Gateshead Health
NHS Foundation Trust

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This policy supersedes all previous issues

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APPENDICES

1 Introduction

Gateshead Health NHS Foundation Trust is committed to promoting the welfare and wellbeing of patients and staff. As a part of this there is often a requirement to balance the need for patient and staff safety against the need to ensure maximum freedom of movement for patients. This in turn places a duty on the Trust to establish clear policies to govern the practice of segregation within clinical areas.

This policy has been developed and should be read in conjunction with the Mental Health Act (MHA) Code of Practice and National Institute for Health and Care Excellence (NICE) Guidance Clinical, Guideline 25, Violence: the short-term management of disturbed/violent behaviour in psychiatric inpatient settings and emergency departments.

2 Policy Scope

This policy applies to all frontline staff, locums, bank staff and voluntary workers involved in delivery of care of patients who are detained, or liable to be detained, under the MHA.

3 Aim of policy

This policy aims to:

- Provide guidance when segregation is used.
- Identify the frequency and duration of segregation and minimise any possible anti-therapeutic effects of segregation.
- Ensure patient care is safe and effective during segregation.

4 Duties, Roles and Responsibilities

The Trust Board

The Trust Board is responsible for implementing a robust system of corporate governance within the organisation. This includes having a systematic process for the development, management and authorisation of policies.

The Chief Executive

The Chief Executive is ultimately responsible for ensuring effective corporate governance within the organisation and therefore supports the Trust-wide implementation of this Policy.

Divisional Managers and Matrons

The Divisional Managers and Matrons are responsible for ensuring staff are aware of and adhere to this policy and that actions comply with the Mental Health Act 1983: Code of Practice.

Ward Managers

Are responsible for ensuring that systems and processes are in place to monitor compliance with the policy.

All Clinical Staff
All clinical staff will adhere to this policy when assessing or providing care and treatment (directly or indirectly) to individuals suffering from a mental illness.

Clinical staff must familiarise themselves with the segregation policy and act in accordance with the stated requirements.

5 Definition of terms

'Segregation refers to supervised confinement and isolation of a patient, away from other patients, in an area from which the patient is prevented from leaving, where it is of immediate necessity for the purposes of containment of severe behavioural disturbance which is likely to cause harm to others.' [MHA CoP (2015) para 26.103]

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 determines that a patient should not be allowed to mix freely with other patients on the ward or unit. In such cases, it should have been determined that the risk of harm to others would not be ameliorated by a short period of Segregation 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. Where consideration is being given to 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 IMHA in cases where a patient has one.

Other terms which are associated with managing violence and aggression are clarified below.

- De-escalation – reduction in intensity of a conflict (within the clinical setting).
- Extra Care Area (ECA) - 'a quiet, low-stimulus space for patients experiencing high levels of arousal during periods of disturbed behaviour and can be used for de-escalation, patient support and management, and treatment in a bespoke space for high intensity intervention.

6 Guiding principles

The MHA CoP has determined the following principles which must be implemented when looking after patients:

- Segregation should only be used where de-escalation measures alone have proved insufficient
- Where possible when determining if segregation is necessary, the following factors should be taken into account, clinical need, safety of patient and others, and, where possible, Advance Statements and agreed care plans. Segregation must be a reasonable and proportionate response to the risk posed by the patient. Consideration should be given to using segregation and or rapid tranquillisation as alternatives to prolonged physical intervention as identified in each individuals care plan, as indicated by individual risk assessment.
- In those service areas that provide mixed gender Wards, and have Segregation facilities, a Delivering Single Sex Accommodation (DSSA) local Ward protocol should

be in place. The use of DSSA protocols, on mixed gender wards, in regards to the use of Segregation will be routinely reviewed via the Ward's Risk Register review process.

- Female patients should not be secluded segregation in a male only area of the ward and a male patient should not be segregated in a female only area of the ward. Where a patient is segregated on another ward, a discussion should take place between the nurse in charge of both wards and Ward Managers or on-call equivalent to ensure that the Segregation facility is available, and consideration should be given to how the patient will be taken to segregation.
- Least restrictive options and maximising independence: Wherever possible, a patient's independence should be encouraged and supported with a focus on promoting recovery
- Empowerment and involvement: Patients should be involved in decisions about care, support and treatment.
- The views of families, carers and others if appropriate should be fully considered when taking decisions. Where decisions are taken which are contradictory to views expressed, professionals should explain reasons for this.
- Respect and dignity: Patients, their families and carers should be treated with respect and dignity and listened to by professionals.
- Purpose and effectiveness: Decisions about care and treatment should be appropriate to the patient, with clear therapeutic aims, promote recovery and should be performed to current national guidelines and/or current, available best practice guidelines.
- There should include a formal review process involving the independent mental health advocate (if available), MDT, senior clinical manager or modern matron, and service commissioners etc. as laid out in MHA CoP (2015) para 26.155. See appendix 2.
- Whenever a patient is separated from their peers in a place from which they would be prevented from leaving, although are never separated from the staff, then a summary of their behaviour should be recorded hourly (MHA CoP (2015) para 26.154). See appendix 2.

6.1 Segregation should not be used;

- As a punishment or threat
- As part of a treatment programme
- Because of shortage of staff
- Where there is a risk of suicide or serious self-harm or as the sole management of serious self-harm
- As sole management for violent or aggressive behaviour

Long-term segregation (LTS)

LTS should provide a similar arrangement to the extended use of the ECA in terms of proximity to, interaction with staff and access to areas of the ECA.

Long-term segregation may involve more opportunities than the extended use of the ECA and may include periodic assess to other areas of the Unit or spaces away from the Unit.

This may include eating in the dining area or visits to the general garden area or activity rooms, consistent with risk assessments.

Patients should not feel isolated from contact with the staff (indeed it is highly likely that they should be supported through enhanced engagement) or deprived of access to therapeutic interventions while subject to long term segregation.

Monitoring and regulation procedures consistent with MHA CoP (2015) paras 26.150–26.160 (Long-term segregation) should be considered whenever a patient is separated from their peers.

Looking after the person in segregation

Wherever a patient is supported in segregation a care plan outlining how they will be supported must be put in place. The guiding principles of good care planning, involvement and risk management must be adhered to, **(Appendix 3)**. Patients in either short or long term segregation (LTS) are guaranteed the following rights and have the right to have them explained verbally and in written / pictorial form as appropriate:

- To be treated with respect and dignity at all times
- To be told under what conditions segregation will cease
- To be aware of the time of day via a clock viewable from the area of segregation or by regular simple orientation being provided for the patient on request.
- To receive adequate food and fluids at regular intervals
- To be given appropriate access to toilet and washing facilities (where continued observation is required, staff should always attempt to provide a nurse of the same gender)
- To be appropriately clothed at all times
- To carry out religious observances with due regard to risk management
- To receive advocacy, legal and family visits with due regard to risk management
- Patients should be given the opportunity to become involved in their treatment, including the short term management of disturbed/violent behaviour. A risk assessment should be completed to identify those people at risk of disturbed/violent behaviour.
- Where possible an advanced statement will be developed and incorporated into the care plan which may reflect a patient's preference for segregation rather than restraint or medication following an assessment of mental capacity.
- The reasons for using segregation must be explained to the patient at the earliest opportunity.

7 Procedure, recording, monitoring of segregation

The decision to use segregation can be made in the first instance by a doctor, a suitably qualified approved clinician or the professional in charge of the ward. The professionals involved should consider all the options in managing the presenting risks in the least restrictive manner, (while supporting the wellbeing and level of distress of the patient been assessed, the safety/wellbeing of all other patients, visitors to the ward and staff). Where

segregation is agreed the Nurse in Charge will ensure that an up to date risk assessment, a care plan & documentation outlining the rationale for the initial use of segregation, (**Appendix 1**), are completed.

Where the decision to segregate a patient is made by an approved clinician who is not a doctor or by the professional in charge of the ward, the medical approved clinician involved with the care of the patient or duty doctor (or equivalent) will be notified at once and should attend unless the segregation is only for a very brief period (**no more** than 30 minutes).

The ward must inform the Modern Matron/Nurse Consultant or other senior nurse/manager, or the onsite equivalent, e.g. Senior Nurse Out Of Hours, as soon as is practicable.

It is mandatory that a patient be monitored by constant arms-length or eyesight observations. (See Supportive Engagement & Observation Policy). Staff will not leave their observation duties until a replacement member of staff arrives to take over the observation of a patient. It is the responsibility of those observing the patient to ensure that continuous observations take place during handover.

The appropriately trained individual will monitor and record the condition and behaviour of the patient and take accurate up to date records of behaviour, compliance, communication and interactions and any change to these; and a record of physical observations.

When segregation has ended, signatures from Ward Manager (or deputy), Modern Matron/Nurse Consultant and RC should be sought as soon as possible on the next working day. Any problems in obtaining signatures must be raised through the Service Line Manager.

An incident report (Datix) must be completed upon the initiation of the segregation and a further one when this ends to provide an accurate duration of the period of segregation.

A full debrief should be undertaken following use of segregation, no matter the duration.

8 Access and egress of segregation area

Staff undertaking supportive observations should remain with the service user at all times.

It will be necessary for other staff to safely enter and exit the segregation area, either as:

- a planned occasion

Or

- unplanned occasion

Planned occasions include such events as a review, to administer medications, offer food and drink, personal hygiene etc.

Unplanned occasions include response to the patient's observed clinical presentation, response to rapid tranquillisation, physical wellbeing and any risk to the patient's health, safety and well-being.

Adequate call facilities should be available to staff supporting a patient i.e. to summon support from other staff immediately as and when required.

Additional resources may be needed if the risk posed by the patient is greater than the current staff in situ. Whilst waiting for assistance, the continuous observation and engagement of the patient must continue to enable a full assessment of the presenting risks.

9 Review of segregation

The findings of the monitoring of segregation and the presenting clinical risk will determine the need for segregation to continue and must be considered in the review of segregation. The following process must be followed (**Appendix 2)**:

An initial multi-disciplinary review of the need for segregation should be carried out as soon as practicable after this begins. If it is concluded that segregation needs to continue, the review should establish the individual care needs of the patient while they are in segregation and the steps that should be taken to bring the need for segregation to an end as quickly as possible.

If a decision to continue with segregation is made following the initial multi- disciplinary review, the need to continue segregation should be reviewed:

The patient's situation should be formally reviewed by 2 registered nurses every 4 hours and an approved clinician who may or not be a doctor at least once in any 24-hour period and at least weekly by the full MDT, (**Appendix 4**)

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.

The patient's care plan should clearly state the reasons why long term segregation is required. 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 ongoing risks have reduced sufficiently to allow the patient to be integrated into the wider ward community and to check on their general health and welfare. 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.

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 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.

At times of acute behavioural 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.. In such a situation, the procedure for Segregation in the Code should be followed with regards to authorising and commencing Segregation, observation, Segregation reviews and ending Segregation.

Medical reviews provide the opportunity to evaluate and amend segregation care plans, as appropriate (See MHA/Code of Practice, paragraph 26.147 re care plans). They should be carried out in person and should include, where appropriate:

- a review of the patient's physical and psychiatric health
- an assessment of adverse effects of medication
- a review of the observations required
- a reassessment of medication prescribed
- an assessment of the risk posed by the patient to others
- an assessment of any risk to the patient from deliberate or accidental self-harm, **and** an assessment of the need for continuing Segregation, and whether it is possible for Segregation measures to be applied more flexibly or in a less restrictive manner.
- The process for review of long-term segregation should be followed is (**Appendix 2**)

10 Rapid Tranquillisation and Segregation

Rapid tranquillisation should be considered only if de-escalation and other measures have failed to calm the patient

The use of segregation with rapid tranquillisation is not absolutely contraindicated, except in the case of a pregnant woman. However the following advice must be carefully considered and followed:

If the patient is segregated, the potential complications of rapid tranquillisation will be taken particularly seriously. Any medication administered to a patient in segregation must be administered following the Trust's policy and appropriate monitoring completed.

The patient will be monitored by constant eyesight observation by staff that are appropriately trained. Vital signs must be monitored, blood pressure, pulse and respiratory rate should be recorded at regular intervals, agreed by medical and nursing staff until the patient becomes active again. If the patient appears to be asleep, more rigorous monitoring is required including the use of a pulse oximeter. Adequate call facilities should be available to staff observing a patient in these circumstances i.e. to summon support from other staff when required.

If patients cannot (due to risk) or are not willing to participate in monitoring of vital signs, this needs to be recorded in Segregation record.

Where a patient appears to be asleep in segregation, the person observing the patient should be alert to and assess the level of consciousness and respirations of the patient as appropriate. Once rapid tranquillisation has taken effect, segregation will be re-assessed and ended if appropriate.

11 Training

All staff expected to use segregation as determined by risk assessment and the unit's operational policy, must receive Segregation Awareness Training. Training will include appropriate monitoring arrangements for patient placed in Segregation and awareness of the legal framework that authorises Segregation. Segregation awareness must be repeated every three years or in line with significant policy change.

The Trust will ensure that all staff has access to appropriate levels of PMVA training, it is the responsibility of each Ward Manager to ensure staff attend. Levels of training are to be identified in the training needs analysis.

All those involved in the administration, prescribing, and monitoring of a patient receiving Segregation must receive training to a minimum of Immediate Life Support (ILS – Resuscitation Council UK) (covers airway, Cardio- Pulmonary Resuscitation [CPR] & automated defibrillators).

All staff will have access to competent internal legal advice in relation to the management of any aspect of disturbed behaviour. This is available through line management.

12 Monitoring compliance

Segregation Policy – Monitoring Framework			
Auditable Standard/Key Performance Indicators		**Frequency/Method/Person Responsible**	**Where results and any associate Action Plan will be reported to, implemented and monitored.**
1.	Identified staff receive segregation awareness training	3 yearly training Service Line Managers will be responsible to maintain a record of staff trained which will be shared with Workforce Information.	Mental Health Performance and Quality Group
2.	Audit of use of segregation within designated time frames with associated action plan	Quarterly audit of all Segregation records	Reportable to Mental Health Performance and Quality Group

13 Implementation of policy

This policy will be implemented in accordance with policy OP27 "Policy for the development, management and authorisation of policies and procedures".

14 Human rights issues

A key issue is to ensure that there is immediate therapeutic necessity, or immediate

necessity due to safety, for segregation whenever it is used. This interacts with human rights law.

The unnecessary use of Segregation may constitute a breach of an individual's right to a private life under Article 8.

Paragraph 26.106 of the Code of Practice states that Segregation should only be used in hospitals and in relation to patients detained under the Act. If an emergency situation arises involving an informal patient and, as a last resort, segregation is necessary to prevent harm to others, then an assessment for an emergency application for detention under the Act should be undertaken immediately.

Segregation should only be considered once de-escalation and other strategies have failed to calm the patient. This is a management strategy and is not regarded as a primary treatment technique. When determining if to use Segregation clinical need, safety of patient and others, and where possible, advance statements should be taken into account. Segregation must be a reasonable and proportionate response to the risk posed by the service user.

In exceptional circumstances some patients may have an agreed segregation care plan, which recognises that the use of segregation is part of the agreed treatment strategy for the patient; this must be agreed as either:

- a preferred treatment option by the patient

and/or

- a multi-disciplinary team clinical strategy, based on presenting risk

NICE Guidelines (February 2005) relating to the short term management of disturbed/violent behaviour in psychiatric inpatient settings states:
'…**there are real dangers with physical intervention in any position. Physical intervention should be avoided if at all possible. Physical intervention should not be used for prolonged periods, and should be brought to an end as soon as possible' and '…to avoid prolonged physical intervention, consider rapid tranquillisation or Segregation/segregation (where available) as alternatives' in the light of NICE Guidelines Segregation can form part of a treatment or management plan'**

This treatment or management plan must follow the principles of the Management Violence and Aggression, Rapid Tranquillisation, Supportive Engagement and Observation and Segregation policies.

The treatment or management plan should be developed in collaboration with members of the clinical team. This should then be reviewed as part of the individual's treatment/care plans e.g. Care Program Approach/ward round/MDT. On each and every occasion all the sections of the care plan should be reviewed by the professionals implementing Segregation to ensure the care plan meets the needs of the patient at the time.

16 Equality impact assessment

This policy has undergone an Equality and Diversity Impact Assessment which has taken into account all human rights in relation to disability, ethnicity, age and gender. The Trust

undertakes to improve the working experience of staff and to ensure everyone is treated in a fair and consistent manner.

17 Standards

The Care Quality Commission requires assurance and information relating to the management of Segregation within the Trust. Clinical information may be considered by the NHS litigation authority. Key performance indicators within service specifications maybe outlined relating to the use of Segregation. It is therefore required that records are maintained as specified within the Segregation policy.

18 Audit

Following every episode of segregation the Service Line Manager will assign a senior clinician to undertake an audit of the records and process (Appendix 5). The results of this audit will be shared with the MDT caring for the patient and discussed at the Performance and Quality meeting to ensure lessons learned are shared.

19 Associated documents

MH03 Patient Observation Policy
RM80 Policy for the Rapid Tranquilisation (RT) of Adult Patients Displaying Acutely Disturbed or Violent Behaviour
RM73 Restrictive Interventions Policy
MH28 Mental Health Act 1983 Policy
RM10 Violence at Work Policy
NICE Guidance Clinical Guideline 25, Violence: the short-term management of disturbed/violent behaviour in psychiatric inpatient settings and emergency departments

20 References

- Mental Health Act Code of Practice 2015
- NICE Guidance Clinical Guideline 25
- Immediate Life Support - Resuscitation Council UK

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Appendix 1

Initial Record of Segregation

Authorisation of Segregation must come from the patient's RC (or another Dr) and two other registered professionals, at least one of whom is senior to the ward staff.

Patient's Name:	**DoB:**
Legal Status:	**Ward:**
Responsible Clinician:	**Primary Nurse:**
M Number	**Datix:**
DATE and TIME at which Segregation commenced: **Date:…… Time……..**	
PRINTED names & posts of those involved in the decision to commence segregation **Name:……,,,….. Designation……..** **Name:……,,,... Designation……..** **Name:……,,,….. Designation……..** **Name:……,,,….. Designation……..** **Name:……,,,….. Designation……..**	
Brief description of the incident(s) leading up to segregation and rationale for this. Include plan for ending segregation where possible.	
PRINTED NAME and signature of Nurse-in-charge: **Name (PRINT)……. Signature……. Time:……**	
PRINTED NAME and signature of the RC or Dr: **Name (PRINT)…… Signature……. Time:……**	
Senior Authorisation (band 8 and above) **Name:…… Date:…… Time:……**	

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Appendix 2

Segregation Flowchart and Review Guidance

MDT determine the need for (Long-Term Segregation) Segregation
MDT to: Include representation from the patient's representative or IMHA (if no IMHA involved submit referral) Gain and take into account the views of the person's family and carers.
MUST be authorised by a senior nurse (matron, nurse consultant or above) within the service prior to the start of Segregation.
Safeguarding team to be informed.
Complete: - Appendix 1 (for initiation of Segregation)
Develop Care Plan utilising Segregation Care Plan Guidance Appendix 3
Complete Datix Incident Report
Complete Observation Chart – Appendix 3 from Enhanced Care and Supportive Engagement Policy – Continuous Observations
Complete reviews as below.

Segregation Reviews	
When	Who By
Every 4 Hours	2 Registered Nurses (Complete Appendix 4)
Every 24 hours	A doctor or medical officer/staff (Complete Appendix 4)
Weekly	MDT to include the person's RC (and medic if the RC is not a medic) and IMHA (Complete Appendix 4)
Monthly	2 senior clinicians from outside this service and who are independent to the case (Complete Appendix 4)
3 - Monthly	2 or more professionals from outside the hospital (can be from another hospital site within the same NHS Trust). The review should include discussions with the patient's IMHA (where appropriate) and Commissioner (Complete Appendix 4)

Elements to consider for inclusion within the patients record as part of the review of segregation

Recording of:
• Names and designations
• The date
• The time of entry
• The antecedents leading to the decision to use segregation
• An opinion of whether or not to continue segregation
• Details of mental state examination
• Physical examination findings
• Presence/absence of side effects (where rapid tranquillisation has been given)

Medical reviews provide the opportunity to evaluate and amend segregation care plans, as appropriate. They should be carried out in person and should include, where appropriate:
• Doctors names and designation
• The date
• The time of entry
• The antecedents leading to the decision to use segregation
• A review of the patient's physical and psychiatric health
• An assessment of adverse effects of medication
• A review of the observations required
• A reassessment of medication prescribed
• An assessment of the risk posed by the patient to others
• An assessment of any risk to the patient from deliberate or accidental self-harm, **and**
• An assessment of the need for continuing segregation and whether measures can be applied more flexibly or in a less restrictive manner

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Appendix 3

Segregation Care Planning

The clinical team should consider the following issues when completing segregation care plans. This list is not exhaustive and is intended to provide a focus for consideration. All care plans including the use of restrictive practices (including segregation) should outline primary and secondary preventive strategies, de-escalation skills to be utilised, and identify reactive strategies. Following incidents the clinical team must work with the service user to identify triggers for the incident and to learn from the response undertaken. All learning should be integrated within a revised care plan. If challenging behaviour requires use of the segregation care plan on more than one occasion, then use of a structured positive behaviour support plan should be considered.

All patients should have their care plan and risk assessment developed as part of a holistic MDT and must include relevant members eg Psychology, Challenging Behaviour Nurse, Nurse Consultant, Clinical Nurse Specialist eg PMVA, Occupational Therapy.

Care plans should always be goal orientated, focussing on recovery and the least restrictive approaches. Care plans should always include the views of the service user and their family.

Patients in segregation are guaranteed the following rights and have the right to have them explained verbally and in written / pictorial form as appropriate. This should form part of their care plan:

• To be treated with respect and dignity at all times

• To be told under what conditions segregation will cease

• To be aware of the time of day via a clock viewable from the area of segregation or by regular simple orientation being provided for the patient on request.

• To receive adequate food and fluids at regular intervals

• To be given appropriate access to toilet and washing facilities (where continued observation is required, staff should always attempt to provide a nurse of the same gender)

• To be appropriately clothed at all times

• To carry out religious observances with due regard to risk management

• To receive advocacy, legal and family visits with due regard to risk management

• Patients should be given the opportunity to become involved in their treatment, including the short term management of disturbed/violent behaviour. A risk assessment should be completed to identify those people at risk of disturbed/violent behaviour.

• Where possible an advanced statement will be developed and incorporated into the care plan which may reflect a patients preference for segregation rather than restraint or medication following an assessment of mental capacity.

• The reasons for using segregation must be explained to the patient at the earliest opportunity.

All care plans should also consider:
Diversity issues

- Cultural
- Religion
- Gender, etc

Dignity and Respect

- Personal hygiene
- Accessing toilet facilities
- Single Sex Accommodation Guidelines

Nutrition and Hydration

- Facilitation of meals and drinks and how these will be facilitated

Communication

- Orientation to time
- Dysphagia/Dysphasia - taking into account individual requirements/care plan

Management of risk

- Level of observation
- Weapons
- Patterns of association

Activity

- Identify and prescribe activities available to the patient

Working towards termination of segregation

- Details of interventions and changes needed for segregation to end
- Details of the support that will be provided when the segregation comes to an end

The care plan should focus on identification of unmet needs at all time and should be person centred. The person should be involved in the development of the care plan or where they lack capacity this should be completed with family or carers and an MCA 1 & 2 should be completed within the MDT. All care plans should focus on the least restrictive principle and should focus on ceasing segregation and reintegration at the earliest opportunity. Care plans should be evaluated daily by a senior nurse as part of the review process (see appendix 2).

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Appendix 4

Segregation Review

Please highlight which review:

Nursing Daily Review Weekly MDT Monthly Independent 3 Monthly Review

Patient's Name:	Ward
M Number:	Datix Number:
Responsible Clinician:	Primary Nurse:

DATE and TIME at which Segregation commenced:

Date:…… Time……..

PRINTED names & posts of Review Team:

Name:…… Signature:…… Designation……

Name:…… Signature:…… Designation……

Name:…… Signature…… Designation……

Name:…… Signature:…… Designation……

Date:…… Time:…… Review Number:……..

ASSESSMENT (to include Mental state, Risks and Physical health: (include record of any physical monitoring)

Agreed summary:

Segregation to continue? Yes ☐ No ☐

If segregation has ended please state time this was implemented……

Rationale for decision:

If Long-term Segregation is to continue/discontinued state details of next review:

Form completed by: Name:…… Signature……..

Designation:…… Date:…… Time:……

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Segregation Audit Tool **Appendix 5**

Ward where patient resident:	Name of ward where patient segregated (if different)
Incident Reference Number:	
Date segregation initiated:	Date segregation ended:
Time segregation initiated:	Time segregation ended:
Duration of segregation **(in minutes)**:	

Interventions used

Intervention Type **(please circle)**	Segregation only Segregation and physical intervention Segregation and medication Segregation, medication and physical intervention	**Did the patient request to go into seclusion?** **Yes / No**

Physical Intervention

Were physical interventions used?	YES	NO
Duration of entire episode of physical intervention (in minutes)		
Duration and type of specific physical intervention over 30 minutes		

Medication

Was medication administered? **If Yes please list <u>all</u> medication given**	YES	NO
1.	Name of medication:	Route: Time administered:
2.	Name of medication:	Route: Time administered:
3.	Name of medication:	Route: Time administered:

Initiation of segregation

Designation of person initiating segregation	
Time Medical Officer informed of initiation of segregation:	
Time Medical Officer attended:	
Were there problems contacting the Medical Officer to inform them of the initiation of segregation?	YES NO
If yes please state what	
Did the Medical Officer attend the period of	YES NO

segregation?	
If no please state why	
Was the Safeguarding team contacted	YES NO (If NO state reason)
Were the Safeguarding team informed the segregation had ended	YES NO (If NO state reason)
Did the Service Line Manager/Modern Matron/ Nurse Consultant attend the episode of segregation?	YES NO
Did the Duty (cover) Manager/SNOOH/Ward Manager attend the episode of segregation?	YES NO NA
Time Duty (cover) Manager/SNOOH/Ward Manager informed of initiation of segregation:	Time Duty (cover) Manager /Ward Manager attended:
Time SLM/MM/NC informed of initiation of segregation:	Time SLM/MM/NC attended:
Were there problems contacting the SLM/MM/NC to inform them of the initiation of segregation?	YES NO
If yes please state what	

Were there problems contacting the Duty (cover) Manager/SNOOH/Ward Manager to inform them of the initiation of segregation?	YES NO
If yes please state what	

Reviews (only complete for long term segregation)

Is the review type stated (including MDT and independent reviews)?	YES NO
Is there evidence that nursing reviews have been held every 4 hours **from the point of initiation** for the duration of segregation?	YES NO
If No please state why (e.g. reviews late, no evidence held, not all professionals in attendance etc)	
Is there evidence that medical reviews have been held every 24 hours from the point of initiation	YES NO N/A
Is there evidence of a full MDT review every 7 days?	YES NO N/A
If No please state why (e.g. reviews late, no evidence held, not all professionals in attendance etc)	
If the segregation lasted more than 3 months is there evidence of an	YES NO N/A

independent review?	
If No please state why	

Documentation

Is there evidence that a care plan was completed for the episode of segregation?	YES NO
Is there evidence that nursing observations have been maintained at 1:1 (arms-length or eyesight as indicated)	YES NO
If No please state why	
Have **all** nursing entries been timed and signed, with name and designation of person making entry?	YES NO
Has the NIC of seclusion at the end of segregation on the observation record?	YES NO
Was an Incident report (Datix) completed?	YES Date: Time: NO
Was the incident Investigated and signed off by MM/NC (or designated person)	YES Date: NO
Following the period of segregation has the:	
▪ Responsible Clinician signed and dated the segregation form?	YES NO
▪ The NiC signed and dated the segregation form?	YES NO
Is documentation completed in line with record keeping standards? If no please state: o Crossing out not initialled o Times/dates/words overwritten o Gaps between nursing observations o Dates/times not entered o Names/designation not entered o Other **(please state)**	YES NO

Physical observations

If RT was utilised is there evidence that physical observations have been completed?	YES NO N/A
If NO have the reasons why been documented?	YES NO
Please indicate what observations been completed: Blood Pressure Pulse Blood Oxygen Level Respiration Other (please state) …….	