Appendix 6

Seclusion Awareness Training

Reviewed and Updated April 2016

Session Objectives

- Describe what seclusion is and when it should be used.
- Identify Human Rights issues associated with secluded patients.
- Outline the principles of seclusion.
- Explain the importance of working with patients.
- Outline the use of rapid tranquillisation and seclusion.
- Outline the procedure, recording, monitoring and documentation required for seclusion.
- Explain the reviewing process for patients both during the day and night for secluded patients.
- Explain the training needs of all staff who are expected to use seclusion.

Introduction

- All information in this training refers to the current Trust policy.
- Trust Policy reflects the guiding principles outlined in the Mental Health Act Code of Practice 2015.
- The policy can be found in your appropriate ward policy file and on the Trust intranet.
- It aims to give you an insight into the safe use of seclusion for all clinical areas.

Definition

"Seclusion refers to the supervised confinement and isolation of a patient, away from other patients, in an area from which the patient is prevented from leaving, where it is of immediate necessity for the purpose of the containment of severe behavioural disturbance which is likely to cause harm to others. If a patient is confined in any way that meets the definition above, even if they have agreed to or requested such confinement, they have been secluded and the use of any local or alternative terms (such as 'therapeutic isolation') or the conditions of the immediate environment do not change the fact that the patient has been secluded."

Human Rights Issues

- The key issue is to ensure that there is immediate therapeutic necessity, or immediate necessity due to safety, for seclusion whenever it is used.
- The unnecessary use of seclusion may constitute a breach of an individual's right to a private life under Article 8.
- Seclusion should only be used in hospitals and in relation to patients detained under the Act. If an emergency situation arises involving an informal patient and, as a last resort, seclusion is necessary to prevent harm to others, then an assessment for an emergency application for detention under the Act should be undertaken immediately.

Human Rights Issues

- Seclusion should only be considered once de-escalation and other strategies have failed to calm the patient. This is a management strategy and is not regarded as a primary treatment technique.
- Seclusion must be a reasonable and proportionate response to the risk posed by the patient.

Human Rights Issues

In exceptional circumstances some patients may have an agreed seclusion care plan which recognises that the use of seclusion is part of the agreed treatment strategy (Advance Decision to Refuse Treatment and Advance Statements Policy NTW(C)12) for the patient and this must be agreed as either:-

- A preferred treatment option by the patient

  and/or

- A multi disciplinary team clinical strategy based on presenting risk.

Human Right Issues

In light of NICE Guidelines (February 2005) seclusion can form part of a treatment or management plan.

The treatment / management plan must

- Follow the principles of the management of violence & aggression, rapid tranquilisation, observation and seclusion policies.
- Be developed in collaboration with members of the clinical team.
- Reviewed as part of the individuals treatment/care plans e.g. CPA/ward round/MDT.
- All sections of the care plan should be reviewed on every occasion by the professionals implementing seclusion to ensure the care plan meets the needs of the patient at the time.

Principles - **Seclusion should only be used where de-escalation measures alone have proved insufficient**

- When determining if seclusion is necessary, the following factors should be taken into account:
  - Clinical need.
  - Safety of patient and others.
  - Where possible, advance decisions and agreed care plans.
  - Seclusion must be a reasonable and proportionate response to the risk posed by the patient.
  - Consideration given to using seclusion and/or rapid tranquillisation as alternatives to prolonged physical intervention as identified in each individuals care plan as indicated by individual risk assessment.

Principles Continued

- Seclusion should **not** be used:
  - As a punishment or threat.
  - As part of a treatment programme (see slide 7).
  - Because of staff shortages.
  - Where there is a risk of suicide or serious self harm or as the sole management of serious self harm.
  - As sole management for violent or aggressive behaviour.

Principles Continued

- The decision to use seclusion can be made in the first instance by a doctor, a suitably qualified approved clinician or the professional in charge of the ward. Where the decision to seclude is made by an approved clinician who is not a doctor or by the professional in charge of the ward, the medical approved clinician involved with the care of the patient or the duty doctor (or equivalent) will attend to complete the first medical review **within one hour of the beginning of seclusion**. If the patient is new to the service or there are concerns regarding the patient's physical presentation then the first medical review must be undertaken without delay.

Principles Continued

- Any problems in securing attendance should be forwarded to the Service Manager using Incident Report.
- Where the decision to seclude is taken by the Psychiatrist the first medical review will be the review they took immediately before authorising seclusion; a medical review within the hour will not be necessary in this instance.
- Where seclusion is for a very short period and the medical approved clinician involved with the care of the patient or the duty doctor (or equivalent) does not visit before seclusion has ended then this must be written onto the seclusion record.
- Seclusion will be for the shortest time possible and will be reviewed at least every 2 hours.

Room used for Seclusion

- Seclusion should be in a safe, secure and properly identified room where the patient cannot harm themselves, accidentally or intentionally.
- The Trust has a set of standards for new, refurbished and existing seclusion rooms.
- Directorates have a responsibility to address seclusion facilities against these standards and undertake risk assessment and management of shortfalls.

Seclusion should have

- Tear resistant seclusion blankets and mattress with an integral pillow ordered via Patient Safety Department. Under NO circumstances should other bedding such as sheets or pillows be used during an episode of seclusion.
- Only vandal resistant/tamper proof furniture allowed.
- Urine bottles and bed pans will be available where risk assessment does not allow access to en-suite facilities.

Seclusion should have

- A patients clothes will **ONLY** be removed when secluded if it is felt that this may compromise their safety and the safety of others based on risk assessment. Alternative seclusion clothing must be anti-tear (available from Patient Safety) and will be considered only on an individual patient basis.

- Patients in seclusion will be allowed to keep personal items of religious or cultural significance (such as items of jewellery) as long as they do not compromise their safety or the safety of others.

Seclusion should have

- Where clothes and or jewellery need to be removed this should be done by staff of the same sex as the patient where possible and in a manner which preserves dignity and maintains safety. This may be pre-planned in terms of PMVA team approach and should be addressed in the care plan.

Seclusion on another ward/area

- Patients should not be secluded in areas meant specifically for the opposite sex. Only in exceptional/emergency circumstances should this occur and the decision must be authorised by a Director. The discussion must be clearly documented in the patients record.

- Where a patient is secluded on another ward, a discussion should take place between the nurse in charge of both wards and ward managers or on call equivalent to ensure the seclusion facility is available.

Seclusion on another ward/area

- Consideration should also be given as to how the patients should be taken to seclusion.
- Where possible, the involvement of PMVA trainers should be sought.
- Areas providing mixed gender wards and have seclusion facilities a Delivering Same Sex Accommodation (DSSA) local ward protocol should be in place.

Working with Patients

- Patients should be given the opportunity to become involved in their treatment, including the short term management of disturbed/violent behaviour.
- A risk assessment should be completed to identify those people at risk of disturbed/violent behaviour.
- Where possible an advanced statement will be developed and incorporated into the care plan which may reflect a patients preference for seclusion rather than restraint or medication following assessment of mental capacity.

Working with Patients

- The patient will be treated with dignity and respect at all times.
- The reasons for using seclusion must be explained to the patient at the earliest opportunity.
- The patient will be made aware that reviews will take place at least every 2 hours.
- An individualised seclusion care plan will be devised on the healthcare record, at the point of initiation of seclusion. The care plan must be reviewed at each use of seclusion and reassessed at each review of seclusion to ensure that it continues to meet all identified needs.

Working with Patients

- Appendix 2 outlines the minimum care plan principles which must be reviewed and added to as appropriate at each seclusion episode/review.

- In view of the potentially traumatising effect of seclusion, care plans should provide details of the support that will be provided when the seclusion comes to an end.

- Patients views on the incident should be used to identify alternative ways of promoting de-escalation and managing their disturbed behaviour. Collecting patient views will reflect their individual communication needs.

Working with Patients

- These views will be integrated into an individualised seclusion care plan by the nursing team and placed in the patient record.

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

Working with Patients

- Where it has been agreed in the care plan that family members will be notified of significant behavioural disturbances and the use of restrictive interventions, this should take place as agreed in the plan.

- If the patient has an IMHA, they should also be notified of the seclusion and be given the opportunity to participate in reviews (section 9.6.1).

Rapid Tranquillisation and Seclusion

Rapid tranquillisation should be considered only if de-escalation and other measures have failed to calm the patient.

- The use of seclusion with rapid tranquillisation is not absolutely contraindicated except in the case of a pregnant woman.

Rapid Tranquillisation and Seclusion

- If the patient is secluded, the potential complications of rapid tranquillisation will be taken particularly seriously. Any medication administered to a patient in seclusion must be administered following the Trust Medicines Policy (NTW (C)17) and appropriate monitoring completed.

- The patient will be monitored by constant eyesight observation by staff who are appropriately trained.

Rapid Tranquillisation and Seclusion

- Vital signs must be monitored, blood pressure, pulse and respiratory rate should be recorded at regular intervals agreed by medical and nursing staff until the patient becomes active again.
- The monitoring of vital signs must be recorded on the seclusion documentation (cross reference with NTW(C)02 Management of Rapid Tranquillisation Policy).
- If patients cannot (due to risk) or are not willing to participate in monitoring of vital signs, this must be recorded in the seclusion record.

Rapid Tranquillisation and Seclusion

- If the patient appears to be asleep then:
  - More rigorous monitoring is required, including the use of a pulse oximeter.
  - The person observing the patient should be alert to and assess the level of consciousness and respirations of the patient as appropriate.
  - Adequate call facilities should be available to staff observing a patient in these circumstances.

- Once rapid tranquillisation has taken effect, seclusion will be re-assessed and ended if appropriate.

Procedure, Recording and Monitoring for Seclusion

- The decision to use seclusion can be made in the first instance by a doctor, a suitably qualified approved clinician or the professional in charge of the ward.

- Where the decision to seclude is made by an approved clinician who is not a doctor or by the professional in charge of the ward, the medical approved clinician involved with the care of the patient or duty doctor (or equivalent) will be notified at once and should attend within one hour unless the seclusion is only for a very brief period (no more than 30 minutes).

Procedure, Recording and Monitoring for Seclusion

- **7.3** During the hours between 0900-1700, the ward must inform the Clinical Nurse Manager (CNM) when a patient has been secluded, as soon as is practicable. The CNM will make arrangements to attend the seclusion or agree to delegate to the ward manager / point of contact / duty (cover) manager.

Procedure, Recording and Monitoring for Seclusion

- **7.4** Out of hours (1700-0900), the ward must inform the identified Point of Contact for the locality or Night Co-ordinator after 20.30 when a patient has been secluded, as soon as is practicable. **The SM/DM on call should only be contacted in exceptional circumstances.** The Point of Contact will make arrangements to attend the seclusion initiation (and reviews). In exceptional circumstances (dependant on locality), it may be necessary to agree to delegate this responsibility to another nurse e.g. Band 6/7 on site the reasons for this should be recorded on seclusion documentation.

Procedure, Recording and Monitoring for Seclusion

- **13.3** Between the hours of 2300 and 0700 the Night Co-ordinator will be informed of seclusion and attend at the initiation and review of seclusion. Update of occurrence of seclusion between these times should be given to the Service Manager/Directorate Manager on call by email the next day at 7.30am. This does not exclude the need for management support to clinical situations should it be required by the Night Co-ordinator.

Procedure, Recording and Monitoring for Seclusion

- **7.9** When seclusion has ended signatures from ward manager (or deputy ward manger), CNM and RC should be sought as soon as possible, the next working day. Any problems obtaining signatures must be raised through the service manager.

Procedure, Recording and Monitoring for Seclusion

- **9.6.2** If the need for seclusion is disputed by any member of the multidisciplinary team, following initial discussion with ward manager, the matter will be referred to a Point of Contact/Clinical Nurse Manager/Service Manager/Directorate Manager by the nurse in charge at the point of dispute. The Directorate/Service Manager will then provide advice. During this time seclusion should continue.

Procedure, Recording and Monitoring for Seclusion

- It is mandatory that the patient will be monitored by constant eyesight observation by an appropriately trained individual. If clinically indicated as being in the best interest of the patient, due to significance of risks observations may be temporarily completed via non recordable CCTV (where available) within the seclusion lobby. This must be agreed as being in the patient's best interest and reflected in the Care Plan.

Procedure, Recording and Monitoring for Seclusion

- Staff **will not** leave observation duties until a replacement member of staff arrives to take over the observation of the patient. It is the responsibility of those observing the patient to ensure that continuous observations take place during handover.

Procedure, Recording and Monitoring for Seclusion

- The appropriately trained individual will monitor and record the condition and behaviour of the patient and take accurate and up to date records of behaviour, compliance, communication and interactions and any change to these and a record of physical observations (cross reference with NTW(C)02 Management of Rapid Tranquillisation Policy).

- A documented report must be made are least **every 15 minutes** or more frequently if required.

Procedure, Recording and Monitoring for Seclusion

- Detailed contemporaneous indelible records will be made on the seclusion record and retained in the patient record in the electronic support file (purple file).
- A step by step account of seclusion should be made including the rationale for the episode of seclusion.
- Staff must only use centrally provided seclusion documentation provided by the Patient Safety Department.
- Each unique number on the Record of Seclusion should be accurately transferred onto all related seclusion paperwork (record of observation, record of review etc.).

Review of Seclusion

The need to continue seclusion will be reviewed:

- Every 2-hours from the point of seclusion by 2 registered nurses (1 of whom was not involved in the decision to seclude – where this is not possible it must be agreed with the CNM/SM/DM and documented on the Review of Seclusion).

- Every 4-hours from the point of seclusion by a doctor alongside the registered nurse.

The timing for review should be **sequential** from the start of seclusion not from the time each subsequent review takes place.

Review of Seclusion

The need to continue seclusion will be reviewed:

- Four-hourly medical reviews should continue to be carried out until the first (internal) Multi-Disciplinary Team (MDT) has taken place.

- Following the first internal MDT review, further medical reviews should continue at least twice in every 24-hour period. Medical reviews should be carried out by a doctor, for example the patient's responsible clinician if they are medically qualified, a medically trained approved clinician or a duty doctor. Any duty doctor will have access to an on-call approved clinician for advice if required.

Review of Seclusion

Medical reviews provide the opportunity to evaluate /amend seclusion care plans, as appropriate. They should be carried out in person and include, where appropriate:

- Review of the patient's physical and psychiatric health.
- Assessment of adverse effects of Medication.
- Review of the observations required.
- Reassessment of medication prescribed.
- Assessment of the risk posed by the patient to others.
- An assessment of any risk to the patient from deliberate or accidental self-harm
- An assessment of the need for continuing seclusion, and whether it is possible for seclusion measures to be applied more flexibly or in a less restrictive manner.

The Code of Practice 2015 recommends that MDT reviews should take place once in every 24-hour period of continuous seclusion. NTW's stance is that this may take place with one of the required medical reviews or in addition to the medical reviews.

Review of Seclusion

If the seclusion continues for more than:

- 8 hours consecutively, or
- 12 hours intermittently over a period of 48 hours

- An independent multi disciplinary review will be completed by a doctor or suitably qualified approved clinician (or identified deputy) and nurses and other professionals, who were not directly involved in the decision to seclude the patient or in the prior incident. IMHAs (in cases where the patient has one) will also be invited to partake in the review. The arrangement of the MDT Review is to be agreed by the RC and the ward manager or delegates. The outcome of this review timescales for further multi disciplinary review, and rationale for timescales, must be recorded in the patient record should this fall outside of the Seclusion Policy review process and will be escalated via Service Manager.

Review of Seclusion

- If the need for seclusion is disputed by any member of the multi-disciplinary team
  - Initial discussion with ward manager.
  - Refer to Point of Contact/CNM/SM/DM by the nurse in charge at the point of dispute.
  - The Directorate/Service Manager will then provide advice. During this time seclusion should continue.

During the Night

- The need for 4-hourly medical review until an MDT review has been completed is cited in the Code of Practice, Mental Health Act, as good practice. However between the hours of 2300 and 0700 and whilst balancing the needs of the patient the following principles must apply:
  - If the patient is awake then the Doctor **must attend** the ward to conduct the review alongside the registered nurse.
  - If the patient is asleep, the doctor does not need to attend for reviews unless asked to do so by the registered nurse in charge of the ward.

During the Night

- In this instance two registered nurses will conduct the review and risk assessment.

- If safe, open the door and enter the room, to establish if the patient is breathing, safe, the room is tidy and comfortable.

- Assess the need for seclusion to continue. The reason for seclusion (and risks) should have be sufficiently subsided or dealt with prior to the person sleeping, for seclusion to be terminated whilst the person is asleep.

During the Night

- If seclusion is terminated or they have concerns regarding the patient's physical presentation they must seek medical assistance.
- If they have concerns about the patient's mental state they must contact the on call psychiatrist.
- The seclusion documentation must be completed.
- The doctor will need to make arrangements to review the patient at 0700 should the patient continue sleeping through the night.

During the Night

- If the patient wakes earlier then the doctor will need to attend for sequential seclusion review.

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

Discontinuation of Seclusion

- The patient must remain in seclusion **only as long as is absolutely necessary.** The nurse in charge of the seclusion makes the decision to end seclusion following agreement with MDT were possible.

- The end of seclusion is defined as when the patient is no longer presenting a risk necessitating seclusion and can leave the room if they wish to do so. If the door has been locked up to this point the door must now be unlocked and opened.

Discontinuation of Seclusion

- The end of seclusion should be recorded on the Seclusion Record of Observation form by the nurse in charge of seclusion.
- The observation level should be reviewed and recorded by the nurse in charge and the doctor at termination of seclusion.
- The FACE Risk Assessment Profile must be revised if required following an episode of seclusion.
- The nurse in charge should ensure the cleaning of the seclusion room.

Training

- All staff expected to use seclusion as determined by risk assessment / unit operational policy must receive seclusion awareness training.

- Band 6 staff to cascade seclusion awareness training within the team. Training must be repeated every 3 years, following significant changes to practice and/or policy or through the supervision process.

- The Trust will ensure that all staff have access to appropriate levels of training as identified in the training needs analysis and Essential Training Guide.

Training

- All those involved in the administration, prescribing and monitoring of a patient receiving seclusion must receive training to a minimum of Immediate Life Support.

- All staff will have access to competent internal legal advice in relation to the management of any aspect of disturbed behaviour. This is available through line management.

Audit / Monitoring of compliance

Once the seclusion record has been completed -

- **Record of Seclusion**
  - **Green** (top copy) to be to be filed in the patient record in the electronic support file (purple file) together with the **green** copy of the corresponding observation and review of seclusion records.
  - Middle copy to be forwarded to the relevant Service Manager.
  - Bottom copy to be forwarded to Patient Safety Department.

Audit / Monitoring of compliance

- **Record of Observation**
  - **Green** copy to be filed in the patient record in the electronic support file (purple file) together with the **green** copy of the Record of Seclusion and **green** copy of the Review of Seclusion.
  - Duplicate copy to remain in the Record of Observation book.

Audit / Monitoring of compliance

Review of Seclusion

- **Green** copy to be filed in the patient record in the electronic support file (purple file) together with the **green** copy of the Record of Seclusion and **green** copy of the Record of Observation.
- Duplicate copy to remain in the Review of Seclusion book.

- A quarterly audit will be completed for the Positive and Safe Steering Group.

Record of Seclusion

Page A

Patient name: ……	Patient RiO number: ……..
Ward: ……	Name of ward where secluded (if different): …..……...
Was the patient secluded on a different sex ward Yes ☐ No ☐ If YES please state which Director authorised: …….	
Please state why seclusion occurred on a different ward: ……	
Date seclusion commenced: ……	Time seclusion commenced: ……
Name of professional authorising (**initiating)** seclusion (Name of doctor, a suitably qualified approved clinician or a Registered Nurse) Signature: …… Name:…… Designation: ……..	
Describe events leading to the initiation of seclusion:	
Please indicate what the patient took into the seclusion room e.g. clothes, shoes …… ……..	
Please indicate which potentially dangerous items, if any, were removed (include any items of clothing or any personal items of jewellery or items of cultural/religious significance): …… Not applicable ☐	

A Incident record must be completed for every episode of seclusion

Were PMVA techniques used? Yes ☐ No ☐	
Was ‘as required’ / ‘rapid tranquillisation’ medication administered? Yes ☐ No ☐	
Please state the Incident reference Number (s) submitted for initial seclusion, PMVA techniques and/or ‘as required’ / ‘rapid tranquillisation’ medication……	

Page B

Medical Officer (Responsible Clinician (medical or non-medical), On Call Psychiatrist, Psychiatrist, Junior Doctor, Duty Doctor) details

Name of Medical Officer informed of seclusion:
Name (print) …….. Time informed of seclusion: ……..

Signature of Medical Officer attending episode of seclusion:
Signature: ……..…… Time attended seclusion: ……..

Were there problems contacting the Medical Officer? Yes ☐ No ☐
If 'Yes' please state what……

Service Manager/Clinical Nurse Manager details (for own working area during normal working hours only)

Name of Service Manager/Clinical Nurse Manager informed of seclusion
Name (print): ……..…… Time informed of seclusion: ……..

Has the Service Manager/Clinical Nurse Manager delegated attendance at the initiation / review of seclusion to the Duty (cover) Manager/Point of Contact/Ward Manager? Yes ☐ No ☐
If No indicate time SM/CNM attended seclusion: ……..

Were there problems contacting the Service Manager/Clinical Nurse Manager? Yes ☐ No ☐
If 'Yes' please state what……

Signature of Service Manager/Clinical Nurse Manager attending the episode of seclusion:
……..…
Nb. Not applicable if delegated

To be completed by Point of Contact/Ward Manager/Night Coordinator when delegated to attend the seclusion or outside normal working hours

Name of the Point of Contact / Ward Manager / Night Coordinator informed of seclusion:
Name (print): …….. Time informed of seclusion: ……..
Signature of the Point of Contact/Ward Manager / Night Coordinator attending episode of seclusion:
Signature: ……. Time attended seclusion: ……..
Designation: ……..

Were there problems contacting the Point of Contact/Ward Manager/Night Coordinator? Yes ☐ No ☐
If 'Yes' please state what……

Page C

Has the patient given their consent for a family member or carer to be informed of the use of seclusion? (as detailed in the patients Behaviour Support Plan / Care Plan / Treatment Plan) Yes ☐ No ☐

If the patient has given their consent who contacted the family member or carer?

Name (print)…… Signature…… Designation……..

Time and date informed of seclusion: Time……..... Date……

The following documentation **must** also be completed for **all** episodes of seclusion:

- Incident Record
- Seclusion Record of Observation
- Review of Seclusion (as necessary)
- Seclusion Care Plan
- Patient record
- Rapid Tranquilisation Monitoring Form in the Core Clinical Documents of the patient record (as necessary), **See NTW(C)02 The Management of Rapid Tranquillisation.**

Seclusion Care Plan Completed by …… Time…… Date……

Physical observations			If NO please state why
BP completed?	Yes	No	
Pulse completed?	Yes	No	
Oxygen sats completed?	Yes	No	
Respirations completed?	Yes	No	

Aide memoire: Where RT is us used please also complete the RT monitoring form as detailed above

End of seclusion

Date seclusion ended: …… Time seclusion ended: ……..	Duration of episode of seclusion (in minutes): ……..……..

	Name	Signature	Date
Responsible Clinician in charge of the patients care and treatment			
Service Manager / Clinical Nurse Manager			
Ward Manager/ Deputy Ward Manager			

Review of Seclusion

Seclusion number ……..…..…	Patient Name: …….
Ward…….	RiO Number……..……..….

Review type – Nursing / Medical / MDT / Independent Senior Clinicians (please indicate)

Review at ……..hours (e.g. 2 hour)	Date ……	Time……
Name ……	Signature: ……..……..	Designation: ……..……
Name: ……..	Signature: ……..…..	Designation: ……..…..
Name: ……..	Signature: ……..……..	Designation: ……..……

If the review is not on time please state why: ……..
……

Physical observations			If **NO** please state why
BP completed?	Yes	No	
Pulse completed?	Yes	No	
Oxygen sats completed?	Yes	No	
Respirations completed?	Yes	No	

Care plan reviewed: Yes ☐ No ☐
If No please state why……..…..
……....

Seclusion to continue: Yes ☐ No ☐
If yes please state why ……..…
……....

Has an MDT review taken place? Yes ☐ No ☐
If No please state why……....
……..

Has an independent review taken place? Yes ☐ No ☐
If No please state why……
……..…
Additional comments……..……..
……

Seclusion – Record of Observation

Date seclusion initiated ……..	Seclusion number ……...
Time seclusion initiated ……...	RiO number…….
Patient Name……	Ward……

Date/time of entry (24 hour clock)	**Observations** A documented report **must** be made at least **every 15 minutes** or more frequently if required (including during reviews etc). Note patient's behaviour, compliance, communication, mental state, personal hygiene, physical observations.	Name **(Print full name)**	Signature	Designation **(Print)**

The entry recording the end of seclusion must be made by the NIC of seclusion

SECLUSION POLICY & SECLUSION AUDIT FINDINGS: Key Message: April 2016

Sent on behalf of the Trust-wide Seclusion Steering Group

"Seclusion refers to the supervised confinement and isolation of a patient, away from other patients, in an area from which the patient is prevented from leaving, where it is of immediate necessity for the purpose of the containment of severe behavioural disturbance which is likely to cause harm to others. If a patient is confined in any way that meets the definition above, even if they have agreed to or requested such confinement, they have been secluded and the use of any local or alternative terms (such as 'therapeutic isolation') or the conditions of the immediate environment do not change the fact that the patient has been secluded."

- The seclusion audit is completed quarterly based on the incident and seclusion reporting process.
- The clinical audit cycle includes audit – identifying areas for change and implementing change – re audit.
- We would like to see greater improvement and recommend consideration of the following main learning points.
- For full audit findings refer to individual group audit reports.
- Seclusion Policy and documentation revised to incorporate amendments within the MHA 1983: Code of Practice 2015.

Main Learning Points:

- Ensure all staff are aware of revised changes within the Seclusion Policy which become operational from April 2016.
- Incident Report (Web) and Record of Seclusion to be completed for all episodes of seclusion; the Incident reference number to be recorded on the Record of Seclusion.
- Medical approved clinician involved with the care of the patient / duty doctor to complete first medical review within one-hour of the beginning of seclusion.
- Complete 2-hourly nursing reviews from the point of initiation in line with policy.
- Complete 4-hourly medical reviews until the first MDT then medical reviews and MDT reviews to be completed in line with policy.
- Wards to have a checking mechanism in place on the ward to ensure all fields in the seclusion documentation are complete.
- The completion (or non completion due to refusal/risk) of physical health observations to be recorded in line with NTW(C)02 The Management of Rapid Tranquillisation.
- Final nursing observation at the point of discontinuation of seclusion must be signed by a Registered Nurse.
- Nursing observations must be recorded every 15 minutes.
- All documentation must be completed in line with NTW Record Keeping Standards MR-PGN-02 Part of NTW(O)09 Management of Records.

Review of Session Objectives

Questions?