PROACTIVE CARE POLICY
INCLUDING DE-ESCALATION AND SECLUSION

(ADULT MENTAL HEALTH INPATIENT AND ASSESSMENT DIVISION AND CAMHS INPATIENT ONLY)

<table>
<thead>
<tr>
<th>Version:</th>
<th>6.1</th>
</tr>
</thead>
</table>
| Date issued: | August 2015  
August 2016 (updated)  
October 2019 minor amendments |
| Review date: | July 2018  
Extended to April 2020 |
| Relevant Staff Groups | All staff on Holford Ward, Ash Ward, Wessex House and on all other mental health inpatient wards where de-escalation techniques are used. |

This document is available in other formats, including easy read summary versions and other languages upon request. Should you require this please contact the Equality and Diversity Lead on 01278 432000.
**Proactive Care Policy**

**Version:** 6.1  
**Date of issue:** August 2015/2016 due to the above update. October 2019 (minor updates)

**Reference:** MH/ Jun14/SDP  
**Status:** Final  
**Author:** Psychiatric Intensive Care Unit Manager

**Amendments**
Updated to reflect changes to the MHA Code of Practice (2015) and reflect current good practice guidance and new documentation. Introduction of procedure for short-term segregation. Updated August 2016 to include new para. 12.17 and new Appendix G – Physiological Observations During and Post Restraint  
Oct 2019 – Clinical Governance Group updated to Safe Governance Group, updated names of policies where appropriate and review date extended to April 2020.

**Document objectives:** To inform all clinical staff and duty doctors of good practice in relation to the use of seclusion facilities and the management of de-escalation; and when de-escalation might be deemed to be seclusion.

| Approving body | Clinical Governance Group  
| Next review to be approved by the Safe Governance Group | Date: July 2015 June 2016 |

| Equality Impact Assessment | Impact Part 1 | Date: March 2014 |

| Clinical Audit Standards | YES | Date: August 2015 |

| Ratification Body | Senior Management Team | Date: August 2015 August 2016 |

| Date of issue | August 2015/2016 due to the above update. October 2019 (minor updates) |

| Review date | July 2018 Extended to April 2020 |

| Contact for review | Psychiatric Intensive Care Ward Manager |

| Lead Director | Chief Operating Officer |

**CONTRIBUTION LIST**

**Key individuals involved in developing the document**

<table>
<thead>
<tr>
<th>Name</th>
<th>Designation or Group</th>
</tr>
</thead>
<tbody>
<tr>
<td>Martin Chapman</td>
<td>Psychiatric Intensive Care Ward Manager</td>
</tr>
<tr>
<td>Nick Woodhead</td>
<td>Mental Health Legal Strategies Manager</td>
</tr>
<tr>
<td>Spencer Ball</td>
<td>Trust Senior PMVA Trainer</td>
</tr>
<tr>
<td>Kayley Forsdike, Tegan Turner</td>
<td>Holford Ward Clinical Team</td>
</tr>
<tr>
<td>All Group Members</td>
<td>Mental Health Legislation Group</td>
</tr>
<tr>
<td>All</td>
<td>Mental Health Ward/Unit Managers</td>
</tr>
<tr>
<td>All Members</td>
<td>Clinical Governance Group</td>
</tr>
<tr>
<td>All Members</td>
<td>Senior Management Team</td>
</tr>
<tr>
<td>Andrew Sinclair</td>
<td>Equality and Diversity Lead</td>
</tr>
<tr>
<td>Section</td>
<td>Summary of Section</td>
</tr>
<tr>
<td>---------</td>
<td>-------------------</td>
</tr>
<tr>
<td>Doc</td>
<td>Document Control</td>
</tr>
<tr>
<td>Cont</td>
<td>Contents</td>
</tr>
<tr>
<td>1</td>
<td>Introduction</td>
</tr>
<tr>
<td>2</td>
<td>Purpose and Scope</td>
</tr>
<tr>
<td>3</td>
<td>Duties and Responsibilities</td>
</tr>
<tr>
<td>4</td>
<td>Explanations of Terms used</td>
</tr>
<tr>
<td>5</td>
<td>Legal Framework</td>
</tr>
<tr>
<td>6</td>
<td>Definition of De-escalation</td>
</tr>
<tr>
<td>7</td>
<td>Definition of Seclusion</td>
</tr>
<tr>
<td>8</td>
<td>Definition of Short-term Segregation</td>
</tr>
<tr>
<td>9</td>
<td>Proactive Care / De-escalation Pathway</td>
</tr>
<tr>
<td>10</td>
<td>Procedure for Short-term Segregation</td>
</tr>
<tr>
<td>11</td>
<td>Condition of the Seclusion Environment</td>
</tr>
<tr>
<td>12</td>
<td>Procedure for Seclusion</td>
</tr>
<tr>
<td>13</td>
<td>Monitoring Seclusion</td>
</tr>
<tr>
<td>14</td>
<td>Seclusion Reviews</td>
</tr>
<tr>
<td>15</td>
<td>Record Keeping</td>
</tr>
<tr>
<td>16</td>
<td>Ending Seclusion</td>
</tr>
<tr>
<td>17</td>
<td>Post Seclusion Procedures</td>
</tr>
<tr>
<td>18</td>
<td>Seclusion Good Practice Guidance</td>
</tr>
<tr>
<td>19</td>
<td>Training Requirements</td>
</tr>
<tr>
<td>20</td>
<td>Equality Impact Assessment</td>
</tr>
<tr>
<td>21</td>
<td>Monitoring Compliance and Effectiveness</td>
</tr>
<tr>
<td>22</td>
<td>Counter Fraud</td>
</tr>
<tr>
<td>23</td>
<td>Relevant Care Quality Commission (CQC) registration standards</td>
</tr>
<tr>
<td>24</td>
<td>References, Acknowledgements and Associated documents</td>
</tr>
<tr>
<td>25</td>
<td>Appendices</td>
</tr>
<tr>
<td>Appendix A</td>
<td>Seclusion and De-Escalation Clinical Audit Standards</td>
</tr>
<tr>
<td>Appendix B</td>
<td>Algorithm for De-escalation/Seclusion Pathway</td>
</tr>
<tr>
<td>Appendix C</td>
<td>The Safety Tool</td>
</tr>
<tr>
<td>Appendix D</td>
<td>Hierarchy of holds</td>
</tr>
<tr>
<td>Appendix E</td>
<td>Seclusion Log</td>
</tr>
<tr>
<td>Appendix F</td>
<td>Seclusion Monitoring Form</td>
</tr>
<tr>
<td>Appendix G</td>
<td>Physiological Observations During and Post Restraint</td>
</tr>
</tbody>
</table>
1. INTRODUCTION

1.1 This policy has been written in accordance with the guiding principles of the Mental Health Act 1983 Code of Practice (2015). The overarching principles are:

- **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 should not be detained. Wherever possible a patient’s independence should be encouraged and supported with a focus on promoting recovery wherever possible.

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

- **Respect and dignity**
  Patients, their families and carers should be treated with respect and dignity and listened to by professionals.

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

- **Efficiency and equity**
  Providers, commissioners and other relevant organisations should 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 should work together to facilitate timely, safe and supportive discharge from detention.

1.2 The primary focus for managing patients who may present with disturbed or violent behaviour is the establishment of a culture focussing on early recognition, prevention and de-escalation of potential aggression, using techniques that minimise the risk of its occurrence.

1.3 Seclusion, as with control and restraint, poses significant ethical and practical dilemmas, awareness of which is essential to good practice. Members of the multidisciplinary team should be aware of the adverse effects on patients and also be aware of the conflicts between the rights of a secluded patient to freedom, choice and autonomy and the rights of others to protection from harm. It is an emergency measure, which should be imposed only when de-escalation and other strategies have failed and where there is an imminent and significant risk of harm to the patient and others. It should be used as infrequently as possible, as a last resort and only for so long as it takes for the patient to return to a calmer frame of mind. It should never be used to manage suicidal or self-harming behaviours. Its use is clearly open to abuse and therefore requires the most rigorous control, monitoring and evaluation.
1.4 Staff must be confident they can justify the implementation of seclusion.

2. PURPOSE & SCOPE

2.1 To ensure the correct and appropriate use of seclusion by setting out the conditions and processes for its use and how it might differ from de-escalation and short term segregation. Decisions made regarding the use of seclusion must be underpinned by the guiding principles of the Act. This will ensure the safety and the wellbeing of the patient, and ensure the patient receives the care and support rendered necessary by their seclusion both during and after it has taken place.

2.2 To help patients retain their dignity. When implementing practices outlined in the policy staff should always be sensitive to the nine protected characteristics defined by the Equality Act 2010 together with learning disability. Great care should be taken not to misinterpret culturally accepted norms of communication or an attempt to communicate by someone with a sensory loss or cognitive deficit.

2.3 Somerset Partnership NHS Foundation Trust has agreed the following policy, which is applicable to Holford Ward (Psychiatric Intensive Treatment Unit), Ash Ward (Low Secure Unit) and all other wards where de-escalation is used.

2.4 All doctors and staff caring for patients on Holford ward, Ash ward and other wards where de-escalation techniques are used should be familiar with the procedures detailed in this document.

2.5 The policy has been informed by the previous ‘Delivering Race Equality’ work and national inquiries including the report into the death of David Bennett.

3. DUTIES AND RESPONSIBILITIES

3.1 The Trust Board has a duty to care for patients looked after by the Trust.

3.2 The Chief Operating Officer is responsible for this policy covering the appropriate use of seclusion within the Trust, but will delegate authority for the operational implementation and ongoing management of this policy to the Mental Health Legal Strategies Manager.

3.3 The Psychiatric Intensive Care Ward Manager and the Mental Health Legal Strategies Manager are the authors of this policy, who will review this policy at least every two years.

3.4 Each registered healthcare professional is accountable for his/her own practice and will be aware of their legal and professional responsibilities relating to their competence and work within the Code of practice of their professional body.

3.5 All staff caring for patients on the wards should be familiar with the procedures detailed in the document and other related policies.

3.6 All Ward Managers are responsible for ensuring all their nursing staff are conversant with this policy and related policies.
3.7 **Ward managers** of wards where de-escalation techniques are used are responsible for ensuring their staff are aware of the policy.

4. **EXPLANATIONS OF TERMS USED**

- **MHA** – Mental Health Act 1983 as amended by the Mental Health Act 2007
- **AC** – Approved Clinician. This could be a suitably qualified Psychologist, Nurse, Social Worker or Occupational Therapist approved to made decisions under the MHA.
- **RC** – Responsible Clinician. Under the MHA, this is the Approved Clinician in overall charge of a patient’s case.
- **PMVA** – Prevention and Management of Violence and Aggression. The regulated model of control and restraint techniques as taught by the Trust training department and practised by Trust staff.
- **ISOLATION** – The act of separating a person from all others. By definition the patient is alone. In the case of this policy it means the removal of therapeutic support and engagement
- **SEGREGATION** – The act of separating a person from a part or a section of others. By definition not from the whole body of others and not to be alone. In the case of this policy it means enhanced levels of therapeutic support and engagement.

5. **LEGAL FRAMEWORK**

5.1 Seclusion does not breach Article 5 of the European Convention on Human Rights (the right to liberty and security of a person) where the patient is already lawfully detained. The court rejected the argument that seclusion was a 'prison within a prison' and deprived patients of their 'residual liberty'. The fact of detention and the conditions of detention were different issues. If the conditions of detention, including seclusion, are to be challenged, they should be challenged under Article 3 (prohibition against inhuman or degrading treatment) or Article 8 (the right to respect for private life, which includes the right to physical and psychological integrity). The Court of Appeal accepted that improper use of seclusion may amount to inhuman or degrading treatment but decided that the State had taken sufficient steps by introducing the Code of Practice.

5.2 The Court of Appeal reviewed seclusion in two cases, one involving a challenge to the seclusion policy at Ashworth Special Hospital and the other the seclusion of a patient in the psychiatric wing of a general hospital. In both cases, the hospitals had departed from guidance for seclusion set out in the Code of Practice to the Act. The Code of Practice should be followed unless there is a good reason for departing from it in individual circumstances; for example, where adhering to the Code is not in the patient’s best interests and/or presents significant risk to others."

6. **DEFINITION OF DE-ESCALATION**

6.1 The Code (2008) describes de-escalation as a secondary preventative strategy. It involves the gradual resolution of a potentially violent or aggressive situation where an individual begins to show signs of agitation and/or arousal that may indicate an impending episode of behavioural disturbance.
6.2 De-escalation strategies promote relaxation, e.g. through the use of verbal and physical expressions of empathy and alliance. They should be tailored to individual needs and should typically involve establishing rapport and the need for mutual co-operation, demonstrating compassion, negotiating realistic options, asking open questions, demonstrating concern and attentiveness, using empathic and non-judgmental listening, distracting, redirecting the individual into alternate pleasurable activities, removing sources of excessive environmental stimulation and being sensitive to non-verbal communication.

6.3 One of the objectives is to achieve this without having to remove the patient from other patients and the communal area for any length of time, although it is recognised that in some cases this may be necessary.

6.4 A patient’s anger or disturbed behaviour needs to be treated with an appropriate, measured and reasonable response.

6.5 De-escalation techniques should be used before other interventions and should continue to be used even if other interventions are necessary.

7. **DEFINITION OF SECLUSION**

7.1 The Mental Health Act, 1983, Code of Practice (2015), paragraph 26.103, defines seclusion in the following way:

“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.”

7.2 The Trust’s seclusion procedures apply in relation to the above definition where de-escalation as defined at paragraph 6.1 (above) has failed and there is a strong likelihood of the severely disturbed behaviour causing harm to others.

7.3 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. This may require the application of Section 5(4) or 5(2).

7.4 A decision to use seclusion should only be made where:

- The patient is behaving in a manner that is likely to injure others in the immediate future
- A clinical risk assessment is completed that indicates that there is an imminent and high risk of harm to the patient and/or others.
- All other interventions have been considered or attempted in particular verbal and PMVA de-escalation techniques, negotiation and anger management techniques and diversion activities.
- Any decision maker has considered and reflected on their own stress levels and feelings towards the patient and ensured that they are making an objective and unbiased decision (Dix, Betteridge and Page 2008)

7.5 Seclusion may not be used:

- As a punishment or threat
• As part of a treatment programme
• As a method for managing inadequate staff numbers
• Solely as a means of managing self-harming behaviour.

7.6 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.

8. DEFINITION OF SHORT-TERM SEGREGATION

8.1 The Trust makes a distinction between seclusion, which is concerned with the isolation of a patient away from both patients and staff, and short-term segregation which is where a patient’s contact with the general ward population is limited but that they are supported constantly with the immediate presence and engagement of staff. This will mean that for this period of time levels of care, therapeutic support and engagement are enhanced and not removed as in the practise of seclusion.

8.2 Short-term segregation may be considered in cases where the de-escalation pathway has been followed and that although the acute behavioural disturbance remains high and sustained, the MDT clinical assessment and judgement determine that seclusion would be over restrictive and that a patient’s clinical presentation would most likely deteriorate due to isolation, anxiety/fear, high energy levels or reduced stimulation (where sensory processing difficulties are present). It is therefore determined that following de-escalation procedure an immediate return to the general ward area would not be safe for the patient or others.

8.3 It may also be seen as a helpful step down procedure following a seclusion episode. Thereby moving a patient from isolation, into a process of engagement, support and assessment orientated towards safely returning to the general ward environment.

8.4 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 injury or harm. Where consideration is being given to the use of short term segregation, wherever appropriate, the views of the person’s family and carers should be elicited and taken into account. The multi-disciplinary review should include an IMHA in cases where a patient has one.
9. PROACTIVE CARE / DE-ESCALATION PATHWAY

9.1 A proactive care/de-escalation pathway algorithm is shown in Appendix B. This algorithm illustrates the pathway (a positive feedback cycle) for the management of an individual’s distressed, disturbed or harmful behaviour. This is initiated from early in a patient’s admission.

9.2 1. Primary Intervention: Early Recognition (assessment, engagement, prediction)

9.2.1 Clinical emphasis for the management of distressed, disturbed or harmful behaviour should be made on preventative high quality care, patient experience and the forming of therapeutic relationships. Early recognition, assessment, engagement and prediction early in a patient’s admission is critical.

9.2.2 Staff should liaise with individuals and those who know their patient well, and take into account clinical assessments, to identify individualised de-escalation approaches which should be recorded as secondary preventative strategies in the individual’s care plan.

9.2.3 Patients identified as being at risk of disturbed or violent behaviour should be given the opportunity to have their views and wishes recorded in relation to these high risk behaviours as early in their admission as possible. The Safety Tool is a positive behaviour support plan and should be used to facilitate, structure, and encourage patient participation in this process (Appendix C). Using the Safety Tool, patients should be encouraged to identify as clearly as possible their own triggers and which interventions they find most helpful in helping them to manage their feelings of anger, frustration and their potential for aggressive behaviour. They should also be helped to identify which they would prefer to be used. This will then inform the patient’s individualised care plan.

9.2.4 In particular the patient’s preferred choice of rapid tranquilisation, physical intervention and/or seclusion should be explored and recorded at a time when the patient is able to discuss these things. It is unlikely that full and considered discussions will be possible at the time these interventions are required.

9.2.5 Patients should be encouraged to review their wishes with staff from time to time and any changes should be recorded.

9.3. 2. Secondary Intervention: De-escalation where the patient is in the communal area of a ward

9.3.1 All attempts should be made to manage the situation as calmly, discreetly and locally as possible. Staff managing de-escalation events should be aware of the wishes of patients recorded in their Safety Tool and individualised care plan.

9.3.2 Consideration should be given to which de-escalation techniques are appropriate and to the management of the immediate physical and social environment.

9.3.4 It may be feasible for families and carers to contribute to de-escalation approaches, for example by talking to their relative over the telephone.
9.3.5 Where the situation is clearly escalating despite positive staff intervention the question that staff should be reflecting on is: “Is it safe and appropriate for the patient to access the communal areas of the ward? If not, what are the risks?”

9.4 3. Tertiary Intervention (Restrictive Interventions) The patient is away from the communal area of the ward

9.4.1 As defined in the Code (2005), paragraph 26.36: “Restrictive interventions are deliberate acts on the part of other person(s) that restrict a patient’s movement, liberty and/or freedom to act independently in order to:

- take immediate control of a dangerous situation where there is a real possibility of harm to the person or others if no action is undertaken, and
- end or reduce significantly the danger to the patient or others.”

9.4.2 Restrictive interventions should not be used to punish or for the sole intention of inflicting pain, suffering or humiliation.

9.4.3 Where a person restricts a patient’s movement, uses force (or warns the patient of the possibility that force may be needed) then that should:

- be used for no longer than necessary to prevent harm to the person or to others
- be a proportionate response to that harm, and
- be the least restrictive option.

9.4.4 Where risk assessments identify that restrictive interventions may be needed, their implementation should be planned in advance and recorded as tertiary strategies within the Safety Tool or care plan.

9.4.5 Where the ward communal area has become an unhelpful environment for verbal de-escalation then the patient should be supported in moving to a de-escalation area where there will be greater control over patient stimulus and seated PMVA de-escalation techniques may be used.

9.4.6 In this context, NICE offer the following guideline for services: All [mental health] services should provide a designated area or room that staff may consider using, with the service user’s agreement, specifically for the purpose of reducing arousal and/or agitation. In services in which seclusion is practised, this area should be in addition to the seclusion room. (NICE 2005)

9.4.7 Staff should be aware of the least restrictive principle as applied to the PMVA model of the Hierarchy of Holds (See Appendix D). This model describes Primary, Secondary and Tertiary PMVA techniques. The objective is always to look to reduce the level of intervention (de-escalate) as soon as it is safe to do so. Successful de-escalation in this context will see a movement to primary intervention and the patient towards returning to the communal area as soon as possible.

9.4.8 It is understood that there will be occasions when disturbed and violent behaviour escalates and staff may be required to move up the hierarchy of holds to use tertiary techniques in order to retain the safety of the patient and staff. Where the levels of PMVA intervention have escalated to meet the current risks posed, without the possibility of imminent cessation, then staff should consider the option of rapid tranquilisation and/or seclusion. In the
event seclusion facilities are not available then a referral to the psychiatric intensive care unit should be made.

9.4.9 When deciding whether attempts at de-escalation have escalated into requiring seclusion, staff should consider the following:
- The level, nature and imminence of the risk of harm to others.
- The length of time the patient has been in restraint. If there remains little perceivable prospect of continued de-escalation efforts being effective, then rapid tranquilisation or seclusion procedures as detailed in the policy/guidance should be considered.
- Whether or not staff can safely remain with the patient. In de-escalation the patient should never be left alone in the room unless it is agreed with the patient as part of their individualised de-escalation process (e.g. a de-stimulation strategy). Otherwise, staff should, as a minimum, remain within physical sight of the patient.
- Whether or not the door to the de-escalation room should be locked. The moment to door is locked, seclusion has begun and seclusion procedures should be followed.

9.5 4: Patient returns to the communal areas of the ward following successful de-escalation

9.5.1 Following an episode of de-escalation or restraint, a post incident discussion should be held as soon as appropriate with the patient. The Safety Tool should be reviewed in this discussion and the warning signs, triggers and preferred coping strategies should be reviewed and evaluated. The care plan and safety tool should then be updated with the patient, thereby creating a positive feedback cycle and opportunity for reflection and growth. See Section 17 for a description of post seclusion procedures.

9.5.2 De-escalation and seclusion may be seen as forming a pathway with patients able to move in both directions within the pathway. The goal for staff is always to influence the de-escalating movement of the patient towards returning to the communal area as soon as possible. Therefore, use of de-escalation facilities or short-term segregation in the Trust does not always constitute seclusion.

9.5.3 A RIO Physical Intervention form should be completed for each de-escalation event that has required the movement of a patient from the communal area to a room used for the purpose of de-escalation with the use of PMVA techniques. The time that a patient moved and then returned to the communal area will be recorded on this form.

10. PROCEDURE FOR SHORT-TERM SEGREGATION

10.1 Short-term segregation may be considered in cases where the de-escalation pathway has been followed and that although the acute behavioural disturbance remains high and sustained, the MDT clinical assessment and judgement determine that seclusion would be over restrictive and that a patient’s clinical presentation would most likely deteriorate due to isolation, anxiety/fear, high energy levels or reduced stimulation (where sensory processing difficulties are present). It is therefore determined that following de-escalation procedure an immediate return to the general ward area would not be safe for the patient or others.
10.2 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 injury or harm.

10.3 It may also be seen as a helpful step down procedure following a seclusion episode. Thereby moving a patient from isolation, into a process of engagement, support and assessment orientated towards safely returning to the general ward environment.

10.4 It is permissible within the Code (2015) to manage this small number of patients by ensuring that their contact with the general ward population is limited.

10.5 Where consideration is being given to the use of short term segregation, wherever appropriate, the views of the person’s family and carers should be elicited and taken into account.

10.6 The environment should be no more restrictive than is necessary. This means it should be as homely and personalised as risk considerations allow. Facilities which are used to accommodate patients in conditions of short-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.

10.7 Patients will not be deprived of access to therapeutic activities and areas of the ward that are deemed to be safe for the patient to access such as gymnasiums, quiet rooms or activity spaces.

10.8 The commencement of the episode of short-term segregation is from the time that a patient is moved from the communal area of the ward for the purpose of de-escalation. This information will be recorded on the patient RiO record within the Restrictive Physical Intervention form.

10.9 When deciding whether attempts at de-escalation have now extended to become an episode of short-term segregation, staff should consider the following:

- How sustained is the patient’s acutely disturbed behaviour, and what is its level, nature and predictability?
- Does the patient require higher levels of staff engagement, support and observation without requiring seclusion (isolation)?
- Is it unsafe and counter therapeutic for the patient to be in the general areas of the ward or engaging with fellow patients, even with staff support?
- There will be no immediate requirement for restraint although this may remain a possibility.

10.10 If the patient remains away from the communal areas of the ward for over 4 hours, then there will be a specific and individualised care plan created that will clearly state the reasons why segregation is required. This will be fully discussed with the patient who should be as involved in this as they are willing or able to be.
10.11 This care plan will clearly lay out a graduated schedule for the patient’s re-
integration into the general ward milieu that will include a flexible programme of
‘testing’ this out by the supported introduction of the patient into ward spaces
with other patients.

10.12 Patients who are subject to being short-term segregated will be on at least
Level 3 of the Trust ‘Observation While Maintaining Safety and Patient
Engagement Policy’. Staff should make written records on the patient’s
condition on at least an hourly basis. This will be done on the Patients
observation record.

10.13 The patient’s situation should be formally reviewed by the responsible clinician,
an approved clinician or duty doctor at least once in any 24-hour period.

10.14 There should be a formal review at least weekly by the ward MDT. This should
include the patient’s responsible clinician and an IMHA where appropriate. The
purpose of a review is to determine whether the ongoing risks have reduced
sufficiently to allow the patient to be integrated into the wider ward community
and to check on their health and welfare.

10.15 The outcome of all reviews and the reasons for continued segregation should
be recorded. Records should demonstrate its necessity and explain why the
patient cannot be supported in a less restrictive manner.

10.16 If a requirement for short-term segregation continues for periods of over 14
days an independent MDT (involving the opinion of the commissioning
authority and an IMHA) will review whether or not the segregation episode has
moved into long-term segregation as defined in the Code of practice (2015)
paragraph 26.150.

10.17 Where this is the case the local safeguarding team should be made aware of
any patient being supported in longer term segregation.

10.18 Segregation should immediately end when an MDT review or a medical review
determines it is no longer warranted. Alternatively where the professional in
charge of the ward feels that segregation is no longer warranted it may end
following consultation with the patient’s responsible clinician or duty doctor.
This consultation may take place in person or by telephone. It is not acceptable
to wait until the next MDT or medical review.

10.19 The decision to end segregation should be taken following a risk assessment
and observations from staff of the patient’s presentation during close
monitoring of the patient in the company of others.

11. CONDITION OF THE SECLUSION ENVIRONMENT

11.1 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.

11.2 On Holford Ward - the Trust’s psychiatric intensive care unit, Ash Ward - the
Trust’s low secure unit and Wessex House (the inpatient CAMHS unit), there
are designated purpose built seclusion facilities. These facilities must be
maintained to ensure the safety of patients and staff.
11.3 On wards where seclusion is not practiced, other than in an exceptional and unavoidable circumstance where an imminent and high risk of injury or harm to others, a room may temporarily be used for seclusion which should:

- Be safe and secure and not contain anything which could cause harm to the patient or others
- Provide privacy from other patients and enable staff to observe the patient at all times
- Be adequately furnished according to perceived risk.
- Be heated, lit and ventilated
- Be quiet but not soundproofed and with some means of calling for attention (operation of which has been explained to the patient).

11.4 A clock should always be visible to the patient from within the room.

12. **PROCEDURE FOR SECLUSION**

12.1 The Mental Health Act Code of Practice (2015) contains the following table of guidance (p.302):

<table>
<thead>
<tr>
<th>Seclusion may be authorised by either:</th>
<th>Additional considerations</th>
</tr>
</thead>
<tbody>
<tr>
<td>A psychiatrist</td>
<td>If the psychiatrist who authorises seclusion is neither the patient's responsible clinician (RC) nor an approved clinician (AC), the RC or duty doctor (or equivalent) should be informed of seclusion as soon as practicable.</td>
</tr>
<tr>
<td>An approved clinician who is not a doctor</td>
<td>Provider policies should determine the appropriateness of using ACs who are not doctors to authorise seclusion. The patient’s RC or duty doctor (or equivalent) should be informed of seclusion as soon as practicable.</td>
</tr>
<tr>
<td>The professional in charge (eg a nurse) of a ward</td>
<td>The patient’s RC or duty doctor (or equivalent) must be informed of seclusion as soon as practicable.</td>
</tr>
</tbody>
</table>

12.2 The seclusion area as a physical environment must be carefully managed and monitored by the ward staff. Staff must always check and ensure the seclusion area is appropriately prepared and free of any non-seclusion items prior to its use. Any items added to the seclusion area such as blankets or pillows should be assessed in terms of the risk they may pose on an individual basis, and recorded as additions to the area on the seclusion log (Appendix E).

12.3 Where possible, any plans to use seclusion should be discussed by the team on shift rather than be made by a sole clinician. The final decision to use seclusion should then only be agreed by a psychiatrist, a suitably qualified approved clinician or the nurse in charge of the ward (Please see table above). In the case of an emergency where the nurse in charge is not immediately available this does not preclude the most senior nurse present agreeing an initial decision to seclude with an immediate referral to the nurse in charge or ward manager for the final decision. It is the name of the clinician making this final decision to seclude that is entered into the seclusion record.

12.4 The person authorising seclusion (see Authorising seclusion table above)
should have seen the patient immediately prior to the commencement of seclusion.

12.5 Where the decision to seclude is taken by the nurse in charge, the patient’s Responsible Clinician (RC) or the on-call duty doctor should be notified at once.

12.6 Should the need for seclusion be disputed by any member of the multi-disciplinary team, the nurse in charge should always refer the matter to the ward manager, who will notify and discuss with the Responsible Clinician (RC). Where the ward manager or RC is not available, the nurse-in-charge should refer the matter direct to the service manager or, if out of hours, the duty ward manager or on call service manager who will engage the on call consultant in the decision.

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

12.8 When physical restraint of a patient is required, there should be sufficient staff available to carry out this action safely and efficiently using the minimum force necessary.

12.9 The nursing team will ensure all potential weapons or harmful items are removed from the patient, but staff must not subject themselves to undue risk. If a situation occurs where staff feel themselves or other patients to be under extreme risk of injury then they should remove themselves and other patients from the immediate area and seek help from the police.

12.10 The patient should never be deprived of appropriate clothing when in seclusion, neither should they be deprived of other aids necessary for their daily living.

12.11 It may be appropriate, in a small number of instances, for individuals to be asked to wear special tear-proof clothing, such a decision should be authorised by the patient’s responsible clinician. An MDT should undertake an individualised risk assessment before this decision is taken. This is particularly likely to be the case where the risk of shredded clothing being used to self-harm or attempt suicide has been assessed and is considered to be very high.

12.12 Removal of clothing or use of tear-proof clothing should never be a first-line response to such risks and should never be used as a substitute for enhanced levels of support and observation. The requirement to wear tear-proof clothing should never be a blanket rule within a service. Careful consideration should be given to patient dignity, a patient’s history (e.g. sexual abuse), gender, religion and other diversity issues. Where high risk behaviours are indicated these issues should be considered and discussed proactively within the context of the Safety Tool and care plan early in a patient’s admission.

12.13 Before being involved in the seclusion episode, and where possible, staff should be careful to remove from their person items that might easily be removed or fall from their person by accident (e.g. keys, watches) when entering the seclusion area.

12.14 Staff re-entry into the seclusion room should be planned. A team of four staff, three of which must be PMVA trained should be used. Coordinating staff should consider gender, rapport, skill and experience when preparing this team. The
objective for entry should be defined and clear.

12.15 Where the nursing team is facilitating the entry of a visitor or another professional then the nurse-in-charge should lead this process.

12.16 The Trust has two inpatient wards with seclusion facilities. As such there will be locally developed seclusion procedures that reflect the physical design of the seclusion room or the nature of the service providing it (e.g. low secure service or adult general psychiatric intensive care). These will be in addition to and will be wholly consistent with the Trust Proactive Care Policy.

12.17 Following an episode of seclusion and/or tertiary restraint (Hierarchy of Holds, Appendix D), the patient’s physiological observations must be monitored for 24 hours, and recorded on the NEWs observations chart (Appendix D of the Physiological Observation of Inpatient and MIU including Wessex Ward). If it is not possible to measure physiological observations due to the patient’s refusal or agitation, non-contact observations must be undertaken and documented, and any concerns escalated appropriately (Please refer to Appendix G, Physiological Observations During and Post Restraint for more information). This process must also be followed if the patient has a lower level of restraint, and the patient’s physical condition gives rise to the suspicion of potential or actual deterioration.

13. MONITORING SECLUSION

13.1 Monitoring the patient’s condition while in seclusion may be done via the video monitoring screen with audio or via the viewing/observation panel in the seclusion room door. This meets the requirement within The Code of Practice that “A suitably skilled professional should as a minimum be readily available within sight and sound of the seclusion area at all times throughout the patient’s period of seclusion.” Although see 11.6 below.

13.2 For patients who have received sedation, a skilled professional will need to be outside the seclusion room door at all times. This will mean that observation will be carried out from a monitoring station within the extra care suite (containing the seclusion room, or by using the viewing/observation panel in the seclusion room door.

13.3 The professional should have the means to summon urgent assistance from other staff at any point.

13.4 Gender, religion, culture and sensory loss issues need to be fully considered when monitoring clients in order to maintain their dignity. Considering whether a male or female person should carry out ongoing observations may be informed by consideration of a patient’s trauma history.

13.5 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.

13.6 Professionals taking responsibility for observing the patient in seclusion must have read and understood this policy. They should be given a handover of the full details of the incident that resulted in the need for seclusion, the indicating criteria (e.g. risk of violence to others) and the criteria for ending its use. They should also be updated on the last review and the time of the next one..
14. **SECLUSION REVIEWS**

**Medical reviews**

14.1 If seclusion was authorised by an approved clinician who is not a doctor, or by the professional in charge of the ward, the responsible clinician or duty doctor (or equivalent) should attend to undertake the first medical review within one hour of the beginning of seclusion.

14.2 If the patient is newly admitted, not well known to the staff, or there has been a significant change in the patient’s physical, mental state and/or behavioural presentation, this medical review should take place without delay.

14.3 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).

14.4 For the purposes of medical reviews, where the responsible clinician is not immediately available, the duty doctor will deputise for the responsible clinician. Whenever the duty doctor is not an approved clinician, they will at all times have access to an on-call doctor who is an approved clinician.

14.5 Continuing four-hourly medical reviews of secluded patients should be carried out until the first (internal) MDT has taken place including in the evenings, night time, on weekends and bank holidays. The multi-disciplinary team can decide to extend these time scales at night when the patient in seclusion is asleep. However the review should take place without delay once the patient has woken.

14.6 Following the first internal MDT 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 (out-of-hours an alternative approved clinician may cover these responsible clinician reviews.

14.7 Medical reviews provide the opportunity to evaluate and amend seclusion care plans, as appropriate. They should be carried out in person and should 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.
Nursing Reviews

14.8 Nursing reviews of the secluded patient should take place at least every two hours following the commencement of seclusion. These should be undertaken by two individuals who are registered nurses, and at least one of whom should not have been involved directly in the decision to seclude.

14.9 In the event of concerns regarding the patient’s condition, this should be immediately brought to the attention of the patient’s responsible clinician or duty doctor.

MDT Reviews

14.10 The first internal MDT seclusion review should be held as soon as is practicable. The review should determine whether seclusion should continue, what the patient care needs are if it is to continue, and what steps to take to ensure seclusion ends as quickly as possible.

14.11 Membership of the MDT review meeting should include the responsible clinician, a doctor who is an approved clinician, the senior nurse on the ward, and staff from other disciplines who would normally be involved in patient reviews, for example an occupational therapist or psychologist.

14.12 At weekends and overnight, membership of the initial MDT review may be limited to medical and nursing staff, in which case the duty ward manager (or equivalent) should also be involved. Further MDT reviews should take place once in every 24-hour period of continuous seclusion.

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

Independent MDT Reviews

14.14 An independent MDT review should be promptly undertaken where a patient has either been secluded for eight hours consecutively or for 12 hours intermittently during a 48-hour period.

14.15 Appropriate membership of the meeting as a minimum should include a doctor who is an approved clinician, or an approved clinician who is not a doctor, 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.

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

14.17 In the extreme event that a patient is secluded for 96 hours (four days) without progress then the Head of Service should be involved in a full MDT review with the RC and ward manager. An independent Consultant Psychiatrist may also be involved. A referral to the Forensic Service for assessment and support should also be considered.
15. **RECORD KEEPING**

15.1 The seclusion record, review and termination forms are electronic and held on RiO. They are found under the assessments menu on the case record screen. There are two components:
- The Seclusion Record (MHMDS Seclusion)
- Seclusion Review and Seclusion Termination

15.2 A documented report of the patient’s presentation whilst in seclusion should be made at least every 15 minutes on a seclusion observation chart (Appendix F).

15.3 The record made should include, where applicable: 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, pallor or cyanosis.

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

15.5 Seclusion observation charts are completed on paper and should then be uploaded onto RiO at the end of the seclusion episode. They must be completed for each episode of seclusion.

15.6 A seclusion log should be commenced for each episode of seclusion (see 10.1 above) (Appendix E). These are completed on paper and then uploaded onto RiO once seclusion has ended.

15.7 The seclusion episode must be recorded in the patient’s progress notes by the patient’s allocated nurse. The record should contain the reasons for the use of seclusion.

15.8 If following the first medical review it is agreed that seclusion should continue a seclusion care plan should be agreed and prepared, which should identify how the patient’s presenting and ongoing needs whilst in seclusion can continue to be met.

15.9 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 in order to bring the need for seclusion to an end as quickly as possible. As a minimum the seclusion care plan should 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 provided
- 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 maintained during the period of seclusion

15.10 Wherever possible, the patient should be supported to contribute to the seclusion care plan and 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. In view of
the potentially traumatising effect of seclusion, care plans should provide details of the support that will be provided when the seclusion comes to an end.

15.11 A DATIX incident form and RiO restraint form should also be completed.

15.12 RiO Risk information, risk screening and risk alerts should also be reviewed and updated.

16. ENDING SECLUSION

16.1 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. It is not acceptable to wait until the next formal review.

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

16.3 Opening a door for toilet and food breaks or medical review does not constitute the end of a period of seclusion.

16.4 A planned pathway for the patient’s safe return to the ward area should be developed involving the patient as far as possible.

17. POST SECLUSION PROCEDURES

17.1 Seclusion is likely to have a detrimental affect on the therapeutic relationship between the service and the patient.

17.2 Following a seclusion episode it is important to ensure a post seclusion review involving the patient takes places as soon as is practicable. This could be some time after the seclusion has ended as staff should be sensitive to how the patient feels, is likely to respond, and what benefit the discussion will be to them.

17.3 If the patient is able and agrees to discuss the incident which led to the use of a restrictive intervention, their understanding and experience of the incident should be explored. The patient should be given a choice as to who they would like to discuss their experience with, wherever possible. Attempts by staff to simply justify decisions to use a restrictive intervention may be counterproductive; the aim is to use empathic therapeutic relationships to explore what aspects of the intervention helped, didn’t help and might be done differently in future.

17.4 Where a patient is not able to participate in a review, methods for assessing the effects of any intervention on their behaviour, emotions and clinical presentation should be fully explored as part of their assessment and recorded in the safety tool or care plan.

17.5 The post seclusion event review should be recorded on the patient’s progress notes. Patients’ accounts of the incident and their feelings, anxieties or concerns following the restrictive intervention should be recorded in their notes. The Safety Tool and/or care plan should be reviewed and updated as...
necessary. Patients should be reminded that they can record their future wishes and feelings about which restrictive interventions (or any other aspect of treatment and care that has been raised by the incident) they would or would not like to be used in an advance statement within the Safety Tool.

17.6 If patients wish to formally raise a concern they should be reminded of how to access the local complaints system and independent advocacy services.

18. SECLUSION GOOD PRACTICE GUIDANCE

18.1 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. Where 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 should be considered during any review of the ongoing need for seclusion. Particularly with prolonged seclusion, it can be difficult to judge when the need for 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, without terminating the seclusion episode.

18.2 Food and nutrition should be carefully considered in seclusion care provision. Patients should be asked for their preferences which should be culturally specific wherever possible. Where only finger foods are being provided, foods such as fruit, wholemeal sandwiches with salad and cereal bars should be considered as well as warm finger foods. Milk, fresh fruit juices and water as well as warm drinks should also be made regularly available. Variety and preference are important. All food and fluid consumption should be carefully monitored and recorded on the seclusion observation record.

18.3 Where appropriate, the opportunity for engagement in meaningful activity should be provided for patients in seclusion, particularly for those who require an extended period of time within a safe environment, but are able to engage. Where risk assessed and not likely to be detrimental to a person’s mental state, the following low-risk activities may be suitable—playing cards, reading a newspaper, having letters or photographs from family, playing relaxation music outside the room.

18.4 Consideration should be given to an individual’s spiritual or religious beliefs, and to provide resources to facilitate practice of this where appropriate such as a religious text, or belief-specific clothing.

18.5 Whilst seclusion importantly provides a safe and low stimulus environment, it is recognised that some patients who are acutely disturbed, agitated or self harming, may actually require a greater amount of stimulation due to co-existing conditions such as ADHD, learning disability, Autistic Spectrum Disorders, or Sensory Processing Disorder. In these cases, specialist Occupational Therapy intervention may be required early on in an individual’s recovery. Relevant assessments as guided by the Model of Human Occupation include the Assessment of Communication and Interaction Skills and Sensory Processing Screening Tool. An Occupational Therapist or member of the activity team should be involved in MDT Seclusion reviews wherever possible.
18.6 It is important to acknowledge protective activities within each individual’s care plan, Safety Tool, Risk Information on RiO and handover notes, including those which could be facilitated safely and therapeutically whilst being nursed within the seclusion environment.

18.7 It is often orientating and helpful for the patient to be able to view the time; this may be discussed with the patient. A clock may be placed within eyesight on the wall opposite the seclusion room viewing panel. Also a dry wipe board may be useful for displaying messages and communicating where verbal communication or information retention is hindered.

19. TRAINING REQUIREMENTS

19.1 The Trust will work towards all staff being appropriated trained in line with the organisation’s Staff Mandatory Training Matrix (training needs analysis).

19.2 Staff involved in the seclusion process will have completed and passed the Module 4 training provided by the Trust PMVA Department. Staff are required to refresh this training on an annual mandatory basis.

19.3 The Module 4 training provides staff with knowledge, skills and practice in all elements of physical restraint, promoting the least restrictive intervention where appropriate whilst considering the legal framework for any physical restraint. The module 4 training incorporates training and practice relating to de-escalation, seclusion and seclusion re-entry.

20. EQUALITY IMPACT ASSESSMENT

20.1 All relevant persons are required to comply with this document and must demonstrate sensitivity and competence in relation to the nine protected characteristics as defined by the Equality Act 2010. In addition, the Trust has identified Learning Disabilities as an additional tenth protected characteristic. If you, or any other groups, believe you are disadvantaged by anything contained in this document please contact the Document Lead who will then actively respond to the enquiry.

21. MONITORING COMPLIANCE AND EFFECTIVENESS

Process for Monitoring Compliance

21.1 The Safe Governance Group is responsible for monitoring overall compliance with this policy.

21.2 This policy will be audited via the Trust three-year audit plan, utilising the clinical audit standards included in this document (Appendix A). Overall monitoring will be by the Safe Governance Group.

21.3 A briefing of the audit will be provided to staff to raise awareness through best practice groups and the staff newsletter.

22. COUNTER FRAUD

22.1 The Trust is committed to the Anti-Fraud, Bribery and Corruption Policy – to reduce fraud in the NHS to a minimum, keep it at that level and put funds stolen
by fraud back into patient care. Therefore, consideration has been given to the inclusion of guidance with regard to the potential for fraud and corruption to occur and what action should be taken in such circumstances during the development of this procedural document.

23. RELEVANT CARE QUALITY COMMISSION (CQC) REGISTRATION STANDARDS

23.1 Under the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 (Part 3), the fundamental standards which inform this procedural document, are set out in the following regulations:

- Regulation 10: Dignity and respect
- Regulation 12: Safe care and treatment
- Regulation 16: Receiving and acting on complaints
- Regulation 20: Duty of candour
- Regulation 20A: Requirement as to display of performance assessments.

23.2 Under the CQC (Registration) Regulations 2009 (Part 4) the requirements which inform this procedural document are set out in the following regulations:

- Regulation 18: Notification of other incidents

23.3 Detailed guidance on meeting the requirements can be found at [http://www.cqc.org.uk/sites/default/files/20150311%20Guidance%20for%20providers%20on%20meeting%20the%20regulations%20FINAL%20FOR%20PUBLISHING.pdf](http://www.cqc.org.uk/sites/default/files/20150311%20Guidance%20for%20providers%20on%20meeting%20the%20regulations%20FINAL%20FOR%20PUBLISHING.pdf)

24. REFERENCES, ACKNOWLEDGEMENTS AND ASSOCIATED DOCUMENTS

24.1 References


24.2 Bibliography


Lee S, Cox A, Whitecross F, Williams P and Hollander Y. 2010. Sensory assessment and therapy to help reduce seclusion use with service users


Positive and Proactive Care: reducing the need for restrictive interventions. 2014. Department of Health.

24.3 Cross reference to other procedural documents
Clinical Assessment and Management of Risk of Harm to Self and Others Policy
Mental Capacity Act (using the MCA) Policy
Fitness to Work – PMVA Policy
Guidance for the Use of Physical Restraint Techniques
Prevention and Management of Violence and Aggression Policy
Professional Interpreting and Translation Service Policy
Record Keeping and Records Management Policy
Integrated Care Planning Approach (ICPA) Policy
Risk Management Policy and Procedure
Observation While Maintaining Safety and Engagement Policy
Safeguarding Adults at Risk Policy
Security Policy
Serious Incidents Requiring Investigation (SIRI) Policy
Staff Appraisal and Management Supervision Policy
Untoward Events Reporting Policy

All current policies and procedures are accessible in the policy section of the public website (on the home page, click on ‘Policies and Procedures’). Trust Guidance is accessible to staff on the Trust Intranet.

25. APPENDICES
For the avoidance of any doubt the appendices in this policy are to constitute part of the body of this policy and shall be treated as such. This should include any relevant Clinical Audit Standards.

Appendix A Seclusion and De-Escalation Clinical Audit Standards
Appendix B Algorithm for Seclusion Policy
Appendix C The Safety Tool
Appendix D PMVA Hierarchy of holds (Public Health Model for PMVA)
Appendix E Seclusion Log
Appendix F Seclusion Monitoring Form
Appendix G Physiological Observations During and Post Restraint
# SECLUSION AND DE-ESCALATION CLINICAL AUDIT STANDARDS

27/03/2014

Service area(s) to which standards apply:

<table>
<thead>
<tr>
<th></th>
<th>Service Area</th>
<th>Service Area</th>
<th>Service Area</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>MH Inpatient (CAMHS)</td>
<td>Community CAMHS</td>
<td>CH Specialist Services</td>
</tr>
<tr>
<td>1</td>
<td>MH Inpatient (Adult)</td>
<td>C &amp; YP Integrated Therapy</td>
<td>MH Specialist Services</td>
</tr>
<tr>
<td>1</td>
<td>MH Inpatient (Older)</td>
<td>School Nursing</td>
<td>MH Community Adult</td>
</tr>
<tr>
<td>1</td>
<td>MH Rehab &amp; Recovery</td>
<td>Health Visitors</td>
<td>MH Community Older</td>
</tr>
<tr>
<td></td>
<td>Community Hospital</td>
<td>CH Rehab</td>
<td>Learning Disabilities</td>
</tr>
<tr>
<td></td>
<td>MIU</td>
<td>Musculo-Skeletal</td>
<td>District Nurses</td>
</tr>
<tr>
<td>Ref No</td>
<td>Standard</td>
<td>Compliance</td>
<td>Exceptions</td>
</tr>
<tr>
<td>--------</td>
<td>----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------</td>
<td>------------</td>
<td>------------</td>
</tr>
</tbody>
</table>
| 1      | Patients identified as being at risk of disturbed or violent behaviour should be given the opportunity to have their views and wishes recorded in relation to their high risk behaviours  
*Policy ref 8.2.2*                                                                                         | 100%       | None       | Views and wishes should include patients own triggers and interventions they find most helpful, and which they would prefer to be used. This should be recorded on the Safety Tool on RiO. This should be used to inform the individualised care plan.                                                                                                                                                                                                                                                                  |
| 2      | Where a potential situation arises in the communal area of a ward, all attempts should be made to manage the situation as calmly, discretely and locally as possible.  
*Policy ref 8.3.1*                                                                                          | 100%       | None       | Consideration should be given to which de-escalation techniques are appropriate and to the management of the immediate physical and relational environment                                                                                                                                                                                                                                                                                                      |
| 3      | If verbal de-escalation has not proved successful the patient should be supported in moving to a de-escalation area  
*Policy ref 8.4.1*                                                                                                | 100%       | None       | A RiO restraint form should be completed for each de-escalation event that has required the movement of a patient from the communal area to a room used for the purposes of de-escalation with the use of PMVA techniques                                                                                                                                                                                                                                               |
| 4      | When deciding whether attempts at de-escalation have crossed the boundary into requiring seclusion, the following should be considered:  
- The level, nature and imminence of the risk of harm to others  
- The length of time the patient has been in restraint  
- Whether or not staff can safely remain with the patient  
- Whether or not the door to the de-escalation room should be locked  
*Policy ref 8.4.5*                                                                                          | 100%       | None       | Decision to be recorded within progress notes and also reflected in the seclusion documentation                                                                                                                                                                                                                                                                                                                                                                             |
## SECLUSION AND DE-ESCALATION CLINICAL AUDIT STANDARDS

<table>
<thead>
<tr>
<th>Ref No</th>
<th>Standard</th>
<th>Compliance</th>
<th>Exceptions</th>
<th>Definitions</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>5</strong></td>
<td>Seclusion should only be used where de-escalation has failed and there is a strong likelihood of the severely disturbed behaviour causing harm to others &lt;br&gt;To be used when de-escalation has failed and there is a strong likelihood of the severely disturbed behaviour causing harm to others &lt;br&gt;<em>Policy ref 7.2</em></td>
<td>100%</td>
<td>None</td>
<td>Decision should be recorded within progress notes and also reflected in the seclusion documentation</td>
</tr>
<tr>
<td><strong>6</strong></td>
<td>Seclusion may not be used: &lt;br&gt;• As a punishment or threat &lt;br&gt;• As part of a treatment programme &lt;br&gt;• As a method for covering staff shortages &lt;br&gt;• For the reason of preventing suicide or self-harm &lt;br&gt;<em>Policy ref 7.5</em></td>
<td>100%</td>
<td>None</td>
<td>The reason for seclusion should be recorded within progress notes and also reflected in the seclusion documentation</td>
</tr>
</tbody>
</table>

### Procedure for seclusion

| | The final decision to use seclusion should be made by a doctor, a suitably qualified approved clinician or the nurse in charge of the ward <br>*Policy ref 10.2* | 100% | None | Where possible, any plans to use seclusion should be discussed by the team on shift. In the case of an emergency where the nurse in charge is not immediately available the senior nurse present can agree an initial decision to seclude with an immediate referral to the nurse in charge or ward manager for the final decision. |
| | Where the decision to seclude is taken by the nurse in charge, the patient’s Responsible Clinician (RC) or the on-call duty junior doctor must be notified at once, and they should attend immediately <br>*Policy ref 10.3* | 100% | Where seclusion lasts for less than 10 minutes | For non-detained patients, or patients detained under S5, the Named Consultant must be notified at once, to ensure the appropriate legal framework is in place. |
### SECLUSION AND DE-ESCALATION CLINICAL AUDIT STANDARDS

<table>
<thead>
<tr>
<th>Ref No</th>
<th>Standard</th>
<th>Compliance</th>
<th>Exceptions</th>
<th>Definitions (e.g. any interpretations, directions, or instructions on where/how to find information)</th>
</tr>
</thead>
</table>
| 9      | An initial multidisciplinary review of the need for seclusion should be carried out as soon as practicable after seclusion begins (see standard 17 for recording)  
*Policy ref 10.8*                                                                                                                                  | 100%       | None       | The review should determine whether seclusion should continue, what the patient care needs are if it is to continue, and what steps to take to ensure seclusion ends as quickly as possible.                                                                                                          |
| 10     | As soon as the imminent and high risk of injury or assault has diminished then seclusion should be ended (see standard 17 for recording)  
*Policy ref 10.11*                                                                                                                                 | 100%       | None       | This will be indicated when the patient is calm as evidenced by verbal and non-verbal clues. Ending seclusion should be discussed and agreed with the shift team; however it is not acceptable to wait until the next formal review but rather to bring the review forward. |

#### Monitoring/Reviewing seclusion

| 11     | Observations must be undertaken and recorded at least every 15 minutes (see standard 16 for recording)  
*Policy ref 11.4 and 11.5*                                                                                                                      | 100%       | None       | This should involve a direct sight of the detained patients, and can be carried out by using the video monitoring screen or via the viewing/observation panel in the seclusion room door.                                                                                                                                                   |
| 12     | Seclusion must be reviewed every 2 hours by two nurses (one of whom should not have been involved in the original decision to seclude) and every 4 hours by a doctor or suitably qualified approved clinician (see standard 17 for recording)  
*Policy ref 11.1*                                                                                                                                      | 100%       | If the multi-disciplinary team decide to review on a different timescale | Any reason to step outside the recommended timescales made by the MDT should be fully recorded. This can include reviews at night when the patient is asleep.                                                                                                    |
## SECLUSION AND DE-ESCALATION CLINICAL AUDIT STANDARDS

<table>
<thead>
<tr>
<th>Ref No</th>
<th>Standard</th>
<th>Compliance</th>
<th>Exceptions</th>
<th>Definitions (e.g. any interpretations, directions, or instructions on where/how to find information)</th>
</tr>
</thead>
<tbody>
<tr>
<td>13</td>
<td>Outside working hours, the on-call doctor can decide whether to visit the patient on the ward or review the situation solely on the basis of information received from nursing staff. <em>Policy ref 11.2</em></td>
<td>100%</td>
<td>None</td>
<td>Information supplied by the nursing staff should include:</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>- Whether the patient is alert</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>- Orientated in time, place and person</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>- Their need for any additional prescription medication</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>- Any physical injuries or physical conditions</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>- Any current side-effects of medication</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>- Current behaviour and perception of risk</td>
</tr>
<tr>
<td>14</td>
<td>Where a patient is secluded for more than 8 hours consecutively, or for 12 hours over a period of 48 hours, an MDT review should be convened. <em>Policy ref 10.14</em></td>
<td>100%</td>
<td>None</td>
<td>The review will include the RC and the ward manager. It should also involve nurses and other professionals who were not involved in the incident which led to the seclusion. Those involved in the original decision to seclude may be consulted where it is felt necessary or appropriate.</td>
</tr>
<tr>
<td>15</td>
<td>Where a patient is secluded for 96 hours (four days) without progress, the Head of Service should be involved in a full MDT review. <em>Policy ref 10.15</em></td>
<td>100%</td>
<td>None</td>
<td>The review will also include the RC and the ward manager. An independent Consultant Psychiatrist may also be involved. A referral to the Forensic Service for assessment and support should be made.</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Recording</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>16</td>
<td>Seclusion monitoring forms (Observation charts) must be completed for each episode of seclusion. <em>Policy ref 12.2</em></td>
<td>100%</td>
<td>None</td>
<td>The monitoring form should be uploaded onto RiO at the end of the seclusion episode</td>
</tr>
<tr>
<td>17</td>
<td>All multidisciplinary monitoring review/s of seclusion by all professionals should be fully recorded. <em>Policy ref 12.1</em></td>
<td>100%</td>
<td>None</td>
<td>Records should be made on the following electronic forms on RiO:</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>- The Seclusion Record (MHMDS Seclusion)</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>- Seclusion Review and Seclusion termination</td>
</tr>
</tbody>
</table>
## SECLUSION AND DE-ESCALATION CLINICAL AUDIT STANDARDS

<table>
<thead>
<tr>
<th>Ref No</th>
<th>Standard</th>
<th>Compliance</th>
<th>Exceptions</th>
<th>Definitions (e.g. any interpretations, directions, or instructions on where/how to find information)</th>
</tr>
</thead>
<tbody>
<tr>
<td>18</td>
<td>The seclusion episode must be recorded in the patient’s progress notes by the patient’s allocated nurse <em>Policy ref 12.5</em></td>
<td>100%</td>
<td>None</td>
<td>The record should include the reasons for the use of seclusion</td>
</tr>
</tbody>
</table>
| 19     | The following should be completed/updated as a result of each seclusion episode:  
  - A DATIX incident form  
  - RiO restraint form  
  - RiO Risk screening, risk information and risk alerts *Policy ref 12.6 and 12.7* | 100%        | None       |                                                                                                  |
|        | Post Seclusion Procedures                                                                                                                                   |
| 20     | A review involving the patient should take place following a seclusion episode *Policy ref 14.2, 14.3, 14.4* | 100%        | Patient refusal | The patient should be given full opportunity to state their views of events. There should be negotiation to establish alternative strategies to seclusion should the future need arise. The Safety Tool on RiO should be updated. |
**PROACTIVE CARE / DE-ESCALATION PATHWAY ALGORITHM**

1. **PRIMARY INTERVENTION / PREVENTION AND EARLY RECOGNITION**
   - Prevention through high quality care, patient experience and therapeutic relationships.
   - Facilitate Safety Tool and Care Plan involving patient, one to one time, shift named nurse, observations.
   - Complete Risk Screen/Assessments involve patient, family/carers where possible.

2. **SECONDARY INTERVENTION / PATIENT IN COMMUNAL AREA**
   - Initial presenting disturbed or aggressive behaviour.
   - Verbal de-escalation, solution focussed and resolution techniques.
   - Is it currently safe and appropriate for the patient to access the communal areas of the ward? If no, what are the risks?

3. **TERTIARY INTERVENTION / PATIENT AWAY FROM COMMUNAL AREA**
   - **ROOM USED FOR PURPOSE OF DE-ESCALATION**
   - Continued Assessment of Restrictive Practice, Risk and Use of De-Escalation Techniques.

   - **RETURN TO PRIMARY INTERVENTION**
     - No Restrictive Physical Intervention: engaging and guiding.
     - Is it safe for the patient to return to the communal area? If not what are the risks?
     - If yes, de-escalation interventions have been successful.

   - **SUCCESSFUL DE-ESCALATION**

   - **SHORT-TERM SEGREGATION**
     - Sustained and unpredictable acutely disturbed behaviour requiring higher levels of staff engagement, support and observation.
     - Unsafe and counter therapeutic to be in general areas of ward even with staff support.
     - No immediate requirement for isolation or restraint although this remains a possibility.

   - **PMVA HIERARCHY OF HOLDS / RESTRICTIVE PHYSICAL INTERVENTION**
     - Verbal and seated de-escalation techniques, team formation.
     - Is it safe for the patient to move to primary intervention? If not what are the risks?

   - **PMVA HIERARCHY OF HOLDS / RESTRICTIVE PHYSICAL INTERVENTION**
     - Full PMVA intervention/restraint, full PMVA team.
     - 1. How long has the patient been in restraint? Position of the patient?
     - 2. Is it safe for staff to remain with the patient?
     - 3. Does the door now need to be locked?

   - **TRANSFER TO SECLUSION**
     - Consider R.T. / REFEERAL TO PICU.

   - **4. PATIENT RETURNS TO COMMUNAL AREA OF THE WARD (POSITIVE FEEDBACK CYCLE)**
     - Post incident review of restrictive practice/seclusion with patient. Involve family/carer where appropriate.
     - Review Safety Tool with patient and update care plan and risk information.
     - Staff support, review, learning.

---

*APPENDIX B*
THE SAFETY TOOL

SAFETY TOOL OBJECTIVES

1. To provide an opportunity for staff to build rapport in the early stages of admission.
2. To assist in developing a patient centred, individualised care plan.
3. To optimise the potential for caring for individuals safely and securely.
4. To encourage the active involvement of patients in their care planning.
5. To encourage individual responsibility and choice.

GUIDELINES FOR USE

1. This is a positive behaviour support plan and will be owned by the patient and they will keep a copy. The first page will be written in the first person and in the patients own words. It will move with them through their inpatient stay and will inform future intervention and individualised care.

2. It is the responsibility of the admitting nurse and the keyworker to initiate the completion of the safety tool with the patient as soon as possible following admission. It may be that this work is done gradually and thoughtfully over a number of sessions and as a helpful relationship develops.

3. This document will become an integral component of the PMVA care plan, guiding and informing our interventions.

4. Reported triggers, warning signs and preferred coping, distraction and de-escalation strategies should be included within the PMVA care plan.

5. When a patient has been subject to restraint or seclusion previously, precipitating risk behaviours, de-escalation strategies and seclusion management plans should be explored and used to inform any current plan.

6. Following an episode of seclusion/restraint a post incident discussion should be held as soon as appropriate with the patient. In this discussion the warning signs, triggers and preferred coping strategies should be reviewed and evaluated. The care plan and safety tool will then be updated with the patient, thereby creating a positive feedback cycle and opportunity for reflection and growth.
Examples of common triggers for client distress:

- Not being listened to
- Lack of privacy
- Overcrowding
- Feeling lonely
- Darkness
- Being teased or picked on
- Particular time of day / night
- Not being able to smoke
- Feeling pressured to talk
- People yelling
- Arguments
- Being isolated
- Contact with family
- Particular time of year
- Anniversaries
- Observing others acting unsafely
- People in uniform
- Being touched
- Not having control
- Not being told why a treatment is being given
- Loud noises
- Being stared at
- Access to belongings

Examples of common warning signs for client distress:

- Sweating
- Clenching teeth
- Wringing hands
- Bouncing legs
- Squatting
- Crying
- Not taking care of self
- Singing inappropriately
- Eating more
- Breathing hard
- Clenching fists
- Loud voice
- Rocking
- Cannot sit still
- Isolating / avoiding people
- Hurting myself
- Sleeping less
- Being rude
- Racing heart
- Red faced
- Sleeping a lot
- Pacing
- Swearing
- Hyper
- Hurting others or things
- Eating less
- Laughing loudly / giddy

Examples of common coping skills or defusing strategies to manage client distress:

- Having a cigarette outside
- Time out in your room
- Deep breathing exercises
- Reading a book / magazine
- Pacing
- Drawing / painting
- Time out in a quiet room
- Sitting with staff
- Talking with peers
- Exercising
- Writing in a journal
- Taking a cold shower
- Walking in the garden / courtyard
- Watching television
- Listening to music
- Talking with staff
- Calling a friend
- Calling family
- Putting hands in cold water
- Taking a hot shower
- Hugging a stuffed toy
SAFETY TOOL

Our ward is committed to providing a **safe and therapeutic environment** for all of our patients. We understand that at times being admitted to a hospital ward can be very difficult. We hope that by answering the following questions **you can help us understand** when and how best to provide additional support to **keep you and others safe**.

1) **I feel upset, frustrated or angry when:**
   OR makes me feel worse when I already feel upset, frustrated or angry

   

2) **You will know I am feeling upset, frustrated or angry because:**

   

3) **When I have been feeling upset, frustrated or angry I feel more relaxed or happier when:**
   
   **We can help you to identify things that will work for you**

Completed by: ____________________ (patient) and ____________________ (Staff)

Signature: ____________________ and ____________________

Date
When staff believe that your behaviour poses a risk to your own safety or to the safety of any other person, we may need to request that you do not spend time in the communal areas of the ward.

We will spend time with you and together try and find solutions to any concerns that you have. Our aim is always to help resolve any difficulties you are experiencing as calmly as possible. This is called de-escalation.

We may need to help you manage your feelings and behaviour in a room designed for the purpose of de-escalation. Staff will remain with you and support you during this time.

As a last resort when all our attempts at resolving the situation with you have not helped it may be necessary to care for you in an extra care area away from your fellow patients with the constant support of staff. If necessary you may be required to spend time in a single, locked room for as short a period of time as possible.

We will work with you to prevent requiring this and will attempt to minimise any distress you may experience. We will always use the least restrictive intervention to support you safely, and we will do this for as short a time as possible.

4) Have you ever experienced restraint, segregation or seclusion at this hospital or elsewhere?  
Yes [ ] No [ ]

If yes, how often? ______ Where/when has this happened? ___________________________________________

What have staff told you are some of the reasons you have been secluded? _____________________________

5) If staff determine that you need to spend some time in a de-escalation area, extra care area or seclusion, what are some things that would make this easier for you?  
(For example: only male or female staff, someone talking to you, being told what will lead to ending any restrictive practice etc.) We will consider your preferences as best we can.

________________________________________________________________________________________

________________________________________________________________________________________

6) If you spend time being cared for in seclusion:  
Should we contact your family, carer or significant other where there has been a requirement for the use of restrictive interventions?  
Yes [ ] No [ ]

Name: __________________________ Contact Details/Phone: __________________________

When you are ready, following any use of restrictive practice your nurse will offer you a chance to discuss the incident and you experience of this, this will help us to support you effectively in the future.

Completed by: ______________________ (patient) and __________________ (Staff)

Signature: ________________________ and ________________________

Date: ____________________________
HIERACHY OF HOLDS
(Public Health Model for PMVA)

Staff must use the least restrictive approach at all times and may move up and down the zones.

- PRIMARY
  - NO HANDS ON
  - Verbal de-escalation and negotiation techniques, Guiding

- SECONDARY
  - HANDS ON
  - Team formation
  - Patient on their feet or seated

- TERTIARY
  - HANDS ON
  - Full PMVA team intervention
APPENDIX E

SECLUSION LOG

Use this form to record all items placed in or removed from the seclusion room.

<table>
<thead>
<tr>
<th>NAME:</th>
<th>DATE:</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>ITEM</th>
<th>DATE AND TIME IN</th>
<th>DATE AND TIME OUT</th>
<th>COMMENTS</th>
</tr>
</thead>
<tbody>
<tr>
<td>Mattress</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
## SECLUSION – OBSERVATION CHART

*To be completed on commencement of seclusion and at a minimum of 15 minute intervals thereafter.*

<table>
<thead>
<tr>
<th>TIME 15 min intervals (24 hr clock)</th>
<th>DESCRIPTION</th>
<th>RECORD Diet/fluid Input/Output</th>
<th>NAME, SIGNATURE</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Behaviour, contact, interventions, responses and medication used/route</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

### SECLUSION REVIEW

<table>
<thead>
<tr>
<th>TIME 15 min intervals (24 hr clock)</th>
<th>DESCRIPTION</th>
<th>RECORD Diet/fluid Input/Output</th>
<th>NAME, SIGNATURE</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

### SECLUSION REVIEW
Physiological Observations During & Post Restraint

During restraint

Visual Physiological Observations
(Record on Non-contact Physiological Assessment Chart)

Pallor, Sweating
Waxy looking
Respiratory rate/effort/noise
AVPU
Pulse

Post incident
Physiological observations completed within an hour

Post Rapid Tranquilisation administration refer to Trust policy

Co-operative patient

Physiological Observations
Pulse
Temperature
Respiratory rate
Blood pressure
O2 sats
AVPU

Record on NEWS Chart

Follow NEWS chart guidance until patient has returned to baseline.
Doctor can apply variants

Unco-operative patient

Physiological Observations
Pallor
Sweating
Waxy looking
Respiratory rate/effort/noise
AVPU

Record on Non-contact Physiological Assessment Chart

Continue with non-contact physiological assessment until MDT review
Review possibility of taking physiological observations, record on the NEWS chart (follow guidance for cooperative patient)