St. Charles Hospital

Seclusion Policy – Competencies for Staff

Competence: *'The state of having the knowledge, judgement, skills, energy, experience and motivation required to respond adequately to the demands of one's professional responsibilities'.*(Roach 1992)

The following competencies should be completed for all staff, new starters to the wards and all bank/agency staff who will be supporting and observing patients in seclusion.

Should the staff member be unable to complete the competencies to the assessor's satisfaction, they should **not** be asked to support and observe patients in seclusion and instead should be given an opportunity for re-assessment.

Opportunity should have been given to read the Trust Seclusion Policy before completing this competence assessment.

Ward …….Date…….....

Name of assessor……Band……...

Name of staff…….....Band……

	Question	Criteria to meet	Achieved Please circle
1	What is seclusion, and where can it take place?	See definition of seclusion in policy. Seclusion can take place only in a room designated for seclusion, that is used for no other purpose.	Yes / No
2	Who can observe/attend to a patient in seclusion room?	A suitably trained member of staff must be in attendance at all times outside the Seclusion Room, or in a position so as to directly observe the person at all times.	Yes / No
3	What is the aim of seclusion observation?	The aim of the observation, as well as maintaining the person's safety, is to ascertain their mental state and whether seclusion can safely be terminated. The Trust's Observation and Therapeutic Engagement Policy requirements must be adhered to at all times.	Yes / No
4	Seclusion review times	• every two hours by two registered nurses • every 4 hours by a doctor • should the seclusion continue for more than 8 hours consecutively or 12 hours intermittently over a period of 48 hours a full MDT review should take place with a consultant / Responsible Clinician (RC), as well as nurses and other professionals if possible. If the review needs to take place out of hours, it should be carried out with the Middle Grade (SpR, Specialty doctor) on-call.	Yes / No
5	What are the key components of reviews?	• a review of the persons physical and mental health • any effects, adverse or otherwise, of medicine that has been administered • review of prescribed medication plan • assessment of the risk to the person and others	Yes / No

	Question	Criteria to meet	Achieved Please circle
		• an assessment of the need for continued seclusion	
6	Can you seclude an informal patient?	The Department of Health Positive and Proactive Care (April 2014), recommend that "staff must not use seclusion other than for people detained under the Mental Health Act 1983. However, if an emergency situation arises involving an informal patient and, as a last resort, seclusion is necessary to protect others from risk of injury or harm, then it should be used for the shortest possible period to manage the emergency situation and an assessment for detention under the MHA should be undertaken immediately."	Yes / No
7	Who will you inform when decision is made to seclude a patient?	In all cases the ward doctor or duty doctor and Site / Unit Co-ordinator should be informed of the decision to implement seclusion, and should attend immediately.	Yes / No
8	What risks would you need to assess prior to, and during, seclusion?	• Search the patient and check for hazardous items. • Assess for any physical conditions or injuries • Ensure full medical review following prolonged restraint • Assess use of drugs and alcohol	Yes / No
9	What action would you take if an informal patient is secluded?	Immediate medical review to assess the need for a formal detention or use of Deprivation of Liberty Safeguards (DOLS). If the outcome is that the patient is not detainable, seclusion must be terminated.	Yes / No
10	De-escalation must be the first response to disturbed behaviour. What approaches to de-escalation might you try?	Articulate process for de-escalation and interventions that that staff member could try.	Yes / No
11	What actions will you take to ensure patient's safety prior seclusion?	All individuals must be searched before entering seclusion in line with the Trust's Search Policy. Any item considered to be potentially harmful must be removed and stored safely in line with the Trust's Patient's Property Procedures.	Yes / No
12	What actions will you take if patient had attempted to self-harm with own clothes?	In line with the MHA CoP, if a person has attempted to self-harm or attempt suicide using clothing the MDT must undertake an individualised risk assessment on the safest approach to managing this whilst in seclusion. The use of protective (strong) clothing or bedding should not be the first choice and should only be used if there is a case where normal attire or bedding may present an imminent risk to the person or others. The authorisation for the use of protective (strong) clothing or bedding will be by the person's RC, or other RC if unavailable, following assessment by the MDT. Out of hours this MDT assessment may consist of the duty doctor and Nurse in charge of the ward who should then consult with the RC on call to authorise. Any use of strong attire or bedding should be proportionate to the perceived risk and last no longer than necessary. The nurse in charge of the ward or an MDT can authorise a return to normal clothing or bedding following an assessment of the continuing risks. These risks will require ongoing assessment and review	Yes / No

	Question	Criteria to meet	Achieved Please circle
13	What sort of things might you consider in order to maintain the patient's communication needs whilst in seclusion?	• To offer information on seclusion, including alternative languages, large print or easy read etc. • Provide interpretation and translation services as required • Other communication aids used by the patient should be made available. • Offer access to basic diversions, such as newspapers or magazines.	Yes / No
14	What would you consider in assessing the patient's observation needs whilst in seclusion?	• A member of staff must be within sight and sound of the seclusion room at all times (i.e. close observation, in accordance with the Observation and Therapeutic Engagement Policy) • Consideration must be given to gender of staff, and the effects on the patient of observation (particularly in the case of sexual disinhibition, extreme paranoia etc.) • Specific details must be determined on an individual basis, and must be documented by a member of the medical team	Yes / No
15	What action would you take if there was a delay in medical input to the secluded patient?	Seek advice from the senior nurse on duty (i.e. coordinator or, if appropriate, on-call matron). Any difficulties must be clearly documented by the nurse in charge.	Yes / No
16	What action would you take if you had reason to suspect that the patient had used drugs or alcohol?	A drug or alcohol screening test must be considered prior to seclusion. Regular checks on physical state must be made and recorded (for patient safety reasons and to observe for signs of withdrawal symptoms).	Yes / No
17	Under what circumstances would you feel that the patient's clothing should be removed, and how would you approach this?	• Where there is an identified risk of the patient harming themselves. • Offer the patient the opportunity to remove clothing themselves. • Provide adequate alternative clothing to maintain dignity • Regularly review the necessity for the patient not be in clothing of their choice	Yes / No
18	What action would you take if the patient appeared to be asleep?	Consider discontinuing seclusion. If this is deemed to be appropriate, open the door and ensure that at least one member of staff continues to observe the patient (level 1B observation). Document the decision and the staff members involved in it. Allow the patient to wake naturally, and assess the risk.	Yes / No
19	What arrangements would you make for observation of a patient who has been subject to rapid tranquillisation?	The potential complications of rapid tranquillisation must be taken seriously. The patient must be monitored in accordance with the Rapid Tranquillisation Policy. Patient's vital signs must be undertaken in line with RT Policy.	Yes / No
20	What will you take into consideration prior to entering seclusion room for reviews?	Staff must undertake a risk assessment in relation to the number of staff required for the safe management of the identified risks. As a minimum there must be a 3-person team available so that physical intervention can be safely implemented if needed. The nurse in charge must plan the entry into the seclusion room, staff must be made clearly aware of their practical roles i.e. who will take the person's right / left arm etc. Staff must ensure that the individual is not near the door, asking	Yes / No

	Question	Criteria to meet	Achieved Please circle
		them to sit on the floor. Staff must explain to the person what is going to happen prior to the door being opened.	
21	If you were the seclusion nurse what would you need to do prior to seclusion review?	It is paramount prior organisation before a seclusion review. According to policy there are clear times for review and preparation must be completed prior to these times. As a seclusion nurse all food fluids, medication, vital physical health and IPC equipment must be organised in advance of the review times. This allows for a plan to be discussed with the team prior to review time and for the response team to enter on time according to policy for the benefit of the patient who has been secluded.	Yes / No
22	What actions will you take following administration of medication?	The nurse in charge must check the person's vital signs before the seclusion room is vacated.	Yes / No
23	How will you be able to monitor a patient's physical health in seclusion room?	Whilst someone is in seclusion it will not generally be possible to record a full set of physical observations. However, all observations that can be made, even without the persons co-operation, such as; breathing, sleeping, pacing about the room, sitting, lying, shouting, etc. should be recorded as an indication of their physical condition. The clinical record of the persons condition must be recorded every 15 minutes, with particular reference to any evidence of physical ill health i.e. concerns regarding breathing, pallor or cyanosis. Should any of these be in evidence, or there are any other specific concerns regarding the person's health and wellbeing, immediate assistance must be sought.	Yes / No
24	What action would you take if the observing nurse reported that the secluded patient was out of view of the seclusion room window?	Assess the patient's presentation, and make a decision about the need to undertake a direct observation.	Yes / No
25	How would you review the need for seclusion to continue? What would you do if there was a disagreement amongst the MDT?	The need for seclusion to continue must be considered at each review. Where practical, the decision to end seclusion must be made by the nurse in charge, a doctor and the duty coordinator. In the event of a disagreement, an urgent MDT must be arranged. Out of hours, this would involve the duty senior medical officer and senior manager on-call.	Yes / No

26	**<u>Long Term segregation</u>** How would you explain the meaning of the term 'long term segregation'?	Longer-term segregation refers to the management (within a designated seclusion room) of a small group of patients (often in high secure services) for whom a risk to others is a constant feature of their presentation.	Yes / No
27	What actions will you take if a patient is classed as long term segregation?	Where a seclusion episode continues for longer than 72 hours, there needs to be a review conducted by a multi-disciplinary team who are not directly involved in the persons care or decision to seclude. Local Management need to ensure that the Divisional Director of Nursing is made aware and also report this to the Mental Health Law Team on 020 3214 5927. These reviews must then be repeated every 72 hours.	Yes / No

Reassessment must take place following review of the Trust's Seclusion Policy, or sooner **at the discretion of the ward matron or ward manager**. I certify that I have assessed …….. and he or she has demonstrated a good understanding of the Seclusion Policy and its use.

Signature of assessor……Band……...

Next review date (if applicable):	

Roach MS (1992) The Human Act of Caring, Ottawa, Ontario; Canadian Hospital Association Press

Training - Observing Staff

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

- Physical Health Training day 1
- Risk Assessment and Management for all staff
- Essential Life Support for unqualified staff/ Basic life support
- Immediate Life Support for qualified staff who may be involved in the administration of rapid tranquilisation for the patient
- Restraint training, (TMVA) for all clinical staff.