Title	Seclusion Policy	Reference Number	Reg_36
Owner	Úna Fowler CNM 3	Version	V15
Author	Restrictive Practice Committee 2023	Effective From	March 2024
Approved By (LEAD)	Dr Christina McGrady (Clinical Director)	Review Date	March 2025
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Title:SeclusionPolicy

Scope: Department of Psychiatry Connolly Hospital, Blanchardstown - High Dependency Unit

Reviewed By: Compliance Committee – 2024.

Owner: Úna Fowler (Clinical Nurse Manger 3)

Signature: Úna Fowler

Date: March 2024

Approved by (LEAD): Dr Christina McGrady (Clinical Director)

Signature: CMcG

Date: March 2024

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Document History			
Changes to this document in different versions must be detailed below. Rationale for any changes should also be given			
Version Number / Name of Document	**Type of Change – i.e. Legislative / Claim / Complaint / Incident Review / Best Practice**	**Date**	**Details of Change**
V01 – 2008	Original Doc	December 2008	Original Doc
V02 – 2012	Code of Practice / Legislative	March 2012	Updated
V03 – 2013	Legislative	March 2013	Updated
V04 – 2014	Legislative	March 2014	Updated
V05 – 2015	Legislative	March 2015	Updated
V06 – 2015	Best Practice	July 2015	Updated
V07- 2016	Legislative	March 2016	Reviewed
V08 -2017	Legislative	April 2017	Reviewed
V09-2018	Legislative	March 2018	Reviewed
V10-2020	Legislative	Jan 2020	Reviewed
V11 - 2020	Reviewed and Best Practice	July 2020	Reviewed/Covid19
V12 – 2021	Legislative	October 2021	Reviewed
V13 – 2022	Legislative	July 2022	Reviewed
V 14 - 2023	Legislative	January 2023	Rule change for use of Seclusion.
V 15 - 2024	Reviewed and Best Practice	March 2024	Reviewed

1.0 Statement

Section 69(2) of the Mental Health Act 2001 obliges the Mental Health Commission (Ireland) to make rules and/or codes providing for the use of seclusion or mechanical restraint. Pursuant to the "Rules Governing the Use of Seclusion and Mechanical Means of Bodily Restraint" issued in 2009 this policy addresses the requirements of the approved centre as set out in these rules.

This policy addresses the compliance requirements of the Judgement Support Framework (2020) that state "documented policies and procedures are available in relation to the management of patient seclusion within the approved centre".

Related policies / documents:

A) Revised Rules governing the use of Seclusion-2022

B) Addendum to the Rules Governing the use of Seclusion and Mechanical Means of Bodily Restraint (2011)

C) Mental Health Act (2001) – Section 69(2)

D) Judgement Support Framework (2020)

E) DNC-DOP Reduction Policy 2023

F) DNC -DOP Infection Prevention & Control Policy

2.0 Definitions

2.1 Seclusion for the purpose of this policy is defined as:

"the placing or leaving of a person in any room, at any time, day or night, such that the person is prevented from leaving the room by any means"

(Revised Rules governing the use of Seclusion and Mechanical Means of Bodily Restraint, 2022).

2.2 Seclusion and Step down Area – Distinction

The term "step down" describes a therapeutic technique which directs the patient, for a period of time to a low stimulus area of the ward. It never involves the use of a locked door, denial of freedom around the ward/unit and is never used as a form of punishment (Griffiths, 2001).

2.3 Person

In keeping with the language of a recovery orientated approach the term person refers to patients, residents and persons admitted to the DOP.

"For the purpose of Section 69 of the mental Health Act 2001 a "patient" refers to a person to whom an admission or renewal order relates" ",... and a voluntary patient as defined by the 2001 Act".

(Revised Rules governing the use of Seclusion and Mechanical Means of Bodily Restraint, 2022).

2.4 Refractory Clothing

"Clothing specifically placed on patients that may be worn by patients in place of their normal clothes whilst in seclusion".

(Rules governing the use of Seclusion and Mechanical Means of Bodily Restraint, 2009).

Refractory clothing is designed to be anti-tear and anti-ligature. Refractory clothing can also be called 'strong clothing'.

3.0 Responsibilities

3.1 This policy applies to all staff working in DNCMHS-DOP.

3.2 This policy applies to all persons of DNCMHS-DOP.

3.3 It is the responsibility of Registered Proprietor to notify MHC of seclusion episode.

3.4 "Named Person" is responsible for DNCMHS-DOP reduction of seclusion.

3.5 The Registered Proprietor has overall responsibility for the use of seclusion.

4.0 Procedure

4.1 A RARE, EXCEPTIONAL and EMERGENCY Circumstance

4.1 There is an immediate threat of serious harm to self and/or others

4.2 An assessment of the best interests of the person is undertaken by staff

4.2 An assessment of other options of intervention other than seclusion is undertaken by staff

4.2 Staff will attempt alternative(s) if possible

4.3 A comprehensive risk assessment is completed

4.3 Consideration is taken of the person care plan

4.3 Psychiatric emergency declared if not already declared

4.4 Most senior Registered Psychiatric Nurse initiates seclusion

4.5 Registered Medical Practitioner initiates and orders seclusion

4.6 Core Care Plan – Patient in Seclusion commenced and followed.
4.6 Commence seclusion register
4.6 Notification to medical practitioner no later than 30mins.

4.7 Direct observation of person for the first 60 minutes of seclusion

4.6 Record the episode in the clinical file.
4.6 Commence seclusion register
4.6 Undertake medical examination of the person within 2 hrs. Notify responsible Consultant Psychiatrist within 30min of medical examination.

4.8 Continuous observation of person thereafter & written record of person every 15min.

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4.9 Persons Nominated representative is informed of seclusion episode as soon as is practicable.

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4.10 Nursing review (every 2 hours)

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4.11 Medical review every 4 hours

4.11 Order for continued use of seclusion by Registered Medical Practitioner

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4.12 Renewal order every 4 hours

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4.13 Examination by Consultant Psychiatrist every 24 hours

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4.14 Notification to the Mental Health Commission of the start time and date and end time and date of each episode of seclusion.
More than 72 hours in seclusion.
4th Seclusion Episode in 5 Days

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4.8 Continuous observation of person thereafter

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4.9 Persons Nominated representative is informed of seclusion episode as soon as is practicable

↓

4.10 Nursing review (every 2 hours)

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4.11 Medical review every 4 hours

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4.12 Renewal order every 4 hours

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4.13 Examination by Consultant Psychiatrist every 24 hours

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4.14 Notification to the Mental Health Commission of the start time and date and end time and date of each episode of seclusion.
More than 72 hours in seclusion.
4th Seclusion Episode in 5 Days.

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4.15 In person debrief occurs within two working days of the seclusion episode

4.16 The Multidisciplinary Team must review the episode of seclusion within five "normal working days" of the seclusion episode

4.15 The person's care plan and risk assessment is updated

4.1 It is the policy of DNCMHS-DOP that seclusion is carried out on a case-by-case basis following a comprehensive risk assessment. It is used in rare , exceptional and emergency circumstances and only in the best interests of the patient when he or she poses an immediate threat of serious harm to self or others and all other options have been exhausted/attempted as deemed suitable by the comprehensive risk assessment.

The use of seclusion is based on the best available contemporary evidence. Cultural awareness and gender sensitivity is demonstrated when considering the use of and when using seclusion. Seclusion is used within a setting, where the safety of persons, staff and visitors is regarded as being essential and equal.

The seclusion episode must not be prolonged beyond the period which is strictly necessary to prevent serious harm.

Seclusion must be used in a professional manner based within an ethical and legal framework and carried out as dictated within the Rules and Policy.

At every stage of seclusion staff should be assessing the possibility of terminating seclusion.

4.2 Every effort should be made by staff to avoid the use of seclusion. At all stages staff shall be cognisant of the best interests of the person.

Alternatives to seclusion must be considered by staff and if possible attempted prior to the ordering and initiation of seclusion.

4.3 Comprehensive risk assessment is undertaken by staff.

Once a risk assessment for the use of seclusion is initiated, this is considered for the purposes of this policy as a Psychiatric Emergency and the 'Psychiatric Emergency Policy' should be initiated if not already activated.

Staff must assess planned or undertaken interventions based on their knowledge of the person's known clinical needs including mental and physical considerations and care plan.

4.4 Following a comprehensive risk assessment, in an emergency circumstance where the person poses an immediate threat of serious harm to self and others; the registered psychiatric nurse initiates seclusion.

4.5 Following a comprehensive risk assessment, in an emergency circumstance where the person poses an immediate threat of serious harm to self and others; the registered medical practitioner initiates and orders seclusion.

This order for seclusion lasts for the first 4 hours.

4.6 Once seclusion is commenced the "Core Care Plan – Patient in Seclusion" (Appendix 1) must be commenced. The core care plan details the required standards of care expected for the use of seclusion. It provides the necessary steps to follow while caring for a person in seclusion. The core care plan allows all interventions and documentation to be located within one focused document.

Once seclusion is commenced the Clinical Nurse Manager or Nurse in Charge shall ensure that the seclusion register is commenced and mandatory documentation completed (Appendix 2).

The staff member who initiated seclusion shall contact the responsible or duty consultant psychiatrist and the Assistant Director of Nursing or Clinical Nurse Manager 3 on duty as soon as practicable. This communication will be documented in the person's clinical record.

The person must be provided with information in a suitable format. The person must be informed of the reasons for, likely duration of and the circumstances which will lead to the discontinuation of seclusion. In the event that this communication does not occur, a record explaining why it has not occurred should be entered in the person's clinical record.

4.7 Direct observation of the person for the first 60 minutes of seclusion shall be undertaken by a registered psychiatric nurse. This observation shall be documented in the "Core Care Plan for Seclusion".

Direct observation is ongoing observation of the person by a registered psychiatric nurse who is within sight and sound of the Seclusion room at all times but is outside the Seclusion room. The observation of a patient by CCTV does not constitute "direct observation".

4.8 Continuous observation of the person following the first 60 minutes of seclusion shall be undertaken by a registered psychiatric nurse. This observation which may include the use of video or other electronic monitoring i.e. CCTV shall be carried out in the seclusion lobby only and shall be documented at a minimum every 15 minutes in the "Core Care Plan – Patient in Seclusion".

The staff member assigned to the continuous observation of the person in seclusion shall be rotated hourly.

4.9 As soon as is practicable, and in line with the persons wish as part of their Individual Care Plan, the persons representative shall be informed of the person's seclusion and a record of this communication should be placed in the clinical record. In the event that this communication does not occur, a record explaining why it has not occurred shall be entered in the clinical record.

Where a person has capacity and does not wish to inform his or her representative of his or her seclusion, no such communication should occur outside the course of that necessary to fulfil legal and professional requirements. This should be recorded in the person's clinical record.

4.10 Following a risk assessment, a nursing review of the person in seclusion must take place every 2 hours, unless, to do so would place the patient or staff at a high risk of injury. This review or postponement of review shall be documented in the "Core Care Plan – Patient in Seclusion".

During this review a minimum of 2 staff one of whom must be a registered psychiatric nurse and one whom was not directly involved with the initiation of the seclusion episode (where possible) will enter the seclusion room and directly observe the patient to consider whether the episode of seclusion can be ended.

To support this active review the nurse must consider all the information documented in the continuous observation record and the person's current behaviour. This will assist the nurse in deciding the need to discontinue/continue seclusion.

During this review the nurse will assess the person's mental state and physical health. To support this assessment the nurse will document the assessment of the person's skin colour (for example cyanosis, pallor), vital signs or at a minimum breathing (rate per minute), position (lying, sitting, standing), activity (sleeping, talking, pacing), behaviour (violent, aggressive) and thought content (delusions, paranoia).

Where a patient is sleeping, clinical judgement needs to be used as to whether it is appropriate to wake the patient for a nursing review. Nursing reviews must continue every 2 hours; however the nature of the nursing review will be such that the patient is not woken.

4.11 A medical review of the person shall be undertaken every 4 hours. The registered medical practitioner must order for continued use of seclusion or order to terminate the seclusion episode.

Where a patient is sleeping, clinical judgement needs to be used as to whether it is appropriate to wake the patient for a medical review. In such instances medical reviews may be suspended.

Medical reviews may consist of the following (This list is not exhaustive) –

4.11.1 Mental State of the Patient

4.11.2 Arousal / Behaviour / Threat / Overt Risks

4.11.3 Communication with the patient including information on what will allow for the termination of the seclusion episode

4.11.4 Review of the 'Core Care Plan Patient in Seclusion'

4.11.5 Medication Review

4.11.6 Physical Health Check (Note any injuries – document noted causes of any injuries)

4.11.7 Patient Welfare (Heat / Clothing / Dignity / Ventilation / Orientation/ hydration/ nutrition/ elimination / hygiene)

4.11.8 Communication with Consultant Psychiatrist (If applicable)

4.11.9 Communication with Nursing Staff

4.11.10 Documented consideration of alternatives and ending seclusion

4.11.11 Documented time/date of review / total time of seclusion at time of review

4.11.12 Documented review of safety plan (Core Care Plan Patient in Seclusion)

4.11.13 Documented – Extension / Ending of Seclusion – Note requirements for notification/review by the Responsible Consultant Psychiatrist and the MHC (24 Hours / 7 Episodes in 7 Days / > 72 Hours)

4.11.14 Confirm that completion of the Seclusion Register is completed in the clinical record.

4.12 A seclusion order must be renewed every 4 hours by the registered medical practitioner.

A seclusion order may be extended by the registered medical practitioner under the supervision of the consultant psychiatrist responsible for the care and treatment of the person or duty consultant psychiatrist following an examination, for a further period not exceeding 4 hours to a maximum of 5 renewals (24 hours) of continuous seclusion.

4.13 If a person's seclusion order is to be renewed after 24 hours continuous seclusion, the consultant psychiatrist responsible for the care and treatment of the person or the duty consultant psychiatrist must examine the patient and this shall be recorded in the patient's clinical file.

4.14 If the consultant psychiatrist or duty consultant psychiatrist responsible for the care and treatment of the person decides to continue seclusion beyond 72 continuous hours, the Mental Health Commission shall be informed on the appropriate form (Appendix 3).

If the person is secluded 4 times within 5 days the Mental Health Commission must be informed on the appropriate form (Appendix 4) by the consultant psychiatrist or duty consultant psychiatrist responsible for the person's care and treatment.

4.15 The multidisciplinary team will meet within five 'normal' working days to review the seclusion episode. This review will be documented on the reverse of the "Core Care Plan – Patient in Seclusion".

The persons care plan and risk assessment will be updated to reflect the seclusion episode.

4.16 The Clinical Nurse Manager or the Nurse in Charge will arrange an In person debrief to be held with the person post the episode of seclusion or within two working days. Should it be the persons preference for debrief to be held outside of the two days this must be documented in the clinical file.

As part of the multidisciplinary team review the person shall have the opportunity to discuss the episode of seclusion and the outcomes from the In person debrief.

4.17 The persons ICP must be updated to reflect the outcome of the debrief, and in particular, the persons preferences in relation too restrictive interventions going forward.

5.0 Additional Procedures

5.1 Seclusion shall not form part of a treatment programme.

5.2 Seclusion shall take place in the specially designated seclusion suite. The seclusion suite shall not be used for any other purpose except seclusion.

5.3 The seclusion suite shall only accommodate one person at a time.

5.4 The seclusion suite will be of a standard that it provides privacy from other persons, visitors and staff but enable appropriate supervision and observation.

The seclusion suite will not contain anything that may cause harm to the person or staff.

The seclusion suite will be quiet but not soundproofed in order to allow communication between the person and staff.

5.5 The "Seclusion Procedures Resource Document" should be used in conjunction with this policy.

5.6 The "CCTV Policy" shall be consulted in addition to this policy.

5.7 The "Rules Governing the use of Seclusion and Mechanical Means of Bodily Restraint and Addendum" produced by the Mental Health Commission shall be read in conjunction with this policy.

5.8 All current COVID-19 acute hospital guidelines to be adhered too as per IPC.

6.0 Document Control

6.1 Where copies of policies and procedures are required, these shall be treated as controlled documents and stored centrally in hard copy folders where they are accessible for all staff.

7.0 Communication

7.1 It is the responsibility of the heads of each discipline to ensure their staff are aware of the Seclusion policy and procedure, ensure they understand the documentation and have signed to demonstrate this.

7.2 The Heads of Discipline shall maintain a record of this communication with staff.

8.0 Document Availability

8.1 This policy and procedure shall be made available to all relevant staff via the Controlled Policy and Procedure Document Folder.

8.2 A controlled copy of this policy and appendices shall be made available in hard format on each ward of DOP. This copy will be in a central location for ease of access.

9.0 Audit and Evaluation

9.1 This policy shall be reviewed at a minimum every year.

9.2 Quarterly audits shall be conducted by the DNCMHS-DOP to ensure that compliance is maintained with the policies, procedures and processes.

9.3 Incident Reports are recorded according to policy and in addition incident reports are completed when non-compliance with the application of this policy and the MHC Code of Practice are noted. Incident Summary Reports are forwarded to the Mental Health Commission on a 6 monthly basis by administration of DNCMHS-DOP.

9.4 MDT oversight committee shall analyse seclusion episodes at least quarterly.

9.5 An annual report on Seclusion within the Approved Centre is completed and opportunities for improvement of the practice and any future learning are disseminated. This requirement is the responsibility of the DNCMHS-DOP management team. This annual report will be forwarded and made available for the Mental Health Commission.

10.0 Training

10.1 All staff within DNCMHS-DOP involved with seclusion should be familiar with this policy, the rules, associated policies and documents as detailed in the introduction.

10.2 It is the responsibility of DNCMHS-DOP management team that the policy, procedures, training and associated processes and implementation regarding seclusion is implemented throughout the DNCMHS-DOP. The mandatory nature of this policy, rules and training will be conveyed to staff.

10.3 It is the responsibility of DNCMHS-DOP management team to ensure that training is provided as per the identified needs of staff, persons and in response to ongoing audit processes. Staff involved with Seclusion are as follows – Nursing, Medical, Occupational Therapy, Social Work, Psychology and Pharmacy. Each Head of Discipline is required to ensure that their staff are trained in Seclusion and associated processes including alternatives to seclusion.

10.4 It is the responsibility of DNCMHS-DOP management team that all staff providing training are suitably qualified and that training is provided during induction and as required by DNCMHS-DOP. This training will be at a minimum at induction and refreshers in conjunction with TMVA training. TMVA Training is as follows –

TMVA Breakaway – 1 Day – Initial and 4 Hour refresher every year

TMVA Control & Restraint – 2 Day – Initial and 1-day refresher every year.

In addition to the TMVA training, Trauma informed Care & additional workshops/training will be provided in response to audit results, changes to policy and at the request of staff / management team

10.5 Any training will document the facilitator(s) (who will be appropriately qualified, i.e. TMVA Instructors and members of the Nursing Leadership team) and all staff in attendance at the training.

10.6 Any training will cover the policy, rules, alternatives and associated documentation.

10.7 As part of the revised rules governing the use of Seclusion and Mechanical Means of Bodily Restraint (2022) staff training will include:

- Trauma Informed Care
- Cultural Competence
- Human rights including the legal principles of restrictive practices
- Positive Behaviour support including the identification of causes or triggers of the person's behaviours including social, environmental, cognitive, emotional or somatic.
- Alternatives to seclusion/restraint

11.0 References

Attorney General (2001) Mental Health Act. Dublin: Government of Ireland.

Attorney General (2006) Statutory Instruments No. 551 of 2006 Mental Health Act 2001 (Approved Centres) Regulations. Dublin: Government of Ireland.

Gaskin, C.J., Elsom, S.J. and Happell, B. (2007) Interventions for reducing the use of seclusion in psychiatric facilities Review of the literature. British Journal of Psychiatry. 191. 298-303.

Griffiths, L. (2001) Does seclusion have a role to play in modern mental health nursing? British Journal of Nursing. 10(10). Pp – 656-661.

Health Protection Surveillance Centre, HPSC (2020). Guidance on the use of surgical masks when Healthcare is being provided in the context of the COVID-19 pandemic. Dublin: HPSC.

Infection Prevention & Control Policy for staff including Covid 19 outbreak control in the DOP (2021).

Mace, F. C., Page, T. J., Ivancic, M. T., & O'Brien, S. (1986). Effectiveness of brief time-out with and without contingent delay: A comparative analysis. Journal of Applied Behaviour Analysis. 19(1), 79-86.

Mental Health Commission (2022) Rules Governing the use of Seclusion and Mechanical Means of Bodily Restraint. Dublin: Mental Health Commission.

Mental Health Commission (2011) Rules Governing the use of Seclusion and Mechanical Means of Bodily Restraint, Addendum. Dublin: Mental Health Commission.

Mental Health Commission (2020) Judgement Support Framework. Dublin: Mental Health Commission.

12.0 Appendices

12.1 **Appendix 1** Core Care Plan – Patient in Seclusion – V07

12.3 **Appendix 2** MHC Form – Decision to extend past 72 hours- Replace with clinical practice form

12.4 **Appendix 3** MHC Form – 7 seclusion episodes in 7 days

12.6 **Appendix 4** Seclusion Pathway – Nursing – V01