SECLUSION FLOW CHART
Seclusion should be used as a last resort and for the least possible time.
*Use CLP41 Appendix 1a to commence seclusion, complete care plan.

**Start Seclusion Observations without delay** Appendix 1b
- Continuous visual observations without delay
- Record every 15 minutes
- To be reviewed without delay if seclusion not authorised by a doctor and if patient is not known or has a significant change from usual presentation.
- If seclusion is not authorised by the Responsible Clinician, a consultant psychiatrist, ward doctor or duty doctor (or equivalent) should attend to undertake the first medical review.
- This can be the doctor authorising seclusion.
- If a consultant psychiatrist authorised the seclusion, their medical review immediately prior to the seclusion satisfies this requirement and no further medical review within the first hour is required.
- These will be undertaken by two registered nurses
- One of whom was not involved directly in the decision to seclude.

**First Hour** Appendix 1a
- Review by RC
- Where RC is not immediately available, a “duty doctor” can deputise for RC. Where the duty doctor is not an Approved Clinician, they should at all times have access to an on call doctor who is an Approved Clinician.
- Night time - if the patient is asleep different medical review arrangements should be agreed and recorded in the patient’s records

**Two-hourly *Review** Appendix 1c
- MDT Review
- Continuing medical reviews every 4 hours until MDT review
- First MDT review can include, Senior Nurse; Psychologist; Occupational Therapist; Clinical Lead/Matron
- Further medical reviews should continue at least twice in every 24 hour period.
- At least one of these should be carried out by the patients RC or an alternative approved clinician.

**Four-hourly *Review** Appendix 1d

**12 hourly medical reviews** Appendix 1e

**Subsequent Independent MDT Review** If the patient is secluded for more than 8 hours consecutively, or 12 hours over a period of 48 hours an independent multi-disciplinary review must be undertaken by clinicians who were not involved in the original decision to seclude the patient. This process should involve the patient’s IMHA where there is one in place.
- The independent MDT should consult with those involved in the original decision.

Seclusion can be terminated using Appendix 1f at any time when the clinical team assess that seclusion is no longer necessary. Seclusion is only to be considered formally discontinued when the service user is informed that they are able to leave the room if they so wish.