Covid-19 Temporary Changes to Arrangements for Seclusion Reviews

Background

Chapter 10 of the Trust's Seclusion Policy sets out our local arrangements for the observation and review of patients in seclusion, in line with the detailed guidance on the subject in Chapter 26 of the MHA Code of Practice.

The significant pressures on staffing levels arising from the current Covid-19 outbreak are presenting providers with an unprecedented imperative to ensure staffing resources are directed where they are most needed to protect the lives of service users, and this inevitably involves making difficult choices about which procedures are not currently tenable. The purpose of this document is to propose temporary changes to our arrangements for seclusion reviews which, in this context, may be justified as cogent reasons to depart from the relevant provisions of the MHA Code of Practice.

Amended Chapter 10 of Seclusion Policy

10.3 Nursing Reviews

Nursing reviews of the secluded patient should take place at least every two hours following the commencement of seclusion. These should be undertaken by two registered nurses, one of whom should not have been involved directly in the decision to seclude; or, in exceptional circumstances during the pandemic, where two registered nurses are not available, by one registered nurse who was not involved in the original decision to seclude.

10.4 In the event of concerns regarding the patient's conditions, this should be immediately brought to the attention of the patient's RC or the duty doctor.

10.5 When patients in seclusion are asleep, seclusion reviews should take place at the designated times. However, whilst the reviewing team are risk managing the situation all efforts should be made to enter the seclusion room or at least review via an open seclusion door. If the patient in seclusion is asleep the management plan needs to reflect why & how this sleep could be disturbed as the patient may have been in a state of excited delirium previously and may benefit from this sleep. The reviewing team though must observe signs of the patients' physical wellbeing for example; breathing, movement etc. Any decision not to wake the patient must be taken after both the nurse in charge and the site (unit) coordinator/ward manager, observe the patient through the seclusion room observation panel/CCTV and the decision with rationale must be clearly documented in the RIO progress notes.

10.6 **Medical reviews**

Unless seclusion was authorised by a psychiatrist, a seclusion review will be undertaken by a doctor within the first hour of seclusion commencing, or without delay if the patient is newly admitted, not well known, or if there is a significant change in their usual presentation. [Chapter 26.116]

If after the first medical review the decision is that seclusion should continue then a seclusion care plan should be developed in collaboration with nursing staff.

The Trust has determined that all medical doctors, irrespective of grade, or level of registration will be considered competent to undertake medical reviews on the provision that they meet the following criteria:

- **Have read this policy**
- **Have access to senior medical (consultant) advice at all times**
- **Have access to senior nursing advice at all times**

As long as a responsible clinician was a member of the internal MDT, further medical reviews should take place at least twice in every 24 hour period from the time of the first internal MDT review [Chapter 26.132].

If an SpR or Associate Specialist was the most senior doctor in the first internal MDT, then further medical reviews may revert to twice in every 24 hour period upon the discretion of the doctor.

At least one of these twice daily reviews should be by the patient's Responsible Clinician, or other consultant on call [Chapter 26.132]
If it is not possible to undertake a medical review at the specified time, consideration may be given to undertaking a review earlier than the scheduled time.

The frequency of medical reviews may be increased based on the current clinical circumstances.

10.7 When patients in seclusion are asleep, seclusion reviews should take place at the designated times. The nurse in charge and reviewing doctor may agree not to wake the patient to undertake the review where the nursing and medical observations give no cause for concern, taking into account the patient's recent history and any relevant history of physical illness. Any decision not to wake the patient must be taken after both the nurse in charge and reviewing doctor observe the patient through the seclusion room observation panel and the decision with rationale must be clearly documented in the RIO progress notes. (**Appendix 5)**

10.8 Medical reviews provide the opportunity to evaluate and amend seclusion care plans (see paragraph 7.12). They should be carried out in person and should include, where appropriate:

- a review of the patient's physical and psychiatric health
- an assessment of adverse effects of medication
- a review of observations required
- a reassessment of medication prescribed
- an assessment of the risk posed by the patient to others
- an assessment of any risk to the patient from accidental or deliberate self-harm
- an assessment of the need for continuing seclusion, and where it is possible, for seclusion measures to be applied more flexibly and in a less restrictive manner (see paragraph 8.5 above).

During the Covid-19 pandemic, a review counts as being conducted 'in person' provided that the reviewer(s) are able to observe and listen to the patient and discuss them with the team. This could include the use of video calling (e.g. Skype / Teams) but a telephone call alone would not suffice.

All medical reviews must be clearly documented in the patient's RiO progress notes by the reviewing doctor. (**Appendix 5)**

10.9 Internal Multi-Disciplinary Team (MDT) Reviews

The first internal MDT review should be held as soon as is practicable and should be within 4 hours of seclusion commencing. Membership of this MDT should include the responsible clinician, a doctor who is an approved clinician, or an approved clinician who is not a doctor but who has appropriate expertise, the senior nurse on the ward, and staff from other disciplines who would normally be involved in patient reviews. At weekends and overnight, membership of may be limited to medical and nursing staff, in which case the senior site manager or equivalent) should also be involved. If the patient's usual responsible clinician is not available for the review, another ward doctor or the duty doctor may undertake this review.

For best practice, we would advise that patients who enter seclusion between 9am-5pm (any day), a consultant review is undertaken by 5pm. Within working hours, this would be the patient's usual consultant or a covering consultant if the usual consultant is not available. Out-of-hours, the on-call consultant will be the patient's Responsible Clinician. For best practice, we would also advise that if patients enter seclusion before 9pm (any day) and have not already had a consultant review, a SpR review is undertaken. Please see section 10.13 for the minimum requirements for the timing of Consultant and SpR reviews.

10.10 Where seclusion continues, these reviews should evaluate and make amendments, as appropriate, to the seclusion care plan.

10.11 Independent Multi-Disciplinary Team Review

10.12 An independent MDT review should be undertaken where a patient has been secluded for 8 hours consecutively or for 12 hours intermittently during a 48-hour period. This should be undertaken by the end of the next working day after commencement of seclusion.

10.13 Membership of the independent review will comprise, at a minimum: a senior nurse, a consultant psychiatrist, a clinician who is neither a doctor nor a nurse (none of whom being involved in the incident which led to seclusion), and an IMHA (if the patient has one). Note that in the vast majority of cases, the patient's usual responsible clinician can be the consultant psychiatrist on the independent MDT as long as they were not involved in the incident which led to seclusion. It is good practice for the independent MDT to consult those involved in the original decision.

The minimum requirements for review are as follows- if the timing of the independent MDT review falls:

1) Between 9am - 5pm- consultant psychiatrist to undertake review (this will be the on-call Consultant on weekends or bank holidays)
2) Between 5 - 9pm – If the patient has not already had a consultant seclusion review, the on-call SpR may undertake the review in place of the Consultant

3) Between 9pm and 9am – If the patient has not already had a consultant or SpR review, the duty doctor should continue 4-hourly reviews

A consultant review should then take place when best practicable during the subsequent day.

10.14 The independent reviews should evaluate and, if appropriate, make recommendations for amendments to the seclusion care plan. The outcome of the independent MDT review should be recorded in the patient electronic record (RIO) and communicated to the nurse in charge of the ward.