Brief guide: Long-Term Segregation

Context and policy position

This brief guide describes how to assess and report on issues arising from the management of patients in Long-Term Segregation (LTS).

The Mental Health Act (MHA) Code of Practice defines LTS as "a situation where, in order to reduce a sustained risk of harm posed by the patient to others, which is a constant feature of their presentation, a multi-disciplinary review and a representative from the responsible commissioning authority determines that a patient should not be allowed to mix freely with other patients on the ward or unit on a long-term basis". The criteria for using LTS should be that it has "been determined that the risk of harm to others would not be ameliorated by a short period of seclusion combined with any other form of treatment. The clinical judgement is that, if the patient were allowed to mix freely in the general ward environment, other patients or staff would continue to be exposed to a high likelihood of serious injury or harm over a prolonged period of time".

The Code provides detailed guidance about consultation and review over the imposition and continuance of LTS, which are included in the summary below. Providers can depart from this statutory guidance where they have a cogent reason to do so, in which case they should have made a record to support their action[1]. Following the last Code update in 2015, the Committee for the Prevention of Torture has also stated that it "understands that seclusion followed by LTS is supposed to be an extreme measure for patients who are considered to be a threat to themselves and/or to others", but that "*in certain cases*, the impact of LTS on patients amounts to inhuman and degrading treatment".

The CQC Position

The key test of whether a patient is segregated is ***whether they can leave the situation of being separated from others when they want to – that is, are they prevented by staff from leaving?*** The reference in the Code of Practice to the "need to reduce a sustained risk of harm posed by the patient to others" has led to some services not recognising as long-term segregation the care of some people **for their own benefit** (for example those with a learning disability or autism or both), even when they are not mixing freely with others on the ward/unit for long periods. Patients segregated to protect **them** from harm or self-harm are entitled to the same protection as those who pose a risk to staff and other patients. The safeguards set out in the Code should be applied to support the patient and reduce the need for continuing long-term segregation.

LTS has the potential, in individual cases, to amount to inhuman and degrading treatment;

- It could do so if it is applied when it is not necessary e.g. by continuing beyond the point where it is justified including delays where people are waiting for beds in other levels of security; or
- if it is applied in such a way as to be inhuman or degrading e.g. extended isolation from any human contact; lack of appropriate activity or diversion; lack of access to fresh air, etc. There is a particular risk that the effects of such privations on a patient in LTS create a circular effect of sustaining the behaviours that are believed to justify continued LTS.

[1] *MHA Code of Practice,* para 11

Brief guides are a learning resource for CQC inspectors. They provide information, references, links to professional guidance, legal requirements or recognised best practice guidance about particular topics in order to assist inspection teams. They do not provide guidance to registered persons about complying with any of the regulations made pursuant to s 20 of the Health and Social Care Act 2008 nor are they further indicators of assessment pursuant to s 46 of the Health and Social Care Act 2008.

LTS does not always mean constant separation from other service users. It may sometimes be used flexibly, as part of a graded therapeutic risk management plan where the degree of segregation varies dynamically with the service user's mental state and the risks perceived by clinical teams. This may allow nursing within the setting of least restrictive practice but provides sufficient risk management to prevent rapid transition back into more restrictive settings of seclusion.

Evidence required

- Data on number of incidents of LTS can be asked for prior to the inspection taking place.
- **Annex A** provides details of how to obtain relevant evidence on the rationale and review of LTS, appropriate involvement of other professionals, carers and families, and on care planning and the physical conditions of LTS.
- **Annex B** contains more detail on the rationale for the evidence required. It draws from The MHA Code of Practice (2015), the CPT report on the UK visit (March 2017)[2], and the NPM guidance on monitoring Isolation in detention (January 2017)[3]

Reporting

- In the 'safe and clean ward environment' section of 'safe', comment on whether the environment for long term segregation meet the expectations of the Code of Practice.
- In the use of restrictive interventions section of 'safe' report how many episodes of LTS took place. State the change in number of uses of long-term segregation in this core service over time.
- In the safeguarding section of 'safe' report on the evidence that the local safeguarding team has been notified of all episodes of LTS.
- In the assessment of needs and planning of care section of 'effective' describe the quality of the LTS care plan. Ensure it includes access to appropriate activities and occupation. Look for a care plan that describes what needs to be achieved for LTS to be terminated.
- In the governance section of 'well-led' comment on whether the provider monitors the use of LTS.
- State whether LTS was used in the service, describe conditions under which patients were held in LTS, describe the nature and quality of the system for instigating and reviewing LTS and note whether LTS was extended due to transfer delays to higher security.

Links to regulations

CQC should consider taking action under:

- **Regulation 9 (1)(3)(a)** where providers/staff are not working collaboratively with the patient to develop and deliver the care plan.
- **Regulation 13** where providers/staff are not safeguarding patients from inhumane or degrading treatment.
- **Regulation 15(1)(c)** where the facilities do not promote recovery, privacy and dignity. Or consider **Regulation 10(1)(2)(a)(b)**
- **Regulation 17 (1)(2)(a)(b)(f)** when the provider does not assess and monitor the use of LTS especially in relation to the welfare of the patients and does not evaluate and improve their practice as a result.

[2] http://www.coe.int/en/web/cpt/united-kingdom

[3] https://s3-eu-west-2.amazonaws.com/npm-prod-storage-19n0nag2nk8xk/uploads/2017/02/NPM-Isolation-Guidance-FINAL.pdf

Annex A: Evidence required on LTS: a guide for Inspection Teams

1) Data on number of cases of LTS (this can be asked for prior to the inspection taking place as part of the data gathering exercise)
   - Ask for records outlining the number of people in LTS and the total number of days collectively spent in LTS over the past 6 months or a year if available.
   - If the data is available, compare both number of episodes of LTS and total number of days spent in LTS with data from preceding years to understand whether the incidence of LTS is increasing or decreasing.
   - If there are patients in LTS who are spending some of their day 'in association' with other patients, or otherwise out of LTS, the number of hours per day spent out of LTS and evidence that this is being used to understand and monitor patient progression.
   - Except where the inspection is of a High Secure Hospital, note whether LTS is or has been used to contain a patient who is awaiting transfer to higher security or specialist services. If so, ask for length of any such LTS episodes and whether there are/were delays in the transfer.

2) For patients currently or recently in LTS (sampling may be appropriate where there are larger numbers):

   2a) Examine care plans and/or written notes for evidence of the following:
      1. A clear rationale for why LTS was started.
      2. Evidence that, where appropriate, carers or family have been consulted before starting LTS.
      3. A care plan that focuses on what needs to be achieved for LTS to be terminated (in some cases, this will be through graduated periods out of segregation, to avoid too rapid termination resulting in more restrictive periods of seclusion). In all cases, the care plan should focus on dynamically understanding the conditions of least restrictive practice, showing evidence of primary, secondary and tertiary preventative strategies that can be acted upon by staff.
      4. A care plan that includes access to occupational therapy and appropriate activities while in LTS
      5. Focused therapeutic plans with access to both psychological and pharmacological treatments where appropriate.
      6. Evidence that the local safeguarding team has been notified regarding the LTS.

   2b) Examine the facilities in which they LTS takes place:
      1. Look for evidence that there is access to a secure outdoor space, a bathroom, a bedroom and a lounge area.
      2. Look for evidence that therapeutic activities are being provided and that patient has access to staff and are not isolated from human contact for long periods.
      3. Look for evidence that the patient as received appropriate health care including; screening programmes, physical and mental health, dental and optical care.

2c) Ask to see evidence that appropriate internal reviews are taking place (this could be in progress notes or elsewhere). These should include evidence of:
1. Hourly documentation of the patients' condition by observing staff.
2. Appropriate monitoring of physical health (e.g. regular physical observations, food and fluid charts if appropriate).
3. A review by an approved clinician every 24 hours.[4]
4. A weekly review by a multi-disciplinary team including an IMHA if the patient has one
5. Periodic reviews (the code of practice does not outline the timescale) by a professional not involved with the case.
6. All reviews would record the reason why continued segregation is required and best practice would link this to the care plan as described in point 2(a)(3) above.

2d) Ask to see evidence that appropriate external reviews are taking place (this could be in progress notes or elsewhere) for those patients that have been in LTS for 3 months or more. These should include evidence of:
1. Review by an external hospital including discussion with commissioners and an IMHA every 3 months.
2. Where these reviews have taken place, evidence that the recommendations have been acted on and, if not, a robust justification as to why.

[4] There may be situations where there are cogent reasons for flexibility over such 'review'. We accept, for example, that in high secure hospitals, weekend medical cover (the on-call consultant) should not be expected to undertake a full review of all LTS cases with a view to ending them, as this is a matter that should be discussed with the wider care team. However, the on-call medical cover should be made aware of, and discuss any arising issues for all the cases of LTS with the senior team who are on site over the weekend. This could be done whilst visiting the service or by telephone.

Annex B – Checklist Items for Inspection Teams and Supporting Guidance and Publications

Checklist Items	Code of Practice	CPT report	NPM guidance
• **Is there a clear rationale for LTS, with evidence that it is a necessary 'last resort' of managing disturbed behaviour?** • **Is this recorded in the notes, on commencement of LTS and also at every subsequent LTS review?** *Note: LTS would only be exceptionally appropriate for people who are a risk to themselves only. Alternative management (1:1 or 2:1 observations, at arm's length if necessary could be likely to be less restrictive).*	Long-term segregation refers to a situation where, in order to reduce a sustained risk of harm posed by the patient to others, which is a constant feature of their presentation, a multi-disciplinary review and a representative from the responsible commissioning authority determines that a patient should not be allowed to mix freely with other patients on the ward or unit on a long-term basis. In such cases, it should have been determined that the risk of harm to others would not be ameliorated by a short period of seclusion combined with any other form of treatment. The clinical judgement is that, if the patient were allowed to mix freely in the general ward environment, other patients or staff would continue to be exposed to a high likelihood of serious injury or harm over a prolonged period of time. (26.150)	('a formal decision with clear reasoning and a description of the risks posed by the patient prior to placing the patient on LTS… information in the records [to] demonstrate the necessity for continued LTS [and] explain why the patient could not be supported in a less restrictive manner' (para 162);	In contrast to other places of detention, such as prisons, the legitimate scope of isolation in health care settings is narrow: it can only be legitimately used to contain dangerous behaviour, and is not legitimate as a form of sanction or punishment. Isolation practices are emergency management procedures, to be used as a last resort and after all other reasonable steps to control the behaviour have been taken. Isolation should never be used solely as a means of managing self-harming behaviour. Where the patient poses a risk of self-harm as well as harm to others, isolation should be used only when the professionals involved are satisfied that the need to protect other individuals outweighs any increased risk to the patient's health or safety arising from their own self-harm and that any such risk can be properly managed.
• **Is LTS only used when there is a cogent rationale for**	It should have been determined that the risk of	As the requirements for reviewing a patient in seclusion	

Checklist Items	Code of Practice	CPT report	NPM guidance
departing from the Code's procedural safeguards over seclusion (and not, therefore, according to a fixed timeframe)? *Reasons might include that interventions to reduce risk to others, tried during seclusion have not been successful and that the patient is likely to need longer-term isolation*	harm to others would not be ameliorated by a short period of seclusion combined with any other form of treatment (26.150)	are more rigorous than those subjected to LTS, the CPT considers that it is appropriate that no strict deadline for transforming seclusion into LTS be decreed. The aim should be to avoid resort to LTS as far as possible. (153)	
• **Do care plans focus on what needs to be achieved to end LTS, by patients and by staff?** • **Are they understood by all involved in the care and treatment of the individual (including people supporting the patient – family, carers, advocates as appropriate)**	**Treatment plans should aim to end long-term segregation.** (26.152). **The patient's treatment plan should clearly state the reasons why long-term segregation is required** (26.157). The patient's care plan should outline how they are to be made aware of what is required of them so that the period of long-term segregation can be brought to an end. (26.158)	The underlying approach towards patients in LTS should be to end the isolation as soon as practicable and to re-integrate patients into the wider ward community. (151)	Information must be given to those subject to isolation about their rights. The focus of all intervention by professionals following the instigation of isolation should be towards ending the intervention as quickly and safely as possible, to place the least restriction possible on the individual concerned. Care plans should be explicit in achieving this aim for every episode of isolation.
• **Has there been consideration of how to nurse in the least restrictive manner possible in the circumstances, including access to fresh air?**	Patients should also be able to access secure outdoor areas (para 26.151)	Patients in LTS should be cared for in conditions of least restriction to maintain safety. (para 151)	

Checklist Items	Code of Practice	CPT report	NPM guidance
• **Are care plans available that include adequate occupational therapy input, activities, distractions and opportunities for human contact?**	Patients should also be able to access … a range activities of interest and relevance to the person. (para 26.151) Patients should not be isolated from contact with staff (indeed it is highly likely they should be supported through enhanced observation) or deprived of access to therapeutic interventions (26.152)	Setting monthly targets for the number of hours patients should be involved in activities and then defining activities as eating or washing or exchanging a few words with staff seems more oriented towards ticking a box than ascertaining whether any meaningful therapeutic activities and exchanges have taken place with the patient. While it is essential to monitor and support patients eating and hygiene habits, they should not be counted as therapeutic activities. Further, it would be more interesting to record the reasons why patients declined to take up particular activities. The activities should of course be adapted to the individual patient, taking into account his interests and history and linked to the therapeutic goals for the patient concerned. (159)	Specifically in relation to detention in health settings, the Subcommittee on the Prevention of Torture (SPT) states that *solitary confinement* must never be used on persons who are detained in health care settings. The SPT further states that 'solitary confinement… segregates persons with serious or acute illness and leaves them without constant attention and access to medical services. It should be differentiated from medical isolation. Medical isolation requires daily monitoring in the presence of trained medical staff and must not deprive the person of contact with others provided that proper precautions are taken.' Depriving any person with mental disorder of human contact for any significant amount of time is never an acceptable practice. Most of the instances of isolation that the UK NPM has identified are likely to fall within the SPT's term 'medical isolation' insofar as the isolated individual is likely to be deprived of free contact with other detainees even if subject to constant monitoring by and in

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			contact with professional staff members. Daily routines [should be] varied and mitigate the harmful mental health impact of isolation.
• **Is the environment and facilities appropriate for the needs of the individual and support the ability for LTS to be no more restrictive than necessary?**	The environment should be no more restrictive than is necessary. This means it should be as homely and personalised as risk considerations allow. Facilities which are used to accommodate patients in conditions of long-term segregation should be configured to allow the patient to access a number of areas including, as a minimum, bathroom facilities, a bedroom and relaxing lounge area. (para 26.151)	The CPT considers that the design of the wards is very important and that every effort needs to be made to provide for discrete accommodation areas for patients placed in LTS with possibilities for association in a secure low stimulus area, easy access to an outdoor garden area and arrangements for enabling good clear communication between the patient and staff… At the same time, care must be taken not to create numerous special LTS suites as the temptation will be to fill them…. The design of the wards, however, was not conducive in most cases to nurturing a therapeutic environment; there was always a lot of noise and there was no easily accessible quiet area or low stimulus room where a patient could begin to adapt to ward life. (para 166)	Conditions are good quality and decent and daily routines are varied and mitigate the harmful mental health impact of isolation.

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• **Is it clear that dignity has been considered and preserved in arrangements for washing, toileting and eating (including attention to the use of hatches for delivering food etc)?**	Individuals should never be deprived of appropriate clothing … neither should they be deprived of other aids necessary for their daily living. (26.161) Any requirement that an individual should wear tear-proof clothing should be proportionate to the assessed risk and documented evidence should show that it is used only as long as absolutely necessary. As soon as the risk is assessed to have diminished, consideration should be given by nursing staff or the MDT team to a return to usual clothing. This will require ongoing dynamic risk assessment. (26.165)		
• **Is there evidence of Meaningful, in-depth local reviews in accordance with requirements of the MHA Code with clear documentation?** • **Is there evidence that progress towards achieving**	**Code of Practice only** The patient's situation should be formally reviewed by an approved clinician who may or not be a doctor at least once in any 24-hour period and at least weekly by the full MDT. The composition of the MDT should be decided by the provider's policy on long-term segregation, but should include the patient's responsible clinician and an IMHA where appropriate. Provider's policies should provide for periodic reviews by a senior professional who is not involved with the case. The outcome of all reviews and the reasons for continued segregation should be recorded and the responsible commissioning authority should be informed of the outcome). (26.155)		

Checklist Items	Code of Practice	CPT report	NPM guidance
the circumstances where LTS can be terminated is incorporated into these reviews?	The way that the patient's situation is reviewed needs to reflect the specific nature of their management plan. The purpose of a review is to determine whether the ongoing risks have reduced sufficiently to allow the patient to be integrated into the wider ward community and to check on their general health and welfare. The decision to end long-term segregation should be taken by the MDT (including consultation with the patient's IMHA where appropriate), following a thorough risk assessment and observations from staff of the patient's presentation during close monitoring of the patient in the company of others. (26.157) Where successive MDT reviews determine that segregation continues to be required, more information should be available to demonstrate its necessity and explain why the patient cannot be supported in a less restrictive manner. (26.159)		
• **Are full external review being completed, with appropriate action taken on recommendations?** • **Is there evidence showing that such reviews are taking place, that the recommendations of the external review have been considered and if rejected, appropriate reasons are provided and understood by those delivering care?**	**Code of Practice only** Where long-term segregation continues for three months or longer, regular three monthly reviews of the patient's circumstances and care should be undertaken by an external hospital. This should include discussion with the patient's IMHA (where appropriate) and commissioner. (26.156)		

Checklist Items	Code of Practice	CPT report	NPM guidance
• **Is there evidence of the involvement of relatives/carers and how their views are being taken into account, where appropriate?** • **Is there evidence of the involvement of advocacy?**	**Code of Practice** Where consideration is being given to long-term segregation, wherever appropriate, the views of the person's family and carers should be elicited and taken into account. (26.150) The multi-disciplinary review should include an IMHA in cases where a patient has one. (26.150)		The detaining body must make efforts to help individuals retain contact with family, friends and carers/advocates, with proper consideration given to the views of these individuals. Multidisciplinary review should include an advocate in cases where a person concerned has one.
• **Has there been a notification of local safeguarding team?**	**Code of Practice only** The local safeguarding team should be made aware of any patient being supported in longer term segregation. (26.153)		
• **Are records clear and include full details of triggers for individuals deterioration?**	**Code of Practice** Staff supporting patients who are long-term segregated should make written records on their condition on at least an hourly basis. (26.154)		A record of the individual's state of health should be kept while in isolation. This should include all potential signs or known triggers for the individual's deterioration so that these can be acted upon.
• **Is there access to full primary health and dental care as appropriate** • **Evidence that physical health of the patient is being regularly monitored and acted upon.**	**CPT Only:** All patients on LTS [should be] reviewed by primary health care and dental care services at intensive frequencies. (para 168)		

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