Rotherham Doncaster and South Humber NHS Foundation Trust

Secluded or segregated policy

DOCUMENT CONTROL:

- **Version:** 15
- **Unique Reference number:** 406
- **Approved by:** director of corporate assurance
- **Date approved: 28 October 2026**
- **Document Author:** MHA manager
- **Title of Accountable Director:** chief medical officer
- **Date issued:** 29 October 2026
- **Review by date:** 31 October 2029

Contents

1. Document summary 4

2. Introduction and aim 5

3. Procedure 5

3.1 Seclusion 5

3.2 Alternatives to seclusion 6

3.3 Safety pod 6

3.4 Seclusion of patients who are self-harming 6

3.5 Seclusion room specifications and monitoring 6

3.6 Legal status of a patient in seclusion 7

3.7 Decision to seclude 7

3.8 Safe transfer of a patient into the seclusion suite 8

3.9 Placing a patient in seclusion 8

3.10 Reviewing a patient in seclusion 10

3.11 Care of the patient in seclusion 13

3.12 Review during the night or when a patient is asleep 14

3.13 Medication 15

3.14 Termination of an episode of seclusion 15

3.15 Cleaning of the seclusion suite 15

3.16 Action if the need for seclusion is disputed 16

3.17 Action in the event of a fire and the ward needing to be evacuated 16

3.18 Action if the unit's seclusion facility is unavailable for any reason 16

3.19 Colleague support 17

3.20 Seclusion documentation 17

3.21 Person centred management plan 17

3.22 Segregation 18

3.23 Advance statements 22

4. Responsibilities 22

5. Training 23

6. Monitoring Arrangements 24

7. Related documents and associated references 24

8. Appendices 25

8.1 Appendix A Guidelines for the use of the door hatch 25

8.2 Appendix B Guidelines for the use of closed-circuit television (CCTV) in seclusion 26
8.3 Appendix C Independent multi-disciplinary team crossover arrangements 28
8.4 Appendix D Audit seclusion 28
8.5 Appendix E Audit segregation 28

1. Document summary

1.1 What is this policy about?

This policy explains how colleagues must care for a patient who needs to be kept away from other people for safety reasons. This may be called **seclusion** or **long-term segregation**.

1.2 What do these words mean?

Seclusion means a patient is cared for alone in a safe room that they cannot leave. It is used only when there is an immediate and serious risk that someone else may be harmed.

Long-term segregation means a patient is cared for separately from other patients for a longer time because there is an ongoing and serious risk to other people.

Important rules

- Seclusion and segregation must only be used when other safe options have been tried or would not work.
- They must never be used as punishment or to control someone's behaviour.
- The least restrictive and safest option must always be used.
- Restrictions must end as soon as they are no longer needed.

1.3 How will the patient be kept safe?

Colleagues must watch and support the patient, check their physical and mental health and make sure they have food, drinks, medicine, personal care and a way to communicate. The patient's privacy, dignity, culture and individual needs must be respected. The patient can also ask for help from an advocate.

1.4 How often is the decision checked?

Seclusion is checked regularly by nurses, doctors and the wider care team. A doctor must usually complete the first review within 1 hour. Nurses review the patient every 2 hours. Extra independent checks are required if seclusion continues for 8 hours, or totals 12 hours within 48 hours.

Long-term segregation is checked by an approved clinician at least every 24 hours and by the multi-disciplinary team every 7 days. If it lasts for 3 months, a team from another hospital must carry out an independent review. This is repeated every 3 months while segregation continues.

1.5 What happens afterwards?

The care team must record all decisions, observations and reviews. When seclusion or segregation ends, the patient's risks and care plan must be reviewed. The patient must be offered a chance to talk about what happened and what may help prevent it from happening again.

2. Introduction and aim

The Mental Health Units (Use of Force) Act 2018 defines the use of force as physical, mechanical or chemical restraint, or isolating a patient. Isolation includes seclusion and segregation.

The Act says that isolation means seclusion or segregation imposed on a patient, but it does not define these terms. Annex A of the Mental Health Act 1983: Code of Practice provides the definitions for patients detained in a mental health unit under the Act:

- Seclusion is the supervised confinement and isolation of a patient away from other patients, in an area they cannot leave. It must be immediately necessary to contain severe behavioural disturbance that is likely to harm other people.
- Long-term segregation is used to reduce a continuing risk of harm to other people when that risk is a constant feature of the patient's presentation. A multi-disciplinary team and a representative of the responsible commissioning authority must decide that the patient should not mix freely with other patients on the ward for a long period.

This policy follows the guidance and principles in the Mental Health Act Code of Practice (2015).

The trust only supports the implementation of seclusion in the designated seclusion rooms on the following wards:

- Kingfisher Ward
- Skelbrooke Ward
- Mulberry House
- Amber Lodge
- Sapphire Lodge (when building in use)

All members of the patient's care team, and their managers, must make sure that seclusion and segregation are used in line with this policy.

3. Procedure

3.1 Seclusion

Colleagues can use the quick glance seclusion guide as a visual summary of the steps they must follow.

Seclusion is not a therapeutic intervention and must never be planned in advance as part of a patient's care.

Seclusion is a protective measure. It must not be used as punishment, discipline, part of a behaviour change programme or as "time out". It should not normally be used for a patient who is self-harming, at risk of suicide, under the influence of alcohol or illicit drugs, has a recent head injury, or is older and frail.

A patient in one of these groups, except an older and frail patient, may still need seclusion if they present an extreme danger and seclusion, is the safest option. In

these circumstances, seclusion must be used for the shortest possible time, and the additional risks must be actively managed.

Seclusion must be used flexibly and in the least restrictive way that is safe, taking account of the patient's individual circumstances.

For prolonged seclusion, a suitable risk assessment may support carefully planned periods of less restriction. This may include visits, short periods in a secure outdoor area or meals in a general ward area. Each review must consider whether this is safe. These arrangements allow the team to assess the patient with fewer restrictions without ending the seclusion episode too early.

3.2 Alternatives to seclusion

Seclusion is a last resort. Before using it, colleagues must try suitable alternatives such as increased nursing support, distraction, de-escalation, additional staffing, use of the patient's positive behaviour support plan and a review of medication.

3.3 Safety pod

The safety pod can be used on the ward or in the seclusion suite. It supports safer physical intervention and can avoid placing a patient on the floor.

Use of the safety pod should be undertaken in line with the trust reducing restrictive interventions (RRI) policy (formerly PMVA policy).

3.4 Seclusion of patients who are self-harming

Seclusion must never be used only to manage self-harm. It may be used when a patient presents a risk of harm to themselves and others, but only when the need to protect other people is greater than any added risk to the patient and that added risk can be safely managed.

In the case of a patient who is using items of clothing as ligatures, colleagues should consider the need to nurse the patient in reduced-ligature clothing.

3.4.1 Guidelines for use of reduced-ligature clothing

Colleagues should refer to the trust ligature risk reduction policy for further guidance on the use of reduced-ligature clothing.

3.5 Seclusion room specifications and monitoring

Seclusion must only take place in a room or suite designed and approved for seclusion. The area must not be used for any other ward purpose.

All seclusion rooms within the trust are designated for this purpose and meet the standards outlined within the Mental Health Act Code of Practice (2015) (opens in new window).

To maintain the seclusion room as a safe environment, the nurse in charge of each shift is to check that the seclusion room is:

- always locked
- in good working order
- free of any items not intended for seclusion

If the room needs maintenance, it must be taken out of use. The team must agree safe alternative arrangements for managing a patient with severe behavioural disturbance.

Note, the seclusion rooms are never to be used as bedrooms.

3.6 Legal status of a patient in seclusion

Seclusion confines a patient in a locked room and removes their freedom to leave. It should therefore not normally be used for an informal patient.

The Mental Health Act Code of Practice allows seclusion to manage an exceptional emergency that puts safety at serious risk. This means that, in rare circumstances, seclusion may be used for a patient who is not detained under the Mental Health Act.

In that emergency, common law powers may be used. Colleagues must use only the level of physical or medical intervention needed to end the emergency.

If an informal patient needs seclusion, an assessment for detention under the Mental Health Act 1983 must take place as soon as reasonably possible.

3.7 Decision to seclude

Seclusion cannot be authorised in advance. The decision must be based on professional judgement, current knowledge of the patient and the immediate risk that the patient may seriously harm other people.

Seclusion will only be used when it is the only practicable means of achieving the protection of colleagues and others.

The decision to use seclusion can be made in the first instance by a doctor, the nurse in charge of the ward or the matron.

If the person authorising seclusion is not a doctor, the responsible clinician or duty doctor must attend within 1 hour to complete the initial medical review. If a consultant psychiatrist authorised seclusion after reviewing the patient, that review counts as the initial medical review.

In an emergency, the registered nurse in charge may start seclusion without prior authority. They must immediately inform the duty doctor, who must attend within 1 hour to complete the initial medical review. This does not apply when seclusion lasts no more than 5 minutes.

If the patient has visitors with them, they are to be moved to a safe area where a member of the clinical team will explain what is happening and why.

3.8 Safe transfer of a patient into the seclusion suite

A patient who must be moved from an open ward or communal area must be transferred using risk-assessed techniques taught in Trust reducing restrictive interventions training and in line with the reducing restrictive interventions policy.

3.9 Placing a patient in seclusion

3.9.1 Decision to seclude

- Search the patient.
- Agree a rota for continuous observations which should be documented every 15 minutes.
- Commence seclusion record.
- Complete incident report.

3.9.2 Initial medical review

- Where the consultant was not involved in the decision to seclude arrange initial medical review.
- Initial medical review to be undertaken within 1 hour of seclusion commencing.
- If first on-call doctor attends, 4 hourly medical reviews are needed until the internal multi-disciplinary team (MDT).
- If first on-call doctor and consultant on-call attends, initial medical review and internal MDT can be undertaken together.

3.9.3 Internal multi-disciplinary team

- The internal MDT should be held as soon as practicable and consist of:
- patient's responsible clinician or on-call consultant
- the nurse in charge of the ward
- professionals from other disciplines who are involved in the care of the patient
- independent mental heath advocate (IMHA)
- out of hours, the unit bed manager or bleep holder or senior nurse should be present

3.9.4 Nursing reviews

- 2 hourly nursing reviews by two registered nurses (one should not have been involved in the initial decision to seclude).

3.9.5 Medical reviews

- 4 hourly medical reviews by a doctor (at 4 hourly intervals until the Internal MDT review has taken place).
- Following the internal MDT, medical reviews, as a minimum, will be held twice in each 24-hour period of seclusion, one of which must be by the responsible clinician (RC) or on-call consultant or approved clinician (AC) and must be 5 or more hours apart.

3.9.6 Independent multi-disciplinary team review

- If a patient is subject to 8 hours consecutive seclusion or 12 hours intermittent seclusion over a 48-hour period, an independent MDT review must be held (even if seclusion has ended).
- The independent MDT review should routinely be convened within 24 hours of the threshold being triggered, however during weekends and bank holidays the review should be convened no later than midday on the first working day

3.9.7 Termination of seclusion

- Nurse in charge to end the period of seclusion on the electronic patient record (EPR).
- MDT to agree level of supportive observation required by patient.
- Patient's risk assessment and treatment plan to be reviewed and updated.

3.9.8 Debrief or evaluation

- Patients debrief to be undertaken as soon as possible (within 48 hours) following termination of seclusion to review the incident or behaviour which led to the decision to seclude, patient can be supported by an advocate.
- Colleague evaluation of seclusion to review decisions made and whether anything could have been done differently.

As part of any review the following should be considered, and an entry made in the patient's electronic patient record:

- patient's physical and mental health
- review of medication and effects
- assessment of risk posed to others
- assessment of any risk of deliberate or accidental self-harm
- agree review process if patient to remain in seclusion overnight
- review of the need to continue the episode of seclusion
- agree what information can be shared with the patient's relatives or carers

3.9.9 Searching a patient

Prior to placing a patient in seclusion, a search must be undertaken in line with the trust searching of a person or their property policy and any potentially harmful objects removed.

The final decision regarding what items a patient can retain on commencement of seclusion rests with the nurse in charge. Consideration should be given at each review around belongings that could be safely returned.

3.9.10 Monitoring a patient in seclusion

- The nurse in charge will implement a rota of colleagues to observe the patient. Colleagues should have completed a supportive therapeutic observation competency check.
- A colleague will be delegated to always remain within sight and sound of the seclusion room, with the key in the lock for access in case of an emergency.
- Observations will be recorded at 15-minute intervals.

- If the patient has been sedated or restrained, colleagues observing must be made aware of this and adhere to physical health monitoring detailed in the rapid tranquillisation policy and guidelines (pharmacological management of violence) and reducing restrictive interventions (RRI) policy (formerly PMVA policy) and are to be aware of any physical changes which may occur.
- All further colleague entries into the seclusion room should be pre-planned in conjunction with the nurse in charge of the ward.
- The nurse in charge will determine the number of colleagues required for safe entrance to the seclusion room.
- Where it has been agreed in a PBSP (or equivalent) 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.

Colleagues must always monitor the patient, even whilst the patient is asleep colleagues will be able to monitor their respirations. Respiratory rate must be documented on the patient's physical observation chart; colleagues must also monitor the depth, sound, and effort of respirations in comparison to the patient's normal breathing.

Where the LIO system (non-contact technology) is available colleagues can utilise this system for the purpose of monitoring. Colleagues should also monitor the colour of skin; observe for mottled or cyanosed skin or mucus membranes. If colleagues have any concerns regarding a patient's respiration rate or level of responsiveness, they must enter the seclusion room and review the patient.

In the event of an emergency where there is an imminent risk of loss of life and a colleague is required to act immediately, they must activate their personal alarm or radio prior to entering the seclusion room. Where possible, colleagues should wait for the appropriate team to arrive before entering the seclusion room.

3.9.10 Closed-circuit television (CCTV)

The trust seclusion suites have CCTV capability, CCTV must be used in conjunction with appendix B guidelines for the use of CCTV in seclusion.

Patients must be informed of the use of CCTV (where in situ) and provided with a patient information leaflet.

Colleagues should refer to the trust security policy for further information on CCTV.

3.10 Reviewing a patient in seclusion

Seclusion starts when the decision is made and restrictions are placed on the patient, even if there is a delay before the patient enters the seclusion room. Required reviews therefore start from the time of that decision. They include the initial medical review within 1 hour, an internal multi-disciplinary team review as soon as possible, nursing reviews every 2 hours, medical reviews every 4 hours when required, and at least two medical reviews in each 24-hour period while seclusion continues.

An independent MDT review is also required when seclusion lasts for 8 continuous hours or for 12 hours in total within a 48-hour period.

All reviews provide an opportunity to determine whether seclusion needs to continue, as well as to review the patient's mental and physical state. Where agreed, family members should be advised of the outcomes of reviews.

Prior to the commencement of any review, the nurse in charge must ensure there are sufficient colleagues available to safely undertake the review (as specified in the trust reducing restrictive interventions (RRI) policy (formerly PMVA policy), including a designated person to manage the seclusion room door.

Colleagues should enter the room to undertake the review if it is deemed safe. If risk is identified and the patient is presenting as very hostile, the assessment can take place from outside the room using the viewing window or camera.

Offers of drinks, food and toilet facilities should be considered at each review.

3.10.1 Initial medical review

The initial medical review must take place within 1 hour unless a consultant was involved in the decision to use seclusion. The responsible clinician may complete the review or ask the duty doctor or a higher-grade trainee to do so. If another doctor completes it, they must discuss the outcome with the responsible clinician immediately and agree arrangements for the internal MDT review. A doctor who is not an approved clinician must have access to an on-call approved clinician.

3.10.2 Four hourly medical reviews

Four hourly medical reviews should be undertaken until the Internal MDT Review has been undertaken (if the initial medical review did not constitute part of the Internal MDT Review for example, if the RC or AC did not undertake this).

The patient must not be secluded for more than 5 hours continuously before being reviewed by the RC or AC.

3.10.3 Internal multi-disciplinary team review

The internal multi-disciplinary team (MDT) review should be held as soon as is practicable and no later than 5 hours following the commencement of seclusion.

The review must include the patient's responsible clinician or, outside normal working hours, the on-call consultant in person; the senior nurse on the ward; and relevant professionals from other disciplines. A remote medical assessment may be used only in exceptional circumstances, and the reason must be exception reported.

At weekends and overnight, membership of the Internal MDT review may be limited to medical and nursing colleagues, in which case the unit bed manager should also be involved. If there are any concerns regarding the membership of this review, the bronze on-call manager should be consulted in the first instance.

3.10.4 Subsequent medical reviews

Following the internal MDT, a minimum of two medical reviews in a 24-hour period must be undertaken (at least one of which must be by the RC or AC in person, which means face to face) inclusive of weekends and bank holidays.

More frequent reviews can be arranged if a need is identified.

These two medical reviews should be undertaken 5 or more hours apart.

Medical reviews must be carried out in person and should include where appropriate:

- review of the patient's physical and psychiatric health
- assessment of adverse effects of medication
- review of the observations required
- a re-assessment of medication prescribed
- an assessment of the risk posed by the patient to others
- an assessment of any risk to the patient by 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

In certain exceptional circumstances (for example, unable to contact RC or AC, RC or AC seriously injured whilst on duty) then medical reviews must be held every 4 hours by the duty doctor or higher-grade trainee and two registered nurses until an RC attends.

3.10.5 Nursing reviews

Nursing reviews are to be undertaken every two hours by two registered nurses (ideally one of whom was not involved in the initial decision to seclude and one of whom should be the same or preferred gender as the patient).

Further consideration should be given whether a male or female colleague should carry out ongoing observations; this may be informed by consideration of a patient's trauma history.

In the event of any concerns regarding the patient's condition, this should be immediately brought to the attention of the patient's RC or duty doctor.

3.10.6 Independent multi-disciplinary team review

The independent MDT review examines the original decision to use seclusion, the care and treatment provided, and whether seclusion must continue. It must also consider compliance with this policy and the Mental Health Act Code of Practice and identify any learning for the service.

The review must be undertaken where a patient has either been secluded for 8 hours consecutively or intermittently for 12 hours during a 48-hour period.

Once the threshold for the independent MDT review has been triggered, the review must take place, even if the episode of seclusion has ended. The Initial and any

subsequent Independent MDT reviews should make recommendations regarding the requirement and frequency of further Independent MDT reviews.

As a minimum the review should include a consultant psychiatrist or AC, nurse and other professionals who were not involved in the incident which led to the seclusion and an IMHA in cases where the patient has one.

To support a comprehensive and truly independent membership, independent MDT reviews should routinely be convened within 24 hours of the threshold being triggered, however during weekends and bank holidays the review should be convened no later than midday on the first working day.

It is considered good practice for those involved in the original decision to seclude the patient to be consulted as part of the review.

Within the trust it has been agreed that clinical representation for the independent MDT review will be sourced from adjacent wards where possible and for stand-alone wards clinical colleagues who work in other ward environments or the local access team. Please refer to appendix C for local guidance on identifying medical involvement in each locality.

If it is agreed that seclusion needs to continue, the review should evaluate and make recommendations, as appropriate, for amendments to the seclusion management plan. Any proposed changes must be approved by the RC who has the legal authority to change the management plan of a detained patient.

3.11 Care of the patient in seclusion

During seclusion, the patient must continue to receive a high standard of nursing care. Colleagues must protect the patient's dignity and meet all personal care needs in the safest possible way.

3.11.1 Hygiene and the use of en-suite facilities

All the trust seclusion suites have an integrated en-suite toilet and shower facility. These should only be restricted where a risk is indicated. Patients should be regularly encouraged to attend to their personal hygiene. The en-suite door should be always secured in an open or close position to reduce the risk of ligaturing.

Due to the potential risk of ingestion and choking, toilet rolls are not fitted in the seclusion room ensuites.

There is to be a box available which contains the following items:

- toilet tissues
- hand gel
- disposable gloves

Once a period of seclusion commences, the box is to be taken into the seclusion lobby for use as required. Items must be returned to the box after use and replenished following each seclusion episode.

Use of the toilet does not end a period of seclusion and the patient should always be allowed to use the toilet facilities if it is safe to do so.

Bedpans and urine bottles should only be utilised in exceptional circumstances where it is not safe to allow use of the toilet.

Colleagues require specific training regarding the use of these facilities, particularly the safe use of the connecting door. This will be provided by the RRI team.

3.11.2 Provision of food and drink

The provision of food and drink must always be available. Whilst dietary preferences will be accommodated where possible, due to the disturbed nature of a patient, diet may be limited to foods that do not require utensils.

Where appropriately risk assessed, disposable or plastic utensils are available for use. These should be removed from the room as soon as practicable.

If a patient is subject to a prolonged episode of seclusion (24 hours plus), an input or output chart (as per the trusts' nutrition policy (promoting good nutrition for patients)) is to be maintained to ensure that adequate diet and fluids are consumed.

3.11.3 Use of the door hatch

There may be circumstances when the patient's presentation is felt to pose a significant health and safety risk to others and that it is considered unsafe to enter the room to offer food, drink, and oral medication. In such circumstances colleagues should refer to appendix A guidance for the use of the door hatch.

3.12 Review during the night or when a patient is asleep

The Code of Practice 2015 permits trusts to have in place alternative arrangements for the review of patients who are asleep.

As it may be in the patients' best interests to be allowed uninterrupted sleep, the agreed arrangements for review of patients who are asleep in seclusion within the trust are as follows:

Daytime arrangements:

- colleagues responsible for the review should discuss and agree if the patient should be woken for the review
- the time of the next planned review, which should be no later than the next required medical or nursing review should be agreed

Night-time arrangements:

- arrangements with the on-call doctor should be made in advance whether seclusion reviews continue during the night
- if it is agreed that no further reviews need to be undertaken during the night, (unless there is a significant change in the patient's presentation), the next nursing review is to be undertaken as soon as practicable after the patient wakes and the medical review no later than 9am

- nursing colleagues should continue to make entries in the nursing review questionnaire every 2 hours. Entries should detail as a minimum their rational for not entering the seclusion room and their observation of the patient

Note, these arrangements do not include the first medical review at the commencement of any episode of seclusion or the internal MDT review undertaken by the RC or consultant psychiatrist as this must always be undertaken by the doctor in person.

3.13 Medication

If any medication has been administered in an effort to reduce acute behavioural disturbance, colleagues are to refer to the trust's rapid tranquillisation policy and guidelines (pharmacological management of violence).

The patient is to be kept under constant visual observation, and their physical condition monitored. Whilst it is accepted that it may be difficult for colleagues to follow the policy in its entirety, as a minimum the observing nurse will check and document the patients:

- respiration rate
- degree of movement
- response to verbal or tactile stimulation

3.14 Termination of an episode of seclusion

Seclusion should immediately end when:

- a review determines it is no longer warranted.
- the professional in charge feels that seclusion is no longer warranted
- a patient is allowed either:
- free and unrestricted access to the normal ward environment or
- transfers
- returns to conditions of long-term segregation

Once seclusion has been terminated the nurse in charge is to complete the ending of seclusion documentation.

The patient is to be assessed by medical and nursing colleagues to determine the required level of observations in accordance with the trust supportive therapeutic observation policy and their risk assessment and treatment plan amended accordingly.

Following an episode of seclusion, the MDT (and patient) should review the incident or behaviour which contributed to the use of seclusion. This review should reflect on the incident or behaviour, identify any triggers, instigate a PBSP if one is not in place and agree amendments to the plan of care to reduce the likelihood of further episodes of seclusion. The patient can be supported by an advocate at the review.

3.15 Cleaning of the seclusion suite

Following each period of seclusion, the seclusion suite should be fully cleaned after use, in line with the trust's cleaning and infection prevention requirements.

3.16 Action if the need for seclusion is disputed

If there is disagreement from any member of the MDT in relation to the need for seclusion to either be implemented or continued, the matter is to be referred to the matron (or on-call manager outside normal working hours) or the associate medical director (provided they were not involved in the original decision to seclude).

3.17 Action in the event of a fire and the ward needing to be evacuated

If the ward must be evacuated, a rapid assessment of the risk posed by the secluded patient should be undertaken.

A request should be made to the other wards for assistance and the secluded patient be transferred to a safe area by an appropriate number of colleagues, as determined by the nurse in charge.

If there are no additional colleagues available due to it being a whole unit evacuation, colleagues are to take whatever action they feel is necessary but should focus on the safety and well-being of the majority.

3.18 Action if the unit's seclusion facility is unavailable for any reason

If a patient is assessed as needing an episode of seclusion and the suite on the unit where the patient is receiving inpatient care is already occupied the nurse in charge of the ward will:

- arrange for a private room to be made as safe as possible for example, through the removal of furniture so that the patient can be cared for by a specified restraint team within that room
- contact the nearest adult acute unit with a seclusion facility to ascertain if it is available for use
- once an alternative seclusion facility has been agreed, arrange for the patient to be safely transferred there. This will involve the use of a specialist transport company in line with the trust safe transportation of patients adult mental health IPS protocol and following the procedure for booking a private ambulance
- a comprehensive handover must be provided for the receiving team
- the care of the patient whilst in the alternative seclusion suite (except Amber Lodge) including nursing reviews and the associated paperwork will sit with the lead nurse on the ward where the seclusion bed is sited, although these responsibilities can be delegated to other nurses if this is reasonable and within the sphere of responsibility and competence of the person to whom it is being delegated. The responsibility for undertaking one of the 24-hour medical reviews can be delegated by the RC to an AC in the unit where seclusion is being utilised 9am to 5pm and outside these times to the on-call medics
- Amber Lodge's seclusion facilities should only be used in exceptional circumstances and with prior agreement. Where used, the Doncaster medics will undertake the medical reviews unless previously agreed with the consultant for Amber Lodge

- as soon as the patient's episode of seclusion ends, they are to be returned to the admitting ward. However, this does not apply if it has been agreed that the patient will be formally transferred to the unit where seclusion is available

When seeking an alternative seclusion facility consideration needs to be given to the fact that on single sex units such as Amber Lodge due to privacy, dignity and safety reasons, patients of the opposite gender should not normally be taken to their seclusion suite.

3.19 Colleague support

It is recognised that any colleagues involved in the initial incident and decision to seclude a patient can be affected by it in different ways, so at the earliest opportunity the nurse in charge should:

- organise a short and informal review of the events which led to the decision to seclude the patient. At this review, colleagues are to be given the opportunity to express their feelings or views and ask questions
- identify if any individual colleagued have been particularly upset by events and meet with them to explore their need for further support (please refer to the healthy workplaces staff support and stress at work policy)

3.20 Seclusion documentation

For all episodes, reviews and decisions relating to seclusion, regardless as to the length, the following documentation is to be completed:

- incident form
- EPR RRI node
- EPR seclusion documentation (staff access only) (opens in new window) for the commencement of seclusion, seclusion reviews and ending of seclusion.
- EPR seclusion template for seclusion observation (15-minute observations)
- Review or update of the EPR clinical risk assessment, risk management plan and PBSP.

3.21 Person centred management plan

A seclusion management plan should set out how the individual care needs of the patient will be met whilst the patient is in seclusion and record the steps that should be taken to bring seclusion to an end as quickly as possible. The seclusion management plan is in the RRI node on the clinical tree of the EPR. As a minimum the seclusion management plan should include:

- a statement of clinical needs (including any physical or mental problems) risks and treatment objectives
- a plan as to how needs are to be met, how de-escalation attempts will continue and how risks will be managed
- details of bedding and clothing to be provided
- details as to how the patient's dietary needs are to be provided for
- details of any family or carer contact or communication which will be maintained during the period of seclusion in accordance with any developed PBSP's

A condensed version of each patient's person-centred seclusion management plan should be discussed with the patient for example, how their individual needs will be

met and what steps have been agreed to bring seclusion to an end as quickly as possible.

It should be reviewed with the patient's involvement and amended after each nursing or medical review.

3.22 Segregation

Colleagues can use the quick glance segregation guide as a visual summary of the steps they must follow.

Long-term segregation may be used to reduce a continuing risk of serious harm to other people when that risk is a constant part of the patient's presentation. An MDT must decide that the patient cannot safely mix freely with other patients on the ward or unit.

Only an MDT may decide to start segregation. A single clinician must never make this decision.

Segregation is a planned response to ongoing violence or aggression. It must only be used after all suitable alternatives have been tried and have not managed the risk.

Because segregation is planned, the decision should not normally be made outside working hours, when a full MDT is unlikely to be available. If the immediate risk cannot wait, seclusion may be used as a short-term measure until an MDT can meet. The seclusion procedure in this policy must then be followed.

3.22.1 Decision to segregate

Segregation may be considered only when the clinical judgement is that allowing the patient to mix freely on the ward would expose other people to a continuing risk of serious injury or harm.

It is permissible to manage this small number of patients by ensuring that their contact with the general ward population is strictly limited but they must be always accompanied by colleagues and a referral is to be made to the advocacy service.

Due to the restrictive nature of segregation, it can only be implemented following a multi-disciplinary review. The multi-disciplinary review must include and consider:

- a representative from the integrated care board
- views of the patient's family and carers

The details of this review must be recorded in the EPR. This record is to include:

- the reason for use of segregation
- what other management strategies have been tried and the reason for them not being successful
- a discussion with the local safeguarding team around the need to nurse the patient in segregation

- the time and date of segregation commencing
- the environment in which segregation is to take place
- how the environment will be managed
- a management plan for how the patient will be managed in segregation including what therapeutic interventions will be offered
- process for reviewing the decision to care for the patient in segregation

The use of segregation does not exclude the option of transferring a patient to a more secure and restrictive environment designed for the purpose of seclusion should they be displaying acute behavioural disturbances where there is a need to contain an immediate risk of harm to others, and in such situation, colleagues are to follow the procedure for the seclusion of patients.

Each episode of segregation must have an incident report completed.

3.22.2 Quick glance segregation guide

3.22.2.1 Considering segregation

- An MDT must be convened to consider and agree the use of long-term segregation (this should include representation from the integrated care board (ICB) and a view from family or carers where appropriate).
- Patient is to be informed that a decision has been made to care for them in long term segregation, the reason why and what the review process or time frame will be. Agree what information can be shared with the patient's relatives or carers.

3.22.2.2 Segregation commenced

- The nurse in charge of the ward is responsible for ensuring that there are suitably skilled colleagues with the patient at all times whilst they are in long term segregation.
- A long-term segregation management plan must be put in place.

3.22.2.3 Monitoring

As minimum there is to be an hourly entry made in the patient's EPR which details the following:

- visual observations of the patient, including behavioural presentation
- how well the patient has interacted
- mental state presentation
- when utilised details of any medication administered and effects

3.22.2.4 Reviews

A patient subject to segregation is to be reviewed:

- by an approved clinician at least once in every 24-hour period to determine if patient still requires nursing in segregation
- by their responsible clinician as part of a wider MDT review every 7 days

3.22.2.5 Independent review
If a patient is subject to long term segregation for period of 3 months, they are to be reviewed by a clinical team from an external hospital. These independent reviews will continue at 3 monthly intervals for the duration of long-term segregation.

3.22.2.6 Terminating segregation
The decision to end long term segregation is to be made by the MDT who should consider assessment of risk to either the patient or others if long term segregation is ended and what steps are to be taken to manage any identified risk.

As part of any review the following should be considered, and an entry made in the patients' clinical records:

- patient's physical and mental health
- review of medication and effects
- assessment of risk posed to others
- assessment of any risk of deliberate or accidental self-harm
- review of the need to continue the episode of segregation

3.22.3 Environmental requirements for segregation
Facilities which are used to accommodate patients in long-term segregation should be arranged to enable the patient to access, as a minimum:

- bathroom facilities
- a bedroom
- relaxing lounge area
- secure outdoor areas
- a range of activities of interest and relevance to the person should be available to them

3.22.4 Information to patients
The nurse in charge of the ward is to inform the patient of the reason for the decision to segregate, what needs to happen for segregation to be terminated and how they will be cared for during the episode of segregation.

Consideration needs to be given to the fact that as patients who are in a heightened emotional state, this may result in difficulty retaining information, so this will need to be repeated at agreed intervals throughout the use of segregation.

3.22.5 Caring for the patient during an episode of segregation
When segregation is in use, the nurse in charge of the ward must ensure that suitably skilled professionals competent to carry out observations and interactions accompany the patient at all times as per the trust supportive therapeutic observation policy.

Meals and drinks must be provided as usual, with consideration given to the crockery and utensils used, for example, plastic beakers and plates, non-metallic cutlery as part of an individual risk assessment. Regular access to fresh air, based on individual risk assessment, must be facilitated, and recorded wherever possible.

3.22.6 Record keeping

As a minimum, there is to be an entry made in the patients EPR on the segregation template (not the enhanced observations template) each hour which provides details of:

- the visual observations of the patient, including behavioural presentation
- how well the patient has interacted
- mental state presentation
- when utilised, details of any medication administered and efficacy

3.22.7 Reviews of segregation

The purpose of the review is to determine whether the patient's ongoing risks have reduced sufficiently to allow the patient to be integrated into the wider ward community and to check on their general health and welfare. The frequency of review needs to reflect the specific nature of each patient's agreed management plan but as a minimum the patient is to be reviewed:

- formally by an AC at least once in every 24-hour period
- every 7 days by their MDT which should include their RC and an IMHA where appropriate

Where long-term segregation continues for 3 months or longer, regular 3 monthly independent reviews of the patient's circumstances and care should be undertaken by an external hospital. This should include discussion with the patient's IMHA (where appropriate) and commissioner (Code of Practice, 2015, 26.156).

The review should capture the following details:

- who was present at the review and the outcome
- risk assessment
- assessment of mental and physical well-being
- consider an opinion from the access assessment service (opens in new window) (detailed can be found in the relevant service specification for the service being sought) to inform decisions about the most appropriate inpatient placement for the person in terms of their care and treatment needs and the level of security required
- any recommendations

In the case of independent reviews, the recommendations will be considered by the patient's multi-disciplinary team and any required amendments made to the patient's management plan.

3.22.8 Terminating segregation

The aim must be to return the patient to the usual ward environment at the earliest possible opportunity. Such a decision can only be taken by the multi-disciplinary team, following a thorough risk assessment, observations from colleagues of the patient's presentation during close monitoring and, or the recommendations of the Independent Reviewer.

At all times when segregation is terminated, the nurse in charge must ensure an appropriate number of colleagues are available to manage the patient's initial potential risk.

Following further risk assessment, management of the patient must be clearly documented. Levels of engagement and observation must be implemented as per the trusts' clinical risk assessment and management policy.

Following an episode of segregation there is to be a review of the incident or behaviour which led to the use of segregation by the multi-disciplinary team. The purpose of the review is to reflect on the incident or behaviour, identify any triggers and agree amendments to the plan of care to reduce the likelihood of any further episodes of segregation. The patient can be supported by an advocate at the review.

3.23 Advance statements

Patients may want to set out their wishes for how they are to be managed in situations when seclusion or segregation becomes necessary and even do so by preparing an advance statement. Colleagues are to refer to the advance statements and advance decisions to refuse treatment policy for further guidance.

Family and carers should be included and involved unless the patient refuses or does not consent to their involvement.

4. Responsibilities

4.1 Medical colleagues

For seclusion, medical colleagues must:

- attend the ward within 1 hour of seclusion starting, unless a consultant psychiatrist authorised seclusion and completed the first medical review
- take part in multi-disciplinary reviews of secluded patients
- take part in multi-disciplinary decisions about reduced-ligature clothing
- for prolonged seclusion, complete medical reviews every 4 hours until the first internal multi-disciplinary team review
- after the first internal MDT review, complete at least two medical reviews in every 24-hour period
- take part in an independent MDT review when seclusion lasts for 8 continuous hours, or for 12 hours in total within a 48-hour period

In relation to segregation medical colleagues will:

- form part of the MDT who initially determines if a patient requires segregation to safely manage their care
- arrange for formal review of the segregated patient at least once every 24 hours by an approved clinician, including weekends and bank holidays
- form part of the formal MDT review at least once every 7 days

4.2 The nurse in charge of the ward

The nurse in charge of the ward must:

- follow this policy when caring for a patient in seclusion or segregation
- report any incident during seclusion or segregation through the Trust's incident reporting system
- make sure that colleagues involved in the patient's care follow this policy

- arrange separate debriefs with the patient and the staff team after seclusion ends
- support audits of any seclusion episodes in which they were involved
- take part in multi-disciplinary reviews of patients who have been secluded or segregated

4.3 Trust patient safety lead

The trust patient safety lead will in conjunction with the relevant matron:

- investigate any untoward incidents which occur during an episode of seclusion or segregation
- advise on any colleague training needs in relation to the use of seclusion or segregation

4.4 Matrons

The responsibility for the management of seclusion and segregation lies with the matrons for the wards detailed in section 3 above. All other inpatient matrons are responsible for the management of segregation part of this policy.
It is the responsibility of the matrons to:

- cover the contents of this procedure as part of the local induction for any new colleagues
- wherever possible be involved in the review of any patient who has been secluded for 8 hours consecutively or 12 hours intermittently over a period of 48 hours
- wherever possible be involved in the review of any patient who is subject to long term segregation at least once in every 7 days
- meet with and debrief colleagues who have been involved in events leading to an episode of seclusion or segregation
- report and investigate in conjunction with the trust's patient safety lead any untoward incidents which occur during an episode of seclusion or segregation
- audit the use of seclusion within their area as detailed in section 8 of this procedure
- scrutinise the seclusion care package to ensure the process of seclusion and documentation has been followed in line with this policy and the Mental Health Act Code of Practice (2015)

4.5 Mental health legislation operational group

In relation to this procedure the trusts' mental health legislation operational group is responsible for:

- the review and issuing of the procedure.
- monitoring the trusts' compliance with the requirement of this procedure

5. Training

This policy does not require separate training. Its requirements are covered in:

- RRI training
- SystmOne training
- immediate life support training

Colleagues will be told about this policy and where to find it through the following routes:

- the policy review and reissue will be publicised in the Trust's daily email
- the policy will be available on the Trust intranet
- relevant services will cover the policy during local induction

6. Monitoring Arrangements

6.1 Compliance with the requirements of this policy and the code of practice guidance

- How: Annual audit as part of the trust audit programme.
- Reported to: Quality committee.
- Frequency: Annually.

6.2 Head of patient safety and Mental Health Act manager compliance with the policy and code of practice guidance and any emerging trends in the use of seclusion

- How: Via exception reporting from environment risk in clinical areas group (ERICA) and MHL-operational group.
- Who by: Head of patient safety and Mental Health Act manager
- Reported to: Care group MHL monitoring group
- Frequency: Monthly.

6.3 Matrons compliance with the policy and code of practice guidance and any emerging trends in the use of seclusion

- How: Via ongoing audit of the seclusion management plans.
- Who by: Matrons.
- Reported to: Care group MHL monitoring group.
- Frequency: Quarterly.

6.4 Any untoward incidents which occur whilst a patient is being cared for in seclusion

- How: Investigation or review of each reported incident.
- Who by: Matron in conjunction with head of patient safety, as appropriate.
- Reported to: Care groups, trust deputy director of safety and quality, and quality committee by exception through the patient safety report.
- Frequency: As incidents occur.

6.5 Number of times patients are subject to segregation and level of compliance with the standards detailed in this policy

- How: Case by case audit and via exception reporting from.
- Who by: ERICA group and MHL-operational group.
- Reported to: Care groups and ERICA group and quality committee by exception through the patient safety report.
- Frequency: As segregation is implemented and quarterly.

7. Related documents and associated references

- Incident management policy opens in a new window
- Healthy workplaces staff support and stress at work policy opens in a new window
- Records management policy opens in a new window

- Supportive therapeutic observation policy opens in a new window
- Advance statements and advance decisions to refuse treatment policy opens in a new window
- Nutrition policy (promoting good nutrition for patients) opens in a new window
- Searching of a person or their property policy (colleagues only access)
- Safe transportation of patients AMH IPS protocol
- Rapid tranquillisation policy and guidelines (pharmacological management of violence) opens in a new window
- Clinical risk assessment and management policy opens in a new window
- Vision based patient monitoring system (VBPMS) policy opens in a new window
- Reducing restrictive interventions (RRI) policy (formerly PMVA policy) opens in a new window
- Department of Health. (1983) Mental Health Act 1983: Code of Practice (opens in new window)
- Gov.uk. (1983) Code of Practice: Mental Health Act 1983 (opens in new window)
- Legislation.org.uk. (2018) Mental Health Units (Use of Force) Act 2018 (opens in new window)
- Patient Safety Incident Response Framework (August 2022) opens in a new window

8. Appendices

8.1 Appendix A Guidelines for the use of the door hatch

At times, a patient's presentation may create a serious risk to other people, making it unsafe for colleagues to enter the room to complete seclusion reviews or offer food, drink and oral medicines.

The seclusion management plan should include how the patient's nutritional needs are to be provided for and managed, particularly where it is considered unsafe to enter the room. This may include the use of the door hatch as a temporary and protective measure, being mindful of the following:

- the use of the door hatch must never be used as a first-line response to such risks and should never be used as a substitute for less restrictive alternatives
- the decision to use the door hatch must never be a blanket rule within a service
- the use of the hatch should aim to always preserve the patient's dignity. It should not be demeaning or stigmatising, and should, where possible, meet any specific cultural or religious requirements
- the use of the hatch should not be used for extended communication
- colleagues should refrain from putting hands through the hatch for any reason whilst the hatch is open to maintain safety

Any requirement to use the hatch should be proportionate to the assessed risk and supported with a clearly documented rationale.

In normal circumstances the hatch will be kept in the locked or closed position, with the key kept in an agreed accessible and secure location in the seclusion suite.

The decision to utilise the hatch should be made by the MDT and the patient's RC should be part of the decision-making process. However, these decisions may at times need to be made urgently and therefore the nurse in charge will make this decision and liaise as soon as practicable with the RC. All alternatives must be considered before the decision is made to use the hatch and the record of the decision MUST include as a minimum:

- the MDT members involved in making the decision, including the patient's RC
- a copy of an updated risk assessment and risk management plan
- other options that had been considered and discounted with a clear rationale for these
- the rationale for requiring the use of the hatch
- a safety plan or management plan for the patient that includes the frequency of being offered food, drink and oral medication; how their privacy and dignity will be maintained, and any cultural and religious factors that need to be considered

Whilst the hatch is in use the following must be recorded:

- an inpatient food and fluid chart should be completed, documenting when and what the patient was offered as well as what was consumed
- the patient should be offered fluids as a minimum during every review and on request if it is felt safe to do so
- a 4 hourly MDT review must be held involving the patients RC, to determine at which point the use of the hatch can be discontinued. Overnight these discussions would be required in line with the medical seclusion reviews, as opposed to 4 hourly reviews

It is not considered best practice to offer the patient medication via the hatch as it is difficult to confirm that the patient has definitely taken it and also increases the risk of it being used improperly for example, secreted and hoarded. Colleagues should assess each case on an individual basis.

8.2 Appendix B Guidelines for the use of closed-circuit television (CCTV) in seclusion

The Trust uses CCTV in seclusion suites to improve patient and colleague safety. CCTV is an extra safety measure. It does not replace direct observation, therapeutic contact or the staffing levels required by this policy.

The use of CCTV in seclusion does not alter the expectations of colleagues performance regarding patient observation contained within the trust's seclusion policy.

The guidance is to be read in conjunction with the trust's policies regarding:

- clinical risk assessment and management policy
- secluded or segregated policy management of a secluded or segregated patient
- security policy, particularly appendix E which deals with the use of CCTV

CCTV is installed in seclusion rooms across the trust. There are no cameras in the attached ensuite wet room for privacy and dignity considerations. The patient cannot be observed via CCTV while using the ensuite wet room.

All colleagues who may be involved in the monitoring of seclusion will receive training regarding the use of CCTV in this environment.

The system provides real–time unrecorded images to a monitor that can only be viewed by colleagues present in the seclusion suite. An information leaflet is to be available for all patients admitted to the trust which contains an explanation of the system and the reasons for its use. It is the responsibility of the patient's named nurse to support each patient's understanding of this. This will be revisited whenever the use of restrictive interventions such as seclusion forms part of a patient's PBSP. This conversation will be recorded in the clinical records and will be revisited if the patient is unable to understand the information offered.

The camera will operate 24 hours a day, 7 days a week. The images will only be fed to the monitor outside the seclusion room to enhance the quality of nursing observations.

The integrity of the system will be routinely inspected as part of the daily checks of the seclusion room when not in use and checked again before and after each use of seclusion. The system has battery backup in the event of a power outage. Any damage or faults must be reported to the ward manager immediately and rectified as soon as possible.

The equipment will be subject to regular maintenance checks.

When seclusion is in use, colleagues allocated to observe the patient will have two options at their disposal:

- direct visual observation
- indirect observation via the CCTV monitor

It is considered good practice for colleagues to avoid complete reliance on indirect observation. It is important to remember that nursing observation is a therapeutic intervention and provides an opportunity to communicate with a patient whilst providing assurance that they are valued and cared for.

CCTV is intended to help in circumstances where there are possible safety concerns for example, when a patient has their back to the colleague or when it is considered unsafe for colleagues to enter the room.

Such considerations are to form part of the personalised safety plan or management plan for each patient while in seclusion and include how they are to be observed and how their privacy and dignity will be maintained. Gender, cultural and religious issues should be considered where appropriate. This should be based on an up-to-date risk assessment and risk management plan.

It is the responsibility of the matron to ensure that an annual review of the privacy impact statement regarding the use of CCTV in seclusion is completed.

8.3 Appendix C Independent multi-disciplinary team crossover arrangements

8.3.1 Rotherham

More than two consultants work across the adult inpatient wards. An independent MDT review can include a consultant who is not the patient's responsible clinician and was not involved in the original decision to use seclusion.

8.3.2 Doncaster

There are more than two consultants working across the adult inpatient wards. Consultant input to the independent MDT can be obtained from the consultant that is not the RC and was not involved in the initial decision to instigate seclusion.

Both Amber and Sapphire wards have seclusion facilities. There is currently no clinical activity on Sapphire. Should Sapphire ward reopen to admission then the consultants covering Amber and Sapphire will adopt the same reciprocal agreement as Rotherham and Doncaster acute inpatient consultants.

Current arrangements for Amber are that the consultant will cross cover independent reviews with the adult inpatient consultants.

8.3.3 North Lincolnshire

It is agreed that the inpatient consultant for adult services and the two older peoples psychiatrists will cross cover.

In the absence of a consultant psychiatrist able to perform this duty, colleagues should discuss with a consultant psychiatrist in the local area (for example, access consultant) so that one of them would be able to undertake the independent MDT review.

8.4 Appendix D Audit seclusion

- Appendix F Audit seclusion (staff access only) (opens in new window)

8.5 Appendix E Audit segregation

- Appendix G Audit segregation (staff access only) (opens in new window)