HSE MID WEST
COMMUNITY HEALTHCARE

Mid-West Mental Health Services

Policy and Procedures for the Use of Seclusion

Policy/Procedure/ Guideline Title	**Policy and Procedure for the Use of Seclusion**		
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Chair Management Team			

<u>This CPPPG is electronically and centrally controlled</u>. Managers are responsible for ensuring that any hard copies in circulation in their areas are the most current version of this PPPG.

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1.0 Policy Statement

The Mental Health Services are committed to ensuring a safe and therapeutic environment for residents/patients in approved centres. To this end, the use of seclusion will be practiced within a culture of respect and in a manner which ensures the rights of residents.

Seclusion should only be used in rare and exceptional circumstances when there is an immediate threat of harm to themselves or others. Seclusion should only be used when all other alternatives to manage the situation have been exhausted.

It is the policy of the Limerick Mental Health Services (LMHS) that no seclusion is used in any clinical area of the service.

It is the policy of Clare Mental Health Services (CMHS) that seclusion is only used in the Acute Psychiatric Unit. Where seclusion is used in the Acute Psychiatric Unit, that seclusion is considered as a management option for patients, in exceptional circumstances. All episodes of seclusion will comply with the Mental Health Commission Rules Governing the Use of Seclusion 2022 and the Mental Health Act (2001).

2.0 Purpose

The purpose of this policy and procedure is to ensure safe and therapeutic practice around the use of seclusion in line with MHC Rules Governing the Use of Seclusion (2022). This policy and procedure does not override the individual responsibility of health professionals to make decisions appropriate to the circumstances of the individual person, in consultation with the resident and/or guardian or carer and members of the MDT

3.0 Scope

This policy applies to Nursing and Medical Staff, Members of the MDT as defined by the MHC and Nursing Students (under the supervision of a registered nurse) in the Mental Health Approved Centre's.

4.0 Legislation and other related policies

This policy is written with due regard to MHC Rules Governing the Use of Seclusion (2022), the BILD (2010) Code of Practice for the use and Reduction of Restrictive Physical Interventions: A guide for trainers and commissioners of training and linking Services and Safety, together creating safer places of service – Strategy for managing work related Aggression and Violence within the Irish health Service (2008), NICE Guidelines (2015) Violence and aggression: short-term management in mental health, health and community setting, Mental Health Commission Seclusion and Restraint Reduction Strategy (2014).

The Use of Restrictive practices in Approved Centres, Promoting Quality, Safety and Human Rights in mental health, Activities Report 2021 (September 2022) and other related policies:

- CP01: Increased Nursing Observations
- CP07: Recording Clinical Information.
- CP13: Confidentiality
- CP18 Policy and Procedures for Searching Resident/Patients Personal Property and Possessions in Approved Centres
- CP38: Use of CCTV
- CP31 - Local Policy on Individual Care Plan
- Seclusion (MHC JSF V6.0 (2024), Best Practice Guidance (BPG) 2017)
- Mental Health Act 2001

- Statutory Instrument No.551 of 2006: Mental Health Act 2001 (Approved Centres) Regulations 2006.
- MHC Code of Practice on the Use of Physical Restraint Issued Pursuant to Section 33(3) (e) of the Mental Health Act 2001-2018 (September 2022).
- MHC Seclusion and Restraint Reduction Strategy 2014.
- CP41: Policy on ligature risk reduction
- Code of Practice Relating to the Admission of Children under the Mental Health Act 2001(2006) and the addendum to the Code of Practice Relating to Admission of Children under the Mental Health Act 2001 (July 2009).
- HSE Child Protection and Welfare Policy 2019.
- HSE Policy on the prevention and Management of Work Related Aggression and Violence 2018.
- Mental Health Commission Judgement Support Framework (2022).

5.0 Abbreviations and Glossary

5.1 Abbreviations (in alphabetical order):

- ADON: Assistant Director of Nursing
- CCTV: Closed Circuit Television
- CNM: Clinical Nurse Manager
- CPPPG: Clinical Polices Procedures Protocols and Guidelines
- CMHS: Clare Mental Health Service
- DON: Director of Nursing
- ECD: Executive Clinical Director
- CD: Clinical Director
- HOD: Heads of Discipline
- MWMH: Mid-West, Mental Health (Refers to Clare, Limerick and North Tipperary)
- LMHS: Limerick Mental Health Services
- MDT: Multi-Disciplinary Team
- MHA: Mental Health Act
- MHC: Mental Health Commission
- ICP: Individualised Care Plan
- PMCB: Professional Management of Complex Behaviours

5.2 Glossary

APPROVED CENTRE: A "centre" means a hospital or other inpatient facility for the care and treatment of persons suffering from mental illness or mental disorder. An "approved centre" is a centre that is registered pursuant to the Mental Health Act 2001-2018. The Mental Health Commission establishes and maintains the register of approved centres pursuant to the Mental Health Act 2001-2018.

BREAKAWAY TECHNIQUES: A set of physical skills to help separate or break away from an aggressor in a safe manner. They do not involve the use of restraint.

CHILD: A person under 18 years of age other than a person who is or has been married.

CLINICAL FILE: A record of the person's referral, assessment, care and treatment while in receipt of mental health services. This documentation must be stored in the one file. If all relevant information is not stored in the one file, the file must record where the other information is held.

CLINICAL GOVERNANCE: A system for improving the standard of clinical practice including clinical audit, education and training, research and development, risk management, clinical effectiveness and openness.

CLOSED CIRCUIT TELEVISION (CCTV): Any monitoring device which captures a person's image, either for recording or live observation.

CONSULTANT PSYCHIATRIST: Means a consultant psychiatrist who is employed by the HSE or by an approved centre or a person whose name is entered on the division of psychiatry or the division of child and adolescent psychiatry of the Register of Medical Specialists maintained by the Medical Council.

CONTINUOUS OBSERVATION: Ongoing observation of the person by a registered nurse and registered medical practitioner, who is within sight and sound of the person at all times, which may include the use of electronic monitoring e.g. CCTV.

DE-ESCALATION: The use of techniques (including verbal and non-verbal communication skills) aimed at defusing anger and averting aggression.

DIGNITY: The right of an individual to privacy, bodily integrity and autonomy, and to be treated with respect as a person in their own right.

DIRECT OBSERVATION: Ongoing observation of the person by a registered nurse who is within sight and sound of the seclusion room at all times but is outside the seclusion room. The observation of a person via electronic monitoring (e.g. CCTV) does not constitute "direct observation".

DUTY CONSULTANT PSYCHIATRIST: The consultant psychiatrist on the on-call duty rota.

INDIVIDUAL CARE PLAN: A documented set of goals developed, regularly reviewed and updated by the person's multidisciplinary team, so far as practicable in consultation with each person receiving care and treatment. The individual care plan must specify the treatment and care required which must be in accordance with best practice, must identify necessary resources and must specify appropriate goals for the person. For children, individual care plans must include education requirements. The care plan is recorded in the one composite set of documentation.

PERSON: All references to 'person' in this document shall be taken to mean a voluntary or involuntary patient or resident, as defined in the 2001 Act.

PERSON-CENTRED: Person-centred focuses on the needs of the person; ensuring that the person's preferences, needs, and values guide clinical decisions or support; and providing care that is respectful and responsive to them.

POLICY: Written statement that clearly indicates the position of the organisation on a given subject.

POSITIVE BEHAVIOUR SUPPORT: Positive behaviour support involves assessments that look beyond the behaviour of a person and seek to understand the causes or triggers of the behaviours. These

causes may be social, environmental, cognitive, or emotional. The approach is one of behaviour change as opposed to behaviour management.

REGISTERED MEDICAL PRACTITIONER: A person whose name appears on the General Register of Medical Practitioners.

REPRESENTATIVE: An individual chosen by the person who is being cared for (e.g. friend, family member, advocate) or a legal professional appointed by the person, statutory organisation or court to represent the person.

RIGHTS-BASED APPROACH: Integrating human rights norms and principles in the design, implementation, monitoring and evaluation of policies and programmes. The principles of equality and freedom from discrimination are central.

RISK ASSESSMENT: An assessment to gauge risk in relation to the person, designed and recognised for use in mental health settings.

TRAUMA-INFORMED CARE: Trauma-informed care is an approach which acknowledges that many people who experience mental health difficulties may have experienced some form of trauma in their life. A trauma-informed approach seeks to resist traumatising or re-traumatising persons using mental health services and staff.

UNSAFE BEHAVIOUR: When a person acts in such a way that they may injure themselves or others.

5.3 Definition

Seclusion 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."** (MHC, Rules Governing the Use of Seclusion 2022)

6.0 Roles and Responsibilities

6.0.1 All multi-disciplinary staff working in the Acute Unit CMHS are responsible for complying with this CPPPG.

6.0.2 Staff as identified on the front sheet of this CPPPG are responsible for the implementation of this CPPPG.

6.0.3 The MWMH CPPPG Management Group is responsible for overseeing the implementation and review of this CPPPG.

6.0.4 Responsibility for revision and audit is outlined in Section 10 of this CPPPG.

6.0.5 It is the responsibility of the senior management of CMHS to:

6.06 Provide for the training of staff in relation to seclusion.

6.0.7 Monitor the implementation of this policy.

6.0.8 Ensure this policy is reviewed within the allocated time frame and or as a result/outcome of incidents accidents/complaints, changes to legislation or learning from practice.

6.0.9. It is the responsibility of all staff to acknowledge and sign that they have read and understood this policy.

7.0 General Principles underpinning the use of Seclusion

7.0.1 Approved centres must recognise the inherent rights of a person to personal dignity and freedom in accordance with national and international human rights instruments and legislation.

7.0.2 The use of seclusion may increase the risk of trauma and may trigger symptoms of previous experiences of trauma. Therefore, it must only be used in rare and exceptional circumstances as an emergency measure.

7.0.3 Persons who are secluded must be treated with dignity and respect at all times before, during, and after the seclusion.

7.0.4 Persons who are secluded must be fully informed and involved in all decisions regarding their care and treatment to include all matters relating to the use of seclusion. The views of persons who are secluded must be listened to, taken into account and recorded.

7.0.5 As seclusion compromises a person's liberty, its use must be the safest and least restrictive option of last resort necessary to manage the immediate situation, be proportionate to the assessed risk, and employed for the shortest possible duration. Its use must only occur following reasonable attempts to use alternative means of de-escalation to enable the person to regain self-control.

7.0.6 Communication with persons who are secluded must be clear, open and transparent, free of medical or legal jargon, and staff must communicate with empathy, compassion and care. Persons who have a sensory impairment may experience an increased level of trauma during seclusion and staff must address the additional communication needs of these persons.

7.0.7 The views of family members, representatives and nominated support persons, must be taken into account, where appropriate.

7.0.8 Cultural awareness and gender sensitivity must be taken into account at all times and must inform the approved centre's policies and procedures for the use of seclusion.

7.0.9 Seclusion must be used in a professional manner and its use must be based within a legal and ethical framework.

7.0.10 The use of seclusion is rare and only used in exceptional circumstances and only in the interests of the patient when he/she poses an immediate threat of serious harm to self or others.

7.1 Order for Seclusion

7.1.1 The seclusion of any person must only be initiated by a registered medical practitioner or the most senior registered nurse on duty in the unit/ward.

7.1.2 Seclusion must only be initiated following as comprehensive an assessment of the person as is practicable. This must include a risk assessment, the outcome of which must be recorded in the person's clinical file. A copy of the risk assessment must be made available to the Mental Health Commission on request.

7.1.3 The registered medical practitioner or registered nurse must record the matter in the clinical file and on the seclusion register.

7.1.4 Where seclusion is initiated by a registered nurse, a registered medical practitioner must be notified of the seclusion episode as soon as is practicable, and no later than 30 minutes following the commencement of the episode.

7.1.5 There must be a medical examination of the person by a registered medical practitioner as soon as is practicable and, in any event, no later than **two hours** after the commencement of the episode of seclusion. This must include an assessment and record of any physical, psychological and/or emotional trauma caused to the person as a result of the seclusion.

7.1.6 As soon as is practicable, and no later than 30 minutes following the medical examination, the registered medical practitioner must contact the person's consultant psychiatrist or the duty consultant psychiatrist to inform them of the episode of seclusion. The consultant psychiatrist must discontinue the use of seclusion unless they order its continued use.

7.1.7 The registered medical practitioner must record this consultation in the clinical file and indicate on the seclusion register that the consultant psychiatrist ordered or did not order the continued use of seclusion.

7.1.8 If the consultant psychiatrist orders the continued use of seclusion, they must advise the duration of the order. The registered medical practitioner must record this information on the seclusion register. A seclusion order must not be made for a period of time longer than **four hours** from the commencement of the seclusion episode.

7.1.9 The order of the consultant psychiatrist must confirm that there are no other less restrictive ways available to manage the person's presentation.

7.1.10 The consultant psychiatrist must undertake a medical examination of the person and sign the seclusion register within 24 hours of the commencement of the seclusion episode. The examination must be recorded in the person's clinical file.

7.1.11 The person must be informed of the reasons for, likely duration of, and the circumstances which will lead to the discontinuation of seclusion, unless the provision of such information might be prejudicial to the person's mental health, well-being or emotional condition. If informed of the reasons, a record of this must be recorded in the person's clinical file as soon as is practicable. In the event that this communication

does not occur, a record explaining why it has not occurred must be entered in the person's clinical file as soon as is practicable.

7.1.12 a) As soon as is practicable, and if it is the person's wish in accordance with their individual care plan, the person's representative must be informed of the person's seclusion and a record of this communication must be entered in the person's clinical file. In the event that this communication does not occur, a record explaining why it has not occurred must be entered in the person's clinical file.

b) Where it is the person's wish in accordance with their individual care plan that the person's representative is not to be informed of the person's seclusion, no such communication must occur outside the course of that necessary to fulfil legal and professional requirements. This must be recorded in the person's clinical file.

7.1.13 The Registered Proprietor or nominated representative must notify the Mental Health Commission of the start time and date, and the end time and date of each episode of seclusion in the format specified by the Mental Health Commission, and within the timeframes set by the Mental Health Commission.

7.2 Patient Dignity and Safety

7.2.1 Seclusion of a person with a known psycho-social/medical condition, in which close confinement would be contraindicated, must only be used when all alternative options have been implemented and proven unsuccessful and following an appropriate risk assessment.

7.2.2 The clothing worn in seclusion must respect the right of the person to dignity, bodily integrity and privacy. The person must be secluded in their own clothing. If, in exceptional circumstances, the decision is made to use any other clothing (e.g. tear-proof clothing, or other clothing that is not the person's), this must only occur following a specific and documented risk assessment which is regularly reviewed no less frequently than at each renewal order. If the person's own clothing is not worn, the reason must be documented in the person's individual care plan.

7.2.3 A person in seclusion must not have access to hazardous objects.

7.2.4. Bodily searches must only be undertaken in the most exceptional circumstances, following a risk assessment (the outcome of which must be recorded in the person's clinical file). Bodily searches must be undertaken in the presence of more than one staff member, and respect the right of the person to dignity, bodily integrity and privacy. Gender and cultural sensitivity and the preferences of the person must be respected when undertaking a bodily search.

7.2.5 All staff members involved in the use of seclusion must have undertaken appropriate training in accordance with the policy outlined in section 11.2 of the MHC Rules Governing Seclusion.

7.3 Provision of information to the Patient

7.3.1 The patient will be informed that seclusion will occur and the reasons for seclusion as soon as the decision is made to seclude the person.

7.3.2 One registered nurse will maintain communication with the patient during the process of transferring or removing the patient to the seclusion facility.

7.3.3 Regular communication will be maintained with the patient by the observing nurse Throughout the period of seclusion and explanations offered as to why seclusion has been used, the likely duration and the circumstances under which it can be terminated.

7.3.4 The patient will be afforded the opportunity to discuss the experience with a member of the multidisciplinary team following an episode of seclusion whereby an explanation can be provided and plans to avoid future episodes made where appropriate. Patient Debriefing Tool to be completed by a member of the multidisciplinary team.

7.4 The monitoring of a patient during seclusion

7.4.1 A person placed in seclusion must be kept **under direct observation** (not CCTV) by a registered nurse for the first hour following the initiation of a seclusion episode.

7.4.2 After the first hour, a registered nurse must keep the person under continuous observation and be within sight and sound of the seclusion room. This observation may be completed in person or with CCTV (or other electronic monitoring).

7.4.3 A written record of the person must be made by a registered nurse at least every 15 minutes. This must include a record of:

i. the person's level of distress;
ii. the person's behaviour (what the person is doing and saying);
iii. the person's level of awareness;
iv. the person's physical health, especially with regard to breathing, pallor or cyanosis;
v. whether elimination/hygiene needs were met;
vi. whether hydration/nutrition needs were met. If the person's unsafe behaviour has abated, the ending of the episode of seclusion must be considered.

7.4.4 Following a risk assessment, a nursing review of the person in seclusion must take place **every two hours**, unless the risk assessment indicates that to do so would place the person or staff at a high risk of injury. During this review, a minimum of two staff members, one of whom must be a registered nurse who was not directly involved in the decision to seclude (where possible), will enter the seclusion room and assess the person to determine whether the episode of seclusion can be ended. This assessment and decision must be recorded.

7.4.5 A medical examination must be carried out by a registered medical practitioner **every four hours.** This examination must take account of the records of the nursing observations and any previous medical examination(s). The decision to end or continue seclusion must be recorded.

7.4.6 Where a person is sleeping, clinical judgement needs to be used as to whether it is appropriate to wake the person for a nursing review or medical examination. In such instances medical examinations may be suspended. Nursing reviews must continue every two hours. However, the nature of the nursing review may be such that the person is not

woken. A registered medical practitioner must be on call to carry out a medical examination during the night, should the need arise.

i. Upon commencement of an episode of seclusion, a Seclusion Care Plan for the person must be developed by a registered nurse. A Seclusion Care Plan must include as a minimum:
ii. personal details;
iii. known clinical needs (including mental and physical considerations);
iv. how de-escalation strategies will continue to be used;
v. the person's preferences in relation to seclusion, where known (e.g. access to music or reading material while in the seclusion room), and take into account outcomes of any previous debrief with the person, if applicable;
vi. recognising signs where the person's behaviour is no longer deemed an unmanageable risk towards themselves or others, e.g. evidence of tension reduction, improved communication etc.;
vii. how potential risks may be managed;
viii. reference to specific support plans for the person and details of how the person's mental health needs will continue to be met while in seclusion;
ix. meeting of food/fluid needs;
x. meeting of needs in relation to personal hygiene/dressing;
xi. meeting of elimination needs (with specific reference to how privacy and dignity will be managed);
xii. medication reviews (in consultation with a registered medical practitioner);
xiii. monitoring of physical observations;
xiv. a strategy for ending seclusion; indicating the criteria required for this to be reached.

7.5 Renewal of Seclusion Orders

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

7.5.2 If the person's seclusion order is to be renewed beyond the initial 24 hours of continuous seclusion, the consultant psychiatrist responsible for the care and treatment of the person or the duty consultant psychiatrist must undertake a medical examination of the person, and this must be recorded in the person's clinical file.

7.5.3 If the person's seclusion order is to be renewed beyond 72 hours of continuous seclusion, the consultant psychiatrist responsible for the care and treatment of the person or the duty consultant psychiatrist must undertake a medical examination of the person, and this must be recorded in the person's clinical file. Following the medical examination, the consultant psychiatrist must discontinue the use of seclusion unless they order its continued use.

7.5.4 If a decision is made by the consultant psychiatrist responsible for the care and treatment of the person, or the duty consultant psychiatrist acting on their behalf, to continue to seclude a person for a total period exceeding 72 hours, the Mental Health Commission must be provided with additional information to include:

i) a record of the reasonable attempts and outcomes to use alternative means of calming and de-escalation to enable the person to regain self-control;

ii) the reasons why continued seclusion is ordered.

7.7.5 If a person has four or more distinct seclusion episodes over a period of five consecutive days, the Mental Health Commission must be provided with additional information, to include the following:

i. a record of the reasonable attempts and outcomes to use alternative means of calming and de-escalation to enable the person to regain self-control;

ii. the reasons why seclusion has been repeatedly ordered.

7.6 Ending Seclusion

7.6.1 Seclusion may be ended:

i. by a registered medical practitioner at any time following discussion with the person in seclusion and relevant nursing staff;

ii. by the most senior registered nurse in the unit/ward, in consultation with the person in seclusion and a registered medical practitioner.

7.6.2 Where seclusion is ended by a registered medical practitioner or the most senior registered nurse on duty in the unit/ward, the consultant psychiatrist responsible for the care and treatment of the person, or the duty consultant psychiatrist acting on their behalf, must be notified.

7.6.3 The person must be informed of the ending of an episode of seclusion.

7.6.4 Leaving seclusion for a toilet break, or for a medical examination does not constitute the end of an episode of seclusion.

7.6.5 The time, date and reason for ending seclusion must be recorded in the person's clinical file on the date seclusion is ended.

7.6.6 An in-person debrief with the person who was secluded must follow every episode of seclusion. This debrief must be person-centred and must:

i) give the person the opportunity to discuss the seclusion with members of the multidisciplinary team involved in the person's care and treatment as part of a structured debrief process;

ii. occur within two working days (i.e. days other than Saturday/Sunday and bank holidays) of the episode of seclusion unless it is the preference of the person who was secluded to have the debrief outside of this timeframe. The person's preferences regarding the timing of the debrief must be recorded;

iii. respect the decision of the person not to participate in a debrief, if that is their wish. If the person declines to participate in the debrief, a record of this must be maintained and recorded in the person's clinical file;

iv. include a discussion regarding alternative de-escalation strategies that could be used to avoid the use of restrictive interventions in the future;

v. include a discussion regarding the person's preferences in the event where a restrictive intervention is needed in the future e.g. preferences in relation to which restrictive intervention they would not like to be used;

vi. give the person the option of having their representative or their nominated support person attend the debrief with them, and, if the person's representative or nominated

support person does not attend the debrief, a record of the reasons why this did not occur must be recorded in the person's clinical file.

7.6.7 Where multiple episodes of seclusion occur within a 48-hour timeframe, these episodes may be reviewed during a single debrief in accordance with point 7.6.6 ii.

7.6.8 A record must be kept of the offer of the debriefing, whether it was accepted and the outcome. The person's individual care plan must be updated to reflect the outcome of the debrief, and in particular, the person's preferences in relation to restrictive interventions going forward.

7.6.9 A record of all attendees who were present at the debrief must be maintained and be recorded in the person's clinical file.

7.6.10 Where a person's representative has been informed of the person entering seclusion, the person's representative must be informed of the ending of the episode of seclusion as soon as is practicable. A record of this communication must be entered in the person's clinical file. In the event that this communication does not occur, a record explaining why it has not occurred must be entered in the person's clinical file.

7.6.11 Any use of a restrictive intervention may be traumatic for the person who experiences it. Appropriate emotional support must be provided to the person in the direct aftermath of the episode. Staff must also offer support, if appropriate, to other persons who may have witnessed the seclusion of the person.

7.7 Seclusion Facilities

7.7.1 Seclusion facilities must be furnished, maintained and cleaned in such a way that ensures the person's inherent right to personal dignity and ensures that the person's privacy is respected.

i. The construction of the seclusion room must be designed to withstand high levels of violence with the potential to damage the physical environment e.g. walls, windows, doors, locks.

ii. There must be no ligature points or electrical fixtures.

iii. There must be an anti-barricade door.

iv. The room must allow for staff to be able to clearly observe the person within the seclusion room.

v. Seclusion rooms must have externally controlled heating and air conditioning, which enables those observing the person to monitor the room temperature.

vi. The seclusion room must include limited furnishings which must include a pillow, mattress, and blanket or covering, all of which must meet current health and safety requirements.

vii. The room must be large enough to support the person and team of staff who may be required to use physical interventions during transition to seclusion.

viii. The person must have sight of a clock displaying the time, day and date.

ix. As far as is possible, the seclusion room must be in an area away from communal sitting rooms and sleeping accommodation, but not isolated. In addition, the

below requirements are applicable to all new seclusion facilities where construction is commenced after 1 January 2023:

x. The seclusion room must have a window which provides the person in seclusion with a clear view of the outdoor environment. xi.

xi. The seclusion room must not be visible to unauthorised persons from the outdoor environment.

7.7.2 The person who is secluded must have ready access to sanitary facilities and sanitary items (unless there is a clearly documented reason recorded in the Seclusion Care Plan).

7.7.3 All furniture and fittings in the seclusion room must be of such a design and quality as not to endanger the safety of the person in seclusion.

7.7.4 Seclusion facilities must not be used as bedrooms.

7.7.5 Bedrooms must not be used as seclusion facilities.

7.7.6 Subject to the outcome of a documented, suitable risk assessment, the person must be permitted periods of access to secure outside areas. A record of daily outdoor access must be maintained.

7.8. Recording of Seclusion Episodes

7.8.1 All uses of seclusion must be clearly recorded in the patient's Seclusion Booklet with booklet being made reference to in patient's clinical file.

7.8.2 All uses of seclusion must be clearly recorded, as soon as is practicable, on the Register for Seclusion in accordance with Rules 3.7, 3.8 and 3.10 in the MHC Rules Governing Seclusion 2022.

7.8.3 A copy of the Register must be placed in the patient's clinical file and a copy must be available to the Mental Health Commission on request.

7.9 The Use of Closed-Circuit Television (CCTV)

7.9.1 Where CCTV or other monitoring devices are installed in seclusion rooms their use is in addition to and does not replace the provisions of section 7.4 "The monitoring of the person during seclusion."

7.9.2 Where CCTV or other monitoring devices are used, the approved centre must:

a) Ensure viewing is restricted to designated personnel as per approved centre policy;

b) Ensure that it is evident and clearly labelled;

c) Ensure that it is incapable of recording, is incapable of storing a person's image in any format, and is incapable of transmitting images other than to the monitoring station being viewed by the staff member responsible for the care and treatment of the person;

d) Stop using it if the person starts to act in a way which compromises the person's

dignity;

e) Have a clear written policy in relation to its use.

7.9.3 An approved centre must ensure that it discloses the existence and usage of electronic monitoring (e.g. CCTV) to persons being cared for and/or their representatives and the Mental Health Commission during the inspection of the approved centre or at any time on request.

7.9.4 This Policy should be read in conjunction with the Policy on CCTV Monitoring (CP38).

7.10 Clinical Governance

7.10.1 Seclusion must never be used:

i. to ameliorate operational difficulties including where there are staff shortages;
ii. as a punitive action;
iii. where mechanical means of bodily restraint is also in use;
iv. solely to protect property;
v. as a substitute for less restrictive interventions.

7.10.2 a) Each approved centre must have a written policy in relation to the use of seclusion which must include sections which identify:

i. who may initiate, and who may carry out, seclusion;
ii. the provision of information to the person which must include information about the person's rights, presented in accessible language and format;
iii. the safety, safeguarding and risk management arrangements that must be followed during any episode of seclusion.

b) The approved centre must maintain a written record indicating that all staff involved in the use of seclusion have read and understand the policy. The record must be available to the Mental Health Commission upon request.

c) The approved centre must review its policy on seclusion as required and, in any event, at least on an annual basis.

7.10.3 Each episode of seclusion must be reviewed by members of the multidisciplinary team involved in the person's care and treatment and documented in the person's clinical file as soon as is practicable and, in any event, no later than five working days (i.e. days other than Saturday/Sunday and bank holidays) after the episode of seclusion. The review must include the following:

i. the identification of the trigger/antecedent events which contributed to the seclusion episode;
ii. a review of any missed opportunities for earlier intervention, in line with the principles of positive behaviour support;
iii. the identification of alternative de-escalation strategies to be used in future;
iv. the duration of the seclusion episode and whether this was for the shortest possible duration;
v. considerations of the outcomes of the person-centred debrief, if available;
vi. an assessment of the factors in the physical environmental that may have contributed to the use of seclusion.

7.10.4 The multidisciplinary team review must be documented and must record actions decided upon, and follow-up plans to eliminate, or reduce, restrictive interventions for the person.

7.10.5 Every approved centre that uses, or permits the use of, seclusion must develop and implement a reduction policy which must be published on the Registered Proprietor's website. This policy must:

i. clearly document how the approved centre aims to reduce or, where possible eliminate, the use of seclusion within the approved centre;

ii. address leadership, the use of data to inform practice, specific reduction tools in use, development of the workforce, and the use of post incident reviews to inform practice;

iii. clearly document how the approved centre will provide positive behaviour support as a means of reducing or, where possible eliminating, the use of seclusion within the approved centre.

7.10.6 The Registered Proprietor has overall accountability for the reduction policy. The Registered Proprietor must appoint a named senior manager who is responsible for the approved centre's reduction of seclusion.

7.10.6 All information gathered regarding the use of seclusion must be held in the approved centre and used to compile an annual report on the use of seclusion at the approved centre. This report, which must be signed by the Registered Proprietor Nominee, must be made publicly available on the Registered Proprietor's website within six months of the end of the calendar year and be made available, upon request, to the public. The annual report must contain:

i. aggregate data that must not identify any individuals;

ii. a statement about the effectiveness of the approved centre's actions to reduce or, where possible, eliminate the use of seclusion;

iii. a statement about the approved centre's compliance with the rules governing the use of seclusion;

iv. a statement about the compliance with the approved centre's own reduction policy;

v. the data as specified in Appendix 5

All approved centres must produce and publish an annual report on their use of seclusion. Where seclusion has not been used in the relevant 12-month period, then points i and ii above must only be reported on.

7.10.7 A multidisciplinary review and oversight committee, which is accountable to the Registered Proprietor Nominee, must be established at each approved centre to analyse in detail every episode of seclusion.

The committee must meet at least quarterly and must:

i. determine if there was compliance with the rules governing the use of seclusion for each episode of seclusion reviewed;

ii. determine if there was compliance with the approved centre's own policies and procedures relating to seclusion;

iii. identify and document any areas for improvement;

iv. identify the actions, the persons responsible, and the timeframes for completion of any actions;

v. provide assurance to the Registered Proprietor Nominee that each use of seclusion was in accordance with the Mental Health Commission's Rules;

vi. produce a report following each meeting of the review and oversight committee. This report must be made available to staff who participate, or may participate, in

seclusion, to promote on-going learning and awareness. This report must also be available to the Mental Health Commission upon request.

7.10.8 The Registered Proprietor has overall accountability for the use of seclusion in the approved centre.

The ADONs and HODs responsible for each Clinical Area in the Approved Centres must;

(a) Maintain a written record indicating all staff involved in the use of seclusion, have read and understood the Policy

(b) The record must be available to the Inspector of Mental Health Service and/or the Mental Health Commission upon request.

7.10.9 Clinical incident forms must be completed for all incidents of seclusion.

7.11 Seclusion reduction

7.11.1 To fulfil MHC requirements for a seclusion reduction strategy and commensurate with international best practice, the organisation shall establish a governance group to oversee and monitor the use of seclusion and to develop a strategy for this purpose by the next review of this policy.

7.11.2 In line with current evidence, all staff working in areas with a seclusion facility will receive training on alternatives to seclusion, patient rights and the impact of seclusion on patients and staff.

7.11.3 Nurses in charge of approved centres with seclusion facilities will develop systems and interpersonal approaches in the nursing team which address issues which commonly precipitate seclusion episodes in line with current evidence and best practice.

8 Implementation Plan

8.1 It is the responsibility of the ECD, Consultant Psychiatrists, DONs, HODs, ADONs, CNMs in charge of the clinical areas, to ensure this policy and protocol is implemented.

8.2 It is the responsibility of all staff identified in Section 3 of this CPPPG to implement and sign to say they have read and understood this CPPPG and to maintain in each clinical area a record of same to be available for inspection as the MHC requires or for audit as required.

9.0 Training

9.1 All staff who participate, or may participate, in the use of seclusion must have received the appropriate training in its use and in the related policies and procedures.

9.2 Each approved centre that uses seclusion must implement a policy and have procedures in place for the training of all staff involved in seclusion. This policy must include, but is not limited to, the following:
a) Who will receive training based on the identified needs of persons who are secluded and staff.
b) The areas to be addressed within the training programme, including training in:
i. alternatives to seclusion;
ii. trauma-informed care;
iii. cultural competence;
iv. human rights including the legal principles of restrictive interventions;
v. the prevention and therapeutic management of violence and aggression (including "breakaway" and de-escalation techniques);
vi. positive behaviour support including the identification of causes or triggers of the person's behaviours including social, environmental, cognitive, emotional, or somatic.
c) The identification of appropriately qualified person(s) to give the training;
d) The mandatory nature of training for those involved in seclusion.

9.3 A record of attendance at training must be maintained.

9.4 Assessment of training needs and training will only be carried out by a registered PMCB Instructor.

9.5 A record of training content and attendance will be maintained in the Practice Development Unit and a copy furnished to the Nurse Manager for the relevant unit.

10.0 Revision and Audit

10.0 The MWMH CPPPG Management Group is responsible for the evaluation and audit of this PPPG.

10.1 The HODs, Consultant Psychiatrists and Clinical Nurse Managers are responsible for auditing the PPPG under the direction of the MWMH CPPPG Management Group.

10.2 The MWMH CPPPG Management Group is responsible for ensuring feedback is provided to relevant employees as required.

10.3 Review will occur by the date identified on the front sheet of this PPPG and in any case within one year as required by the MHC. Please note that the MHC have received Submission to the Mental Health Commission's Public Consultation on the Rules and Code of Practice governing the use of seclusion and restraint (November 2021) from the Irish Human Rights and Equality Commission Submission-to-the-Mental-Health-Commissions-Public-Consultation-on-the-Rules-and-Code-of-Practice-governing-the-use-of-seclusion-and-restraint-002.pdf (ihrec.ie) and are also considering moving to electronic copies of the Seclusion Register so this policy may require to be reviewed earlier than renewal date.

11.0 Child Resident/Children

Children are particularly vulnerable to trauma and harm as a result of restrictive interventions. Seclusion can have particularly adverse implications for the emotional development of a child. These points must be taken into account in any decision to seclude a child.

11.1 Upon admission to an approved centre that uses seclusion as a restrictive intervention on children, a documented risk assessment must be carried out by a registered medical practitioner or registered nurse. This must show that careful consideration has been given to the potential effects of secluding a child or adolescent, having regard to the physical status and emotional development of the child, and their particular vulnerability to trauma and harm as a result of restrictive interventions. The outcome of the risk assessment shall determine if seclusion can be safely used or not.

11.2 Children must have the reasons for, likely duration of, and the circumstances which will lead to the discontinuation of seclusion explained in a way that the child can understand and in a format that is appropriate to their age. A record must be maintained of this communication and clearly outline how it met the child's individual communication needs.

11.3 An approved centre secluding a child must ensure the child's parent or guardian is informed as soon as possible of the child's seclusion, and the circumstances which led to the child being secluded. The child's parent or guardian must also be informed when the episode of seclusion has ended.

11.4 An approved centre secluding a child must have in place child protection policies and procedures in line with relevant legislation and regulations made thereunder.

11.5 An approved centre secluding a child must have a policy and procedure in place addressing appropriate training for staff in relation to child protection.

12.0 References:

All references identified are available through the Chair of the CPPPG Management Group.

Reference
Mental Health Commission of Ireland (2022) *Rules Governing the Use of Seclusion.* Dublin: Government Publications.
BILD (2010) *Code of Practice for the use and Reduction of Restrictive Physical Interventions. A guide for trainers and commissioners of training.* Third edition. Glasgow: BILD Publications.
Mental Health Commission of Ireland (Jan 2011) Addendum to *Rules Governing the Use of Seclusion and Mechanical Means of Bodily Restraint.* Ref No: R-S69/02/2009
Health Service Executive (2017) *Best Practice Guidance for Mental Health Services: Supporting you to meet Regulatory Requirements and towards Continuous Quality Improvement*, HSE, Dublin.
NICE (2015) Violence and Aggression: Short-term Management in mental health, health and community settings. UK: National Institute for Health and Care Excellence.
MHC (2014) Seclusion and Restraint Reduction Strategy. Ireland: Mental Health Commission.
MHC (2022) The Use of Restrictive Practices in Approved Centers. Promoting Quality, Safety and Human Rights in Mental Health, Activities Report 2021. Ireland: Mental Health Commission.
HSE (2018) Policy on Prevention and Management of Work Related Aggression and Violence. Ireland: HSE
MHC (2024) Judgement Support Framework Version 6.0 Ireland: Mental Health Commission.

HSE (2019) HSE Child Protection and Welfare Policy. Ireland: HSE

13.0 Approval Document

MWMH
Clinical PPPG Approval Document

Policy No:	CP22
Policy Title:	**Policy and Procedures for the Use of Seclusion in Approved Centres**
Date of Approval:	April 2024
Date for Implementation:	April 2024

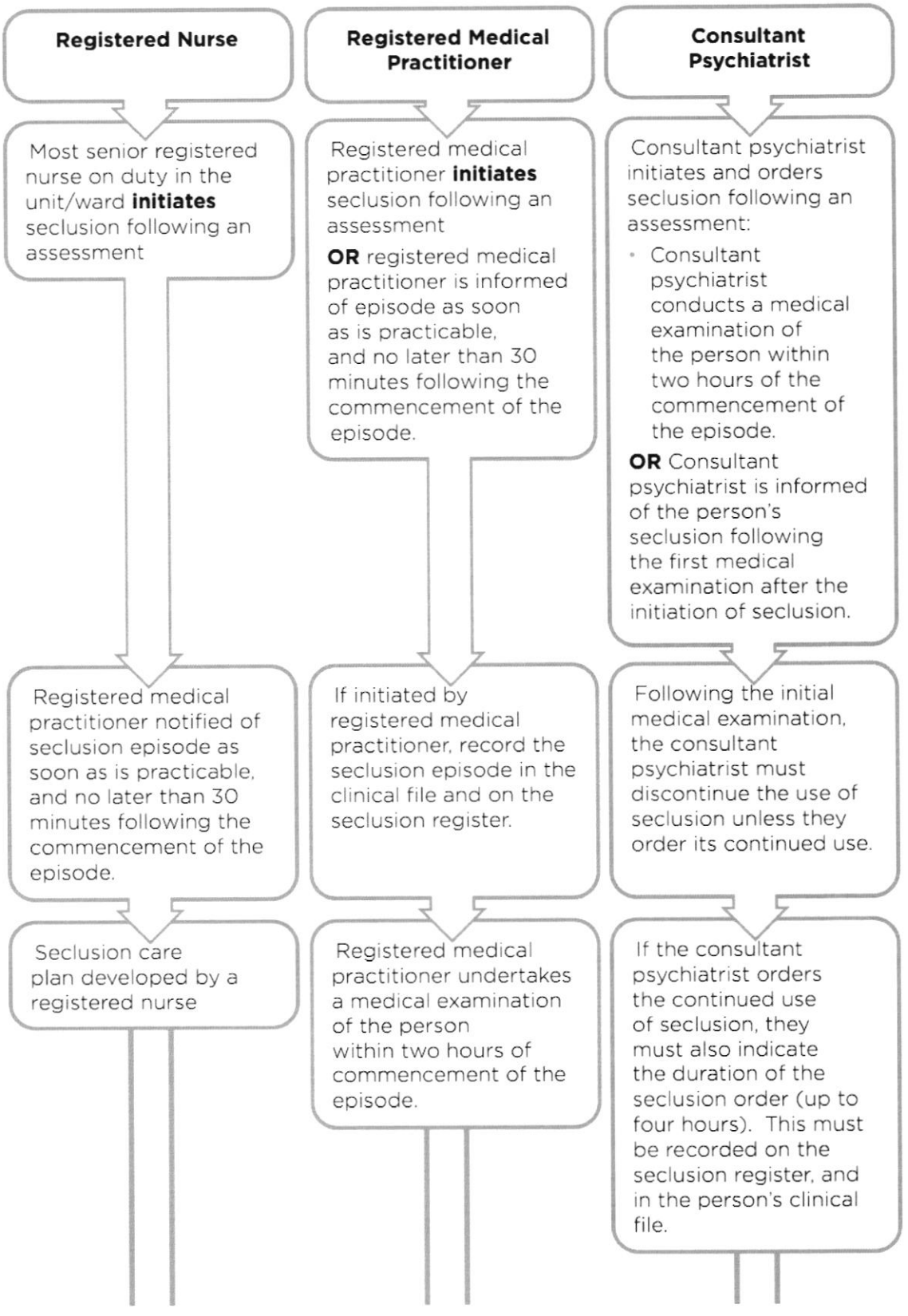
This Policy was reviewed and recommended by the Executive Clinical Director and Area Director of Nursing on behalf of the CPPPG Management Group to the Mid West Mental Health Management Team for sign-off by the Chair

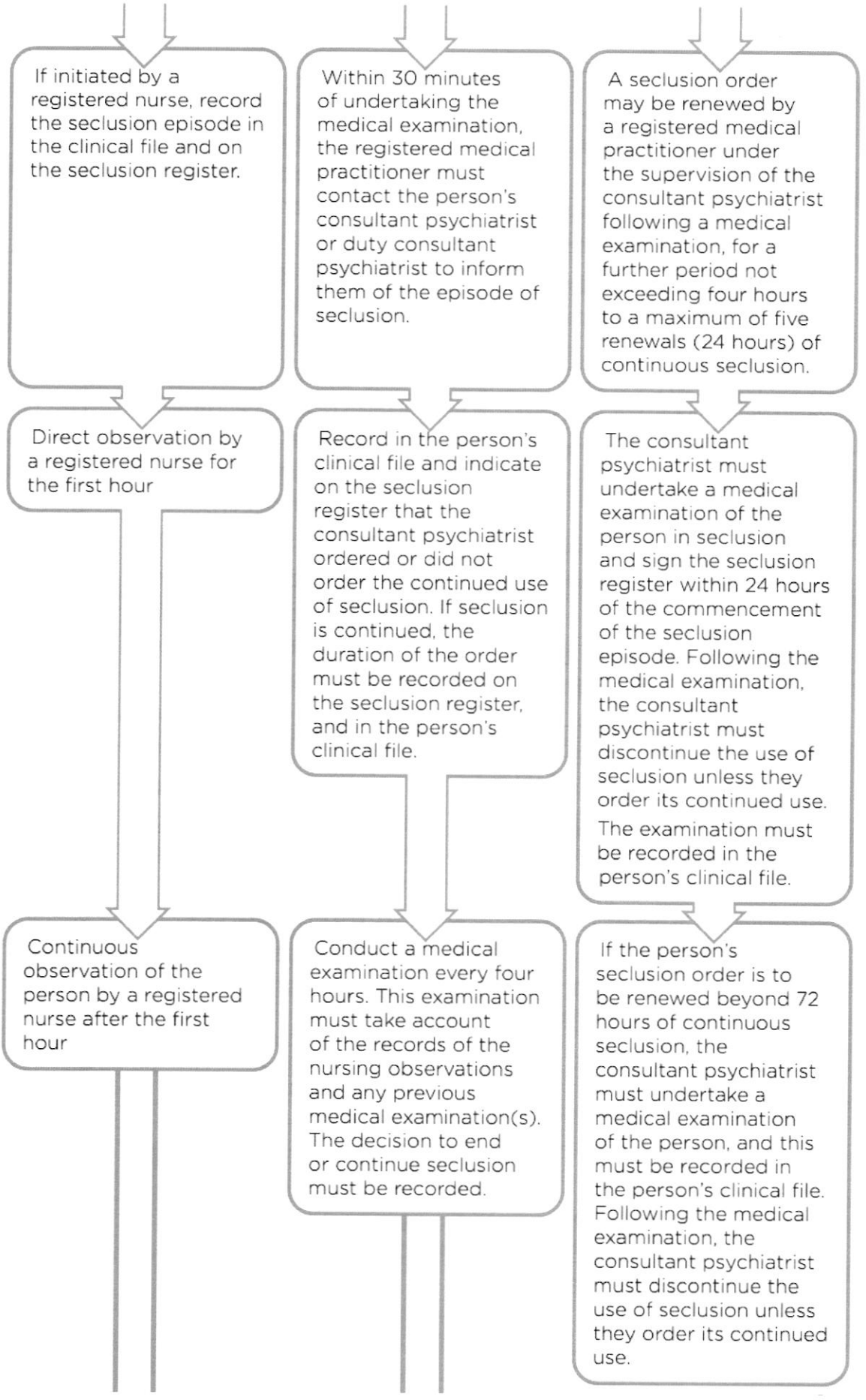
Dr. Tom Reynolds
Executive Clinical Director,
Mid West Mental Health Service

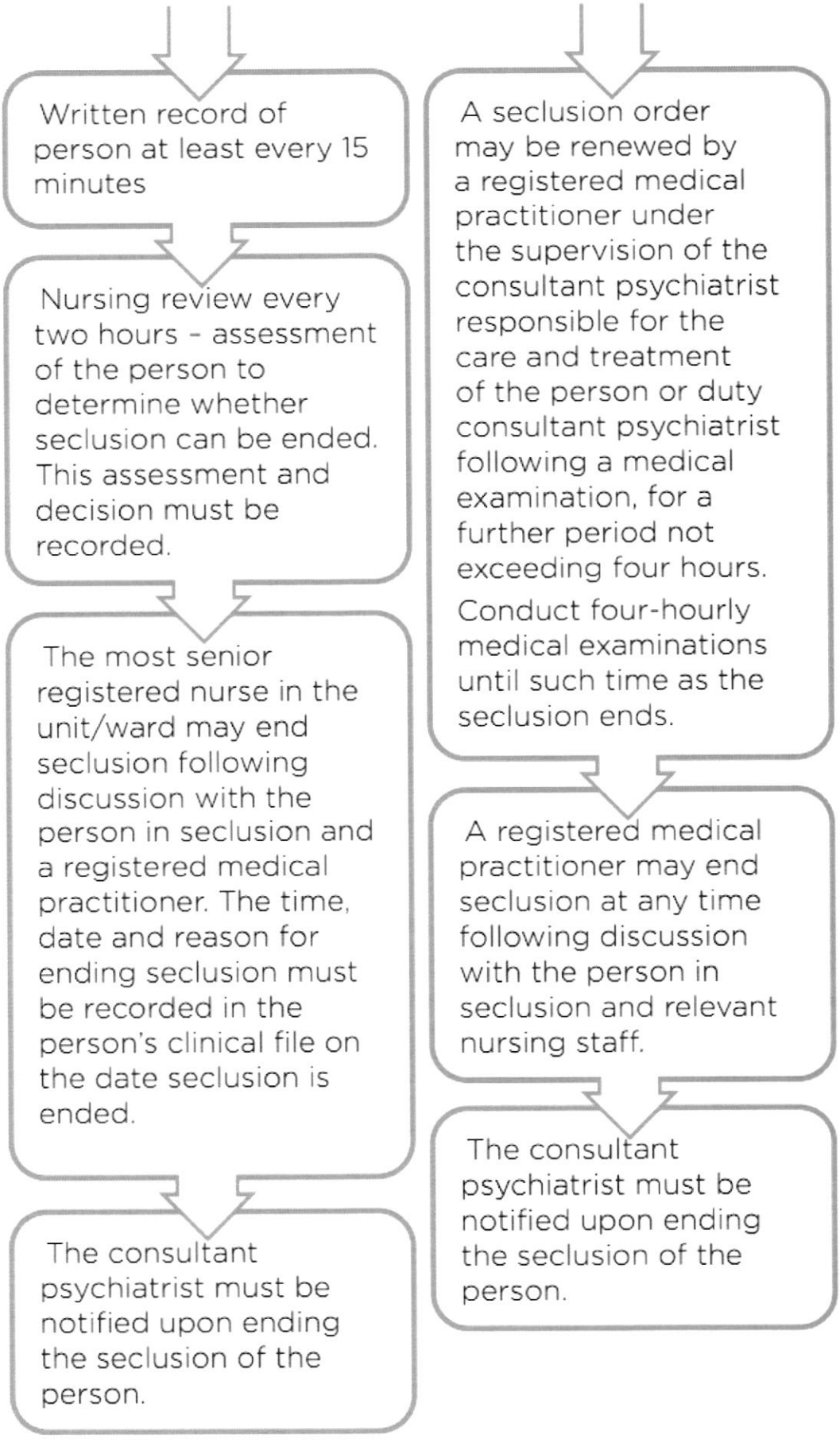
Mr James Harrington
Interim Area Director of Nursing,
Mid West Mental Health Service

14.0 Appendix 1:

Key Steps in Seclusion Process




If initiated by a registered nurse, record the seclusion episode in the clinical file and on the seclusion register.
Within 30 minutes of undertaking the medical examination, the registered medical practitioner must contact the person's consultant psychiatrist or duty consultant psychiatrist to inform them of the episode of seclusion.
A seclusion order may be renewed by a registered medical practitioner under the supervision of the consultant psychiatrist following a medical examination, for a further period not exceeding four hours to a maximum of five renewals (24 hours) of continuous seclusion.
Direct observation by a registered nurse for the first hour
Record in the person's clinical file and indicate on the seclusion register that the consultant psychiatrist ordered or did not order the continued use of seclusion. If seclusion is continued, the duration of the order must be recorded on the seclusion register, and in the person's clinical file.
The consultant psychiatrist must undertake a medical examination of the person in seclusion and sign the seclusion register within 24 hours of the commencement of the seclusion episode. Following the medical examination, the consultant psychiatrist must discontinue the use of seclusion unless they order its continued use.
The examination must be recorded in the person's clinical file.
Continuous observation of the person by a registered nurse after the first hour
Conduct a medical examination every four hours. This examination must take account of the records of the nursing observations and any previous medical examination(s). The decision to end or continue seclusion must be recorded.
If the person's seclusion order is to be renewed beyond 72 hours of continuous seclusion, the consultant psychiatrist must undertake a medical examination of the person, and this must be recorded in the person's clinical file. Following the medical examination, the consultant psychiatrist must discontinue the use of seclusion unless they order its continued use.


Written record of person at least every 15 minutes
Nursing review every two hours - assessment of the person to determine whether seclusion can be ended. This assessment and decision must be recorded.
The most senior registered nurse in the unit/ward may end seclusion following discussion with the person in seclusion and a registered medical practitioner. The time, date and reason for ending seclusion must be recorded in the person's clinical file on the date seclusion is ended.
The consultant psychiatrist must be notified upon ending the seclusion of the person.
A seclusion order may be renewed by a registered medical practitioner under the supervision of the consultant psychiatrist responsible for the care and treatment of the person or duty consultant psychiatrist following a medical examination, for a further period not exceeding four hours.
Conduct four-hourly medical examinations until such time as the seclusion ends.
A registered medical practitioner may end seclusion at any time following discussion with the person in seclusion and relevant nursing staff.
The consultant psychiatrist must be notified upon ending the seclusion of the person.

Appendix 2 – Seclusion Booklet

ACUTE PSYCHIATRIC UNIT
UNIVERSITY HOSPITAL ENNIS
HEALTH SERVICE EXECUTIVE,
ENNIS, CO. CLARE

Seclusion Booklet

Date: _____

Time of Commencement of Seclusion: _____

Time of ending of seclusion: _____

How many renewals have been required: _____

Seclusion pack completed by: _____

Record episode of seclusion/time commenced and reference this booklet in clinical notes

Please ensure that Seclusion Register is completed

**** Please complete all sections and sign ****

Guidance – Formulating decision for the use of Seclusion

- Please mark 'x' in **Pre** box identifying current risk
- Once Seclusion has ended and should a risk still remain, please complete Post section of risk assessment and make reference to it in post seclusion comments

A AGGRESSION / harm risk	Pre	S SUICIDE / self-harm risk	Pre
Ideas of harming others		Ideas of self-harm/suicidal ideation	
Physical harm to others		Suicidal attempts	
Threats/ Intimidation		Plans to commit suicide	
Impulsive			

P PSYCHOTIC symptoms indicating risk	Pre
Delusions (with content indicating risk)	
Command Hallucinations	

RISK SUMMARY AND RISK MANAGEMENT PLAN

Give details of risks identified and assess remaining risk (aggression/psychosis /suicide pertaining to active risk to self or other requiring Seclusion as other interventions outlined in register failed)

NB

Was Physical Restraint used prior to commencement of Seclusion episode? Yes ☐ No

If yes, please ensure the following is completed;

- ☐ **Clinical Practice Form for Physical Restraint**
- ☐ **Physical Restraint Booklet**
- ☐ **NIMS Incident Form**

Episode of Seclusion

Describe in detail the precipitating factors contributing to _____**(patient name)** increase in distress, agitation, restlessness, aggression or high risk behaviour (include attempts to self-harm)

Describe what efforts were made to de-escalate the patient. Specify what interventions were used to support the patient

What steps taken to ensure compliance with the Rules Governing the Use of Seclusion in terms of maintaining the person's dignity and safety throughout the episode

Have the Principles of Trauma Informed Care been considered for the patient		
Gender sensitivity was maintained throughout the physical restraint.	Yes	No

I _____ have informed the patient of the reasons for, likely duration of and circumstances which would lead to the discontinuation of Seclusion	Yes	No

If the reasons for, likely duration of and circumstances which would lead to the discontinuation of seclusion were not discussed, please document why this did not occur.

I _____ have advised the patient and the team members when it was safe for the seclusion to conclude.	Yes	No

A medical examination has taken place within 2 hours of the commencement of Seclusion. (please document on page 7)	Yes	No
Name of Doctor	Time of Examination	

Medical Examination must take place <u>no later than 2 hours</u> after commencement of episode of seclusion and must include an assessment and record of any physical, psychological and/or emotional trauma

Has the patient consented to their representative being informed of the episode of Seclusion?	Yes	No

If consent is given, document the communication.
If consent is **not** given, document why not

Outline what supports were offered to the patient following the episode of Seclusion

Please indicate form of clothing worn in Seclusion

Practice Form for Conducting a Search

Search carried out **with** Consent ☐ Search carried out **without** Consent ☐

Rationale for Search: Please clearly state risk identified:

_____

_____

The Patient has been informed of the policy on Searches Yes ☐ No ☐

Was the purpose of the search explained to the patient? Yes ☐ No ☐

Who assisted with search **(Minimum of 2 Clinical Staff)**?

Name (Block letters) _____ Signature_____

Name (Block letters) _____ Signature _____

Other Staff in Attendance _____ Signature _____

Was the resident's/patient's privacy/dignity/gender considered and respected during this search?

Yes ☐ No ☐ If no, why

_____

_____

Please report items taken during the search, the outcome and actions taken. In the event, that illicit drugs are found, please ensure drug confiscation form is completed

_____

_____

_____

_____

Incident Form Completed Yes ☐ No ☐

Completed by _____Signature _____

Completed by _____ Signature _____

Retain copies as per CP18 Searches

Observation Record

Reference Codes
DO= Patient viewed through observation window and door panel (1st Hour)
CO= Patient viewed continuously via CCTV
NR= Nursing Review (every 2 hrs with 2 nursing staff)
MR= Medical Review (every 4 hrs)
T= Toilet
S= Shower
C= Room Cleaned
M= Meals
F= Fluids
V= Vital signs

Document every 15 minutes from commencement of episode including
Ensure dignity is maintained at all times, should same be compromised CCTV to be switched off and direct observation to be recommenced
Should episode roll into the next day (date), please identify same in the first column (Time Section)
When seclusion has ended, please draw line through empty observation pages

Time	Code	Patient Activity/Level of Distress/Behaviours	Signature

Time	Code	Patient Activity/Level of Distress/Behaviours	Signature

Time	Code	Patient Activity/Level of Distress/Behaviours	Signature

Time	Code	Patient Activity/Level of Distress/Behaviours	Signature

Time	Code	Patient Activity/Level of Distress/Behaviours	Signature

Time	Code	Patient Activity/Level of Distress/Behaviours	Signature

Post-Seclusion Risk Assessment

A AGGRESSION / harm risk		S SUICIDE / self-harm risk	
	POST		POST
Ideas of harming others		Ideas of self-harm/suicidal ideation	
Physical harm to others		Suicidal attempts	
Threats/ Intimidation		Plans to commit suicide	
Impulsive			

PSYCHOTIC symptoms indicating risk	
	POST
Delusions (with content indicating risk)	
Command Hallucinations	

RISK SUMMARY AND RISK MANAGEMENT PLAN

Give details of risks identified and assess remaining risk (aggression/psychosis /suicide pertaining to active risk to self or other requiring Seclusion as other interventions outlined in register unsuccessful)

Post-Seclusion Comments:

Physical Examination of Patient in Seclusion

To be completed within 2 hours of commencement of seclusion

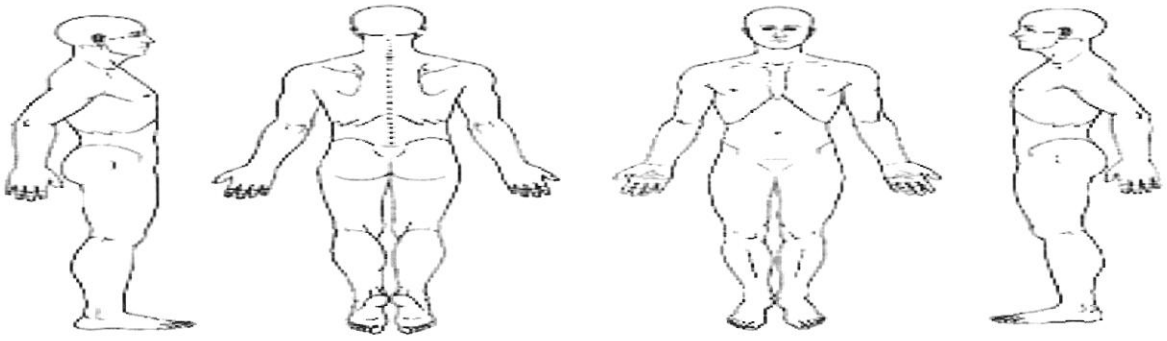
Time: _____

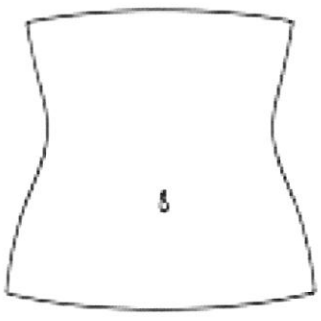
Vitals

Heart Rate	
Blood Pressure	
Respiratory Rate	
Temperature	
SpO_2	

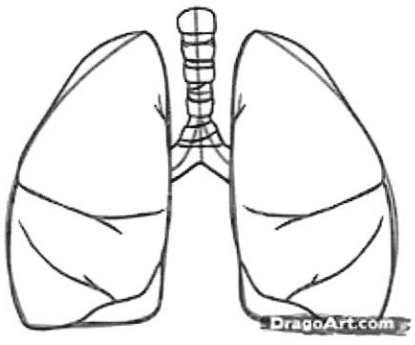
Assessment of any physical/psychological and/or emotional trauma caused as a result of the use of seclusion: _____

Any Body Marking / Scars: Please indicate below





Abdomen system



Respiratory system

Signature: _____ **Date:** _____

Print: _____

PATIENT DEBRIEFING TOOL FOLLOWING SECLUSION

To be completed as soon as is practical after an episode of Seclusion

(Within two working days or prior to discharge or if it is the decision of the client to have the debrief at a later time please document reason or if patient declines)

Date: _____ **Time:** _____

Present at Debrief: (Print and signature)

If nominated support person or representative not present for de-brief please document reason for absence

_____

_____

_____

1. Would you like to discuss your recent episode of Seclusion? Yes ❒ No ❒

*if no please respect their wish to not participate and document in clinical file

_____

_____

_____

_____

_____

2. What is your understanding of why you were placed in Seclusion?

_____

_____

_____

_____

_____

3. Alternative de-escalation strategies that you would prefer in the future in an effort to avoid the use of restrictive interventions

_____

_____

_____

_____

4. Preference of restrictive intervention in the future should its use be unavoidable (i.e which intervention you would not like to be used)

Other Comments/Concerns

Signature: _____ (Nurse leading debrief)

Signature: _____ (Patient)

Date: _____

MDT Review Tool Following an Episode of Seclusion

To be completed as soon as is practical after an episode of Seclusion
(no later than five working days after the episode of Seclusion)

Date: _____ **Time:** _____

Present at Debrief: (Print and signature)

1. What were the triggers/antecedents that contributed to the episode of Seclusion?

_____
_____
_____
_____
_____

2. Were there any missed opportunities for earlier intervention?

_____
_____
_____
_____
_____

3. Alternative de-escalation strategies that could be implemented in the future in an effort to avoid the use of restrictive interventions

_____
_____
_____
_____

4. Were there any factors in the physical environment that may have contributed to the episode of Seclusion?

5. Was the episode of seclusion for the shortest possible duration?

6. Consideration/Outcomes of the person centred debrief (if held)

7. Follow up plans to eliminate or reduce restrictive interventions in the future

Update individual care plan to reflect outcome of debriefing and preferences in relation to restrictive interventions going forward.

APPENDIX 5:

DATA THAT IS REQUIRED TO BE PUBLISHED AS PART OF THE APPROVED CENTRE'S ANNUAL REPORT ON THE USE OF SECLUSION

1 The total number of persons that the centre can accommodate at any one time*
2 The total number of persons that were admitted during the reporting period*
3 The total number of persons who were secluded during the reporting period*
4 The total number of seclusion episodes
5 The shortest episode of seclusion
6 The longest episode of seclusion

**Where this number is five or less the report must state "less than or equal to five"*

Signature Sheet

I have read, understand and agree to adhere to the attached Policy, Procedure, Protocol or Guideline:

Print Name	Signature	Area of Work	Date:

Print Name	Signature	Area of Work	Date: