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Regional Policy on the use of Restrictive Practices in Health and Social Care Settings

And regional operational procedure for the use of Seclusion

Northern Ireland

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1. Introduction

Purpose of this Guidance

1.1. Restrictive Practice is an umbrella term that refers to the entire range of interventions that are considered restrictive and which infringe a person's rights.

1.2. This policy provides the regional framework to integrate best practice in the management of restrictive interventions, restraint and seclusion across all areas where health and social care is delivered in Northern Ireland, with the emphasis on, ideally, elimination of their use, but certainly a minimisation of their use. It is applicable across the lifespan - children, young people[i], adults and older people, to all health and social care staff and within all health and social care services.

1.3. The policy draws upon the views of people who use health and social care services, those who have experience of restrictive practices, restraint and seclusion, and best practice from other jurisdictions. It aims to ensure that when restrictive practices are used, they are managed in a proportionate and well-governed system. This will assist in protecting people, reducing the risk of misuse and potential over-reliance on restrictive practices.

1.4. The use of restrictive interventions, restraint or seclusion may be necessary on occasion, as one element of managing a high-risk situation. Best practice highlights that restrictive interventions, restraint and seclusion should only be used as last resort when all other interventions have been exhausted and there is a presenting risk to the person or to others.[ii] [iii] [iv] Nevertheless, some of those who have been involved with or subject to seclusion, restraint or restrictive interventions recall traumatic experiences which can hinder recovery and relationship building. Reports from across the UK and Ireland have highlighted the need for change regarding the use of restrictive interventions, restraint and seclusion.[v] [vi] [vii] [viii] [ix]

1.5. The use of restraint and seclusion across health and social care settings and services in Northern Ireland is difficult to quantify, with challenges in capturing and articulating data on a regional basis. Whilst many organisations will have their own governance systems relating to monitoring the use of seclusion, there will be clear benefits to an agreed regional approach to this.

What will this Policy do?

1.6. This regional policy sets out the expectations for minimising use of restrictive interventions, restraint and seclusion. It also provides requirements for decision making, reporting and governance arrangements for the use of any restrictive practice. The policy provides this through seven standards.

1.7. The standards are underpinned by the principle of early intervention measures to minimise and eliminate their occurrence and promote the principle of least restriction possible. The standards set out in this policy must be applied to the

management of behaviours of concern and distressed reactions, even if they are unforeseen, or in contexts where they cannot be anticipated and/or responses pre-planned.

1.8. This policy sets accountability for the minimisation strategy at the top level of each organisation, emanating from the drive for a rights-based approach to practice, culture, and policy from the centre of organisational decision-making. Organisations must establish a baseline of the use of all restrictive interventions to enable organisational minimisation strategies.

1.9. This policy requires the development of a standardised, regional approach to recognition, implementation, recording, monitoring, learning and quality improvement. This will improve the understanding of what constitutes restraint, seclusion and interventions that fall under the umbrella term of restrictive practices and will drive minimisation strategies, embedded in a rights-based approach.

Who is this Policy for?

1.10. This policy is intended for use by people who work in health and social care across all health and social care services in both statutory (which refers to all six Health and Social Care Trusts) and non-statutory sectors (which refers to all other services providing health and social care). Health and social care staff working in non-health settings, and the employing organisation, should also consider the requirements of this policy document in conjunction with other legislation, policy and procedure relevant to the particular work setting, using it to inform their decision-making and practices.

Status of this Policy

1.11. This policy is issued by the Department of Health with the clear expectation that all Health and Social Care organisations understand their individual and collective roles and that they implement the guidance in full.

1.12. This policy is issued with strong recommendation for implementation in full by non-statutory health and social care providers.

1.13. HSC organisations commissioning services from non-statutory health and social care providers will include compliance with this policy within contracting arrangements.

1.14. Anyone working in a health and social care setting must follow all relevant legislation. There are a number of legal requirements relating to restrictive practices. At all times people working in the health and social care system must be mindful of the requirements under human rights obligations and must always act with the best interests of the patient/person in mind.

1.15. In Northern Ireland care homes are by law required to only use restraint when it is in the welfare of the patient. Each instance of restraint must be recorded in respect of each resident[x] [xi]. This policy does not remove or change this requirement.

1.16. When commenced in full, the Mental Capacity Act (Northern Ireland) 2016 will provide requirements relating to restraint when a person over 16 lacks capacity to consent to the action[xii]. This policy is compatible with that Act.

1.17. If restraint becomes a deprivation of liberty, a legal authority must be in place for the deprivation of liberty to be lawful. This can be the Mental Health (Northern Ireland) Order 1986[xiii], the Mental Capacity Act (Northern Ireland) 2016, an Order from a Court or another statute. Only in emergency situations can the common law defence of necessity be relied upon.

1.18. Seclusion is always a deprivation of liberty and must therefore have a legal authority prior to being carried out. Secluding a person without a legal authority is unlawful.

2. The Standards

1. **All organisations must use the standard definitions to identify all interventions which are potentially restrictive.**

2. **All local policies and practices must embed use of the *Three Steps to Positive Practice Framework* when considering and reviewing the use of restrictive interventions.**

3. **Effective and person-centred communication must be central to care and treatment planning.**

4. **Proactive, preventative strategies and evidence-based interventions that achieve positive outcomes for people must be the basis on which to build agreed care and treatment plans.**

5. **Organisational strategies and related policies for minimising the use of restrictive interventions must follow a shared and consistent content.**

6. **Roles and responsibilities are defined in terms of monitoring, reporting and governance.**

7. **Any use of seclusion as a last resort intervention must follow the regional operating procedures.**

3. Key Principles

3.1. Restrictive Practice is an umbrella term that refers to the entire range of interventions that are considered restrictive and which infringe a person's rights.

3.2. Evidence of therapeutic benefits for use of restraint and seclusion is limited.

3.3. Organisations must have robust monitoring arrangements in place that provide assurances that restrictive practices are used only as a last resort, and that any restrictive practice used provides a therapeutic benefit to the person.

3.4. Minimisation strategies, culture change and practice improvement will only be successful with robust monitoring, oversight and assurance, led by identified individuals in each organisation.

Rights Based Approach

3.5. The value of each and every person receiving services is recognised through service delivery founded on a rights-based approach which empowers and involves the individual in decision making.

3.6. The lived experience is a critical contribution for all aspects of minimisation strategies.

3.7. Rights based approaches, evidenced based interventions, robust monitoring and governance, and a drive to "always do better" for people receiving services and staff delivering care, treatment and support will be the foundations of any and all policy and practice. The routine use of *Three Steps to Positive Practice*[xiv] will contribute to ensuring that any use of any restrictive practice, restraint or seclusion has been considered as the least restrictive, most therapeutic intervention available to meet a person's needs.

3.8. The routine use of *Three Steps to Positive Practice* will drive any culture change necessary to realise the organisation's minimisation strategy at both practice and strategic levels.

3.9. Transparency is key in building relationships, authentic communication, developing person-centred, rights based and evidence-based care. Transparency must therefore be part of treatment and support plans, reviewing and debriefing incidents, and improving service delivery.

4. Key Actions

Leadership and Accountability throughout Health and Social Care Statutory and Non-Statutory Organisations

Action 1. Health and Social Care organisations, where restrictive interventions are used, must develop minimisation strategies centred on rights based and evidence based positive and preventative approaches.

Action 2. HSC organisations must embed the use of the *Three Steps to Positive Practice Framework* ensuring that any restrictive practice has been considered through a "least restrictive" lens.

Action 3. Non-statutory health and social care organisations, where restrictive interventions are used, should develop minimisation strategies centred on rights based and evidence based positive and preventative approaches.

Action 4. Non-statutory organisations should embed the use of the *Three Steps to Positive Practice Framework* ensuring that any restrictive practice has been considered through a "least restrictive" lens.

Action 5. Identified senior staff are responsible and accountable for leading the restrictive practice minimisation strategy for their own organisation, as well as contributing to a regional vision of eliminating unnecessary restrictive interventions, restraint and seclusion.

Action 6. Leadership will be modelled in practice by organisations adopting/developing "Positive Practice" champions/teams.

Monitoring, Oversight and Assurance

Action 7. Each individual organisation is responsible for ensuring the requirements of this policy are implemented, providing evidence of monitoring, oversight and action to address deviation from the policy.

Action 8. Identified individuals in each organisation will lead the minimisation strategy, driving culture change and practice improvement underpinned by robust monitoring, oversight and assurance.

Action 9. The DoH Strategic Performance and Planning Group (SPPG) will be tasked with overall monitoring of organisations' implementation of restrictive practice minimisation strategies and plans and providing assurances. SPPG will work with all organisations involved to set the systems and structures in place to facilitate this.

Action 10. This will include establishing systems and processes for standardising terminology across the region to allow data collection, mandatory reporting etc., leading to a baseline position to inform minimisation strategies. This will also involve developing regional quality improvement programmes, aiming to

support organisations and staff in safely and effectively implementing the minimisation strategy.

Action 11. The Public Health Agency (PHA) through its safety and quality functions, will support analysis of incident reporting for the purposes of learning and service improvement and develop regional quality improvement initiatives informed by that data analysis and learning.

Action 12. The Regulation and Quality Improvement Authority (RQIA) will have a monitoring and assurance role consistent with their role and function set out in the Health and Personal Social Services (Quality, Improvement and Regulation) (Northern Ireland) Order 2003, Mental Health (Northern Ireland) Order 1986, Mental Capacity Act (Northern Ireland) 2016, service specific regulations and inspection key themes. This will include reviewing the implementation of rights-based approaches for individuals and achievement of organisational restrictive practice minimisation measures.

5. Standard 1 – All organisations must use the standard definitions to identify all interventions which are potentially restrictive.

Restrictive Practices

Restrictive practices are those that limit a person's movement, day to day activity or function.

Restrictive Interventions

Environmental restrictions

The use of obstacles, barriers or locks to prevent a person from moving around freely. This could also include the use of electronic monitoring.

Psychological restrictions

Depriving a person of choices, controlling them through not permitting them to do something, making them do something or setting limits on what they can do.

Coercion

The practice of persuading someone to do something by using force or threats.

Observation

A restrictive intervention of varying intensity in which a member of healthcare staff observes and maintains contact with a person to ensure the person's safety and the safety of others.

Restraint

Physical Restraint

Any direct physical contact where the intervener prevents, restricts or subdues movement of the body, or part of the body, of another person.

Mechanical Restraint

The use of a device to prevent, restrict or subdue movement of a person's body, or part of the body, for the primary purpose of behavioural control.

Chemical Restraint

The use of medication, which is prescribed and administered for the purposes of controlling or subduing acute behavioural disturbance, or for the management of on-going behavioural disturbance.

Seclusion

The confinement of a person in a room or area from which free exit is prevented.

5.1. The use of restrictive interventions can be traumatic for all those involved. They have the potential to have a long-term negative impact on people subject to the intervention and the staff involved, with damage to any therapeutic relationship. There must be a focus on person centred practice and promotion of positive relationships, to support recognition of any potentially restrictive intervention is recognised as aiming to minimise/eliminate such interventions.

General principles for any use of restrictive practices

These principles apply across the lifespan, but specific techniques may need adjusted to suit individuals, for example, children, young people, older people, condition specific considerations, etc.

Decisions to use restrictive practices must be supported by robust justification.

Children and young people should never be subject to seclusion.

Restrictive interventions, restraint and seclusion should not be used for reasons related to disability.

Any use of restrictive practices must only be considered as a last resort.

Initial attempts of restraint should as far as possible be non-physical.

There must be a real possibility of imminent harm to the person or to staff, the public or others if no action is undertaken.

Any use of restrictive practice must be most effective and therapeutic intervention possible with regards to reducing behaviours associated with risk and/or their impact.

The nature of the technique used must be proportionate to the risk of harm and the seriousness of that harm and be the least restrictive option that will meet the need.

Any restriction should be imposed for no longer than absolutely necessary.

Restrictive interventions, restraint or seclusion must never be used as discipline, to inflict pain or humiliation, or a substitute for the provision of proper, person-centred care.

Use of restraint or seclusion must be considered in the context of the legal authority for its use, and fully compliant with a rights-based approach.

5.2. There is significant value in all health and social care organisations using the same language and descriptors to identify all interventions which are potentially restrictive[xv]. Therefore, all organisations must use the standard definitions to identify all interventions which are potentially restrictive, including restraint measures and seclusion, across all health and social care settings, statutory and non-statutory. This will support staff in identifying which practices are restrictive and contribute to considered decision making about their use.

5.3. "Restrictive practice" is an umbrella term that refers to the entire range of interventions that are considered restrictive – from a person's walking aid, controlling their access to kitchen cupboards, covert administration of medication, or continuous observations, through to various methods of restraint and on to seclusion at the far end of restrictive measures that infringe a person's rights.

5.4. This definition encompasses all restrictive practices and is wide enough to invoke a considered thought process around any and all interventions that may be potentially restrictive. Even though an intervention may be considered to be in an individual's best interest or to ensure safety, it may still potentially be restrictive and should be considered as such.

Restrictive Practices

5.5. In its broadest sense, the regional definition incorporates any and all restrictive practices; those which are obvious, for example, hands on physical restraint or the use of seclusion, as well as those which are less obvious, including coercion and psychological measures like controlling how often and for how long someone watches television.

5.6. Organisations must identify and include all potentially restrictive interventions, including those that are not always obvious. With effective definitions it will be possible to monitor the use of restrictive practices or put in place mechanisms to minimise their use; actions which protect both people who use health and social care services and staff implementing the measures.

5.7. Recognising and acknowledging the use of restrictive interventions in the context of the regional definition will enable organisations and individual staff to understand the extent to which restrictive practices are used in the everyday care, treatment and support they deliver, realising the ethical and legal implications.

5.8. Every use of restrictive practice must be described in a care/support/treatment plan that meets the requirements of the *Three Steps to Positive Practice Framework,* ensuring that it is the least restrictive, most effective and therapeutic intervention that will be used for the shortest period of time possible, with a defined review period specified. Using the *Three Steps to Positive Practice Framework* will ensure that the intervention is supported by best evidence for its use and is human rights compliant and lawful.

Environmental Restrictions

5.9. Environmental restrictions include the use of obstacles, barriers or locks to prevent a person from moving around freely. It could also include the use of electronic monitoring in the form of 'wandering' technology such as 'tag' monitors or alarm mats. If the restrictive intervention prevents a person from leaving, the intervention constitutes a deprivation of that person's liberty and a breach of the international Human Rights law (European Convention of Human Rightsxvi Article 5, or the United Nations Convention on the Rights of the Childxvii, Article 37), and is unlawful unless undertaken within a legislative framework.

5.10. The Mental Health (Northern Ireland) Order, 1986, The Mental Capacity Act (Northern Ireland) 2016, The Children (Northern Ireland) Order, 1995, and in some cases individual Court Orders provide authorisations for lawful health and social care related deprivations of liberty. Whilst the common law Doctrine of Necessity will allow a temporary deprivation of liberty, to keep a person safe from immediate danger, any sustained or planned deprivation of liberty is only lawful when used with the most appropriate legislation. This includes any use of seclusion.

5.11. Organisations have a responsibility to ensure that staff are aware of and fully understand the relevant legislation and apply that legislation comprehensively and correctly. At an individual practitioner level, the values, competencies and professional registration requirements of health and social care staff dictate understanding and practice compliant with current legislation.

Psychological/Psychosocial Restrictions

5.12. Psychological/psychosocial restriction refers to depriving a person of choices, controlling them through not permitting them to do something, making them do something or setting limits on what they can do. This could include "punishment" interventions for children such as potentially removing contact with parents or carers[xviii] or access to social interaction/digital access, withholding nutrition or fluids, or corporal punishment, to force compliance.

5.13. All staff must be aware that the use of body language, non-verbal and paraverbal communication, in an attempt to apply control or force compliance are equally restrictive interventions, and possibly constitute coercion.

5.14. Health and social care staff have a responsibility to keep people safe and healthy. For those who cannot understand the consequences of making positive and negative choices/do not have the capacity to understand such consequences, due to neurodevelopmental and/or cognitive difficulties and challenges, there will sometimes be a necessity to "control" choices to keep people safe, for example limiting access to unhealthy food choices.

5.15. There are times when strategies to increase motivation to complete less preferred, but essential or important tasks required to build skills and independence, could be considered as making "someone do something they don't want to do". However, health and social care professionals must understand how this can relate to the imbalance of power between those who provide a service - staff - and those who

use the service. Power imbalance can lead to the use of coercion, abuse and degrading treatment[xix].

Coercion

5.16. Coercion is defined as the practice of persuading someone to do something by using force or threats. However, in reality, coercion may not be obvious "force or threats", but much subtler. Coercive atmospheres create tension and conflict, with the potential to generate increasingly restrictive staff interventions and environments. Coercive language and behaviour will harm relationships and damage therapeutic milieus and is something of which staff must always be conscious. Coercion should never be used in any of its forms.

> ***"If you take all your medicines, I will be able to tell the doctor and you won't have to go back to hospital"***
>
> ***"If you don't have any fizzy drinks this week, you will be able to see your mummy at the weekend"***
>
> *Some examples of more subtle coercive practice*

Observation

5.17. Observations are "*restrictive interventions of varying intensity in which a member of the healthcare staff observes and maintains contact with a person to ensure the person's safety and the safety of others*". While it is clear that the intention is to provide a therapeutic component or opportunity, observation as an intervention is restrictive and often limits a person's movement, day to day activity or function[xx] [xxi].

Restraint

5.18. Restraint must only be used as an emergency last resort when all other non-restrictive measures have been exhausted and only when the specific risks to self or others posed by the individual's behaviour cannot be managed by other reasonable means. The use of restraint should always be viewed as a temporary solution to any behaviour causing concern and should only be used following assessment and decision making measuring the likelihood and severity of the outcome.

5.19. Any restraint should represent the least restrictive intervention, for the least amount of time possible, and a reasonable, and proportionate response to the prevailing risks[xxii].

5.20. The application of restraint for any reason is an imposition on an individual's rights and dignity, by its nature restricts a person's liberty, and in some cases may subject the person to an increased risk of physical and/or psychological harm[xxiii].

5.21. The use of restraint must also be considered in the context of the legal authority for its use. All use of restraint must be monitored and recorded. Monitoring must be proportionate to the level of restriction. Regulated services registered with the Regulation and Quality Improvement Authority[xxiv] must ensure alignment with any relevant standards applicable to the setting. For the statutory sector, this means ensuring that the same level of recording takes place, regardless of setting.

Physical Restraint

5.22. Physical restraint is defined as any direct physical contact where the intervener prevents, restricts or subdues movement of the body, or part of the body, of another person. The use of any physical restraint is not without risks, despite any legal and professional justifications. Staff must be aware of the potential risks involved when applying any physical restraint technique to minimise the potential impacts that are associated with the use of physical restraint[xxv]

> *"Physical restraint can be humiliating, terrifying and even life-threatening. It should only be used as the last resort, when there is no other way of de-escalating a situation where someone may harm themselves or others."*

5.23. Health and social care staff must also be aware that certain groups are more vulnerable to risks and adverse outcomes associated with restraint – either intrinsically, or because they are more likely to be restrained. These groups are those people with serious mental health illness, intellectual disabilities or cognitive impairment, people from ethnic minority groups, individuals with high BMI, men aged 30-40, children and young people below the age of 20[xxvi].

5.24. Prone restraint must not be used by health and social care staff unless in exceptional circumstances[xxvii xxviii xxix].

5.25. Any other uses of physical restraint must not be prolonged (exceeding 10 minutes) unless in exceptional circumstances and must follow best practice standards. Alternative non-physical interventions must be considered before and during the restraint episode. If restraint is required for longer than 10 minutes alternative non-physical interventions such as rapid tranquillisation or seclusion should be considered.

5.26. For these reasons and in line with NICE guidelines any use of physical restraint reaching or exceeding the threshold of "prolonged" must be subject to a formal incident review, in line with organisational policy.

5.27. A person who suddenly stops resisting a physical restraint intervention may be experiencing cardio-respiratory de-compensation which is a medical emergency.

5.28. In the circumstance where physical restraint may be required:

- Staff must be appropriately trained by an accredited training organisation;

- Deliberate pain or the threat of use of pain must not be used by staff in an attempt to force compliance;

- People must not be restrained in a way that impacts their airway, breathing or circulation - pallor, cyanosis or complaining of not being able to breathe are clear indicators of respiratory arrest or positional asphyxia;

- The mouth and/or nose must never be covered, and techniques should not incur pressure on the neck region, ribcage and/or abdomen;

- There must be no planned or intentional restraint of a person in a prone/face down position on any surface, not just the floor;

- One member of staff involved must take overall responsibility for monitoring the person's airway and physical condition throughout the restraint event. If the person's physical condition and/or their expressions of distress give rise to concern, the restraint should cease immediately;

- Avoid "taking the person to the floor". If this is unavoidable, any movement towards the floor is dictated by the person as they descend; staff involved should support the safety of the descent. Where possible a supine position must be used instead of a prone position. However, **if** there are exceptional circumstances where prone restraint is unavoidable, it should be for the shortest amount of time possible[xxx] [xxxi].

- Clinical observations including pulse, respiratory rate, temperature, blood pressure and observation of the person's colour should be undertaken during the event and for a period of time after the event to be determined by the lead clinician.

5.29. In the exceptional circumstances where physical restraint is considered for use for a child or young person[xxxii], staff must have the appropriate training to ensure that they undertake any interventions in line with NICE guidelines[xxxiii]. NICE advise that restraint[xxxiv] techniques are adjusted according to the child or young person's height, weight and physical strength. Staff must also be trained in the use of resuscitation equipment on children and young people.

5.30. If possible, staff members who are the same sex as the child or young person should undertake the physical restraint intervention. There may be times when physical restraint is required to safely support a person with essential personal care needs, specialist care and treatment or in an emergency for essential medical treatment, in the circumstances where the person cannot provide/lacks the capacity to provide informed consent[xxxv] [xxxvi]for the intervention.

5.31. The use of restraint for clinical treatment, essential treatment in an emergency or for essential care tasks has been differentiated from that of physical restraint in regard to the rationale and intention of using holding skills.[xxxvii] However, health and social care staff must be aware that these techniques are considered physical restraint and they must be trained in their use.[xxxviii] [xxxix]

5.32. Physical restraint for clinical treatment, essential treatment in an emergency or for essential care tasks cannot proceed where a person has the capacity to provide informed consent but chooses to withhold that consent.

5.33. In circumstances where a person requires physical restraint to meet their needs as result of lack of capacity and inability to consent to an intervention, then this should be agreed within the context of best interests and by a multi-disciplinary team, using the *Three Steps to Positive Practice Framework*. As with all restrictive practices, physical restraint in these circumstances must only be used in the context of a last resort, least restrictive and most effective intervention. A detailed care plan is required where physical restraint might be used for essential clinical treatment, essential treatment in an emergency or for essential care tasks.

5.34. Any and every use of physical restraint, including when used for clinical treatment, essential treatment in an emergency or for essential care tasks, should be subject to a review of the restraint event and the person's care and treatment plans amended where required and appropriate, to mitigate against continued need for the use of restraint.

5.35. The review should include:

- the type of restraint technique employed;
- the date and the duration of the intervention;
- the names of the staff and people involved;
- reasons for using the restraint technique employed (rather than an alternative less restrictive approach);
- whether the person or anyone else experienced injury or distress;
- the person's views of the incident (if appropriate, through family, caregiver or advocate);
- what follow-up action was taken, including the need for any formal emotional support.

Mechanical Restraint

5.36. Mechanical restraint is the use of a device to prevent, restrict or subdue movement of a person's body, or part of the body, for the primary purpose of behavioural control[xl].

5.37. Mechanical restraint can involve the use of authorised equipment, for example handcuffs or restraining belts, applied in a skilled manner by designated healthcare professionals. Its purpose is to safely immobilise or restrict movement of part(s) of a person's body. This type of intrusive mechanical restraint should not be used outside of a designated secure setting[xli]. It must only be used in limited and exceptional circumstances for management of extreme violence directed towards others, or to limit self-injurious behaviour of extremely high frequency or intensity.

5.38. Nice guidelines[xlii] advise against use of this type of restraint for children and young people.

5.39. Organisations must have policies for the use of this type of restraint, detailing what would constitute the limited and exceptional circumstance of extreme violence/self-injurious behaviour that would warrant use of such equipment, in which designated facility and the robust governance arrangements that authorises, monitors, and reviews their use.

5.40. The use of mechanical restraint should be avoided where possible. However, there may be exceptional circumstances where mechanical restraints (other than those for exceptional use within secure settings only (5.31 above)) are required to limit self-injurious behaviour of high frequency or intensity, for example, use of arm splints, use of cushioned helmets etc.

5.41. Mechanical restraint may also, for example, be the use of "safe space" equipment, lap straps, bed rails and harnesses for the purposes of preventing harm to the person or endangering others, and by their nature restrict liberty. The use of the *Three Steps to Positive Practice Framework* will assist in the assessment, planning and review of these measures in these exceptional circumstances and provide assurances regarding the application of a proportionate and least restrictive use of mechanical restraint.

5.42. Mechanical restraint in these cases must be:

- robustly assessed as the least restrictive measure possible that will maintain the safety, well-being and dignity of the person;
- part of a support/care plan that includes actions and interventions that aims to bring about the circumstances where continued use of mechanical restraint will no longer be required (where possible);
- reviewed at pre-determined intervals, according to the individual's unique situation, to include:
    - the type of mechanical restraint used;
    - the date and the duration of the intervention;
    - reasons for using the type of mechanical restraint (rather than an alternative less restrictive approach);
    - whether the person or anyone else experienced injury or distress;
    - the person's views on the use of mechanical restraint (if appropriate, through family, caregiver or advocate);
    - any amendments to care/support plans or follow up action, including the need for any formal emotional support.

5.43. Mechanical restraint should not be used:

- as a substitute for other less restrictive interventions;
- as a form of discipline or punishment;

- as a substitute for inadequate staffing levels;
- as a substitute for staff training in crisis prevention and intervention to manage aggressive, harmful behaviours; or
- when seclusion is being used simultaneously.

Chemical Restraint

5.44. Chemical restraint refers to the use of medication to control or subdue acute behavioural disturbance, or the management of on-going behavioural disturbance. It is important to recognise that it can bring therapeutic benefit to a person experiencing particularly distressing symptoms, such as hallucinations.

5.45. Acute Behavioural Disturbance is an acute mental state associated with an underlying mental or physical disorder[xliii]. The symptoms associated with acute behavioural disturbance range from agitation, distress and actual or potential aggression and violence, that causes the person to harm themselves or cause harm to another person, or where a person causes damage to property, with the intent to use objects to harm self or others.

5.46. Responses to and management of acute behavioural disturbance will require combined evidence based and therapeutic strategies, including management and treatment of physical ill health, de-escalation, and other non-pharmacological approaches[xliv], to be used in advance of a pharmacological approach, and/or along with a pharmacological approach.

5.47. In these cases, the purpose of the use of medication is to “control or subdue” behaviours which may potentially result in harm to the person or to others. This use of medication is considered chemical restraint.

5.48. Potentially sedating medications might be used over months or even years in the management of on-going behavioural disturbance. This captures a wide range of practice from high dose sedating medications over a period of weeks (when an individual might be experiencing a very acute disorder) through to occasional use of low dose medications which may cause a degree of sedation in individuals with long term conditions. The use of these medications aims to bring relief from behavioural or psychological symptoms associated with long term neurodevelopmental or neuropsychiatric conditions (e.g. autism, dementia etc) and will therefore be therapeutic

5.49. Staff should assess whether the person will accept oral medication as part of a de-escalation technique where non-pharmacological de-escalation techniques were not adequate to diffuse anger or avert aggression, and there is not an immediate risk of violence or aggression. This is sometimes known as “pre-rapid tranquillisation. NICE[xlv] guidelines advise that oral Pro Re Nata (PRN) medication on its own is not de-escalation.

5.50. If the pharmacological response is rapid tranquillisation – medication by the parenteral route (which means by methods other than taken orally, usually intramuscular injection or exceptionally, intravenously, if oral medication is not possible or appropriate and urgent sedation with medication is needed) – a formal incident review is required for each episode of administration.

5.51. Health and social care staff who are involved in the management of Acute Behavioural Disturbance using pharmacological responses must follow the requirements set out in local policy and procedure, relevant best practice guidance and/or regional protocols.

5.52. There are situations where the use of medication to undertake a specific procedure – for example general anaesthesia for dental extraction - *is* intended to subdue, control or restrict the individual, to allow the intervention to proceed. The use of pharmacology in this circumstance is not in response to acute behavioural disturbance but is nonetheless considered chemical restraint. Staff should recognise the intervention as chemical restraint and use the *Three Steps to Positive Practice Framework,* to determine that the proposed pharmacological response is the least restrictive, most proportionate intervention available at that time.

5.53. There are situations where the use of medication in the treatment of a particular illness, condition or presentation is not intended to subdue, control or restrict that individual, but potentially has restrictive side effects. In these cases, the intent behind the medication must be considered.

5.54. In all cases where potentially sedating medications are being used for management of behavioural symptoms, irrespective of the nature or degree of 'restriction' these might cause, the *Three Steps to Positive Practice* will provide a useful framework for decision-making and interdisciplinary review of the use of potentially sedating medications in line with NICE guidance.

Frequency of review of the use of restrictive practices

5.55. The regional procedures for use of seclusion (Standard 7) dictate a specific timeline for review of its use. However, it is not appropriate to define a "minimum/maximum" timeframe for review of other restrictive practices within this policy document.

5.56. The frequency for review of the use of restrictive practices will be agreed on an individualised basis and in the context of changing presentation, assessed risk of harm to the person or others, changing circumstances and/or any fluctuation in capacity to consent to interventions.

5.57. For example:

- the presentation of a person with delirium who is subject to restrictive practices, such as close observation or deprivation of liberty, may change day to day, meaning that any restrictive practice should be reviewed on a daily basis;

- a person with advanced dementia who requires to be deprived of liberty is unlikely to present significantly differently day to day, meaning that the intervals between review periods will likely be longer;
- the requirement for the use of arm splints to manage the risk of a person causing harm to themselves will be assessed and reviewed at every use, possibly multiple times per day, with the shortest interval possible between review to allow the mechanical restraint intervention to end;
- the use of PRN medication and Rapid Tranquillisation will be reviewed after every use as part of an incident review with the intention of mitigating against recurring use;
- The use of physical restraint will be reviewed after the restraint event with the intention of mitigating against recurring use.

5.58. The Three Steps to Positive Practice requires an agreed timeframe for review of any restrictive practice, before the intervention is initiated.

Seclusion

5.59. Seclusion is the confinement of a person in a room or area from which the person is not free to leave.

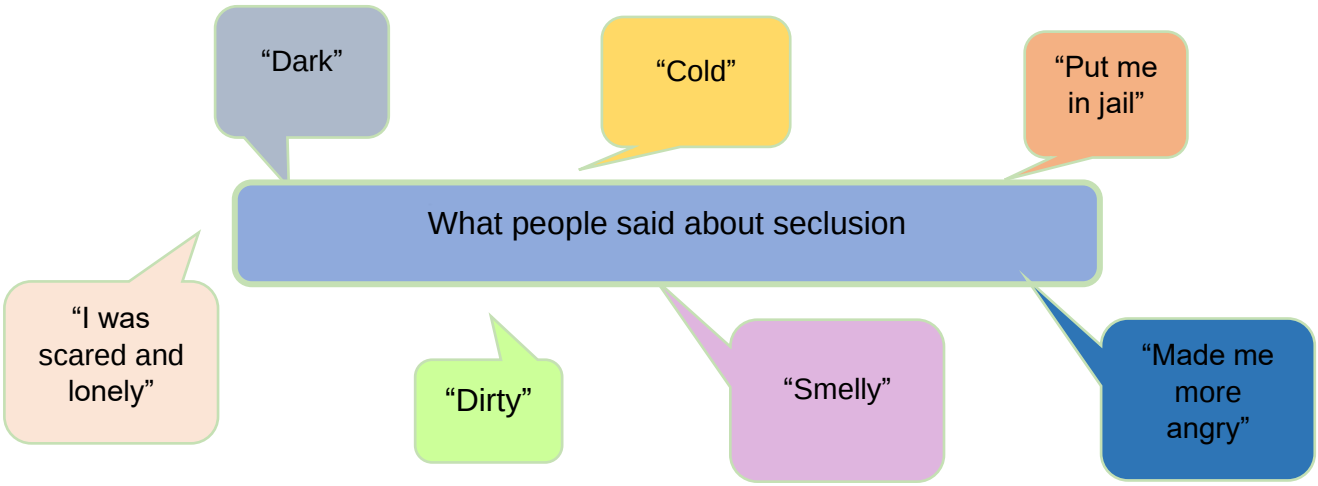
5.60. Children and young people should not be subject to seclusion.

5.61. Not being free to leave does not require a locked door. It can be staff locking the door but can also be the person believing that the door is locked, staff holding the door handle, blocking exit, refusing exit, coercing the person and so on. The key point being that the person being secluded can only leave the confinement area when permitted to do so.

5.62. If seclusion is required, it must only be used:

- As a last resort intervention in an emergency where there is an unmanageable risk to others and other less restrictive methods are deemed insufficient to manage that immediate risk;
- When a person is, or is liable to be, detained in accordance with an appropriate legal framework;
- In a hospital setting in a room or suite specifically designated for this purpose;
- In accordance with the regional operating procedures (see Standard 7).

5.63. Worldwide evidence provides no definitive conclusion that the use of seclusion has a therapeutic benefit[xlvi]. It can be seen as punitive and can cause psychological harm.[xlvii] [xlviii] The use of seclusion can often be a traumatic experience for those involved and can cause potential damage to therapeutic relationships compromising recovery and well-being.



5.64. In every circumstance where a person is confined in a room, or an area, and the person is not free to leave, no matter the name given to the intervention, the person is subject to deprivation of liberty, which may also amount to seclusion.[xlix] Seclusion used outside of the circumstances set out at 5.62 is not acceptable. Seclusion used outside of a legal framework breaches human rights and is unlawful. This applies to both adults and children. A health and social care professional using seclusion outside of a lawful process may be subject to prosecution for false imprisonment or unlawful detention of the person.

5.65. There is no such thing as “consenting” to deprivation of liberty and therefore no one can consent to seclusion, even if the situation is believed to be one where the person has “requested” seclusion and/or can “ask” to be released. Health and social care staff must consider the practice in question in the context of the definition and the circumstances in which it is considered for use. Plans should be put in place to replace the seclusion intervention as soon as is possible with an intervention that has an evidence based therapeutic intent, with the aim of eliminating any use of seclusion for that individual.

5.66. Some individuals may express a preference for seclusion rather than physical restraint, for example, in circumstances that they exhibit behaviours that present an immediate and unmanageable risk of serious harm to others when acutely mentally unwell. This is not to be confused with a person “consenting” to seclusion but can be an important aspect of care planning. Advance statements – a written statement which primarily informs all staff of the person’s wishes, feelings, beliefs, values and preferences regarding their future treatment – is recommended.

5.67. All those who are capable and wishing to do so should be encouraged to make an advance statement with regards to the use of any restrictive intervention. An advance statement does not provide legal authority but must be taken into account by all health and social care professionals when making decisions about the management of a person where their behaviour is presenting as a risk towards themselves or others.

5.68. There may be circumstances where a person is confined to an area supported by staff, promoting the use of a lesser stimulating environment to support emotional

regulation. Decision making around an intervention such as this must provide therapeutic benefits and outcomes for the person, which must be clearly set out in care/support plans.

5.69. All staff must be aware that their actions, if preventing free exit, amount to a deprivation of liberty. All staff must consider if, in implementing the intervention, their action amounts to secluding the person, that is – are they acting in an emergency, confining a person in response to an unmanageable risk of harm to others where other responses have been deemed insufficient?

5.70. Where the intervention amounts to deprivation of liberty, there must be a regular review process that reflects the least restrictive approach for the least amount of time possible. The person's care and treatment plan must be reviewed to consider other proactive and positive approaches to prevent re-occurrence.

5.71. Where the intervention amounts to seclusion, there must be an urgent, in-depth review of the person's care and treatment plan, with the aim of eliminating any use of seclusion for that individual with an intervention that has an evidence based therapeutic intent.

5.72. All staff need to ensure that they are acting within the requirements of this regional policy, and relevant legislative frameworks.

5.73. Seclusion must not happen outside of the hospital environment. NICE guidelines[l] advise against the use of seclusion in the emergency department.

5.74. If an emergency situation occurs outside of the hospital setting where a person requires to be deprived of their liberty in circumstances that amount to seclusion, urgent and in-depth review of the incident and the person's care and treatment plans is required, and appropriate therapeutic actions taken to avoid recurrence. However, seclusion outside hospital cannot be part of the person's care plan and must only ever be in response to an emergency.

Long term segregation

5.75. People can be subjected to a range of restrictions that fall short of seclusion but may result in an extreme restriction of social contact over a prolonged period of time. It is different from seclusion.

5.76. While formal 'long term segregation' is not a recognised form of care in Northern Ireland, people can spend very long periods of time with minimal or no contact with their peers and without having any time out of the health and social care facility, be that a hospital, a care home, or their own home. This is comparable to long term segregation. It is key that policies and procedures provide safeguards for people who may be subject to this type of arrangement. Segregation from others is a form of restrictive intervention.

5.77. Staff must be alert to this practice, recognise it as restrictive and use the *Three Steps to Positive Practice Framework* to ensure there is a clear plan to minimise and eliminate the use of segregation as quickly as possible.

5.78. Organisational policies must include mechanisms and safeguards that prevent any person being cared for, supported, or treated in a situation that amounts to long-term segregation.

6 Standard 2 – All local policies and practices must embed the use of the *Three Steps to Positive Practice Framework* when considering and reviewing the use of restrictive interventions

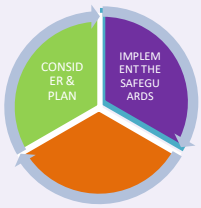
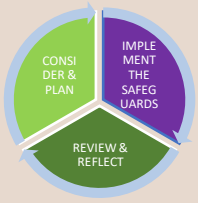
6.1. All local policies and practices must embed the use of the *Three Steps to Positive Practice Framework* when considering and reviewing the use of any restrictive intervention, from locking cupboard doors right through to use of seclusion.[i] [ii]

6.2. There are occasions when the use of restrictive practice is unavoidable in order to keep a person or others safe from harm. Not all restrictive interventions are inherently wrong, harmful or illegal; they are sometimes necessary and could form part of health and social care delivery. In this context it is essential that any use of restrictive practice is therapeutic, ethical and lawful.

6.3. *The Three Steps to Positive Practice* is a collaborative Royal College framework designed and endorsed by the Royal College of Nursing, Royal College of Psychiatrists, the British Association of Social Workers, and the Royal College of Occupational Therapists. This framework assists health and social care professionals to think about culture and practices and to guide professional, ethical and legal decision making when considering the use of potentially restrictive practices document, supporting legal, ethical and professional decision making around the use of restrictive interventions, every time a decision is made, or an action is taken.

6.4. *The Three Steps to Positive Practice* is a continuous and cyclical process which requires a health and social care professional to routinely adhere to all three steps of the framework. This framework has been designed to be applied at points of assessment, implementation, evaluation and review, and in situations where the use of restrictive interventions has been in place for some time or associated with a particular environment.

STEP 1 Consider and plan 	Has a multi-disciplinary discussion around how to keep the person (or others) safe resulted in recommending a potentially restrictive practice? Does the proposed intervention or the way in which care is being delivered: • limit the person's movement, daily activity or function; • result in the loss of objects or activities that the person values; or, • require the person to engage in a behaviour that he/she would not engage in given freedom of choice? If you answer yes to any of these questions, then the proposed intervention is potentially restrictive.	You must ensure that a multi-disciplinary discussion has taken place before you proceed. The plan must be discussed with the person and/or their representative, including advocates. Decisions must be clearly documented and communicated to all parties. Remember that some decisions may require a legal opinion.
	What other less restrictive options have been considered?	You must ensure that other, less restrictive options, starting from the point of no restriction or least restriction have been discussed. A clear rationale must be documented to evidence why they are not appropriate at this time.
	How will the proposed intervention reduce risk, and build or retain the person's skills and the opportunities available to them?	You must ensure that the proposed intervention is the best and only approach to reducing an identified risk and achieving therapeutic benefit. You must ensure that the proposed intervention is a positive and evidence based therapeutic approach which clearly articulates how the intervention will reduce the identified risk. The intervention must also support the person's ability to develop and retain skills and learn through experiences.

Implement the safeguards 	Is this proposed intervention considered to be in the person's best interests?	You must consider the areas of capacity and consent when deciding if the proposed intervention is in the person's best interests. You must ask questions if you are not satisfied that the evidence confirms that the implementation of the proposed intervention will be in the person's best interests. Documentation must clearly record the formal discussions and processes involved in reaching a multi-disciplinary agreement.
	How do I ensure that I am using a rights-based approach?	You must ensure that the plan is fully considerate of human rights and the FREDA principles and can be implemented under an appropriate legal framework. You must support the person and their representatives to understand their rights and provide information on how they can raise any objections or complaints.
	What professional accountability frameworks must be considered?	You must ensure that the decisions you make are ethical and fully considerate of your individual professional responsibilities, and your organisation's accountability and governance structures.
STEP 3 **Review and reflect** 	Has a regular and timely review of the intervention been planned?	You must ensure that a pre-determined timeframe for review of the intervention has been agreed before the intervention is implemented.
	Is there a plan to ensure that the intervention will be for the shortest length of time possible?	You must ensure that there is a positive therapeutic care plan that includes a planned reduction of the restrictive practice. The review must re-consider steps 1 and 2.
	Are there mechanisms available to you as an individual and to your team to enable reflection about the impact of using restrictive interventions?	You must recognise that the use of restrictive interventions, especially restraint, can have a negative emotional impact. It is important that opportunities for supportive discussion and reflection are made available to you and your colleagues.

6.5. The Three Steps to Positive Practice Framework seeks to build a culture of practice embedded in a rights-based approach as the “norm”. The truest articulation of a rights-based approach that meets the needs and circumstances of the individual is based on person-centred culture and practice, which will be realised with embedding the rights-based approach of this framework in policy. A professional using the framework is directed towards the use of a rights-based approach, thereby ensuring the minimisation of such interventions. As the agreed regional framework, every member health and social care staff must follow the Three Steps to Positive Practice Framework when considering the use of any restrictive practice. Where the process is not being implemented and staff are aware of the use of restrictive practices, it should be recognised as a potential safeguarding issue. Staff must escalate their concerns using organisational reporting processes highlighting the requirements of this regional policy.

Rights Based Approach

6.6. A rights-based approach to health and social care means two things – ensuring that the rights of individuals enshrined in law, known as “Human Rights”[liii] [liv] [lv] are upheld and influence decision making about health and social care delivery; and practice that is shaped by the core principles and values that put the person receiving the service at the centre of decision making about that service, the FREDA principles. A rights-based approach means that all restrictive practices must be subject to appropriate procedural safeguards. In particular, a fair balance must be struck between the severity and consequences of interfering with the rights of the person restricted, the main purpose of which is to ensure the safety of the individual and others.

6.7. A rights-based approach puts the person at the centre of decision making supporting an individualised plan to meet their individual needs. The person subject to the restrictive practice and/or their representatives must be actively involved in all consultation, decision-making and monitoring processes regarding the use and minimisation of restrictive practices. This is an essential aspect of the partnership working that is required in developing proactive, preventative strategies and evidence-based interventions that achieve positive outcomes for people**.**

Human Rights

6.8. The application of Human Rights is particularly relevant to a rights-based health and social care provision. These rights are realised through European Convention on Human Rights (ECHR), The United Nations Convention on the Rights of the Child (UNCRC) & the United Nations Convention on the Rights of Persons with Disabilities (UNCRPD). There are additional internationally accepted human rights standards, which may have relevance for how health and social care staff and organisations shape rights-based practice[lvi] [lvii]

6.9. These legal frameworks set out how both individual practitioners and organisations must provide and deliver health and social care services. They recognise and protect the dignity of all human beings, and impose legal duties on authorities, both local and national, to respect the human rights set out in the Conventions in their

decisions and actions. Importantly, ECHR, UNCRC and UNCRPD are vital in providing a rights-based approach to health and social care delivery, protecting the key human rights set out in the table below:

	Specific Article		
	ECHR	**UNCRC**	**UNCPD**
Right to life The right to life is protected by law.	2	6	10
Prohibition of Torture The right not to be tortured or treated in an inhumane or degrading way.	3	37	15
Right to Liberty and Security The right not to be deprived of liberty "arrested or detained" – except where there is proper legal basis.	5	37	14
Right to Respect for Private and Family Life The right to family, relationships, well-being, privacy, correspondence and home, including seeing family and being heard.	8	16	22 23
Prohibition of Discrimination The right not to be treated differently because of race, religion, sex, political views or any other personal status, unless this can be justified objectively.	14	2	5

6.10. Every health and social care professional must understand the rights enshrined in human rights law and how this must influence their practice and be alert to the potential for breaches of human rights in everyday practice[lviii].

6.11. These laws are not mutually exclusive. The ECHR applies to every human being, adult and child, with the UNCRC and UNCRPD providing more explicit detail of

human rights law and rights specifically for children and persons with disabilities respectfully. The additional internationally accepted human rights standards contribute to full recognition and application of human rights.

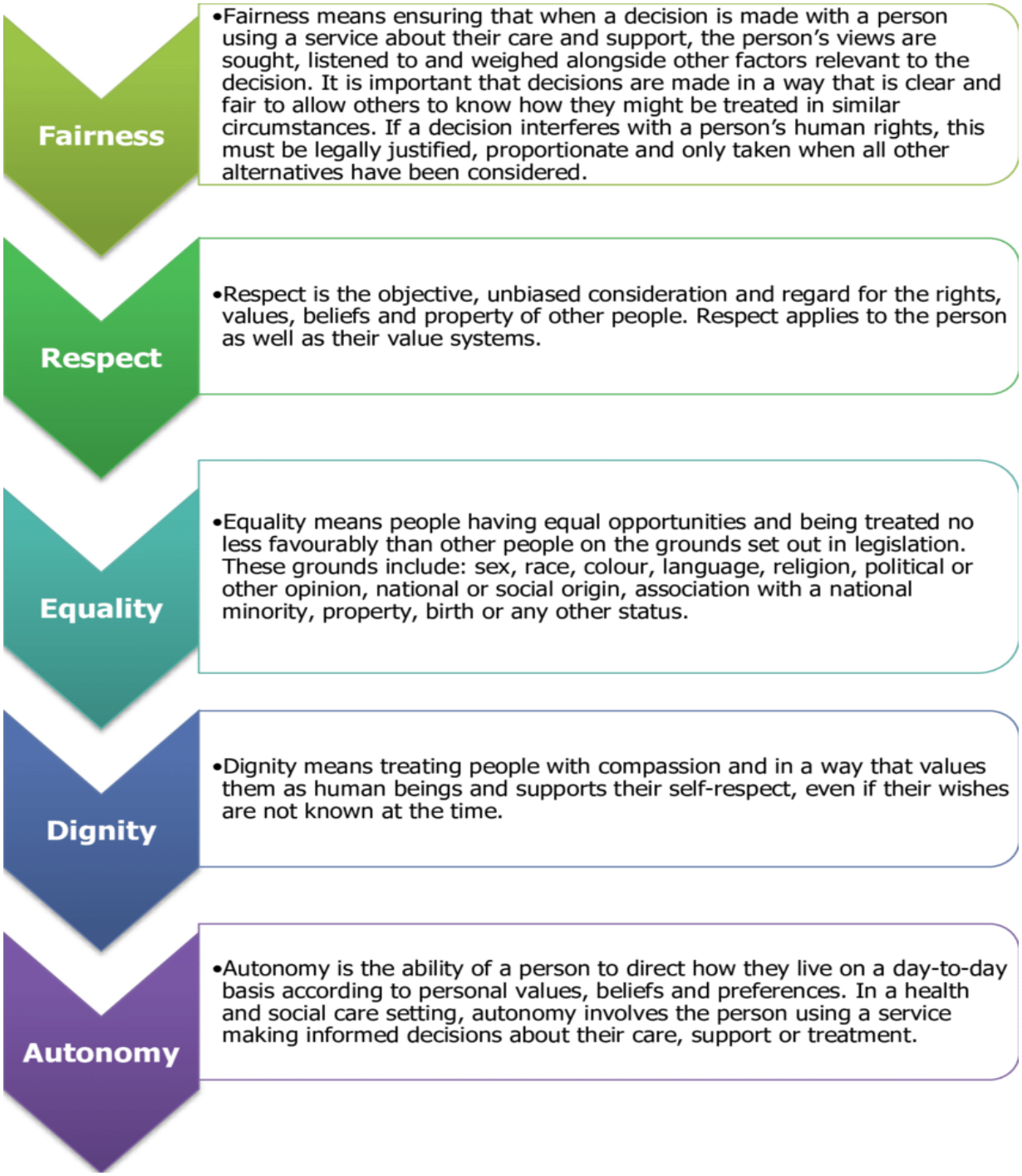
6.12. Health and social care organisations are corporately responsible for creating the circumstances which ensure that staff understand and apply human rights laws and for ensuring that the human rights of everyone who uses their services are upheld. All organisations should ensure that all policy and practice are compatible with the relevant human rights instruments[lix].

FREDA Principles

6.13. A rights-based approach can be achieved by applying the FREDA Principles, the core values that shape practice and which underpin the articles in the human rights frameworks.

6.14. The FREDA Principles are the basis of good health and social care which should be used mutually and individually to inform decision making, supported by inclusive communication strategies. They are a useful guide for health and social care staff to ensure that everyone for whom they are providing care, treatment, support and/or services is:

- Treated with dignity and respect;
- Provided with care which best suits their individual needs;
- Able to live free from abuse, neglect or discrimination;
- Able to participate in the choices and decisions made about their lives;



6.15. Whilst the principal components of a rights-based approach are modelling the core values in the FREDA principles to support the fulfilment of an individual's human rights, there are other elements that are essential in the realisation of a rights-based approach.

Working within a Legislative Framework

6.16. Restrictive interventions must only be used within a relevant legislative framework. All health and social care professionals must be familiar with the laws which are

relevant, to them, their area of practice and their organisation. This protects the individual, staff and the organisation.

6.17. The use of legislative frameworks allows staff to make reasonable and proportionate decisions regarding the use of restrictive interventions. It is important that the justification process is reflective and inclusive of legal, professional and ethical considerations. Organisations must provide the necessary mechanisms, supports and environments to ensure employees can operate within all relevant legislative requirements.

6.18. This includes understanding that every starting point in decision making regarding care, support and treatment is presuming that every adult can make that decision independently (given the correct support to do so where needed), and that the person can provide or withhold consent to that care, support or treatment. This is a foundation step in a rights-based approach to service delivery, putting the person at the centre of the decision-making process.

6.19. Continuing with a restrictive intervention in the situation where a capacitous person withholds consent can only happen in circumstances permitted by the Mental Health (Northern Ireland) Order, 1986, a High Court Declaratory Order or in response to an immediate risk of harm to a person or others around them using the common law Doctrine of Necessity.

6.20. In the situation where a person aged over 16 years has been assessed as lacking the capacity to independently make decisions regarding care, support or treatment, (and if detention for care and treatment in a hospital in accordance with the Mental Health Order does not apply) the Mental Capacity Act (Northern Ireland) 2016 sets out the requirements in terms of lawful deprivation of liberty with all other decisions requiring collective “best interests’” discussions and agreements.

6.21. An adult with parental responsibility can provide consent for a child. In addition to the legislation above, The Children (Northern Ireland) Order 1995, The Children (Secure Accommodation) Regulations (Northern Ireland) 1996, The Age of Majority Act (Northern Ireland) 1995 as well as Gillick Competence principles must be considered relating to decisions involving children.

6.22. As noted at 5.64, there is no such thing as consenting to deprivation of liberty. For a young person aged 16-17, where legislation permits a parent or the State with parental responsibility to provide consent for care and treatment, health and social care staff and organisations must be aware that this does not extend to consenting to deprivation of liberty[lx].

6.23. The situation is less clear for those under 16 years of age. However, in the absence of any definitive Court ruling, where a legal process exists, for example, the Mental Health Order or The Children Order, it is advisable to use the legal process to ensure the child or young person has access to the safeguards within the processes that protect their rights.

6.24. In all circumstances, adherence to a rights-based approach to minimising the use of restrictive interventions will be achieved through the routine use of the *Three Steps to Positive Practice Framework*.

6.25. A list of relevant legislation is provided at Appendix 9. Whilst this is a wide-ranging list, it may not be exhaustive. Health and social care staff may be aware of other legislation that may be applicable to their practice and/or where they deliver their service.

6.26. It is vital that organisations and individual staff work to the legislative framework applicable to their service delivery and practices at any particular time and be aware of and responsive to changes in relevant legislation.

Staff Support

6.27. Even when a decision to implement a restrictive intervention is the last resort, lawful, ethical and in a person's best interests, staff involved can find the implementation of restrictive practices morally and emotionally challenging. Witnessing or being directly involved in a restrictive practice could contribute to work-related stress.

6.28. The Three Steps to Positive Practice includes "reflection" as a supportive mechanism for staff within the Framework and must be considered as important and essential as every other part of the process. There are various evidence-based methodologies to guide this type of activity, for example, structured de-briefing. Structured de-briefing (which has been included as a requirement within the operational procedure for use of seclusion) provides emotional and educational support immediately following incidences of behaviours that challenge and can contribute to the reduced use of restrictive practices. However, those involved should be mindful that the process of discussing incidences in which restrictive practices have been used may be traumatic for both person subject to the intervention and the staff involved or witnessing the event. Organisations must ensure that opportunities for supportive discussions and reflection for individuals and teams are provided as standard, with other pastoral type support available where an individual member of staff might require additional support.

Advocacy

6.29. Advocacy in all its forms seeks to ensure that people can have their voice heard. Organisations should involve an independent advocate in all "best interests" decision-making processes, particularly where a restrictive practice is proposed, if there is an advocate available. For those unable to articulate their views about their care, support and treatment for whatever reason advocacy can be an important method by which a person can be considered and protected in what might be quite complex decision making about how they live their lives and how their care is provided. This is an essential element of a rights-based approach.

Provision of Appropriate Training

6.30. Organisations providing services where people's behaviours can present as a risk, have at times a challenging job that requires a specialised skill set to balance risk, welfare and safety. Training that includes any form of restrictive intervention has potential risks associated and is distressing for everyone involved.

6.31. For this reason, organisations must ensure that the training delivered to staff in the management of such behaviours is accredited and provided by a certified training body. The content must provide training models which are strong on proactive and preventative strategies, human rights-based interventions, and embrace the monitoring, oversight and assurance required in relation to restrictive practices. This approach minimises the use of restrictive practices and creates and maintains a positive and enabling service delivery culture beyond the application of physical restraint or other restrictive interventions.

6.32. Organisations and line managers are responsible for continual assessment of staff competence.

6.33. Education providers are expected to incorporate the principles in this policy into all pre-registration courses preparing future health and social care practitioners.

Co-Production

6.34. Working in partnership is about realising value through people; identifying and using their different skills, experience, and expertise and working supportively and collaboratively to deliver improved outcomes and experiences of health and social care by being part of designing, planning and delivering those improvements.[lxi]

6.35. Crucially, it is also about providing a direct link to the co-design, co-production and co-delivery of services, at strategic level, so those improvements can be embedded and cascaded to benefit everyone in Northern Ireland.

6.36. By connecting those providing health and social care, those with lived experience of care, their families and carers, staff, policy makers and local communities in the planning, delivery and evaluation of healthcare services, people will truly be at the heart of making decisions and choices about services. Doing so supports people to receive the service they want and need with better outcomes and enables service providers to deliver better quality, more targeted health and social care provision.

7 Standard 3 – Effective and person-centred communication must be central to care and treatment planning.

7.1 Inclusive, effective and person-centred communication must be central to care and treatment planning. Inclusive or total communication means sharing information in a way that everybody can understand.[lxii] A person centred approach to communication is a commitment to include a person in all aspects of their care, to gain an understanding of who they are and how to support them best,[lxiii] promoting proactive and ethical methods of reactive and ethical restrictive interventions.[lxiv]

7.2. The Royal College of Speech and Language Therapists has developed a set of practice standards[lxv] that describe what "good communication" looks like, with supporting references and resources. Whilst these were developed in the first instance to support inclusive and effective communication for people with learning disability and autism, they are equally applicable and supportive for anyone who experiences speech, language or communication challenges. Organisations should use the standards to shape their communication policies and practice.

Standard 1 There is a detailed description of how best to communicate with individuals.	In order to communicate effectively it is essential that everyone understands and values an individual's speech, language and communication needs. Individuals should be supported and involved, together with the people who know them best, to develop a rich description of the best ways to interact together. This description needs to be agreed, active, regularly updated and readily available. The description is sometimes referred to as a communication passport, guideline or profile. It includes the best ways of supporting their understanding and expression, the best methods of promoting interaction and involvement and describes 'how to be with someone'
Standard 2 Services demonstrate how they support individuals with communication needs to be involved with decisions about their care and their services.	Individuals with speech, language and communication needs are often either excluded from patient experience feedback processes or included in a tokenistic way. There is a risk that their needs and opinions are assumed, misinterpreted or ignored. All communication needs to be inclusive. For service providers, this means making sure they recognise that people understand and express themselves in different ways. For individuals this means getting information and expressing themselves in ways that meet their needs[lxvi]. Inclusive Communication is an approach that seeks to 'create a supportive and effective communication environment, using every available means of communication to understand and be understood'.[lxvii] For services to demonstrate inclusion and involvement innovative and creative solutions to understanding the views of individuals are often required due to the nature of communication needs.
Standard 3	Staff working in specialist hospital and residential services must recognise communication difficulties. They must

Staff value and competently use the best approaches to communication with each individual they support.	understand that they need to change their communication style to support the service user and have the knowledge and skills to adapt their communication levels, styles and methods. Staff are aware of factors that impact on communication, especially hearing, sight and sensory integration. They understand that what they say and how they say it matters and can impact positively or negatively on the individual. Staff also understand how good communication underpins informed consent and capacity. They are able to promote the individual's understanding and expression and create opportunities for positive communication.
Standard 4 Services create opportunities, relationships and environments that make individuals want to communicate.	An understanding, welcoming and socially rich environment is fundamental to relationships for all individuals, and particularly people with communication needs. Relationships are central to wellbeing. Getting the communication environment right will contribute to enabling people to live valued and meaningful lives. Individuals need to have the opportunity to communicate about all the things that all people talk about in everyday life such as dreams, hopes, fears, choices as well as everyday wants and needs. Good communication needs to be considered broadly. It is about social interactions – greetings, sharing stories and fun. It is the quality of interaction that contributes to overall emotional and mental wellbeing; providing a sense of belonging, involvement and inclusion. Interaction may not necessarily involve speech. For someone without formal language, interactive approaches are a way of 'being' with another person, making meaningful contact with those who are hard to reach or easy to ignore. It may be about very basic early developmental interaction and communication and relationship building.
Standard 5 Individuals are supported to understand and express their needs in relation to their health and wellbeing.	It is essential to consider communication needs in order to support individuals with their health. Arriving at a diagnosis can prove difficult if a person cannot describe signs and symptoms easily, or their behaviour is misunderstood and misconstrued. Staff need to be aware of how individuals communicate about their health and how they show that they are in pain. This includes considering ill health as a cause for changes in behaviour. Knowing how much a person can understand is also essential in making a decision about their capacity to have a health treatment. It is also required to meet the principles of nursing practice that everyone can expect[lxviii]. This includes treating individuals with compassion and dignity and providing person-centred care.

Key Themes underpinning inclusive, effective and person-centred communication

7.3. Inclusive and effective communication is a key element within an organisational restrictive practice minimisation strategy, centred on collaborative relationships.

7.4. Transparent and trusting relationships support the foundation for effective communication sharing and being able to support a person and their families to be part of their care and treatment. Use of independent advocacy will be an important support for a person in articulating their views for planning their care and treatment. Relationships based on transparency and openness can address the power imbalance so often felt by people dependent on service provision.

7.5. This is especially important in terms of sharing of information[lxix]. Sharing of information between the members of the interdisciplinary team and the person's wider support system is to be expected in pursuit of positive outcomes for the person. However, a balance required with respect to what information can or should be shared with others regarding the person's care and treatment – balancing confidentiality and right to privacy in any communication seeking to develop care and treatment plans with those who know the person best.

7.6. Professionals must also remember that their professional registrations and “Codes of Conduct” require a professional duty of candour, regardless of any potential future statutory requirement.

7.7. A Partnership approach to care and wellbeing is vital. It underpins a rights-based approach, further developing the positive relationships required to ensure that people feel protected, treated fairly, listened to and respected. The organisational ethos must be one of leading from the top and by example where policies, procedures and management of practice sets out a co-production approach as an organisational value.

7.8. How communication happens is important. Those with speech, language or communication needs (SLCN) require services and processes to be inclusive and accessible to enable full participation in all decision making. People with SLCN may need support to make decisions. Their needs must be considered in terms of how they communicate/understand and what support is required to promote involvement and empowerment. This will include those who know the person best – possibly a family member, or someone who works closely with them, as well as the possible need for specialist professional staff for example, nursing staff, speech and language therapy staff, psychology staff and other allied health professional staff. It is a potential breach of a person’s human rights if staff are unable to communicate in a way that the person understands.

7.9. Staff must be appropriately trained in a range of communication methods and inclusive communication strategies to ensure that the people that they care for are understood. For some individuals, the fluctuating nature of communication must be acknowledged and recognised, supporting flexibility whereby staff can adapt to meet the needs of the person. Effective communication skills and identifying a person’s needs are vital in supporting them and preventing situations escalating to the point where restrictive interventions, restraint or seclusion is required.

7.10. This may include identifying barriers to effective and inclusive communications, such as sensory impairment or the need for translation.

7.11. This also includes proverbial communication training (voice, tone, pace) which supports a trauma informed approach to care delivery and the use of de-escalation techniques which consist of a variety of psychosocial techniques, aiming to reduce disruptive and/or behaviours of concern and risk using verbal and non-verbal communication skills.

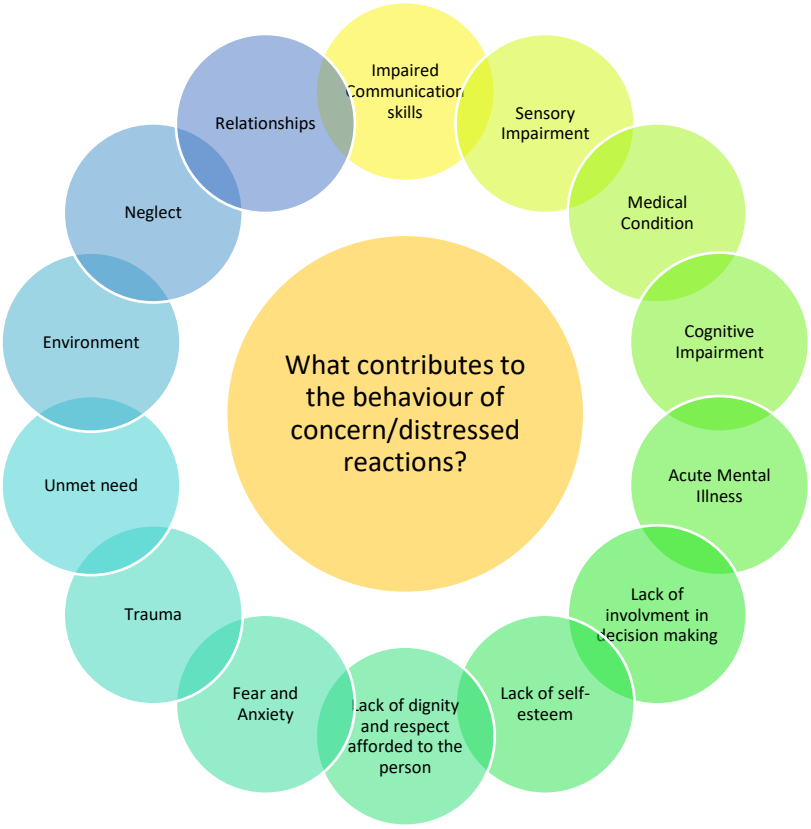
7.12. Organisations should recognise when additional staff training is required, with access to and use of appropriate communication support tools which assist staff to facilitate effective communication. Behaviours of concern and distressed reactions are communicating something; therefore, it is essential that people are helped to communicate in a way that is supportive and as safe as possible– physically and psychologically.

8 Standard 4 – Proactive, preventative strategies and evidence-based interventions that achieve positive outcomes for people must be the basis on which to build agreed care and treatment plans

8.1. Proactive, preventative strategies and evidence-based interventions that achieve positive outcomes for people must be the basis on which to build agreed care and treatment plans. All organisations must adopt positive approaches in the delivery of care, support and treatment plans that deliver proactive and preventative strategies, to better support the people using services and improve outcomes that support a better quality of life.

8.2. Using positive, proactive and preventative evidence-based strategies will support working towards reducing reliance on reactive and restrictive interventions[lxx]. This is a crucial component of a rights based, person centred approach, steering the organisational drive to minimise the use of restrictive interventions, restraint and seclusion, and must be reflected in organisational policy through to individual practice.[lxxi lxxii lxxiii lxxiv]

8.3. The key to establishing positive and proactive approaches is the need for health and social care staff to understand the reason and meaning behind behaviour. This will include areas such as environment, understanding history, and understanding family support and family dynamics, which could be influencing or contributing to how or why an individual behaves in a particular way.



8.4. Positive and proactive interventions assist the development of a therapeutic relationship between health and social care staff and those that they care for. The establishment of a therapeutic relationship aids communication, promotes recovery and supports the development of skills building to allow people to express themselves appropriately, therefore reducing the likelihood of behaviours of concern.

8.5. Underpinning positive, proactive and preventative approaches requires:

8.6. Proactive strategies may include:

- Incorporated meaningful activities.
- Promoting mental health and well-being.
- Promoting outdoor activity to support good mental and physical well-being.
- Promoting engagement using structured daily activities and routine.
- The removal of precipitating factors such as changes within the environment.

- Promoting the use of an environment and strategies to support the person to develop alternative behaviour patterns to support their needs.

- Use of communication aids to support identification and understanding of the person's needs[lxxv].

- Respecting culture and ethnicity.

- Working in partnership, ensuring that people (where capable) are involved in decision making around their care and treatment.

8.7. Creating a therapeutic culture and environment is key in supporting a person who may display a behaviour of concern and/or a distressed reaction which presents as a risk towards themselves and/or others. Staff must consider the physical environment, in addition to other external environmental factors, when thinking about proactive and preventative strategies to support the person.[lxxvi]

8.8. Preventative strategies may include:

- Use of relaxation.

- Individual personalised therapeutic activities/routines to promote wellbeing and behaviours and reduce avoid the need for a restrictive practice.

- Offering opportunity to discuss thoughts/feelings.

- Supportive approach – communicating in a way that suits the individual person and their needs.

- Environmental cues, optimal use of lighting, colour, contrast, signage, noise reduction, or stimulation as preferred by the individual, temperature, space and the ability to walk and explore freely but safely, other people.

- Timely access to specialist assessment and comprehensive, evidence-based treatment.

8.9. Providing person centred care is essential to the development of care and treatment plans. In order to provide good quality care and support to a person, it is important that all professionals are able to work together in partnership with the person, and their families and/or carers identified as partners in care, to ensure respect and dignity is afforded to everyone involved.

8.10. Cognisance of preventative and proactive measures in care and support provision are critical to the application of a rights-based approach in all health and social care settings. In order to ensure this is threaded throughout all policy and practice proactive measures must be considered in advance of any decision making regarding the planning and implementation of care, treatment and support plans. This requires staff, teams and services to define proactive measures several steps

back in any organisational and service delivery planning or decision-making processes.

8.11. Staff must be aware of the accumulative impact of a number of separate restrictive interventions, the potential for physical and psychological risks to the person, as well as unintended consequences of any restrictive practice.

8.12. When health and care needs are appropriately assessed and met, crises are rare. Analysing behaviours to identify antecedents and anticipating an individual's needs, including any current or potential behaviours of concern or risk assessments, should initiate discussion around proactive steps in care, treatment and support that are likely to reduce or prevent any need for consideration or use of restrictive practices. Where required, for those with SLCN challenges, specialist assessment and support by speech and language therapy services may be necessary.

9 Standard 5 – Organisational strategies and related policies for minimising the use of restrictive interventions must follow a shared and consistent content

9.1 All organisations must follow a minimum policy content format in relevant policy documents that includes details of the organisational strategy for minimising the use of restrictive interventions. Language used must be free from jargon and accessible to all age groups and abilities. Terminology must be regionally standardised.

9.2 People using health and social care services have a legitimate expectation of consistent treatment and application of approaches, particularly those who might move between different settings. Scope for differing interpretation is unfair and potentially detrimental. Therefore, a consistent approach in all aspects of application of this policy and, in particular, setting the context for practice, implementation and oversight in local and organisational policy, is important in articulating the wider principles and values that people should expect and indeed be in receipt of, from health and social care provision.

9.3 All organisations must have clear vision, values and philosophy that demonstrate how they aim to eliminate, where possible, or minimise the use of restrictive interventions within services. Any restrictive practice elimination/minimisation programme should address leadership, the use of data to inform practice, specific reduction tools, development of the workforce, and use of models for post incident review

9.4 It is important there are mechanisms by which organisations can produce evidence demonstrating the steps have been taken within the service to eliminate or minimise restrictive interventions.

9.5 Local and organisational policy frameworks should be co-produced and must include as a minimum:

- the organisational values that underpin the approach to minimising restrictive interventions;
- the detail of the organisational vision and strategy for minimising restrictive interventions;
- details of job roles within the organisation with specific restrictive practice minimisation responsibility and accountability;
- communication requirements and strategies;
- standard definitions;
- clear professional/clinical guidance;
- reference to working within current legislative frameworks and professional registration requirements;

- an emphasis on positive, proactive, preventative and evidence-based interventions and strategies;

- how the Three Steps to Positive Practice Framework as the organisational methodology for considering and reviewing the use of restrictive interventions is embedded and operationalised;

- details of accredited training required, including training required for specific interventions;

- details of interfaces with other regional and local policies, agreed protocols and any associated requirements;

- reference to clear recording, reporting, monitoring and governance arrangements (including how data will be used in the minimisation strategy, ensuring alignment with the UK Data Protection Act 2018 (DPA18) & the General Data Protection Regulations (UK GDPR));

- support mechanisms for those who are subject to restrictive interventions; and

- support mechanisms for staff who restrict, restrain and/or seclude those in their care.

10 Standard 6 – Roles and responsibilities are defined in terms of monitoring, reporting and governance

10.1 Each organisation must define roles and responsibilities within their restrictive practice minimisation strategies in terms of monitoring, reporting and governance.

10.2 A total organisational approach is required in the minimisation of restrictive interventions at the organisational level[lxxvii]. A regional approach is also required to understand behaviours and responses, the impact of those responses with analysis of that understanding underpinning actions required to minimise use of restrictive interventions.

Roles and Responsibilities

Department of Health (DoH)

10.3 The Department of Health (DoH) is responsible for setting regional policy and holding overall accountability for regional minimisation of restrictive practices, restraint and seclusion.

Strategic Performance and Planning Group (SPPG)

10.4 The Strategic Performance and Planning Group (SPPG) in DoH is responsible for monitoring the effectiveness of Health and Social Care Trust (HSCT) strategies in minimising the use of restrictive practices, restraint and seclusion.

10.5 SPPG must appoint a relevant Director who is responsible for:

- Agreeing the structures for reporting data and supporting narrative with Trusts and non-statutory provider organisations to ensure that the requirements of this regional policy can be produced in the format that facilitates both organisational and regional information across all relevant services;
- Agreeing the detail of data to be collected and format for reporting (in line with the Information Commissioner's Office guidance for data sharing)[lxxviii] , ensuring consistency across statutory and non-statutory provider organisations, with particular reference to agreeing terminology;
- Providing assurances regarding robust incident specific review and analysis of use of prolonged physical restraint, rapid tranquillisation and seclusion (and any incidents that amount to seclusion); and
- Providing a monitoring and assurance report on behalf of the Department of Health on an annual basis regarding the effectiveness of Trust strategies in minimising the use of restrictive practices, restraint and seclusion.

Provider Organisations – Health and Social Care Trusts (HSCTs)

10.6 Each Health and Social Care Trust is responsible for approving their evidence-based and co-produced restrictive practices minimisation strategy.

10.7 Each HSCT must appoint an identified Director who is responsible and accountable for realising the organisational minimisation of restrictive practices, restraint and seclusion.

10.8 The Director is responsible for:

- Articulating the organisational vision and strategy to minimise the use of restrictive practices across all services;
- Developing the required policy and embedding the processes required to implement the restrictive practice minimisation strategy ensuring adherence to the regional policy;
- Obtaining the baseline information and data and achieving the subsequent restrictive intervention minimisation set out within organisational strategy;
- Oversight of the organisational use of restrictive practices, restraint and seclusion, to include specific issues escalated via restrictive practice analysis and reporting;
- Oversight of the review of incident-by-incident use of prolonged physical restraint, rapid tranquillisation, and seclusion (or incident that amounts to seclusion) and the agreed plan to mitigate against any recurrence;
- Oversight of assurances provided by non-statutory services regarding minimisation of the use of restrictive practices; and
- Preparation and submission of six-monthly assurance reports with monitoring data to SPPG.

Provider Organisations – Non-Statutory Provider Organisations

10.9 This policy cannot make requirements on non-statutory organisations. However, this policy provides non-statutory best practice recommendations:

- Non statutory provider organisations should appoint an identified health and social care Director /Senior Manager who is responsible and accountable for realising the organisational minimisation of restrictive practices, restraint and seclusion.
- The identified Director /Senior Manager is responsible for:
    - Articulating the organisational vision and strategy to minimise the use of restrictive practices across all services;

- Developing the required policy and embed the processes required to implement the restrictive practice minimisation strategy ensuring adherence to the regional policy;

- Obtaining the baseline information and data and achieving the subsequent restrictive intervention minimisation set out within organisational strategy;

- Oversight of the organisational use of restrictive practices, restraint and seclusion, to include specific issues escalated via restrictive practice analysis and reporting;

- Oversight of the review of incident-by-incident use of prolonged physical restraint, rapid tranquillisation, and seclusion (or incident that amounts to seclusion) and the agreed plan to avoid any recurrence; and

- Providing reports where required to commissioning HSCTs and RQIA.

Regulation and Quality Improvement Authority (RQIA)

10.10 RQIA will have a monitoring and assurance role consistent with their role and function set out in the Health and Personal Social Services (Quality, Improvement and Regulation) (Northern Ireland) Order, 2003, Mental Health (Northern Ireland) Order, 1986, Mental Capacity Act (Northern Ireland) 2016, service specific regulations and inspection key themes. This includes reviewing the implementation of rights-based approaches for individuals and achievement of organisational restrictive practice minimisation measures.

Monitoring

Incident by Incident Review

10.11 Management of incidents that carry significant risk must be subject to incident-by-incident review (which should not be confused with de-briefing) no longer than 72[lxxix] hours after the incident to establish learning and promotion of preventative strategies in the work towards minimisation of restrictive interventions.

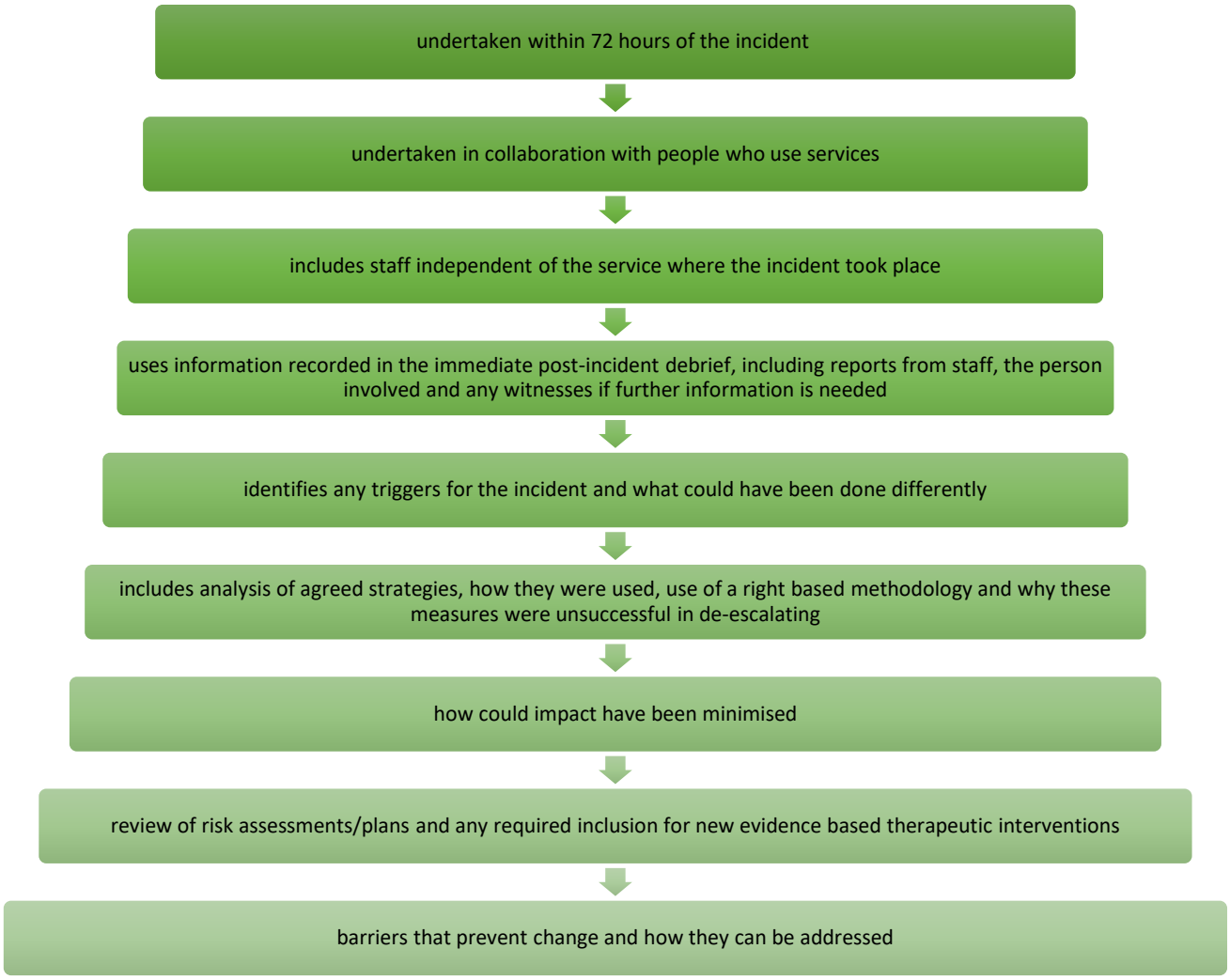
10.12 This includes incidents of: [lxxx]

- prolonged physical restraint;
- rapid tranquillisation;
- seclusion; and
- any incident that amounts to seclusion.

10.13 The use of a formal incident-by-incident review process is important in identifying the causes of the incident and the impact on all those involved. Doing so will create

learning for prevention of further incidents, improvements in an individual's care plan and safety improvements for all.

10.14 Incident by incident review considerations:



Restrictive Practice Register

10.15 All organisations must retain restrictive practice registers at local service level, maintained and reviewed by the local service manager.

10.16 The register must provide a current overview of the number and type of restrictive interventions in use within a service, supporting the link from local minimisation actions to the overall organisational strategy.

Leading Positive Practice

10.17 Organisations may wish to consider adopting a “Positive Practice Champion” role (smaller organisations), or “Positive Practice Teams” (larger organisations).

10.18 The Champion or Team is key in supporting the organisation’s minimisation strategy at service delivery level to produce better outcomes for people. This may include:

- assisting and contributing to the detail of minimisation strategy and implementation plans;
- supporting the implementation of minimisation plans, monitoring effectiveness and value to the individual, the service and the organisation;
- undertaking audit of practice in line with minimisation strategy and plans;
- advising on policy content, communication strategies, terminology and language;
- advising and supporting quality improvement initiatives for minimisation of restrictive interventions;
- supporting de-brief and review processes;
- undertaking training needs analysis;
- contributing to data analysis; and
- producing data reports, quality assessment reports, quality improvement recommendations.

Learning for Improvement

10.19 Learning for improvement in safety and quality is essential – for individuals, for services and for the system as a whole. The Public Health Agency through its safety and quality functions, is responsible for supporting analysis of incident reporting for purposes of learning and service improvement and developing regional quality improvement initiatives informed by that data analysis and learning.

11 Standard 7 – Any use of seclusion as a last resort intervention must follow the regional operating procedures

11.1 Seclusion is the confinement of a person in a room or area from which free exit is prevented.

Purpose

11.2 The operating procedure set out below provides the requirements for all health and social care organisations for the use of seclusion. HSC Trusts must follow this procedure.

Scope

11.3 Seclusion is an intervention of **last resort**. Seclusion must only be used in hospitals in a room or area that has been specifically designed for that purpose.

11.4 The designated room or area that has been specifically designed for the use of seclusion must not be used for any other purpose.

11.5 Seclusion can only be used where a person is (or liable to be) detained in hospital within an appropriate legal framework.

11.6 Seclusion can never be voluntary or consented to. Some individuals may express a preference for seclusion rather than physical restraint, for example, in circumstances where they exhibit behaviours that present an immediate and unmanageable risk of serious harm to others when acutely mentally unwell. This is not to be confused with a person "consenting" to seclusion and does not provide legal protection for seclusion. Expressed preferences may be part of care planning and may form part of an advance statement. This does not provide legal authority but should be considered by all health and social care professionals when making decisions about the management of a person where their behaviour is presenting as a risk towards themselves or others.

Responsibilities, Accountabilities, Duties

Chief Executive

11.7 The Chief Executive of each organisation is responsible for:

- Ensuring that there is a policy in place that governs the safe use of seclusion, which all staff have access to.
- Ensuring the ethos of *last resort* and *least restrictive* is embedded within organisational culture to work towards the minimisation of restrictive interventions.

Directors

11.8 The Directors of relevant areas are responsible for:

- Ensuring that all staff are aware and compliant in the delivery of the seclusion operating procedures.
- Ensuring that any local level procedures are reflective of the ethos outlined within the regional seclusion operating procedures.
- Ensuring that all episodes of seclusion are documented and recorded appropriately.
- Ensuring that all staff are appropriately equipped with knowledge and skills required in understanding and managing incidents of crisis behaviour/acute behavioural disturbance that may require seclusion.
- Ensuring that all incidents of seclusion are appropriately governed/audited in line with individual organisational procedures.

Service Specific Lead Nurse/Social Worker

11.9 Service Specific Lead Nurses/Social Workers are responsible for:

- Completion of a training needs analysis and overseeing training for seclusion awareness and any other relevant training needs (including Deprivation of Liberty Safeguards, Mental Health (NI) Order 1986, Human Rights etc.), and ensuring training is accessible for all staff.

Service Manager/Assistant Service Manager

11.10 Service Managers/Assistant Service Managers are responsible for:

- Monitoring overall compliance with the policy.
- Ensuring that all staff who require the training have access to it.
- Ensuring that clear systems for reviewing those who require seclusion and recording are in place.

Inter-disciplinary Team (IDT)

11.11 All Inter-Disciplinary Team staff are responsible for:

- Being aware of the policy and being compliant in the delivery of the operating procedures

- Ensuring that an IDT approach is taken in reviewing, developing and updating treatment plans and risk assessments.

- Ensuring that there is clear communication and regular incident reviews as per NICE guidelines.

Line managers

11.12 Line managers are responsible for:

- Ensuring that mechanisms are in place so that all staff are aware of the policy and are compliant in the delivery of operational procedures.

- Ensuring that all staff attend mandatory training which includes seclusion operating procedures.

- Promoting an ethos of human rights-based approach where staff are committed to protecting the rights of those they care for and treating them with dignity and respect.

- Ongoing monitoring and review of working practices regarding seclusion operating procedures.

- Where possible ensuring that the person, families and carers are included in decision making regarding the use of seclusion.

All staff

11.13 All staff are responsible for:

- Complying with the operational procedures.

- Reporting any untoward incidents regarding seclusion in line with organisational safeguarding procedures and incident reporting procedures.

- Ensuring that any episode of seclusion is documented and recorded appropriately.

- Working with people in line with a human rights-based approach.

- Having an understanding of integrated experience – the understanding of the potential impact of their behaviour towards people in their care and how this can affect the behaviour of others, becoming a precipitating factor.

- Where possible, ensuring that the person, families and carers are included in decision making regarding the use of seclusion.

- Ensuring care plans and risk assessments being kept up to date.

- Organisational policies must be referred to and contact should be made (where or if required) with the relevant organisation's training team for support and guidance on the management of a person presenting with unmanageable risk and/or supporting transition of the person to designated seclusion room.

Procedure for Seclusion

Use of seclusion

11.14 There are several factors that need to be considered with regards to the use of seclusion.

11.15 Seclusion can cause psychological harm with no definitive evidence that it has any therapeutic benefit. The use of seclusion can often be seen as negative and a non-therapeutic experience, with potentially harmful physical and psychological effects. The effectiveness and adverse effects of seclusion and restraint seem to be similar, although the evidence base for both is limited.

11.16 Seclusion must only be used in an emergency in response to an unmanageable risk of harm to others where other responses have been deemed insufficient. However, seclusion may form part of a patient's care plan for use in emergency situations.

11.17 In the absence of clinical guidance to review every potential situation that may arise, any interventions regarding the use of seclusion will be based on clinical judgement by the relevant nursing and medical staff who are involved. All interventions regarding the use of seclusion must be a last resort option that is proportionate and justifiable to the presenting risk.

11.18 Seclusion might be used as an alternative to physical restraint or rapid tranquillisation. The factors influencing this will be specific to the individual and situation, and the individual's preference should be determined as soon as possible.

11.19 The use of seclusion for a person not detained in accordance with a relevant legal framework will necessitate a review of their legal status with a view to legal detention. Seclusion, outside of an emergency, is unacceptable, potentially unlawful and in breach of human rights and could be considered as a crime as result of false imprisonment of the person.

11.20 Seclusion should **not** be used:

- Where there is a risk of suicide.
- Where a person is engaging in self-harm or there is evident risk of serious self-harm.
- Due to a lack of resources to manage an incident where the person is displaying risk behaviour.

- As a punitive action.
- As part of a treatment plan – unless the person has completed an advance statement expressing their wishes/preference.
- Where mechanical restraint is also in use.
- Where a person has a pre-existing condition that staff are aware of and where care plan documentation indicates seclusion should not be used.

Seclusion Room

11.21 Seclusion should only occur in a room or area designed specifically for that purpose.[lxxxi,lxxxii,lxxxiii]

11.22 Seclusion room specifics:

- The construction of the room must be designed to withstand high levels of violence with the potential to damage the physical environment e.g. walls, window, doors and locks.
- There should be no:
    - ligature points;
    - access to electrical fixtures that could pose a risk of harm.
- There must be an anti-barricade door system.
- The room must allow for staff to be able to clearly observe and hear the person within the designated room.
- The designated room should be in an area free from others but not isolated.
- The person in seclusion must be able to have a clear view of the outside environment but those on the outside must not be able to have any view of the person within seclusion.
- 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.
- Adequate lighting must be provided, in particular a window in order to provide natural light. Lighting should be able to be controlled both by the person within seclusion and those external.
- The room must be equipped with adequate temperature and ventilation system with heat sensor for effective monitoring.
- The room must be decorated in a calming manner that appears non-threatening to the person.

- The room must be kept clean and fresh.
- The room must have direct access to washing and toilet facilities.
- The room must be safe and secure.
- There must be a visible clock.
- There should be limited furnishings. Any furnishings must be as safe as possible and must not include anything that could potentially cause harm. Furnishing must be comfortable and in good condition.

11.23 To ensure that the designated seclusion room or suite is maintained appropriately, all organisations should ensure the following mechanisms are in place:

- Weekly maintenance check (see Appendix 1).
- Ensure the designated room remains locked at all other times when not in use.
- Is part of routine cleaning schedules (in situations where the room requires deep clean, each organisation should follow individual IPC procedures and set out interim guidance for management of the person should seclusion require early termination to facilitate deep cleaning).
- Ensure that only appropriate equipment i.e. soft furnishings are kept within the designated room/suite.

11.24 If at any stage there is requirement for maintenance work to be carried out, then each organisation should ensure that there is interim plan in place for management of a person in an emergency situation where there is deemed unmanageable risk and ensure that all staff are aware of the interim arrangements.

Commencement of Seclusion

Decision to seclude

11.25 Seclusion should only ever be used as an emergency intervention.

11.26 The use of seclusion must always be a reasonable and proportionate response to the level of risk shown and where decision making clearly shows that there has been consideration to the use of other restrictive interventions. Decision making might reflect the use of seclusion as a safer alternative than prolonged restraint or the use of medication.

11.27 The decision to seclude a person is based on clinical professional judgement regarding knowledge of the patient and potential unmanageable risk towards others.

11.28 The person making the decision to seclude should be:

- The nurse in charge of the team providing the person's care at the time of seclusion;

OR

- A doctor with responsibility for the care of the person or the duty doctor on call.

11.29 The person making the decision to seclude should ensure that:

- There is an appropriate legal framework in place;
- They have seen the person immediately before seclusion commences;
- They have consulted with the team providing the person's care at the time of seclusion;
- They are familiar with relevant aspects of the person's healthcare records (e.g. risk assessment) as far as possible;
- They are aware of the person's advance wishes in relation to what should happen in an emergency, as far as possible;
- The intervention is necessary, appropriate and can happen safely, and that reasonable alternatives have been considered;
- The necessary observation and review can take place to monitor the person's physical and mental wellbeing; and
- Where required, individual organisation search policies are adhered to, if there are concerns about any items that a person may have.

Review Process

11.30 There are a number of review processes which should be commenced as soon as a period of seclusion is initiated.

11.31 All reviews should be considered as an opportunity to determine whether the seclusion period can be terminated or if it requires continuation.

Roles and Responsibilities

Medical staff

11.32 Medical reviews must be carried out in person and must include the following:

- Assess and review the need for seclusion period to continue;
- Review mental and physical health;
- Review level of risk towards others;
- Review level of observations;
- Review potential risk to self; and
- Review prescribed medication and consider/assess any potential adverse effects of medication.

11.33 If a doctor was involved in the decision to seclude then their assessment at the time seclusion was commenced will be considered as the first medical review and they will not be required to complete a separate first medical review.

11.34 If a doctor was not involved in the decision to seclude then they must be notified to attend immediately to undertake the first medical review. The first review should take priority over routine tasks or any of those which are anticipated to cause further delay. Any potential delay should be discussed with the Consultant Psychiatrist on call, to ensure that any delays are considered reasonable and justifiable.

11.35 Where the seclusion period is so short that the doctor does not visit before termination then this must be recorded on the seclusion care plan and within the person's care record.

11.36 Medical reviews must take place every four hours - one of which should be undertaken by the person's Consultant Psychiatrist within 24 hours unless stipulated during the first internal IDT review.

11.37 A medical review should be undertaken by the Consultant Psychiatrist at least once in every 24-hour period.

11.38 Medical staff must complete an individualised seclusion care plan in partnership with nursing staff and provide input following the review process.

11.39 The outcome of the medical review must be documented in the person's care record.

Senior Management

11.40 Senior management staff will be contacted by nursing staff to inform them of the commencement of a period of seclusion.

11.41 The senior manager in receipt of the call should arrange to attend the ward to receive a report on the decision to seclude – the senior manager should sign records acknowledging receipt of the report and any other information or advice provided. If the senior manager does not attend in person, the nurse in charge must document the detail of conversation and decisions agreed as per telephone

conversation. The senior manager should email confirmed details of the conversation and agreement reached to the nurse in charge as soon as possible

11.42 The senior manager should provide support and guidance to support the person within seclusion and staff involved in managing the period of seclusion.

11.43 The Senior Manager should discuss presentation, risks and agreed management plan with nurse in charge.

Nursing Staff

11.44 Nursing staff will contact and inform the multi-disciplinary team (who have caring responsibility for the person) of the commencement of a period of seclusion period as soon as possible, making a contemporaneous entry in the person's records. They will also contact the senior manager to inform them of the commencement of the period of seclusion.

11.45 The nurse in charge will complete a formal review of the on-going seclusion every one hour during the seclusion period to ascertain if there is an opportunity for seclusion to be terminated. If it is not yet safe to terminate seclusion, the nurse in charge will review the implementation of the seclusion care plan actions to ensure that everything that can be done to end the period of seclusion is being done.

11.46 Every two hours, the nurse in charge will be accompanied by a registered nurse to ascertain if there is an opportunity for seclusion to be terminated. Ideally the second nurse should not be directly involved in the incident that led to a decision to seclude. If it is not yet safe to terminate seclusion, both nurses will review the implementation of the seclusion care plan actions to ensure that everything that can be done to end the period of seclusion is being done.

11.47 Outcomes for the nursing reviews should be recorded contemporaneously in the person's care records.

11.48 Where a doctor fails to attend immediately, as requested, to complete the first medical review (where they were not a part of the initial decision to seclude) an incident form should be completed by the nurse in charge, for review by senior management.

11.49 The next of kin/significant others should be informed in a timely manner of the necessity for seclusion but in a considerate manner taking into account the time of day/night. Consent for sharing information should be clarified[lxxxiv].

Reviews of seclusion

Internal multi-disciplinary team review

11.50 An internal multi-disciplinary team review must include the patient, their doctor, nurse in charge, and other professionals who may usually be involved with the person. An initial review must be carried out as soon as practicable once the seclusion period commences.

11.51 An internal review must also take place once in every 24-hour period of continuous seclusion.

Independent multi-disciplinary team review

11.52 If a patient is secluded for more than 8 hours repeatedly or 12 hours over a period of 48 hours, there must be an independent review undertaken by professionals who were not involved in the incident that led to the period of seclusion or where part of the decision to commence the seclusion period. The review must include the patient, with a review team comprising of a doctor, nurse and other professionals, and an independent advocate.

11.53 Even if the seclusion period has since ended, once a trigger point has been reached, the review must be held. If the seclusion period is ongoing, then the independent review can make additional recommendations as appropriate to the seclusion care plan.

Recording and Documentation

11.54 Seclusion records must include as a minimum:

- Personal details of the person in seclusion;
- Date and time the seclusion commences;
- Decision to seclude the person, preceding incident(s) and other unsuccessful measures used to manage the situation (including use of physical intervention where required to support transition to seclusion room);
- If search procedure was required;
- Nurse in charge details;
- Details of doctor contacted;
- Details of senior manager (or others) contacted;
- Legal status of person – and any actions taken to review legal status;
- Date and time of termination of seclusion;

- Consent for information sharing with next of kin and / or family; and
- The Seclusion care plan.

11.55 A seclusion care plan must be completed as soon as the seclusion period commences. It must reflect the person-centred care needs of the person and record the actions that should be taken to end the period of seclusion in the shortest time possible.

11.56 A seclusion care plan must include as a minimum:

- Personal details;
- Known clinical needs (including mental and physical considerations);
- How de-escalation strategies will continue to be used;
- Outline actions towards termination of seclusion;
- Recognising signs where behaviour is no longer considered an unmanageable risk towards others, e.g. evidence of tension reduction, improved communication etc;
- How potential risks may be managed;
- Reference to individual care plans, support plans, behaviour support plans, sensory regulation strategies etc;
- Meeting of food/fluid needs;
- Meeting of needs in regard to personal hygiene/dressing;
- Meeting of elimination needs (with specific reference to how privacy and dignity will be managed);
- Medication reviews (in consultation with a doctor or other as delegated);
- Monitoring of physical observations;
- Person's views in regards to the seclusion process; and
- Information about informing next of kin and/or families as stated within individual support plans or as previously discussed in advance statements regarding emergency situations.

11.57 A template for a seclusion care plan is included in Annex B.

Observations

11.58 A registered nurse must observe and monitor the person and their action's whilst in the seclusion room and determine whether seclusion can be terminated.

11.59 The registered nurse may be outside the person's room (or in an adjacent room with a connecting window), provided that the person can fully see the registered nurse and can continuously observe and hear the person.

11.60 CCTV must not be used to replace continuous staff presence. CCTV does not replace the usual observation process but can be used to enhance observation and to increase safety and security of the person within the seclusion room. The observing nurse should remain in the immediate vicinity (directly outside the seclusion room door) and be available to provide immediate (including discrete) observation and assessment at any stage during the seclusion period. Immediately after the commencement of the seclusion period, the person must be placed on 1:1 observation. **A registered nurse** must be delegated to undertake 1:1 observation of the person within the seclusion room, for the period of seclusion. The registered nurse must be exempt from undertaking other duties for the period of seclusion.

11.61 Observation of a person subject to seclusion involves a range of other professional and intricate competencies, including assessment, using clinical judgement, making clinical decisions, risk management, and, very importantly, the delivery of person centred and human rights-based care. Therefore 1:1 observation of a person in seclusion should be only undertaken by a registered nurse.

11.62 Consideration must be given to the registered nurse chosen to support the person in seclusion, and any potential impact on the person. This must be considered on an individual basis.

11.63 An observation record must be documented at a minimum of every 15 minutes; this can be reviewed based on clinical presentation and risk assessment.

11.64 The registered nurse completing the observations must monitor the following:

- Physical appearance and documenting any evidence of physical ill health such as shortness of breath, unusual facial pallor or potential cyanosis;
- Mental state presentation;
- What the person is doing or saying whilst in seclusion;
- Level of communication; and
- Level of alertness/awareness (particularly following administration of medication).

11.65 If medication has been administered prior to the person entering seclusion, with intent to subdue acute behavioural disturbance, individual organisational policies

(developed in line with regional guidelines) should be followed and the person should be observed in accordance with same.

11.66 It may be difficult at this time to complete full clinical monitoring and NEWS chart. As a minimum the registered nurse observing, should record:

- Person's respiration rate;
- Person's response to verbal or tactile stimulation;
- Person's level of movement;
- Person's level of awareness; and
- Any attempts to complete physical monitoring, whether successful or not, must be recorded.

11.67 Observing staff must have access to a personal alarm or call system should they need to seek urgent assistance in an emergency.

11.68 Handover between staff observing must be documented. Observing staff should be able to respond to a situation where patient safety becomes compromised i.e. self-injurious behaviour.

Care of the Person in Seclusion

11.69 During a period of seclusion, staff must ensure that a good level of care is maintained and delivered, ensuring that the person's privacy and dignity is maintained. The health, safety and wellbeing of the person is paramount.

Personal care/elimination/dressing needs

11.70 Seclusion rooms must have toilet and shower facilities.

11.71 Staff must be able to supply the person with toilet paper, hand soap, towels and other hygiene products as and when required.

11.72 If a person is in seclusion for a period prolonging 24 hours, they should be encouraged and, where required, assisted to meet their personal hygiene needs.

11.73 A persons' privacy and dignity must be maintained at all times throughout seclusion. Items of clothing must only be removed where there is potential for the person to use the items of clothing as ligatures and cause serious risk of harm to self.

11.74 Each individual organisation must consider the use of tear proof clothing should it be required.

Provision of food/fluids

11.75 The provision of food must not be denied to the person within seclusion. All meals and drinks must be provided as normal.

11.76 Crockery and utensil items that are considered safe to use i.e. plastic and non-metallic must be used.

11.77 All offers, acceptance and refusal of food and fluid items must be documented within the seclusion observation form and within the person's records.

Accessing seclusion room in planned or unplanned scenarios

11.78 Staff may at times be required to enter the seclusion room in planned/unplanned scenarios. Planned scenarios may include (but are not exhaustive to) facilitating reviews, supporting access to toilet/showering facilities, providing food/fluids or administering medication.

11.79 Unplanned scenarios may include (but are not exhaustive to) when the person's health, safety and wellbeing is compromised, deterioration in clinical presentation or engaging in risk behaviour where there is imminent risk to the person.

Administration of Rapid Tranquillisation whilst the person is in seclusion

11.80 There may be occasions where the person in seclusion may require the administration of medication via rapid tranquillisation. If required, staff should refer to the guidance within local policy and procedure, relevant best practice guidance and/or regional protocols.

11.81 Staff must be aware of potential side effects and be prepared to address any complications that may arise.

11.82 A registered nurse must observe the person within sight. A doctor and nurse in charge must review the seclusion care plan and associated risks and consider the termination of seclusion once rapid tranquillisation has had the desired effect.

11.83 If there is an identified risk to the person at any time, then the seclusion room must be entered at the earliest and safest opportunity.

11.84 In a scenario where staff are unable to clearly see the person within seclusion due to covering of the head or face, the observing staff member should encourage the person to remove the covering to maintain observations and also assess the person's clinical and physical presentation. If the person is non-communicative the observing staff member should seek immediate assistance and assess the need to enter the seclusion room. This will be a decision based on clinical judgement and the need to maintain safety of the person whilst in the seclusion room.

11.85 Any need for staff entry or exit of the seclusion room (outside of a response to an emergency) must be informed by careful application of specific skills learnt in training for managing situations where an individual presents with behaviour of concern/distressed behaviour.

Termination of Seclusion

11.86 Seclusion must be terminated at the earliest opportunity when it is assessed to no longer be required.

11.87 The seclusion care plan must detail safe management and support of the person on the ending of seclusion, and during reintegration of the person to the general ward setting within the hospital.

11.88 If the person is sleeping, then the risk is no longer immediate and unmanageable, and seclusion must be terminated. The continuation of observation if the person is sleeping will be based on clinical judgement of the situation at the time.

11.89 Opening of the seclusion room door in order to facilitate reviews, support access to toilet or showering facilities, provide food/fluids, administer medication does not constitute an end to seclusion.

Post Seclusion

11.90 Nursing staff will complete the documentation required for the seclusion period. The end of seclusion must be recorded in the observation record by the nurse in charge.

11.91 When seclusion is ended, a body chart must be completed. The next of kin must be informed of the termination of seclusion (taking into account consent from the person and appropriateness of the time of day/night to provide update).

11.92 Following seclusion, the nurse in charge must make arrangements for the room to be reviewed, maintenance checks to be complete and cleaning procedures in line with IPC guidance.

Incident review

11.93 The purpose of a post incident review is to provide opportunity for learning and provide support to the person and staff. A post incident review must take place as soon as possible, but no later than 72 hours[lxxxv] following termination of seclusion.

11.94 There must be a designated person to lead the incident review, and where possible they should not have been involved in the seclusion incident.

11.95 The review process must include discussing the incident with the person secluded to ascertain their thoughts and views.

11.96 The review will consider the following key points:

- What happened during the incident?
- Why did it happen? (Possible triggers, precipitating factors or early warning signs/Any noticeable patterns)
- How can a recurrence be avoided?
- What might be done differently the next time?
- What has been learned?
- Any changes to care plan or risk assessments?
- Any additional emotional support required for the person who has been secluded and any staff involved in the seclusion?

Use of CCTV in a Period of Seclusion

11.97 The use of CCTV for a period of seclusion within a hospital setting is to enhance the safety of all involved. The use of CCTV must not replace staff presence[lxxxvi]. Where organisations use CCTV, staff must refer to individual organisational policies for guidance. Data protection requirements[lxxxvii] related to the use of CCTV must be incorporated in organisational policies for use of CCTV and guide decision-making for each individual use of CCTV for monitoring a period of seclusion. This will include a Data Protection Impact Assessment[lxxxviii] that outlines the necessity, fairness and proportionality of the decision to use CCTV to monitor a period of seclusion. In addition to the above, each organisation that uses CCTV to monitor a period of seclusion should consider and outline how the proposed processing meets the seven key principles under the UK GDPR.

11.98 CCTV does not replace the usual observation process but can be used to enhance observation and to increase safety and security of the person within the seclusion room.

11.99 The privacy and dignity of the person must be protected at all times.

Emergency scenarios

Fire Alarm

11.100 If the fire alarm was to sound whilst a person is in seclusion, the observing staff member must immediately seek direction from the nurse in charge and take direction in line with evacuation procedures.

11.101 Where there is a potential immediate risk to life, then seclusion must be terminated, and the person escorted out of the building in line with evacuation procedures to the nearest fire assembly point.

11.102 There must be an appropriate level of staffing in order to enter seclusion and evacuate the person.

Medical emergency

11.103 All staff involved must have the appropriate training and associated skills in order to manage a medical emergency.[lxxxix] [xc]

Monitoring and Governance

11.104 Organisations must develop their policies in support of the regional seclusion operating procedures in regard to the monitoring and governance arrangements for the use of seclusion.

11.105 The Seclusion Audit tool (see Appendix 6) provides an opportunity for the Nurse with overall responsibility of the hospital ward, in which seclusion occurred, to review key procedures and processes.

12 Appendices

Appendix 1 – Seclusion Maintenance Record

Seclusion Maintenance Record

DATE		TIME	

SIGNED	
PRINT NAME	
IS THE ROOM FIT FOR USE/SATISFACTORY/WORKING ORDER: **ALL STAFF SHOULD ASSESS THE ROOM AND ENSURE ADEQUATE STANDARDS**	

	YES/NO	COMMENTS/ACTION (IF REQUIRED)
Safe (free from harm/weapons)		
Clean		
Lighting		
Heating		
Clock		
Locks		
Appropriate furnishings		
Doors/Door Frames		
Vision Panels		
Flooring		
Windows		
Skirting/Window Frames		
CCTV		
Ventilation		
Safety alarms in area		

ANY OTHER COMMENTS/ACTIONS REQUIRED FROM MAINTENANCE CHECK:

Appendix 2 – Record of Seclusion

Record of Seclusion

Person	**D.O.B** **Hospital Number** **Paris Number**
Ward	**Date of completion**
Date seclusion commenced	**Time seclusion commenced**
Name of those involved in decision to seclude:	**Name of professional initiating seclusion (doctor, nurse):** **Print Name:** **Signature:** **Designation:**
Medical Staff **Name of Doctor/Duty doctor informed of seclusion period:** **Time informed:** **Signature of Doctor who attended:** **Time attended seclusion:** **Were there problems in contacting doctor?** **If yes, please state what/why:** **Did Doctor attend to review immediately?** **If no, please state why?**	**Senior Management or Other (outside of usual working hours)** **Name of Senior Management/Other informed of seclusion period:** **Time informed:** **Signature of Senior Management/Other who attended:** **Time attended seclusion:** **Were there problems in contacting senior management?** **If yes, please state what/why:**

If no, complete incident form, reference no:	

Decision to seclude (Events leading to initiation of seclusion)

_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____

Alternative measures utilised prior to decision that seclusion was required as last resort option

_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____

Where Search procedures required due to potential risk of harms:

Yes ☐

No ☐

Items on the person within the seclusion room, if any items were removed for potential to cause harm (i.e. ligatures) Please detail below:

Not applicable ☐

Tear proof clothing required ☐

Consent to share information with NOK/family ☐

Consent to share information

Consent provided through advance statements ☐

Detail below where consent may not have been sought to information share/provide update (i.e. lack capacity)

_____

_____

_____

Were Physical intervention techniques required? Yes ☐ No ☐

Was 'as required' / 'rapid tranquillisation' medication administered? Yes ☐ No ☐

Incident Form Complete: Yes ☐ No ☐

Datix number:

Termination of Seclusion

Date seclusion terminated	**Time seclusion terminated**

Duration of seclusion (total):

Name of those involved in decision to terminate seclusion:

Name of professional terminating seclusion:
Print Name:

Signature:

Designation:

Post Seclusion

Clinical observations complete ☐

Debriefing with person ☐

Debriefing with staff ☐

Incident review ☐

Appendix 3 - Seclusion Care Plan

Seclusion Care Plan

Person	**D.O.B** **Hospital Number** **Paris Number**
Ward	**Date of completion**
Date seclusion commenced	**Time seclusion commenced**

Clinical needs of the person/Physical and Mental state considerations/Potential risks
Management of any potential risks as outlined above
De-escalation strategies and outline of actions that will continue to be used to support termination of seclusion at earliest opportunity
How to recognise signs of tension reduction in person
Meeting person's needs and how this is planned for during seclusion period (food/fluid/elimination/personal hygiene/clothing)

Person's views regarding seclusion process
Process of information sharing as in main care plan

Appendix 4 – Seclusion Observation Record

Seclusion Observation Record

A documented report **must** be made at least **every 15 minutes** or more frequently if required (including during reviews etc.).

Things to observe: person's physical and mental state presentation, person's behaviour, communication, personal hygiene, therapeutic interventions, food and fluid intake.

<table>
<tr><td colspan="2"></td><td>Person

DOB</td><td colspan="2">Hospital No:

Paris No:</td></tr>
<tr><td></td><td></td><td>Name of professional who initiated seclusion:</td><td colspan="2">Hospital setting:</td></tr>
<tr><td>Date</td><td>Time</td><td>Comments</td><td colspan="2">Print and Sign Name
Signature/Designation</td></tr>
<tr><td></td><td></td><td></td><td colspan="2"></td></tr>
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<tr><td></td><td></td><td></td><td colspan="2"></td></tr>
<tr><td></td><td rowspan="2">Hourly review by Nurse in Charge</td><td rowspan="2"><u>Comments</u></td><td rowspan="2"><u>Outcome</u></td><td>NIC signature</td></tr>
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<tr><td></td><td rowspan="2">Hourly review by Nurse in Charge</td><td rowspan="2"><u>Comments</u></td><td rowspan="2"><u>Outcome</u></td><td>NIC Signature</td></tr>
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Appendix 5 – Seclusion Review Record

Seclusion Review Record

There are a number of review processes which should be commenced once a seclusion period is commenced.
All reviews should be considered as an opportunity to determine whether the seclusion period can be terminated or if it requires continuation.

Medical Staff Review

Initial Assessment by Doctor/Duty Doctor *(Required immediately if the Doctor is not the professional implementing period of seclusion):* **Discussion:** **Outcomes:**
Name and Designation Print_____ Signature_____

Hour Review by Doctor/Duty Doctor: **Discussion:** **Outcomes:**
Name and Designation Print_____ Signature_____

Nursing Staff Reviews

2 Hour Review by 2 Registered Nurses, one who is the Nurse In Charge **Discussion:** **Outcomes:**
Name and Designation Print_____ Signature_____ **Name and Designation** Print_____ Signature_____

_____ Hour Review by 2 Registered Nurses, one who is the Nurse In Charge **Discussion:** **Outcomes:**
Name and Designation Print_____ Signature_____ **Name and Designation** Print_____ Signature_____

Internal IDT Review

Names of those participating in Internal IDT review: **Discussion:** **Outcomes and Actions**
Name and Designation Print_____ Signature_____ **Name and Designation** Print_____ Signature_____ **Name and Designation** Print_____ Signature_____ **Name and Designation** Print_____ Signature_____ **Name and Designation** Print_____ Signature_____

Independent IDT Review

Names of those participating in Independent IDT review: **Discussion:** **Outcomes and Actions:**
Name and Designation Print_____ Signature_____ **Name and Designation** Print_____ Signature_____ **Name and Designation** Print_____ Signature_____ **Name and Designation** Print_____ Signature_____ **Name and Designation** Print_____ Signature_____

Appendix 6 – Seclusion Audit Form

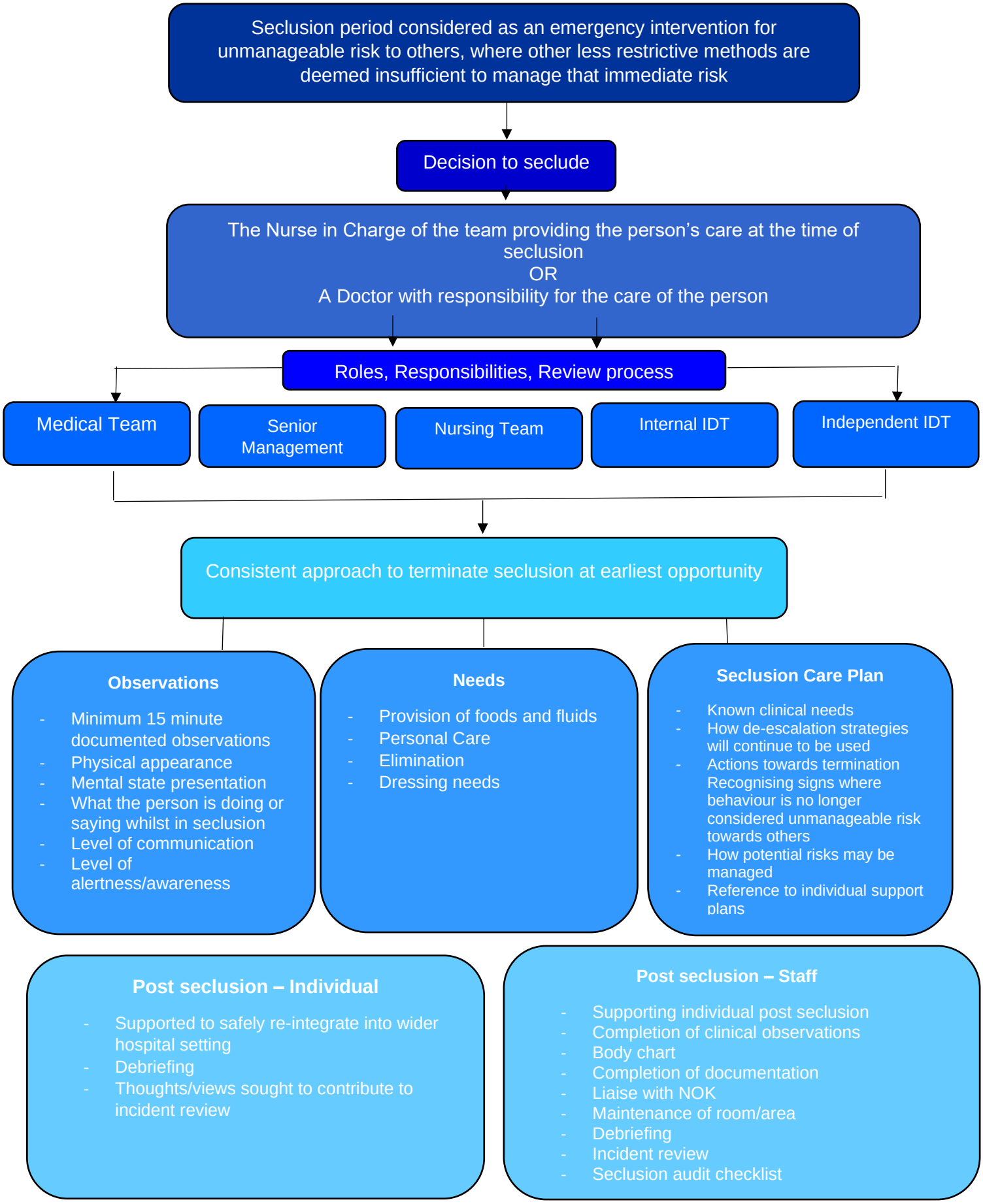
Seclusion Audit Form

		Yes	No	N/A	Comments
1.	Is there evidence that other alternative interventions were considered prior to the use of seclusion				
2.	Has the following documentation been completed as required:				
	• Record of Seclusion				
	• Seclusion Care plan				
	• Seclusion Observation record				
	• Seclusion Review record				
	• Seclusion maintenance record				
	• Incident form				
	• NEWS Chart (or equivalent)				
3.	Is there evidence that seclusion process was explained to the person If additional resources are required to support/aid understanding, is it evidenced that they were utilised				
4.	If a doctor was not the professional authorising seclusion, did they attend for review immediately If not, was an incident form complete				
5.	Is there evidence of completion/attempts to complete clinical observations during seclusion period				
6.	Is there evidence that following administration of medication before/during seclusion period that the following was monitored:				
	• Respiration Rate				
	• Response to verbal or tactile stimulation				
	• Level of movement				
	• Level of awareness				
	If no, is it evidenced as to why staff were unable to monitor and record				
7.	Was the person searched prior to entering seclusion				
	• Is this evidenced				
	• Is it evidence that this was discussed with the person and rationale explained				
8.	Is it evidenced that the NIC completed an hourly review				

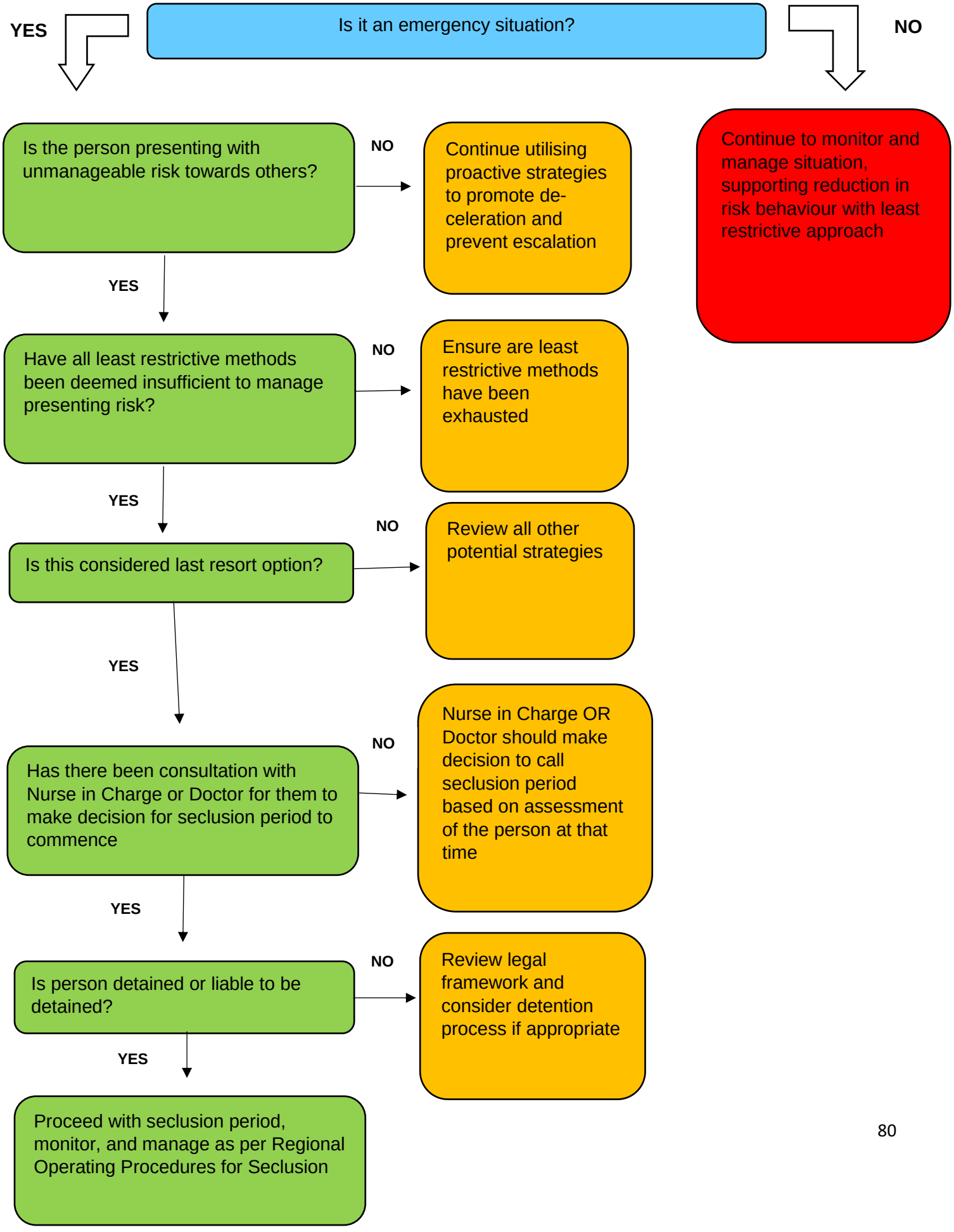
9.	It is evidenced that medical staff completed 4 hourly reviews after initial review				
10.	Is it evidenced that Nursing staff completed 2 hourly reviews x 2, one whom being the NIC				
11.	Is it evidenced that seclusion met the trigger for internal IDT review Did an internal review take place Are the outcomes of this evidenced and actions agreed				
12.	Is it evidenced that seclusion met the trigger for an independent IDT review Did an independent review take place Are the outcomes of this evidenced and actions agreed				
13.	Is it evidenced that consent has been given to share information with NOK/family. If not, are reasons explained as to why				
14.	Is there evidence that the person was offered food/fluids				
15.	Is there evidence of incident review by IDT following period of seclusion Is there key learning identified Are there actions set out to prevent incident from re-occurring Has this been reflected in the person's care record and where required care record and risk assessments updated				
16.	Is there evidence of post incident debrief • For the person who required seclusion • For staff involved				

Appendix 7 – Seclusion Flowcharts

Quick Reference Chart – Procedure for Seclusion



Quick Reference Flowchart – Decision to Seclude



Quick reference flowchart – Roles and Review process

Medical Team

- Assess and review need for seclusion period to continue
- Review mental and physical health
- Review level of risk to others
- Review level of observations
- Potential risk to self
- Review medication and potential adverse effects

- If the doctor was not involved in the decision to seclude the person, then they must attend immediately to complete review
- Medical review complete every 4 hours
- Medical reviews must take place every four hours - one of which should be undertaken by the person's Consultant Psychiatrist within 24 hours unless stipulated during the first internal IDT review
- Document review within review record and care plan
- Complete seclusion care plan with nursing staff and make amendments as required following review

Senior Management

- Provide support and guidance to person in seclusion and staff supporting
- Discuss presentation, potential risks and agreed management plan with NIC
- Assure appropriate resources in place until termination

- Senior management staff will be contacted by nursing staff to inform them of commencement of a period of seclusion
- The senior manager in receipt of the call should arrange to attend the ward to receive a report on the decision to seclude – the senior manager should sign records acknowledging receipt of report and any other information or advice provided. If the senior manager does not attend in person, the NIC must document the detail of conversation and decisions agreed as per telephone conversation.

Nursing Team

- Monitor physical and mental state presentation of person via observations
- Inform and update professionals and NOK
- Complete and review seclusion care plan
- Completion of documentation

- Commence 1:1 observations at commencement of seclusion
- Registered nurse must monitor and observe the person in seclusion
- An observation record must be documented at a minimum of every 15 minutes
- NIC must complete formal hourly review
- NIC and further RN (ideally one not involved in decision to seclude) will undertake formal 2 hourly review

Internal IDT

- Review seclusion period and incident that led to seclusion
- Review care plan and ensure appropriate actions in place to terminate seclusion at earliest opportunity
- Document any actions required

- An initial internal IDT review of the need for seclusion will be carried out as soon as practicable once the seclusion period commences.
- An internal IDT review will include the person's doctor, nurse in charge, and other IDT professionals who may usually be involved with the person
- An internal IDT review should take place once in every 24 hour period of continuous seclusion

Independent IDT

- Independent professionals **not** involved in initial incident or that led to decision to seclude
- Review seclusion period and incident that led to seclusion
- Review care plan and ensure appropriate actions in place to terminate seclusion at earliest opportunity
- Document any actions required

- An independent IDT review should take place where a person has been secluded for 8 hours consistently or 12 hours intermittingly during a 48 hour period
- Even if the seclusion period has since ended, once a trigger point has been reached, the review must be held. If the seclusion period is ongoing then the independent IDT review should make recommendations as appropriate to the seclusion care plan

Quick reference guide– Care of the person in seclusion

During a period of seclusion, staff must ensure that a good level of care is maintained and delivered, ensuring that their privacy and dignity is maintained. The health, safety and wellbeing of the person is paramount.

Clothing

-If there are any concerns regarding use of clothing as potential ligatures or concealing of unsafe items

- Follow local organisational policy Search procedures
- Document if anything found during search that is deemed unsafe
- If any items or clothing deemed unsafe and require removal due to potential to compromise safety then they must be removed by staff who have received appropriate training and are competent
- Privacy and dignity should be maintained at all times
- If tear proof clothing is required then this must be provided

Personal Care/Elimination

- Encouragement and prompting for individual to meet personal care needs
- Support for individual where required
- Access to appropriate items/resources

- Privacy and Dignity should be maintained at all times
- Providing of resources i.e. hygiene products to support person to meet their needs
- Support individual as required to meet personal care and elimination needs

Food/Fluids

-All meals and drinks must be provided as normal

- All offers/acceptance and refusal of food and fluid items should be documented within the seclusion observation form and within the person's records
- Consider use of fluid chart to monitor and document fluid intake and promote adequate fluid intake as required
- Safe to use crockery and utensil items provided

Safety

- Any potential risk to the person
- Deterioration in clinical presentation

- If there is an identified risk to the person at any time then the seclusion room must be entered at the earliest and safest opportunity (Staff must have complete required training and be deemed competent)
- This will be a decision based on clinical judgement and need to maintain safety of the person whilst in the seclusion room.

Quick reference flowchart – Termination of Seclusion

Seclusion must be terminated at the earliest opportunity when it is no longer assessed as required. Seclusion can be terminated by one of the following:

- Nurse in Charge
- Doctor
- Medical Review
- Internal IDT Review
- Independent Review

Seclusion terminated

Yes

No

Identify management plan to safely support person following termination of seclusion and reintegration into general ward setting. Including offering/planning to support person in preferred activities, having meals with others and engaging in therapeutic activities with staff

Nursing team to complete relevant documentation:

- NIC must document termination on observation record
- Complete documentation in person's care plan
- Body chart
- Incident form
- Clinical Observations on NEWS Chart
- Inform NOK (as appropriate)

The seclusion room/area must be reviewed, maintenance record complete and cleaning complete in line with IPC procedures

Ensure debriefing process is completed with both the person and staff involved. All efforts to promote and encourage completion of debriefing but where person has not engaged should be documented

Incident review must be complete post seclusion period.

- Within 72 hours
- Person's thoughts/views included
- Identified learning

Completion of seclusion audit tool.

Quality assurance against regional operating procedures

Continue with review process and continue to monitor person, follow seclusion care plan and utilisation of de-escalation strategies and outline of actions that will continue to support termination of seclusion at earliest opportunity.

Appendix 8 - References

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Appendix 9 – Relevant Legislation

Legislative Context

Relevant legislation and Guidance should always be adhered to and staff should ensure that they are up to date with the most up to date Legal framework relating to use of Seclusion.

Criminal Law Act (1967)
Data Protection Act (2018)
Disability Discrimination Act (1995)
European Convention on Human Rights
Mental Capacity Act (Northern Ireland) 2016
Mental Capacity Act (Northern Ireland) 2016 – Deprivation of Liberty Safeguards – Code of Practice
Mental Health (Northern Ireland) Order 1986 and Code of Practice
Northern Ireland Act 1998
Northern Ireland Children's Order (1995)
Race Relations (Northern Ireland) Order (1997)
Section 75 of the Northern Ireland Act (1998)
Special Educational Needs and Disability Act (Northern Ireland) 2016
The Age of Majority Act (Northern Ireland) 1969
The Children (Northern Ireland) Order 1995
The Children (Secure Accommodation) Regulations (Northern Ireland) 1996
The Criminal Justice (Children) Northern Ireland Order 1998
The Day Centre Setting Regulations (Northern Ireland) 2007
The Equality Act 2010
The Health and Personal Social Services (Quality, Improvement and Regulation) (Northern Ireland) Order 2003
The Health and Safety at Work Act 1974
The Human Rights Act (1998)
The Protection of Children and Vulnerable Adults Order (Northern Ireland) 2004
The Public Order (Northern Ireland) Order 1987
The United Nations Convention on the Rights of the Persons with Disabilities, 2006
United Nations Convention on the Rights of the Child 1989
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Appendix 10 - Acknowledgements

Rosaline Kelly	Author and Project Lead
Amanda Scott	Author and Project Manager
Claire Henry	Project Officer

The Project Team would like to offer thanks to those professionals, service user representatives, family members, carers, and other organisations who contributed to the guidance document through focus groups and staff engagement events.

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ArcNI	Bryson House	VOYPIC
Cause	Mencap	

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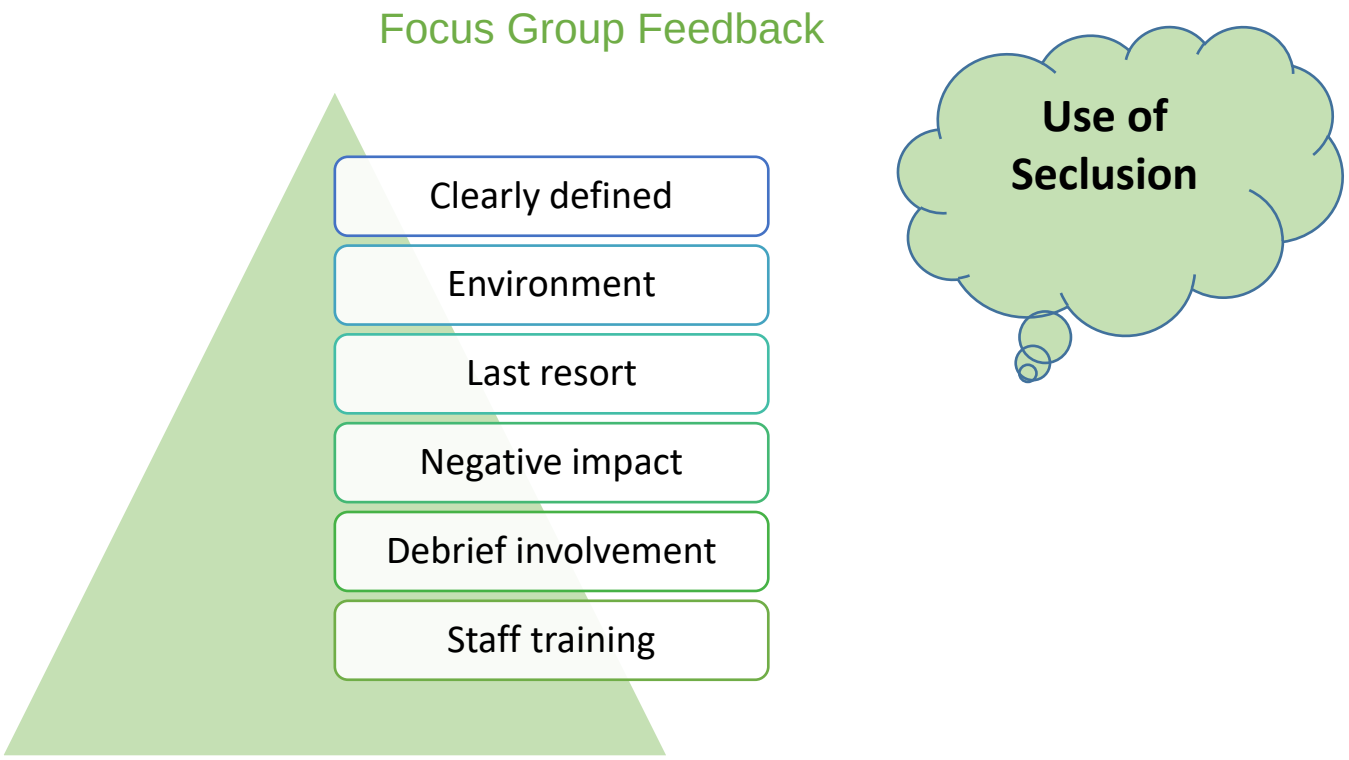
Appendix 11 – Themes and Feedback



All focus groups agreed that seclusion should only be used as a last resort once all other methods had been exhausted.

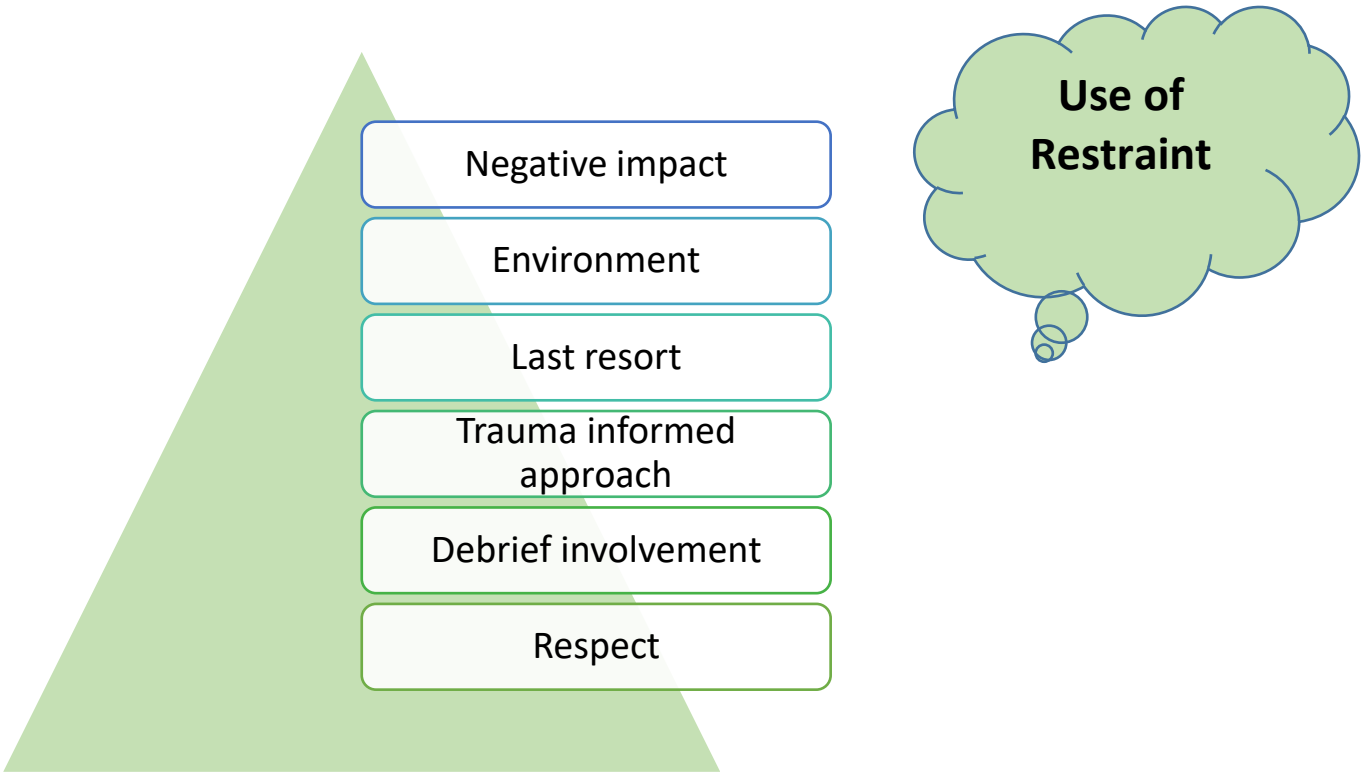
Focus groups agreed that reasons for using seclusion should clearly be defined and communicated to the person, their families and carers.

Focus groups fed back that seclusion had a negative impact on their health and wellbeing and in some cases made them feel worse.

Seclusion rooms have been described as “cold, dark, lonely, disgusting, like a jail”. A low stimulus room would be nice. Comfortable, safe, calming, with drinking water available. Possibly slow, quiet, calming music in the background.

Staff should know their patients and their specific needs; this would help to avoid incidents arising as staff would be able to recognise triggers. Staff should try to deescalate in the first instance. Focus groups members did recognise that sometimes staff are at risk too but felt that staff need more training.

Feedback suggested that staff should have conversations and a debriefing process should be completed, with the person and their families/carers, whenever an incident occurrs.



All focus groups agreed that restraint should only be used as a last resort, however members agreed that sometimes there is a need for restraint, especially if someone may hurt themselves or others.

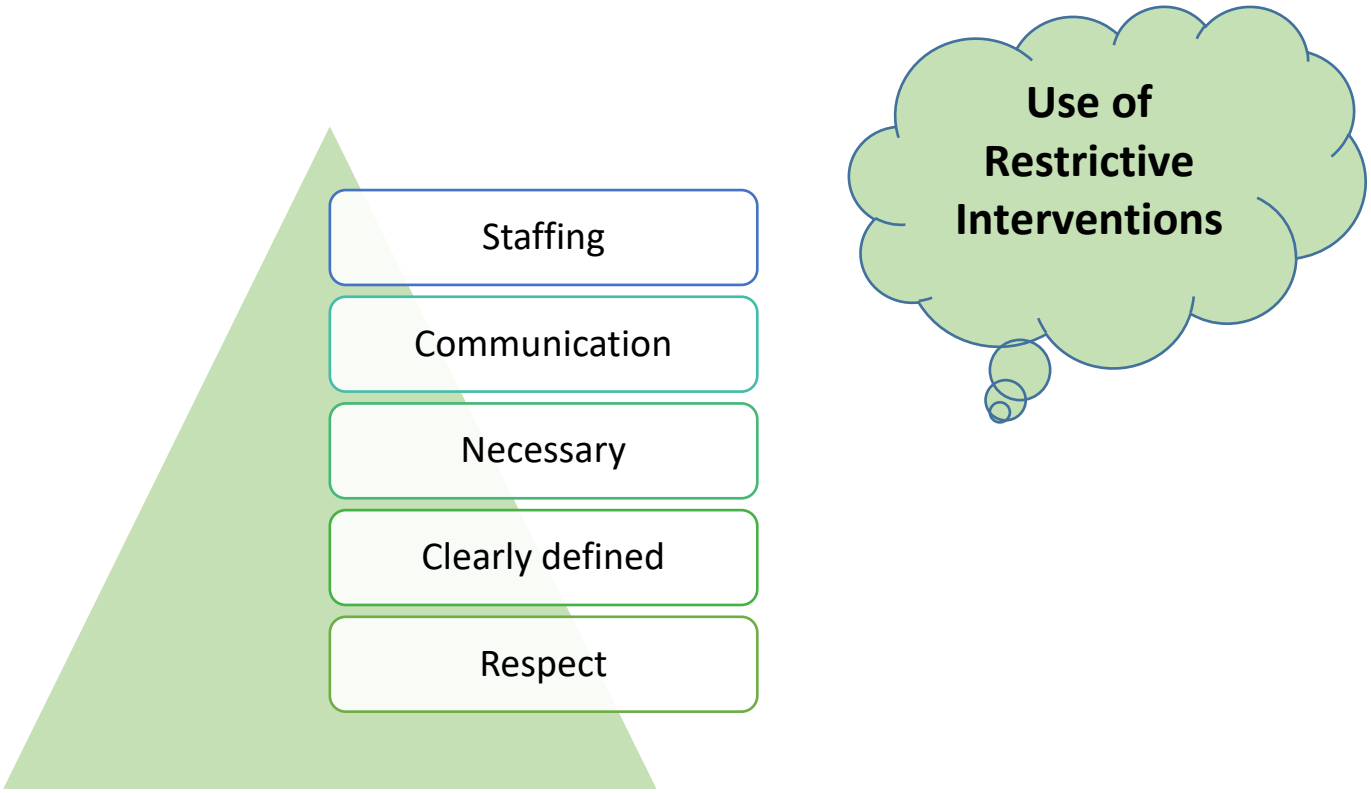
Accommodation or the environment in which a person is living should be spacious to help de-escalate emotion and reduce any potential for physical or chemical restraint.

All focus groups agreed that being restrained was negative to a person's health and wellbeing.

Group participants called for a trauma-informed care approach in order to help identify triggers and encourage sensitivity in approach.

Families should be informed about any use of restraint to discuss what and why, in order to create better understanding.

Focus groups said they realised staff were at risk of being hurt, but they want to be respected and listened to.



Feedback suggested that staff don't always have enough time and felt that staff shortages should not affect them being able to live their life or restrict their movements.

Focus group participants acknowledged that sometimes restrictive interventions are needed in order to keep individuals well, like sleep hygiene, but suggested restrictive interventions should be reviewed every fortnight/month.

Participants suggested there should be better communication between staff and patients. They thought staff should be explaining why they are taking things away or locking doors.

Feedback asked for clearer definitions of restrictive interventions and suggested that any restrictions should be agreed to through dialogue and not just enforced.

Feedback suggested that staff should be respectful of age and patient needs for example accommodating for later bedtimes, allowing freedoms like accessing beverage making facilities or items that are self-soothing.

Focus group feedback included suggestions regarding the use of developing technology in accommodations, such as use of keypads, water taps being on a timer, showers on a timer and better monitoring devices.

Staff Engagement Day

Feedback from breakout room discussions

It's important to identify and explore options around practises, while balancing risk and safeguarding patients.

We need to ensure all interventions are captured consistently.

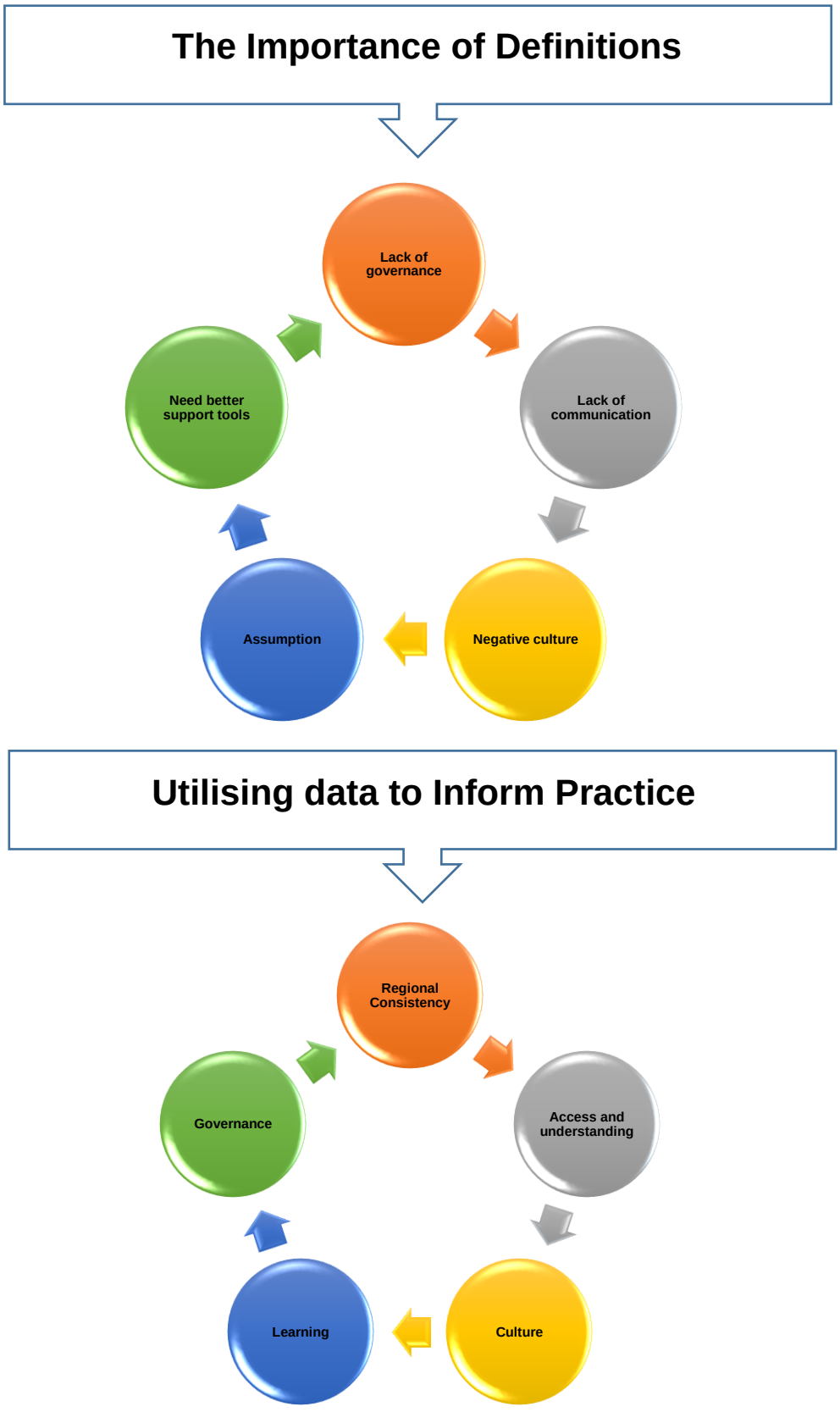
Human rights for patients starts on ground floor.

Better leadership to help staff to feel valued.

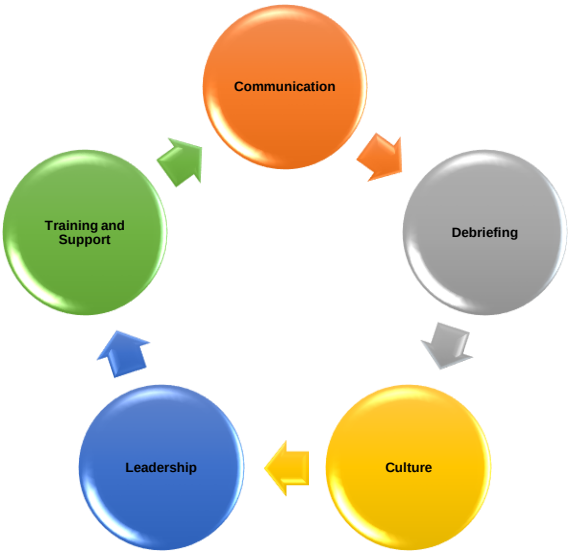
It's important to view the person as human.

There should be clearer evidence of how you're actually supporting people.

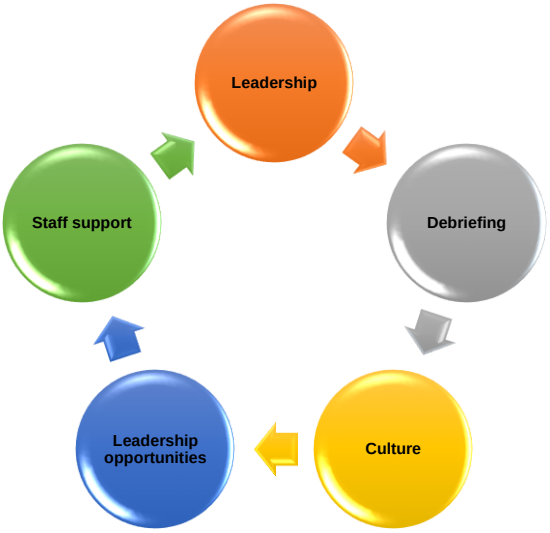
Emerging Themes



How human rights affects those that we care for



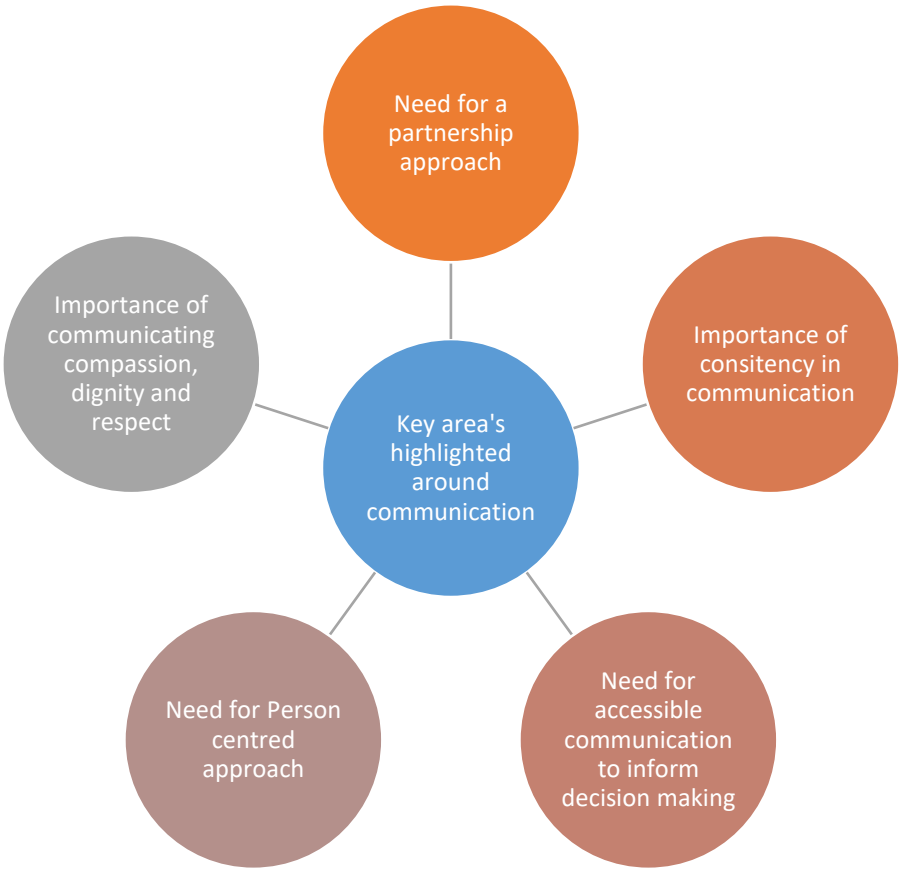
Supporting Cultural Change



Communication Sub-Group Feedback

Throughout engagement with those who helped develop this policy, communication was a repeated theme. Reports of poor communication impacting on the quality-of-care delivery could be rectified by a partnership approach and regular, authentic communication that will assist informed decision-making, allowing for more person-centred, more therapeutic and less restrictive alternative strategies to be agreed.

This is considered critical to minimising restrictive interventions.



Whilst not everyone expressed a negative experience, it was agreed that this did not suggest that improvements in effective communication would not be important.

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