Authorisation to seclude for   
more than 2 hours

Enter details below

|  |  |
| --- | --- |
| Unit | Add |
| Name | Add |
| DOB | Add |
| NHI | Add |
| Ethnicity | Add |
| Legal status | Add |
| Gender | Add |

Date and time of assessment and review

|  |  |  |  |
| --- | --- | --- | --- |
| Date | DD MM YYYY | **Time** | HH:MM |

Participants in the 2-hour seclusion assessment and review

|  |  |
| --- | --- |
| Name | Designation/Role |
| Name Surname | Add |
| Name Surname | Add |
| Name Surname | Add |

Initial post-event staff defusing/debrief

|  |  |
| --- | --- |
| Nil | |
| Lead | Add |
| Participants | Add  Add |

Advance directive implemented?

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
|  | Yes |  | No |  | Not in place |

Details of alternative therapeutic interventions attempted

|  |
| --- |
| Add here |

Others involved in providing alternatives to avoid seclusion, eg, tāngata whaiora, whānau/family, peer support, consumer advisor support, cultural support, allied health

|  |
| --- |
| Add here   * Table bullets if needed |

Recommendations and planning from the assessment, review and defusing/debrief

|  |
| --- |
| Add here   * Table bullets if needed |

What is the rationale for seclusion; what led to seclusion being the only option remaining?

|  |
| --- |
| Add here   * Table bullets if needed |

|  |  |
| --- | --- |
| Seclusion care requirements | |
| **Yes**  **No** | Seclusion care requirements (see *Guidelines for Reducing and Eliminating Seclusion and Restraint Under the Mental Health (Compulsory Assessment and Treatment)  Act 1992*, section 8.6) have been delegated and initiated for tāngata whaiora? |

|  |  |  |  |
| --- | --- | --- | --- |
| Authorising clinician | | | |
| Name | Add | | |
| Signature | Add | | |
| Designation | Add | | |
| Date | DD MM YYYY | **Time** | HH:MM |

|  |  |  |  |
| --- | --- | --- | --- |
| Supporting clinician | | | |
| Name | Add | | |
| Signature | Add | | |
| Designation | Add | | |
| Date | DD MM YYYY | **Time** | HH:MM |

|  |  |  |  |
| --- | --- | --- | --- |
| Responsible clinician notified (if not the supporting clinician) | | | |
| Name | Add | | |
| Signature | Add | | |
| Designation | Add | | |
| Date | DD MM YYYY | **Time** | HH:MM |