Hertfordshire Partnership University NHS Foundation Trust

HPFT

Recorded Guidelines When Cohorting Service Users on Inpatient Wards

HPFT Guidelines

Version	6
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Approved Date	N/A
Approved By	Clinical Professional Advisory Committee
Ratified Date	15/05/2020
Ratified By	Tactical Command
Issue Date	10/08/2020
Expiry Date	10/08/2023
Target Audience	All Staff

Main Changes made to document from previous version: • Minimum isolation time for Covid positive patients is now 14 days • The increase of minimum self - isolation time from 7 days to 10 days is for community patients • Guidance for stepdown of infection control precautions and discharging COVID-19 patients recommends that all patients with COVID-19 who have been admitted to hospital should be isolated within hospital or remain in self-isolation on discharge for 14 days from their first positive SARS-CoV-2 PCR test, compared to the 10 day isolation rule for patients with milder disease managed in the community. https://www.gov.uk/government/publications/covid-19-guidance-for-stepdown-of-infection-control-precautions-within-hospitals-and-discharging-covid-19-patients-from-hospital-to-home-settings

Please Note

The Scenarios included Appendix 6 are provided in order to broaden your horizon and support your decision making when making clinical decisions. We know that no two situations are going to be exactly the same, just like each service user is unique. So, bearing this in mind, we in CPAC hope that these scenarios may help you develop the questions you may wish to ask the clinical team when formulating a plan of care.

Thanks

CPAC Committee

Introduction

The purpose of the CPAC (Clinical Professional Advisory Committee) is to offer expert clinical and professional advice to the TCT to inform decision making relating to COVID 19 Emergency Planning and Business Continuity.

Psychiatric inpatients are particularly vulnerable to the transmission and effects of COVID-19. As such, healthcare providers should implement measures to prevent its spread within mental health units, including adequate testing, cohorting, and in some cases, the isolation of service users.

CPAC were requested by Tactical command to develop algorithms to support ward staff to cohort our service users. This guidance has been updated to include the National guidance entitled: Legal guidance for mental health, learning disability and autism, and specialised commissioning services supporting people of all ages during the coronavirus pandemic 19 May 2020, Version 2

The Law and guidance:

There are currently no enacted changes to the Mental Health Act 1983 (MHA) legislation. The MHA legal framework is a basic protection of rights. Emergency changes to the current MHA legal framework, set out in the Coronavirus Act, will only be enacted if patient safety is deemed to be at considerable risk – the overarching aim of the emergency powers is to ensure that those people in critical need of mental healthcare are able to access this throughout the pandemic period.

MHA powers must not be used to enforce treatment or isolation for any reason unrelated to the management of a person's mental health, such as detaining inpatients whose refusal to be tested/isolated is unrelated to their mental disorder.

Departures from the MHA Code of Practice:

While there are currently no legislative changes, the Department of Health and Social Care (DHSC) has provided advice on using the MHA Code of Practice during the COVID-19 pandemic period. This aims to offer specific advice and guidance on areas, which are posing a particular challenge as a result of the pandemic and where temporary departures from the Code of Practice may be justified in the interests of minimising risk to patients, staff, and the public. There needs to be cogent reasons to do this and any departure should be justified and recorded clearly, as it may later be subject to scrutiny by the courts.

Blanket Restrictions:

For currently detained patients, blanket restrictions must not be imposed, but the use of the MHA may offer authority for enforcing social distancing and isolation of

symptomatic patients. It is vital these powers are used with regard to the principles of the MHA Code of Practice.

While the NHS and social care are facing unprecedented challenges relating to COVID-19, wherever possible health and care services and professionals must continue to guard against overly restrictive practice.

Ensure that you are following policy/guidance that is agreed:

Decisions about the application of the Mental Capacity Act 2005 (MCA) and MHA have always involved significant nuance and complexity. During the COVID-19 outbreak, providers and Local Authorities should follow their organisational policies to ensure the safety of staff and patients and decide on the appropriate use of the relevant legal framework on a case-by-case basis following on from discussions with MDT.

Decisions made on a case by case basis in relation to isolation:

Isolating patients due to suspected or confirmed COVID-19 in mental health settings may be challenging for all those involved, particularly where the patient refuses to be isolated. This needs to be managed safely to protect patients and staff from transmission and risk of physical injury within legal constraints, including their obligations under the Human Rights Act (1998). As already indicated in this document, colleagues should determine appropriate use of the relevant legal framework on a case-by-case basis, following on from discussions with MDT and support from medicolegal colleagues as required, the key human right that is at risk when considering the management of people, who will not self-isolate, is the Right to Liberty, which is a limited right, and any restriction on this right has to be lawful, necessary and proportionate.

Least Restriction:

Services are operating in unprecedented circumstances, which pose new and complex challenges for staff. It is acknowledged that the impact of COVID-19 may occasionally result in a justifiable need for restrictive practice in order to maintain both patient and staff safety. However, with this in mind, it remains important that at every opportunity we use the least restrictive methods possible in line with the MHA and MCA Codes of practice. Any use of restriction must be proportionate to the risks involved and discussions on a case by case basis must take place.

Where it is necessary to increase restrictions, it is particularly important to make sure that inpatient environments provide sufficient meaningful activities and therapeutic interactions for people.

Cohorting and Process:

HPFT have developed algorithms around cohorting and these should be read in conjunction with the Trust swabbing procedures as well as other guidance such as, PPE and Physical health examinations whilst also taking into account such matters as good hand hygiene, social distancing and infection control measures on the ward.

Definition of a **cohort area** - An area in which Service Users (cohort) with the same infection status (confirmed or suspected) are grouped. Please see the Trust's Swabbing Guidance for further details (Please Click Here for Guidance).

Definition of Isolation – Nursing an individual alone or in an appropriate cohorted area.

When cohorting service users, CPAC has recommended that you take the following principles into account.

Agreed principles

1. New admissions and existing service users who become symptomatic that have been swabbed and are awaiting results, but who refuse to self-isolate represent a challenging group to care for as they may present a risk to other service users. Decisions regarding cohorting for this group of service users should take the risk of spreading infection to others into account. For Symptomatic service users and swab results indicate they are COVID 19 negative, decisions will need to be made exercising clinical judgement and take into consideration the high false negative rate with swabbing.

Asymptomatic COVID-19

It is possible that a large proportion of the population will have COVID-19 yet have no symptoms at all, but we don't know that yet. It seems likely that this will occur more often in the healthiest and the younger age groups, including most children.

Being asymptomatic means that you have no symptoms.

If you live in a house/ward with people with probable COVID-19 infection and you have no symptoms, you may be an asymptomatic case.

Symptomatic COVID-19

Symptomatic can mean showing symptoms, or it may concern a specific symptom. Symptoms are signs of disease or injury. They are noticed by the person. Many conditions and diseases have symptoms. A cough can be symptomatic of an upper respiratory infection

The main symptoms of coronavirus (COVID-19) are a high temperature, a new, continuous cough and a loss or change to your sense of smell or taste.

This terms generally used to classify the illness are:

- Asymptomatic
- Mild
- Moderate
- Severe
- Critical

2. Factors to consider when making cohorting decision include –

    - Symptomatic
    - Asymptomatic
    - COVID test positive
    - COVID test negative
    - People who are refusing to have a swab test or isolate.
    - People who are awaiting a test result
    - People who are unable to have a swab test (including those who lack capacity)
    - Whether service users are shielding or considered vulnerable

    Pay particular attention to the distinction between people who are symptomatic and asymptomatic. In particular be aware that people may present with false negative results.

3. Limits on time service users spend in cohorts need to be considered, informed by clinical judgement.

4. To consider those who have received shielding letters or appear to fall under shielding category following enquiry (due to age/health conditions). To limit interaction with other people and look at how they are nursed. This group of service users should be prioritised for en-suite facilities and be under protective isolation.

5. Services to provide support to service users to access their relatives particularly if they are in isolation. To ensure they have contact via video call with family and friends regardless of where they are cohorted to. (Please see Trust's Visitor Guidance for further details (Please Click Here for guidance)).

We are advising that there are four main types of COVID19 cohort area for an SBU or service. These are:

- An initial admissions COVID19 area
- An initial admissions 'results pending/ admissions area'
- An admitted ward COVID19 area
- An admitted ward 'results pending/ admissions area'

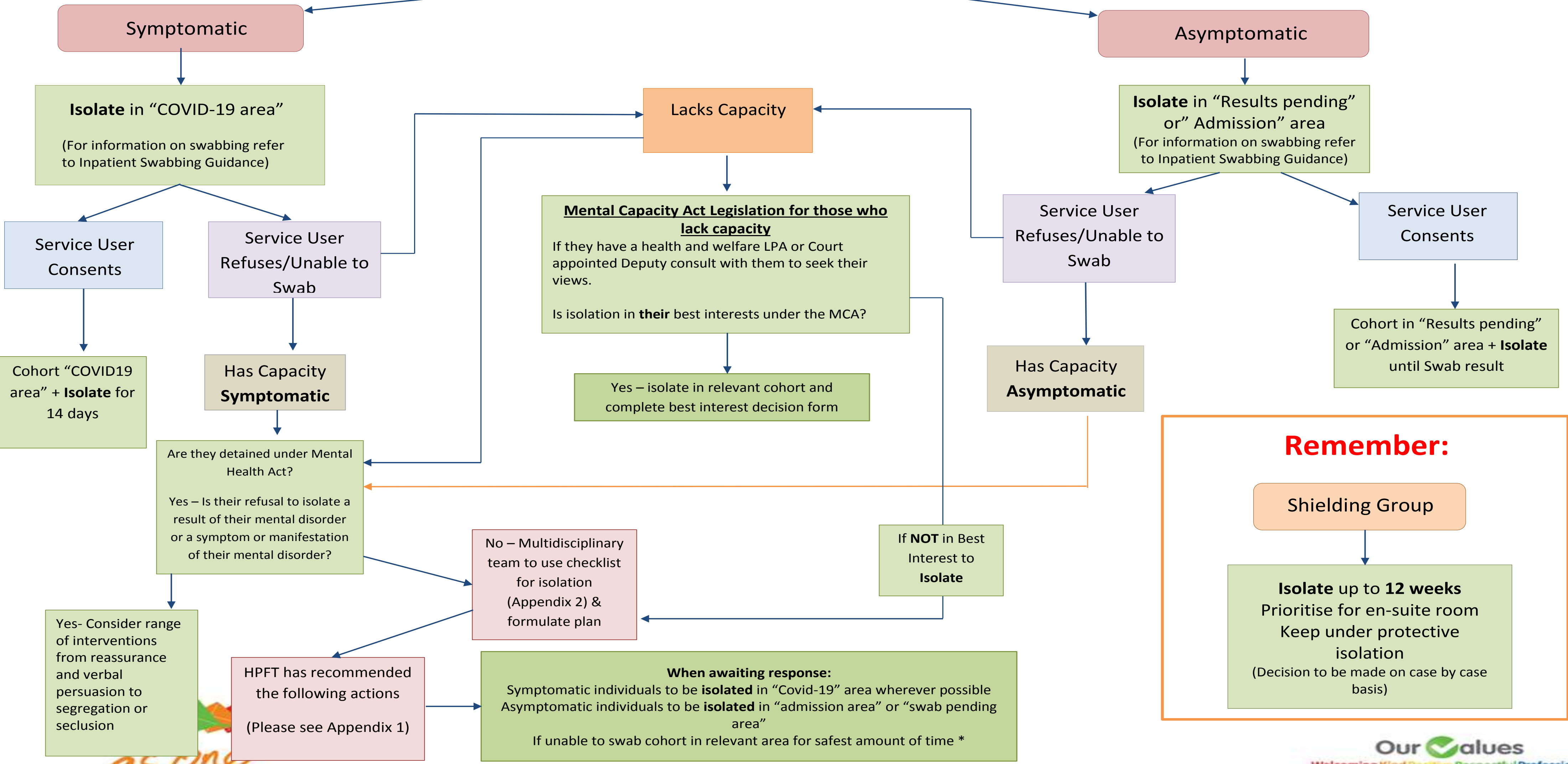
Where possible services should also consider have a 'COVID negative' area, if the estate allows, for the further protection of shielded/ vulnerable groups who have swabbed negative. These are not reflected in the algorithms.

For Additional Guidance for Vulnerable Service Users please see Appendix 3 and Appendix 4.

Service Users on Admission

In the interests of public protection we need to ensure that we balance the rights of individuals with the need to act reasonably and responsibly as an organisation to prevent the spread of Corona Virus.

- **All** SU should be made aware prior to and on admission that:
  - They will be **cohorted** based on symptoms and stage of patient journey (i.e. admitted and swab pending, symptomatic area etc.)
  - They will be **swabbed** as part of their admission process
  - Depending on their symptoms / medical conditions etc. they may be required to **isolate** when on the ward, just as they would be expected to if they were in the community. Additionally they may be required to move rooms during their admission
- If a SU refuses to adhere to these steps at this stage it is important to **start to consider**:
  1. Does this refusal relate to their current mental state? If their refusal is a **symptom or manifestation of mental disorder**? If so think of whether a Mental Health Act Assessment is necessary if they are not already detained.
  2. Will this refusal impact on the safety of other ward users? If so then think of risk assessing this specifically now. Consider discharging if they have capacity.
  3. Does this person have the capacity to refuse cohorting? If not consider now acting based on Mental Capacity Act if this is in their best interest



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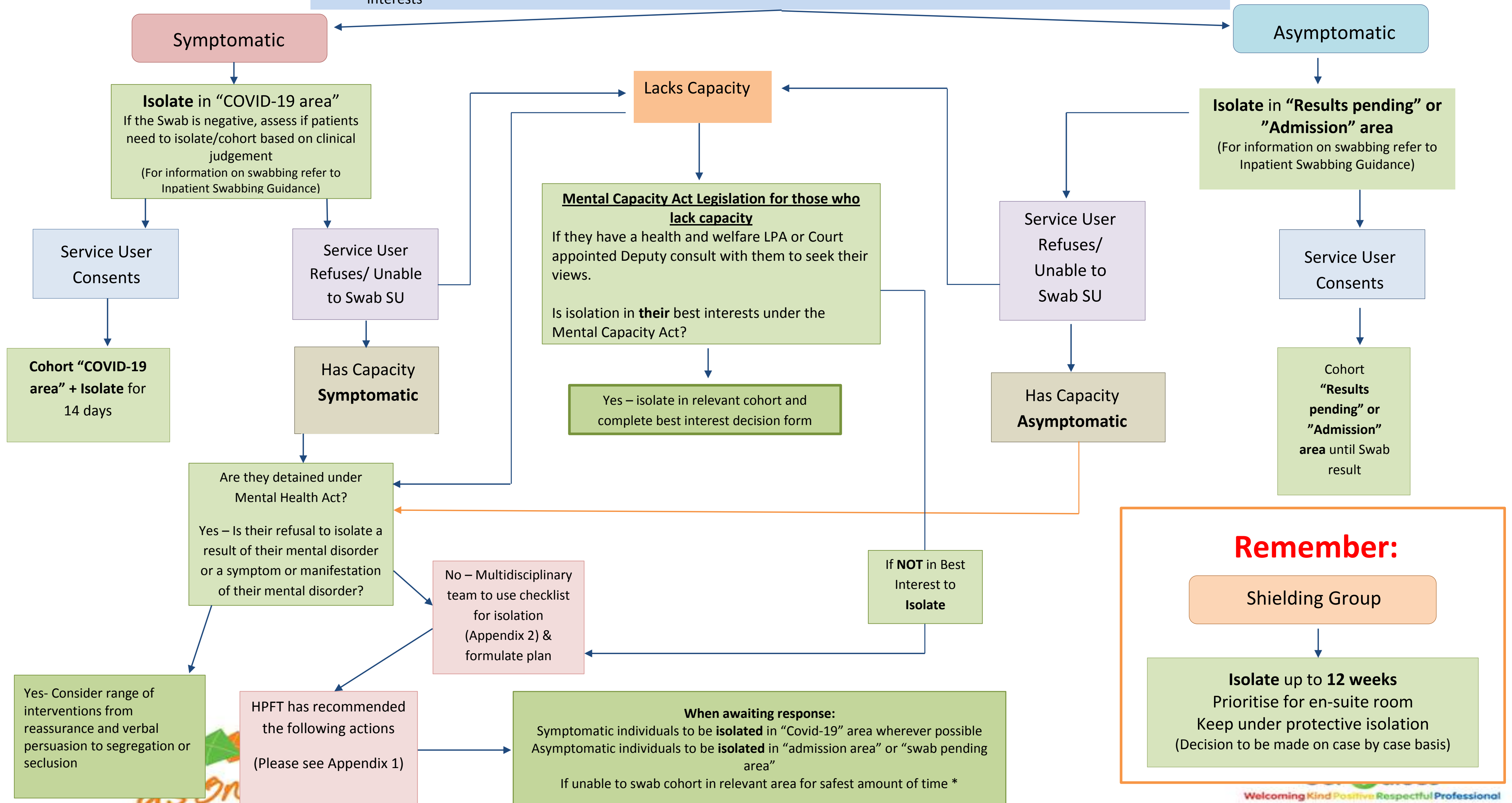
Service Users on Ward

In the interests of public protection we need to ensure that we balance the rights of individuals with the need to act reasonably and responsibly as an organisation to prevent the spread of Corona Virus.

- **All** SU should be made aware on the ward that due to COVID-19:
  - They will be **cohorted** based on symptoms and stage of patient journey (i.e. admitted and swab pending, symptomatic area etc.)
  - They will be **swabbed** as part of their stay if not already done so on their admission
  - Depending on their symptoms / medical conditions etc. they may be required to **isolate** when on the ward, just as they would be expected to if they were in the community. Additionally they may be required to move rooms during their admission
- If a SU refuses to adhere to these steps at this stage it is important to **start to consider**:
  1. Does this refusal relate to their current mental state and is their **refusal a symptom or manifestation of their mental disorder**? If so think of whether a Mental Health Act Assessment is necessary if they are not already detained.
  2. Will this refusal impact on the safety of other ward users? If so then think of risk assessing this specifically now
  3. Does this person have the capacity to refuse cohorting? If not consider now acting based on Mental Capacity Act if this is in **their** best interests



Appendix 1

Recommended actions to take where Service users has capacity and refuses/unable to be swabbed (as mentioned in the cohorting algorithm)

Due to no response received from Public Health England, the following recommended actions are to be followed;

- Refer back to good practice principles
- Undertake a MDT- include a Senior Manager, a Consultant and a Nurse (this may be a Clinical Lead on call out of hours or over a weekend)
- Ensure that your decision making process is clearly documented (no blanket statements)
- Evidence how you reached your decision (please use the checklist below in Appendix 2)
- If the clinical issue is not resolved, then escalate it to your SBU for wider discussion
- If the situation requires a legal view point , then discuss with Tina Kavanagh on 07885377088
- If Tina is not available, raise the matter with Tactical Command
- If the situation cannot be resolved, inform Tina Kavanagh who can then contact Public Health England to enquire if they can assist with Schedule 21 powers.

Appendix 2

COVID-19 Checklist for Isolation

1. Have the specific symptoms that necessitate isolation been recorded in the individual's record to justify isolation?
2. Is the service user/resident agreeing to isolation?
3. If no, is the refusal or inability to co-operate a manifestation of mental disorder?
4. If refusing or unable to cooperate, has the service user/resident's capacity been considered and a record made of this?
5. Have all appropriate people been involved in the decision to isolate and those involved recorded in the individual's record?
6. Has an individual care and support plan been created specifically for the isolation and the restrictions surrounding it, taking into account safety and least restrictive practice principles?
7. Where restrictive action is taken, is it reasonable, necessary and proportionate to the individual situation?
8. Have the following been considered in the care/support plan according to risk assessment and the Human Rights Act (1998):
    a) How physical health care needs will be met (both for COVID-19 symptoms and pre-existing health conditions
    b) Access to fresh air and exercise
    c) Access to personal care facilities e.g. bath/shower, laundry, etc.
    d) How the individual's room will be cleaned
    e) Access to meaningful therapeutic and leisure activities
    f) Access to smoking/vaping/nicotine replacement therapy (where applicable)
    g) Access to family and friends via the use of telecommunications, social media, etc.
    h) Access to money and shopping for personal items
    i) Access to advocacy services
9. Has the service user/resident (and/or advocate and family/carers as appropriate) been fully involved in developing the care plan?
10. Has the individual been given appropriate infection prevention and control advice and education and this evidenced in the written records e.g. taught how to wash their hands properly?
11. Is an up to date risk assessment completed where restrictive interventions are used to manage behaviour that challenges?
12. Where isolation is taking place away from the individual's room, does the service user/resident have access to their own property as per risk assessment
13. Does the isolation environment promote care, welfare and safety?
14. Have alternative arrangements been considered for meetings e.g. ward round, CPAs, tribunals, etc.

Appendix 3

Vulnerable Service Users Admission – Cohorting & Isolation Considerations

The Trust acknowledges that some of our Service Users fit into the "vulnerable" category of patients with regard to COVID-19. We know that these Service Users require heightened care with regard to COVID-19 and a more careful approach needs to be taken to protect them from contracting COVID-19.

This guidance has been drawn up with the assumption that vulnerable service users will likely be admitted onto a ward with other vulnerable service users. Therefore we need to be more careful when admitting these service users to ensure they do not pass on a COVID-19 infection to the ward

It is important to note that each case should be considered on a case by case basis but below are some considerations for the cohorting and testing of newly admitted Service Users who fall into the "vulnerable" or "high risk" categories with regard to COVID-19.

This guidance should be read in conjunction with:

- HPFT Inpatient Swabbing Guidance
- HPFT Cohorting Guidance in COVID-19
- HPFT Guide for those with Intellectual Disability and Mental Health/ Behavioural Problems in COVID-19
- The most up-to-date Public Health England Guidance

This guidance was devised to protect groups of vulnerable service users from new COVID-19 infections and not specifically for the service user who is being admitted. This must be considered when taking decisions about isolation and cohorting for the service user.

Note: this guidance is to be used as a prompt and tool to help you make decisions about how to protect our most vulnerable service users during the COVID-19 pandemic. However the following points must be considered before reading this document:

1) This guidance **should not** be used to enforce **blanket restrictions** on any of our service users
2) As such decisions about how to manage each service user should be done on a **case by case basis**
3) Each case should have input from the **MDT** when considering the best approach for each individual
4) This guidance aims to **keep groups** of service users **safe**; its aim is to reduce exposure to the virus for vulnerable service users
5) Where possible service users should be isolated during the below situations but attention must be paid to using proportionate, reasonable and the least restrictive practice during this time. Also staff should be aware that if a service user does not wish to isolate careful consideration needs to be taken about the next steps. These are outlined in detail in HPFT Cohorting Guidance

In order to verify who falls into the “Vulnerable Service User” group please see **Appendix 4**

Note:

Definition of a **cohort area** - An area in which Service Users (cohort) with the same infection status (confirmed or suspected) are grouped. Please see the Trust’s Swabbing Guidance for further details (Please Click Here for Guidance).

Definition of **isolation** – Nursing an individual alone or in an appropriate cohorted area.

Consideration for newly admitted service users falling into the "vulnerable" groups:

1. Vulnerable service users should be cohorted and ideally isolated on admission for a minimum of 14 days from their first COVID-19 swab **regardless of the result**
    a. COVID-19 positive cases should be cohorted together as per the Cohorting Guidance
    b. Asymptomatic individuals should be cohorted and ideally isolated in a "COVID-19 triage" or "admission asymptomatic" area or identified cohorting facility where possible. There is an understanding that these areas may not be present in all locations so local considerations regarding isolation and cohorting need to be taken into account here
    c. If the service user refuses to isolate or cohort appropriately then please see the cohorting guidance for the next steps

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Note:

This step is important as we know that service users may take 7 days from contracting the infection to displaying symptoms and a further 7 days from that to recover. In addition we know that up to 30% of negative swabs may show an incorrect negative result.

We are aware vulnerable service users are likely to be cohorted with other vulnerable service users so the above step tries to reduce the risk of transmission of COVID-19

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2. If a service user is transferred during this initial 14 day period then they are to be cohorted and ideally isolated in the appropriate cohorting area on the new ward until the 14 days from the swab result is finished. There is no need to start a new 14 day period of isolation following transfer
    a. NB COVID-19 positive or symptomatic cases should not be transferred during their isolation / cohorting phase

3. At the end of the 14 days the Service Users should be medically assessed before stopping their isolation / cohorting. If there are any suspicions of a COVID-19 infection the service user should be swabbed and cohorted in accordance with the swabbing and cohorting guidance

4. If a Service User is unable to be swabbed on admission they should be cohorted according to symptoms of COVID-19 and if possible isolated for an observation

period of 14 days. Attempts to swab the Service User should be retried during this 14 days

5. All service users whether they are vulnerable or not need to be swabbed prior to discharge (this includes those being transferred to a Continuing Care Placement)

References:

1) Legal guidance for mental health, learning disability and autism, and specialised commissioning services supporting people of all ages during the coronavirus pandemic. 19 May 2020, Version 2. NHS. Publications approval reference: 001559
2) Guidance on shielding and protecting people who are clinically extremely vulnerable from COVID-19. Public Health England. Updated 5 June 2020. Available from: https://www.gov.uk/government/publications/guidance-on-shielding-and-protecting-extremely-vulnerable-persons-from-covid-19/guidance-on-shielding-and-protecting-extremely-vulnerable-persons-from-covid-19 Downloaded on 15/06/2020
3) Coronavirus disease 2019 (COVID-19). BMJ Best Practice. Available from: https://bestpractice.bmj.com/topics/en-gb/3000168. Downloaded on: 17/06/2020
4) OpenSAFELY: factors associated with COVID-19-related hospital death in the linked electronic health records of 17 million adult NHS patients. *The Open Safety Collabortaive & Scientific Advisory Group for Emergencies.* 5/06/20 Available from: https://www.gov.uk/government/publications/opensafely-factors-associated-with-covid-19-related-hospital-deaths-in-adult-nhs-patients-28-april-2020. Accessed on: 17/06/2020
5) Interpreting a covid-19 test result: British Medical Journal. 2020;369:m1808. Available from: https://www.bmj.com/content/369/bmj.m1808. Accessed on: 17/06/20
6) Coronavirus (COVID-19) Clinical homeless sector plan: triage – assess – cohort – care. NHS England and NHS Improvement. 14/04/20. Available from: https://www.wscp.org.uk/media/1295/covid19_clinical_homeless_sector_plan.pdf. Downloaded: 17/06/20

Appendix 4

Vulnerable service user checklist

If any of your Service Users receive a tick from the list below they can be considered a COVID-19 vulnerable service user.

If you are unsure of definitions or categories check with a Doctor or the Service Users GP

"Extremely vulnerable service users" – these are those who are classified as the Shielding Group

- ☐ Solid organ transplant recipient
- ☐ People with specific cancers
    - ☐ people with cancer who are undergoing active chemotherapy
    - ☐ people with lung cancer who are undergoing radical radiotherapy
    - ☐ people with cancers of the blood or bone marrow such as leukaemia, lymphoma or myeloma who are at any stage of treatment
    - ☐ people having immunotherapy or other continuing antibody treatments for cancer
    - ☐ people having other targeted cancer treatments which can affect the immune system, such as protein kinase inhibitors or PARP inhibitors
    - ☐ people who have had bone marrow or stem cell transplants in the last 6 months, or who are still taking immunosuppression drugs
- ☐ People with severe respiratory conditions including all cystic fibrosis, severe asthma and severe chronic obstructive pulmonary (COPD).
- ☐ People with rare diseases and inborn errors of metabolism that significantly increase the risk of infections (such as Severe combined immunodeficiency (SCID), homozygous sickle cell).
- ☐ People on immunosuppression therapies sufficient to significantly increase risk of infection.
- ☐ Women who are pregnant with significant heart disease, congenital or acquired.

“Moderately vulnerable service users”

This includes service users whoe are eligible for the annual flu vaccination (except those aged 65 to 69 year old inclusive who have no other qualifying conditions) **AND** they do not fit inot the “extremely vulnerable” group.

This includes:

- ☐ Aged 70 or older (regardless of medical conditions)
- ☐ Under 70 with an underlying health condition listed below (for adults this is usually anyone instructed to get a flu jab as an adult each year on medical grounds):
    - ☐ chronic (long-term) respiratory diseases, such as asthma, chronic obstructive pulmonary disease (COPD), emphysema or bronchitis
    - ☐ chronic heart disease, such as heart failure
    - ☐ chronic kidney disease
    - ☐ chronic liver disease, such as hepatitis
    - ☐ chronic neurological conditions, such as Parkinson’s disease, motor neurone disease, multiple sclerosis (MS) or cerebral palsy
    - ☐ diabetes
    - ☐ those with a weakened immune system caused by a medical condition or medications such as steroid tablets or chemotherapy
    - ☐ being seriously overweight (a BMI of 40 or above)
    - ☐ those who are pregnant
- ☐ Aged 55yrs or older and homeless

Appendix 5

Prevention and Management of Acute Disturbance in the context of COVID-19

1. Introduction

This guidance relates to the stages to be used when managing behaviours which challenge and are associated with suspected or confirmed COVID-19.

This guidance should also be referenced against the following:

- Management of Violence and Aggression Policy
- Recorded Guidelines when Cohorting Service Users on Inpatient Wards
- Inpatient swabbing guidance
- Seclusion and Long Term Segregation (LTS) Policy
- Personal and Protective Equipment (PPE) guidance
- Chapter 26 of the Mental Health Act (MHA) Code of Practice, Department of Health (2015) MHA 1983
- Safewards interventions
- National Association of Psychiatric Intensive Care Units (NAPICU) guidance
- Rapid Tranquilisiation Policy.

2. Legal and Ethical Issues

Every service user should be reviewed on an individual case by case basis, ensuring that interventions are the least restrictive and in their best interests. When there is a suspected or confirmed case of COVID-19, the Trust's cohorting guidance and key principles should be followed.

Isolating service users owing to suspected or confirmed COVID-19 in inpatient settings may be challenging for all those involved, particularly where the service user refuses to be isolated. This needs to be managed safely to protect service users and staff from transmission and risk of physical injury within legal constraints, including their obligations under the Human Rights Act (1998).

The multi-disciplinary team (MDT) should determine appropriate use of the relevant legal framework on a case-by-case basis, and seek support from medicolegal colleagues as required. The key human right that is at risk when considering the management of people, who will not self-isolate, is the Right to Liberty, which is a limited Right and any restriction on this Right has to be lawful, necessary and proportionate.

Blanket restrictions must not be imposed, but the use of the MHA may offer authority for enforcing social distancing and isolation of symptomatic service users, particularly where their refusal is a symptom or a manifestation of their mental disorder. It is vital that these powers are used with regard to the principles of the MHA Code of Practice. While the NHS and social care are facing unprecedented challenges relating to COVID-19, health and care

services and professionals must continue to guard against overly restrictive practice.

Where legal and ethical issues require resolution the following process should be followed via the following recommended actions:

- Refer back to good practice principles
- Undertake a MDT- include a senior manager, a consultant and a senior nurse (this may be a Clinical Lead Out of Hours)
- Ensure that the decision making process is clearly documented (no blanket statements)
- Evidence how the decision was reached (using the checklist in Appendix 2 of the Cohorting Guidance)
- If the clinical issue is not resolved, then escalate it to the Strategic Business Unit's (SBU) senior management for wider discussion
- If the situation requires a legal view point, then discuss with the Trust's Mental Health Legislation Team and also with Tactical Command
- If the situation cannot be resolved, discuss further with Tina Kavanagh who can then contact Public Health England to enquire if they can assist with Schedule 21 powers.

3. Primary Interventions - proactive approaches to prevent violence and aggression upon admission

Upon admission

Past experiences should be considered and an assessment completed, to include risk of violence, trauma history and treatment history including factors that raise anxiety or trigger behaviours which challenge. Inability to read non-verbal communication, because of face coverings or diagnosis such as Learning Disability or Autism can raise anxiety and escalating behaviour. The use of pre-prepared information in an easy read format, alongside on-going reassurance is useful *(see Safewards interventions).*

Managing anxiety and distress

Improved communication through notice boards, written communication, groups, text, and digital messaging is an option. Individuals may be fearful of COVID-19 which can be stressful. Removing ward activities can be counterproductive and wards should adapt communal activities, avoiding unnecessary large group gatherings and also to increase personal space. Anxiety may affect tolerance and self–awareness, increasing the risk of frustration and conflict *(see Safewards interventions).*

Assessing Capacity

A service user identified as an infection risk, may need to be in isolation. If refusing or unable to cooperate, the service user's capacity should be considered and a record made of this *(see Recorded Guidelines When Cohorting Service Users on Inpatient Wards, Appendix 2: COVID -19 Checklist for Isolation).*

4. Secondary Prevention – active interventions being used to reduce harm relating to violence and aggression

Early Interventions

Include early interventions to minimise and resolve concerns when they occur to manage risk of conflict, through the use of timely risk assessment that offers clear and guided safety plans. This should focus on the use of the least restrictive interventions, jointly planned with the service users where possible.

Legislative Guidance

The Management of Disturbed Behaviours is covered in Chapter 26 of the MHA Code of Practice, Department of Health (2015), also referenced in the Trust's Management of Violence and Aggression Policy. Where there is any departure from the Code of Practice, clear robust MDT documentation must be completed to justify the management plan.

Support Plans

The ward should have a clear method of identification of service users who may present risk if suspected or infected by COVID-19 and showing signs of behaviours that challenge. This should be based on a robust checklist of symptoms and COVID-19 testing wherever this is possible. *(See Cohorting Service Users on Inpatient Wards Appendix 2: COVID-19 Checklist for Isolation)* alongside a support plan.

Tertiary Intervention – Reactive intervention to manage violence and aggression

Tertiary interventions should include a process of de-brief and post incident support designed to reduce the impact of potential trauma, through approaches such as Huddles, SWARMs and individual support. An individual service user who is positive for COVID-19 and experiencing acute mental and behavioural disturbance, may inadvertently increase the infection risk to others; this may involve physical resistance and a proportional response is required to manage the situation.

In these circumstances, this could be considered as disturbed behaviour in the context of their mental disorder representing a significant risk to others. This should be managed using the least restrictive and last resort interventions, where alternatives have been explored to manage these exist. Justification for Seclusion or LTS on for those with a mental disorder, who are detained under the MHA (1983) or where there is consideration to assessing them under the MHA(1983) - falls under the safeguards detailed in the MHA Code of Practice 2015, which is cross referenced in the Trust's Seclusion and LTS Policy.

Assessment and review of Long Term Segregation and Seclusion

This guidance does not provide authority for service users presenting with the risk of infection to others with COVID-19 to be secluded or placed in LTS for this risk alone. Least restrictive options must be employed wherever possible. The application of the MHA Code of Practice 2015 should be considered in the context of The Coronavirus Act 2020 (in particular Schedule 21). Whilst these measures may not be considered proportionate to those within the MHA Code of Practice 2015, they may offer a cogent reason to depart from the Code and provide rationale for this. Where there are such departures from the MHA Code of Practice 2015 required, every effort should be made to ensure the principles of the MHA Code of Practice 2015 and the related safeguards are followed.

Where isolation is required for infection prevention and purposes only and the service user disagrees but does not actively resist the isolation care plan, this may not reach the threshold for seclusion. If their refusal to isolate is a result of their mental disorder or a symptom or manifestation of their mental disorder, then the MHA may be used to isolate or seclude them.

Where risk of infection has been robustly established, it could be considered as a cogent reason to depart from the Code's definition of seclusion, providing that the service user is willing to cooperate and/or not physically actively resist the isolation care plan. It is possible that there may be no alternative to using bedrooms or locking off areas of a ward.

PPE

Any use of PPE must be worn in line with Trust guidelines when undertaking restrictive practices, such as restraint.

Monitoring in Seclusion, Isolation and Longer Term Segregation

Specific care plans around diet, fluid intake and activities of daily living should be developed. Contact with relatives should be encouraged via electronic means, to establish contact and links with wider family and friends. The Trust's Seclusion and LTS Policy must be adhered to at all times.

Medication use for acute disturbance

Medication should follow the Trust's Rapid Tranquilisation guidance but require some additional consideration to the specific contra-indications and side effects that are known with COVID-19 and other infections. Importantly, the current physical health of the service user is a key factor in the choice.

If suspected or diagnosed COVID-19 and acutely disturbed, with no signs of respiratory compromise (decreased or increased respiratory rate), cardiovascular disease or decreased level of consciousness; then medication can be used with caution, as the full effects of COVID-19 are still unknown. Consider short acting medication as service users physical health condition may rapidly deteriorate.

Ensure the medication for acute disturbance is an effective dose, as an ineffective dose may lead to the increased need for additional injections. Oral medication should be offered as the first choice. Parenteral medication is more likely to cause dose-related side effects, such as respiratory depression, postural drop, the QTc prolongation and extra-pyramidal side effects (EPS).

COVID-19 affects the respiratory function. Psychotropic medications, especially benzodiazepines, can cause respiratory depression. Benzodiazepines should not be used when a service user has acute pulmonary Insufficiency. Promethazine is a suitable alternative for service users in whom respiratory function is compromised or in those sensitive/tolerant to Benzodiazepines.

Lorazepam would be the preferred Benzodiazepine as it has a shorter half-life. Simultaneous injections of Olanzapine and Benzodiazepines can result in excessive sedation and cardiorespiratory depression so must be given at least an hour apart. **Ensure immediate access to Flumazenil is available if Benzodiazepines are given**. If there is evidence of cardiovascular disease, including a prolonged QTc interval, or no recent electrocardiogram (ECG), avoid intramuscular haloperidol combined with intramuscular Promethazine. Consider intramuscular Olanzapine or intramuscular Lorazepam.

Febrile individuals with a history of seizures may have their seizure threshold altered by some medications. Medical advice should be sought if there is any doubt. All antipsychotics can cause Neuroleptic Malignant Syndrome (NMS). If NMS occurs, immediately discontinue antipsychotics and other drugs that may contribute to the underlying disorder, monitor, and treat symptoms, and treat any concomitant serious medical problems.

Physical health monitoring, especially respiratory rate and level of consciousness should be carried out when either oral or parenteral rapid tranquillisation is given.

July 17th 2020. V1. A. Cashmore, T.Kavanagh, R.Talbot, A.Berry, Dr J. Sutcliffe, J.Vincent, Dr D. Vekaria, Dr S.Syed

Appendix 6

Please Note

The following Scenarios are provided in order to broaden your horizon and support your decision making when making clinical decisions. We know that no two situations are going to be exactly the same, just like each service user is unique. So, bearing this in mind, we in CPAC hope that these scenarios may help you develop the questions you may wish to ask the clinical team when formulating a plan of care.

Thanks

CPAC Committee

Case vignettes

Having considered the context and rationale for isolation of patients in mental health settings, as well as some of the legal background, we will illustrate the practical application of the law as it stands, using a number of hypothetical cases. These have been written to explore the issue of *isolation* in particular – and we acknowledge therefore some artificiality in their construction. We emphasise at the outset that, where applicable, the principles of the MHA 1983 demand that all less restrictive options (e.g. cohorting, or community treatment) should have been considered before resorting to isolation.

3.1. Case 1: A voluntary patient refuses to comply with isolation on a ward

Caroline has been admitted voluntarily ('informally') due to concerns that she is experiencing a relapse in her bipolar affective disorder. She understands that she's unwell, that her erratic behaviour in the community was putting her at risk, and was distressing to her family. She understands the need for treatment, and appears to be able to consent validly to an informal psychiatric admission. She has begun coughing and has had a documented fever of 38.5C. She doesn't think that she has COVID-19, and believes that even if she did, the media has over-blown the risks, and that she shouldn't self-isolate in her bedroom. A viral swab has been sent but there is a 2–3 day wait for results. There is no capacity to 'cohort' patients.

As discussed in the introduction, in the absence of a cohorting option, there are compelling reasons for Caroline to be isolated from other patients on her ward – she presents a significant infection risk to a number of physically vulnerable people.

We might start by considering whether she has capacity to make the decision not to self-isolate. There certainly is evidence of a disturbance in the functioning of her mind or brain – she is hypomanic, and her resultant grandiosity may have impacted her appraisal of the situation – or she may be engaging in a 'manic defence', denial in the face of significant health-anxiety. It is unclear whether she really understands the concerns of the team and her need for isolation (given her denial of the facts and risks), and her hypomania may also have affected her ability to weigh up her options appropriately. However, as discussed even if on balance we felt that Caroline lacked capacity with regards to this decision, the MCA 2005 cannot be relied upon to justify a deprivation of liberty in this context. The relevant risk is to others, not to herself, and so it is a considerable stretch to argue that it is in *her* best interests to be locked in her bedroom for a week.

Clearly, if it was felt that Caroline did have the relevant capacity, the MCA 2005 would not be of any assistance. In the *very* short-term, and to prevent her posing an immediate risk of serious harm to others, it may be necessary and proportionate to stop Caroline from leaving her room – relying on

common law to do so.[39] However, as discussed, this is far from satisfactory for the days-long period required for respiratory isolation.

We may then reassess whether or not Caroline is truly consenting to being on the ward, if she is unable to comply with self-isolation. Whilst blanket restrictions and rules should usually be avoided, they may be justified on the basis of necessity and proportionality. For example, patients are usually not allowed to enter staff areas, other patients' bedrooms, or areas designated for the opposite sex. Patients are expected not to make lots of noise at night or constantly set-off alarms for no reason – to do otherwise would be a clear reason to reconsider whether they were consenting validly to being on the ward. In our view it is arguable that self-isolation of suspected or confirmed COVID-19 cases is a necessary and proportionate response to the risks of not doing so – and an expectation on voluntary patients to comply with this as a condition for admission would therefore be justifiable.

Given the above, and assuming that a satisfactory discussion was had with Caroline about the issue, and it was understood she had the relevant decision-making capacity, it would appear that she is no longer consenting validly (or indeed, agreeing) to the conditions of informal admission. *If* this is accepted, her risks to self / others should be reassessed and it considered whether or not she is detainable under the MHA 1983, or whether she could better be managed in the community (taking into consideration the risks she now presents on the ward). If it was felt that Caroline had capacity with regards to the decision to stay on the ward or not, she could make this choice herself, though her capacity status does not preclude the use of the MHA 1983.

If detained under the MHA 1983, questions and considerations about how best to review her deprivation of liberty and meet her physical and mental health needs remain, to which we return below.

3.2. Case 2: Detained patient who is too thought disordered to comply with self-isolation

Owen has a long history of paranoid schizophrenia which has been in remission for over a decade. He usually has a supportive network of friends and carers, he has a voluntary job three days a week, and attends a day center the other two. Since the COVID-19 outbreak, almost all of his usual support disappeared. He became anxious and started taking a reduced dose of his clozapine. He was detained under s.3 of the MHA 1983 after being found wandering in a state of self-neglect outside his flat. On admission he was found to have a fever, though he appears otherwise physically well. He appears distracted and profoundly thought disordered. He is neither aggressive nor violent. He seems incapable of engaging in a conversation around isolation and repeatedly tries to leave his bedroom. In order to prevent him from doing so, he has been placed by staff on 1:1 observations, and his bedroom door is intermittently being locked.

Once again, there is good reason for Owen to be isolated at present on the ward. He lacks capacity regarding the decision to self-isolate, but as discussed above, that is unlikely to affect our management. He is being locked in his room (which has an en-suite bathroom), though even if the door was unlocked, he'd be stopped from leaving by his 1:1 nurse – either way his movement has been restricted very severely.

Owen's team may explore public health legislation, but for the same reasons as discussed in relation to Caroline, these would be of questionable application to someone who by virtue of their mental disorder cannot comply with isolation, and lacks relevant capacity regarding this decision.

Owen's leaving his room presents a risk of harm to other patients, and is the result of disordered behaviour as a result of his mental illness. It is arguable as to whether his behaviour represents '*severe* behavioural disturbance'. Compared to presentations which would usually warrant seclusion, he is *not* severely behaviourally disturbed. Compared to how he usually is at his voluntary job, his behaviour certainly *is* severely disturbed. It is arguable therefore that he meets criteria to be secluded.

Owen currently has an en-suite bathroom, his room is well proportioned, and he has a selection of his own belongings, including his mobile phone, so he can call his friends. Furthermore, he may have COVID-19 and transporting him to a dedicated seclusion room on another unit will bring about a multitude of opportunities to pass this on. Given that he's not physically aggressive or overtly distressed, there seems to be cogent reason to depart from the CoP on this aspect of seclusion policy. Very few wards outside of the high secure estate would have adequate facilities to seclude patients requiring isolation in the long-term.

As discussed previously, there are three broad reasons for regular seclusion reviews, the first being to consider whether seclusion can be terminated. Depending on local infection control policy, it may be clear at the outset that Owen needs to be isolated for seven days. If so, this aspect of the review becomes far less relevant – indeed it would seem disingenuous to pretend otherwise. Despite this, it *may*, for example, be legitimate to 'terminate seclusion' if Owen's mental state improves such that he can self-isolate on a voluntary basis – though we will discuss the appropriateness of this in a later vignette.

The other two reasons (assessment of psychiatric and physical health needs) remain relevant. Indeed, consideration of the patient's physical health most definitely increases in importance, given the possibility of a serious respiratory condition. However, in the context of COVID-19, the frequency and manner of reviews must also consider the infection risk to staff. As such, psychiatric aspects of the review may justifiably take place remotely using videoconferencing (as long as this was felt clinically sufficient). Physical health will need to be kept under close review (given that patients with COVID-19 can deteriorate rapidly), and concerns escalated to the medical team as needed. It should

go without saying that adequate PPE ought to be used, both by staff, and by the patient if they are able to safely tolerate this. The CoP's minimum standards for regular review must not override clinical judgment if a patient needs closer medical supervision.

It is quite possible that during the COVID-19 pandemic, a high proportion of patients will need respiratory isolation. If this were the case it would be particularly important to implement cohorting strategies, so as to minimise restrictions on liberty. However, there may be points at which there are simultaneously no provisions for cohorting, and large numbers of patients being isolated. If each were subject to normal seclusion review schedules, this would have a very significant resource implication for staffing. This may be unavoidable, and therefore first require preparation-for by providers – though may in extremis provide cogent reason for individual provider policies to temporarily deviate from the CoP.

There is, however, an important legal issue arising, which has not yet been the subject of consideration by the courts in England & Wales. Owen is lawfully detained at the hospital, because he has been admitted under the MHA 1983. However, Owen is subject to *additional* restrictions at the hospital because he is in isolation. In *Munjaz v United Kingdom*,[40] the European Court of Human Rights ('ECtHR') recognised that individuals detained in hospital under the MHA 1983 enjoy residual liberty there, and that it is possible on the facts of any given case for additional restrictions imposed upon them to amount to an *additional* deprivation of liberty itself requiring authorisation by way of a procedure prescribed by law. The ECtHR found that the periods of seclusion that Colonel Munjaz was subject to (which were as long as 21 days at a time) did not cross the line. It placed weight upon four factors[41]: (1) that he was already in a high security hospital; (2) that the seclusion was not imposed as a punishment but was such as to contain severely disturbed behaviour which is likely to cause harm to others[42]; (3) the length of his seclusion each time was a matter of clinical judgment; and (4) (the factor upon which the court placed the greatest weight) the seclusion was implemented in as liberal a fashion as possible.

The reasoning of the court is perhaps a little obscure – after all, whether or not a confinement should be seen as a deprivation of liberty arguably has nothing to do with whether it is said to be clinically necessary: that goes to whether the deprivation of liberty is justified.[43] The first of the factors will also not apply in most situations. However, the logic of the judgment does suggest that, especially if seclusion in isolation is carefully monitored, and the impact upon the patient minimised, the line may not always be crossed into the situation of an additional deprivation of liberty.

This is to say that the manner in which providers safeguard Article 5 rights, e.g. using seclusion provisions of the MHA CoP, or otherwise, may be determinative of whether or not that person has been deprived of residual liberty. And, if they have been so deprived, then unless the public health

mechanisms described above in relation to Caroline are invoked, it seems likely that an application to court would be required.

Otherwise, there must be grounds to doubt as to whether there would be lawful authority for the additional deprivation of liberty to which Owen would be subject.[44] Although there are powers to seclude ancillary upon detention (discussed above), those powers have never been tested against the proposition that, for purposes of Article 5, the person is to be seen as *deprived* of their liberty, as opposed merely to having their liberty restricted. If they are so deprived, then whatever the position at common law,[45] there would have to be specific additional consideration, justification, and authorisation of the position to satisfy Article 5(1) ECHR and (arguably) specific additional appeal rights to a court so as to satisfy Article 5(4). Indeed, even if seclusion proceeded by reference to the procedure set down in Chapter 26 of the MHA 1983 CoP, it is arguable that would not be sufficient to satisfy Article 5 (for instance, Owen would have no stand-alone right of appeal to a court against his seclusion). This paragraph is quite difficult to read if you don't have a legal background.

The question therefore is whether seclusion itself (as applied to COVID-19 isolation for a fixed time duration), flexible application of seclusion, or indeed bespoke policies developed for COVID-19, would risk crossing this line.

The decision in Colonel Munjaz's case is also of importance for reminding us that, whether or not Article 5 is engaged, Article 8 is undoubtedly engaged, and that:

"the importance of the notion of personal autonomy to Article 8 and the need for a practical and effective interpretation of private life demand that, when a person's personal autonomy is already restricted, greater scrutiny be given to measures which remove the little personal autonomy that is left."[46]

It would be infinitely preferable were the Government to issue an addendum to the CoP to address the position in relation to those such as Owen, because, without such addendum, Trusts (and private hospitals) are operating without any very clear framework. Even with such a framework, and as noted above, a question would still arise as to whether that would suffice to comply with Article 5 in the event that the line were crossed from restriction to deprivation of liberty, but it would make it much easier to contend that the line was *not* crossed.

At a minimum, and pending any addendum, a very clear policy should be put in place – and, ideally, agreed with CQC.[47] If I recall correctly we were told that CQC can't help us in these matters.

3.3. Case 3: A capacitous patient refuses to self-isolate on a forensic ward

Vaughn is a 36 year old man with diagnoses of schizoaffective disorder (currently well-manged on a depot antipsychotic) and antisocial personality disorder (ASPD), currently detained under s.37/41 on a medium secure forensic unit. He's developed a new continuous cough, and says that he must have got it from staff as they're the only people who enter and leave the otherwise locked building. He thinks he probably has COVID-19 but says he doesn't care if he gives it to other patients or staff, and says it is his right to use the TV lounge as much as he wants. He quickly became aroused and threatening when told that he should be self-isolating. He is unlikely to be discharged as he is in the midst of offence-related psychological work, and has not yet had leave granted by the Ministry of Justice, due to a succession of violent incidents on the ward.

Vaughn's relevant mental disorder (ASPD) is resulting in behaviour which is putting others at risk of harm. When asked to comply with a plan which would mitigate this risk, his behaviour becomes more aggressive, and could be described as 'severely disturbed'. In this context it seems that seclusion, in a dedicated seclusion room, may be the only way to manage his risk to others (both in terms of physical aggression, and infection risk). Important considerations remain as to how to meet his physical health needs and minimise infection risk.

Given that he appears to have capacity with regards to his decision not to self-isolate – practical difficulties notwithstanding, it may be appropriate to seek to invoke the public health legislation set out above. This legislation is enforceable by the police, even if they may not necessarily be willing to seek to do so. It may, however, provide a deterrent to Vaughn in this situation. It is unlikely that it would be justifiable to remove a patient from a mental health ward to custody on public health grounds – though as discussed above, risk to other patients on the ward needs to be factored into the equation as to whether admission is the least risky way to manage the patient, and may give cause to discharge a patient. Were Vaughn to actively spit at another person he could be charged with assault.

It is not impossible that Vaughn may decide, after being informed of the relevant public health legislation, that he is happy to self-isolate on the ward. We will return to the legitimacy of such 'voluntary' self-isolation in the final vignette.

3.4. Case 4: The compliant but non-capacitous patient

Ines is a 46 year old lady who is severely depressed and detained under S3 of the MHA 1983. She displays profound psychomotor retardation and very rarely leaves her room. She is provided meals in her room. She is mute, and appears distracted. It is not possible to engage her in conversation and it is not clear that she understands that given her new cough, she presents an infection risk to others and is being asked to self-isolate. Nonetheless, she 'passively complies', never trying to leave her room. Crucially, if she did try to do so, she would be stopped.

The same issues will arise as in Owen's case, as to whether Ines' situation amounts to a deprivation of the residual liberty to which she is subject. Applying the logic of Colonel Munjaz's case, it is *less* likely that she should be seen as subject to an additional deprivation of liberty than Owen, because there are no actual steps being taken to seclude her by clinical staff. Equally, however, it will be just as – if not more – important that steps be taken to ensure that her autonomy is maximised (and her physical and mental health do not suffer). As with Owen, if she is deprived of her liberty then it seems likely that an application to the High Court will be required for it to authorise that additional deprivation of liberty under its inherent jurisdiction.

3.5. Case 5: Voluntary self-isolation on inpatient wards

David is a 52 year old man who's been admitted voluntarily following a highly risky suicide attempt. He's recently lost his job, separated from his wife and family, and been made homeless. He has no support network. He is clinically depressed and consented validly to inpatient admission on this basis, recognising that until his mood improves and he has accommodation, he would present a very significant risk to himself if he weren't admitted. He develops a cough and fever and, being aware of the government guidance, is happy to self-isolate in his en-suite bedroom on the ward. He says he's happy to be prevented (by locking his door, if need-be) from leaving his room for the next 14 days.

We have alluded throughout to the possibility that patients might voluntarily self-isolate, much in the same way that they may voluntarily be admitted to hospital. Consent to such measures is valid only if made by a person who is adequately informed (of the risks, benefits, and alternatives to the proposed intervention), has capacity with regards to the decision, and who has come to their decision freely, that is, in the absence of coercion.

It would be wholly inappropriate to accept as valid the consent of an individual to admission, if this consent was given on the understanding that they would otherwise be detained (e.g. initially using s.5 holding powers). This amounts to de facto detention, in which patients are effectively detained but have no recourse to the safeguards of the MHA 1983. The CoP states that *“The threat of detention must not be used to coerce a patient to consent to admission to hospital or to treatment (and is likely to invalidate any apparent consent)”*.[48]

The CoP states that seclusion should be regarded as seclusion, even if the patient has ‘agreed to or requested such confinement’.[49] By extension, even if the patient consents to isolation, and particularly if that isolation will be enforced for a set, non-negligible period of time – that restriction of their right to liberty should be accompanied by appropriate procedural safeguards.

Further, a patient's initial consent to admission cannot be used to authorise someone's detention should they subsequently change their mind, or lack capacity to continue to consent to their

admission.[50] If the next day, David said he had changed his mind and wanted to use the TV lounge on the ward, it would be unlawful to prevent him from doing so *solely* on the basis that he had consented to a week's isolation the day prior. There is no provision for Ulysses clauses such as these in English law.

If we accept that isolation for COVID-19 symptoms is a reasonable ‘blanket restriction’ (as discussed in relation to Caroline's case), then potentially David could voluntary self-isolate in a room in the hospital, but only on the conditions that it is clearly understood that the choice he had is (1) stay in the room; or (2) leave the hospital – and that he was making this choice freely.

For voluntary patients who are truly free from the threat of s.5 holding powers and subsequent detention, voluntary isolation may then be free from coercion. However, for detained patients, particularly those for whom immediate discharge is a very remote possibility (e.g. those subject to s.41 restriction orders), there can be no pretence that patients requiring respiratory isolation face a true choice. In the absence of cohorting arrangements, they will either ‘voluntarily’ agree to self-isolation or be secluded in their rooms.

There are patients who are admitted voluntarily who would have been detained had they not consented to admission. It is widespread practice, and considered a less restrictive approach, to allow this, so long as the patient was not ‘threatened’ with detention and therefore coerced them into admission. This is ethically difficult territory, as without knowledge of their ‘true’ range of options (in order to ensure it is given freely), their consent is arguably not truly informed. It could be argued that if a detained patient were not to be informed that they would be made to isolate should they not comply with isolation (in an attempt to avoid coercion), that they could voluntarily self-isolate. However, it is clear that this faces similar ethical difficulties insofar as their choice is poorly informed, and the validity of their consent somewhat artificial.

If it is the case that detained patients cannot avoid being coerced regarding requests to self-isolate, then it follows that they cannot validly consent to self-isolation. Returning to the issue of voluntary patients, voluntarily self-isolating – our position on detained patients is instructive, given the fine line between the duties of providers to detained and voluntary patients, as highlighted in the case of *Rabone*.[51] This returns us to the issue of the voluntariness of consent if voluntary patients nonetheless fall within the scope of the MHA 1983 and therefore may be made subject to s.5 holding orders.

In short, voluntary self-isolation on a psychiatric ward is likely to be a tenable legal position in few circumstances, and perhaps never when the patient is already detained.