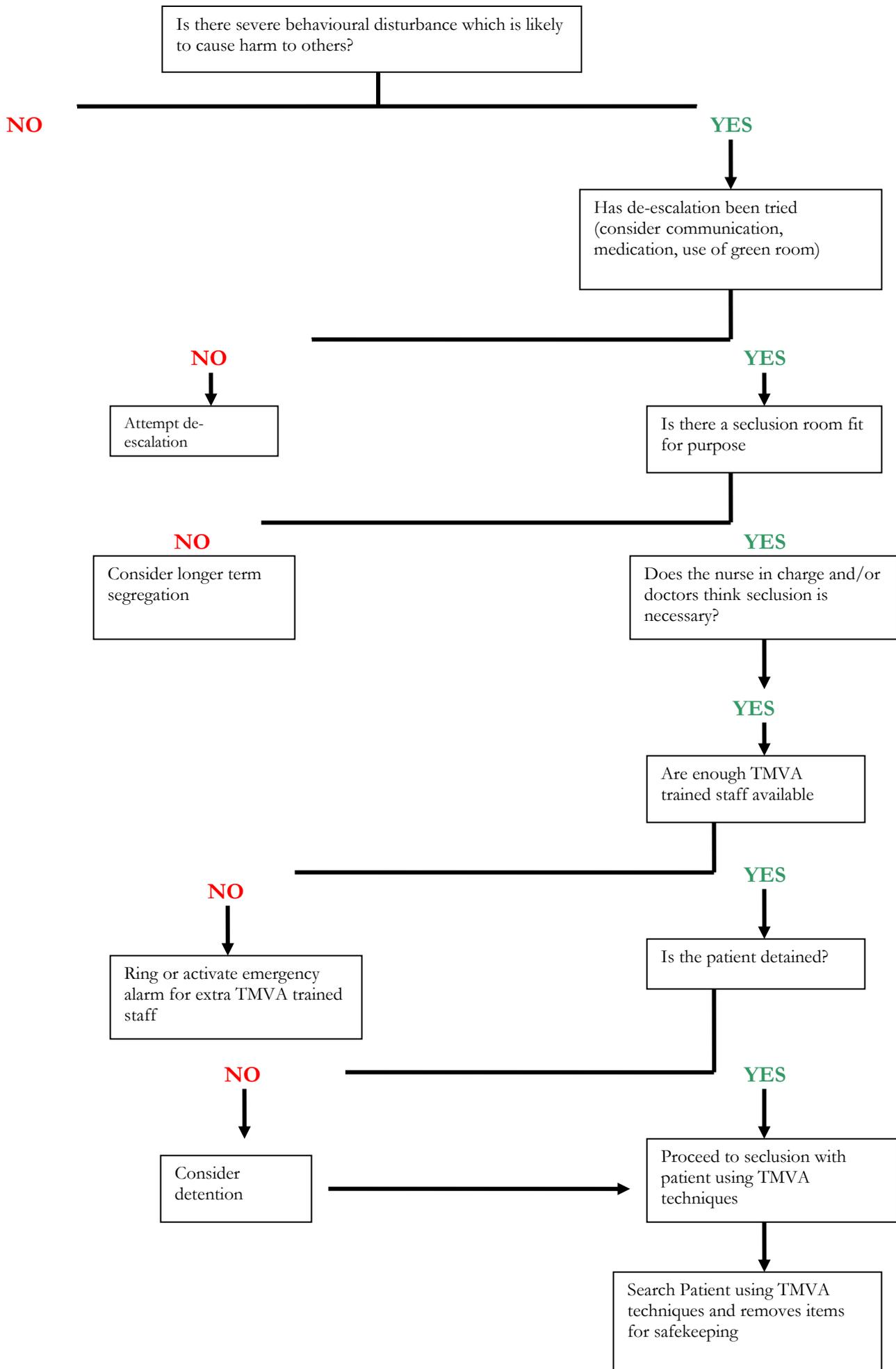


Seclusion Competencies

Seclusion PACK

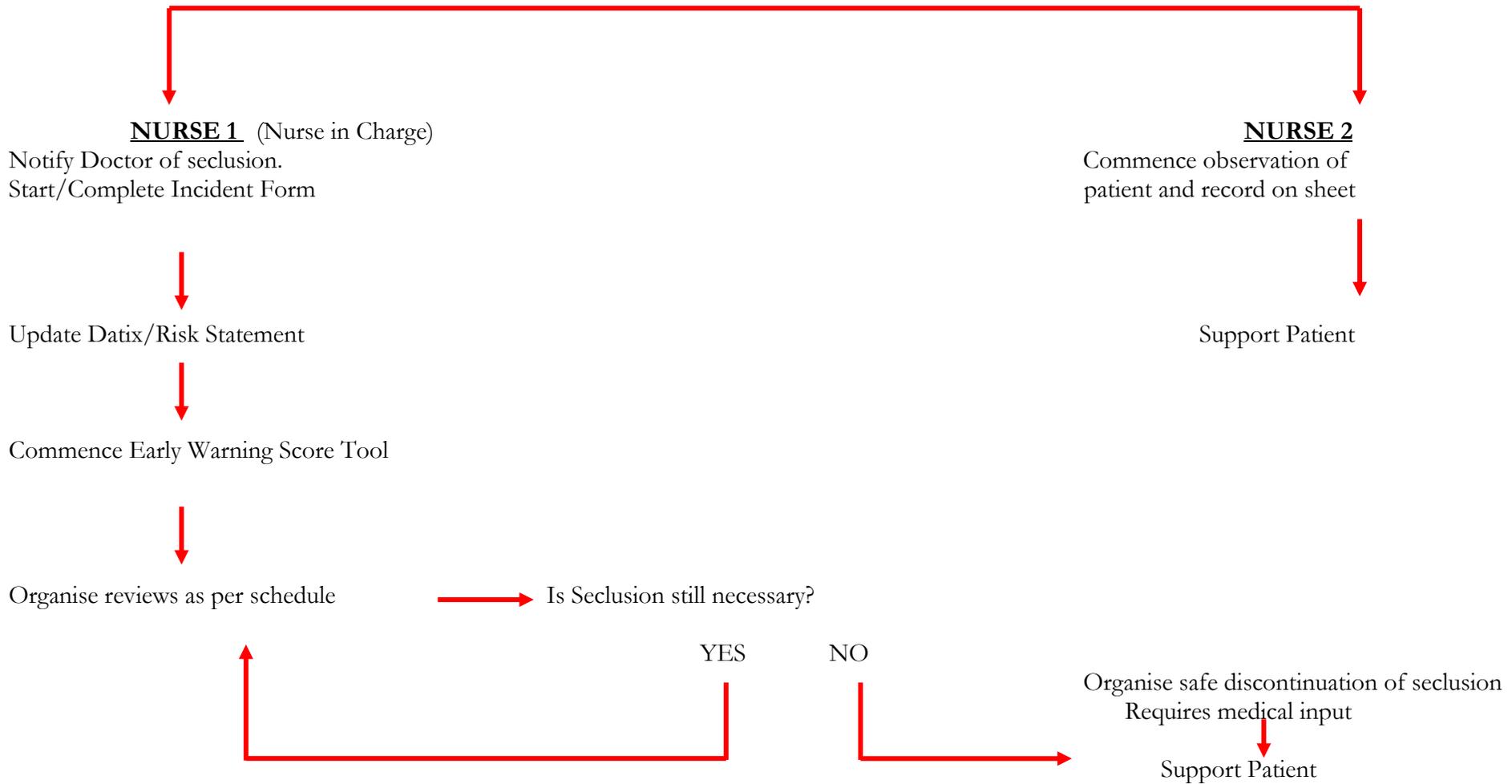
Seclusion may take place in the event of 'Severe Behavioural Disturbance'

Severe behavioural disturbance refers to behaviour that puts the person/service user or others at immediate risk of serious harm and may include threatening or aggressive behaviour or other actions likely (in the view of a Multi-disciplinary Team) to cause high levels of distress in others, and serious self-harm which could cause major injury or death.



On Commencement of Seclusion

Commence seclusion sheet (1) Inform medical staff Inc R.C (or deputy e.g. SPR)



Seclusion Competencies

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.

Handover

Any staff taking over responsibility for observing the patient must be provided with a full handover, which includes details of the incident that resulted in seclusion and the outcomes of subsequent reviews.

Carrying out Observations

- When carrying out observations the nurse should communicate with the patient using clear and plain language so as to maintain the therapeutic relationship.
- Observing staff will maintain regular communication with the patient where rapid tranquilisation has been administered to ascertain the effect of the medication using the AVPU (alert, verbal, pain and unresponsive) scale in those situations where it is deemed there is a risk to staff in entering the room to complete physical observations.
- A documented report must be made at least every 15 minutes. The report made will include where applicable, the patients 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.
- The individual must be allowed, on request, to go to the toilet. This is within easy access of the seclusion room.
- The patient should be provided with food and drink as appropriate and commensurate with patient and staff safety.
- The staff must be readily available within sight and sound of seclusion
- The staff member must continuously observe the patient to monitor their physical and psychological wellbeing.
- The observing staff must have the means to summon urgent assistance from other staff at any point

The purpose of observation:

- safeguard the patient
- monitor the condition and behaviour of the patient
- identify the time seclusion can be terminated
- ensure the period of seclusion is minimised.

Consideration should be given to whether a male or female person should carry out ongoing observations; this decision should be informed by a consideration of a patient's trauma history.

Reviews (Nursing and Medical)

- A minimum of 4 staff are required to enter seclusion room for reviews. Three of the four staff members will form the TMVA team and the fourth will undertake the communication.
- 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 take the right/left arm etc. Staff must ensure that the patient is not near the door, asking them to sit on the floor. Staff must explain to the patient what is going to happen prior to the door being opened.
- There must be 1 staff member, 5th staff, at the door. This person must be trained in manning seclusion door.
- Staff must prepare all required items prior to entering seclusion room to avoid people walking in and out of the room. These items may include vital signs monitoring equipment, drinks, food, change of clothing if required, and medication.
- Staff who are not involved in the four as mentioned above must be readily available within sight and sound of seclusion
- The TMVA team must always be in discrete readiness to undertake either restrictive intervention or break away technique as required.
- Bleep holders must be in attendance at all seclusion reviews.
- Response nurse from respective wards must attend seclusion reviews at the specified times.

Reviews

In line with the requirements set down by the MHA CoP the following reviews of the patient in seclusion must take place:

- **Nursing Review:** every two hours by two nurses (one of whom was not involved in the decision to seclude);
- **Medical Review:** every 4 hours by a doctor;
- **SpR, Specialty 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.
- **RC:** should the seclusion continue for more than 24 hours, together with the reviews stated above, the patient must be reviewed by their consultant/RC and a senior nurse on duty, at the earliest opportunity.

Nursing reviews

- 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, where possible, and at least one of whom should not have been involved directly in the decision to seclude,
- Staff from other wards should be asked to assist. In all circumstances ensuring the reviews occur should be the main concern.

- Reviews should not be delayed on account of repeated involvement of the same staff where this is unavoidable.
- The content of the review should follow the guidelines for the medical review, above.
- 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.
- If the patient in seclusion is asleep the need for review during the night should be discussed with the on-call medic who would be responsible for undertaking the medical review, and with the senior nurse on duty for the night shift.

If it is agreed that the medical and nursing reviews can be omitted if the service user remains asleep throughout the night, this decision should be recorded on the seclusion documentation. Observations must be maintained and a record made at least every 15 minutes.

Medical Reviews

Medical reviews provide the opportunity to evaluate and amend seclusion care plans. They should be carried out in person (ie the doctor should be present on the ward and see the patient, even if the seclusion room is not entered)

The review 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
- 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
- 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.
- If the patient in seclusion is asleep the need for review during the night should be discussed with the on-call medic who would be responsible for undertaking the medical review, and with the senior nurse on duty for the night shift.

When the Seclusion room is being used

The door to the seclusion room must be locked and disabled from opening by the patient. For a patient who is transferred to the PICU from an open ward, due to the need for seclusion, the responsibility for providing staffing for the seclusion facility and ensuring compliance with the Seclusion Policy, will remain with the Nurse in Charge of the ward where the patient has come from at the time seclusion commenced.

Post incident reviews following Seclusion:

Following a period of seclusion the individual must be given the opportunity to participate in a discussion about the incident; this is a post incident review. A document to guide and support this process can be found below. As part of this discussion the clinical rationale for the period of seclusion should be explored with the service user and they should be supported in the process of re-integration to normal ward activities.

Nursing time should be set aside to facilitate this process. Following a period of seclusion it is essential that the nursing staff re-establish the therapeutic relationship with the person using services.

Elements of this discussion will include:

- Does the individual understand why they were secluded?
- Does the individual agree that seclusion was necessary?
- Does the individual accept that the action taken was reasonable and appropriate?
- How does the individual feel now, after the event?
- How can we avoid the need for any further episodes of seclusion in the future?

A post incident review must take place within 72 hours of an incident ending. The internal review should be led by the Team manager or someone who was not involved in the incident.

Essential Documentation for Seclusion:-

- **Seclusion log** – This is completed throughout the duration of the seclusion. It must be updated every 15 minutes by seclusion nurse for patient observation, and all seclusion reviews must be clearly documented with all interventions carried out. This is to be uploaded to JADE under patient documents, and once seclusion terminated for it to be finalised.
- **Seclusion Checklist** – This outlines what duties are expected when seclusion is commenced and terminated. It is also a record of number of seclusions
- **Response nurse planning record** – This is to aid the organisation of seclusion reviews to ensure they take place according to policy. It documents all key individuals who are present in the review, and monitors the timings of response and seclusion reviews.
- **Food and Fluid Chart** – This must be completed for every patient who enters seclusion to ensure that they are adequately maintaining food and fluid.
- **Medication Chart** – When seclusion is commenced the patient's medication chart must be brought to seclusion in order for the patient to receive prescribed treatment, and chart is accurately completed to NMC standards to avoid medication errors.
- **Observation Chart for NEWS-** This is essential to monitor patient's physical health at every review. Seclusion is the most restrictive practice and it is likely a patient has received rapid tranquilisation therefore physical monitoring is paramount to prevent any deterioration.