Seclusion and Long-Term Segregation Policy

Please be aware that this printed version of the Policy may NOT be the latest version. Staff are reminded that they must always refer to the Intranet for the latest version.

Purpose of Agreement	To set and define the safe and lawful use of the seclusion Suite within Maple Ward, The Orchards
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Review Log

Version Number	Review Date	Name of Reviewer	Ratification Process	Reason for Amendments
1	January 2012	RB Seclusion Room Clinical Reference Group AMH Essential Standards Meeting	N/A Document review	Updated sections to ensure Code of Practice Compliance, updated operational considerations, updated links to other policies.
2	February	AMH Essential Standards Meeting	AMH ratification before passing to NHSLA Operational Meeting	Amendments made. Now ready for presentation at the NHSLA Operational Meeting.
3	March 2012	NHSLA Operational Group and Richard Brown	Virtual ratification from group members	Amendments made.
4	March 2012	Mick Tutt, Dr Mustafa Soomro, Richard Brown	Prior to presentation at Assurance Committee	Amendments made.
5	April 2012	Assurance Committee members, Richard Brown	Prior to re-presentation at Assurance Committee and re- tabling at NHSLA Operational	Amendments made.
6	June 2012	Clinical Expert Panel	Prior to re-submission through the Solent policy ratification process	Minor Amendments made. Agreed to progress to NHSLA meeting
7	March 2015	Robert Pollock		Amended in light of the new Code of Practice
8	June 2015	Richard Webb, Richard Murphy and Robert Pollock	Prior to re-submission through the Solent policy ratification process	Amended and updated in light of the new Code of Practice to ensure compliance.
9	August 2015	Mick Tutt	Prior to presentation at Policies Committee	Amendments made

10	June 2019	Robert Pollock	Review of policy	Amendments made.
11	July 2019	Teresa Henry, Cheryl Sullivan, Jo Perry and Nina King	Prior to presentation at Policies Committee	Amendments made.
12	April 2021	Ben Martin-Lihou	Amendment agreed via Policy Steering Group Chairs Action	Appendix 1, Page 32 amended “4 hourly form” to “2 hourly form” to ensure that the correct form is used

SUMMARY OF POLICY

This policy addresses the use of seclusion taking into account the physical and emotional wellbeing of the individual. It also provides guidance to staff to ensure the safety of others from severe behavioural disturbance which is likely to cause harm to others. It ensures the patient receives the care and support rendered necessary by their seclusion both during seclusion and after it has taken place. It describes the need to minimise the frequency and duration of seclusion and prevent any inappropriate use of seclusion. It provides the distinction between seclusion and other restrictive interventions and psychological behaviour therapy interventions, (‘time out’) and the difference in levels of seclusion, i.e. tertiary and secondary. It distinguishes what would constitute seclusion and what would be described as a clinical intervention in the management of challenging behaviour. It also ensures proper monitoring and reporting of periods of seclusion and to provide a complete record of all periods and audit.

The term ‘restrictive interventions’ is used here to reflect current terms used by the Department of Health and in order to encompass training systems currently employed by the Trust, namely the Prevention & Management of Violence & Aggression (PMVA). All use of restrictive interventions by employees must be lawful, necessary, reasonable in the circumstances, and undertaken in good faith. The policy details why and when an individual would be managed in seclusion.

The policy offers some context and guidance for staff, and reflects current national guidance relating to the use of seclusion and the prevention & management of violence & aggression when it does occur. It is underpinned by the Mental Health Act Code of Practice Guidelines 2015. Overall, it sets out Solent NHS Trust’s approach to minimising the risk of harm to all persons in its mental health inpatient services.

Seclusion and Long-Term Segregation Policy

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Seclusion and Long-Term Segregation Policy

1. INTRODUCTION & PURPOSE

1.1 This policy will outline the use of Seclusion which is ordinarily facilitated within Maple ward, The Orchards. Maple Ward is an Adult Mental Health (AMH) Psychiatric Intensive Care Unit (PICU) which provides care and treatment for adults experiencing a mental health crisis who require an intensive level of support due to the increased needs and risks of the patients admitted.

1.2 The overriding principle of inpatient care is the provision of effective care within a minimally restrictive environment, in accordance with the Mental Health Act (1983, amended 2007). The decision to utilise more restrictive interventions (such as seclusion) must be based upon an assessment of the patient, their risks and mental state. Seclusion must not be used as a punishment or a threat, or because of a shortage of staff. It must not form part of any treatment programme (Mental Health Act Code of Practice 2015).

1.3 The use of the Seclusion suite must not be common place within modern day mental health inpatient care. The use of seclusion engages a person's right to private and family life and could be deemed a further deprivation of their residual liberty. Its use must never be taken lightly and must occur fully within the law.

1.4 The use of the Seclusion suite must never be considered primary treatment techniques, but instead strategies for the safe management of patients who present with heightened risks to others and only in situations in which the criteria for its use, as set out in this policy and the Mental Health Act Code of Practice 2015 is met. 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 regardless of whether any local or alternative terms are used (such as 'therapeutic isolation') or the conditions of the immediate environment. If a patient is taken to their own bed area and prevented from leaving on their own free will, then this would constitute seclusion as described above.

1.5 The Seclusion suite has been specifically designed to ensure that it provides an appropriate physical environment to safely manage patients who may be presenting with increased agitation and aggression. The physical environment can have a strong and mitigating effect on the short term management of disturbed or violent behaviour (NICE Guideline, Violence, CG25). If there is a situation whereby seclusion is used outside of the seclusion suite on Maple ward, then this information must immediately be escalated to the Clinical Matron or on-call manager.

1.6 Seclusion must never be used as a means of managing self-harming behaviour. Where the patient poses a risk of self-harm as well as harm to others, seclusion must be used only when the professionals involved are satisfied that the need to protect other people outweighs any increased risk to the patient's health or safety arising from their own self-harm and that any such risk can be properly managed. (Mental Health Act Code of Practice 2015).

1.7 The Seclusion suite on Maple Ward consists of 4 areas:

- An enclosed, secure garden area

- A day room area with access to T.V.
- A bedroom area with ensuite toilet/shower facilities
- A tertiary seclusion room.

1.8 The suite enables 2 distinct and separate clinical practices/areas to enable patients to be cared for in the most appropriate area dependant upon their needs and level of risk. These are:

- Secondary level seclusion area (made up of the secure garden area, the day room and the bedroom area)
- Tertiary level seclusion Room (made up of the locked seclusion room only)

1.9 Secondary level seclusion areas, are recognised areas within psychiatric intensive units in order to care for people with increased levels of need or risk. Secondary level seclusion areas are covered within the most recent national guidance relating to best practice standards within a PICU and are referred to as extra care areas including seclusion facilities. The Mental Health Policy Implementation Guide: National Minimum Standards for general adult services in Psychiatric Intensive Care Units (PICU), (2014).

1.10 Furthermore, the guide states that Enhanced Care Areas may include seclusion rooms as per the enhanced care area suite on Maple Ward. However, the definition of seclusion was reviewed with the release of the Mental Health Act Code of Practice 2015 and the nursing of a single patient in the Extra Care Area is now considered a form of seclusion, (secondary), and must follow the procedures set out in the Mental Health Act Code of Practice. It is therefore referred to as the Seclusion suite within this policy.

1.11 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. Its sole aim is the containment of severely disturbed behaviour which is likely to cause harm to others. Seclusion must ordinarily only be undertaken in a room or suite of rooms that have been specifically designed and designated for the purposes of seclusion and which serves no other function on the ward. (Mental Health Act Code of Practice Guidelines 2015). However, if a patient is prevented from leaving an area other than the seclusion suite, then this will constitute seclusion and the pathway must be commenced. (1.5).

1.12 When making decisions as to the appropriate use of the seclusion suite, practitioners must give due regard and consideration to the Code of Practice, particularly the five guiding principles:

(i) Least restrictive option and maximising independence
Where it is possible to treat a patient safely and lawfully without detaining them under the Act, the patient must not be detained. Wherever possible a patient's independence must be encouraged and supported with a focus on promoting recovery wherever possible.

(ii) Empowerment and involvement
Patients must be fully involved in decisions about care, support and treatment. The views of families, carers and others, if appropriate, must be fully considered when taking decisions. Where decisions are taken which are contradictory to views expressed, professionals must explain the reasons for this.

(iii) Respect and dignity
Patients, their families and carers must be treated with respect and dignity and listened to by professionals.

(iv) Purpose and effectiveness
Decisions about care and treatment must be appropriate to the patient, with clear therapeutic aims, promote recovery and must be performed to current national guidelines and/or current, available best practice guidelines.

(v) Efficiency and equity
Providers, commissioners and other relevant organisations must work together to ensure that the quality of commissioning and provision of mental healthcare services are of high quality and are given equal priority to physical health and social care services. All relevant services must work together to facilitate timely, safe and supportive discharge from detention.

1.13 Regarding informal patients

Seclusion should only be used 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". (Mental Health Act Code of Practice Guidelines 2015).

1.14 In line with the guiding principles as laid out in Point 1.10, the use of the seclusion suite, or the patient's own bed area, must only ever be as a last resort taken by the staff team to safely manage the needs and risks of the patient. All other de-escalation and engagement techniques must, where practicable, be used in the first instance in attempting to safely manage patient's behaviour in the general ward environment. Staff must be aware that isolating a patient away from the general ward population constitutes seclusion.

1.15 Whenever a patient is cared for in the seclusion suite, the staff team are responsible for ensuring that the patient is cared for in this way for the shortest time possible and therefore must review the care and treatment being offered to ensure it meets the needs of the patient in a timely fashion to support their recovery. The review procedures are set out in this policy and must be followed.

1.16 The safety and well being of patients being cared for in the seclusion suite, is a significant concern and needs to be considered alongside their rights to autonomy. Through the use of dedicated psychiatric observations, responsive treatment and positive patient engagement, staff will ensure that patients' needs are met and safety is maintained whilst they are being nursed in these areas.

1.17 The need for a therapeutic programme of engagement and the implementation of; will provide meaningful activity for all patients and must be considered as a de-escalation tool with the risks taken into account.

1.18 Persons aged under 18 can be admitted to the Unit in the event of there being no CAMHS beds available. Any under 18 admissions will require 1:1 observations which should be organised and staffed by CAMHS staff. The use of secondary seclusion can be considered and used if the adolescent presents an immediate risk to others. The use of tertiary seclusion must only be if the

presenting risk of violence to others is to a degree that cannot be safely managed in the main ward environment or in secondary seclusion.

2. SCOPE & DEFINITIONS

SCOPE

2.1 This policy applies to locum, permanent, and fixed term contract employees (including apprentices) who hold a contract of employment or engagement with the Trust, and secondees (including students), volunteers (including Associate Hospital Managers), bank staff, Non-Executive Directors and those undertaking research working within Solent NHS Trust, in line with Solent NHS Trust's Equality, Diversity and Human Rights Policy. It also applies to external contractors, agency workers, and other workers who are assigned to Solent NHS Trust.

2.2 Solent NHS Trust is committed to the principles of Equality and Diversity and will strive to eliminate unlawful discrimination in all its forms. We will strive towards demonstrating fairness and Equal Opportunities for users of services, carers, the wider community and our staff..

DEFINITIONS

2.3 **Advocacy:** The Advocacy Service ensures that the views, wishes and feelings of those using health and social care services are promoted to service providers. Patients on Maple Ward have access to general advocacy services, Independent Mental Health Advocates (IMHA) and Independent Mental Capacity Advocates (IMCA).

2.4 **Detained Patients:** A detained patient is one whereby the person is detained under the Mental Health Act and the care and treatment provided for this person has to be in accordance with the parameters of this act. Engagement with the patient and their views and opinions about the care and treatment they receive must where practicable be sought and built into care planning.

2.5 **Seclusion Suite:** As per point 1.8 above.

2.6 **Informal Patients:** An informal (or voluntary) patient is one whereby the person consents to receive care and treatment in an inpatient setting or a patient that lacks capacity to consent and does not object and is not deprived of their liberty. As such, engagement with them and having their consent and agreement to receive the care and treatment planned and offered is paramount. At times, whereby the professionals providing this care and treatment feel that that the informal patient no longer has the capacity to consent to this care and treatment, the use of the Mental Health Act must be considered.

2.7 **Mental Health Act (1983, amended 2007):** An act of Parliament which primarily deals with the detention in hospital of people with mental disorders. It sets out the criteria that must be met before compulsory measures can be taken, along with protections and safeguards for patients.

2.8 **Multidisciplinary Team (MDT):** A group of clinicians from a variety of

professional backgrounds who contribute to the care and treatment that a patient receives.

2.9 **Psychiatric Observations:** A routine clinical intervention whereby patients are monitored at regular intervals as per the clinical decision making process. It has two main purposes; firstly to promote therapeutic engagement between staff and patients and secondly, to meet the patients' needs and manage the risks that they pose.

2.10 **Psychiatric Observation Levels:** 4 predetermined observation levels to ensure that the staff team can meet the needs and minimise the risks posed by patients to either themselves or others. Information relating to the different observation levels can be found in Appendix 5.

2.11 **Rapid Tranquilisation:** The use of medication to calm/slightly sedate patients and thereby reduce the risks to themselves or others by achieving a reduction in agitation and arousal. Medication may be given either orally or via Intramuscular Injection (IM), though the oral route must always be the first line of treatment. Further information can be found in the Managing Violence and Aggression Policy – including Rapid Tranquilisation Policy.

2.12 **Responsible Clinician:** The Responsible Clinician (RC) replaces the term Responsible Medical Officer (RMO). The RC is an approved clinician with overall responsibility for the patients' care and treatment for persons detained under the Mental Health Act. This is usually a Consultant Psychiatrist, though can be persons from other professional groups.

2.13 **Seclusion:** 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. Seclusion will only be practiced in the designated seclusion suite and for this sole purpose.

3. PROCESS/REQUIREMENTS

3.1 The Seclusion suite consists of 2 separate clinical areas – **a secondary level seclusion area** and **a tertiary level seclusion room**. The suite as a whole must continue to meet the following requirements:

- The room must allow for communication with the patient when the patient is in the room and the door is locked, i.e. inspection hatch.
- Rooms must include limited furnishings which must include a bed, pillow, mattress and blanket or covering
- There must be no apparent safety hazards
- Rooms must have robust, reinforced window(s) that provide natural light (where possible the window must be positioned to enable a view outside)
- Rooms must have externally controlled lighting, including a main light and subdued lighting for night time
- Rooms must have robust door(s) which open outwards
- Rooms must have externally controlled heating and/or air conditioning, which enables those observing the patient to monitor the room temperature
- Rooms must not have blind spots and alternate viewing panels must be available where required

- A clock must always be visible to the patient from within the room, and
- Rooms must have access to toilet and washing facilities.

Operational Process for the use of Secondary Level Seclusion Area

3.2. **When the Secondary Level Seclusion Area is not in Use.**

3.2.1. Whilst the secondary level seclusion area is not in use, its upkeep and security will be maintained via the Environment Check process on Maple Ward. This occurs at the beginning of each shift – so 3 times a day. Its purpose will be to ensure that the area (including the secure garden area) is fit for use and secure to enable it to be operational at any given time. The checklist for the area will include:

- All doors within the room are locked and without damage
- The ensuite toilet/shower is clean and without damage
- Floors and walls are clean
- Bedding is clean and without damage
- Window blind is set to partially closed and window is intact
- Day room fixtures, fittings and furniture is clean and without damage
- The door to the secure garden area is locked
- The secure garden area is clean, tidy and without damage.

3.2.2 During the environment check, should any areas within the room be noted to be broken/missing/not at the required standard, this must be reported to the Nurse in Charge immediately who will liaise with relevant personnel to ensure swift remedial action.

3.2.3 The house-keeping staff will be responsible for cleaning the area on a daily basis according to the cleaning schedule.

3.2.4 Located outside the area in the corridor cupboard will be equipment to assist staff in the safe management of the patient whilst they are in the extra care area and to also enable the area to be cleaned in the event of bodily fluids or other substances contaminating the area. This cupboard shall contain (though is not limited to):

- Gloves – 1 box of small, medium and large sizes
- 3 Towels
- First Aid box
- Roll of Aprons
- Cardboard receptacles including sick bowls, urinals, bedpans
- Roll of Clinical Waste Bags
- Change of bedding
- Cleaning materials, general detergent and chlorine releasing agents e.g. Actichlor Plus, disposable wipes
- Thumb loop gowns and all in one body suit overalls
- 5 pairs of goggles
- Paper towels.

3.2.5 In the event of the area becoming contaminated with bodily fluids, it will be necessary to arrange for the area to be deep cleaned. Clinical staff are responsible for removal and cleaning of blood and body fluids in accordance with the Solent NHS Trust's Infection Prevention & Control Decontamination Policy. Once this has been satisfactorily completed a deep clean of the area can be

arranged via the housekeeping Department. If the area requires deep cleaning whilst a patient is in the seclusion suite, then the team must undertake a risk assessment to ascertain if it is appropriate to manage the patient in other areas of the suite that are not soiled whilst the cleaning is taking place. If this is deemed not be appropriate, the deep clean must take place as soon as is practicably possible following the patient leaving the area.

3.2.6 Staff must advise the patient that the room does have dual purpose of being the bedroom within the secondary area suite. Staff must ensure that the patient is assured that the proximity of the day room and the tertiary seclusion room is not threatening or intimidating for the patient and not part of their care plan.

3.3 **When the Secondary Level Seclusion Area is being used**

3.3.1 The door to the main corridor must be locked and disabled from opening by the patient. The 'Vistomatic' window must remain closed at all times

3.3.2 There must be staff present at all times. A minimum of 2 staff must be allocated, but following a risk assessment by a senior nurse, this can be increased as required, but should never be decreased to a single staff.

3.4 **Facilities and Use of the Garden Area**

3.4.1 Whilst in the seclusion suite, patients must be risk assessed as to which parts of the area they can have access. This must be done on commencement of seclusion and kept under review throughout the episode. Patients may be kept in the tertiary level seclusion room or have access to one or more parts of the secondary level seclusion area.

3.4.2 Within the lounge of the secondary level seclusion area, patients will be provided with soft furnishing seating, a table at which they can eat their meals, (risk assessment permitting), television which will be projected upon the wall and access to activities/games to provide them with distraction and engagement opportunities. The staff observing the patient must risk assess the suitability of the patient accessing these facilities.

3.4.3 The television projector will be set in the adjoining TV room that is part of the main ward area. This will then be projected onto a wall within the secondary level seclusion lounge. It will be remote controlled which will only be accessible to staff.

3.4.4 Food and drinks will be provided for the patient via staff on the main ward areas. Staff will risk assess the suitability of the patient using ward cutlery and prevent this if the risk assessment indicates as such. In such instances, staff will ensure the patient has access to finger food, or approved seclusion safe cutlery. This risk assessment must occur each time the patient has food and what is given recorded on the food/fluid chart.

3.4.5 The private garden area can only be accessed by the patient through the door in the secondary level seclusion area lounge. This door will be locked when not in use. If a patient wishes to access the garden area, staff will unlock the door and staff must enter the garden area with the patient. Under no circumstances must the patient be allowed to be in the garden area alone.

3.4.6 If at any time staff have cause for concern that the patient is using the garden area inappropriately – such as attempting to abscond, damaging property or

becoming agitated or aggressive, the patient must be brought back into the seclusion suite immediately.

3.4.7 Solent now operates a non – smoking policy so patients are not allowed to smoke within the unit. If the patient smokes, they can be offered Nicotine Replacement Therapy, (NRT), following a risk assessment. This may include patches or approved 'E-Burn' cigarettes as per the unit protocol.

Operational Process for the Use of Tertiary Level Seclusion

3.5 When the Tertiary Level Seclusion Room is not in Use

3.5.1 Whilst the tertiary level seclusion room is not in use, its upkeep and security will be maintained via the Environment Check process on Maple Ward. This occurs at the beginning of each shift – so 3 times a day. Its purpose will be to ensure that Room and surrounding area is fit for use and secure to enable it to be operational at any given time. The checklist for the area will include:

- All doors within the room are locked and without damage
- The ensuite toilet/shower is clean and without damage
- Floors and walls are clean
- Bedding is clean and without damage
- Window blind is set to partially closed and window is in tact
- Controls on outside of suite (e.g. blind mechanism) work appropriately
- Fire Alarm is unobstructed/free from fluff.

3.5.2 Other considerations relating to the tertiary level seclusion room when it is not in use are the same as in points 3.1.2 – 3.1.5 in this policy which relate to the secondary level seclusion area.

3.6 Decision to place a Patient in Tertiary Level Seclusion

3.6.1 The decision to place a patient into the tertiary level seclusion room must only be made once all other attempts to try to manage the patient's behaviour have been discounted and to manage the patients' risks to others. The Code of Practice's guiding principles outlined in section 1.10 must be followed at all times and other least restrictive practices must have been demonstrated as having being attempted, or rationale given to as why they could not.

3.6.2 Decisions to place a patient into tertiary level seclusion must be clinical judgements made at the time the decision needs to be made. Tertiary level seclusion must **only** be used for the sole purpose to contain severely disturbed behaviour which is likely to cause harm to others. **It must never be used as a way of managing staff shortages or as a punishment or threat.**

3.6.3 In the event that a new admission to Maple ward has arrived and is exhibiting severely disturbed behaviour, it is essential that an immediate assessment by the nursing team is undertaken on the ward. Information from the escorting team and police must be taken into account, but must not solely be the rationale for the use of seclusion. The removal of handcuffs should occur on arrival on the ward unless the risk of doing so outweighs the decision.

3.6.4 There is no limit to the number of occasions that a patient may be placed in

the tertiary level seclusion room. In order to maintain appropriate governance and monitoring arrangements of the use of seclusion, all episodes of seclusion will be reported to the Mental Health Act Scrutiny Committee, after being discussed at the Mental Health Act Monitoring Meeting and then The Clinical Governance Meeting. Explanations will also be provided for patients who are repeatedly placed in seclusion. This will also apply to patients placed in the secondary level seclusion area. The level of information brought to the Scrutiny committee should be in a succinct statement which sets out the essential information and that confirm the criteria has been met with any exceptional issues raised. This statement will use the 'SBARD' criteria. A copy of the monthly and individual reports will be available on the local 'G' drive in order for staff to be able to view.

3.6.5 The duration of a patients' stay within tertiary level seclusion will vary as to the individual needs of the patient. The safeguards in this policy must be closely complied with to ensure that tertiary level seclusion is only used when it is demonstrated that it is necessary, proportionate, the least restrictive alternative, having regard to the purpose for which it is needed and that it is ended as soon as possible. If a patient is placed within tertiary level seclusion on more than one occasion during their inpatient stay, then this must be raised with the patients' MDT as soon as possible to investigate why this is the case and what the longer term management plan will be and reported as above in section 3.9.3.

3.6.6 In rare circumstances, patients' may need to remain in tertiary level seclusion for a protracted period of time. In order to ensure that tertiary level seclusion measures have a minimal impact on a patient's autonomy, tertiary level seclusion must be applied flexibly and in the least restrictive manner possible, considering the patient's circumstances. Where tertiary level seclusion is used for prolonged periods then, subject to suitable risk assessments, flexibility may include allowing patients to receive visitors, facilitating brief periods of access to secure outside areas or allowing meals to be taken in general areas of the ward. The possibility of facilitating such flexibility must be considered during any review of the ongoing need for tertiary level seclusion. Particularly with prolonged tertiary level seclusion, it can be difficult to judge when the need for tertiary level seclusion has ended. This flexibility can provide a means of evaluating the patient's mood and degree of agitation under a lesser degree of restriction and moving to secondary level seclusion. If the need arises, then tertiary level seclusion can be re-implemented. It may be that the seclusion is re-graded to Long – term segregation as described in 3.15.

3.6.7 In the unlikely event that the presentations of 2 patients indicate that they both should be nursed within the seclusion suite, the team must assess which patient is in more need of requiring to be placed into seclusion. This assessment must cover the imminent risk of harm to others as a determining factor. The team must then plan resources and the physical environment accordingly to manage the patient not placed within seclusion to ensure that their needs and risks are managed. It may be appropriate to use the 136 suite as a seclusion room if the risks are so high that taking the other patient out of seclusion would constitute too high a risk to others. To facilitate this decision making process, the Nurse in Charge of the ward must seek advice and support from either:

- The patients' MDT, including the ward management, in hours.
- The senior nurse out of hours co-ordinator (OOH), duty doctor and on-call manager out of hours.

3.6.8 At times, patients may request to enter the seclusion room as means of taking time away from the general ward environment. This **must not** be facilitated as this is not a permitted use of seclusion and the seclusion suite needs to be available at all times in the event of requiring its immediate use. The patient must be directed to their bed space or the relaxation room to facilitate some time away from the general ward environment.

3.6.9 The seclusion suite may not be used to segregate patients with either infectious conditions (such as scabies) or any other physical health needs. If a patient has to be barrier nursed to prevent the risk of infection, this would not constitute seclusion as per this policy, but regarded as a clinical intervention. If the individual refuses to comply with this, this would then constitute seclusion and advice sought from senior management.

3.6.10 The decision to use seclusion must be made in the first instance by the nurse in charge of the ward and they must notify the patients Responsible Clinician, Advanced Nurse Practitioner, or the out of hours doctor.

3.6.11 Although situated in Maple Ward, patients within Hawthorn Ward may be transferred to the seclusion suite on Maple Ward when clinically and legally indicated as the required intervention for the patient. In such circumstances, staff must ensure that they protect the dignity of the patient and ensure Maple Ward staff are aware of the plan.

3.6.12 Seclusion should only be used 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”. [Chapter 26.106]. Seclusion of an informal patient must lead to a an urgent request for a Mental Health Act Assessment and if two doctors are not available then the Approved Mental Health Professional must be requested to consider the use of s4 of the Mental Health Act 1983. However, the nurse in charge would have to invoke a section 5(4) in the first instance.

3.6.13 Staff may decide what a patient can take into the seclusion suite. The patient must never be deprived of clothing when in any part of seclusion. The safety of the patient entering the tertiary level seclusion room is a significant consideration and therefore staff must remove from the patient any items that they may use to either harm themselves or others following a thorough risk assessment. Staff will search the patient and remove any items which could cause harm either to them, or the staff entering the room. This will include: shoes, belts, certain items of jewellery. All items removed from the patient will be recorded on the Seclusion Pathway Record within Appendix 1 and stored in the patients’ store room or if not risk items, an appropriate place, i.e. their own room.

3.6.14 The person authorising seclusion must have seen the patient immediately prior to the commencement of seclusion.

3.6.15 When a patient is placed in seclusion, the start time of the seclusion must be recorded in the seclusion record and in the electronic notes. Once the Nurse In Charge of the ward or doctor has made the decision to transfer a patient to seclusion and the door of the seclusion suite is locked preventing the patient leaving, the Nurse In Charge of the ward must inform the following people, as a

matter of urgency, that a seclusion episode has begun:

- A Doctor (team doctor or cross cover doctor in hours or duty doctor out of hours) who must attend immediately or at the earliest opportunity (if it was not an approved clinician who initiated the seclusion episode) Whenever the duty doctor is not an approved clinician, they must at all times have access to an on-call doctor who is an approved clinician.
- The senior nurse co-ordinator (OOH), who must attend immediately or at the earliest opportunity.
- The inpatient Lead Nurses, Clinical matron and Physical Intervention Lead via e-mail.
- The IMHA, and if out of hours, a message can be left.
- The patients next of kin if consent to share has been obtained and it is appropriate to do so.

3.7 Observations during Tertiary Level Seclusion

3.7.1 The patient must be observed continuously by a member of staff from either the tertiary level seclusion room door situated in the secondary level area bedroom, or the door in the ward corridor. The observing staff must have sight of the patient at all times. For the first hour this person must be a suitably skilled registrant. After the first hour, when this person is not a registered nurse, then there must, as a minimum, be readily available within sight and sound of the seclusion area at all times throughout the patient's period of tertiary level seclusion. The staff member observing must have the means to summon urgent assistance from other staff at any point. All staff who, are assigned to complete the observation must be deemed competent by the nurse in charge to do so and understand the rationale for what they are doing. Physical observations must be carried out on the patient as soon as practicable following risk assessment. If the risk is too high, then the patients breathing, verbal response and skin colour must be observed, (see appendix 6). If the observing member of staff is not satisfied that the patient is not in physical distress, then help must be summoned and staff must enter the room.

3.7.2 Any staff taking over responsibility for observing a patient in tertiary level seclusion must be fully aware of the risks and any other significant information, including details of the incident that resulted in the need for seclusion and subsequent reviews. This handover will be between the staff member leaving their observation duties and the staff member taking over and this will be evidenced by both staff members signing the Seclusion Observation Record within Appendix 1. Care must be taken that the information shared is not overheard by other patients.

3.7.3 The role of the staff observing the patient must be to offer supportive engagement, to safeguard the patient, monitor their condition and behaviour and to identify the earliest time at which seclusion can be either ended or regarded to secondary level. Staff must individually assess each patient as to their wishes whilst they are in the tertiary level seclusion room, with the intention to support the patient to move towards a less restrictive environment at the earliest opportunity. Staff must give the patient a copy of their rights leaflet upon them entering the tertiary level seclusion room. A copy of this leaflet can be seen in Appendix 2.

3.7.4 For patients who have received sedation either prior to going into or whilst in tertiary level seclusion, a member of staff who has previously deemed

competent and assessed as so, will need to be outside the door at all times with adequate call facilities available to them. Staff must observe for the effects associated with this, particularly rapid tranquilisation. This may include changes to their mental and physical health. Vital signs must be monitored where practical and safe, e.g. observing breathing, skin colour and if risk assessment is completed, the patient can be asked to offer their arm through the inspection hatch in order to take a pulse reading and possibly blood pressure. This will depend on the level of compliance the patient is exhibiting.

3.7.5 If the person is being managed in the tertiary level seclusion room and it is necessary to enter the room to give the patient medication, this must be done by staff appropriately trained in Prevention and Management of Violence and aggression, (PMVA), with a minimum of 4 staff being present, 1 being responsible for unlocking and locking the door, at all times. Once medication has been given, staff must leave the area as quickly as possible ensuring that all staff leave safely. If oral medication is to be given, it can be given through the seclusion room door hatch, but the nurse must be satisfied that the patient has taken the medication and ideally it should be given face to face with the patient, (i.e. not through the tertiary level seclusion room door), to ensure concordance on behalf of the patient. Consideration must be given to the risk the patient poses at that time versus the benefits of medication. This must be risk assessed by the nurse administering the medication.

3.7.6 In the event of a patient receiving rapid tranquilisation either immediately before entering or whilst in tertiary level seclusion, the rapid tranquilisation pathway must be commenced as per the Rapid Tranquillisation policy. Staff must make every effort to follow the pathway where possible, though a risk assessment may determine that some parts of the pathway will not be achievable. For example staff may assess that the risks are too high and the patient too disturbed for the staff to enter the tertiary level seclusion room to take their physical observations every 15 minutes for the first 2 hours post rapid tranquilisation. In these situations, the Nurse In Charge of the ward must seek advice and support from senior staff members and medical colleagues as to most appropriate action to take.

3.7.7 During the first hour of the patient being in tertiary level seclusion, staff must carefully risk assess any requests by the patient for either food or drink. Patients may be provided water or snack items (no cutlery unless approved seclusion safe cutlery) through the seclusion room door if requested. Patient compliance with requests by staff is the best indicator. If the risk assessment does not indicate that it would be safe to open the door for the patient, the patient must be told the reasons why and offered alternative receptacles through the tertiary level seclusion room door.

3.7.8 Consideration must be given to whether a male or female person should carry out ongoing observations; good practice would dictate same gender, however this may not always be possible due to gender mix of staff on shift. This may be informed by consideration of a patient's trauma history and if they are exhibiting sexual disinhibition.

3.7.9 A record of the patient's behaviour must be made at least every 15 minutes. The record made must include, where applicable: the patient's appearance, what they are doing and saying, their mood, their level of awareness, food and fluid input/output (Appendix 6), hostility or aggression, interaction with the staff member and any evidence of physical ill health especially with regard to their

breathing, pallor or cyanosis.

3.7.10 Where a patient appears to be asleep in tertiary level seclusion, the person observing the patient must be alert to and assess the level of consciousness and respirations of the patient as appropriate.

3.8 Secondary and Tertiary Level Seclusion Reviews

3.8.1 A series of review processes must be instigated when a patient is secluded. These include the multi-disciplinary team (MDT), nursing, medical and independent MDT reviews. All reviews provide an opportunity to determine whether seclusion needs to continue or should be stopped, as well as to review the patient's mental and physical state. Where agreed, family members should be advised of the outcomes of reviews.

3.9 Medical Reviews

3.9.1 If the person making the decision to commence seclusion was not an approved clinician then the first medical review must occur within one hour of seclusion commencing. If it is agreed that seclusion needs to continue, a seclusion care plan must be agreed and prepared, which must identify how the patient's presenting and ongoing needs whilst in seclusion can continue to be met and record the steps that must be taken in order to bring the need for seclusion to an end as quickly as possible. As a minimum the seclusion care plan must include:

- A statement of clinical needs (including any physical or mental health problems), risks and treatment objectives
- A plan as to how needs are to be met, how de-escalation attempts will continue and how risks will be managed
- Details of bedding and clothing to be provide
- Details as to how the patient's dietary needs are to be provided for, and
- Details of any family or carer contact/communication which will be maintained during the period of seclusion.

3.9.2 Wherever possible, the patient should be supported to contribute to the seclusion care plan and steps must be taken to ensure that the patient is aware of what they need to do for the seclusion to come to an end. In view of the potentially traumatising effect of seclusion, care plans must provide details of the support that will be provided when the seclusion comes to an end. This must include a debrief with the patient after the patient has left the seclusion room and is back on the main ward area.

3.9.3 Continuing four-hourly medical reviews of secluded patients must be carried out until the first (internal) MDT has taken place (which must occur as soon as possible following the commencement of seclusion), including in the evenings, night time, on weekends and bank holidays. Where possible the review must be undertaken by the person's responsible clinician. If this is not possible then the duty doctor or Advanced Nurse Practioner must undertake the review. If the patient is asleep and it is deemed not in their best interest to wake them then no more than two reviews can be missed in a row.

3.9.4 Following the first internal MDT review (which must occur as soon as possible following the commencement of seclusion), further medical reviews must continue at least twice in every 24-hour period. At least one of these must be carried out by the patient's responsible clinician. Outside of normal working hours the out of hours SHO will act on behalf of the approved clinician and may

access the on call consultant for advice and support as required.

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

- A review of the patient's physical and psychiatric health
- An assessment of adverse effects of medication
- A review of the observations required
- A reassessment of medication prescribed
- An assessment of the risk posed by the patient to others
- An assessment of any risk to the patient from deliberate or accidental self-harm, and
- 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.

3.10 Nursing Reviews

3.10.1 Nursing reviews of the secluded patient must take place at least every two hours following the commencement of seclusion. These must be undertaken by two individuals who are registered nurses, and at least one of whom must not have been involved directly in the decision to seclude. In the event the patient is asleep and it is deemed that it is not in their best interest to wake them then no more than 8 hours can lapse without a review taking place.

3.10.2 In the event of concerns regarding the patient's condition, this must be immediately brought to the attention of the patient's responsible clinician or duty doctor.

3.11 Multi- Disciplinary Team (MDT) Reviews

3.11.1 The first internal MDT seclusion review must be held as soon as is practicable.

3.11.2 Wherever possible the MDT review must include an approved clinician. If one is not available then it must include a doctor or Advanced Nurse Practioner, who has access to the advice of an approved clinician, the nurse in charge of the ward, and other members of the MDT who can contribute to the patient's care and treatment, including their psychological, physical health and occupational needs.

3.11.3 At weekends and overnight, membership of the initial MDT review may be limited to medical and nursing staff, in which case a senior nurse which can include the out of hours co-ordinator (OOH), must also be involved.

3.11.4 Further multi-disciplinary seclusion reviews should take place once in every 24 hour period of continuous seclusion.

3.11.5 Where seclusion continues, these reviews must evaluate and make amendments, as appropriate, to the seclusion care plan.

3.12 Independent MDT Review

3.12.1 An independent MDT review must be promptly undertaken where a patient has either been secluded for eight hours consecutively or for 12 hours

intermittently during a 48-hour period.

3.12.2 Appropriate membership must as a minimum include a doctor who is an approved clinician, a nurse and other professionals who were not involved in the incident which led to the seclusion and an IMHA (in cases where the patient has one). It is good practice for the independent MDT to consult those involved in the original decision.

3.12.3 The CoP does not specify the membership of the Independent MDT review at weekends and overnight. **The Trust therefore requires the review to be carried out by the on-call Approved Clinician, a nurse as well as a senior nurse all of whom were not involved in the incident which led to seclusion**

3.12.4 If it is agreed that seclusion needs to continue, the review must evaluate and make recommendations, as appropriate, for amendments to the seclusion care plan.

3.13 Ending Seclusion

3.13.1 Seclusion must immediately end when a MDT review, a medical review or the independent MDT review determines it is no longer warranted. Alternatively where the professional in charge of the ward and another registrant feels that seclusion is no longer warranted, seclusion may end. At least one of the registrants must be a senior nurse.

3.13.2 Seclusion ends when a patient is allowed free and unrestricted access to the normal ward environment. Opening a door for toilet and food breaks or medical review does not constitute the end of a period of seclusion.

3.13.3 If the need for seclusion – or continued seclusion - is disputed by any member of the MDT, the matter must be referred to a senior manager or clinician. Therefore, disputes must be referred to one of the following people depending upon their availability:

- **In hours** – either the Clinical matron, Head of Access and Unplanned Care Mental Health or the Lead Clinician
- **Out of Hours** – the senior nurse out of hours co-ordinator (OOH)

3.13.4 In order to effectively arbitrate over any disputes, the above people must ensure that they are aware of all the factors and risks relating to the patient. They may choose to attend the ward to interview the patient themselves and any other staff members they feel may help them make an informed decision. Once arbitration has been achieved and a decision has been reached, the clinical team caring for the patient will be expected to adhere to the arbitrator's decision.

3.14 Care Plan and Management

3.14.1 At the earliest opportunity, a member of staff (normally the Nurse In Charge) must explain to the patient why they are in seclusion a negotiated approach between the staff member and the patient to agree what needs to change to facilitate the patient leaving the seclusion room and be reassured as to their safety. If it is assumed that the patient is not capable of understanding this information at the time that it is given (through either a deteriorating mental state or increased levels of arousal/agitation), this must be recorded as being

attempted and subsequent attempts must be planned.

3.14.2 The Nurse in Charge must begin to write a care plan with the patient upon them entering seclusion. This must include consideration of the information covered at the initial medical review. All attempts to engage the patient in this process must be encouraged to ensure that they can give their views about the care they receive. This care planning process will cover all the steps taken to manage the behaviour/needs/risks of the patient which were not successful that necessitated in seclusion being required and the ongoing review, care plan and management of the patient for as long as they have to remain in seclusion. All efforts have to be targeted to enable the patient to leave seclusion as quickly as possible.

3.14.3 The care plan and management plan must ensure that the safety and wellbeing of the patient is paramount and must also prescribe what is required to enable the patient to leave seclusion. Within the care plan it must make reference to:

- Medication regime and issues covered in the medical care plan
- Access to food and fluid and how to meet their daily needs
- Access to en-suite area and conditions surrounding this relating to risk
- Engagement with the patient
- What the patient needs to do to enable seclusion to end
- The patients' wishes and views about the care they receive.

This care plan would constitute a support plan for the individual and must include their views.

3.14.4 As soon as any level of seclusion is commenced, the team must refer the patient to Advocacy, (IMHA) services; this is in order that they can attend to support the patient whilst they are in seclusion. This referral will be made whether it is requested by the patient or not, however the patient may refuse to see the Advocate upon their arrival to the ward.

3.14.5 Whilst in seclusion, the patient will only be able to receive visitors if it is risk assessed as suitable. An employee from the Care Quality Commission, a member of the Trust Board, a representative from their legal team or their advocate must be enabled to visit if requested and it is safe to do so. Any other visits must only be undertaken with the agreement of the nurse in charge. This engages the patient's right to private and family life and the Mental Health Act Policy on restricting visiting must be followed.

3.14.6 Whilst in seclusion, the gender, cultural and religious needs of the patient must be upheld and facilitated wherever possible. This will include support to use the shower facility by staff of the same gender, opportunities to maintain prayer and other religious practices or the provision of food to meet the patient's cultural needs.

3.14.7 As well as completion of the Seclusion Pathway Record in Appendix 1, staff must ensure that relevant sections of the patients' electronic record are also updated to provide an accurate reflection of the care and treatment the patient is receiving. On termination of seclusion, the seclusion paperwork must be uploaded to clinical documentation on the electronic patient records.

3.15 Prolonged Stay in the Seclusion Suite/Long –term segregation

3.15.1 The processes and safeguards outlined in this policy will, for the vast majority of patients, ensure that their time in any part of the seclusion suite is short. However, a small minority of patients will have needs and risks that will not respond quickly to the treatment and care being offered. Therefore the review procedures as outlined in this policy must be strictly followed.

3.15.2 If during the multi-disciplinary teams review of seclusion the team determine that the criteria for long term segregation is met then the process to begin long-term segregation should be started by that team. The team should ask themselves, 'Is the review timetable for seclusion no longer serving any useful purpose, and are the less frequent but more exacting reviews, for Long Term Segregation (LTS), now appropriate?.'

In answering the question the team need to be mindful that LTS can only be used for patients in order to reduce a sustained risk of harm posed by the patient to others, which is a constant feature of their presentation. In answering this question, it should have been determined that the risk of harm to others would not be ameliorated by a short period of seclusion combined with any other form of treatment. The clinical judgement is that, if the patient were allowed to mix freely in the general ward environment, other patients or staff would continue to be exposed to a high likelihood of serious injury or harm over a prolonged period of time.

Each case must be decided on its own facts by applying the above criteria to them. Reasons why the criteria are met should be clearly recorded. The team should seek the views of any IMHA involved, the family and the agreement of a representative from the Solent executive board. A view should also be given to the responsible commissioning authority as to whether transfer to a more suitable hospital is appropriate and if so agree how to expedite the transfer.

It is permissible to manage this small number of patients by ensuring that their contact with the general ward population is limited. In Solent NHS Trust the only ward authorised to practice Long Term Segregation is Maples. The environment should be made no more restrictive than is necessary. This means it should be as homely and personalised as risk considerations allow. The area used to accommodate the patient in conditions of long-term segregation should be configured to allow the patient to access a number of areas including, as a minimum, bathroom facilities, a bedroom and relaxing lounge area. Patients should also be able to access secure outdoor areas and a range of activities of interest and relevance to the person. They must have a clear risk assessment and care plan setting out what areas they can access, the risks and how these will be managed. Patients should not be isolated from contact with staff (indeed it is highly likely they should be supported through enhanced observation) or deprived of access to therapeutic interventions. Treatment plans should aim to end long-term segregation.

The Portsmouth City Council local safeguarding team should be made aware of any patient being supported in longer term segregation for the normal referral process. Staff supporting patients who are long-term segregated should make written records on their condition on at least an hourly basis. The patient's situation should be formally reviewed by an approved clinician at least once in any 24-hour period and at least weekly by the full Maple ward MDT and it should include IMHA if there is one. Out of normal working hours, the approved clinician is the on-call consultant psychiatrist. The operations Manager for mental Health Service or a suitably senior deputy will review the use of long term segregation fortnightly.

The outcome of all reviews and the reasons for continued segregation should be recorded and the responsible commissioning authority should be informed of the outcome). LTS should be ended as soon as is possible. This could be by formally ending it or transfer of the patient to a more suitable ward. The view of Solent NHS Trust is that longer term use of LTS is not appropriate in its psychiatric units. Therefore it is extremely unlikely that LTS will occur for longer than three months. However, if this changes and it does, an external hospital should be approached to undertake regular three monthly reviews of the patient's circumstances and care. This should include discussion with the patient's IMHA (where appropriate) and commissioner. The patient's treatment plan should clearly state the reasons why long-term segregation is required.

The way that the patient's situation is reviewed needs to reflect the specific nature of their management plan. The purpose of a review is to determine whether the on-going 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 decision to end long-term segregation should be taken by the MDT (including consultation with the patient's IMHA where appropriate), following a thorough risk assessment and observations from staff of the patient's presentation during close monitoring of the patient in the company of others.

The patient's care plan should outline how they are to be made aware of what is required of them so that the period of long-term segregation can be brought to an end. Where successive MDT reviews determine that segregation continues to be required, more information should be available to demonstrate its necessity and explain why the patient cannot be supported in a less restrictive manner. At times of acute behavioural disturbance where there is a need to contain an immediate risk of harm to others, there may be a need to transfer the person, for a short period of time, to the seclusion area. In such a situation, the procedure for seclusion should be followed with regards to authorising and commencing seclusion, observation, seclusion reviews and ending seclusion.

3.15.3 A patient in need of Long Term segregation would not be appropriately placed upon Maple Ward. Transfer to a more secure ward must be considered in these cases.

3.16 Support for Patients Leaving the Secondary Level Seclusion Area

3.16.1 The service recognises that being cared for in the seclusion suite can have a significant effect on the patient. Staff must ensure that time is set aside to re-integrate the patient into their new environment and to discuss seclusion episode with the patient to re-establish the therapeutic relationship which may have been affected.

3.16.2 In order to facilitate this process, staff members must consider discussing the following questions with the patients:

- Does the patient understand why he/she was in seclusion?
- Does the patient agree that this was necessary?
- How does the patient feel now, after the event?
- How can future episodes of extra care/seclusion be avoided?
- Can they offer any alternative that they feel would work and include this in an advance statement?

3.16.3 The debrief session between the staff and the patient must be recorded within the patients' notes and the patient must be offered a copy of these. This will enable both the patient and the staff team caring for them to learn from this experience and to enable it to inform the future management and care given to the patient.

3.16.4 As soon as is practicably possible following a patient leaving the suite, the patients' MDT must meet to discuss and review the patients time during seclusion. The purpose of this must be to identify precipitating factors that led to the need for seclusion and how care can be planned to avoid this being required in the future. The patient must also be invited to attend this review in order to give their views and feelings.

3.17 Bank and Agency Staff

3.17.1 During times of increased clinical need and or staff shortages caused by short term sickness, all inpatient areas will use Bank or Agency staff to fill the gaps left by regular staff and/or provide extra resource for inpatient wards during times of increased acuity. It is vitally important that these staff receive a full handover of the needs and risks of the current inpatients prior to them beginning their shift and specifically, their roles and responsibilities for patients within the seclusion suite.

3.17.2 All Bank or Agency Staff, who have not worked on the ward before, must be given a copy of this policy to read prior to starting their shift. They must then be orientated to the ward layout and made aware of security considerations (e.g. doors that need to be locked) and the location of the fire exits.

3.17.3 The Nurse in Charge of the ward must ensure that the Bank or Agency members of staff are aware of any patients within the suite and must agree with them their roles and responsibilities for these patients. This includes the training competencies of such staff.

3.17.4 Students or other visitors to the ward, who are not employed to work on the ward within the shift numbers, will not be expected to undertake responsible care for patients within seclusion. It may be appropriate for student to spend time in the seclusion suite for their learning requirements as long as this is not detrimental to the patient.

4. ROLES & RESPONSIBILITIES

4.1 Staff

4.1.1 The Chief Executive has ultimate accountability for the strategic and operational management of the organisation, including ensuring all policies are adhered to.

4.1.2 The Chief Nurse is responsible for ensuring that this policy is clinically appropriate in ensuring that patients' needs and safeguards are met and that best practice is proposed.

4.1.3 The Head of Access and Unplanned Care Mental Health has the responsibility of ensuring that this policy is cascaded down to the AMH Clinical matron as appropriate for dissemination and implementation within the inpatient

environments.

4.1.4 The AMH Clinical matron is responsible for the dissemination and implementation and monitoring of this policy in the areas that they are accountable for.

4.1.5 Lead Nurses are accountable for ensuring that this policy is adhered to and implemented by their staff teams. They are responsible for ensuring that staff, receive appropriate support and guidance on how to follow the guidance within this policy and will monitor for breaches of this policy and take action as appropriate to rectify this.

4.1.6 Inpatient staff are responsible for being aware of and following the guidance within this policy at all times. Whilst this policy only relates to the use of the seclusion suite on Maple Ward, all AMH residential inpatient staff are expected to provide cover across all inpatient areas, therefore all staff need to be aware of what is required of them with regard to this policy. They must also raise potential clinical problems that may arise from this policy with the Clinical matron for the Orchards to enable a review of its contents and suitability. They are also responsible for ensuring new starters to the team and Bank and Agency staff are aware of this policy.

4.1.7 AMH inpatient services now have a dedicated Physical Intervention Lead who has responsibility for maintaining the standards set out in this policy by ensuring that all staff are trained both in restraint and the use of seclusion. The Physical Intervention Lead will review all incidences of seclusion and provide a report, which will be shared with staff. They will also be responsible for reviewing practice and developing strategies that will support both staff and patients.

4.2 Committees/Groups

4.2.1 The Policies Committee and the Trust Management Team Meeting have the responsibility of policy ratification and will seek assurances from clinical services that it represents best practice and is based upon current evidence based information.

4.2.2 The Trust Management Team, (TMT) & Operational Steering Group will consider this policy following its presentation from the document manager to ensure that it complies with the format and content as stipulated in the Policy for the Development and Implementation of Procedural Documents (Solent NHST/Policy/GO/01) and agree to progress it to approval through the organisation.

4.2.3 In order to maintain appropriate governance and monitoring arrangements of the use of seclusion, all episodes of seclusion will be reported to the Mental Health Act Scrutiny Committee, as per point 3.9.3 Explanations will also be provided for patients who are repeatedly placed in seclusion.

5. TRAINING

5.1 Solent NHS Trust recognises the importance of appropriate training for staff. For training requirements and refresher frequencies in relation to this policy subject matter, please refer to the Training Needs Analysis (TNA) on the

intranet.

5.2 In order for staff to provide effective and safe patient care whilst patients are in the seclusion suite, staff must have attended training in the following areas:

- Risk Assessment and Management for all staff
- Deteriorating and Resuscitation Training, (DART), for all staff.
- Restraint training, (PMVA) for all clinical staff.

5.3 All staff members must maintain responsibility for not only attending such training sessions but that they remain in date with them to enable them to work to best practice guidelines at all times. The training needs and records of the staff are liable for reporting to the Mental Health Act Scrutiny Committee.

5.4 It is vital that the Clinical matrons, Lead nurses and Senior Nurses accountable for AMH inpatient services can demonstrate that their staff members have attended the above training courses and have the necessary level of competence to nurse patients in the seclusion suite. This will be achieved through reviews and audits of individual and team training records.

5.5 On the job shadowing, mentoring and support will be given to all new starters, Bank and Agency members of staff to ensure that they are aware of this policy and that they can be supported to achieve high standards of providing care for patients within the seclusion suite. Where appropriate competence checklists to support this practice will be utilised

6. EQUALITY IMPACT ASSESSMENT AND MENTAL CAPACITY

6.1 The Equality Impact Assessment and Mental Capacity Act Assessment identified that this policy is unlikely to lead to discrimination against any particular group and that it takes the situations of service users who lack capacity to make decisions into account. The Impact Assessment can be seen in Appendix 3.

7. SUCCESS CRITERIA / MONITORING EFFECTIVENESS

7.1 The success criteria for this policy would be that the seclusion suite is used appropriately in meeting patients' needs and managing their risks. This will include:

- Patients are only cared for in the suite when clinically indicated
- Patients' Human and Legal rights are protected and supported
- Patients only remain in the suite for as long as they require it, with clear evidence to show the treatment and interventions planned to enable the patient to recover as quickly as possible.

7.2 In order to monitor the effectiveness of this policy and to ascertain that it successfully achieves its aims, a number of auditing and benchmarking standards will be used by managers and matrons. This will include the following:

- All episodes of seclusion will be raised via the High Risk Incident, process to ensure that thorough investigations into the reasons why seclusion was required can be carried out and to ensure that it was a

proportionate response to meet the needs of the patient at that time

- Inclusion of this policy and guidance on its implications for clinical practice in all local induction packs for new staff/students/temporary staff
- Review of incidents that are raised via the online reporting system or via the HIRI (High Incident Requiring Investigation) process to enable trends to be identified and/or lessons learnt to improve practice
- Feedback and or complaints from people who use the service
- Ongoing audit and spot checks relating to the use of the suite on Maple
- Ward and regular reviews of documentation pertaining to these areas
- Discussions between individual staff with their line manager through the supervision format.

7.3 A guide to assist in the audit of the standards required when the suite has been used can be seen in Appendix 4. The Clinical matron for The Orchards (or nominated deputy) will be required to complete this audit at least every 3 months (quarterly).

7.4 Results from ongoing audits and spot checks will be taken to staff team meetings and/or individual staff to raise awareness of good and bad practice that may be occurring. Issues relating to the implementation of this policy must also be taken to the AMH Clinical Governance Meeting so that these can be addressed accordingly. Furthermore, results from the quarterly audit completed by the Clinical matron will be tabled at the following meetings for information and discussion:

- Monthly Mental Health Act Monitoring Meeting
- Mental Health Act Scrutiny Committee.

7.5 All staff members working for Solent NHS Trust or within inpatient areas run by Solent NHS Trust are expected to comply with the contents of this policy at all times. In rare circumstances, if staff members are **unable** to comply with this policy it must be immediately reported to the Line Manager who must consider what remedial steps will be taken to manage this risk. The Non-Compliance Form (Appendix 6 within the Policy for the Development and Implementation of Procedural Documents (Solent NHST/Policy/GO/01)) must also be completed.

8. REVIEW

8.1 This document may be reviewed at any time at the request of either staff side or management, but will automatically be reviewed twelve months from initial approval and thereafter on a bi-annual basis unless organisational changes, legislation, guidance or non-compliance prompt an earlier review.

9. REFERENCES AND LINKS TO OTHER DOCUMENTS

9.1 REFERENCES

- Department of Health, (1983) "Mental Health Act". HMSO. London.
- Department of Health, (2002) '*Mental Health Policy Implementation Guide: National Minimum Standards for general adult services in Psychiatric Intensive Care Units (PICU) and Low Secure Environments'.* London
- Department of Health, (2015) 'The Code of Practice – The Mental Health Act

(1983) TSO London

- Mental Health Chief Psychiatrists Guideline (2002) '*Chief Psychiatrist's guidelines: High Dependency Unit Guidelines*. Accessed at www.health.vic.gov.au/mentalhealth/cpg/hdug_guidelines.pdf
- NICE Guideline [2005, revised in 2006] *'Violence: The short term management of disturbed/violent behaviour in psychiatric in-patient settings and emergency departments.* NHS. London
- Seclusion Policy (2007) Suffolk Mental Health Partnerships NHS Trust
- Seclusion Policy (2008) West London Mental Health NHS Trust
- Seclusion and Long-Term Segregation Policy (2017) Southern Health Foundation Trust

9.2 LINKS TO RELATED SOLENT NHS TRUST DOCUMENTS

- Deprivation of Liberty Safeguards and Mental Capacity Act Policy
- Information Governance Policy
- Safeguarding Children, Young People and Adults at Risk Policy
- Management of Violence Aggression and Abuse against Staff Policy
- Physical Security policy
- Rapid Tranquilisation policy
- Risk Management Strategy Policy
- Mental Health Act Policy
- Infection Prevention and Control Decontamination Policy
- Psychiatric Observations and Engagement Policy
- Creating a Smoke Free Workplace Policy
- Serious Incident Requiring Investigation (SIRI) Policy

10. GLOSSARY

10.1

PMVA	Prevention of Violence and Aggression
AMH	Adult Mental Health
OOH	Out of Hours
PICU	Psychiatric Intensive Care Unit
NICE	National Institute for Clinical Excellence
MDT	Multi-Disciplinary Team
RC	Responsible Clinician
NRT	Nicotine Replacement Therapy
NIC	Nurse in Charge
IMHA	Independent Mental Health Advocates
IMCA	Independent Mental Capacity Advocates
NHS	National Health Service
TNA	Training Needs Analysis
NHST	National Health Service Trust
CoP	Code of Practice
TMT	Trust Management Team

Appendixes

Appendix	Title
Appendix 1:	Seclusion Pathway Record Paperwork
Appendix 2:	Patient Rights Leaflet whilst in Seclusion
Appendix 3:	Equality Impact Assessment
Appendix 4:	Audit Tool for the use of the Extra Care Area and Seclusion Room
Appendix 5:	Psychiatric Observation Levels
Appendix 6:	Food and Fluid intake/output chart
Appendix 7	Non – contact physical health observations tool

Appendix 1

SECLUSION PATHWAY RECORD

Patient Name:	
Date of Birth:	
NHS Number	
Gender:	
MHA Status:	

Date and time seclusion commenced:	
Level of seclusion, secondary or tertiary.	
Name and designation of person initiating seclusion episode:	
Incident No.	
Care plan commenced Y/N	
Staff de-brief completed Y/N	

Staff Members Involved in placing the patient into Seclusion	
NAME	**DESIGNATION**

PROFESSIONALS NOTIFIED OF SECLUSION EPISODE

	Name	**Date and time**	**Date and time**	**E X**
Doctor				
Senior Nurse on Duty (OOH)				
Responsible Clinician				
Mental Health Act Admin Team				
Advocacy Services				
Physical Intervention Lead				

Staff de-brief				
Patient de-brief				

Brief Description of events and rationale for seclusion (THIS MUST STATE WHAT WAS THE RISK OF SEVERELY DISTURBED BEHAVIOR WHICH PRESENTED A RISK TO OTHERS AND WHY IT COULD NOT BE MANAGED IN A LESS RESTRICTIVE WAY) / patient response to seclusion / details about medical staff involvement:

Items removed from patient entering seclusion and where these have been stored

Details of medication given to patient either prior to seclusion episode starting and within the first 30 minutes of seclusion episode starting – rapid tranquilisation pathway started?

Date and Time that 1st 2 hour review is due

Form Completed By:	**Name:**	
	Designation:	
	Date and Time:	

Seclusion Record Nursing Review - (2 Hourly Form)

Patient Name:		**MHA Status**	

Name and Designation of 1st Reviewer	
Name and Designation of 2nd Reviewer	
Date and Time of Review:	

Appearance: (Physical Obs, Behaviour, Food/Fluid Intake, Aggression etc.)

Details of Review: (changes to care plan and reasons for decisions made) THIS MUST STATE HOW THE CRITERIA ARE STILL MET OR NOT

Date and Time of next review (2 hourly form)

Signature of 1st Reviewer		**Date and Time**	
Signature of 2nd Reviewer		**Date and Time**	

Seclusion Record Medical Review -

Patient Name:		**MHA Status**	

Name and Designation of 1st Reviewer	
Name and Designation of 2nd Reviewer	
Date and Time of Review:	

Appearance: (Physical Obs, Behaviour, Food/Fluid Intake, Aggression etc.)

Details of Review: (changes to care plan and reasons for decisions made) THIS MUST STATE HOW THE CRITERIA ARE STILL MET OR NOT

Signature of 1st Reviewer		**Date and Time**	
Signature of 2nd Reviewer		**Date and Time**	

Seclusion Record MDT review

Patient Name:		**MHA Status**	

Date and Time of Review	

INDEPENDENT REVIEW CARE TEAM REVIEW

(delete as appropriate)

Details of Review and ongoing Care Plan THIS MUST STATE HOW THE CRITERIA ARE STILL MET OR NOT

Signature of Doctor	
Print Name and Designation	

Signature of Nurse	
Print Name and Designation	

Signature of the senior nurse out of hours co-ordinator (OOH) or Manager	
Print Name and Designation	

Seclusion Observation Record

Patient Name:		**MHA Status**	
Date and Time Seclusion Started			

An entry in this record has to be made at least every 15 minutes by the staff member observing the patient. Records must make reference to the following points:

Mental State
Physical Health
Food and Fluid input/output
Behaviour
Hostility and Aggression
Interaction with staff member

When handing over observation responsibilities both staff members must sign this record to acknowledge that the handing over of information relevant to the patient has occurred

Date and Time	Observations as per guidance above	Signature	Print Name / Designation

Page No:

Seclusion Observation Record (Continuation Sheet)

Patient Name:		MHA Status	

Date and Time	Observations as per guidance above	Signature	Print Name / Designation

Termination of Seclusion Episode

Patient Name:		MHA Status	

Date and Time Seclusion Terminated	

Name and Designation of Staff member terminating seclusion episode	

Reasons for Seclusion Episode being terminated – include risk assessment, behaviour, engagement with staff

Plan for the Patient now that Seclusion has ended – gradual or full termination? Transfer to Enhanced Care or Ward?

Patients' view of time within Seclusion – include date and time that debrief will occur

PROFESSIONALS NOTIFIED OF SECLUSION EPISODE ENDING

	Name	Date and time informed
Doctor		
The senior nurse out of hours co-ordinator (OOH)		
Responsible Clinician		
Mental Health Act Admin Team		
Advocacy Services		
Physical Intervention Lead		

Appendix 2

Patient Information Sheet
Seclusion – Your Rights

Information

Staff will verbally inform you about your rights. They will tell you:-

Why you have been secluded/ segregated from the main ward
How long seclusion will last and how it will end
How to call them if you need to

Your Safety

A member of staff will stay outside the room to make sure that you're ok. If staff need to search you, they will tell you why and ask for your permission. Staff may take items such as shoes, belts, jewellery and any other items that may potentially be used in a harmful way. You will get these items back when it is safe to return them to you

Dignity and Respect

You will be treated with respect at all times
You can wear your own clothes
You can use the toilet and have a wash when you need to

Food and Drink

You will get food at regular intervals
You will be offered a drink at regular intervals

Visits and Messages

You will be visited regularly by doctors and nurses responsible for your care and you will be able to tell them your views about this. When possible, you can send messages to your friends and relatives through the staff member who is outside your room

Questions and complaints

If you have any questions or complaints, please raise them with the member of staff dealing with you. If you prefer you could speak to either your doctor when they come to visit you or ask to speak to the Lead nurse or Clinical matron.

Appendix 3 **Equality Impact Assessment**

Step 1 – Scoping; identify the policies aims	Answer
1. What are the main aims and objectives of the document?	To support the operational use of the seclusion suite within a PICU whereby patient safety is maintained and recovery is supported by appropriately trained and skilled staff.
2. Who will be affected by it?	Potentially all patients admitted to AMH and OPMH; Maple Ward or Hawthorn Ward on The Orchards.
3. What are the existing performance indicators/measures for this? What are the outcomes you want to achieve?	Reviews of every period of seclusion completed as an HIRI report by The Physical Intervention Lead and this will be presented to the Scrutiny Committee. The outcome is to have a clearly defined operational policy and process that underpins roles and responsibilities of the inpatient staff and Solent NHS Trust in the safe provision of a seclusion suite to facilitate the safe management and supportive treatment of its patients.
4. What information do you already have on the equality impact of this document?	National evidence suggests that those from minority ethnic groups are disproportionately detained and placed in higher levels of security. Currently there is no local evidence/statistics relating to the use of higher levels of security for patients from minority ethnic groups. With regard to local statistics relating to disproportionate detentions the evidence is not clear. This policy will provide assurance that decisions to use any area of the suite (either secondary or tertiary seclusion) are made solely on clinical grounds, are subject to stringent review processes and that all patients have access to independent support (Advocacy Services).
5. Are there demographic changes or trends locally to be considered?	None identified.
6. What other information do you need?	None

Step 2 - Assessing the Impact; consider the data and research	**Yes**	**No**	**Answer** (Evidence)
1. Could the document act unlawfully against any Group		x	By having this clear operational policy and ensuring the guidance and practice laid out within it is applied to all inpatients at all times, it ensures that no group could be unlawfully treated favourably or unfavourably compared to another.
2. Can any group benefit or be excluded?		x	As per the answer above.
3. Can any group be denied fair and equal access to or treatment as a result of this document?		x	As per the answer above.
4. Can this actively promote good relations with and between different groups?	x		By ensuring that the use of the seclusion suite is solely determined by the needs of the individual, it can show parity between different groups and fairness to all.
5. Have you carried out any consultation internally/externally with relevant individual groups?	x		All relevant staff have been consulted. A steering group was established to write the processes of this policy and this group consisted of: • Medical Staff • Nursing Staff • Auxiliary Staff • Allied Health Professionals • Advocacy • Pharmacy • Local Security Management Specialists • Facilities Manager • Physical Health Matron • MHA Lead • Non-Executive Directors.
6. Have you used a variety of different methods of consultation/involvement	x		Different methods of consultation have included: • Steering Groups • Team Meetings • Emails • Demonstrations/Walk through.
Mental Capacity Act implications			
7. Will this document require a decision to be made by or about a service user? (Refer to the Mental Capacity Act document for further information)	x		MCA taken into account in the policy and supports the decision making identified within this policy to ensure patients' needs are represented and met.
External considerations			

8. What external factors have been considered in the development of this policy?			Communication with the carers and relatives of the individual following the use of the seclusion suite. National guidance around reducing the use of seclusion and promoting reducing restrictive practices.
9. Are there any external implications in relation to this policy?		x	
10. Which external groups may be affected positively or adversely as a consequence of this policy being implemented?			Carers group may view the use of seclusion negatively.

If there is no negative impact – end the Impact Assessment here.

Step 3 - Recommendations and Action Plans	**Answer**
1. Is the impact low, medium or high?	Medium.
2. What action/modification needs to be taken to minimise or eliminate the negative impact?	Ensuring that this policy is followed at all times by inpatient staff will eliminate the potential for negative impacts being caused by the use of the seclusion suite.
3. Are there likely to be different outcomes with any modifications? Explain these?	The use of the seclusion suite will be subject to continuous and stringent monitoring and reviews from all areas of Solent NHS Trust. As a result of this monitoring and reviewing process, different outcomes and modifications of either this policy or the practice of seclusion in Maple Ward may occur.

Step 4- Implementation, Monitoring and Review	**Answer**
1. What are the implementation and monitoring arrangements, including timescales?	Once ratified by Solent NHS Trust, this policy shall be disseminated via the trust intranet. The Clinical matron for The Orchards will ensure that this is implemented within the team by tabling this at team meetings and giving all staff members their own copy. This will be completed in July 2015. Monitoring arrangements are documented within the main body of the text.
2. Who within the Department/Team will be responsible for monitoring and regular review of the document?	The Clinical matron for The Orchards will maintain overall responsibility for the monitoring and review of this document. Support in this process and comments for amendments will be received from significant groups and committees which include, the AMH Essential Standards Group, the Acute Services Operational Meeting, the Acute Care Forum and the Mental Health Act Scrutiny Committee.

Step 5 - Publishing the Results	Answer
1. How will the results of this assessment be published and where? (It is essential that there is documented evidence of why decisions were made).	Attached to this policy and published as such on the intranet.

****Retain a copy and also include as an appendix to the document****

Appendix 4

Audit Standards for the use of the Enhanced Care Area Suite on Maple Ward, The Orchards

- Audit to be completed on a quarterly basis by Clinical matron
- Audit to cover Seclusion Pathway Record sheets and RiO notes
- A minimum of 5 clinical episodes of either of the areas being used must be audited

Patient Name:		**MHA Status:**	
NHS number		**Date of Audit**	

Area where patient was placed

Extra Care ☐ **Seclusion Room** ☐ **Both** ☐

	Audit Standards	Yes	No	If no, give rationale
1	Was the patient informed of the rationale for the Seclusion suite being used and clearly identified what is expected of them?			
2	Was the ward or duty doctor informed of the decision to place in seclusion suite in the agreed time frame? Is this recorded appropriately?			
3	Was the Lead nurse/Matron/548/RC informed (during working hours) or 548/On Call Manager (out of hours) in the agreed time frame? Is this recorded appropriately?			
4	If the patient was informal at the time of Seclusion being used was consideration given to formal detention under the Act?			
5	Were the patient's valuables or any other belongings considered to be potentially harmful removed before entering Seclusion suite? Is this recorded appropriately?			
6	Were Advocacy Services informed in a timely fashion?			
7	Is the observation records completed correctly? Points to consider: - Are the records timed and dated? - Are the records completed in full and cover the required clinical detail? - Are the records signed and have printed names and designation of the observing member of staff? - Are staff members replaced on observations every hour? - was the first hour of observations completed by a RMN?			

8	Is the 2 hourly – 2 nurse Nursing Review completed on time and in the appropriate format - Seclusion Pathway Record and electronic notes?			
9	Is the 4 hourly joint Medical and Nursing Review completed on time and involving direct contact with the patient, inside the suite?			
	Entries to be made in the Seclusion Pathway Record and RiO notes.			
10	Did the seclusion episode continue for more than 8 hours or 12 hours over a 48 hour period? If so, were the relevant persons informed (e.g. Matron/RC/on call manager/on call SPR/Consultant) and did the required review occur on time?			
11	Is the need for secondary level seclusion assessed and reviewed each shift by nursing staff and each day by medical staff? Is this recorded within the patients' RiO notes?			
12	Names of the staff involved in all reviews are to be clearly written in the Seclusion Pathway Record			
13	Is there clear documentation as to the rationale for the Seclusion episode ending?			
14	If the Seclusion suite was required again, was a new process of documentation started?			
15	Is there evidence that use of the Seclusion suite was discussed at the next Care Planning meeting with the MDT?			
16	Is there evidence that the patient was debriefed at the end of Seclusion episode?			

Appendix 5

Psychiatric Observation Levels

Under the new code of practice, enhanced observation is acknowledged to be a restrictive practice but states:-

"Research suggests that most attempted suicides are discovered and prevented by staff checking on patients, particularly in the more private areas of wards. For patients assessed as being at risk of suicide or serious self-harm, a significant preventive mechanism is for nursing staff to be 'caringly vigilant and inquisitive'. For such patients, staff must have a thorough knowledge of the patient as a person, and be constantly and consistently attentive to their state of mind, whereabouts and safety. Unusual circumstances and noises must be noticed and investigated."

The observation levels described below must be implemented as such, but consideration must be given to:-

- Which discipline(s) of staff are best placed to carry out enhanced observation and under what circumstances it might be appropriate to delegate this duty to another member of the team.
- How the selection of a staff member to undertake enhanced observation will take account the patient's unique characteristics and circumstances (including factors such as ethnicity, sexual identity, age and gender)
- How enhanced observation can be undertaken in a way which minimises the likelihood of patients perceiving the intervention to be coercive
- How observation can be carried out in a way that respects the patient's privacy as far as practicable and minimises any distress. In particular provider policies must outline steps to maximise dignity without compromising safety when patients are in a state of undress, such as when using the toilet, bathing, showering, dressing etc.

Staff must balance the potentially distressing effect on the patient of increased levels of observation, particularly if these levels of observation are proposed for many hours or days, against the identified risk of self-injury or behavioural disturbance. Levels of observation and risk must be regularly reviewed and a record made of agreed decisions in relation to increasing or decreasing the observation.

There are the 4 levels of psychiatric observations described in the NICE guidelines which have been adopted by Solent NHS Trust:

Level 1 - General Observation – 60 minutes

- This is the minimum acceptable level for all patients.
- The location of the service user must be known to all staff at all times but they are not necessarily within sight.
- Positive engagement with the patient is an integral clinical duty for patients on this observation level.
- Evaluate the patient's moods and behaviours associated with disturbed/violent behaviour and record these in the notes.

Level 2 – Intermittent Observation – 10-30 minutes

- This level is appropriate for patients who are potentially at risk of disturbed/violent behaviour, including those who have previously been at risk but are in the process of recovery.

- The patient's location must be checked every 10-30 minutes. Adult Mental Health Services use either 15 or 30 minute intervals; Older Persons Mental Health Services use 10, 15, 20 or 30 minute intervals. The exact interval of the observation level (e.g. every 15 minutes) must be recorded in the patient's record.

- Intrusion must be minimised and positive engagement with the patient must take place.

Level 3 – One to One Observation - Within eyesight

- Patient's who could, at any time, make an attempt to harm themselves or others must be observed at this level.
- The patient must be within eyesight and accessible at all times, day and night.
- Any possible tools or instruments that could be used to harm either the patient or anybody else must be removed, if deemed necessary.
- Searching of the patient and their belongings may be necessary, which must be conducted sensitively and with due regard to legal rights. Best practice indicates that 2 members of staff must conduct patient searches, with one staff member being the same gender as the patient.
- Positive engagement with the patient is essential.

Level 4 – One to One Observation - Within arms length

- Patients at the highest levels of risk of harming themselves or others may need to be observed at this level.
- The patient must be supervised in close proximity.
- More than one staff member may be necessary on specified occasions.
- Issues of privacy and dignity, consideration of gender issues and environmental dangers must be discussed and incorporated into the care plan.
- Positive engagement with the patient is essential.

However please note, if a patient under long-term enhanced observation is also being prevented from having contact with anyone outside the area in which they are confined then this will amount to either seclusion or long-term segregation.

Appendix 6

Combined Food and Fluid Record

Affix Patient Label	Previous day oral intake **Risks:** Choking Yes / No Swallowing difficulty Yes / No Special Diet Yes / No Supplement required Yes / No Level of assistance required Yes / No Aids required Yes / No

Time	Description of all food offered and amount served	Amount left	Fluid Intake - (Including fluid offered consumed and refused)			Urine Output	
			Description	ml	Total	ml	Total
08:00							
12:00							
12:00							
18:00							
18:00							
24:00							
24:00							
08:00							

Other Loss and comments:

	Amount of sugar in tea (tsp)		Daily total at midnight (to be recorded on Systemone)
	Amount of sugar in coffee (tsp)		
	Amount of sugar in …… (tsp)		

NON-CONTACT PHYSICAL HEALTH OBSERVATIONS TOOL

NHS Solent NHS Trust

IF A RED BOX STATEMENT IS TRUE: IMMEDIATELY ESCALATE. DO NOT LEAVE THE PATIENT.
DEPENDING ON OUTCOME: CONTACT MEDICAL TEAM USING SBAR OR EMERGENCY AMBULANCE

Document assessment on reverse of this form and also in patients electronic record

Airway clear? • If awake, can they speak? (Not just moans and groans)	**AIRWAY**	• Airway obstructed? Silence? Coughing? Stridor? *(Suggestive of possible swelling)* Gurgling? Wheezing? Snoring? *(Consider: opening airway, back blows, abdominal thrusts, oral suction)* • Is airway unsafe? (Especially if asleep or resting) Are they at risk of vomiting? *(Consider: moving onto their side and carry out constant observations to prevent choking / aspiration)*
Breathing is quiet and regular? • Breathing 12 - 20 respirations per min? • Breathing causes no extra effort or difficulty? • No abnormal breath sounds?	**BREATHING**	• Noisy? Irregular? Shallow? Rapid? Malodourous/unpleasant odour (E.g. pear drops)? • Difficulty breathing, even with open airway? • Rate: more than 20 breaths per min? Or less than 12 breaths per min? *(Consider: COPD, asthma, heart failure, chest infection? Acute illness? Recent rapid tranquilisation? Or restraint? Need for emergency oxygen? Assisted ventilations with bag & valve mask?)*
Warm, comfortable presentation? • Well perfused skin? • "Normal" complexion for them? • Pink mucous membranes inside the mouth? (If easily visible) • If asleep, monitor movement	**CIRCULATION**	• Obvious trauma? Bleeding? Physiological shock? Dehydrated / Malnourished? • Skin: Flushed? Clammy? Sweating? Cold? Pale? Swollen? Ashen (grey)? Mottled (purplish discoloration)? Swollen? Cyanosed (blue tinge, or discoloration of lips, nail beds, tip of nose or ear lobes)? Blue grey tinge to mucous membranes inside the mouth (Dark skin best seen in inner eye lids and lips)? Pallor: white/light coloured skin = skin takes on white hue, especially on face, inside of lips, eyelids & nail beds? Brown skin = yellow/red. Black skin = ashen grey.
Alert? • Responsive to voice? • No other physical health concerns?	**DISABILITY**	• AVPU assessment = Unresponsive? Only responds to verbal or physical stimulus? • Orientation - New or unexplained: Confusion? Disorientation? Sleepy? Drowsy? Fitting? *(Consider: overdose, epilepsy & blood glucose level)* • Temperature: If able to touch - is skin Hot? Cold? Clammy? • Other physical health concern requiring additional interventions / monitoring e.g. Asthma? Diabetes? Epilepsy? Intoxication? Drug / Medication side effects?
Active, walking, steady gait, resting / sleeping NOT unconscious? *(See note on reverse)* • Eating and Drinking? • Presenting as "Normal" for them? • No Patient, Carer, Health / Social Care / Professional concerns	**EXPOSURE**	• Change in ability to mobilise? Inability to stand unaided? • Muscle rigidity? Change in their ability to mobilise? (E.g. weakness in any limbs?) • Not eating & drinking? Signs of dehydration? (Dry cracked lips? Not passing urine?) • Increased: thirst (polydipsia)? And urination (polyuria)? • Signs of Physical Injury / bleeding / bruising / rash / self-harm? • Signs of Infection – Think: Could this Be Sepsis? (Check Sepsis Screening Tool) • Patient, Carer, Health / Social / Professional concerns? (Use clinical judgement

Patient Name **DOB** **NHS No**												**Please** **If ANY "RED" statements are triggered overleaf, tick relevant A, B, C, D or E box below Note your concerns to red trigger in larger box provided** **(Include escalations, support, monitoring & outcomes)**	**Name, Signature & Role**
Date: **Time:**		A	B	C	D	E	A	B	C	D	E		
Date: **Time:**		A	B	C	D	E	A	B	C	D	E		
Date: **Time:**		A	B	C	D	E	A	B	C	D	E		
Date: **Time:**		A	B	C	D	E	A	B	C	D	E		
Date: **Time:**		A	B	C	D	E	A	B	C	D	E		
Date: **Time:**		A	B	C	D	E	A	B	C	D	E		
Date: **Time:**		A	B	C	D	E	A	B	C	D	E		
Date: **Time:**		A	B	C	D	E	A	B	C	D	E		

Important Notes: NEWS (contact physical health observations) is always preferred, in conjunction with an ABCDE assessment. The decision to use only this Non-Contact Physical Health Guidance & Assessment Framework tool is a Registered Nurse decision, on a case by case basis and should be determined each time physical health observations are required. This tool aids assessment, but Registered Nurses should always act on their best professional clinical judgement too. NB: Circumstances why non-contact PHO rather than full NEWS should be summarised on the NEWS chart along with RR and AVPU.

Differentiating between unconsciousness and sleep: Being asleep is not the same as being unconscious. If someone is asleep we would expect them to occasionally change position while sleeping and for them to have a "normal" complexion for them. If you are at all concerned that the patient is not sleeping, and may be unconscious escalate / evoke full AVPU assessment of consciousness immediately.