Seclusion and long-term segregation review QIP

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Background

This audit evaluated compliance with the seclusion and long-term segregation policy at Guild Lodge, an inpatient forensic mental health unit in Lancashire, UK. The project aimed to improve seclusion review documentation and ensure it met Trust policy standards, informed by Royal College of Psychiatrists guidance. The policy requires documenting seclusion review methods, rationales, seclusion care plans (SCP) and positive behaviour support plans (PBSP), physical observations, mental state examinations, risk assessments, and prescribed medication benefits and adverse effects.

At the audit's time, Rio documentation could be completed through unstructured free-text progress notes or the designated seclusion review tab. The free-text option lacked standardisation and could lead to omissions. The seclusion review tab provided a structured format aligned with policy standards. The project compared practice at Guild Lodge against Trust standards and developed strategies to improve compliance and documentation quality.

Methods

The audit adopted a comparative quality improvement design conducted over two data collection periods. The cohort included all inpatients placed in seclusion, long-term segregation (LTS), or the enhanced care area (ECA) over a four-week period at Guild Lodge. Data was initially collected in February 2024 and repeated in April 2024 following targeted interventions. A total of approximately 62 seclusion reviews were analysed in February and 53 in April, providing comparable sample sizes.

For each review, data were collected on the date and time, type of restrictive intervention (ECA, LTS, or seclusion), whether the seclusion review tab was completed, whether the SCP was considered, and whether the effects of prescribed medication were reviewed. The intervention consisted of educational and procedural changes. Following induction of new core trainees, individual reminders were circulated outlining the rationale behind structured seclusion reviews and providing guidance.. Additionally, the clinical handover checklist was modified to emphasise completion of the seclusion tab which covered the domains.

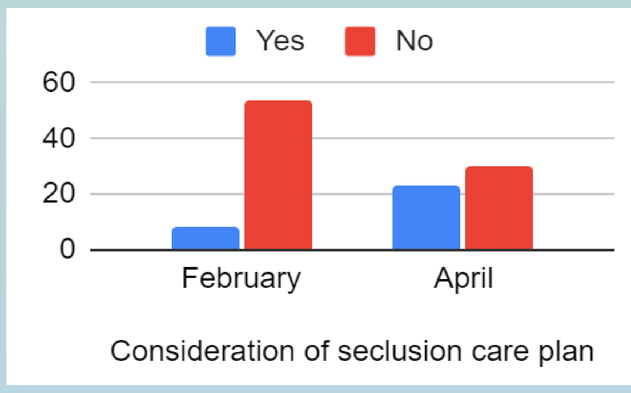
Data from both cycles were compared using chi-square statistical testing to determine whether observed differences in compliance were statistically significant.

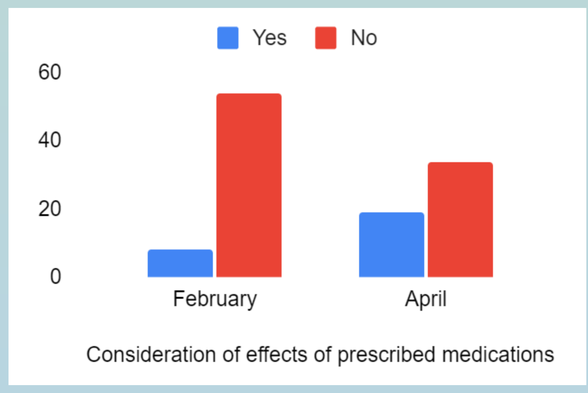
Results

Analysis demonstrated statistically significant improvements. Completion rates of the dedicated seclusion tab form increased between February and April (p-value <0.05), suggesting structured input and procedural reinforcement improved documentation.

Similarly, consideration of the SCP during reviews improved. Prior to intervention, reliance on free-text documentation meant that essential domains were frequently omitted or inadequately addressed. The structured tab prompted clinicians to systematically consider each required element, reducing the likelihood of missed components. Review of prescribed medication effects also showed improvement.

Common reasons for failure to document medication review included patient non-compliance with treatment and instances where the patient was no longer in seclusion or long-term segregation at the time of review. Despite measurable gains, the audit highlighted persistent variability in documenting PBSP reviews and providing clear rationale for omissions





Conclusion and Recommendations

Reliance on free-text documentation resulted in inconsistent and incomplete seclusion reviews, with key policy-mandated domains frequently overlooked. Introducing structured interventions and reinforcing expectations through handover processes significantly improved compliance with the seclusion review tab and documentation of care plan and medication considerations. The statistical significance of the findings supports the effectiveness of these relatively simple system-level changes.

Achieving 100% compliance across all domains was challenging. In particular review of SCPs and PBSPs remained inconsistent, and explanations were not always provided when domains were not assessed. To build on these improvements, embedding the intervention more firmly into electronic systems is recommended. Integrating prompts into electronic handovers and limiting reliance on free-text could further standardise practice.

Future cycles should assess sustainability and explore additional barriers to compliance. Ongoing monitoring, reinforcement during induction, and periodic refresher training are necessary to maintain gains. Ultimately, improving documentation quality enhances patient safety and adherence to best practice in restrictive interventions.