**Long Term Segregation Policy**

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| Name of originator/author: | Lead Nurse ForensicServices (original author), updated Head of Nursing and Associate Clinical Director of Safety April 2020 |
| Executive Director lead : | Chief Nurse  |
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| **4.0** | April 2013 | Lorraine Sunduza, Lead Nurse, Forensic Services.Edwin Ndlovu, Lead Nurse, Newham MH Services. Andy Cruickshank, Lead Nurse, Tower Hamlets MH Services. | Approved | Addition of flow chart |
| **5.0** | December2015 | Lorraine Sunduza - DeputyDirector of Nursing.Day Njovana Lead Nurse Shaun Wright – MatronTrust wide Restrictive Intervention Reduction QI group | Approved | * Policy updated in line with Code of Practice 2015
* Segregation records are electronic. Included relevant codes and guidance.
* All band 4 and 5 inpatient staff should undertake seclusion training (to include Long term segregation)
* All junior doctors to have segregation at induction
* Segregation procedure now available as a separate policy
* Added segregation audit tool
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| **6.0** | November2016 | Lorraine Sunduza ,Deputy Director of Nursing Paul Gilluley , Head of Forensic services |  | * Policy updated regarding reviews at weekends. Approved clinician review can be via telephone
* Code of Practice required
* Approved clinician to review ‘Patients situation’.
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| **7.0**  | March 2020  | Day Njovana , Head Of nursing Forensic Services  |  | * Amended Escalation Process to NHS England
 |
| **8.0** | September 2022 | Huda Mohamed, Modern Matron  |  | * Policy updated to include Use of Force policy
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 **1.0 Aim of the Policy**

**1.1.** This policy has been developed to guide good practice when initiating or managing patients who are in long term segregation.

**1.2.** The aim of this policy is to ensure that:

a. The segregated patient, other patients, and members of staff are safe.

b. The patient is cared for and supported, both during and after Long term segregation.

c. Long term segregation takes place in a suitable environment, and takes account of the patient’s dignity and physical well-being.

d. The continuing need for segregation is reviewed utilising the skills and experience of available staff.

e. Each period of segregation is recorded completely and contemporaneously

f. The care plans and risk assessments of a segregated patient are up-dated as required.

g. Members of staff understand their roles and responsibilities and work within legal and procedural guidelines.

h. Patients are not segregated in seclusion rooms as identified by the Trust.

i. All staff are working with the least restrictive options that can be offered to patients based on their presentation and risks.

**1.3.** The policy must not be used as a stand-alone document but in conjunction with all

Trust policies and guidelines, in particular the policies li sted:

a. Seclusion policy

b. Physical Holding skills policy

c. Medicine policy

d. Guidelines for the management of acutely disturbed adults. e. Guidelines for PRN medication

f. High dose antipsychotic medication guidelines

g. Rapid Tranquillisation Policy for Adults and Older People

h. Incident policy

i. Use of force policy

**2.0. Scope**

**2.1.** This Policy applies at all times to all staff working within inpatient mental health services provided by East London NHS Foundation Trust. Locality specific protocols must be observed.

**2.2.** The policy applies to all patients cared for in Long term segregation at any time. All patients on long term segregation must be formally detained.

**2.3.** Although the act of placing a patient in Long term segregation cannot be planned for in advance as part of their care or treatment plan, planning should be made about how to support the patient working towards termination of Long term segregation once it has started.

**2.4.** Use of segregation strictly monitored and recorded in accordance with the guidance provided in the Mental Health Act 1983 amended 2007 and Code of Practice (2015).

2.5 The policy should be read in conjunction with the Mental Health Units (Use of Force) Act 2018 and Trust policies that cover restrictive practices such as seclusion, physical, mechanical and chemical restraint (rapid tranquilisation).

2.6 All uses of force must be recorded in an incident form. ELFT have set up the incident reporting system to ensure that we adhere to the formal reporting systems that satisfy the legal requirements, but also contractual reporting requirements with NHSEI.

**3.0. Definition of Segregation**

**3.1.** The 2015 Code of Practice defines Long term segregation as:

**3.2.** Long-term segregation refers to a situation where, in order to reduce a sustained risk of harm posed by the patient to others, which is a constant feature of their presentation, a multi-disciplinary review and a representative from the responsible commissioning authority determines that a patient should not be allowed to mix freely with other a patients on the ward or unit on a long -term basis. In such cases, it should have been determined that the risk of harm to others would not be ameliorated by a short period of seclusion combined with any other form of treatment. 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 serious injury or harm over a prolonged period of time. Where consideration is being given to long-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 Independent Mental Health Advocate (IMHA) in cases where a patient has one.

**3.3.** Segregation can be considered if:

* If a patient has been repeatedly violent and continues to make threats of violence
* If a patient has not responded to the full range of alternative remediation attempts
* If there is a historical precedent of the patient being persistently violent during an episode of illness

**3.4**. It is permissible to manage this small number of patients by ensuring that their contact with the general ward population is limited. The environment should be no more restrictive than is necessary. This means it should be as comfortable and personalised as risk considerations allow. Facilities which are used to accommodate patients in conditions of long -term segregation should be configured to allow the patient to access a number of a reas including, as a minimum, bathroom facilities, a bedroom and relaxing lounge area. Patients should also be able to access secure outdoor areas and a range of activities of interest and relevance to the person.

**4.0. Principles**

**4.1.** When determining whether to segregate a patient, the clinical and safety needs of the patient and other patients should be taken into account.

**4.2.** Previous trauma or abuse and physical health issues should be considered

**4.3.** Care plans should always be used in conjunction with any management care plan

**4.4.** Segregation must be a reasonable and proportionate response t o the risk posed by the patient

**4.5.** Segregation should not be used:

a. as a punishment or threat;

b. as part of a treatment programme;

c. because of shortage of staff

*(Where the patient poses a risk of self-harm as well as harm to others, Long term segregation 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 and that any such risk can be managed)*

**5.0. Observation of Long Term Segregation**

**5.1.** The aim of observation is to monitor the condition and behavior of the patient to assist staff to determine when Long term segregation can be terminated.

**5.2.** In line with the Trust observation policy observing staff should only continuously observe for a maximum of one hour. The staff will observe the patient, ensuring that the patient remains in sight and sound at all times.

**5.3.** The observations will be carried a member of staff. All clinical band 3, 4 and band 5 staff who observe patients should have completed observation training.

**5.4.** All Long term segregations should be observed for the first 2 hours by Registered Nurses or doctors. If Rapid tranquilisation is given the first hour after should be a registered nurse or a doctor.

**5.5.** It is the observing staff responsibility to enter all electronic record codes and documentation related to the activity during their observing hour except during MDT reviews. (**Appe ndix 1)**

**5.6.** A record of observation must be made every 1 hour. **RCODE SEGRG03: Long Term Segregation observation hourly.** When handing over responsibility for observation the member of staff handing over will make an entry of who they are handing over to and the patient’s current state.

**5.7.** Staff who carry- out observation should:

a. engage positively with the patient;

b. be appropriately briefed about the patient’s history, background, risk factors and

needs;

c. be familiar with the ward, ward policy for emergency procedures and potential environmental risk

d. be able to increase or decrease the level of engagement based on their judgement of the patients presentation.

**5.8** Patients should not be isolated from contact with staff or deprive d of access to therapeutic interventions. Staff supporting patients who are long -term segregated should make written records on their condition on at least an hourly basis therefore all segregated patients should be on enhanced observations (intermittent, close or continuous)

**5.9** The patient’s care plan should outline how they are to be made aware of what is required of them so that the period of long -term segregation can be brought to an end. Where successive MDT reviews determine that segregation continues to be required, more information should be available to demonstrate its necessity and explain why the patient cannot be supported in a less restrictive manner. The care plan should clearly state which areas that the patient can access and conditions (e.g. garden with two staff twice a day with no other patients).

**5.10** In these cases, the way that the patient’s situation is reviewed needs to reflect the specific nature of their management plan. The purpose of a review is to determine whether the patient has settled sufficiently to return to the ward community and to check on their general health and welfare.

**6.0 Responsibilities (Once it has been identified that the criteria for longer-term segregation is met):**

**6.1** The MDT (including the patients RC) and a representative from the commissioning authority should make the decision to initiate segregation. An incident form should be completed at the initiation of long term segregation. **RCODE SEGRG01: Long Term Segregation Authorisation**

**6.2.** Following must be informed within 3 working days and recorded using:

**RCODE SEGRG02: Long Term Segregation Escalation:**

* The Care Quality Commission (CQC)
* Directorate Management Team (DMT)
* Executive Nursing and Medical Trust Directors
* Local safeguarding team
* Next of Kin
* Independent Mental Health Advocate
* NHS ENGLAND- Case Managers (Appendix 2)

**6.3** The patient must have a timetable completed with planned and agreed activities for each of the day of the week.

**7.0 Reviews: The reviews during that period of segregation must be as follows:**

* 1 review per day from the treating team. The reviews have to comprise of at least an approved clinician, a senior nurse and another profession. At weekend the reviews must be from a senior nurse and an approved clinician. During the weekends the approved clinician review can be via a telephone conversation with the duty senior nurse. This must be based on clinical judgement of the distress that having unfamiliar staff reviewing may cause to the patient. **RCODE SEGRG04: Long term segregation MDT 24 hour review**
* Segregation to be subject to an independent review every 72 hours by 2 senior clinical members of staff who is not involved with the initial decision to use segregation. This can be a Matron, Consultant Psychiatrist, Psychologist or Social Worker. The outcome of each review (whether internal or external) and the reasons for continued segregation should be recorded. **RCODE SEGRG05: Long term segregation Independent MDT 72 hour review**
* A member of the DMT must be involved in at least one review per week. **RCODE SEGRG06: Long term Segregation DMT weekly review**
* The treating team should review the appropriateness of the patient’s current placement – (e.g. consideration for high security if in medium security) at every review however a through a Professional meeting must be convened every four weeks. This meeting must include a DMT member. Consideration must be made to seeking second opinions from external experts (e.g. National Psychosis Unit)
* Where long-term segregation continues for three months or longer, regular three monthly reviews of the patient’s circumstances and care should be undertaken by an external hospital. This should include discussion with the patient’s IMHA (where appropriate) and commissioner. **RCODE SEGRG07: Long term segregation external hospital 3 monthly review**
* The MDT (minimum one senior nurse Band 7 and above and Responsible clinician) and one DMT member can terminate long term segregation. The decision to end long-term segregation should be taken by the MDT (including consultation with the patient’s IMHA where appropriate), following a thorough risk assessment and observations from staff of the patient’s presentation during close monitoring of the patient in the company of others. **RCODE SEGRG08: Long term Segregation Termination**
* At times of acute behavioral disturbance where there is a need to contain an immediate risk of harm to others, there may be a need to transfer the person, for a short period of time, to a physical area that is more secure and restrictive and which has been designed for the purpose of seclusion. In such a situation, the procedure for seclusion with regards to authorising and commencing seclusion, observation, seclusion reviews and ending seclusion.

**8.0 Informal Patients**

**8.1** Long term segregation must only be used with patients detained under mental health act.

**9.0 Visits by the Care Quality Commission**

**9.1** Members of the Commission and staff employed by them may request to see a patient in Long term segregation. However, the risks associated with this may preclude the visit occurring.

**10.0 Reporting and Monitoring**

**10.1** For each episode of Long term segregation an incident form should also be completed.

**10.2** The Matron must submit Long term segregation usage statistics at monthly intervals to a designated person in the service/trust; Local areas will have their own arrangements for compilation and collection and review of trends, occurrences this should be reviewed at local governance meetings.

**10.3** Use of Long term segregation should be reported at directorate level.

**11.0 Training**

**11.1** Long term segregation training is part seclusion training for band 4s and band 5 nurses.

**11.2** Long term segregation training to be part of all in patient trainee doctors inductions.

**References:**

* *Mental Health Act Code of Practice, 2015*
* Mental Capacity Act 2005 Code of Practice DoH 2007
* Deprivation of Liberty Safeguards DoH2008
* Violence CG 25: The short-term management of disturbed/violent behaviour in in-patient psychiatric settings and emergency departments NICE 2005

**Appendix 1**

**Electronic documentation of Long term segregation**

All information relating to the Long term segregation of a patient must be recorded in RiO progress notes in conjunction with Datix incident reporting. In RiO Long term segregation is recorded in Progress Notes only.

**Progress Notes**

* In order to capture all required information into RiO, the format below must be followed. To assist clinicians this can be cut and pasted directly into RiO progress notes as a template to be filled-in.
* All observations and reviews must be recorded in RiO with codes in order to allow audit and to check standards have been met. The names of all those participating in the actual review must be recorded on RiO, i.e. the full names of the reviewing nurse, doctor, social worker, psychologist or occupational therapist along with the names of each nurse present. It is the responsibility of the professional documenting the interaction or review to gather and enter all staff names present at each review and record in RiO
* It is the observing nurse responsibility to enter all codes except the medical review, MDT, DMT etc. code which is the responsibility of the lead of that review to use in their RiO entry. A record of observation must be made eve ry hour.

All RiO codes as follows are accessible using the RiO “?” help button when writing in the progress notes.

 **Segregation RiO Codes**

RCODE SEGRG01: Long term Segregation authorisation

RCODE SEGRG02: Long term Segregation escalation

RCODE SEGRG03: Long Term segregation observation hourly

RCODE SEGRG04: Long term Segregation MDT 24 hour review

RCODE SEGRG05: Long term Segregation Independent MDT 72 hour review

RCODE SEGRG06: Long term Segregation DMT weekly review

RCODE SEGRG07: Long term Segregation External hospital 3 monthly Review

RCODE SEGRG08: Long term Segregation Termination

**Appendix 2 – Long Term Segregation Template – NHS England Reporting**

**To be completed and returned via nhs.net to the responsible case manager NHSE**

|  |  |
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| **Patient name, dob, ward/ hospital** |  |
| **Describe presenting risk and current diagnosis** |  |
| **Detail current interventions and other interventions tried with description of outcomes** |  |
| **Describe the MDT plan for LTS to include details of access to fresh air, meaningful activity/ education, therapeutic engagement with MDT, pharmacological interventions, access to advocacy and how family contact will be maintained and supported.** |  |
| **Describe plans for internal review of regime e.g. peer review** |  |
| **Detail of process of external review at 3 months**  |  |
| **Any other supporting information** |  |