Livewell Southwest

Seclusion Policy

Version No. 2.5

Review: July 2019

Notice to staff using a paper copy of this guidance

The policies and procedures page of Intranet holds the most recent version of this guidance. Staff must ensure they are using the most recent guidance.

Author: **Matron, Recovery Services Mental Health**

Asset Number: **57**

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Document Review History

Version no.	Type of change	Date	Originator of change	Description of change
For previous review history please contact the PRG secretary.				
1.3	Amendment	October 2012	Modern Matron Recovery Services	Extraction of a line that relates to females. Small addition to form to detail communication in relation to police involvement. Updated to PCH Format.
2	Ratified	Nov 2012	PRG	Ratified.
2.1	Amendment	July 2014	Modern Matron Recovery Service	Addition of Pathway For Seclusion Audit tool (Appendix F) Format changes to forms Minor amendments to main body of document.
2.2	Amendment	November 2014	Modern Matron Recovery Service	Amendment made in light of SystmOne record keeping requirements. clarifying staff responsibilities.
2.3	Amendment	April 2015	Modern Matron	Amendment in of Audit some minor wording changes
2.4	Amendment	June 2015	Modern Matron and MHA Manager	To reflect changes as per the reviewed Code of Practice 2015
2.5	Paperwork updated	June 2016	Professional Lead	Minor changes following final audit. Updated to LSW.

Seclusion Policy

This policy should be read in conjunction with Chapter 26 of the revised Mental Health Act 1983 Code of Practice 2015 (The Code), which came into force on 1st April 2015 *"Safe and therapeutic responses to disturbed behaviour"*. In particular the paragraphs relating to seclusion are applicable. All the guiding principles contained in the Code of Practice should be considered when making decisions in relation to care, support, or treatment provided under the Act. Chapter 1 of the Code gives further guidance on the principles and their meaning. The principles are:

Least restrictive option
Empowerment and involvement
Respect and dignity
Purpose and effectiveness
Efficiency and equity.

"The Code describes legislative functions and duties and provides guidance. Whilst the whole of the Code should be followed, please note that where 'must' is used, it reflects legal obligations in legislation (including other legislation such as the Human Rights Act 1998) or case law, and must be followed. Where the Code uses the term 'should' then departures should be documented and recorded; paragraphs II to VI explains the status of this guidance. Where the Code gives guidance using the terms 'may', 'can' or 'could' then the guidance in the Code is to be followed wherever possible."
(The Mental Health Act 1983 Code of Practice 2015 Introduction Page 13).

1. Introduction

1.1 The Mental Health Act 1983 Code of Practice, revised in 2015 defines seclusion in the following way, "Seclusion refers to the supervised confinement and isolation of a patient, away from other patients, in an area from which the patient is prevented from leaving, where it is of immediate necessity for the containment of severe behavioural disturbance which is likely to cause harm to others."

1.2 Seclusion should only be used in hospitals and in relation to patients detained under the Act. If an emergency situation arises involving an informal patient and, as a last resort, seclusion is necessary to prevent harm to others, then an assessment for an application for detention under the Act should be taken immediately.

1.3 When confronted with an acute behavioural disturbance. The choice of restrictive intervention must always represent the least restrictive option to meet immediate need. Positive and Proactive Care: *(Reducing the need for restrictive interventions 2014 Department of Health).*

1.4 Seclusion is not a treatment technique and should not feature as part of any treatment programme.

1.5 Seclusion should never be used as a means of managing self-harming behaviour. Seclusion should only be used when professional involved are satisfied that the need to protect other people outweigh any increased risk to the patient's health or safety arising from their own self-harm and any such risk can be effectively managed.

1.6 Seclusion should only take place in in a room that has been specifically designed for the purpose of seclusion.

1.7 Lee Mill has 2 seclusion rooms, which are for the patients at Lee Mill. However, in exceptional circumstances the Glenbourne Unit can access the seclusion room, for male patients. This would be as part of the transition to Psychiatric Intensive Care Unit (PICU) or medium security.

- The use of seclusion must be agreed by the nurse in charge at Lee Mill. An agreed time for arrival must be agreed with both parties.
- There must be a time limited agreement as part of a management plan of discharge within 24 hours.
- The clinical team and Responsible Clinician (RC) must retain responsibility and provision of care for the patient. The staff monitoring seclusion will be provided for by Glenbourne.
- The transport arrangements and safe transfer are the responsibility of the Glenbourne staff.
- Detained patients will be moved to Lee Mill using section 17 leave granted by the RC.
- Patients should be transferred to Lee Mill on SystmOne.

Any intervention required once the patient is in seclusion will be supported by the Lee Mill staff.

1.8 In order to ensure that seclusion measures have a minimal impact on a patient's autonomy, seclusion should be applied flexibly and in the least restrictive manner possible, considering the patient's circumstances. Where seclusion is used for prolonged periods then, subject to suitable risk assessments, flexibility may include allowing patients to receive visitors, facilitating brief periods of access to secure outside areas or allowing meals to be taken in general areas of the ward. The possibility of facilitating such flexibility should be considered during any review of the ongoing need for seclusion. Particularly with prolonged seclusion, it can be difficult to judge when the need for seclusion has ended. This flexibility can provide a means of evaluating the patient's mood and degree of agitation under a lesser degree of restriction, without terminating the seclusion episode.

2. Purpose

2.1 The purpose of the policy is to provide guidance regarding the procedure of Seclusion underpinned by guiding principles of the Mental Health Act 1983, Code of

Practice Revised 2015.

2.2 The policy is implemented with knowledge of Physical Intervention policy and associated mandatory training for clinical staff.

3 Other Related Policies.

This policy is to be read in conjunction with the following policies.

Search policy
Rapid Tranquilisation policy
Observation policy
Physical Intervention Policy
CPA Policy
Mental Capacity Act 2005 Policy
Violence and Aggression Policy
Serious Incidents Requiring Investigation (SIRI) Policy

4 Duties

4.1 The policy was devised by Managers of in-patient units within Livewell Southwest.

4.2 The Chief Executive is ultimately responsible for the content of policies and their implementation.

4.3 Locality Managers are responsible for identifying, producing and implementing policies relevant to their area.

4.4 Deputy Locality Managers will support and enable Operational Managers to fulfil their responsibilities and ensure the effective implementation of this policy.

4.5 The Deputy Director of Professional Practice/Matron/Team Manager is responsible for monitoring and auditing the use of seclusion.

4.6 The Team Manager is responsible for ensuring the policy is in place and all Staff adheres to its contents.

5. Definitions

MHA - The Mental Health Act 1983,

MCA - The Mental Capacity Act 2005.

Rapid tranquilisation Policy (Adults aged 18 and over).

RC – Responsible Clinician.

MDT - Multi-Disciplinary Team

Section 17 leave – Leave that is granted by the RC to service users detained under the Mental Health Act.

The Code - The Mental Health Act 1983 Code of Practice Revised 2015

6. Seclusion Room Requirements

6.1 Purposely designated seclusion room which should meet the following criteria:

(i) The whole interior of the room may be observed from outside.

(ii) The door of the room opens outwards.

(iii) The door of the room is lockable and entry can be gained easily and quickly in an emergency.

(iv) The furnishings and fittings of the room have been checked for safety hazards.

(v) The room should include limited furnishings which should include a bed, pillow, mattress and blanket or covering for the patient to rest on.

(vi) The patient is appropriately clothed and the room is heated or ventilated or both as dictated by the weather and the clothing worn by the patient. Ideally, the regulating mechanisms should be outside the room.

(vii) The person being secluded has ready access to toilet and washing facilities following risk assessment.

(viii) The person being secluded should be able to communicate verbally with the observing nurse. For the purpose of this policy an observing nurse/designated nurse this will include all staff members within the clinical team who have a good clinical knowledge of the needs and risk history of the service user.

(ix) A clock should be visible to the patient from within the room.

7. Staff Responsibility

7.1 A designated nurse must be in attendance outside the seclusion room throughout the period of the patient's seclusion. The key for the seclusion room must be kept in possession of the nurse in charge. Its whereabouts needs to be known so that easy access can be made to the seclusion room should this be necessary. The staff member who is in possession of the key must not leave the unit. The professional should have the means to summon urgent assistance from other staff at any point.

7.2 When a patient has been medicated in the process of being secluded, the nurse in charge is responsible for checking the patient's vital signs before the seclusion room is vacated. If rapid tranquillisation is implemented the appropriate form must be completed.

7.3 Continuous observation is essential in these circumstances. Nurses may remain in the seclusion room to monitor the patient's condition. (How long the nurses remain in the room with the patient depends on their clinical assessment of the situation). A registered nurse will need to remain outside seclusion to continue monitoring of the patient's condition for an agreed period of time in line with policy. Consideration should be given to whether a male or female person should carry out ongoing observations; this may be informed by consideration of a patient's trauma history.

7.4 The Seclusion Record (Appendix A) must be completed immediately, the Seclusion Observation Record (Appendix E) begun and detailed records kept in the patient's Multi-Disciplinary Team Notes (MDT).

7.5 All interactions between staff and secluded patients and all reviews of seclusion must be fully documented on the Appendices A-D contained in this document and on the electronic system.

8. Procedures for Seclusion

Overview of seclusion and monitoring process Figure 16 Para 26.112 the Code of Practice 2015

Action	Paragraphs in the Code	How and Who
If not authorised by a psychiatrist, there must be a medical review within one hour or without delay if the individual is not known or there is a significant change from their usual presentation	Paragraphs 26.116 and 26.127	Appendix A - By decision maker at commencement of seclusion and Appendix C - By Dr and Nurse in Charge
Seclusion area to be within constant sight and sound of staff member	Paragraphs 26.118 – 26.121	
Documented report by person monitoring every 15 minutes	Paragraphs 26.123 – 26.124	Appendix E - By Observing Nurse
Nursing reviews by two nurses every two hours throughout seclusion	Paragraphs 26.132-26.134	Appendix B - By Nurse
Continuing medical reviews every four hours until the first [internal] multi-disciplinary team	Paragraphs 26.129	Appendix C - By Dr and Nurse in Charge
First (internal) multi-disciplinary team as soon as is practicable	Paragraphs 26.135 – 26.138	
Independent multi-disciplinary team after eight hours consecutive or 12 hours intermittent seclusion (within a 48 hour period)	Paragraphs 26.139 – 26.141	Appendix D – By RC, Senior Nurse, Matron
Following first (internal) multi-disciplinary team continuing medical reviews at least twice daily (one by the responsible clinician)	Paragraph 26.130	Appendix D – By RC, Senior Nurse, Matron

Seclusion may be authorised by either:	Additional considerations
A psychiatrist	if the psychiatrist who authorises seclusion is neither the patient's responsible clinician (RC) nor an approved clinician (AC), the RC or duty doctor (or equivalent) should be informed of seclusion as soon as practicable.
An approved clinician who is not a doctor	provider policies should determine the appropriateness of using ACs who are not doctors to authorise seclusion.
The professional in charge (e.g. a nurse) of a ward	the patient's RC or duty doctor (or equivalent) should be informed of seclusion as soon as practicable.

8.1 The person authorising seclusion should have seen the patient immediately prior to the commencement of seclusion.

8.2 The initial decision to seclude a patient must be made by an authorised practitioner. This could be any of the following: - a Psychiatrist, approved clinician, duty doctor or nurse in charge. If the decision to authorise seclusion is made by anyone other than a Psychiatrist a medical review will be required within 1 hour.

8.3 If seclusion was authorised by an approved clinician who is not a doctor, or by the professional in charge of the ward, the responsible clinician or duty doctor (or equivalent) should attend to undertake the first medical review (see paragraph 26.128 Code of Practice) within one hour of the beginning of seclusion. If the patient is newly admitted, not well known to the staff, or there has been a significant change in the patient's physical, mental state and/or behavioural presentation, this medical review should take place without delay. Where seclusion has been authorised by a psychiatrist, whether or not they are the patient's responsible clinician or an approved clinician, the first medical review will be the review that they undertook immediately before authorising seclusion (meaning that a medical review within one hour of seclusion is not necessary).

8.4 When the patient is placed in seclusion the start time is recorded on Appendix A.

8.5 Staff involved in disturbed incidents who have been the subject of assault/abuse should not usually be involved in secluding the patient where possible. The nurse in charge directs the procedure and assumes responsibility for ensuring the procedure is followed.

8.6 Clear rationale for police involvement and attendance should be discussed with the senior person on duty and recorded on Appendix A contained within the Serious Incidents Requiring Investigation (SIRI) Policy. If the police attend, to assist in seclusion of a patient this also needs to be detailed on an Appendix A within 1 working day.

8.7 The nurse in charge will inform the patient of the rationale for the seclusion and make it clear what is expected of them. Where it has been agreed in a positive behaviour

support plan (or equivalent) that family members will be notified of significant behavioural disturbances and the use of restrictive interventions, this should take place as agreed in the plan.

8.8 The Senior nurse / Matron on duty (during working hours) should be informed. They will inform other staff such as the RC, Manager/ on call Manager.

8.9 The patient's valuables or any other belongings considered to be potentially harmful should be removed from the patient in accordance with the organisations Searching Property or Person Policy. These should be recorded on Appendix A.

8.10 When entering or exiting the Seclusion Room, physical intervention techniques must be planned and implemented as required.

8.11 A designated nurse must be in attendance at all times outside the Seclusion Room. He/she must be relieved hourly. The aim of the observation, as well as maintaining the patient's safety, is to ascertain the patient's mental state and whether seclusion can be terminated.

8.12 The Seclusion recording (Appendix A) must be completed immediately and an entry made in the multi–professional record describing the behaviour and mental state of the patient prior to seclusion and detailing what other interventions were made.

8.13 A written and signed entry to be made at least every 15 minutes by the observing nurse, on the Seclusion Observation Record (Appendix E). This should represent accurate descriptions of the observations made throughout the 15 minute period. This would require continual observations; however this may at times require the staff to be discreet. Unregistered staff entries need to be countersigned.

8.14 A nursing review carried out by two nurses must take place every two hours and whenever possible this should be done by direct contact with the patient inside the room. This review is to be recorded in the multi-professional notes. Attempts should be made to carry out physical observations including pulse and blood pressure at these reviews. This should be documented on the Seclusion Record Nursing Review (Appendix B). (If it was not possible to carry out the physical observations the reasons why must be detailed on the form). The record made should include, where applicable: the patient's appearance, what they are doing and saying, their mood, their level of awareness and any evidence of physical ill health especially with regard to their breathing, pallor or cyanosis. Where a patient appears to be asleep in seclusion, the person observing the patient should be alert to and assess the level of consciousness and respirations of the patient as appropriate.

9 Further Guidance

9.1 A seclusion care plan should set out how the individual care needs of the patient will be met whilst the patient is in seclusion and record the steps that should be taken in order to bring the need for seclusion to an end as quickly as possible. As a minimum the seclusion care plan should include:

• A statement of clinical needs (including any physical or mental health problems), risks and treatment objectives.

• A plan as to how needs are to be met, how de-escalation attempts will continue and how risks will be managed.

• Details of bedding and clothing to be provided.

• Details as to how the patient's dietary needs are to be provided for, and

• Details of any family or carer contact/communication which will maintain during the period of seclusion.

10 Reviews

10.1 Within four hours, a joint medical and nursing review must take place, involving direct contact with the patient, inside the room. Entries to be made in the MDT notes and the review noted on the Record of Seclusion and the Joint Medical/Nursing review (Appendix C). This should be following a risk assessment. Names of the staff involved in the review are to be clearly written in the notes.

10.2 Thereafter, joint medical and nursing reviews must take place every four hours. Doctors and nurses involved in reviews should use their professional judgement to decide whether or not they need to consult with senior colleagues.

10.3 If, for any reason, joint medical and nurse assessments are delayed the reason for the delay must be documented in the patient's notes.

10.4 If the seclusion is during the night hours, and the patient falls asleep, the following may happen:

- The decision is made to keep the patient in seclusion, and two hourly reviews take place, indicating that the patient is asleep; this must be reviewed with the consultant the next day.

- The decision may be taken that the patient no longer requires seclusion, but rather than wake the patient the seclusion door is unlocked and opened. A nurse must remain observing the patient until the patient wakes.

10.5 In both of the above instances, as soon as patient awakes a further nursing review must take place.

10.6 If seclusion continues for more than eight hours consecutively, or for more than twelve hours intermittently over a period of 48 hours, an independent review must take place with the RC or other doctor of suitable seniority and competence, and the Ward Manager/Nurse in Charge of the ward. If there is no agreement on ensuing action, the matter should be referred to the Unit Manager / Matron and Locality Manager or Nominated Deputy. The outcome of this review should be recorded on the Seclusion Record – 8 hour Review Form (Appendix D).

10.7 Continuing four-hourly medical reviews of secluded patients should be carried out until the first (internal) MDT has taken place including in the evenings, night time, on weekends and bank holidays.

10.8 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. For out-of-hours one MDT review may take place in the 24hr period with the approved clinician covering the RC.

11 Ending Seclusion

11.1 Seclusion should immediately end when a MDT review, a medical review or the independent MDT review determines it is no longer warranted. Alternatively where the professional in charge of the ward feels that seclusion is no longer warranted, seclusion may end following consultation with the patient's responsible clinician or duty doctor. This consultation may take place in person or by telephone as outlined in the Code of Practice.

11.2 Decision to terminate seclusion could be taken by the nurse in charge of the ward in consultation with the designated ward doctor/RC. The manager on duty for the hospital is to be informed, at an appropriate time i.e. within working hours. All data must be appropriately recorded and signed – i.e. Record of Seclusion form / MDT notes.

11.3 If a patient needs to be secluded again after termination of the initial seclusion, a new Record of Seclusion form must be started.

11.4 Any incident of seclusion, the circumstances leading up to it and method of management should be discussed at the next meeting of the clinical team with patient present if possible.

11.5 The patient should be "debriefed" about the events and decision, which led to their seclusion. This should be recorded in the clinical record.

11.6 A summary of all incident forms relating to seclusion for Lee Mill patients is available from the risk management team. These are collated and provided to the Case Manager, NHS England in line with current contracting arrangements. The risk team are responsible for the provision of these in a timely manner.

12. **Training**

12.1 All staff working at Lee Mill must receive appropriate and relevant induction and knowledge of the seclusion process. This will be integral to staff induction/preceptor processes. This will include a working knowledge of the operational policy, chapter 26 of the Code and all associated paperwork.

12.2 All staff at Lee Mill will receive annual security training.

13. Monitoring Compliance and Effectiveness

13.1 The Unit Manager / Matron will be responsible for monitoring the use of Seclusion. The completed Seclusion paperwork will be kept centrally within Lee Mill. Any incident occurring during or following the seclusion procedure will be reviewed with the relevant Locality Manager, Deputy Director of Professional Practice, the Responsible Clinician and the senior Unit Manager / Matron.

13.2 The use of seclusion will be monitored on a six monthly basis.

13.3 All incidents of seclusion are recorded on the incident recording system.

13.4 Pathway For Seclusion (Appendix F) will be completed after each episode of seclusion in order to review practice.

All policies are required to be electronically signed by the Lead Director. Proof of the electronic signature is stored in the policies database.

The Lead Director approves this document and any attached appendices. For operational policies this will be the Locality Manager.

The Executive signature is subject to the understanding that the policy owner has followed the organisation process for policy Ratification.

Signed: Director of Operations

Date: 6th July 2016

Seclusion Record

Appendix A

Date & time seclusion commenced:	
Date & time seclusion ended:	
Who was involved in the ending of seclusion:	

Name of Patient:	
Mental Health Status:	
NHS number:	
Address:	
Incident Form number:	

Carer or relative as indicated by the patient involved:	
Contact Telephone Number:	

Brief description of events and rationale for seclusion / Patient response to seclusion and make it clear what is expected of them: Please include any property that has been taken from the patient prior to placing into seclusion and make a note that the service user has been checked before placing in seclusion e.g. belts, shoe laces, valuable items.	
Details of who informed of seclusion:	

Police called: YES/NO record time	
Police Arrived: record time	
Police involvement: provide full details including any physical restraint and rationale as to why Police were called:	

Plan for seclusion reviews. Include details if patient falls asleep/ when Doctor to be called etc.	
2hr nursing review due:	
4hr joint review due:	

Copies to: Unit Manager / Matron

Seclusion Record Nursing Review (2 hourly)

Appendix B

Date:	

Name of Patient:	
NHS No:	
Mental Health Status:	

Time of Review:	

Review: (include physical obs recording if completed - Pulse, Blood Pressure, Behaviour, Mental state, risks.) **Please include rationale for any interventions needed but not completed.**

Details of future reviews i.e. when medical staff need to be involved, what happens overnight or if patient falls asleep: (and reasons for decisions made)

Next Review due:	

Please detail any exceptions:

Print name: **Signature of Reviewing Staff:** **Designation:**	1)
	2)

Appendix C

Seclusion Record Joint Medical / Nursing Review (1 hour medical review or 4 hourly review)

Date:	

Name of Patient:	
Hospital No / NHS No:	
Mental health Status	

Time of Review:	

Review: (include physical obs recording if completed - Pulse, Blood Pressure, Behaviour, Mental state, risks.) Please include rationale for any interventions needed but not completed.

Details of future reviews i.e. when medical staff need to be involved, what happens overnight or if patient falls asleep:
Please detail any exceptions:

Print name: **Signature of Reviewing Staff:** **Designation:**	1)Doctor
	2)Nurse in Charge

Seclusion Record (8 hourly Review)

Appendix D

Date:	

Name of Patient:	
Hospital No / NHS No:	
Mental Health Status:	

Time of Review:	

Details of Review and Care Plan:
Please detail rationale if the review is late, if the manager/medical staff were not in attendance and when the next review will take place

Signature of Doctor: **Print name / designation:**	
Signature of Senior Nurse: **Print name / designation**	
Signature of Manager/On-Call Manager: **Print name / designation**	

Appendix E

Seclusion Observation Record

Name:	
NHS No:	
MHA Status:	
Ethnicity:	

Date & time seclusion started:	
Date & time seclusion ended:	

An entry in these notes should be made every fifteen minutes, by the Nurse assigned to the observation duty. When seclusion ends a detailed entry is to be made outlining the decisions and rationale for ending seclusion.

Date:	**Time:**	**Observations** **(e.g. verbally hostile, physically aggressive presenting as agitated, high level of psychotic symptoms, tearful) Please describe in detail.**	**Print Name** **Signature** **Designation** **Countersignature**
			Signature:
			Signature:
			Signature:
			Signature: Countersignature:
			Signature:
			Signature:
			Signature:
			Signature: Countersignature:

Seclusion Observation Record Continuation Sheet **Page Number:**

Name:	
NHS No:	

Date:	**Time:**	**Observations** (e.g. verbally hostile, physically aggressive presenting as agitated, high level of psychotic symptoms, tearful) Please describe in detail.	**Print Name Signature Designation (Countersign every hour)**
			Signature:
			Signature:
			Signature:
			Signature: Countersignature:
			Signature:
			Signature:
			Signature:
			Signature: Countersignature:
			Signature:
			Signature:
			Signature:
			Signature: Countersignature:

Appendix F

Pathway for Seclusion Review

To be completed retrospectively by unit manager/senior nurse

Date & time of seclusion (include start and end):	**Start:** **End:**

Date & time of pathway review completed:	
Name of Patient:	
Mental Health Status:	
NHS number:	
Incident form no:	
Who is completing Pathway form:	

Inform the patient of the rationale for the seclusion and make it clear what is expected of them recorded on Appendix A.

Completed by: _____Signed: _____Dated:_____

Rationale for non-completion:

Inform the Senior Nurse/ Matron on duty/ Doctor (during working hours). They will inform other staff such as the RE, Manager/ on call Manager as necessary- record on Appendix A.

Completed by: _____Signed: _____Dated:_____

Rationale for non-completion:

Plan for seclusion future reviews detailed clearly on Appendix A.

Completed by: _____Signed: _____Dated:_____

Rationale for non-completion:

Date:	

Name of Patient:	
Mental Health Status:	
NHS number:	

Remove patient's valuables or any other belongings considered to be potentially harmful before entering in accordance with LSW Search Procedure. These should be recorded in Appendix A.

Completed by: _____Signed: _____Dated:_____

Rationale for non-completion:

A designated nurse is in attendance outside the seclusion room at all times and must be relieved hourly. (This is to maintain patient safety and evaluate mental health status to discontinue the use of seclusion).

Completed by: _____Signed: _____Dated:_____

Rationale for non-completion:

A written and signed entry by the observing Nurse is made every 15minutes into Appendix E; the Seclusion Observation Record.

Completed by: _____Signed: _____Dated:_____

Rationale for non-completion:

Date:	

Name of Patient:	
Mental Health Status:	
NHS number:	

2 hourly – 2 nurses must complete the nursing review (Appendix B) or document a rationale if this is not possible.

Completed by: _____Signed: _____Dated:_____

Rationale for non-completion:

2 hourly – 2 nurses must complete the nursing review (Appendix B) or document a rationale if this is not possible.

Completed by: _____Signed: _____Dated:_____

Rationale for non-completion:

Within four hours, a joint medical and nursing review must take place, inside the room on Record of Seclusion and the Joint Medical/Nursing review (Appendix C) completed. This should be following a risk assessment.

Completed by: _____Signed: _____Dated:_____

Rationale for non-completion:

Names of the staff involved in the review are to be clearly written in the notes.

Completed by: _____Signed: _____Dated:_____

Rationale for non-completion:

Joint Medical and Nursing review every 4 hours – document if delayed.

Completed by: _____Signed: _____Dated:_____

Rationale for non-completion:

Date:	

Name of Patient:	
Mental Health Status:	
NHS number:	

If seclusion continues for more than 8 hours or 12 hours over a 48hr period, inform the Matron and Locality Manager and document their response in the seclusion record (Appendix D).

Completed by: _____Signed: _____Dated:_____

Rationale for non-completion:

Seclusion may be terminated by the nurse in charge in consultation with the doctor and document in the MDT notes and seclusion notes.

Completed by: _____Signed: _____Dated:_____

Rationale for non-completion:

If Seclusion is required again a new record of seclusion must be started.

Completed by: _____Signed: _____Dated:_____

Rationale for non-completion:

The incident of seclusion should be discussed at the next clinical team meeting with patient present if possible.

Completed by: _____Signed: _____Dated:_____

Rationale for non-completion:

Date:	

Name of Patient:	
Mental Health Status:	
NHS number:	

Debrief Patient.

Completed by: _____Signed: _____Dated:_____

Rationale for non-completion:

The seclusion documents and rapid tranquilization documents must be scanned into the patient record on SystmOne.

Completed by: _____Signed: _____Dated:_____

Rationale for non-completion: