# Seclusion and Longer Term Segregation

**Target Audience**

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<td>All Inpatient Medical and Clinical Staff working in ward/units with seclusion facilities</td>
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Explanation of terms used in this policy

Seclusion – Seclusion refers to the supervised confinement and isolation of a patient, away from other patients, in an area from which the patient is prevented from leaving, where it is of immediate necessity for the purpose of the containment of severe behavioural disturbance which is likely to cause harm to others (Mental Health Act 1983 Code of Practice 2015, 26.103)

Extra Care Area – A low stimulus, structured and supportive environment distinct from the general ward for use by patients following periods of extreme agitation or aggressive behaviour.

Longer term segregation – Long term segregation refers to a situation where, in order to reduce a sustained risk of harm posed by the patient to others, which is a constant feature of their presentation, a multi-disciplinary review and a representative from the responsible commissioning authority determines that a patient should not be allowed to mix freely with other patients on the ward or unit on a long-term basis (Mental Health Act 1983 Code of Practice 2015, 26.150)

Management of Aggression and Potential Aggression (MAPA) – Refers to the Trust approved programme that teaches management and intervention techniques to cope with escalating behaviours in a professional and safe manner.

Responsible Clinician (RC) – A Responsible Clinician is the Approved Clinician who has been given overall responsibility for a patient’s case.

Approved Clinician - A mental health professional approved by the Secretary of State to act as an approved clinician for the purposes of the Act. Some decisions under the Act can only be taken by people who are approved clinicians. All responsible clinicians must be approved clinicians.

De-escalation techniques – A set of non-physical interventions intended to reduce a person’s heightened state of arousal and the risk of harm to self, others and the environment. See Violence + Aggression Policy

Multi-disciplinary review (MDT) – A review of seclusion by at least three professionals from nursing, medical, psychology, social work or occupational therapy

Advance Statement / Crisis Management Plan – A plan that has been previously agreed with the patient and care team that outlines potential courses of intervention should the patient express a wish to be confined at a time when he maintains capacity to make that decision

Aggression - A disposition, a willingness to inflict harm, regardless of whether this is behaviourally or verbally expressed and regardless of whether physical harm is sustained (NICE Guideline)

Assault - The intentional application of force against the person of another without lawful justification, resulting in physical injury or personal discomfort (NHS Security Management Service)

Non-Physical Assault - The use of inappropriate words or behaviour causing distress and/or constituting harassment (NHS Security Management Service)

Violence - A physical act or verbal assault which produces damaging effects, physically or emotionally upon people

Independent Mental Health Advocate (IMHA) - Anyone who is detained in a secure Mental Health setting, under the Mental Health Act, is entitled to access support from an Independent Mental Health Advocate. They are specialist advocates who are trained to work within the framework of the Act and will support patients to exercise their rights, which can include representing or speaking on their behalf.

Time Out - A behaviour modification technique which denies a patient, for a period of no more than 15 minutes, opportunities to participate in an activity or to obtain positive reinforcers immediately following an incident of unacceptable behaviour. The patient is then returned to his or her original environment. Time out should never include the use of a locked room and should be clearly
Seclusion and Longer Term Segregation Policy

distinguished from seclusion which is for use in an emergency only and should never form part of a behaviour programme.

**Clinical Risk Assessment** - Clinical risk assessment is the process used to determine risk management priorities for patient care by evaluating and comparing the level of risk against organisational standards, predetermined target risk levels or other criteria. The focus should always be on patient safety

**Clinical Risk Assessment Tool** - Forms or formats specifically designed to inform systematic clinical risk management decision making and practice

**Clinical Observation** - The practice of maintaining knowledge of the patient’s location in the clinical area by use of visual contact and is a therapeutic intervention that can be used intensively to increase safety for patients at risk and should be an integral part of clinical risk management. Clinical observation can be used with different levels of intensity dependent upon the clinical risks and the clinical needs presented by the patient. There are 4 x levels of observation:-

- Level 1 = General
- Level 2 = Intermittent
- Level 3 = Constant within eyesight
- Level 4 = Constant at arms length

**DATIX** - The name of the Trust’s electronic Incident Reporting System

**Contemporaneous** - A term that is used to state that records should be written at the time of, or as close to, the event described in the record

**Policy** - Sets out the aims and principles under which services, groups, or units will operate. A policy outlines roles and responsibilities, defines the scope of the subject covered, and provides a high level description of the controls that must be in place to ensure compliance.
1.0 Introduction
Black Country Partnership NHS Foundation Trust recognises that there may be times when a patient needs to be removed from the ward environment and secluded or segregated away from others for the safety of all.

Seclusion can only be used in the Trusts approved Seclusion suites on Gerry Simon Unit and Macarthur Centre.

However, seclusion and segregation are only to be used as a last resort, when all other methods of dealing with a situation have failed. Seclusion or segregation will only be for the shortest period of time that is necessary to promote alternative approaches to the care and treatment and must adhere to the use as described in the Mental Health Act 1983 Code of Practice (2015).

This policy explains how seclusion and longer term segregation should take place within the Trust’s in-patient areas where this may be used to maintain the safety, dignity and care of patients.

2.0 Purpose
The aim of this policy is to ensure that clinical staff working within all inpatient areas of the Trust have clear direction and guidance on the use of seclusion and longer term segregation and work within the Mental Health Act 1983 Code of Practice (2015).

3.0 Objectives
- Inpatient clinical staff understand their roles and responsibilities in relation to the use of seclusion and longer term segregation and work within legal and procedural guidelines
- Seclusion or longer term segregation takes place in a suitable environment and takes account of the patient’s dignity and physical well-being
- To promote best practice principles and ensure consistency across the Trust
- To safeguard a patient’s rights and maintain their welfare throughout any episode of seclusion or longer term segregation
- Each period of seclusion or longer term segregation is recorded completely and contemporaneously

4.0 Seclusion
5.1 Authority to Seclude
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4.0 Seclusion
Seclusion should be used only as a last resort and for the shortest possible time. Seclusion should not be used as a punishment or a threat, or because of a shortage of staff. It should not form part of a treatment programme.

Seclusion should never be used solely as a means of managing self-harming behaviour. Where the patient poses a risk of self-harm as well as harm to others, seclusion should be used only when 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.

The seclusion suite should support maintaining the patient’s dignity and physical well-being. Seclusion should not be used:

- As a punishment or threat.
- As part of a treatment programme.
- Due to shortage of staff.
- Where there is a risk of suicide or self-harm.
- Where increased staffing could manage the identified risks.

A clear justification for using seclusion must be indicated within the Seclusion Record.

4.1 Authority to Seclude
The decision to use seclusion can be made in the first instance by a doctor, a suitably qualified approved clinician or the professional in charge of the ward. The person authorising seclusion should have seen the patient immediately prior to the commencement of seclusion.

If not authorised by a psychiatrist i.e. where the professional in charge of the ward takes the decision, the patient’s responsible clinician, or the duty doctor or equivalent, should be notified at once. A medical review needs to be undertaken without delay or within one hour if the individual is not known, or there is a significant change from their usual presentation.

NB: It is for individual units to determine which of their non-medical approved clinicians are suitably qualified to fulfil functions in relation to seclusion.

If the psychiatrist who authorises seclusion is not the patient’s Responsible Clinician nor an Approved Clinician the Responsible Clinician or duty doctor should be informed of seclusion as soon as practicable. Where seclusion has been authorised by a psychiatrist, whether or not they are the patient’s Responsible Clinician or an Approved Clinician, the first medical review will be the review that they undertook immediately before authorising seclusion (meaning that a medical review within one hour of seclusion is not necessary)

Where it has been agreed in a positive behaviour support plan (or equivalent) that family members will be notified of significant behavioural disturbance and the use of restrictive interventions, this should take place as agreed in the plan.
Authorisation to seclude documentation must be completed. Seclusion procedure must be followed and all necessary documentation maintained.

The Nurse in Charge must advise the Service Manager of the decision to seclude immediately within working hours or the Senior Manager on-call out of hours.

An initial multidisciplinary review of the need for seclusions should be carried out as soon as practicable after the seclusion begins. If it is concluded that seclusion needs to continue the review should establish the individual needs of the patient while they are in seclusion and the steps that should be taken in order to bring the need for seclusion to an end as quickly as possible. A seclusion care plan should be agreed and prepared which should identify how the patient’s presenting and on-going needs whilst in seclusion can continue to be met.

4.2 Seclusion Environment

Only the designated seclusion room should be used for seclusion. This room must adhere to the guidance within the Code of Practice as described in Section 26.109.

The room used for seclusion should:-

- Provide privacy from other patients
- Enable staff to observe the patient at all times
- Be safe, secure and clean
- Not contain anything which could cause harm to the patient or others.
- Be adequately furnished, heated, lit and ventilated
- Be quiet but not soundproofed and with some means of calling for attention, the means of operation should be explained to the patient

Where are the Trust's Seclusion Facilities?

There are 2 seclusion rooms located across the Trust:-

- Gerry Simon Clinic at Heath Lane Hospital
- Macarthur Centre (PICU) at Heath Lane Hospital

Staff may decide what a patient may take into the seclusion room, but the patient should always be clothed.

A clock must be visible from the observation panel for the patient to clearly see.

The seclusion room must only be used for seclusion and must never be used for Time Out or any other purpose.

The seclusion room will be checked every day to ensure that the room is always prepared for use. A seclusion room checklist will be located adjacent to the seclusion room. The seclusion room will also be checked for safety and compliance including any remedial action required to be taken following each episode of seclusion. Such checks are aimed at providing a safe environment for future use.

4.3 Safe use of Seclusion

In order to ensure that seclusion measures have a minimal impact on a patient’s autonomy, seclusion should be applied flexibly and in the least restrictive manner.
possible, considering the patient’s circumstances when it is used for prolonged periods (Mental Health Act Code of Practice 2015, 26.111).

4.3.1 Secluding Patients
A minimum of 3 staff utilising MAPA holding skills are required to seclude patients.

4.3.2 Seclusion Observations
A member of staff must never enter the seclusion room on their own when a patient is secluded - as a minimum checks should always be undertaken by 2 members of staff.

Prior to entering, staff should assess the behaviour and presentation of the patient and unless circumstances demand entry, refrain from entering when it is concluded that such entry is likely to further disturb the patient. In any event, before entering the seclusion room, staff should inform the patient in a respectful manner that they are about to enter.

Whenever the seclusion room is not in use the door must remain fully open and unlocked. It is the responsibility of the nurse in charge to ensure that this is so.

4.4 Capacity Issues
Seclusion should only be used in hospitals and in relation to patients detained under the Mental Health Act. The issue of capacity is overridden within the context of the detention and an emergency where the danger to others and its safe management is paramount.

4.4.1 Seclusion and Informal Patients
In the unlikely, but possible situation where an informal patient presents behaviour warranting seclusion, this policy would be enacted concurrently with an immediate application of either a Doctor’s Holding Power section 5(2) or a Nurses Holding Power section 5(4). This would be followed by an immediate Mental Health Assessment.

4.5 Advance Statements
Patients must have the opportunity to complete an advance statement that expresses their preference on how an episode of severe behavioural disturbance should be dealt with. The purpose of this is to minimise the use of restraint, seclusion and long-term segregation.

Nevertheless, the Trust recognises that some patients may indicate, as part of their advance statements, that they would choose seclusion over restraint as a way of managing their behaviour. In such circumstances, it must be explained to the patient that the Trust is obliged to attempt de-escalation in the first instance, that seclusion is a measure of last resort to be used only for managing behaviour that may harm others, and that its use cannot be included in a Care Plan/Positive Behaviour Support Plan.

4.6 Seclusion Procedure
The period of seclusion should be confined to a minimum and should cease immediately the danger ends, being discontinued at the earliest opportunity whatever the time of day or night.

Version 3.3 November 2018
The implementation of seclusion must follow the procedure set out in the Implementation and Review of Seclusion Flow Chart (Appendix 1). A copy of the flow chart must be displayed directly adjacent to the seclusion room for staff reference.

The need to continue seclusion should be reviewed:

- Every 2 hours by 2 registered nurses, one of whom was not involved directly in the decision to seclude – in exceptional circumstances the review may include a nurse who was involved in the decision to seclude, on such occasions this must be recorded in the patient’s notes. Every 4 hours by a doctor until the first internal multi-disciplinary team review.

Details of these observations/examinations must be noted in the Seclusion Record and signed by the nurse/doctor.

It is the responsibility of the Nurse in Charge to allocate a member of staff to maintain constant observation of the secluded person keeping them within sight and sound at all times. Ideally the observation of seclusion should be completed by a registered nurse however in exceptional circumstances if a registered nurse is not available (e.g. only one registered nurse available due to other clinical activity (emergency situation on the ward, physical health emergency, dual administration of medication), injury/sickness of second nurse) then a Senior Healthcare Support Worker (SHCSW) who has completed Emergency Life Support (ELS) training can be utilised to observe seclusion at the discretion of the Nurse in Charge.

Consideration should be given as to whether a male or female person should carry out on-going observations; this may be informed by consideration of a patient’s trauma history. The aim of the observation is to constantly monitor the patient’s condition and to ascertain whether a recommendation should be made to terminate seclusion.

A Nurse must record observations of the patient’s mental state in the Seclusion Record noting all changes in behaviour and making entries at regular intervals of not more than 10 minutes. The aim of observation is to safeguard the patient, monitor their condition and behaviour and to identify the earliest time at which seclusion can end.

This documented report should include a statement about the patient’s appearance, what they are doing and saying, their mood, their level of awareness and any evidence of physical ill health, especially with regard to their breathing, any pallor or cyanosis. If a decision is made to continue the seclusion, this should be clarified by affirming a YES or NO in the “seclusion to continue” section and the reason why this is necessary given. Every entry must be signed, timed and dated.

Whilst in seclusion, the patient should always be clothed. Staff must assess if the patient is wearing any items of clothing that could be used to self-harm before seclusion commences. It may be decided however that it would be inappropriate to leave the patient with certain items such as belts, ties, hooded tops with drawstrings, scarves, shoe laces. In this case, any items deemed to be dangerous or a potential ligature risk should be removed. In the event this occurs and any items of clothing need to be taken off the person, a member of the same sex as the patient should do this where possible. If necessary, staff will implement approved MAPA techniques;
however staff must ensure this is a proportionate response to the perceived level of risk taking into account that constant observation and all safeguarding measures will be in place.

It is the responsibility of the Nurse in Charge, in consultation with the patient’s responsible clinician or duty doctor, to decide when seclusion is no longer necessary and when this has been decided to immediately terminate the period of seclusion.

If seclusion continues, a direct assessment of the patient must take place on the first hour in the Seclusion Room (Primary Review - Seclusion Record). This must be carried out by two members of staff, one of whom must be the Nurse in Charge at that time and one, where possible, who has not been involved in the secluding of the patient. Both staff must enter the seclusion room and carry out direct observation of the patient, unless it is deemed too unsafe to enter. Details of this review must be recorded in the Seclusion Record and signed by both members of staff.

For patients who have received sedation, a skilled professional will need to be outside the door at all times. Continuing 4 hourly medical reviews of secluded patients should be carried out until the first internal multi-disciplinary team meeting has taken place.

Following the first internal multi-disciplinary team review, further medical reviews should continue at least twice in every 24 hour period. At least one of these should be carried out by the patient’s Responsible Clinician or the ‘out of hours’ covering Consultant.

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

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

Nursing staff must be attentive to the patient’s toilet requirements. If it should be necessary to place toilet facilities in the seclusion room then they should be disposable in design, and be removed immediately after use.

Meals given to a secluded patient must always be supervised. Disposable paper plates and metal spoons should be used, for drinks a plastic disposable cup or an unbreakable beaker. Food and drinks should not be too hot.

If the patient is too disturbed to take on a regular diet, then a liquid diet should be encouraged. Every effort should be made to maintain a high level of fluid intake to combat dehydration.
It is important that nursing/seclusion records evidence the intake of diet and fluids during an episode of seclusion. The responsibility for initiating this rests with the Nurse in Charge.

4.7 Sensitivity to Cultural and Spiritual Needs
The Trust provides care for patients of various ethnic groups with diverse cultural and spiritual needs. By its very nature seclusion or longer-term segregation can restrict patient exposure to normal hospital life and the ability to engage in usual everyday social, recreational, vocational and spiritual activities. Consideration should always be given to involving patients in their normal routine at the earliest opportunity and of ensuring, as far as is practicable, that individual cultural and spiritual needs are identified and met throughout the episode of seclusion or longer-term segregation.

Further consideration should be given to liaising and consulting with external agencies for advice and support if appropriate. The Trust is particularly committed to the monitoring of ethnicity in patients who are secluded or segregated, and understanding the basis for any differences that may arise.

4.8 Termination of Seclusion
In accordance with the Code of Practice 2015, section 26.144, seclusion should 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 feels that seclusion is no longer warranted, seclusion may end following consultation with the patient’s responsible clinician or duty doctor. This consultation may take place in person or by telephone. Where for whatever reason, the Duty Doctor is not available the Duty Consultant should be contacted.

Seclusion ends when a patient is allowed free and unrestricted access to the normal ward environment or transfers to conditions of long-term segregation.

If staff have concerns about the well-being of the secluded patient then 2 nurses must undertake a visual and sound check of the individual. In the event of concerns regarding the patient’s condition, this should immediately be brought to the attention of the duty doctor or Responsible Clinician. If the individual’s physical health is a cause for concern seclusion should be terminated and appropriate actions followed to address i.e. medical emergencies.

4.9 Extraordinary Reporting
If the patient is secluded for more than:-

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

an independent multidisciplinary review should be completed by a Senior Doctor or suitably qualified approved clinician and nurses and other professionals who are not involved in the incident which led to the seclusion. Where an independent multidisciplinary takes place it is good practice for those involved in the original decision to be consulted in the review.

If a patient is secluded for twelve hours continuously then the Service Manager must inform the General Manager. In the event of this being reported out of hours the Senior Manager on-call must inform the Director on-call.
The Responsible Clinician, Service Manager with responsibility for the area and relevant members of the multi-disciplinary team, should be informed about every seclusion regardless of the duration at the earliest opportunity. This can take place by telephone. A full review of this incident should then take place with relevant members of the multi-disciplinary team within a week of the incident, if necessary at an extraordinary meeting prior to the full regular multi-disciplinary meeting.

If the need for seclusion is disputed by any member of the multidisciplinary team and they are unable to agree a course of action the local arrangements are:

- During office hours refer to the Clinical Director or their Nominated Deputy
- Out of Hours refer to the Senior Manager on-call or the On-Call Director
- If necessary the On-Call Director will consult with the Chief Executive

4.10 Record Keeping
The Seclusion record will provide:

- 10 minute recordings by the person undertaking continuous direct observations
- Full demographic details of the patient
- A detailed explanation of the reason why seclusion was requested
- Who gave authority to seclude
- What the patient took into the seclusion room
- A step by step account, with dated authorising persons and signatories.
- Details of who undertook nursing, medical and independent reviews, their assessments and a record of the patient’s condition and recommendations
- If and when a family member, carer and/or advocate was informed of the use of seclusion
- Details of who undertook the scheduled multi-disciplinary team reviews, their assessment and a record of the patient’s condition and recommendations
- Date and time seclusion ended
- Details of who determined that seclusion should come to an end
- The full seclusion report post incident within 2 hours

It will be the responsibility of the Nurse in Charge at that time to ensure that the Seclusion Record is correct and complete.

Copies of the completed Seclusion Record must be placed within the patient’s clinical notes.

It is the responsibility of the Nurse in Charge to ensure that all the relevant documentation is completed with respect to the incident, which led to seclusion including the completion of a DATIX Incident Form.

A record of the seclusion must be made in the nursing and medical records.

All incidents of seclusion must be reported to the multi-disciplinary team meeting.

4.11 Seclusion Care Plan
A seclusion care plan should set out how the individual care needs of the patient will be met whilst the patient is in seclusion and record the steps that should be taken to bring the need for seclusion to an end as quickly as possible. The seclusion care plan should include:
- A statement of clinical needs, including any physical or mental health problems, risks and treatment objective.
- A plan as to how needs are to be met, how de-escalation attempts will continue and how risks will be managed.
- Details of bedding and clothing to be provided.
- Details as to how the patient’s dietary needs are to be provided for.
- Details of any family or carer contact/communication which will be maintained during the period of seclusion.

Whenever possible, the patient should be supported to contribute to the seclusion care plan. Steps should be taken to ensure that the patient is aware of what they need to do for the seclusion to come to an end.

Care plans should also provide details of the support that will be provided when seclusion comes to an end.

### 4.12 Patient Debrief/ Reintegration to Ward/ Unit

It is the responsibility of the Nurse in Charge at the time at which the seclusion is terminated to allocate a member of staff to specifically spend time with the patient, unless the patient objects, discussing the preceding events and offering support. Discussions will include:-

- Does the patient understand why they were secluded?
- How does the patient feel after the event?
- Does the patient feel the action taken was reasonable and appropriate?
- How can the need for any further episodes of seclusion be avoided in the future?

Ensure that all details of the debriefing process are fully recorded within the patient’s clinical notes.

With his/her consent the patient should also be sensitively examined for any injuries sustained during the incidents leading up to or during seclusion. Any injuries should be recorded on an incident form, the seclusion report, a body map, nursing record, and where necessary reported to the Doctor.

It is the responsibility of the Nurse in Charge at the time at which the seclusion is terminated, to ensure that all staff have the opportunity to discuss any issues that have arisen.

It is the responsibility of the Nurse in Charge at the time at which the seclusion is terminated, to ensure that the seclusion room is inspected to ensure that no damage has occurred and that the room is cleaned as necessary.

All incidents of seclusion must be reviewed in the next multi-disciplinary team or if deemed appropriate in an earlier review if used more than three times in one week with one patient. The review should explore issues of staff deployment, skill mix, the staff responsible for authorising the seclusion and consistency with the individuals’ plan of care for intervention for challenging behaviour.

In addition to the usual multidisciplinary review of seclusion an independent multidisciplinary review should be completed by a consultant or other senior doctor, nurses and other professionals, who were not involved in the incident, which led to
the seclusion if the seclusion continues for more than 8 hours consecutively; or 12 hours intermittently over a period of 48 hours.

5.0 Longer Term Segregation (LTS)

Longer term segregation refers to a situation whereby in order to reduce a sustained risk of harm posed by the patient to others, which is a constant feature of their presentation, and when it is determined that a patient should not be allowed to mix freely with other patients on the ward or unit on a long-term basis. In such cases, 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.

If a patient has been in seclusion or ECA for 72 hours or more, then the LTS process commences.
Patients should not be denied access to staff or to therapeutic activities (risk dependent) if risks cannot be managed via LTS, seclusion should commence.

Process:
Multi-disciplinary review,
- A representative from the local commissioning body should be invited however if they are unable to attend then the service manager or matron will provide feedback to the commissioning representative at the earliest opportunity.
- Service manager and/or matron must also be invited or at least informed of the meeting.
- Advocacy input should be sought.
- Clearly discuss and document the reasons why LTS is being considered, other alternative risk management strategies that have been unsuccessful, or the reasons why alternative options are not being considered at this time.
- Document those present at the MDT meeting.
- Document the views of the patient and family, if these have not been obtained, why?

If LTS is agreed;
Service manager and matron to be made aware of the decision, if not already.
Service managers will liaise with commissioners.
Care plan to be drawn up clearly stating;
- The justification for commencing LTS
- What measurable progress needed from the patient (for example medication compliance, reduction in physical and verbal aggression, positive engagement with staff)
- The actions that staff will attempt to gradually expose the patient to general ward environment. (for example meals in ADL kitchen with staff only, structured ward time during a settled period)
- A safeguarding adults referral raised

LTS to be reviewed at least every 24 hours by an approved clinician and a record of this.
LTS will be reviewed by the full MDT at least weekly and the care plan reviewed.
If LTS continues for more than three months, the situation must be reviewed by an external hospital, and at three monthly intervals thereafter. When LTS ends, the service manager will be informed and inform commissioners of the intervention ceasing. Safeguarding to be informed to close referral.

The environment should be no more restrictive than is necessary. Facilities should be configured to allow the patient access to a number of areas, including bathroom facilities, a bedroom and a relaxing lounge area as far as the environment will allow. Patients should also be able to access secure outside areas and a range of activities of interest and relevance to them.

At times of acute behavioural disturbance whilst in long term segregation, the need may arise to transfer the patient into seclusion for a short period. In such a situation, the procedure for seclusion in the Mental Health Act 1983 Code of Practice (2015) should be followed with regards to authorising and commencing seclusion, observation, seclusion reviews and ending seclusion.

6.0 Extra Care Area (ECA)

Extra Care Area is distinct from seclusion in that the use of ECA is an agreed therapeutic intervention between patient and staff. The decision to enter ECA is voluntary. If a patient wishes to leave ECA they should not be prevented from doing so. If the patient requires further intervention away from the general clinical area and seclusion is deemed clinically appropriate the patient must be transferred to the designated seclusion room and all appropriate policies and safeguards appropriate to seclusion must then be initiated and adhered to.

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

7.0 Procedures connected to this Policy

Seclusion and Longer Term Segregation - SOP O1 - Extra Care Area Use

8.0 Links to Relevant Legislation


The Code provide guidance on how professionals can ensure that their roles and responsibilities under the Mental Health Act 1983 are carried out in a manner that ensures the delivery of safe and high quality care to patients.

The Code has a wide-ranging application; it applies to the care and treatment of all patients in England, who are subject to the exercise of powers and duties under the Act. The Code notes that the 1983 Act, “affects the lives and liberty of many people, impacting upon them, their families and community. In 2013-14, there were more than 53,000 detentions in England under the Act.”

Key Changes in 2015

- The introduction of 5 new overarching principles (listed below), which should always be considered when taking decisions on matters covered by the Act. Although each of the principles is of equal importance, the weight given to each
principle in reaching a particular decision will vary depending on the context and nature of the decision being made.

- Additional chapters on equality and health inequalities, care planning and human rights.
- New guidance on when to use the 1983 Act and when to use the Mental Capacity Act 2005 and Deprivation of Liberty Safeguards (DoLS).
- Additional guidance on blanket restrictions, immigration detainees, supporting patients (including young people) with autism and learning disabilities, supporting patients with dementia and physical health care.
- Revisions to the chapters on restrictive interventions (including seclusion and longer term segregation).

The 5 Overarching Principles

a. Least restrictive option and maximising independence
   Where a patient can be treated safely and lawfully without detention under the 1983 Act, the Code is clear: the patient should not be detained. Wherever possible, the focus should be on promoting the patient’s recovery and independence.

b. Empowerment and involvement
   Patients should be fully involved in decisions about their treatment, care and support and able to participate in decision-making as far as they can. Where appropriate, the views of the patient’s family and carers should also be considered.

   A patient’s views, wishes and feelings (including past, present and those expressed in advance) should be considered so far as they can be ascertained. With this in mind, the Code encourages professionals to support patients to develop advance statements of their feelings and wishes so that, during period of wellness, they may express views about their future treatment and care.

c. Respect and Dignity
   Not only should patients be treated with respect and dignity but these principles should also apply to the treatment of their families and carers.

d. Purpose and Effectiveness
   Decisions about a patient’s care should:
   - have a clear therapeutic aim
   - promote recovery
   - be performed to current national/best practice guidelines

e. Efficiency and Equity
   The organisations involved in providing care and treatment to patients should work together to ensure that mental health care services are of high quality and are given equal priority to both physical health and social care services.

The Mental Capacity Act 2005

The Act is designed to provide a legal framework for acting and making decisions on behalf of adults who lack the capacity to make particular decisions for themselves.
The Act outlines 5 statutory principles. These are designed to protect people who lack capacity to make particular decisions, but also to maximise their ability to make decisions, or to participate in decision-making, as far as they are able to do so.

1. A person must be assumed to have capacity unless it is established that he/she lacks capacity.
2. A person is not to be treated as unable to make a decision unless all practicable steps to help him/her to do so have been taken without success.
3. A person is not to be treated as unable to make a decision merely because he/she makes an unwise decision.
4. An act done, or decision made, under this Act for or on behalf of a person who lacks capacity must be done, or made, in his/ her best interests.
5. Before the act is done, or the decision is made, regard must be had to whether the purpose for which it is needed can be as effectively achieved in a way that is less restrictive of the person’s rights and freedom of action.

**Summary of other key elements of the Act**

- The Act makes provision for people to plan ahead for a time when they may need support. This introduces advanced decisions to refuse treatment.
- The Act is decision specific in that it deals with difficulties a person may have with a particular issue.
- The Act upholds the principle of Best Interest for the individual concerned.
- A Court of Protection will help with difficult decisions and to make final decisions about whether someone lacks capacity.
- The Office of the Public Guardian the administrative arm of the Court of Protection, enables the Act to work in practice and gives guidance to the general public.
- An Independent Mental Capacity Advocate service will provide help for people who have no intimate support network.
- The Act makes it a criminal offence to willfully neglect someone without capacity.
- The Act generally applies only to those over the age of 16 years, although may apply to some younger people if it is supposed that their capacity will continue to be impaired into adulthood.
- The Mental Capacity Act Deprivation of Liberty Safeguards introduced as an amendment under the Mental Health Act 2007 (but forms part of the Mental Capacity Act), provides a legal framework to ensure people are deprived of their liberty only when there is no other way to care for them or safely provide treatment. They established administrative procedures to ensure the Act's processes are observed in cases of adults who are, or may be, deprived of their liberty in care homes or hospitals, thus protecting health and social care providers from prosecution under human rights legislation.

Key elements include that the person must be provided with a representative and given the right to challenge the deprivation of liberty through the Court of
Protection, and that there must be a mechanism for the deprivation of liberty to be reviewed and monitored regularly.

- **The Human Rights Act 1998**

One of the main laws protecting human rights in the UK, it contains a list of 16 rights (called articles) which belong to all people in the UK, and outlines several ways that these rights should be protected. These rights are drawn from the European Convention on Human Rights, which were developed by the UK and others in the aftermath of World War II.

The Human Rights Act may be used by every person resident in the United Kingdom regardless of whether or not they are a British citizen or a foreign national, a child or an adult, a prisoner or a member of the public.

The Human Rights Act has two main aims, to promote a ‘culture of human rights’ by making sure that basic human rights underpin the workings of government at the national and local level and enabling access to human rights here at home, instead of only being able to go to the European Court of Human Rights.

It does this by placing a legal duty on all public authorities, including NHS organisations and staff and mental health tribunals carrying out public functions, to respect and protect human rights in everything that they do. This means that public authorities have legal responsibilities for respecting, protecting and fulfilling human rights. This duty is important in everyday situations because it enables individuals to challenge poor treatment and to negotiate better solutions.

- **Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 (Part 3)**

These regulations introduce the new fundamental standards, which describe requirements that reflect the recommendations made by Sir Robert Francis following his inquiry into care at Mid Staffordshire NHS Foundation Trust. They enable the Care Quality Commission to pinpoint more clearly the fundamental standards below which the provision of regulated activities and the care provided to people must not fall, and to take appropriate enforcement action where we find it does.

Part 3 has two sections: Section 1 describes the requirements relating to persons carrying on or managing a regulated activity.

Section 2 introduces the fundamental standards below which the provision of regulated activities and the care people receive must never fall. They came into force for all health and adult social care services on 1 April 2015.

Regulation 8: General
Regulation 9: Person-centred care
Regulation 10: Dignity and respect
Regulation 11: Need for consent
Regulation 12: Safe care and treatment
Regulation 13: Safeguarding service users from abuse and improper treatment
Regulation 14: Meeting nutritional and hydration needs
Regulation 15: Premises and equipment
Regulation 16: Receiving and acting on complaints
Regulation 17: Good governance
Regulation 18: Staffing
Regulation 19: Fit and proper persons employed
Regulation 20: Duty of candour
Regulation 20A: Requirement as to display of performance assessments

8.1 Links to Relevant National Standards

- The Mental Health Act 1983 Code of Practice (2015) – see above section
- Care Quality Commission’s Fundamental Standards introduced 1 April 2015

Regulation 10: Dignity and respect
All staff must treat people receiving care and treatment with dignity and respect at all times. This includes all communication with people using services must be respectful; using or facilitating the most suitable means of communication and respecting a person’s right to engage or not to engage in communication; respecting respect people’s personal preferences, lifestyle and care choices.

Regulation 11: Need for consent
Where a person lacks mental capacity to make an informed decision, or give consent, staff must act in accordance with the requirements of the Mental Capacity Act 2005 and associated code of practice.

Discussions about consent must be held in a way that meets people’s communication needs. This may include the use of different formats or languages and may involve others such as a speech language therapist or independent advocate. Consent may be implied and include non-verbal communication such as sign language or by someone offering their hand when asked if they would like help to move. Consent must be treated as a process that continues throughout the duration of care and treatment, recognising that it may be withheld and/or withdrawn at any time.

When a person using a service or a person acting lawfully on their behalf refuses to give consent or withdraws it, all people providing care and treatment must respect this.

Regulation 13: Safeguarding service users from abuse and improper treatment
The intention of this regulation is to safeguard people who use services from suffering any form of abuse or improper treatment while receiving care and treatment.

Providers must have robust procedures and processes to prevent people using the service from being abused by staff or other people they may have contact with when using the service. Where any form of abuse is suspected, occurs, is discovered, or reported by a third party, the provider must take appropriate action without delay. The action they must take includes investigation and/or referral to the appropriate body. This applies whether the third party reporting an occurrence is internal or external to the provider.

- Guidance for NHS Organisations on the Secure Management of Patients’ Property - NHS Protect
While not a recognised national standard this document provides the necessary tools to enable NHS organisations to identify appropriate ways to help protect and secure the property of patients in their care. NHS Protect is the body responsible for tackling crime affecting the NHS, including the creation of a secure environment for all those who use, visit or work in the NHS.

8.2 Links to other Key Policies

- Clinical Observation and Engagement Policy

Clinical observation can be defined as “regarding the patient attentively” whilst minimising the extent to which patients feel they are under surveillance. Observation provides a period of safety for people during temporary periods of distress or pronounced ill-health when they are at risk of harm to themselves or others, and should be undertaken as a component of therapeutic engagement.

The Code of Practice for the “Mental Health Act 1983” states that, “Any restrictions imposed upon the patient by his/her treatment should be kept to a minimum and should be part of a therapeutic plan of treatment that should be reviewed regularly.”

Observation and Engagement is integral to promoting wellbeing and recovery by providing therapeutic interactions that seek to understand the person’s experiences and strengths; addresses their health needs and assesses their mental state.

The policy makes clear the standards expected of clinical staff for the observation and engagement of patients, and to provide them with direction and guidance for making decisions about observation levels including reviews, carrying out observations, correct completion of documentation and their training requirements.

- Prevention and Management of Violence and Aggression including NHS Sanctions Policy

NHS staff and other healthcare workers have a right to expect a safe and secure workplace. This policy sets out a clear framework by which the Trust manages violence and aggression, in line with the requirements and guidance of NHS Protect.

The Trust will, as far as is reasonably practicable, ensure a safe and secure working environment, protecting patients, staff and visitors from acts of violence or aggression, both verbal and physical. The policy explains the responsibilities and arrangements in place to realise this commitment. It applies to all Trust premises, employees, agency, temporary, locum staff, contractors, patients, visitors and others who may be affected by its undertaking. The policy covers the following areas:

- Antisocial, offensive or disruptive behaviour
- Verbal aggression: threatening language, abusive language, discriminatory remarks
- Physical violence and assault
- Psychological Aggression: bullying, intimidation, harassment (including racial & sexual); and
- Damage to personal or Trust property (further reference can be made to the Security Management Policy)

Version 3.3 November 2018
8.3 References

- Closing the gap: Priorities for essential change in mental health,(February 2014) Department of Health
- NHS Security Management Service (November 2004) - A framework for reporting and dealing with non-physical assaults against NHS staff and professionals: Explanatory Notes
## 9.0 Roles and Responsibilities for this Policy

<table>
<thead>
<tr>
<th>Title</th>
<th>Role</th>
<th>Key Responsibilities</th>
</tr>
</thead>
</table>
| Ward/Unit Inpatient Clinical Staff who work within a ward/unit environment where seclusion facilities are provided | Adherence             | - have a responsibility to familiarise themselves with this policy and adhere to its principles in order to be able to respond to the immediate needs of patients and service users  
- attend training applicable to their role  
- promote the well-being and dignity of the patient at all times  
- compliance with all Trust policies is a condition of employment and a breach of this policy may result in disciplinary action  
- any errors or incidents relating to this policy and area of practice are reported on DATIX, the Trust's electronic incident reporting system.  
- if a member of staff has concerns about the way this policy is being implemented or about this area of practice in general, they should raise this with their line manager. If they feel unable to raise the matter with them, he/she may write to an Executive Director. If they feel unable to raise the matter with an Executive Director, he/she may write to the Chairman or a Non-Executive Director. If he/she is unsure about raising a concern or requires independent advice or support, they can contact:-  
  - their Trade Union representative  
  - the relevant professional body  
  - the NHS Whistleblowing Helpline - 08000 724 725  
  - their Trade Union representative  
  - the relevant professional body  
  - the NHS Whistleblowing Helpline - 08000 724 725 |
| Corporate Governance Assurance Unit                                  | Governance            | - monitor all incidents reported via DATIX Trust’s electronic reporting system, which will include all incidents of seclusion  
- initiate reports that are discussed at the Senior Managers/Clinicians Weekly Conference Call and monthly meetings of Group Quality and Safety Groups and the Trust's Quality and Safety Steering Group  
- These reports are then discussed at monthly Clinical Quality Review Meetings with Commissioners  
- all serious incidents are reported to commissioners and NHS England via the Strategic Executive Information System (SIEIS) within two working days – longer term segregation would fall within this category |
| Medical Staff                                                        | Assessment and Treatment | - completion of authorisation to seclude  
- carry out a full review at 4 hours  
- participate in wider multidisciplinary review if the patient is secluded for more than 8 hours consecutively or 12 hours over a period of 48 hours |
| Ward/Unit Managers in ward/units with seclusion facilities          | Implementation        | - ensure patients have thorough risk assessments and management plans in place  
- assess environmental Health and Safety factors  
- monitor staffing and skill mix is appropriate to maintain the safety, dignity and care of patients in seclusion or segregation  
- all incidents of seclusion and segregation are reported  
- seclusion reports are always completed in a thorough and timely manner  
- staff are fully aware that seclusion is only to be used as a last resort when other options have been exhausted  
- staff attend appropriate training applicable to their role  
- disseminate and discuss this policy with their staff to ensure that staff are aware of the requirements for seclusion and segregation, their training needs as necessary and their respective roles and responsibilities  
- provide post incident care and support to staff as necessary |
<table>
<thead>
<tr>
<th>Title</th>
<th>Role</th>
<th>Key Responsibilities</th>
</tr>
</thead>
</table>
| Nurse in Charge                           | Implementation           | - seclusion is only to be used as a last resort when other options have been exhausted  
- ensure that appropriate staffing and skill mix in the event that seclusion is required  
- commencement of seclusion is always reported — out of hours this would be to the on call manager  
- where the review team are unable to agree a further course of action at the 8 hour review, or in the event of 12 hour intermittent seclusion (accumulative seclusion within a 48 hour period), to escalate this to the clinical director or nominated deputy (in hours) or on call manager (out of hours).  
- ensure that seclusion reports and all appropriate documentation is completed |
| Clinical Directors/ Heads of Nursing/ General Managers | Leadership               | - to ensure policy distribution, implementation and compliance throughout relevant wards, units and services within their group  
- to ensure appropriate staffing and skill mix in wards/units with seclusion facilities  
- lead discussions around this topic area and policy at Group Quality and Safety Group meetings  
- oversee the completion of audits in respect of this topic area and policy  
- provide updates on this area of practice and policy within their Group to the Quality and Safety Steering Group |
| Group Quality and Safety Groups            | Monitoring               | - monitor and review all incidents, complaints and claims relating to this area of practice and policy within their Group  
- review the use of seclusion and segregation to ensure that it is used appropriately and in line with this policy  
- receive the results and recommendations of all related completed clinical audits and be responsible for monitoring action plans to implement changes to current practice until completion |
| Quality and Safety Steering Group         | Scrutiny and Performance | - scrutinising the implementation of a systematic and consistent approach to this policy in all service areas and provides exception and progress reports to the Quality and Safety Committee |
| Director of Nursing AHPs and Governance    | Executive Lead           | - lead responsibility for the implementation of this policy  
- allocation of resources to support the implementation of this policy  
- any serious concerns regarding the implementation of this policy are brought to the attention of the Board of Directors  
- lead on strategies and innovations to improve current practice |

### 10.0 Training

<table>
<thead>
<tr>
<th>What aspect(s) of this policy will require staff training?</th>
<th>Which staff groups require this training?</th>
<th>Is this training covered in the Trust’s Mandatory and Risk Management Training Needs Analysis document?</th>
<th>How will the training be delivered?</th>
<th>Who will deliver the training?</th>
<th>How often will staff require training</th>
<th>Who will ensure and monitor that staff have this training?</th>
</tr>
</thead>
<tbody>
<tr>
<td>Physical holding skills to support a patient to enter seclusion and then leave safely</td>
<td>Inpatient clinical staff who work within a ward/unit environment where seclusion facilities are provided</td>
<td>Yes</td>
<td>This training is delivered within the Management of Actual and Potential Aggression (MAPA) training</td>
<td>Internal MAPA Team</td>
<td>Annually</td>
<td>Learning and Development Team</td>
</tr>
<tr>
<td>Immediate Life Support</td>
<td>As above</td>
<td>Yes</td>
<td>Practical one day courses</td>
<td>External Training Provider</td>
<td>Annually</td>
<td>Learning and Development Team</td>
</tr>
</tbody>
</table>
11.0 Equality Impact Assessment
Black Country Partnership NHS Foundation Trust is committed to ensuring that the way we provide services and the way we recruit and treat staff reflects individual needs, promotes equality and does not discriminate unfairly against any particular individual or group. The Equality Impact Assessment for this policy has been completed and is readily available on the Intranet. If you require this in a different format e.g. larger print, Braille, different languages or audio tape, please contact the Equality & Diversity Team on Ext. 8067 or email bcpft.equalityimpactassessment@nhs.net

12.0 Data Protection and Freedom of Information

Data Protection Act provides controls for the way information is handled and to gives legal rights to individuals in relation to the use of their data. It sets out strict rules for people who use or store data about individuals and gives rights to those people whose data has been collected. The law applies to all personal data held including electronic and manual records. The Information Commissioner’s Office has powers to enforce the Data Protection Act and can do this through the use of compulsory audits, warrants, notices and monetary penalties which can be up to €20million or 4% of the Trust's annual turnover for serious breaches of the Data Protection Act. In addition to this the Information Commissioner can limit or stop data processing activities where there has been a serious breach of the Act and there remains a risk to the data.

The Freedom of Information Act provides public access to information held by public authorities. The main principle behind freedom of information legislation is that people have a right to know about the activities of public authorities; unless there is a good reason for them not to. The Freedom of Information Act applies to corporate data and personal data generally cannot be released under this Act.

All staffs have a responsibility to ensure that they do not disclose information about the Trust's activities; this includes information about service users in its care, staff members and corporate documentation to unauthorised individuals. This responsibility applies whether you are currently employed or after your employment ends and in certain aspects of your personal life e.g. use of social networking sites etc. The Trust seeks to ensure a high level of transparency in all its business activities but reserves the right not to disclose information where relevant legislation applies. The Information Governance Team provides a central point for release of information under Data Protection and Freedom of Information following formal requests for information; any queries about the disclosure of information can be forwarded to the Information Governance Team.
### 13.0 Monitoring this policy is working in practice

<table>
<thead>
<tr>
<th>What key elements will be monitored? (measurable policy objectives)</th>
<th>Where described in policy?</th>
<th>How will they be monitored? (method + sample size)</th>
<th>Who will undertake this monitoring?</th>
<th>How Frequently?</th>
<th>Group/Committee that will receive and review results</th>
<th>Group/Committee to ensure actions are completed</th>
<th>Evidence this has happened</th>
</tr>
</thead>
<tbody>
<tr>
<td>Seclusion or segregation must adhere to the use as described in the Mental Health Act 1983 Code of Practice (2015)</td>
<td>1.0</td>
<td>Every incident is routinely reported on DATIX Trust’s Incident Reporting System and collated into a report</td>
<td>Mental Health Legislation Forum</td>
<td>Quarterly</td>
<td>Quality and Safety Steering Group</td>
<td>Quality and Safety Steering Group</td>
<td>Monthly Reports and minutes of meetings</td>
</tr>
<tr>
<td>Use of Longer term Segregation is managed appropriately and effectively</td>
<td>4.0</td>
<td>Every incident is routinely reported on DATIX Trust’s Incident Reporting System and collated into a report</td>
<td>MH and LD Quality and Safety Groups</td>
<td>Monthly</td>
<td>Quality and Safety Steering Group</td>
<td>Quality and Safety Steering Group</td>
<td>Monthly Reports and minutes of meetings</td>
</tr>
<tr>
<td>Use of Seclusion is managed appropriately and effectively</td>
<td>5.0</td>
<td>Every incident is routinely reported on DATIX Trust’s Incident Reporting System and collated into a report</td>
<td>MH and LD Quality and Safety Groups</td>
<td>Monthly</td>
<td>Quality and Safety Steering Group</td>
<td>Quality and Safety Steering Group</td>
<td>Monthly Reports and minutes of meetings</td>
</tr>
<tr>
<td>Seclusion Rooms are always ready for use</td>
<td>5.2</td>
<td>Regular checking of Seclusion Rooms</td>
<td>Unit/Ward staff</td>
<td>Daily</td>
<td>MH and LD Quality and Safety Groups</td>
<td>MH and LD Quality and Safety Groups</td>
<td>Monthly Reports and minutes of meetings</td>
</tr>
<tr>
<td>Seclusion Records</td>
<td>5.10</td>
<td>Audit of Seclusion Books</td>
<td>Heads of Nursing</td>
<td>Annually</td>
<td>MH and LD Quality and Safety Groups</td>
<td>Quality and Safety Steering Group</td>
<td>Monthly Reports and minutes of meetings</td>
</tr>
</tbody>
</table>
Implementation and Review of Seclusion

All other treatment options and alternatives to seclusion have been exhausted

PATIENT PLACED IN SECLUSION

AUTHORITY TO SECLUDE
Registered Nurse in Charge or a Psychiatrist

Doctor to attend without delay or within the hour to authorise and review the need for seclusion

TWO HOURS REVIEW OF SECLUSION
2 Registered Nurses (1 being independent of the initial decision to seclude)

FOUR HOURS REVIEW
Registered Nurse in Charge + Doctor

SIX HOURS REVIEW
2 Registered Nurses (1 being independent of the initial decision to seclude)

EIGHT HOURS REVIEW OR TWELVE HOURS INTERMITTENTLY WITHIN A PERIOD OF 48 HOURS
Responsible Clinician or nominated Deputy
Nurse in Charge
Independent Registered Nurse
Other Professionals (if available)

SECLUSION TERMINATED
Following consultation with the patient’s Responsible Clinician or Duty Doctor

PATIENT DEBRIEF
To be documented within clinical notes

CYCLE IS REPEATED

SECLUSION CONTINUES

Review Team- Dispute/unable to agree course of action. In hours Clinical Director or Nominated Deputy Out of Hours Senior Manager on Call or On Call Manager at Director level

If necessary On Call Director consults Chief Executive.
Seclusion and Longer Term Segregation Policy

Policy Details

<table>
<thead>
<tr>
<th>Title of Policy</th>
<th>Seclusion and Longer Term Segregation Policy</th>
</tr>
</thead>
<tbody>
<tr>
<td>Unique Identifier for this policy</td>
<td>BCPFT-CB-POL-01</td>
</tr>
<tr>
<td>State if policy is New or Revised</td>
<td>Revised</td>
</tr>
<tr>
<td>Previous Policy Title where applicable</td>
<td>Seclusion Policy</td>
</tr>
<tr>
<td>Policy Category</td>
<td>Challenging Behaviour</td>
</tr>
<tr>
<td>Clinical, HR, H&amp;S, Infection Control etc.</td>
<td></td>
</tr>
<tr>
<td>Executive Director whose portfolio this policy comes under</td>
<td>Director of Nursing, AHPs and Governance</td>
</tr>
<tr>
<td>Policy Lead/Author Job titles only</td>
<td>Clinical Director, Learning Disabilities</td>
</tr>
<tr>
<td>Committee/Group responsible for the approval of this policy</td>
<td>Quality and Safety Steering Group</td>
</tr>
<tr>
<td>Month/year consultation process completed *</td>
<td>December 2018</td>
</tr>
<tr>
<td>Month/year policy approved</td>
<td>March 2019</td>
</tr>
<tr>
<td>Month/year policy ratified and issued</td>
<td>March 2019</td>
</tr>
<tr>
<td>Next review date</td>
<td>November 2021</td>
</tr>
<tr>
<td>Implementation Plan completed *</td>
<td>Yes</td>
</tr>
<tr>
<td>Equality Impact Assessment completed *</td>
<td>Yes</td>
</tr>
<tr>
<td>Previous version(s) archived *</td>
<td>Yes</td>
</tr>
<tr>
<td>Disclosure status</td>
<td>‘B’ can be disclosed to patients and the public</td>
</tr>
<tr>
<td>Key Words for this policy</td>
<td>seclusion, segregation, MAPA, violence, aggression</td>
</tr>
</tbody>
</table>

* For more information on the consultation process, implementation plan, equality impact assessment, or archiving arrangements, please contact Corporate Governance

Review and Amendment History

<table>
<thead>
<tr>
<th>Version</th>
<th>Date</th>
<th>Details of Change</th>
</tr>
</thead>
<tbody>
<tr>
<td>3.3</td>
<td>Nov 2018</td>
<td>Changes made to longer term segregatin section 4.0 to clarify process</td>
</tr>
<tr>
<td>3.2</td>
<td>Oct 2016</td>
<td>Extra Care Area (ECA) section added, minor amendment to 5.6 seclusion procedure and amendments made to some definitions</td>
</tr>
<tr>
<td>3.1</td>
<td>May 2016</td>
<td>Changes made to section 5.8/ Appendix 1 flowchart to reflect comments received during CQC inspection</td>
</tr>
<tr>
<td>3.0</td>
<td>June 2015</td>
<td>Changes to reflect the revised Mental Health Act Code of Practice 1 April 2015 and new policy format</td>
</tr>
<tr>
<td>2.0</td>
<td>Jan 2014</td>
<td>Changes to reflect changes to Mental Health Act Code of Practice</td>
</tr>
<tr>
<td>1.0</td>
<td>Sept 2012</td>
<td>Policy for the new organisation BCPFT</td>
</tr>
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</table>