of Nursing is responsible for ensuring mechanisms are put in place to ensure nursing professionals within the services are aware of and comply with the requirements of the policy and procedure for the use of seclusion.

3.4 Hospital Management Team is responsible for disseminating the policy and ensuring that all staff work to achieve policy standards. They are responsible for ensuring review of data with regards to seclusion and ensuring change is actioned as required.

3.5 Ward management teams/ heads of service/ ward managers are responsible for disseminating policy to their staff and ensuring that staff are trained in its use. They are responsible for monitoring use of seclusion and completing reports as requested. In conjunction with the hospital management team they are responsible for reviewing data with regards to seclusion and effecting change as required.

3.6 Nurse in Charge of the Ward

The nurse in charge of the ward is responsible for managing any incident of seclusion in accordance with this policy and procedure.

3.7 All staff

All inpatient LD staff within the Trust with front-line care to patients have a responsibility to provide care in accordance with this policy and procedure.

4.0 CONSULTATION

Consultation for this policy involved:

- All managers within Learning Disability
- Carer representatives
- TILI Group and Patients with capacity
- Bryson Advocate Service
- Colleagues from other Trusts
- Royal College of Psychiatry
- DLS

5.0 POLICY STATEMENT/IMPLEMENTATION

5.1 Definitions

5.1.1 Seclusion

The Code of Practice relevant to the Mental Health (Northern Ireland) Order 1986 defines seclusion as:

" the forcible denial of the company of other people by constraint within a closed environment. The patient is usually confined alone in a room, the door of which cannot be open from the inside and from which there is no means of exit open to the patient."

This situation would also arise where the door is not locked from outside but the patient has no reasonable means of exit, due to, for example, the height of the door handles, the weight of the door or the person's physical, sensory, neurodiverse or learning disability.

The Code of Practice also states that:

"Seclusion is an emergency management procedure for the short term control of patients whose behaviour is seriously disturbed and should be used as a last resort, after all other reasonable steps to control the behaviour have been taken. The sole aim in using seclusion is to contain severely disturbed behaviour that is likely to cause harm to others. It should never be used where there is a risk that the patient may take his own life".

Seclusion should only be used in a hospital setting and in relation to patients' detained under the Mental Health Order. If an emergency situation arises involving a voluntary patient and, as a last resort seclusion is necessary to prevent harm to others, then an assessment under the Mental Health (NI) Order 1986 should be considered. Form 6 (nursing holding power) or Form 5 (Doctor's holding power) can be used as a holding power until an assessment is carried out by a GP and ASW or next of Kin under the Mental Health Order (NI) 1986.

NICE Guidelines (2015) require staff to consider rapid tranquilisation or seclusion as an alternative to prolonged manual restraint (ie longer than 10 minutes).

It is important that the Human Rights of all patients be upheld and that they are considered at every stage of the decision making and monitoring of seclusion –that the use of seclusion is legal, justifiable, least restrictive and proportionate. Article 2 the right to life, Article 3 the right to be free from inhuman or degrading treatment, Article 5 the right to liberty and security and Article 14 the right to be free from discrimination must be considered and documented and that the impact of seclusion in this context is understood and considered by staff. All patients should be treated with dignity and respect and equality and diversity issues should be maintained.

5.1.2 Voluntary confinement

The overarching principle for voluntary confinement is that the patient has the ability to have their confinement or isolation ended at a time of their choosing. Thus, the patient must have the ability to communicate their desire to do so, either verbally or non-verbally. It is this distinction that separates voluntary confinement from the definition of seclusion, which is "the supervised confinement and isolation of a patient, away from other patients, in an area from which the patient is prevented from leaving"

5.1.3 Long term segregation

Long term segregation is a situation where a patient is prevented from mixing freely with other patients in the ward.

This form of restrictive intervention should rarely be used and only ever for hospital patients who present an almost continuous risk of serious harm to others. It will be agreed by the multidisciplinary team that they benefit from a period of intensive care and support in a discrete area that minimises their contact with other patients.

The use of long term segregation must be supported by a person-centred, value based approach to care, in which personal relationships, continuity of care and a positive approach to promoting health underpin the therapeutic relationship.

The use of Long term segregation will be agreed through a Multi-disciplinary Team approach with input and agreement sought from family and Carers.

5.2 Key Policy Statement(s)

5.2.1 Safeguarding is everybody's business

All Belfast Health & Social Care Trust employees have a statutory duty to safeguard and promote the welfare of children and vulnerable adults, including:

- being alert to the possibility of child/vulnerable adult abuse and neglect through their observation of abuse, or by professional judgement made as a result of information gathered about the child/vulnerable adult;
- knowing how to deal with a disclosure or allegation of child/adult abuse;
- undertaking training as appropriate for their role and keeping themselves updated;
- being aware of and following the local policies and procedures they need to follow if they have a child/vulnerable adult concern;
- ensuring appropriate advice and support is accessed either from managers,or the trust's safeguarding team;
- participating in multi-agency working to safeguard the child or vulnerable adult (if appropriate to your role);
- ensuring contemporaneous records are kept at all times and record keeping is in strict adherence to Belfast Health & Social Care Trust policy and procedures and professional guidelines. Roles, responsibilities and accountabilities, will differ depending on the post you hold within the organisation;
- ensuring that all staff and their managers discuss and record any safeguarding issues that arise at each supervision session.

5.2.2 Equality and Human Rights: Everyone's Responsibility

Belfast Trust is committed to delivering safe, high quality and compassionate services. Employees are expected to deliver services and behave in a manner that is compatible with this commitment. Belfast Trust expects all employees to treat people with dignity and respect whether service users, visitors or colleagues.

Belfast Trust is committed to carrying out its functions in line with the core principles and values that underline human rights legislation namely Freedom, Respect, Equality, Dignity and Autonomy (FREDA). Staff should use FREDA principles to red flag any behaviour that is not compatible with the Trust ethos of delivering safe, quality and compassionate care or which violates our equality and human rights statutory commitments

In such circumstances, the least restrictive option will always be carefully considered. A Human Rights based approach will be explicitly evident in all decision making such that

1. Where possible the process of risk assessment and management will involve people with a learning disability and/or their carers.

2. Risk assessment and management processes will utilise positive risk-taking strategies, where appropriate to ensure that risks are not overstated nor overly risk-averse.

3. The processes will ensure shared, multi-professional collaboration and accountability within a supportive organisational structure.

4. Consistent and standardised processes will be promoted.

5. Robust documentation will exist including evidence of a human rights based approach.

All employees will make every effort to ensure that human rights are protected, that respect for human rights, is part of day to day work and that human rights are an integral part of all actions and decision making. The Trust will keep human rights considerations, relevant legislation and previous judicial reviews at the core of decision making

The decision to use seclusion will be robustly documented with explicit reference to human rights and with particular reference to issues relating to proportionality, necessity and the legitimacy of the aim which deprivation of liberty (seclusion) causes

In addition to anti-discrimination legislation Belfast Health & Social Care Trust employees have a duty to deliver services in a manner that meets our statutory equality, human rights and good relations duties. These duties include:

- Section 75 of the NI Act 1998:
  - Promotion of Equality of Opportunity in relation to the nine equality categories.
  - Promotion of Good Relations between persons of different religious belief; political opinion; and racial group.

- Section 49A of the Disability Discrimination Act 1995:
  - Promotion of positive attitudes towards disabled persons,
  - Encouraging the participation by disabled persons in public life.

- Duty to respect, protect and fulfil rights outlined in the Human Rights Act 1998 including:
  - Article 2 - the right to life
  - Article 3 - the right not to be tortured or inhumanly or degradingly treated or punished
  - Article 5 - the right to liberty and security of the person
  - Article 8 - the right to respect for one's private and family life, correspondence and home

- United Nations (UN) International Covenant on Economic, Social and Cultural Rights (ICESCR) [UK ratification 1976] which includes the right to the highest attainable standard of health.

- The Trust is committed to upholding the principles of the UN Convention on the Rights of Persons with Disability (UNCRPD) which seeks to promote, protect and ensure full and equal enjoyment of all human rights and fundamental freedoms by all persons with disabilities and to promote respect for their inherent dignity.

5.3 Policy Principles

Trust staff will focus primarily on providing a positive and therapeutic culture, which aims at preventing behavioural disturbances through positive behavioural support, early recognition and de-escalation.

Discussion should be had with Next of Kin and the patient (if they have capacity) on admission regarding possible need for seclusion and they should be kept informed of its usage and be involved, where appropriate, in discussions with the patient. Inclusive communication and information in alternative formats will be available so that every effort is made to communicate effectively with patients with varying levels of capacity and cognisance.

De-escalation will be the first response and seclusion will always be a last resort once all alternative strategies have been exhausted. The use of seclusion must be safe, reasonable and justifiable. Its use must only be in order to preserve safety and to reduce any risk to others.

Staff need to be aware of the potentially harmful psychological consequences of seclusion, notably:

- Feelings of increased despair and isolation
- Feelings of anger and confusion
- Worsening of mental health symptoms including delusions and hallucinations
- Fear and trauma
- Worsening/heightening anxiety.

It is essential that patients receive the necessary care and support both during and after seclusion. At the earliest possible safe moment following the cessation of seclusion, and taking into account capacity and communication issues, the patient should be given the opportunity to discuss the incident with the most appropriate member of their clinical team. The aim of this discussion is to understand and discuss the patient's perceptions of what happened and why and consider future strategies in the event of a similar situation. The role of Next of Kin in this feedback should be discussed at admission.

Staff must also be involved in reflecting about the incident in order to learn from the patient and event and understand how the environment and antecedents may have contributed towards the incident. This feedback should inform patient care plans, Positive Behaviour Support Plans and wider service quality improvement work.

Seclusion must be used:

- As a last resort only for the management of acute behavioural disturbance
- For the shortest possible time
- In a room specifically designated as a seclusion room
- Be subject to continuous review.

Seclusion must not be used:

- As a punishment or threat
- As part of a treatment programme (although it may feature in a patient's PBS or Care plan)
- Because of staff shortages or lack of staff training
- As a method of controlling self -harming behaviour. Where the patient poses a risk of self harm as well as harm to others, seclusion must only be used when the professionals involved are satisfied that the need to protect others outweighs any increased risk to the patient's health or safety and that any such risk can be properly managed.
- Solely to protect property.

Seclusion must be recorded on the seclusion record (**Appendix A**)

5.3.1 Where to seclude

Seclusion should only take place in a room or suite of rooms that have been specifically designed and designated for the purposes of seclusion and which serve no other function on the ward.

These rooms are characterised as:

- Providing privacy from other patients
- Enabling staff to maintain observation at all times
- Safe and secure
- Povide access to toilet and refreshement access when required
- Not containing any item that could cause harm to patient or others
- Adequately furnished, heated, lit and ventilated
- Allowing for communication with patient when they are in the room and door is locked eg via intercom, visability through glass for non-verbal patients.

In exceptional circumstances and for cogent clinical reasons it may be considered more therapeutic and less restrictive to manage a patient requiring isolation from peers and/or staff in their own bedroom. Such occasions should be rare and should only be considered if the multi-disciplinary team believe there are cogent clinical reasons for doing so, there is no safe alternative and that any risks presented by the physical environment such as items that can be broken or cause harm or injury can be safely managed. Assessment of these risks should be kept under regular review. The decision to use a patient's bedroom for the purpose of seclusion or other isolation should be

based on a sound clinical rationale and not due to a lack of suitable designated seclusion facilities.

If seclusion takes place outside of designated seclusion rooms or a room not agreed in the patients care plan Eg: their bedroom or a shared communal area to prevent immediate risk of harm to the patient or others, this should be investigated and reviewed under an SEA methodology.

5.3.2 Voluntary Confinement

On occasion patients may request to be voluntarily confined to either their own room or a designated seclusion room as a means of self regulating and managing their own risks to others. Such occasions will be rare, but on those occasions where the patient requests such confinement, there needs to be robust monitoring and governance arrangements to ensure appropriate safeguards are in place. These should be the same as occurs for seclusion.

Patients must have capacity to agree to voluntary confinement.

When patients are deemed to have capacity, and are considered able to make decisions for themselves, an expressed wish to be confined in either their own room or seclusion room may not be considered seclusion as long as the following criteria has been met:

- There is a care plan previously agreed that has been collaboratively formulated and discussed with the patient, their family or carers and agreed by the multidisciplinary team.
- That the patient retains a means of summoning the attention of staff at all times
- That the patient retains the right to have the confinement curtailed at a time of their choosing.
- That the nurse in charge of the ward is satisfied that the conditions of confinement/environment do not present undue risk to the patient or others.

The overarching principle for voluntary confinement is that the patient has the ability to have their confinement or isolation ended at a time of their choosing. Thus the patient must have the ability to communicate their desire to do so, either verbally or non-verbally. It is this distinction that separates voluntary confinement from the definition of seclusion, which is "the supervised confinement and isolation of a patient, away from other patients, in an area from which the patient is prevented from leaving"

All instances of patients enacting voluntary confinement will be recorded in the patient's healthcare record and reported alongside the seclusion data as voluntary confinement.

To ensure the physical and psychological wellbeing of patients utilising voluntary confinement, the same observation and review requirements should be followed as for seclusion.

Should a patient voluntarily confined as part of a crisis intervention plan **not** have their confinement curtailed on request for **any** reason then this amounts to seclusion and will be managed and reported as such.

5.3.3 Decision to Seclude (Appendix B flowchart)

The decision to take a patient to seclusion should be made by the secluding nurse, who will always be a registered nurse.

The nurse in charge of the ward will contact the Consultant Psychiatrist for authorisation.

Following a decision to seclude the following people should be informed, within 30 minutes of initiating seclusion or as soon as is practical:

- Consultant Psychiatrist on call or patient's Responsible Clinician (in hours)
- The duty doctor (this can be trainee psychiatrist on-call, unless indicated otherwise by discussion with consultant, for example in the situation of serial seclusion episodes).
- Senior Manager on call with site responsibility
- Family and/or carer as agreed in care plan.

This may be by telephone and will include:

- The reason for seclusion
- A discussion that all strategies have been exhausted prior to seclusion starting
- A clear plan discussed as to how seclusion might be terminated.

The person making the decision to seclude should have seen the patient immediately prior to the commencement of seclusion.

There will be clear documentation regarding all other interventions tried prior to considering seclusion in the seclusion record. Staff should be familiar with PBS plans, recommended communications strategies, sensory needs and care plans in order to ensure seclusion is a last resort.

Seclusion should only be used in a hospital setting and in relation to patients detained under the Mental Health Order. If an emergency situation arises involving a voluntary patient and, as a last resort seclusion is necessary to prevent harm to others, then an assessment under the Mental Health (NI) Order 1986 should be considered. Form 6 (nursing holding power) or Form 5 (Doctor's holding power) can be used as a holding power until an assessment is carried out by a GP and ASW or next of Kin under the Mental Health Order (NI) 1986.

As far as possible, and taking into account their communication needs and any PBS plans (if relevant), patients who are being placed in seclusion should be informed of the reason that seclusion is necessary and how it might end.

This information will be made available in easyread/talking mats or other means of inclusive communication and shared with the patient on admission.

Where the decision to seclude was taken by someone other than a consultant psychiatrist on the ward, a first medical review (by duty Doctor) should be undertaken within one hour of beginning seclusion, unless indicated otherwise by discussion with consultant, for example in the situation of serial seclusion episodes. If the patient is new to the service or there are concerns regarding their physical presentation then a medical review must be undertaken without delay.

If decision to seclude is made by the consultant psychiatrist, having first seen the patient, the first medical review will be the review they took immediately before authorising seclusion. A medical review within the hour will then not be necessary in this instance. This is unlikely however as the decision to seclude often in practice is made by the nurse in charge of the ward.

Where seclusion is so short that the doctor does not visit before seclusion is ended then this must be recorded on the seclusion record. The doctor should still see the patient.

Following a decision to seclude the following people should be informed, within 30 minutes of initiating seclusion or as soon as is practical:

- Consultant Psychiatrist on call or patient's Responsible Clinician (in hours)
- The duty doctor (this can be trainee psychiatrist on-call).
- Senior Manager on call with site responsibility
- Family and/or carer as agreed in care plan.

On decision to seclude, a Seclusion Record should be commenced (Appendix A).

5.3.4 Needs and Risk Assessment

All decisions around seclusion will be clearly documented. This will include documentation of human rights considerations in the restrictive practice record.

Once the decision to seclude has been taken an assessment of the patients' needs and presenting risks should be undertaken by a registered nurse.

A visual check should be carried out to reduce availability of objects that could be used as a weapon eg shoes, belts, keys.

If staff feel that a physical search is necessary the patient's clothes may need to be searched. This should be undertaken by same gender staff if possible or at least one member of staff of the same gender must be present. Staff should refer to "Procedure for search of Patients, their belongings and the environment of care within AMH and LD inpatient facilities."

The patient should always be clothed, with the exception of belts, dressing gown cords, shoes or other items that could be used to cause self-harm, or harm to others. Where possible patients should wear their personal clothing and retain personal items if this does not compromise their safety or that of others. When appropriate disposable seclusion gowns will be available. Staff should at all times be mindful of treating the person with dignity and respect.

Where indicated and as soon as is practicable post seclusion, the patients vital signs will be recorded.

5.3.5 Medication

There is no expectation that additional medication will be given whilst a patient is in seclusion. However, where the administration of additional medication is required then oral medication should be offered before parenteral (IM) medication.

If additional oral or parenteral (IM) medication has been administered within approximately 30 minutes prior to seclusion it must be brought to the attention of the attending doctor and senior nurse attending and the details recorded clearly.

If the patient is detained under the Mental Health (Northern Ireland) Order 1986, any prescribed medication must be administered within the legal framework of that Act and in line with the BHSC Trust 'Policy and procedure for the use of rapid tranquillisation'

The nurse observer for the patient requiring seclusion must be made aware of what medication has been given, dosage and timing.

If a patient in seclusion has received medication or received emergency parenteral (IM) medication before or during seclusion then observations should be carried out in accordance with the Trust 'Policy and procedure for the use of rapid tranquillisation' and include:

- The monitoring of the patient's blood pressure, temperature, pulse, respiration, degree of movement and response to verbal or tactile simulation
- Attempts, whether successful or not, to measure the patient's vital signs must be recorded on a BP/TPR chart and in the patient's healthcare record
- A pulse Oximeter should be available
- Nursing staff should report any concerns about physical parameters immediately to the doctor on call. In the case of a medical emergency, the NIAS emergency services should be called without delay.

If a patient has been sedated then they should be monitored 'within eyesight' observation by a named registrant, until such time as a medical review indicates otherwise.

If it has been assessed as the risk being too high for staff to enter the

seclusion room, then visual observations can be used to assess patients physical state, these should be recorded. Physical observtions must commence as soon as it is safe and practical to do so.

5.3.6 Ongoing Monitoring/Observations

The aim of observation is to safeguard the patient, monitor their condition and behaviour and identify the earliest opportunity at which seclusion can be safely terminated.

A registrant nurse will be identified as an named Observing Nurse and will be within sight and sound of the patient at all times during the seclusion episode. The room should offer complete observation from the outside whilst also offering the patient privacy from others.

A seclusion record will be commenced on decision to seclude (Appendix A). A record of entries of observations will be documented on the seclusion record at least every 15 minutes. The registered nurse observing will make an entry on the seclusion form indicating the patient's condition, physical behaviour and verbal indicators if significant, for example, threats/demonstrations of insight into incident, their mood.

The Nurse in Charge should ensure that staff do not carry out constant observations for periods over 1 hour. After an hour there should be hand over to another named registrant nurse. Records must be contemporaneous.

The Observing nurse should have the ability to quickly raise the alarm for additional support via the use of a personal alarm.

It is always good practice to consider the gender of the nurse carrying out the ongoing observations, particularly if the patient has a known trauma history.

Staff who carry out observations should:

- Engage positively with patient
- Be appropriately briefed about the patient's history, background, risk factors and needs
- Be familiar with patients care plan and PBS plan and any communication or sensory needs
- Be familiar with ward, ward policy for emergency procedures and potential environmental risks
- Be able to decease/increase the level of engagement based on their judgement of the patient's individual needs and presentation.

Staff must respond immediately to any display of self-injurious behaviour that compromises patient safety.

The patient will be offered drinks, food and toilet facilities as required for their comfort. This should be noted in seclusion record.

5.3.7 Review of seclusion

Nursing review

A member of the nursing team should be available outside the seclusion room at all times during the seclusion.

A registered nurse will observe and review the patient at 15 minute intervals

Seclusion should be reviewed hourly by the Nurse in charge of the ward. Decisions and rationales should be noted on Seclusion record.

Review will be taken every 2 hours from point of seclusion by 2 registrant nurses (1 of whom was not involved in decision to seclude). Variations to this should be noted on Seclusion Record.

At any point during the 15 minute observations, if the Nurse Observer feels there is observational evidence to review seclusion this should be highlighted to the nurse in charge and facilitated as quickly as possible.

A joint review should be conducted by a consultant psychiatrist and registered nurse every 4 hours until the first MDT review has taken place.

If seclusion continues for more than 8 hours consecutively or 12 hours intermittently over a period of 48 hours, an independent MDT review will be completed by a doctor/ nurses and other professionals who were not involved in the decision to seclude or in the prior incident

Medical Review

If decision to seclude is made by the consultant psychiatrist, having first seen the patient on the ward, a seclusion review will be undertaken by a doctor within the first hour of seclusion commencing, or without delay if the patient is newly admitted, not well known, or if there is a significant change in their usual presentation

After this a joint review should be conducted by a consultant psychiatrist and registered nurse every 4 hours until the first MDT review has taken place

Following MDT Review medical reviews should occur at least twice daily in every 24 hour period. At least one review should be carried out by the patient's Responsible Clinician.

The trust has determined that all medical doctors, irrespective of grade, or level of registration will be considered competent to undertake medical reviews on the provision that they meet the following criteria:

- Have read this policy
- Have access to senior medical (consultant) advice at all times
- Have access to senior nursing advice at all times

- Have received training on Human Rights and Restrictive Practices.

Medical reviews should include:

- Review of patients physical and psychiatric health
- Assessment of adverse effects of medication
- Review of observations required
- Re-assessment of medication prescribed
- Assessment of risk posed by patient to others
- Assessment of risk to patient from deliberate or accidental self -harm
- Assessment of need for continuing seclusion and whether it is possible for seclusion measures to be applied more flexibly or in a less restrictive measure.
- Potential for discussion with RMO.

Night Reviews

Reviews and observations continue at night as per daytime

Sleeping patients

Wherever possible consideration should be given to end seclusion prior to the patient falling asleep.

If the patient falls asleep the seclusion episode will end and the door is unlocked. Taking account the individual needs and ability of each individual, if the patient has fallen asleep, before there has been adequate opportunity to talk about and explore with him/her the events leading up to seclusion, it must be assumed that the matter has not been adequately resolved, and it should be discussed with the patient at a suitable moment following return to usual environment.

Observations must continue as per seclusion guidelines, in particular to assess patient's presentation on awakening.

If a patient is asleep:

- the door should be opened and suitable bedding provided
- or the patient asked if they want to go to their own bedroom and seclusion will be terminated.

If the patient is awake, the doctor must attend the ward to conduct the 4 hourly review alongside the registered nurse.

Where a patient appears to be sleeping, a clinical judgement needs to be made on whether it is appropriate to wake them for a medical review. In such instances the doctor's attendance for the medical review may be replaced by a telephone review with the nurse in charge of the ward. The Trust recognises the value in allowing patients periods of uninterrupted sleep and the

potentially disturbing nature of reviews during the night. In such cases a medical review will be prioritised the next morning.

The decision to hold a telephone review needs to be agreed jointly by the doctor and nurse in charge of the ward and may only be agreed on an individual basis subject to the patient being asleep at the time the review is due. In the absence of a positive decision to have a telephone review, the default position will be that the doctor attends for the medical review.

When there are specific concerns around the physical health of the patient, the default position of the doctor attending for medical reviews should continue during the night. If the patient is asleep these reviews should be carried out in such a way that the doctor can satisfy themselves that the patient is safe and that any concerns for physical health and wellbeing can be addressed safely.

When the patient is asleep, the two hour nursing reviews should be carried out in such a way that the registered nurse can satisfy themselves that the patient is safe and there are signs of life.

It is not practical to undertake an MDT Review (senior doctor, nurses and other professionals) during night hours. This will be conducted as soon as practical.

Upon wakening, the patients' mental state must be assessed to allow an appropriate Care Plan to be identified, and/or a review of nursing supervision.

Multi-disciplinary Team Reviews

Internal Multi-disciplinary Team Reivews

The Internal Multi-Disciplinary Team should review the patient as soon as is practicable. This should be within 24 hours of seclusion commencing.

Membership of this Internal MDT will include a Responsible Clinician, the senior nurse on the ward, and staff from other disciplines normally involved in the patient's care. A Psychologist or Behaviour Therapist should be part of the review.

At weekends or public holidays the internal MDT Review should happen on the first day of return to normal working.

These reviews should evaluate and make recommendations, as appropriate, for amendments to the care plan and/or Behaviour Support Plan

The outcome of internal MDT reviews should be recorded in the patient's healthcare record.

Independent Multi-disciplinary team Reviews

If the period of seclusion continues for longer than 8hrs consecutively or 12hrs intermittently during a 48hr period then an independent MDT review should be undertaken.

This review should be undertaken by end of next working day after commencement of seclusion.

Membership of this independent MDT will include a Responsible Clinician, a senior nurse, other professionals not involved in the decision to seclude. A Psychologist or Behaviour Therapist should be part of the review.

It is good practice for this team to consult with staff involved in the decision to authorise seclusion and have access to the seclusion record.

These reviews should evaluate and make recommendations, as appropriate, for amendments to the care plan and/or Behaviour Support Plan.

The outcome of the independent MDT reviews should be recorded in the patient's record.

5.3.8 Termination of Seclusion

The patient should remain in seclusion only as long as absolutely necessary. The initial rationale with regards to "The sole aim in using seclusion is to contain severely disturbed behaviour that is likely to cause harm to others" should remain the criteria whereby the situation is assessed.
Seclusion should be terminated immediately when it is determined that it is no longer warranted. It can be ended by:

- The nurse in charge of the ward followed by consultation with the patient's Responsible Clinician or Consultant Psychiatrist on call (either in person or by telephone)
- Following an internal or independent multi-disciplinary review
- Following a Consultant medical review
- The patient falling asleep and being asked to be escorted to their room.

The door should only be opened when there is an adequate team present as deemed appropriate by the Nurse in Charge.

Opening a door for short periods does not constitute an end to seclusion but it may appropriately prompt a review of the need for its continued use.

An observation of the patient's physical, mental and psychological state, with the patient's consent, will be completed by nursing staff and any concerns referred immediately to the duty doctor or doctor on call for examination, if felt to be necessary.

The seclusion record will be completed.

Details of seclusion will be recorded in day/night report and discussed at handover periods such as safety briefs and daily report outs.

Following all episodes of seclusion there should be a post-incident review/de-brief to ensure analysis of the clinical detail, organizational learning and support for all parties involved, including patients. This should take place at relevant meetings.

Any patient who has been secluded should be supported after the event to help him or her understand why the seclusion took place. The patient will be given opportunity to discuss the events leading to the seclusion episode. The details of the discussion will be recorded in the patient's Care Plan or PBS Plan, which will be updated if required. It may be appropriate to involve Next of Kin in these discussions and this should be discussed with Next of Kin at admission.

5.3.9 Involvement of Next of Kin

Involvement of next of kin is dependent on patient's expressed wishes for next of kin involvement and capacity to consent to this sharing of information
If a patient has capacity and consents then:

Seclusion should be discussed with all next of kin on admission and their wishes regarding when they wish to be informed documented

When a patient is secluded for first time Next of Kin should be informed. This should be done in a timely but considerate manner taking into account time of day/night and their wishes as noted in the patient's care plan.

Any subsequent notification of further episodes should be agreed with the patient/Next of Kin and the agreement recorded in the patient's record, this should include the option to be involved in any post seclusion review.

If the patient has capacity and indicates they do not want the NOK informed, this will be recorded in the patient' care plan and noted in the seclusion plan

5.4 Dissemination

This policy will be disseminated by email, ward meetings and a copy available on the ward to all staff working with adults within Learning Disability Inpatient Services within the BHSCT. It will also from part of the induction process for all new staff.

5.5 Resources

All staff will be trained on use of seclusion and Human Rights and Restrictive Practices. Usage will be monitoring through data gathering and auditing of records

5.6 Exceptions

This policy refers to adult learning disability inpatient services only.

6.0 MONITORING AND REVIEW

LD services will have a robust seclusion monitoring process in order to ensure that their governance arrangements "enable them to demonstrate that they have taken all reasonable steps to prevent the misuse and misapplication of restrictive interventions", including use of seclusion.

The monitoring process will include a monthly audit on the compliance of the use of the policy with a report to be given to the co-director and discussed at hospital management meetings.

The levels of Seclusion will be reported in a weekly Safety Brief which will be provided to the Board of Directors. Feedback from patients, families, carers and advocates will be used to review and monitor use of the policy.

This process will be overseen by the hospital management team

The role of this group will be to:

- Monitor the adherence of seclusion to the Code of Practice and any departures from such
- Receive and analyse data relating to, monitor and report overall trends in the use of seclusion
- Monitor and report on other areas of restrictive practice as determined appropriate by each clinical division
- Review documentation for and information about the use of seclusion and alternative management strategies via multidisciplinary team feedback
- Review use of seclusion for each patient including where there is prolonged or multiple episodes of seclusion with the teams .
- Consider any staff training and education issues and make relevant recommendations
- Monitor the use of seclusion for areas of section 75
- Share and disseminate good practice
- To report 6-monthly to the wider LD service Governance Group.

Instances of seclusion should be reviewed for each individual patient, new use of seclusion, abnormal levels of seclusion, seclusion being used multiple times in course of weeks or a few months, or seclusion lasting for greater than 48 hours, or any general change in trends at individual patient level should be escalated to the hospital management team for review. This will occur at the live governance meetings.

The ward multidisciplinary team will discuss the use of seclusion through regular reports and reviews at safety briefings, daily report outs, live

governance meetings and monthly clinical improvement groups and provide information to the hospital management team.

Weekly statistical data on the use of seclusion is provided to the hospital management team.

Regular reports will be produced on the use of seclusion and presented to the Trust Board.

The policy will be reviewed on a five yearly basis.

7.0 EVIDENCE BASE / REFERENCES

Good Practice in Consent for Treatment or Examination: Implementation Guide for Health Care Professionals, DHSSPS, 2007

BPS/ Royal College "Challenging Behaviours: a unified approach"

Consent for Examination, Treatment or Care www.dhsspsni.gov.uk;

RCN guidelines on restrictive practice

NMC Guidelines for Records and Record Keeping

Code of Professional Conduct: standards for conduct, performance and ethics (NMC) www.nmc-uk.org

'Guidance on the Use of Restrictive Physical Interventions' (Department of Health, July 2002);

'BILD Mental Health Procedure Implementation Guide. Developing POSITIVE Practice to support the safe and Therapeutic Management of Aggression and Violence in Mental Health In-patient Settings. National Institute for Mental Health in England. 2004;

Violence -The short-term management of disturbed/violent behaviour in in-patient psychiatric settings and emergency departments. National Institute of Clinical Excellence. 2005 CG25.

Guidance for Restrictive Practices. How to provide safe services for people with Learning Disabilities and Autistic Spectrum Disorders. Dept of Health, 2002

Safeguarding Vulnerable Adults

The Mental Health (NI) Order 1986 and its associated Code of Practice

Good Practice in Consent: Implementation Guide for Health Care Professionals

Positive and Proactive Care: reducing the need for restrictive interventions, Social Care, Local Government and Care Partnership Directorate April 2014

Minimum standards for seclusion practice at St Charles 2018

8.0 APPENDICES

Appendix A: Seclusion Record
Appendix B: Flowchart: Deciding to seclude
Appendix C: Flowchart: Review in Seclusion

9.0 NURSING AND MIDWIFERY STUDENTS

Nursing and/or Midwifery students on pre-registration education programmes, approved under relevant 2018/2019 NMC education standards, must be given the opportunity to have experience of and become proficient in the **Policy and Procedure for Use of Seclusion in Adult Learning Disability Inpatient Services** where required by the student's programme. This experience must be under the appropriate supervision of a registered nurse, registered midwife or registered health and social care professional who is adequately experienced in this skill and who will be accountable for determining the required level of direct or indirect supervision and responsible for signing/countersigning documentation.

Direct and indirect supervision

- Direct supervision means that the supervising registered nurse, registered midwife or registered health and social care professional is actually present and works alongside the student when they are undertaking a delegated role or activity.
- Indirect supervision occurs when the registered nurse, registered midwife or registered health and social care professional does not directly observe the student undertaking a delegated role or activity. (NIPEC, 2020)

This policy has been developed in accordance with the above statement.

Wording within this section must not be removed.

10.0 EQUALITY IMPACT ASSESSMENT

The Trust has legal responsibilities in terms of equality (Section 75 of the Northern Ireland Act 1998), disability discrimination and human rights to undertake a screening exercise to ascertain if the policy has potential impact and if it must be subject to a full impact assessment. The process is the

responsibility of the Policy Author. The template to be complete by the Policy Author and guidance are available on the Trust Intranet or via this **link**.

All policies (apart from those regionally adopted) must complete the template and submit with a copy of the policy to the Equality & Planning Team via the generic email address equalityscreenings@belfasttrust.hscni.net

The outcome of the equality screening for the policy is:

Major impact ☐
Minor impact ☐
No impact ☐

Wording within this section must not be removed

11.0 DATA PROTECTION IMPACT ASSESSMENT

New activities involving collecting and using personal data can result in privacy risks. In line with requirements of the General Data Protection Regulation and the Data Protection Act 2018 the Trust considers the impact on the privacy of individuals and ways to militate against any risks. A screening exercise must be carried out by the Policy Author to ascertain if the policy must be subject to a full assessment. Guidance is available on the Trust Intranet or via this **link**.

If a full impact assessment is required, the Policy Author must carry out the process. They can contact colleagues in the Information Governance Department for advice on Tel: 028 950 46576

Completed Data Protection Impact Assessment forms must be returned to the Equality & Planning Team via the generic email address equalityscreenings@belfasttrust.hscni.net

The outcome of the Data Protection Impact Assessment screening for the policy is:

Not necessary – no personal data involved ☐
A full data protection impact assessment is required ☐
A full data protection impact assessment is not required ☐

Wording within this section must not be removed.

12.0 RURAL NEEDS IMPACT ASSESSMENT

The Trust has a legal responsibility to have due regard to rural needs when developing, adopting, implementing or revising policies, and when designing and delivering public services. A screening exercise should be carried out by the Policy Author to ascertain if the policy must be subject to a full assessment. Guidance is available on the Trust Intranet or via this link.

If a full assessment is required the Policy Author must complete the shortened rural needs assessment template on the Trust Intranet. Each Directorate has a Rural Needs Champion who can provide support/assistance.

Completed Rural Impact Assessment forms must be returned to the Equality & Planning Team via the generic email address equalityscreenings@belfasttrust.hscni.net

Wording within this section must not be removed.

13.0 REASONABLE ADJUSTMENT ASSESSMENT

Under the Disability Discrimination Act 1995 (as amended) (DDA), all staff/ service providers have a duty to make Reasonable Adjustments to any barrier a person with a disability faces when accessing or using goods, facilities and services, in order to remove or reduce such barriers. E.g. physical access, communicating with people who have a disability, producing information such as leaflets or letters in accessible alternative formats. E.g. easy read, braille, or audio or being flexible regarding appointments. This is a non-delegable duty.

The policy has been developed in accordance with the Trust's legal duty to consider the need to make reasonable adjustments under the DDA.

Wording within this section must not be removed.

SIGNATORIES
(Policy – Guidance should be signed off by the author of the policy and the identified responsible Director).

[redacted] 13/09/2021

Authors **Date:**

[redacted] 13/09/2021

Director **Date:**

Appendix A

Seclusion Record/Voluntary Confinement Record

Patients name		**Date:**	
Ward		**Paris id.**	
Place of seclusion			
Legal status	**Voluntary** ☐	**Detained** ☐	**Under 18** ☐
Authorising Consultant		**Time contacted**	
Senior Manager on call with site responsibility informed		**Time contacted**	
Secluding Nurse		**Duty Doctor informed (include time contacted)**	
Next of Kin		**Time contacted/or reason recorded for not contacting.**	
Time seclusion commenced			**Duration of seclusion**
Time seclusion ended			
Accident/incident form completed		Patient ☐ Staff Other patient ☐ Incident number	

A Narrative of the reason for the decision to seclude the patient

B Describe briefly efforts and methods used to prevent placing patient in seclusion (include a description of PBS interventions employed, if no time to implemented state this – be descriptive)

Staff involved:

C Seclusion Plan

A written plan must be prepared immediately, the primary aim being to ensure patients safety and that the episode lasts for the shortest time.

Plan to ensure seclusion ends at the earliest opportunity

D Observations and Clinical Review Sheet (Description of patients presentation throughout the previous 15 minute period, including how the staff intervened/what the staff were doing)

15 minute Observations			
	Time	**Observations**	**Staff intervention (include name)**
First 15 mins after the beginning seclusion			
15 to 30 mins after beginning seclusion			
30 to 45 mins after beginning seclusion			
45 to 60 mins after beginning seclusion			

1 hour review **Time:**	
Nurse in Charge: _____	**Outcome:**

1 hour medical review

Time:

Signature	**Outcome:**
_____	

15 minute Observations

	Time	**Observations**	**Staff intervention (include name)**
60 - 75 mins after the beginning seclusion			
75 - 90 mins after beginning seclusion			
90 - 105 mins after beginning seclusion			
105 - 120 mins after beginning seclusion			

2 hour review

Time:

Nurse in Charge of secluding ward:	**Independent nurse:**
_____	_____

Outcome:

15 minute Observations

	Time	**Observations**	**Staff intervention (include name)**
120 - 135 mins after the beginning seclusion			
135 - 150 mins after beginning seclusion			

150 - 165 mins after beginning seclusion			
165 - 180 mins after beginning seclusion			

3 hour review

Time:

Nurse in Charge:	**Outcome:**
_____	

15 minute Observations

	Time	**Observations**	**Staff intervention (include name)**
180 - 195 mins after the beginning seclusion			
195 - 210 mins after beginning seclusion			
210 - 225 mins after beginning seclusion			
225 - 240 mins after beginning seclusion			

4 hour review

Time:

Nurse in Charge:	**Independent Nurse:**
_____	_____
Consultant involved in review	
_____	

Outcome: **Plan if seclusion is to continue:**

If seclusion lasts more than 4 hours, the Nurse in charge, Nurse and consultant will decide and document who should be involved in subsequent reviews.

15 minute Observations			
	Time	**Observations**	**Staff intervention (include name)**
240 - 255 mins after the beginning seclusion			
255 - 270 mins after beginning seclusion			
270 - 285 mins after beginning seclusion			
285 - 300 mins after beginning seclusion			

5 hour review **Time:**	
Nurse in Charge:	**Names of others involved in review:**
Outcome:	

15 minute Observations			
	Time	**Observations**	**Staff intervention (include name)**
300 - 315 mins after the beginning seclusion			

315 - 330 mins after beginning seclusion			
330 - 345 mins after beginning seclusion			
345 - 360 mins after beginning seclusion			

6 hour review **Time:**	
Nurse in Charge:	**Names of others involved in review:**
Outcome:	

15 minute Observations

	Time	**Observations**	**Staff intervention (include name)**
360 - 375 mins after the beginning seclusion			
375 - 390 mins after beginning seclusion			
390 - 405 mins after beginning seclusion			
405 – 420 mins after beginning seclusion			

7 hour review **Time:**	
Nurse in Charge:	**Names of others involved in review:**
Outcome	

15 minute Observations

	Time	**Observations**	**Staff intervention (include name)**

420 - 435 mins after the beginning seclusion			
435 - 450 mins after beginning seclusion			
450 = 465 mins after beginning seclusion			
465 - 480 mins after beginning seclusion			

8 hour review

Time: Outcome:

Nurse In Charge:	**Names of others involved in review:**

E Independent MDT review

Date:

Staff involved:

F How was seclusion ended?

By NIC followed by consultation with the patient's Responsible Clinician or Consultant on call (either in person or by telephone)

The patient falling asleep and being asked to be escorted to their room

Following an internal or independent multi-disciplinary review

Following a Consultant medical review

Patient engaging with staff/ appearing with less risk (Decision by of NIC based on level of presenting risk)

G Evaluation of patient following period of seclusion (be descriptive, include how the patient is emotionally, their demeanour, their attitude. When appropriate, discuss the incident with the patient - ask how they feel/how they think the incident could be managed differently)

Have clinical observations been completed? Yes No (if no, include reason)
Staff involved:

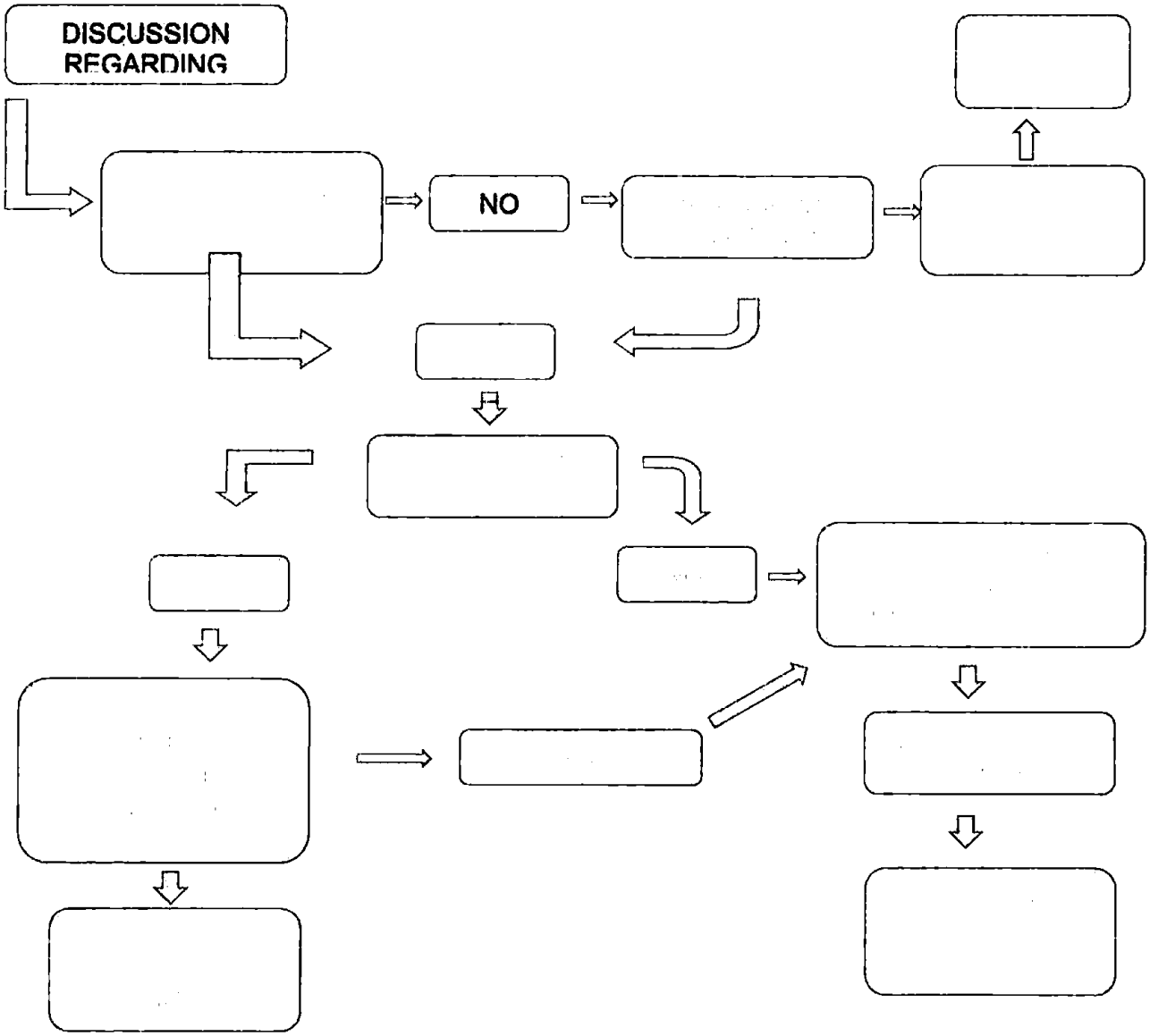
G MDT review

Date:

Staff involved:

Appendix B

Flowchart – Deciding To Seclude



Appendix C

Flowchart – Seclusion Review

DECISION TAKEN TO SECLUDE – see Appendix B Flowchart – Deciding to Seclude

DECISION TAKEN TO TERMINATE SECLUSION

If the Nurse Registrant in charge of the ward feels that seclusion is no longer warranted, seclusion may end following consultation with the patient's Responsible Clinician (RC) or duty doctor; in person or by telephone

Immediately	Contact patient's responsible clinician or the consultant on call and senior nurse on call with site responsibility
As per care plan	Contact Next of Kin as agreed at time of admission
Within first Hour	Medical Review by duty doctor or doctor on call unless seen by by Consultant Psychiatrist
Every 15 minutes	Nursing Observations must be documented every 15 minutes on Seclusion Record
Every Hour	Nurse in charge of ward should review patient and decision to seclude every hour
Every 2 Hours	Review by 2 Registrants - one of which was not involved in decision to seclude
Every 4 hours	Medical Review by Consultant Psychiatrist
	Independent MDT Review
	Independent MDT Review
Within 24 hours	Ward MDT Team to review seclusion Medical review by Responsible Clinician or Deputy

All episodes of seclusion should be reviewed by ward MDT processes