

# CLINICAL POLICY

## De-Escalation Suite (DS) or Extra Care Area (ECA) Policy

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<b>Impact Assessments:</b>	This Policy has been subjected to an Equality Impact Assessment. This concluded that this policy will not create any adverse effect or discrimination on any individual or particular group and will not negatively impact upon the quality of services provided by the Trust

### Version History

Version	Date Issued	Reason for Change
V1		Original Policy
V2	Aug 2011	Minor Changes
V3	Feb 2013	Policy review
V4	June 2014	Policy review
V5	Sept 2015	Policy update ██████████ updated to reflect change in new MHA Code of Practice 2015

V6	May 2016 – Dec17	Policy update [REDACTED] – updated to reflect changes to use of ECA longer than 72 hours and trust wide position on seclusion.
V6.1	July 2019	Format Update
V6.2	March 2021	Extension of review date requested [REDACTED]
V6.3	Aug 2021	Extension of review date requested [REDACTED]
V7	01/03/2022	Policy update to reflect out of hours procedures
V8	30/10/2025	Addition of abbreviation table, Monitoring compliance section updated, format amended with the addition of number paragraphs and formulation of flowchart to support organisational notification.

## SUMMARY

The Trust is committed to providing safe and effective services. Having a clear policy on how to manage the occasions that require the use of the De-Escalation Suite (DS) or the Extra Care Area (ECA) within inpatient settings is important for understanding the range of options for managing staff and service user safety.

The use of de-escalation and Extra Care Areas is different to traditional seclusion (i.e. locking a service user alone in a room) as outlined in this policy.

It is important to ensure there is a consistent approach to safeguarding. The policy also supports the framework to ensure that the procedures employed are consistent with the Mental Health Act Code of Practice (2015).

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## ABBREVIATIONS

<i>Abbreviation</i>	<i>Full Description</i>
DS	De-Escalation Suite
ECA	Extra Care Area
GHC	Gloucestershire Health and Care NHS Foundation Trust
ICB	Integrated Care Board
IMHA	Independent Mental Health Advocate
LSU	Low Secure Unit
MDT	Multi-Disciplinary Team
PICU	Psychiatric Intensive Care Unit
PARRI	Proactive Approaches Reducing Restrictive Interventions

### 1. INTRODUCTION

- 1.1 There may be occasions, for the safety of the service user and for the safety of other service users, for a service user to be supported separately (away) from other service users on the ward.
- 1.2 It is important that the use of the De-escalation Suite or Extra Care Area is well understood, defined and regulated. Currently within the trust designated De-escalation Suites and Extra Care Areas are located on Greyfriars Psychiatric Intensive Care Unit (PICU), Montpellier Unit Low Secure Unit (LSU) and Berkeley House.
- 1.3 The Trust can designate additional areas within the inpatient estate to serve as areas for de-escalation and extra care areas, for example Charlton Lane Centre have the capacity to utilise the end of the male corridor on Willow Ward and the end of the female corridor on Mulberry ward (needing to close one room to make this viable) which meets the minimum requirement for this purpose. It is important that these areas then adopt all of the guidance and monitoring frameworks within this policy.
- 1.4 The Trust procedures governing the use of the De-Escalation Suite or the Extra Care Area are robust and, in some areas, may be more than those required by the Chapter 26 of the Mental Health Act Code of Practice (2015) for Seclusion and Long-term segregation.
- 1.5 There are key differences between the use of the DS and ECA from the use of traditional seclusion (patient locked alone in a room) which are:
- 1.6 The use of the DS and ECA is to provide a therapeutic and low stimulus environment to engage a service user in intensive support to manage high levels of aggression, disturbed, problematic and disruptive behaviour.
- 1.7 The service user will at no time be restricted to a single room from which they are prevented from leaving within the DS or ECA.
- 1.8 There will always be a minimum of 2 healthcare staff in the DS and ECA with the service user and never separated by a fixed barrier e.g. door that has been fixed shut by locking

or other means.

- 1.9** The DS and ECA allows for the staff to implement a wide variety of therapeutic interventions within the Proactive Approaches Reducing Restrictive Interventions (PARRI) continuum to work with the service user through an episode of aggression where there is increased risk to others.

## **2. PURPOSE**

- 2.1** The Trust is committed to providing safe and effective services. Having clear policy procedure on how to manage the occasions that require the use of the De-Escalation Suite (DS) or the Extra Care Area (ECA) within inpatient settings is important for understanding the range of options for managing staff and service user safety.
- 2.2** The use of DS and ECA is different to traditional seclusion (i.e. locking a service user alone in a room) as outlined in this policy.
- 2.3** It is important to ensure there is a consistent approach to safeguarding. The policy also supports the framework to ensure that the procedures employed are consistent with the Mental Health Act Code of Practice (2015).

## **3. SCOPE**

- 3.1** This policy has been written to provide detail to clinical staff on the procedure for implementing the care within the DS or ECA.
- 3.2** This policy applies to Trust designated DS and ECA which are located on Greyfriars Psychiatric Intensive Care Unit, Montpellier Unit Low Secure Unit and Berkeley House.

## **4. DUTIES**

- 4.1 General Roles, Responsibilities and Accountability**  
**Gloucestershire Health and Care NHS Foundation Trust (GHC)** aims to take all reasonable steps to ensure the safety and independence of its patients and service users to make their own decisions about their care and treatment.

In addition, **GHC** will ensure that:

- All employees have access to current, evidence-based policy documents.
- Appropriate training and updates are provided to support staff in their roles.
- Staff have access to equipment that meets safety standards and maintenance requirements.

**Managers and Heads of Service** will ensure that:

- All staff are aware of and have access to relevant policy documents.
- All staff are supported to access training and development as appropriate to individual employee needs.
- All staff participate in the appraisal process, including the review of competencies.

**Employees (including bank, agency and locum staff)** must ensure that they:

- Practice within their level of competency and within the scope of their professional

bodies where appropriate.

- Familiarise themselves with and adhere to relevant GHC policies and procedures.
- Identify any areas for skill update or training required.
- Participate in the appraisal process.
- Ensure that all care and consent complies with the Mental Capacity Act (2005) – see section on [MCA Compliance below](#).

## 5. MENTAL CAPACITY ACT COMPLIANCE

### 5.1 Where parts of this document relate to decisions about providing any form of care treatment or accommodation, staff using the document must do the following: -

- Establish if the person is able to consent to the care, treatment or accommodation that is proposed. (Consider the 5 principles of the Mental Capacity Act 2005 as outlined in section 1 of the Act. In particular principles 1,2 and 3) [Mental Capacity Act 2005 \(legislation.gov.uk\)](#).
- Where there are concerns that the person may not have mental capacity to make the specific decision, complete and record a formal mental capacity assessment on the GHC Trust approved MCA forms. These are available as templates on clinical record systems and on the GHC intranet.
- Where it has been evidenced that a person lacks the mental capacity to make the specific decision, complete and record a formal best interest decision making process using the best interest checklist as outlined in section 4 of the Mental Capacity Act 2005 [Mental Capacity Act 2005 \(legislation.gov.uk\)](#). Evidence of Best Interests decision making must be provided on the GHC Trust approved forms. These are available as templates on clinical record systems and on the GHC intranet.
- Where a person is admitted to hospital for the treatment of a physical health condition and is assessed as being unable to consent to admission, care or treatment, an application for an Urgent DOLS Authorisation must be submitted to the Local Authority. This applies in all cases where the person lacks capacity, regardless of their compliance with or objection to their admission. Establish if there is an attorney under a relevant and registered Lasting Power of Attorney (LPA) or a deputy appointed by the Court of Protection to make specific decisions on behalf of the person (N.B. they will be the decision maker where a relevant best interest decision is required. The validity of an LPA or a court order can be checked with the Office of the Public Guardian) [Office of the Public Guardian - GOV.UK \(www.gov.uk\)](#).
- If a person lacks mental capacity, it is important to establish if there is a valid and applicable Advance Decision before medical treatment is given. The Advance Decision is legally binding if it complies with the MCA, is valid and applies to the specific situation. If these principles are met it takes precedence over decisions made in the person's best interests by other people. To be legally binding the person must have been over 18 when the Advance Decision was signed and had capacity to make, understand and communicate the decision. It must specifically state which medical treatments, and in which circumstances the person refuses and only these must be considered. If a patient is detained under the Mental Health Act 1983 treatment can be given for a psychiatric disorder.
- Where the decision relates to a child under the age of 16, the MCA does not apply. In these cases, the competence of the child must be considered under Gillick competence. If the child is deemed not to have the competence to make the decision, then those who hold Parental Responsibility will make the decision, assuming it falls

within the Zone of Parental control. Where the decision relates to treatment which is life sustaining, or which will prevent significant long-term damage to a child under 18 their refusal to consent can be overridden even if they have capacity or competence to consent.

## 6. POLICY DETAIL

There are a very small number of service users who are not responsive to short-term management of their aggression and violence and as such they present a risk to others which is a constant feature of their presentation and is not subject to amelioration by a short period of intervention.

The clinical judgement in these cases is that, if the service user were allowed to mix freely in the general ward environment, the other service users or staff would continuously be open to the potential of assault, injury or harm.

Under these circumstances it would be appropriate for consideration to use the DS or ECA to manage the increasing risk profile of the service user where more concentrated PARRI techniques can be employed.

This policy covers the interventions of extended use of the ECA through to Long Term Segregation.

### 6.1 The Environment of the De-escalation Suite or Extra Care Area (ECA)

Kinsella and Brosman (1993) first suggested the use of an ECA as an alternative to seclusion and this was later described by Dix (2008).

An ECA can be an alternative to traditional seclusion (service user locked alone in a room). This is defined by the Department of Health in 'The National Minimum Standards for General Adult Services in PICU and Low Secure Environments (2014)' as:

- A closely supervised living space,
- Away from the main clinical area,
- In which a single patient may be engaged away from rest of the patients.
- Staff will remain with the patient at all times, rather than the patient being locked alone in a room with the staff monitoring from the other side of a locked door.
- The ECA comprises of a number of rooms and is separate to the main body of the ward. It is a designated area offering a low stimulus safer environment within which a service user can be closely supported by staff at all times. The service user will **never** be physically separated from staff by means of fixed physical barrier at any time during engagement in the ECA.
- The ECA should be able to provide for the daily living needs of a single service user. This will require the following all in close proximity to each other:
  - De-escalation room / bedroom.
  - A toilet and shower facility.
  - A sitting room with robust furnishings.

### 6.2 In Psychiatric Intensive Care Units (PICU) and Low Secure Environments, this should also include:

- Access to the garden.
- An intercom system to the main office.

### 6.3 Before Considering using the DS/ECA

The non-voluntary (defined as the service user being taken to this location by staff and prevented from leaving at the conclusion of PARRI interventions) use of the ECA should be considered a last resort.

Prior to the Extended use of DS/ECA the following interventions should have been tried, concluded and it is assessed that *risks remain* to the extent the unit standard levels of autonomy cannot be returned to the service user.

### 6.4 Intervention Attempted before Extended use of the ECA

- Verbal de-escalation; Encourage the person to move away from the incident to a quieter area, e.g. bedroom/interview room.
- Consider alternative therapeutic interventions, e.g. further negotiation, reassurance, engagement in activity (where possible walk etc.) and problem solving regarding the triggers for the episode and continued attempts at de-escalation.
- De-escalation techniques should be utilised in accordance with staff training and the Prevention and Safe Management of Risk Incidents (including Violent and Aggressive Behaviour) policy.

### 6.5 Use of the DS/ECA in the Management of Disturbance

Staff must be present with the service user at all times, the use of the DS/ECA requires levels of support greater than that required for the use of traditional seclusion where a staff member can monitor from the other side of a locked (or by any other means fixed) door. This is **not** permissible in the use of the ECA.

Any episodes in the DS or ECA will be monitored on an ongoing basis by the Hospital Matron.

The fact that the Trust governance procedures and recording procedures for these facilities are equivalent to, and in some respects, greater than the MHA Code of Practice (2015) requirement for traditional seclusion - offers no justification under this policy for instigating traditional seclusion i.e. locking a patient alone in a room or area.

### 6.6 Criteria and Guidance for using the DS/ECA

Criteria for underpinning the need to use the DS/ECA include:

- Where an individual's behaviour is sufficiently disturbed resulting in significant **ongoing risk** that is not responding to the interventions suggested above.
- When an individual's behaviour is sufficiently aggressive that access to potential victims and/or weapons cannot be safely managed in the main ward.
- Where an individual's mental / behavioural state is disturbed and / or disinhibited to the extent that they would be highly vulnerable and at risk.
- With measures other than the use of the DS/ECA, e.g. increased observation / engagement allowing unit standard levels of autonomy, which have already been attempted and shown to be ineffective.

- Where de-escalation techniques have not been effective.

## **6.7 Criteria / Guidance for Discontinuing the use of the DS/ECA**

The DS/ECA should be used for the shortest possible time. Episodes of DS/ECA use would ordinarily be measured in terms of minutes rather than hours or days. As soon as the immediate risk has passed the use of the DS/ECA should be discontinued. If the service user appears behaviourally calm and / or has offered verbal reassurance this should lead to consideration to discontinue the use of the DS/ECA.

If the service user is not attacking or threatening the staff present within the DS/ECA or giving indication of the same towards others e.g. threatening other people to whom they would have access if they left the DS/ECA, then consideration should be given to discontinuing its use.

Most episodes of using the ECA are expected to be measured in minutes rather than hours.

## **6.8 Extended use of the DS/ECA**

The DS/ECA should be used only as a last resort and for the shortest possible time. It should never be used as a punishment or a threat, or because of a shortage of staff. In fact, the use of the ECA requires a minimum of 2 staff to be allocated specifically for that purpose.

It should not form part of a treatment programme. It should never be used solely as a means of managing self-harming behaviour. Where the service user poses a risk of self-harm as well as harm to others, the DS/ECA should be used only when the professionals involved are satisfied that the need to protect other people outweighs any increased risk to the service user's health or safety and that any such risk can be properly managed.

The need to use the DS/ECA for an informal service user should be taken as an indication of the need to consider formal detention.

## **6.9 Procedure Governing the use of the DS/ECA at the Conclusion of PARRI Interventions**

The decision to continue to use DS/ECA at the conclusion of PARRI intervention can be made in the first instance by the registered healthcare professional in charge of the ward. Where the registered healthcare professional in charge of the ward takes the decision, the service user's Responsible Clinician (RC) or the duty doctor (or equivalent) should be notified as soon as is practicable and should attend immediately unless the DS/ECA is used only for a very brief period following a PARRI or Rapid Tranquilisation.

Staff should involve the service user in this process as much as possible, informing them why the use of the DS/ECA has been initiated and the steps they need to take to try and end it.

An initial multi-disciplinary review of the need for DS/ECA should be carried out as soon as practicable after the DS/ECA episode begins. If it is concluded that DS/ECA needs to

continue, the review should establish the individual care needs of the service user while they are in the DS/ECA and the steps that should be taken in order to bring the need for DS/ECA to an end as quickly as possible.

#### **6.10 When does Formal DS/ECA Monitoring begin?**

The DS/ECA is designated to support the application of Primary, Secondary and Tertiary interventions consistent with the MHA CoP (2015) Chapter 26 and the Trusts PARRI policy. These interventions include verbal de-escalation, physical restraint etc.

Formal monitoring, review and recording consistent with the MHA Cop (2015) starts in circumstances detailed in the check list below:

- The service user has been taken to the ECA (or other area being used for this purpose).
- Any PARRI interventions have concluded.
- Following the conclusion of PARRI interventions the service user is required to remain within the DS/ECA against their wishes.
- Staff would stop the service user leaving if they wished to do so (for any reason e.g. monitoring the effect of rapid tranquilisation, further needs to assess potential for repeat aggression etc.).
- A record of this monitoring is set out in [Appendix 1](#).

#### **6.11 Procedures that *must* be undertaken and recorded**

A detailed account of the rationale and the circumstances in which the Extended use of DS/ECA was initiated must be recorded in the healthcare record. If any reviews detailed below concludes that DS/ECA is no longer necessary, it should be ended.

#### **6.12 Every 2 Hours**

Every two hours documented review by two nurses or other suitably skilled professionals (one of who was not involved directly in the decision to indicate the DS/ECA).

#### **6.13 Every 4 Hours**

Every four hours reviewed by a doctor or a suitably qualified Approved Clinician (AC).

#### **6.14 Over 8 Hours**

If the service user is subject to DS/ECA care for more than 8 hours consecutively; or 12 hours over a period of 48 hours accumulatively a multi-disciplinary review should be completed including a senior doctor or suitably qualified Approved Clinician, and nurses and other professionals who were not involved in the incident which led to the use DS/ECA.

Where an independent multi-disciplinary review takes place, it is good practice for those involved in the original decision to be consulted in the review.

Following the first internal MDT review, further medical reviews should continue at least twice in every 24-hour period. At least one of these should be carried out by the patient's responsible clinician.

## 6.15 Medical Reviews

Medical reviews provide the opportunity to evaluate and amend care plans, as appropriate (see paragraph 26.147 MHA COP). 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 the 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 deliberate or accidental self-harm, and
- an assessment of the need for continuing seclusion, and whether it is possible for seclusion measures to be applied more flexibly or in a less restrictive manner.

In accordance with the MHA COP Chapter 26.127 for the purposes of medical reviews, where the responsible clinician is not immediately available, e.g. outside of normal working hours, the on call 'duty doctor' can deputise for the approved clinician and can complete the face-to-face medical reviews as above. The policy should also identify which of their doctors are competent to carry out a medical review (see paragraph 26.133). Whenever the duty doctor is not an approved clinician, they should at all times have access to an on-call doctor who is an approved clinician. Access to the approved clinician will be accessible through the normal on call arrangements.

For out of hours the following procedure will apply:

Between the hours of 17:00 and 09:00 (Monday to Friday) and the entire 24-hour period over weekends/bank holidays hours only:

When a four hourly medical review is required by the Code, the waking on call duty doctor can complete the face-to-face physical review.

When an eight-hour approved clinician review is required, again the waking on call duty doctor can complete the face-to-face review and then consult with the on call approved clinician via the normal route.

The results of this assessment and discussion with the on-call duty approved clinician will be documented in the healthcare record.

## 6.16 Nursing Reviews

Nursing reviews of the patient placed in extended segregation should take place at least every two hours following the commencement of extended segregation. These should be undertaken by two individuals who are registered nurses, and at least one of whom should not have been involved directly in the decision to commence extended segregation.

In the event of concerns regarding the patient's condition, this should be immediately brought to the attention of the patient's responsible clinician or duty doctor.

When patients in ECA are asleep a documented conversation with the responsible clinician or duty doctor to revise the scheduled review is appropriate to maintain sleep hygiene and avoid disrupting a resting pattern.

Any professional taking over responsibility for engaging a service user subject to the provision of the DS/ECA should have a full handover, including details of the incident that resulted in the need for DS/ECA and subsequent reviews.

A record of all periods of use of the DS or ECA will be kept within a log held in the ward main office using the form in [Appendix 1](#).

In addition, a summary of observation will be entered into the healthcare record at the end of each staff rotation which will normally be hourly. This will be agreed by the team supporting the intervention.

[Appendix 3](#) provides a flow chart which should form the standard operating procedure and supports this policy.

### **6.17 After 72 Hours**

If extended use of the ECA is required beyond 72 hours a review should take place regarding the criteria for the Mental Health Act Code of Practice for “long-term segregation”.

### **6.18 Definition of Long-Term Segregation**

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 time in the ECA 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. Where consideration is being given to long-term segregation, wherever appropriate, the views of the person’s family and carers should be elicited and considered. The multi-disciplinary review should include an IMHA in cases where a patient has one.

### **6.19 Procedure for Considering / Implementing Long-Term Segregation**

A multi-disciplinary team (MDT) comprising of the:

- Patient’s RC (or nominated deputy).
- Senior members of the Unit nursing team.
- Other members of the Unit multidisciplinary team.
- Where possible, another senior clinician who knows the patient not from within the Unit team.
- The above MDT should consider the criteria for long-term segregation within a specific documented meeting.

### **6.20 Characteristics of Long-Term Segregation; Implementation:**

- As with the extended use of the ECA procedure, at no time should the patient be locked alone in a room or separated from the staff by means of physical fixed barrier.

- Long-term segregation should provide a similar arrangement to the extended use of the ECA in terms of proximity to, interaction with staff and access to areas of the ECA.
- Long-term segregation may also involve increased opportunities than the extended use of the ECA and may include periodic assess to other areas of the Unit or spaces away from the Unit.
- This may include eating in the dining area or visits to the general garden area/activity rooms consistent with risk assessments.
- Patients should not feel isolated from contact with the staff (indeed it is highly likely that they should be supported through enhanced engagement) or deprived of access to therapeutic interventions while subject to long term segregation.

#### **6.21 Monitoring and Review of Long-Term Segregation:**

- At the point the Long-Term Segregation has been considered, a representative of the commissioning authority (Gloucester ICB), should be informed.
- The Local safeguarding team should be informed.
- An independent mental health advocate should be consulted.
- Staff supporting the patient through long-term segregation should keep continuous records summarising the patient's behaviour on an hourly basis.

#### **6.22 Every 24 Hours**

Patient's situation should be formally reviewed by an approved Clinician once in every 24-hour period.

#### **6.23 Every 7 Days**

- Patient's situation should be reviewed by an MDT at least once weekly.
- Where possible this should include an IMHA advocate.
- Notifications should be issued to the local safeguarding team
- Notifications and dialogue with the local commissioning authority (ICB) should also take place.
- Reviews for the need of continued long-term segregation beyond those of the Approved Clinician and the multi-disciplinary team should take place on a regular basis.

#### **6.24 Recording Reviews of Long-Term Segregation**

Records that the appropriate reviews have taken place should be entered on the record of Long-term Segregation form ([Appendix 2](#)).

#### **6.25 Discontinuing Long-Term Segregation**

Long-term segregation should be discontinued at the first possible opportunity. This should take place within a multi-disciplinary review.

#### **6.26 Limitations to the use of the DS/ECA**

The DS/ECA should be used for the shortest possible time most often measured in minutes rather than hours or days.

The evidence, as well as experience, suggests that the longer-term use of DS/ECA can quickly become counterproductive. Over longer time periods (e.g. more than a few hours) the close proximity of people (staff and service user) and diminished opportunities for activity and wider interaction available outside of the DS/ECA, has the potential to promote rather than reduce problematic behaviour. All efforts should therefore be made to avoid the use of DS/ECA beyond 72 hours (Dix et al 2008).

If the use of the DS/ECA has continued for more the 72 hours, then this may be indication that it has become ineffective in fulfilling its primary purpose of providing a short-term opportunity to improve safety and reduce risk.

Other approaches rather than the continued use of the DS/ECA should be considered.

If the assessment concludes that the use of the ECA cannot be discontinued after 72 hours, then consideration should be given towards the need for long term Segregation as detailed above.

## **6.27 Following use of the DS/ECA**

The service user will be assessed and care delivered with the aim of:

Identifying precipitating factors which led to the incident requiring the use of the DS/ECA.

Working towards preventing a further occurrence of the behaviour that warranted the use of the DS/ECA.

Review the patient's care plan to consider how the patient can be supported to try and minimise any future harm to the service user or others, and to try and reduce the need for the use of the DS/ECA in the future.

Involve the service user in this process as far as possible.

It is recommended that following any period of DS or ECA that a de-brief with the available staff should be conducted to support those involved in the procedure and identify any learning points to inform future practice.

## **6.28 Record Keeping**

Detailed and contemporaneous records should be kept in the service user's electronic record of any use of the DS/ECA, it should be titled "DS or ECA" and should be indicated as a 'risk incident' under 'other risk behaviours' on the progress notes on EPR to assist with reporting.

The body of the note should include as a minimum:

- The reasons for its use
- the involvement of the service user in explaining the initiation of the use of the DS/ECA and the necessary steps to try and end it.
- subsequent activity;
- supporting risk assessments;
- the review/s completed; and

- the time the service user went into the DS/ECA and the time for the next review.

Every episode of DS or ECA that meets the conditions outlined in 6.19 above will be recorded on the DS/ECA monitoring form (**Appendix 1 and 2**) and updated on every review in line with section 6.25-6.47 (enhance use of the ECA) and 6.51-6.54 (long-term segregation). This will be uploaded to the healthcare recorded and a paper copy maintained in the DS or ECA ward folder.

## 6.29 Traditional Seclusion

The use of the DS and ECA should not be confused with traditional seclusion involving locking a service user alone in a room or area.

It is important to note that if a service user is in a room on their own and is prevented from leaving by a physical barrier secured by any means (e.g. lock, holding of a handle, standing the other side of the door and physically keeping this closed) then this would constitute traditional seclusion which is not a supported intervention within the acute mental health, learning disability or older people's settings within the Trust services. Staff must remain with the service user in the ECA.

## 7. DEFINITIONS

### Service User

The term 'service user' is used in this policy for clarity, however, the Trust recognises that those who access mental health or learning disability services may prefer to be referred to by other terms including patients, clients or users.

### De-escalation

*"De-escalation (also referred to as 'defusing' or 'talk-down') involves the use of various psychosocial short-term techniques aimed at calming disruptive behaviour and preventing disturbed/violent behaviour from occurring. Every effort is made to avoid confrontation. This can include talking to the service user, often known as verbal de-escalation, moving service users to a less confrontational area, or making use of a specially designated space for de-escalation"* (NICE 2015).

### De-escalation Suite (DS) and Extra Care Area (ECA)

This is defined as a closely supervised living space, away from the main clinical area, in which a single service user may be nursed away from the rest of the service users (Dix 2008). It cannot be a single room.

## 8. PROCESS FOR MONITORING COMPLIANCE

Are the systems or processes in this document monitored in line with national, regional, trust or local requirements?	YES
---	-----

Monitoring Requirements and Methodology	Frequency	Further Actions
The ward must inform the Matron/Senior Nurse or on call clinical manager if out of hours when the De-escalation Suite or Extra Care Area has been used for a service user as outlined below. The Datix report supporting the extended use of the ECA at the conclusion of PARRI techniques should indicate	On-going	All completed incident reports are sent for information to a range of health and safety representatives and

that the use of the DS or ECA has been utilised requiring monitoring as described in the policy.		senior operational management. <ul style="list-style-type: none"> <li>The incident report is then reviewed by the unit management, who will update the action taken as a result of the review and identify any lessons learnt.</li> </ul>
The Unit Manager must submit notification to the Matron/Inpatient Manager on the day extended DS/ECA use commences. (If out of hours this can be reported on the next business working day) detailing the following: <ul style="list-style-type: none"> <li>All episodes where DS/ECA has been used longer than 2 hours.</li> <li>The duration of each period of use for the DS/ECA.</li> <li>Details of all reviews of DS/ECA</li> <li>The legal status of the service user using DS/ECA.</li> <li>Details of the reasons for DS/ECA</li> </ul>	On-going	Clinical oversight sought to consider whether the intervention is appropriate and proportionate. Review will take place in regard to ensuring all relevant guidance as been adhered to and whether additional resource may need to be sought to support.
The use of DS and ECA will be reported into the monthly Mental Health and Learning Disability and Urgent Care Governance and Performance Meeting.	Monthly (dependent on usage)	This information will be presented to allow for review and for assurance.
Annual audit of the use of DS and ECA will be undertaken by the relevant clinical area and reported to Trust wide Mental Health Act Scrutiny Committee and the Governance Committee	Annually	This information will be presented to allow for review and for assurance.

## 9. INCIDENT AND NEAR MISS REPORTING AND REGULATION 20 DUTY OF CANDOUR REQUIREMENTS

9.1 To support monitoring and learning from harm, staff should utilise the Trust's Incident Reporting System, DATIX. For further guidance, staff and managers should reference the [Incident Reporting Policy](#). For moderate and severe harm, or deaths, related to patient safety incidents, Regulation 20 Duty of Candour must be considered and guidance for staff can be found in the [Duty of Candour Policy](#) and Intranet resources. Professional Duty of Candour and the overarching principle of 'being open' should apply to all incidents.

## 10. TRAINING

10.1 Training and information for staff will be given initially on local induction to the Trust. Line managers who work on wards that have ECAs, within local induction, will make staff aware of how the policy is implemented in practice.

## 11. REFERENCES

*NICE (2015) Overview | Violence and aggression: short-term management in mental health, health and community settings | Guidance | NICE.*  
<https://www.nice.org.uk/guidance/ng10>.

**Appendix 1** – click on this [link](#) to download an editable version



**Gloucestershire Health and Care**  
NHS Foundation Trust

**De-Escalation Suite and Extra Care (DS & ECA) Area Log**

**Service User Name:**.....**Time DS & ECA Commenced:**.....

**Service User No:**..... **Date Commenced:** .....

Actual time	Elapsed time		Name and title	Name and title	Has the EPR progress note been updated Y/N
	02.00	FORMAL NURSING REVIEW ON RIO			

Actual time	Elapsed time		Name and title	Name and title	Has the EPR progress note been updated Y/N
	04.00	FORMAL MEDICAL REVIEW ON RIO			

Actual time	Elapsed time		Name and title	Name and title	Has the EPR progress note been updated Y/N
	06.00	FORMAL NURSING REVIEW ON RIO			

Actual time	Elapsed time		Name and title	Name and title	Has the EPR progress note been updated Y/N
	08.00	FORMAL APPROVED CLINICAN REVIEW ON RIO			

Actual time	Elapsed time		Name and title	Name and title	Has the EPR progress note been updated Y/N
	10.00	FORMAL NURSING REVIEW ON RIO			

Actual time	Elapsed time		Name and title	Name and title	Has the EPR progress note been updated Y/N
	12.00	FORMAL MEDICAL REVIEW ON RIO			

**After 12 hours the process of review restarts as above.**

**Appendix 2** – click on this [link](#) to download an editable version



**Gloucestershire Health and Care**  
NHS Foundation Trust

**LONG TERM SEGREGATION MONITORING AND REVIEW LOG**

(as per MHA CoP 2015)

Service User name:..... NHS No:.....

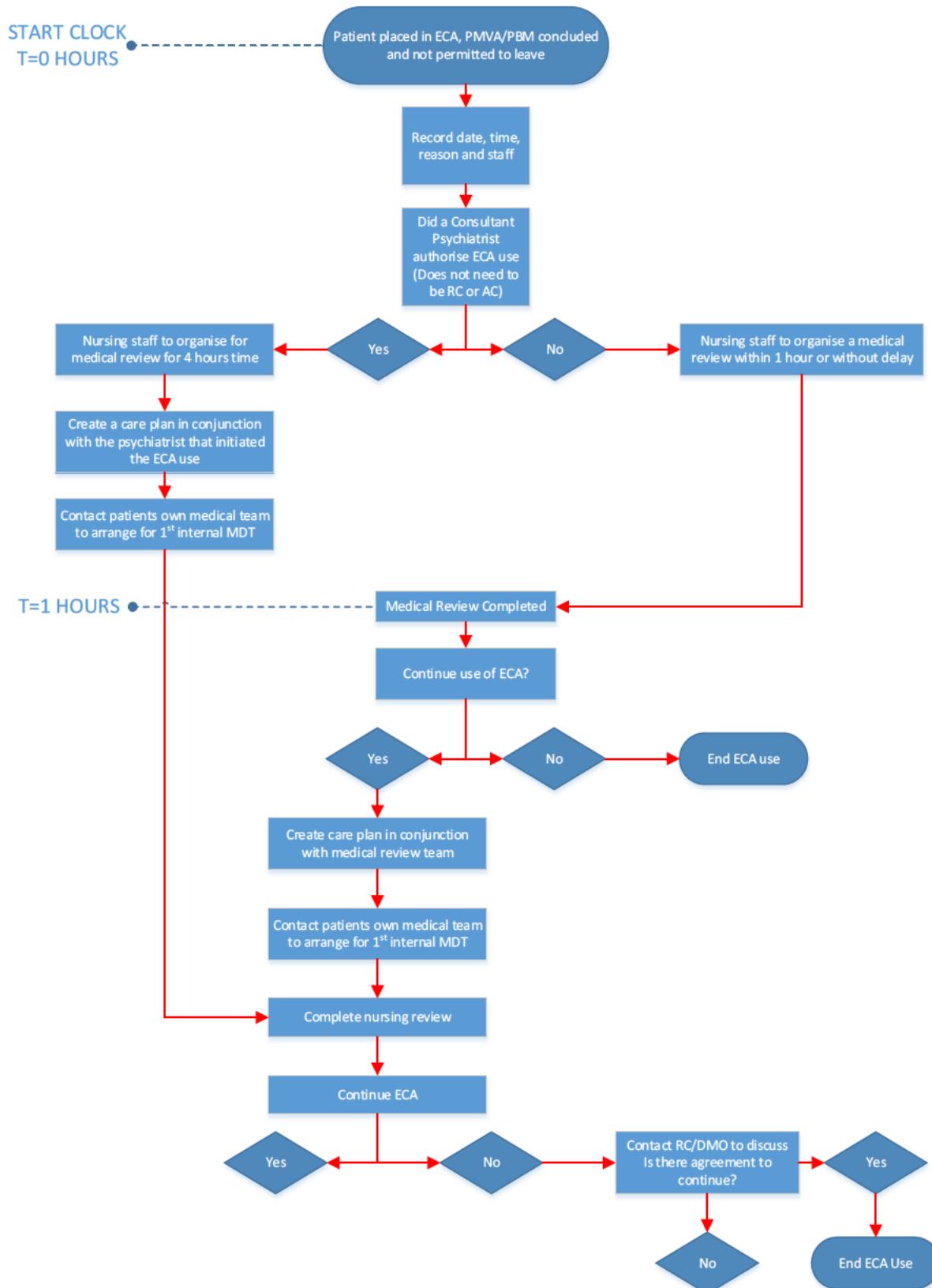
LTS commenced: ...../...../.....

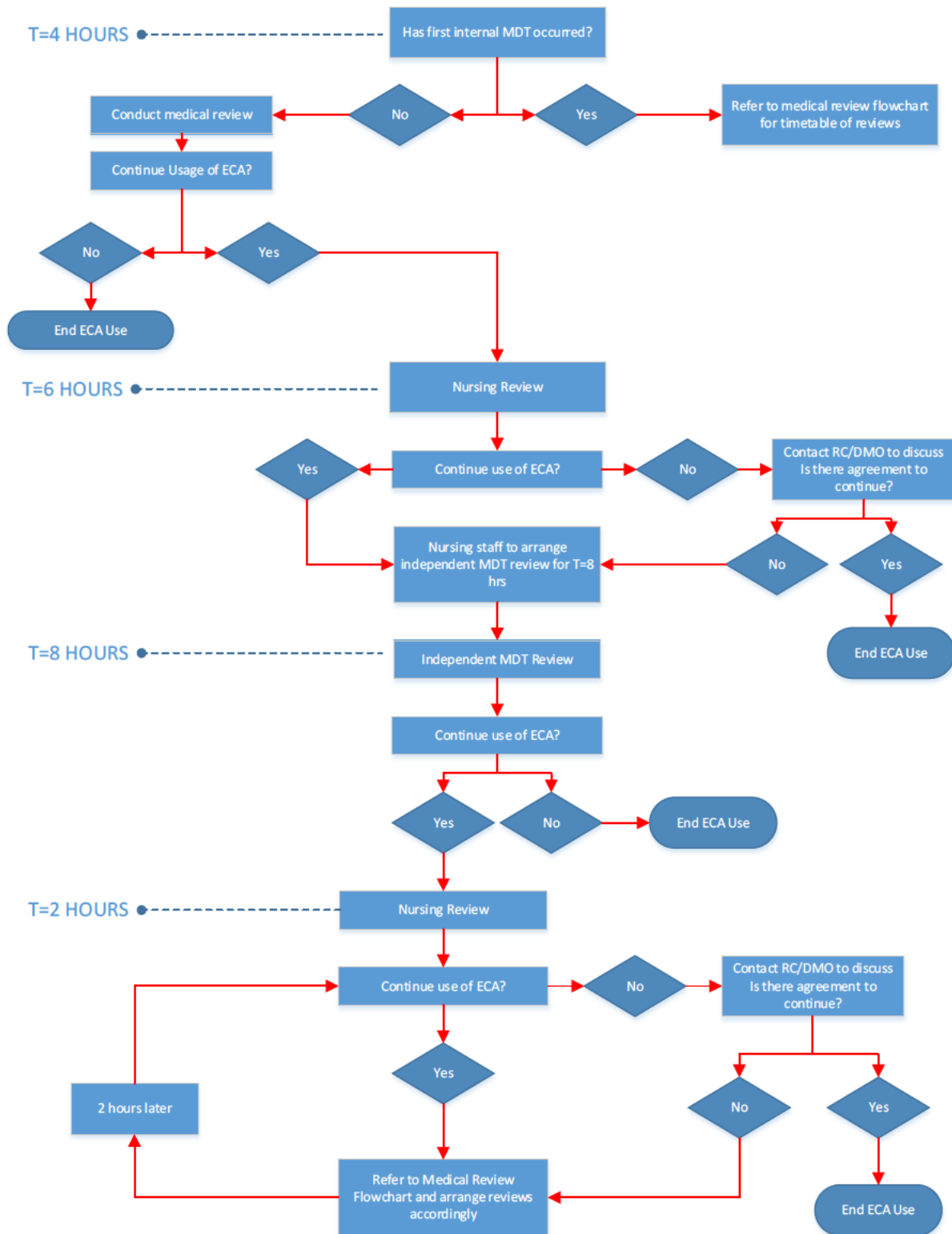
W/C...../...../.....		Mon Time/ Initial	Tues Time/ Initial	Weds Time/ Initial	Thurs Time/ Initial	Fri Time/ Initial	Sat Time/ Initial	Sun Time/ Initial
Has the patient been reviewed by an approved Clinician?	(At least once every 24hrs)							
Has the patient had a physical health review by a medic?	(At least three times a week)							
Has the patient been reviewed by a Multi-Disciplinary Team?	(At least once every week)							

To be informed upon weekly review:	Date	Sign
Family/Carers		
Safeguarding team		
IMHA (if appropriate)		
Integrated Care Board (ICB)		

### Appendix 3

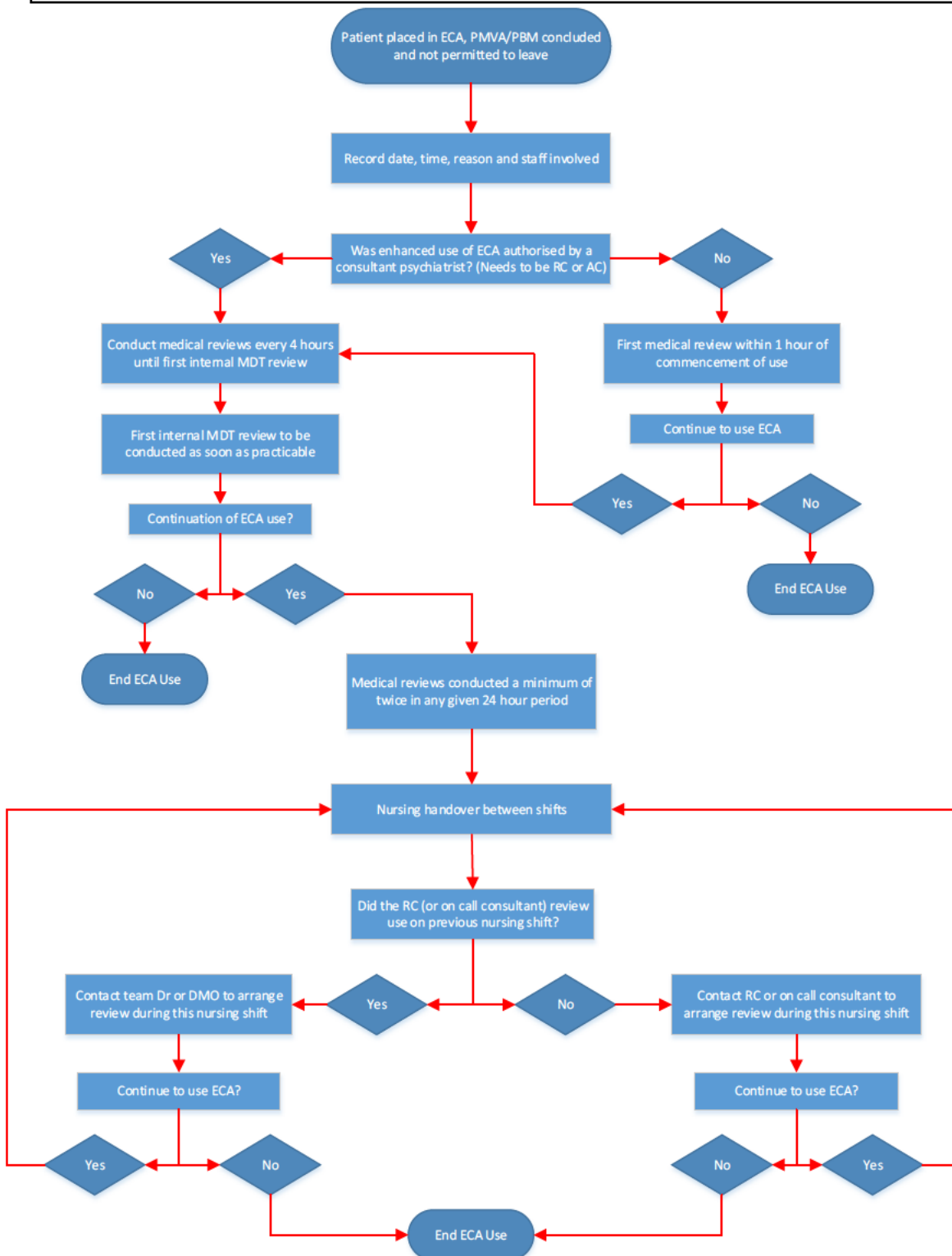
## FLOWCHART FOR NURSES RESPONSIBILITIES DURING ENHANCED USE OF EXTRA CARE AREA





**NOTE: AFTER 72 HOURS OF CONTINUED USE OF THE ECA CONSIDERATION MUST BE GIVEN TO WHETHER THE CRITERIA FOR THE PROCEDURE FOR LONG TERM SEGREGATION IS APPROPRIATE AS PER POLICY GUIDANCE**

# FLOWCHART FOR MEDICAL REVIEWS FOR ENHANCED USE OF THE EXTRA CARE AREA



NOTE: AFTER 72 HOURS OF CONTINUED USE OF THE ECA CONSIDERATION MUST BE GIVEN TO WHETHER THE CRITERIA FOR THE PROCEDURE FOR LONG TERM SEGREGATION IS APPROPRIATE AS PER POLICY GUIDANCE

Appendix 4

FLOWCHART FOR ORGANISATIONAL NOTIFICATION

