Barnet, Enfield and Haringey NHS
Mental Health NHS Trust
A University Teaching Trust

Restrictive Practice Guidance: Current Inpatients Positive and Suspected for COVID-19

Background

The current Covid-19 situation will have some serious implications when providing care to service users who are suspected or confirmed to have contracted the corona virus (Covid-19).

This guidance is to act as a framework for the purpose of isolating patients through least restrictive interventions. This document should be used in conjunction with Trust relevant policies and the National Association of Psychiatric Intensive care & low secure units (NAPICU) guidance that can be found at https://napicu.org.uk/wp-content/uploads/2020/03/COVID-19_guidance_appendix.pdf

This guidance therefore intends to provide support to ongoing response planning and decision-making to ensure that ample consideration is given to a series of clinical, ethical values and principles when organising, planning and implementing in-patients isolation within the Trust. This framework is intended to serve as a guide for decisions around restrictive practices and the consideration of any potential harm that might be suffered and the needs of all individuals.

Abbreviations:

MCA: Mental Capacity Act

MDT: Multi-Disciplinary Team

MHA: Mental Health Act

MHA CoP: Mental Health Act, Code of Practice

NAPICU: National Association of Psychiatric Intensive care & low secure units

PBS: Positive Behaviour Support

PPE: Personal Protection Equipment

Initial frame work of considerations

As experience increases, the approaches and techniques that are effective for supporting patients experiencing acute disturbance who also present infection risks will improve.

Of particular concern, are those who are experiencing acute disturbance and;

a) represent COVID 19 infection risk to others, or;
b) who are in a high risk group for infection.
c) who are in a ward that is “locked down” or “self-isolating”

Covid-19

Some of the key symptoms of Covid-19[1]:

- **a high temperature** – this means feeling hot to touch on the chest or back
- **a new, continuous cough** – this means coughing a lot for more than an hour, or 3 or more coughing episodes in 24 hours (if already presenting with a cough this may be worse than usual)
- **Headache**
- Shortness of breath- breathing difficulties
- Muscle pain and tiredness

Coronavirus seems to start with a fever, followed by a dry cough and then, after a week leads to shortness of breath[2]. Table 1 is a comparative illustration of Covid 19 symptoms compared to other common conditions.

[1] Public Health England: https://www.nhs.uk/conditions/coronavirus-covid-19/

[2] World Health Organisation

COVID-19 symptoms compared to common conditions

SYMPTOM	COVID-19	COMMON COLD	FLU	ALLERGIES
Fever	Common	Rare	Common	Sometimes
Dry cough	Common	Mild	Common	Sometimes
Shortness of breath	Common	No	No	Common
Headaches	Sometimes	Rare	Common	Sometimes
Aches and pains	Sometimes	Common	Common	No
Sore throat	Sometimes	Common	Common	No

Table 1: Symptoms of Covid-19

Legal and ethical considerations

The interventions and management plans that may be required to safely care for this particular group of patients whilst also minimising the risk of spreading the infection could present ethical and legal challenges in respect to professional practice, the MCA and the MHA.

The following guidance represents an initial description of the issues that may be helpful. This guidance aims to provide a guide to considering some of the ethical, legal and practice issues at a time when legislation is currently being reviewed and drafted.

It is expected that as experience of supporting patients exhibiting acute disturbance who may also represent a COVID-19 infection risk increases, national, local and professional guidance will be further revised, amended and developed.

Hierarchy of response for acutely disturbed patients who may also be an infection risk regarding COVID-19

Interventions for supporting patients can be divided into;

a) Primary,
b) Secondary and
c) Tertiary interventions.

This approach is similar to when engaging with patients who do not present an infection risk of COVID-19, although the additional considerations arising from infection risk are the focus of this guidance. Table 2 is a summary of the hierarchy of interventions for supporting patients in the context of Covid-19 situation.

Primary Interventions	Secondary Interventions	Tertiary Interventions
Engaged in information sharing and preparation for potential isolation and the risks of infection, i.e. change of ward, use of PPE	Identification of patients who may present risks of infection through a robust checklist of symptoms	This level of intervention applies to patients who are positive for Covid 19 and persistently resisting any isolation plan. Staff will continue to use the principles of *Safewards* and PBS to support patients.
New admissions to go through a checklist of symptoms and history	Identification of high risk patients as described by Public Health England and the subsequent physical health monitoring	While all efforts would be to avoid tertiary interventions it may be necessary to consider the use of segregation/and or seclusion.
Conduct a formal capacity assessment (capacity to understand Infection control measures, purpose of isolation, capacity to engage an advance statement) which is documented in patient notes. Consider developing an advance statement/directive	Specific care plans for when infection risks are confirmed. These care plans should be aimed at maintaining cooperation and diminishing the need for physical intervention. Considering a hierarchy of interventions as in Appendix 1	Patients may have to be transferred to Shannon ward or nursed in locked bedrooms The use of PPE to be used at every point of potential infection
Discuss infection control measures such as social distancing, handwashing, personally allocated utensils for dietary/fluid intake	Consider ward isolation or a transfer to Shannon ward. The use of PPE is required	If the use of IM medications is required then staff will follow medical advice and pharmacy guidance.
Staff to continue with *safewards* and positive behaviour support plans	Consider activities/items for patients that would improve cooperation and engagement during isolation. In some cases where for instance a mobile phone, as a restricted item, may be	

	allowed to certain patients.	
MDT approach to developing ward activities	If a patient disagrees with Covid 19 care plans and a risk of infection is robustly established, this is considered as a cogent reason to depart from the Code's definition of seclusion	
	If the patient lacks capacity, staff to make best interest decision	
	Departure from Chapter 26 of MHA Code of Practice (, 2015) and the Trust seclusion & Long Term segregation S policy can be considered under the governance of the Trust Ethics and decision making committee. Application of the MHA CoP to be used in the context of 'The Health Protection Coronavirus Regulations, 2020' https://www.legislation.gov.uk/uksi/2020/129/regulation/8/made	Departure from Chapter 26 of MHA Code of Practice (2015) and the Trust seclusion & Long Term segregation S policy can be considered under the governance of the Trust Ethics and decision making committee. Application of the MHA CoP to be used in the context of 'The Health Protection Coronavirus Regulations, 2020' https://www.legislation.gov.uk/uksi/2020/129/regulation/8/made

Table 2: Summary of the hierarchy of interventions

Inpatients with possible or suspected Covid-19

Patients who are suspected or confirmed with the corona virus will be nursed on Shannon ward and will have access to the ward areas. However, in situations where patients' isolation is required in other areas of the Trust, it is incumbent upon staff to ensure that necessary arrangements are in place to ensure a safe and therapeutic approach to isolation. Wards may need to think of equipment such as I-Pads, TVs and other appropriate measures to keep patients busy with some form of meaningful activities. Occupational Therapists are also developing packs to help with this; and additionally all wards would have inside out booklets (https://insideguide.nhs.uk/home/) that can be used accordingly.

In some cases, it may be possible to use a separate room or area during patients' isolation. This process will be based on a risk assessment and the principle of minimising risks.

It is expected that isolation can cause added anxiety, stress and frustration to our service users. Therefore, staff should ensure that there is on-going communication with service users providing reassurance and updates.

Inpatients positive for COVID-19 who refuse to self-isolate:

Core principles:

It is anticipated that in situations where service users lack capacity and/or refuse to self-isolate, there would be some challenges and staff will need to address this on a case to case basis. Appendix 1 provides an illustration of the escalation process. Table 1 summarises the stages of interventions in extreme cases.

It is advised that interventions are informed by a thorough risk assessment of the individual's physical and mental health; and a measured approach is taken to maintain safety and minimise risk to the individual and others.

A capacity assessment would assist in the decision making process and in some cases a best interest discussion may help. However, actions and interventions will need to be reasonable, necessary and proportionate to the risks.

Staff should have strategies in place if situation escalates detailing the most appropriate response in that particular context.

Rights based framework for formulating care plans:

To consider:

- What are the clinical, ethical and legal basis of the restriction/isolation and the subsequent proposed care plans?
    - Seclusion and Long term segregation policy
    - MHA
    - Capacity assessment
    - Public Health England Legislation - Isolation on the basis of positive test for Covid-19

- What are the aims of the intervention and how would this be achieved?
    - Protection of vulnerable patients
    - Duty of care

- Preventing the spread of Covid-19
- Maintaining parity of esteem between mental health and physical healthcare.

- Have any other alternative considered to achieve the stated aims?
  - Can the patient be discharged?
  - Use of PPE in cases of refusal to isolate
  - Moving vulnerable patients to other wards
  - Use of seclusion where appropriate
  - Use of rapid tranquilisation

Seclusion vs. Isolation on the basis of infection control:

A confirmed Covid-19 test would not in itself warrant seclusion under the Mental Health Act provisions.
Patients who have tested positive for Covid-19 and who are isolated on the basis of infection control guidance/ advice are done so on the basis of the Health Protection (Coronavirus) Regulations (2020). The expectation is this would occur in a patient's bedroom or area of a ward rather than a seclusion room. This does not constitute seclusion under the MHA and seclusion policy and procedures do not apply. However, if patients are being locked in their bedrooms then this would constitute seclusion and this practice needs to be recorded and reported as such.

Definitions:

"Seclusion"

Seclusion refers to the supervised confinement and isolation of a patient, away from other patients, in an area from which the patient is prevented from leaving, where it is of immediate necessity for the purpose of the containment of severe behavioural disturbance which is likely to cause harm to others in a specified area. [3]

'Isolation'

Isolation is used to separate ill persons who have a communicable disease from those who are healthy. Isolation restricts the movement of ill persons to help stop the spread of certain diseases. In this context it is the Covid-19.[4]

[3] MHA Code of Practice 26.103

[4] Public Health England

When seclusion may be considered:

Where a person has a mental disorder, lacks decision-making capacity and is posing an immediate risk to others.
For example, a current in-patient, detained under the MHA, who does not co-operate with self-isolation guidance because of a lack of understanding resulting from their mental incapacity and is posing an immediate risk to others.
In this context a departure from the MHA CoP may be appropriate provided the cogent reasons/justifications are clearly documented and communicated to the ethical decision making committee. Normally this decision would be made by the nurse in charge in consultation with the junior Doctor. Any departure from MHA CoP should be documented on Ulysses under the category 'Covid-19' by the nurse in charge.

Inpatient positive for COVID-19 who may require seclusion:

We believe if *Safewards* model or Positive Behaviour Support is used on the ward it would help support service users with behaviours of concerns. However, if a patient positive for Covid-19 becomes violent or aggressive and poses an immediate risk to others they may need to be secluded to uphold the safety of others on the ward. In such circumstances the following guidance applies.

1. Reviews must continue in line with the MHA Code of Practice and the Trust Seclusion and Long Term Segregation Policy.
2. The clinicians leading the review must attend in person and as a minimum conduct the review from outside of the seclusion room using the intercom system.
3. The number of reviews in which staff physically enter the room should be minimised in order to reduce the risk of transmission. As such 2 hourly nursing led reviews can be conducted without entering the room as long as the presentation of the patient does not indicate the need for a contact review as per point 5. See non-contact reviews below for guidance.
4. As a minimum during all doctor led (medical) reviews, staff must enter the room to carry out physical observations, providing food and fluids and review the patient. The use of PPE applies. (https://www.youtube.com/watch?v=8jz0ecujwtY&feature=youtube)
5. However, if any of the following apply staff must enter the room;
    - Medical emergency
    - Full physical observations are required as per regular monitoring or indicated by patient presentation
    - The person requires/ requests food and/or fluids
    - The room needs cleaning – this will need to happen at least once a day but may also need to be carried out in response to the patient's presentation.
    - Medication is due to be administered

Seclusion Reviews:

The aim is to minimise contact with the patient whilst upholding their rights under the MHA and to ensure their care and safety two types of review will apply.

1. Non-Contact Reviews:

Non-contact reviews will involve reviewing the patient without entering the seclusion room itself.
All non-contact reviews must be attended by:

- The nurse in charge of the ward,
- The Duty Senior Nurse
- A medical doctor OR an Approved Clinician or Responsible Clinician as per trust protocol.

A non-contact ABCDE physical assessment must be conducted and recorded.
Mental state assessment conducted and recorded as per normal review procedures.
Decision to terminate seclusion will undergo normal review procedures. Please refer to the Trust Seclusion and Long Term segregation policy.
Immediate actions and longer term care plan that will enable ending of seclusion as per normal review procedures.

2. Contact Reviews:

For reviews which will involve staff members entering the seclusion room normal procedures for seclusion reviews will be followed. However, all staff involved in the review must
Wear PPE as per infection control guidance and follow barrier nursing protocols.
Procedures for putting on and taking off PPE must be adhered to.
The number of staff entering the seclusion room should be the minimum required to safely conduct the review.
Where possible it should be staff members from the ward rather than the emergency team and the same staff members should form the reviewing team for the duration of the shift (so as to minimise the number of staff members having contact with the patient).

Further support and guidance:

For further help with decision making around use of restrictive practices in inpatients positive for Covid-19 please contact:

Monday – Friday 09.00- 17.00

1. Ward Managers/ Team Leaders

2. Modern Matron
3. Head of Nursing
4. Nurse Consultant (Positive and Safe)

Out of hours:

Manager on call
Unit co-ordinator

Useful references/guides:

1. Royal College of Psychiatrists : https://www.rcpsych.ac.uk/about-us/responding-to-covid-19/guidance-for-clinicians/community-and-inpatient-services-covid-19-guidance-for-clinicians
2. Restraint Reduction Network:https://restraintreductionnetwork.org/uncategorized/comment-on-the-potential-impact-of-covid-19/
3. Royal College of Nursing: https://www.rcn.org.uk/clinical-topics/mental-health/covid-19-guidance. COVID-19-Guidance-for-inpatient-mental-health-staff.pdf
4. National Association of Psychiatric Intensive Care & low secure unite : https://napicu.org.uk/wp-content/uploads/2020/03/COVID-19_guidance_appendix.pdf
5. BEH-MHT Seclusion and Long Term segregation policy: http://staff.beh-mht.nhs.uk/Downloads/Policies%20and%20procedures/Clinical%20care%20and%20practice/Seclusion%20Policy%20.pdf

Appendix 1

COVID 19 Restrictive Interventions flow chart