Appendix 3

Seclusion Review and Flowchart

Elements to consider for inclusion within the patients record as part of the review of seclusion (9.5). Recording of:

- Names and designations
- the date
- the time of entry
- the antecedents leading to the seclusion
- an opinion of whether or not to continue seclusion
- details of mental state examination
- physical examination findings
- presence/absence of side effects (where rapid tranquillisation has been given)

Medical reviews (9.3.5) provide the opportunity to evaluate and amend seclusion care plans, as appropriate. They should be carried out in person and should include, where appropriate:

- Doctors names and designation
- the date
- the time of entry
- the antecedents leading to the seclusion
- a review of the patient’s physical and psychiatric health
- an assessment of adverse effects of medication
- a review of the observations required
- a reassessment of medication prescribed
- an assessment of the risk posed by the patient to others
- an assessment of any risk to the patient from deliberate or accidental self-harm, and
- an assessment of the need for continuing seclusion, and whether it is possible for seclusion measures to be applied more flexibly or in a less restrictive manner
Every 2 hours – 2 Registered Nurses
Every 4 hours – Duty Doctor and Qualified Nurse

During night 2300-0700:

- Every 2 hours – 2 Registered Nurses
- At 4 hours – if patient awake – Duty Doctor and Qualified Nurse. If patient sleeping – Night POC (or delegate) Registered Nurse. Update Senior Manager on-call by e-mail @ 07.30

Medical reviews to continue at 4-hourly intervals until first MDT review has taken place, thereafter further medical reviews to be completed at least twice in every 24-hour period (9.3.3 and 9.3.4).

Further MDT reviews should take place once in every 24-hour period (9.3.6)

Seclusions over 8-hours or 12-hours in total over a 48-hour period – independent multi-disciplinary review required (9.6.1). IMHAs (in cases where the patient has one) will be invited to partake in the review.

End of seclusion must be recorded by a Registered Nurse in the seclusion record.

Signatures of the RC, Ward Manager and Clinical Manager / Associate Director on completed Record of Seclusion.

Top copy of Record of Seclusion to be filed in RiO Support File with top copies of Observation and Review
Middle copy of Record of Seclusion to be forwarded to the Associate Director
Bottom copy of the Record of Seclusion to be forwarded to Safer Care Group.