Brief guide: seclusion rooms

Context

Secluding a patient can be a traumatic experience and may lead to harm for the patient involved. This is recognised by the Mental Health Act (MHA) Code of Practice 2015, which also highlights that inadequate seclusion facilities can make the experience worse.

Through our inspections, CQC has found that some hospital seclusion facilities are unfit for use. Examples of poor practice include: a lack of respect for the privacy and dignity of patients in seclusion; inadequate furnishing (so that patients are kept in a bare room with only a mattress or blankets for comfort); little or no access to toilets; inadequate clothing for patients; and patients being disturbed by staff playing a radio or talking loudly in the observation area. Other problems include rooms either always being too hot (which may be a particular problem if the room has padding on walls) or too cold; or that are dirty (in some cases made dirty by a previous patient and not cleaned properly between uses).

This briefing only deals with the requirements relating to physical facilities for seclusion. For requirements regarding seclusion procedures, see the MHA Code of Practice[1] and NICE guideline[2].

Evidence required

1. Examine the provider's seclusion room and seclusion policies against the requirements of the Code of Practice.
2. Ask the ward manager or other staff whether there are any problems or concerns with the physical structure of the seclusion room and, if so, whether there are plans to address these.
3. Speak with patients who have experience of seclusion on the unit and ask if they have any concerns. In particular, find out whether while in seclusion the person had concerns about their:
    a. Privacy and dignity.
    b. Physical comfort.
    c. Access to food and drink.
    d. Communication with staff.
4. If there are any causes for concern, check in seclusion records and if these have been evidenced. A lack of written evidence should not be taken to discount causes of concern, but may itself be an additional concern to raise with staff. It may be possible to corroborate evidence from what patients say by looking at CCTV footage.

Reporting

In the **'safe and clean ward environment'** section of **'safe'**, comment on whether the seclusion room meets the expectations of the Code of Practice.

[1] MHA *Code of Practice* (2015), pages 302-311
[2] Violence and aggression: short-term management in mental health, health and community settings (May 2015).

Policy position

The MHA Code of Practice states that seclusion should only take place in a designated seclusion facility that is not used for any other purpose[3]. The Code requires that the design of seclusion rooms or areas should[4]:

- Allow for communication with the patient when the patient is in the room and the door is locked, for example, via an intercom.
- Include limited furnishings, which should include a bed, pillow, mattress and blanket or covering.
- Have no apparent safety hazards.
- Have robust, reinforced window(s) that provide natural light (where possible the window should be positioned to enable a view outside).
- Have externally controlled lighting, including a main light and subdued lighting for night time.
- Have robust door(s) which open outwards.
- Have externally controlled heating and/or air conditioning, which enables those observing the patient to monitor the room temperature.
- Have no blind spots and alternate viewing panels should be available where required.
- Always have a clock visible to the patient from within the room[5].
- Have access to toilet and washing facilities[6].

Services with dedicated seclusion facilities must meet the above Code of Practice guidelines. However, CQC does not expect all services to have dedicated seclusion facilities available as we recognise that there may be valid reasons why they are not needed. For example on some rehabilitation wards where the regular use of seclusion is considered unlikely.

Regardless of location, services must recognise when a patient is being secluded. This is important to make sure that they are following the guiding principles of the Code, and that they are applying the Code's safeguards in relation to seclusion.

Link to regulations

Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, Regulations 10, 12, 13, 14 and 15 are relevant.

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[3] MHA *Code of Practice* (2015), para 26.105

[4] MHA *Code of Practice* (2015), para 26.109

[5] CQC has for a number of years stressed that patients in seclusion should have sight of a clock to avoid becoming disorientated in time. In its 2013 MHA report (p.45/6) it stated that a clock is always necessary and should be a visible fixture: it was not adequate for staff of one unit to say that they would 'try to remember' to put a portable clock within the patient's sight when seclusion was used.

[6] Any toileting arrangements for patients in seclusion require a balance between ensuring the safety of the person and maintaining their dignity and physical well-being. Total privacy when using the toilet is not always achievable in seclusion. The best practice standard is to have en-suite toilet and washing facilities. This will be an expectation for any new-build service and a requirement of registration for such services, and any refurbishment of seclusion facilities should create en-suite facilities where possible. If the seclusion room is a single room and includes a toilet, the room should as far as is practicable be arranged or adapted to provide elements of privacy afforded by en-suite arrangements. Where a seclusion room has no toilet facility, patients should be escorted to use toilet facilities on the ward, unless doing so would pose a serious risk of harm to the patient or staff. Suitable receptacles should be available where it is not possible to use facilities outside the room, and these should be replaced after use and not left in the room. Consideration should be given to any means by which privacy and dignity can be safely maintained in the use of such receptacles.