**Canberra Health Services**

**Procedure**

**Seclusion of Persons Detained under the Mental Health Act 2015**

|  |
| --- |
| Contents |

[Contents 1](#_Toc102733716)

[Purpose 2](#_Toc102733717)

[Alerts 2](#_Toc102733718)

[Scope 3](#_Toc102733719)

[Section 1 – Principles 3](#_Toc102733720)

[Section 2 – Authorisation 7](#_Toc102733721)

[Section 3 – Placing a person in seclusion 9](#_Toc102733722)

[Section 4 – During Seclusion 10](#_Toc102733723)

[Section 5 – Cessation of Seclusion 12](#_Toc102733724)

[Section 6 – Documentation 14](#_Toc102733725)

[Evaluation 15](#_Toc102733726)

[Related Policies, Procedures, Guidelines and Legislation 16](#_Toc102733727)

[References 16](#_Toc102733728)

[Definition of Terms 17](#_Toc102733729)

[Search Terms 17](#_Toc102733730)

[Attachments 17](#_Toc102733731)

|  |
| --- |
| Purpose |

This procedure provides guidance to Canberra Health Services (CHS) staff on the involuntary seclusion of people under the *Mental Health Act 2015,* ensuring CHS meets its obligations under the *Human Rights Act 2004.*

CHS aims to minimise and where possible eliminate the use of restrictive practices, including seclusion. Seclusion is a traumatic experience for people and is used only when other behaviour management options have been exhausted to prevent a person from causing harm to themselves or another person. This procedure aims to ensure that the human rights and dignity of any person who may be subject to an episode of seclusion are protected and that seclusion where indicated is provided in the least restrictive environment.

[*Back to Table of Contents*](#Contents)

|  |
| --- |
| Alerts |

* Seclusion must only be used as a last resort when less restrictive means to prevent the person from causing harm to themselves and/or others have been tried and failed.
* A period of seclusion may only be authorised for a period of up to maximum of four hours at any one time. If further seclusion is required a new authorisation must be obtained. Seclusion must be ceased as soon as clinically possible.
* ThePublic Advocate must be notified, in writing, within twelve hours when a person is secluded. The person authorising the seclusion must complete the seclusion form and email it to the Public Advocate.
* Wherever possible, a consumer’s Advance Consent Directions (ACD) and Advance Agreements (AA) and/or Nominated Person must be consulted prior to, or during a seclusion episode.  An ACD and AA cannot over-ride the clinical decision to seclude a person.
* Where appropriate, and the person has provided consent for information to be shared, the following people are to be informed as soon as possible of the seclusion episode:
* a nominated person identified in accordance with the *Mental Health Act 2015*
* people with parental responsibilities
* guardian
* their family
* a person with nominated power of attorney
* health attorney.

This procedure should be read in conjunction with the *Restraint of Person Detained under the Mental Health Act 2015 Procedure* and for de-escalation and physical restraint training/techniques the *Occupational Violence Policy and Procedure*.

[*Back to Table of Contents*](#Contents)

|  |
| --- |
| Scope |

This procedure applies to all CHS staff providing care to people being secluded under the *Mental Health Act* *2015*.

For the purposes of this procedure, seclusion is defined as the involuntary placing of a person alone, in any room or area from which free exit is prevented.

This procedure applies to the following CHS staff working within their scope of practice:

* Medical Officers
* Mental Health Officers
* Nurses and Midwives
* Allied Health Professionals
* Students under direct supervision.

When this document refers to a mental health order under the *Mental Health Act* 2015 it refers to any of the following :

* Emergency Order (EO) or Emergency Assessment Order (EA) , or
* Emergency Detention three day order (ED3) or an Emergency Detention 11 day order (ED11)(ss. 85(1)(b)(2)), or
* Psychiatric Treatment Order (PTO) or Forensic Psychiatric Treatment Order (FPTO), where the Treatment Plan and Location Determination states that the person may be admitted to an approved mental health facility (ss. 59(1)(a) and 102(1)(a)(5)), or
* Community Care Order (CCO), or Forensic Community Care Order (FCCO) where the Treatment Plan and Location Determination states that the person may be admitted to an approved community care facility (ss. 102(1)(d)(ii)and 109(1)(c)(ii)).

[*Back to Table of Contents*](#Contents)

|  |
| --- |
| Section 1 – Principles  |

* CHS staff will respond to challenging behaviour, including behaviour that limits the ability to safely provide care, in ways that engage with the person and carer, and respect the individual’s rights, dignity, autonomy and decision-making capacity, while effectively managing risk to the person, health care professionals and others. Refer to *Challenging Behaviour Guideline*
* The use of seclusion should be a last resort, and only occurs where:
	+ alternative strategies have failed to achieve or maintain safety for the person experiencing distress, health care professionals or others
	+ alternative strategies have failed to enable safe provision of treatment, for example medications required by an Inpatient Treatment Order
	+ behaviours and actions are assessed to be imminently or actually harmful to a person or others, or
	+ the health practitioner believes a failure to do so could put the person, health care professionals or public at a significant health or safety risk.
* Seclusion is a traumatic experience for people. All actions undertaken during the seclusion process should be trauma informed, including treating people with respect and dignity, communicating what is happening and why, and providing psychological support following seclusion. The person’s treating team is responsible for ensuring that the person is told about what is happening and why in a manner that they can understand and that they are offered the opportunity of engaging in a post seclusion debrief.
* CHS staff are public authorities under *Human Rights Act 2004.* They have obligation to ensure the human rights of the person subject to seclusion are upheld by:
* Protecting them from cruel, inhuman or degrading treatment
* Where possible ensuring the liberty and security of the person
* Delivering humane treatment when the person is deprived of liberty
* Ensuring equal and effective protection against discrimination.
* Restricitve Practices, including seclusion, should not be used:
	+ as an alternative to adequate staffing, equipment or facilities to safely carry out the practice
	+ as a punishment or for the convenience of others, or as a substitute for adequate surveillance, health care professionals, resources or facilities to provide safe care.
* CHS staff should take into account different cultural backgrounds of people subject to seclusion. There are increasing numbers of people from culturally and linguistically diverse (CALD) communities who have come from war torn countries, have been the victims of abuse and torture in their country of origin, or have been subjected to lengthy periods of incarceration upon arrival in Australia. The risk of re-traumatisation is significant among this group. Their fear of authority figures may be substantial and care with the use of security staff is advised. Consider the use of an interpreter to ensure effective communication, refer to *Language Services – Interpreters and Translated Materials Procedure.*
* For Aboriginal and Torres Strait Islander people subject to seclusion take into account traditional beliefs and practice, and when practicable and appropriate, involve Aboriginal and Torres Strait Islander Liaison Officers in the care of the person. For MHJHADS specific service contact CHS.ALO-MHJHADS@act.gov.au or call extension 44137 or for CHS service contact ALOservice@act.gov.au or call extension 42055.
* CHS staff should also take into consideration the age and developmental stage of the person and the needs of the older person. Refer to Paediatric Adolescent Ward information below for more information on children and young people.
* The use of seclusion of a person under the *Mental Health Act 2015* is to be applied following the principles outlined in Section 6 of the Act. In regard to seclusion CHS staff should provide services that:
	+ consider and respect the preferences of the person, including those expressed in an advance agreement
	+ are for the benefit of the person and are never administered as punishment or for the benefit of someone other than the person
	+ are provided in a way that ensures the person is aware of their rights
	+ are delivered in a way that builds on evidence of effective treatment, care or support.
* The person in seclusion is automatically placed on an At-Risk Category (ARC) score of five and should be observed constantly by clinical staff during their period in seclusion (refer to *Adult Mental Health Unit Operational Procedure*). Seclusion should be broken as soon as risk is mitigated or there is a change in presentation or state such that seclusion is no longer required.
* Where appropriate, and the person has provided consent for information to be shared, the following people are to be informed as soon as possible of the seclusion episode:
* a nominated person identified in accordance with the *Mental Health Act 2015*
* people with parental responsibilities
* guardian
* their family
* a person with nominated power of attorney
* health attorney.
* Refer to Attachment 1 for a flowchart of how to manage an episode of seclusion including steps to prevent an episode of seclusion.

**1.1 De-escalation of behaviour**

General information

The person’s Nominated Person, family members and/or carer, where appropriate, should be utilised to better understand the person and inform de-escalation techniques that may/do work for this particular person. Investigate if the person has any known triggers and/or management plans in place.

Consider environmental modifications to assist in reducing escalating behaviour:

* reducing noise levels
* ensuring privacy
* ensuring the area is clean
* orientating the person to the environment
* using natural lighting where possible
* providing access to alternative spaces (if available)
* providing access to outside areas (if available).

Communicate respectfully with the person at all times. Body language and non-verbal communication comprise 90% of all communication. The following considerations are important in order to demonstrate respect and empathy for the person:

* listening without interruption
* tone, volume and cadence of voice
* respecting the person’s personal space
* body language - non-threatening and non-judgemental
* paraphrasing to ensure understanding.

All staff across Acute Mental Health Units are to undertake approved training which assists staff to recognise the early signs of clinical deterioration and effectively manage escalating behaviours that may result in an episode of seclusion. Refer to *Occupational Violence Procedure.* Clinical staff will provide rapid assessment and intervention to reduce the likelihood of an episode of seclusion.

* + 1. Emergency Department
* People with multiple presentations to the Emergency Department that result in an episode of seclusion whilst under a Mental Health Order should have a management plan created and alert added on the person’s record in Clinical Patient Folder Alerts Management System, refer to *Alerts Management Procedure*.
* Emergency Department de-escalation rooms should be utilised. While in the de-escalation area further de-escalation techniques should be attempted to manage the situation.
	+ 1. Adult Mental Health Unit(AMHU)
* When a person’s behaviour is noted to be escalating and staff are concerned about a risk of harm, the person should be guided by staff to the de-escalation area in the High Dependency Unit (HDU) before seclusion is considered. While in the de-escalation area further de-escalation techniques should be attempted to manage the situation.
* A person can use the de-escalation space as a low stimulus environment. A person using this space should be informed of time frames that they can use this space. The door to the de-escalation space should be kept unlocked, where appropriate, to allow the person using the space to leave freely. If there is an appropriate need for the door to be locked (e.g. to prevent another person from entering) and the person is agreeable to stay in the de-escalation space, needs and requests from this person should be attended to immediately – including a choice to leave the de-escalation space.
* If the decision is made to proceed with seclusion staff must ensure that all interior doors to the seclusion room are locked prior to the person entering the room and the period of seclusion commencing.
	+ 1. Mental Health Short Stay Unit (MHSSU)

• If a person in MHSSU presents as an immediate risk to themselves or others and all other options for their safe clinical management have been exhausted, MHSSU staff may request access to use one of the two secure de-escalation rooms in the Emergency Department. This request must be directed to the Emergency Department Nurse Navigator and Senior Emergency Department Doctor on shift.

* The Emergency Department Nurse Navigator must document that the room is in use on Emergency Department Information System (EDIS).
* While in the de-escalation area further de-escalation techniques should be attempted to manage the situation.
	+ 1. Ward 12b
* When a person’s behaviour is noted to be escalating and staff are concerned about a risk of harm, the person should be guided by staff to the de-escalation area in 12b before seclusion is considered.
* While in the de-escalation area further de-escalation techniques should be attempted to manage the situation.
	+ 1. Dhulwa Mental Health Unit
* As an interim measure, when a person’s behaviour is noted to be escalating and staff are concerned about a risk of harm, the person should be guided by staff to the de-escalation area, adjacent to the seclusion rooms on Lomandra. While in the de-escalation area, further de-escalation techniques should be attempted to manage the situation. Consideration might be given to unlocking the courtyard to facilitate this. At no time is the person to be left alone in the de-escalation area.
* If the decision is made to proceed with seclusion staff must ensure that all interior doors to the seclusion room are locked prior to seclusion.
	+ 1. Paediatric Adolescent Ward
* Staff need to consider the young person’s cognitive and psychological maturity and any problems with communication and behaviour. Developmental considerations are essential in the management of challenging behaviour in children and young people. In this age group behaviour should be viewed as a form of communication – “what feeling is this behaviour trying to express?”
* The Adolescent Unit at the Centenary Hospital for Women and Children uses sensory modulation and de-escalation techniques to manage escalating behaviours that may result in an episode of seclusion. Clinical staff will provide rapid assessment and intervention in an attempt to reduce the likelihood of an episode of seclusion for a child or young person being detained under the *Mental Health Act 2015*.
* As an interim measure when a young person’s behaviour is noted to be escalating and staff are concerned about a risk of harm, the young person should be guided by staff to one of the multi-purpose rooms, i.e. rooms 7 and 8. Whilst in the multi-purpose room, further de-escalation techniques should be attempted to manage the situation.

[*Back to Table of Contents*](#Contents)

|  |
| --- |
| Section 2 – Authorisation  |

Refer to Attachment 1 for a flowchart of how to manage an episode of seclusion including steps to prevent an episode of seclusion.

**2.1 General Information**

* The *Mental Health Act 2015* specifies the following positions are able to authorise a period of seclusion:
	+ For a person under a ED3 or ED 11 the person in charge of the facility
	+ For a person under a PTO or forensic PTO the Chief Psychiatrist
	+ For a person under a CCO or forensic CCO the Care Coordinator

At CHS the responsibility to authorise a period of seclusion is delegated to the Consultant Psychiatrist treating the person or after hours to the Consultant Psychiatrist on call.

* Seclusion of a person under a mental health order must be authorised by:
	+ Consultant Psychiatrist before the person is placed in seclusion. The seclusion episode is to be for a period of no more than four hours.
	+ Nursing staff, only when a person is in immediate danger of harming themselves or others and where a Consultant Psychiatrist is not available. As soon as it is safe to do so, the Nurse in Charge (NIC) must seek authorisation from the Consultant Psychiatrist via telephone. During business hours in Paediatric Adolescent Ward, this will be the Child and Adolescent Mental Health Services (CAMHS) Consultant Psychiatrist. If authority is not provided by the Consultant Psychiatrist, the person must be released from seclusion immediately.
* Authorisation must be sought for each episode of seclusion and documented in the person’s clinical record.
* For every episode of seclusion a seclusion form needs to be completed by the person authorising the seclusion. This form must be emailed to the Public Advocate at jacspublicadvocate-mentalhealth@act.gov.au . The seclusion register for the clinical area must be completed with details of the seclusion. The seclusion is also recorded in the person’s clinical record.
* If a second period of seclusion is required after the initial four hour period has past the person is to be reviewed by a multidisciplinary team including:
	+ a senior clinician who has not been involved in the decision to initiate the seclusion
	+ senior clinicians with skills in risk management, clinical safety and trauma informed care.

The senior clinicians may vary depending on time of day, context, local resources and available skill mix. Examples include staff specialist, visiting medical officer, nurse unit manager, clinical nurse consultant. The review is to be carried out in person or, where required, via phone or videoconference.

### 2.2 Emergency Department

* The secure de-escalation rooms should be used if a person is receiving treatment in the Emergency Department and requires seclusion.
* Authorisation for the seclusion, must be sought from the Mental Health Consultation Liaison (MHCL) Psychiatrist or on-call Psychiatrist either immediately prior to seclusion or as soon as possible after the commencement of seclusion. If no such authority is given, the person must be released from seclusion immediately.
* If a Psychiatrist is physically not immediately available and the person is in immediate danger of harming themselves or others, a psychiatry registrar or another doctor, in consultation with a consultant psychiatrist*,* must attend and may authorise seclusion in collaboration with senior nursing staff. The authorisation must be documented in the person’s clinical record.

**2.3 Adult Mental Health Unit (AMHU)**

### Business hours (0830 – 1700) authority must be sought from the AMHU Consultant Psychiatrist and ideally this should be the treating Psychiatrist for the person. If the treating AMHU Psychiatrist is not available, authority can be given by any of the Consultant Psychiatrists at AMHU.

### After hours (1700 – 0830), Weekends and Public Holidays, authorisation for seclusion must be sought from the on-call Consultant Psychiatrist for the division (contacted through Canberra Hospital switchboard).

### 2.4 Mental Health Short Stay Unit (MHSSU)

* The authorisation to proceed with seclusion, refer to 2.3 above.

### 2.5 Ward 12b Mental Health Unit (12b)

* The authorisation to proceed with seclusion, refer to 2.3 above.

### 2.6 Dhulwa Mental Health Unit (DMHU)

* Business hours authority must be sought from the DMHU Consultant Psychiatrist, and ideally this should be the treating Psychiatrist for the person. If the treating Psychiatrist is not available, authority can be given by any of the Consultant Psychiatrists at DMHU.
* After hours, authorisation for seclusion must be sought from the on-call Consultant Psychiatrist for the division (contacted through Canberra Hospital switchboard).
* ADON and CNC are to be notified prior to moving a person to de-escalation suite or applying seclusion.

### 2.7 Paediatric Adolescent Ward, Centenary Hospital for Women and Children

* If the young person is detained under the *Mental Health Act 2015* and all possible behavioural management strategies have been tried and failed and the young person is at risk of harm to themselves and or others, a decision may be made to seclude the young person.
* **During business hours** weekdays (0830 – 1700) authority must be sought from the CAMHS Consultant Psychiatrist. If the CAMHS Psychiatrist is not available, authority is to be made by the afterhours Consultant Psychiatrist (see step below).
* **After hours** weekdays (1700 – 0830), weekends and Public Holidays authorisation for seclusion must be sought from the on-call Consultant Psychiatrist from AMHU (contacted through Canberra Hospital switchboard).
* Where appropriate the young person’s treating team, ACAT and Public Advocate must be informed as soon as practicable of the seclusion episode.

[*Back to Table of Contents*](#Contents)

|  |
| --- |
| Section 3 – Placing a person in seclusion  |

###

### General Information

* All people placed in seclusion must be advised of the plan to seclude them and the reasons for this. This may occur simultaneously with the enacting of seclusion. The person’s treating team is responsible for ensuring that the person is told about what is happening and why in a manner that they can understand and that they are offered the opportunity of engaging in a post seclusion debrief.
* Staff must ensure that the room is free of objects that may be dangerous for the person or staff.
* Where safe for staff to do so, all of the person’s clothing and contents of pockets must be checked for prohibited items such as drugs or sharp implements before placing a person into seclusion. Refer to *Searching of a Consumer’s Person or Property Policy,*  DMHU see *DMHU Prohibited and Restricted Items and Items Requiring Approval Procedure,* for Adult Acute Mental Health Inpatient Units (AAMIU) see *Adult Mental Health Unit Procedure*. Other items to be removed include shoelaces, belts, any cords or ties, elastic bands and jewellery.
* When there is reasonable suspicion that the person has hidden a harmful item about their body, a full personal search is to be completed. Refer to *Searching of a Consumer’s Person or Property Policy.* The reasons for search must be documented in the person’s Clinical Record.
* A minimum of two staff must be present for such a search, at least one of which should be of the same gender as the person being searched.
* In DMHU any person being placed in seclusion must be searched in accordance with directives contained in the *DMHU Searching Procedure*. This includes documenting the completion of any search in the DMHU Clinical Search Register*.*
* The person is to be placed in the seclusion room in a safe manner and respecting their dignity as much as possible. It should involve as many staff as necessary, including a mix of genders as required, to ensure the safety and wellbeing of all. This should be balanced with least restrictive practices, trauma informed care and recognising the potential for trauma related to the experience of seclusion and the significance of maintaining a rapport with the person. At least one of the staff should be of the same gender as the person being secluded.
* Tear-proof bed linen is to be used when a person is at risk of self-harm.

[*Back to Table of Contents*](#Contents)

|  |
| --- |
| Section 4 – During Seclusion |

## General Information

* Authorisation for seclusion from a Consultant Psychiatrist is valid from the time seclusion begins for a **maximum of four hours**. If the seclusion period needs to be extended, new authorisation must be sought from a Consultant Psychiatrist. For extension of seclusion period there must be evidence that all other less restrictive behaviour management has been tried or that the person’s behaviour is still escalating, or they are an imminent danger to themselves or others.
* All people in seclusion must be under constant visual observation (ARC level 5). If a person is still or asleep the nursing observations must note respirations. Any concerns for the person’s health should be immediately notified to the Nurse in Charge (NIC) and responsible Doctor. Only break seclusion when a person is sleeping if it has been assessed as safe to do so.
* Seclusion is considered not to have been broken, when the person is attending to their personal hygiene such as toileting, showering, or being given medication, food or fluid. Seclusion is considered to be broken when the door is left open and the person can exit the room of their own accord.
* When a period of seclusion crosses between business and after hours shifts nursing staff will liaise with the regular treating Consultant Psychiatrist or Registrar and the on-call Consultant as necessary.
* During the period of seclusion, the NIC must ensure that the person’s needs are met, and the person’s dignity is protected by the provision of appropriate facilities and supplies. This includes, but is not limited to the following:
* Discussion with the person and providing explanation and reassurance
* Meeting individual needs (based on culture, language, age, disability, religion, gender, sexuality, trauma history and vulnerability)
* Meals, wherever possible, should be provided without the use of utensils, served on a paper plate and fluids are to be served in disposable cups
* Access to the ensuite as necessary, including for washing and showering, and
* Ensuring clothing is comfortable and appropriate.
* The person who is secluded must undergo a physical and mental health assessment every four hours after commencement of seclusion by a relevant Doctor, i.e. by a Psychiatric Registrar, a Medical Officer or a Junior Medical Officer (if on rotation and as outlined as part of their routine duties). This assessment is to be documented in the person’s clinical record .
* The Medical Officer is to consider what vital signs are to be attended. Observations should be conducted by nursing staff. The Medical Officer in consultation with nursing staff will determine the need to continue seclusion. When continuation of seclusion is deemed necessary, a new authorisation is required.
* Within the Paediatric Adolescent ward the Medical Officer is only responsible for the medical assessment, all other assessments including the continuation and ceasing of seclusion are to be made by the CAMHS Consultant Psychiatrist, Psychiatry Registrar or on-call Psychiatrist.
* If the period of seclusion is to continue, a management and safety plan is to be developed by the person’s assigned nurse in collaboration with the treating team, aimed at moving the person out of seclusion at the earliest opportunity.
* At least three staff members trained in approved techniques for de escalation and restraint must be available to attend a person when the seclusion room is opened for any reason. At least one of these staff members needs to be of the same gender as the person under seclusion. Additional staff may be required if there are safety concerns. These can be staff members of any discipline. Refer to *Occupational Violence Procedure.*

**Note**: Each seclusion room within all MHJHADS inpatient facilities and Emergency Department has an ensuite bathroom containing a toilet, basin and shower facilities. The door to this is generally kept closed to ensure safety of people and staff and only accessed when required. An external control is fitted to all seclusion rooms which allows staff to provide access to the ensuite facilities without staff having to break an episode of seclusion or enter the seclusion room. People subject to an episode of seclusion are never left alone and have a staff member in attendance outside of the seclusion room at all times. A consumer is able to request access to the ensuite facilities at any time.

## Additional area specific information

## Emergency Department

* Any concerns for the person’s health should be immediately notified to the Clinical Coordinator/Navigator and responsible Doctor.

## MHSSU

* If a person requires seclusion while in the care of MHSSU, MHSSU must request to use one of the two secure de-escalation rooms in the Emergency Department. This request must be directed to the Emergency Department Nurse Navigator and Senior Emergency Department Doctor on shift. The Nurse Navigator must document that the room is in use.
* The relevant room must appear on the Emergency Department Information System (EDIS) as locked and Emergency Department triage informed to avoid allocation of other persons to this space.
* The person remains an inpatient of the MHSSU, remains on ACT Patient Administration System (ACTPAS).
* Any concerns for the person’s health should be immediately notified to the Nurse in Charge (NIC) and responsible Doctor

## AMHU, Ward 12b and DMHU

* All people in seclusion must be under constant visual observation. These will be recorded in the *Seclusion/Confinement Observations Form*, available on MAJICeR.
* Any concerns for the person’s health should be immediately notified to the Nurse in Charge (NIC) and responsible Doctor

## Paediatric Adolescent Ward, Centenary Hospital for Women and Children

* All young people in seclusion must be under constant visual observation. This will be recorded in the *Seclusion/Confinement Observations Form*, available on the CHS Clinical Forms Register. Any concerns for the person’s health should be immediately notified to the Nurse in Charge (NIC) and responsible Doctor.

[*Back to Table of Contents*](#Contents)

|  |
| --- |
| Section 5 – Cessation of Seclusion |

## 5.1 General Information

* Seclusion must be ceased as soon as other strategies can be used to prevent a person from causing harm to themselves or others.
* When a person falls asleep while secluded, staff should assess whether it is appropriate to cease seclusion. If seclusion is continued, reasons for this must be documented in the person’s clinical record.
* All people who have been secluded are to be offered an opportunity for psychological support from a clinician who is a member of their treating team, as soon as practicable and within 24-48 hours after being released from seclusion, or as requested by the person. If the person declines offer of psychological support or is too unwell to engage, attempts to offer support must be recorded in the person’s clinical record. The person may not want to speak to the team members involved in the seclusion episode, the person should be offered support by team members who were not directly involved in the seclusion episode.
* The person is to be reviewed by the treating team and/or on-call clinical staff within 24 hours after the seclusion episode and a treatment plan formulated. The review is to include the nursing observations and details of food and fluids provided and consumed.
* Details of the information discussed at the debrief and reflection are to be provided for the person and others who witnessed or were involved in the incident for their information.
* In addition to psychological support, for people in a MHJHADS inpatient ward a staff member will also conduct a seclusion review with the person following the period of seclusion to examine in more detail what happened to lead to the seclusion and how the person feels. This information is presented in the 5 W’s format (when, where, who, what, and why) and documented in the person’s clinical record and provided to the Restraint, Seclusion and Restrictive Practices Committee.
* As soon as practicable after the incident, those staff members involved in episodes of seclusion will hold a debriefing, chaired by the Assistant Director of Nursing (ADON), Clinical Nurse Consultant (CNC) or NIC. The NIC will be mindful of the potential traumatic impact on staff involved and support them at this time and assist in seeking further assistance if needed.
* Further discussion in relation to identifying early warning signs and alternative management strategies for the person should take place in a collaborative MDT meeting.

## 5.2 Emergency Department

* Prior to seclusion being ceased, the senior nurse on duty and another nurse must conduct an assessment to determine the person’s level of risk. The MHCL Psychiatrist must ratify the risk assessment as soon as practicable.
* If the MHCL Psychiatrist or Psychiatry Registrar is not present, then two staff members, one of whom must be a Registered Nurse, can ratify the risk assessment, on authorisation from the Consultant Psychiatrist or Psychiatric Registrar. An entry is to be made in the person’s clinical record that authorisation for this was obtained, via telephone, by the Consultant Psychiatrist/Psychiatry Registrar.
* Each episode of seclusion will be documented in the seclusion register. Seclusion episodes are reviewed to identify what could be improved. The outcome of the review will be circulated to all staff to ensure ongoing efforts to maintain high standards of care.

## 5.3 MHSSU, AMHU, Ward 12b Mental Health Unit and DMHU

* Prior to seclusion being ceased, the senior nurse on duty and another nurse are to complete a risk assessment to determine the person’s level of risk. The risk assessment must reflect the person’s reduced risk level before the person is released from seclusion. The Consultant Psychiatrist or Psychiatry Registrar must ratify the revised risk score as soon as practicable.
* If the Psychiatrist or Psychiatry Registrar is not present, then two staff members, one of whom must be a Registered Nurse, can revise the risk assessment score. Following authorisation of seclusion, an entry is to be made in the person’s MAJICeR indicating the date, name and time of the Consultant Psychiatrist/Psychiatry Registrar authorising seclusion.
* Each episode of seclusion will be presented at the Restraint, Seclusion and Restrictive Practices Committee and individual cases reviewed by the committee as clinically relevant. The outcome of the review will be circulated to all staff to ensure ongoing efforts to maintain high standards of care.

## 5.4 Paediatric Adolescent Ward, Centenary Hospital for Women and Children

* Prior to seclusion being ceased, the CAMHS Psychiatrist or Psychiatry Registrar must review and document the assessment within the medical records, including the At Risk Category (ARC). The ARC score must be below five to reflect the person’s reduced risk level before the person is released from seclusion.
* If the CAMHS or Psychiatry Registrar is not present, then two staff members, one of whom must be a Registered Nurse, can revise the ARC score. An entry is to be made in the young person’s medical records that this review occurred and was discussed with the Consultant Psychiatrist/Psychiatry Registrar and authorisation for seclusion to be ceased was obtained.
* Each episode of seclusion will be reviewed monthly to identify what could be improved. The outcome of the review will be circulated to all staff to ensure ongoing efforts to maintain high standards of care.
* Other people involved in, or who witnessed the incident resulting in seclusion, are to be offered appropriate supports, which may include debriefing, if requested.

[*Back to Table of Contents*](#Contents)

|  |
| --- |
| Section 6 – Documentation |

* When a person is secluded, the person authorising the seclusion must notify thePublic Advocate, using the Seclusion Form (50010), available on the Clinical Forms Register and in MHJHADS Electronic Medical Record. A copy of the Seclusion form must be sent to the Public Advocate within twelve hours at JACSPublicAdvocate-MentalHealth@act.gov.au
* The original Seclusion form must be scanned and entered into the person’s clinical record.
* For each episode of seclusion, an entry needs to be made in the person’s clinical record indicating the following:
* When authorisation of seclusion was obtained by the Consultant Psychiatrist (including the name of the authorising Consultant).
* The date and time of when seclusion was commenced and ceased.
* A description of the person’s behaviour prior to the episode of seclusion.
* A description of alternatives to seclusion that were implemented, and outcomes where applicable.
* The explanation given to the person regarding the reason for seclusion and their response.
* If a person undertakes debriefing about the incident, an outline of this discussion.
* The healthand personal care provided including the administration of medications during seclusion.
* The psychological support and reflection provided for the person and others who witnessed or were involved in the incident.
* If staff sustain an injury a staff incident report needs to be completed in Riskman, refer to *Occupational Violence Procedure*. If the person who was secluded sustains an injury or a significant clinical incident led to the seclusion a clinical incident report should be completed in Riskman. A seclusion episode with no injury to a person is not a clinical incident, refer to *Incident Management – Clinical Procedure.*
* If any restraint, use of force or the forcible giving of medication is used during the seclusion, this must be documented in the person’s clinical record. Refer to *Restraint of Persons under the Mental Health Act Procedure*.
* Seclusion Register:
	+ All seclusions occurring in the Emergency Department must be documented in the *Emergency Department Seclusion Register*, available at the nurses’ station.
	+ All seclusions occurring on the Adolescent Ward must be documented in the *Paediatric Department Seclusion Register*, available in the medication room located in the Adolescent Ward.
	+ For all other areas, i.e. AMHU, 12b, MHSSU and DMHU, a register of seclusions may be printed from MAJICeR for viewing by the Public Advocate.

[*Back to Table of Contents*](#Contents)

|  |
| --- |
| Evaluation  |

**Outcome**

* People assessed as requiring seclusion will be managed as per this procedure.
* Debriefing is offered to people who are placed in seclusion and any witnesses to the event.

**Measures**

* Monthly review of each seclusion episode at the Restraint, Seclusion and Restrictive Practices Committee.

[*Back to Table of Contents*](#Contents)

|  |
| --- |
| Related Policies, Procedures, Guidelines and Legislation |

**Policies**

* Searching a Consumer’s Person or Property
* Occupational Violence
* Informed Consent (Clinical)

**Procedures**

* Restraint of a person detained under the *Mental Health Act* 205
* Adult Mental Health Unit
* Dhulwa Mental Health Unit Prohibited and Restricted Items and Items Requiring Approval
* Emergency Department and Mental Health Interface
* Occupational Violence
* Patient Identification and Procedure Matching
* Clinical Handover
* Advance Agreements, Advance Consent Directions and Nominated Persons under the Mental Health Act 2015
* Care of Persons subject to Psychiatric Treatment Orders (PTOs) with or without a Restriction Order (RO)

**Legislation**

* *Mental Health Act 2015*
* *Human Rights Act 2004*
* *Children and Young People Act 2008*
* *Human Rights Commission Act 2005*
* *Work Health and Safety Act 2011*

**Other**

* Australian Charter of Healthcare Rights

[*Back to Table of Contents*](#Contents)

|  |
| --- |
| References |

1. SA Health, 2015, Restraint and Seclusion in Mental Health Services Policy Guideline. Accessed at: [https://www.sahealth.sa.gov.au/wps/wcm/connect/5dd2f58048f79928929df70e3d7ae4ad/Guideline\_restraint+and+seclusion\_july2015.pdf?MOD=AJPERES](https://www.sahealth.sa.gov.au/wps/wcm/connect/5dd2f58048f79928929df70e3d7ae4ad/Guideline_restraint%2Band%2Bseclusion_july2015.pdf?MOD=AJPERES) Accessed on 21/02/2022
2. ACT legislation, 2021. Mental Health Act 2015. Accessed at <https://www.legislation.act.gov.au/a/2015-38>
3. NSW Health, 2020. Seclusion and Restraint in NSW Health Settings Policy Directive. Accessed at: <https://www1.health.nsw.gov.au/pds/ActivePDSDocuments/PD2020_004.pdf> Accessed on 21/02/2022.

[*Back to Table of Contents*](#Contents)

|  |
| --- |
| Definition of Terms |

**Community Care Order** – means an order made under s. 66 of the *Mental Health Act 2015*

Forensic Community Order – means an order made under s. 108 of the *Mental Health Act 2015*

**Emergency Detention 3** (ED3) – 3 day emergency detention

**Emergency Detention 11** (ED11) – 11 day emergency detention

**Forensic Psychiatric Treatment Order** (FPTO) – means an order made under s. 101 of the *Mental Health Act 2015*

**Psychiatric Treatment Order** (PTO) – means an order made under s. 58 of the *Mental Health Act 2015*

**Seclusion** – the involuntary placing of a person alone, in a room with the door closed or in an area from which free exit is prevented.

**Trauma Informed Care** – is an approach that recognises and acknowledges trauma and it’s prevalence, alongside awareness and sensitivity to it’s dynamics, in all aspects of service delivery.

**Young Person** – for the purpose of this document a young person is someone who is 16 years and under and admitted to the Paediatric Adolescent ward. Once the person turns 17 years, they are considered an adult.

[*Back to Table of Contents*](#Contents)

|  |
| --- |
| Search Terms  |

Mental Health, Seclusion, Dhulwa Mental Health Unit, DMHU, AMHU, MHSSU, Emergency Department, Paediatric, Paed, Adolescent, Adolescence, MH, 12B

|  |
| --- |
| Attachments  |

Attachment 1 – Seclusion flow chart

**Disclaimer**: *This document has been developed by Canberra Health Services specifically for its own use. Use of this document and any reliance on the information contained therein by any third party is at his or her own risk and Canberra Health Services assumes no responsibility whatsoever.*

*Policy Team ONLY to complete the following:*

|  |  |  |  |
| --- | --- | --- | --- |
| *Date Amended* | *Section Amended* | *Divisional Approval* | *Final Approval*  |
| *5/05/2022* | *Complete Review* | *Katie McKenzie a/g ED MHJHADS* | *Policy Committee*  |
|  |  |  |  |

*This document supersedes the following:*

|  |  |
| --- | --- |
| *Document Number* | *Document Name* |
| *CHS19/090* | *Seclusion of persons with a Mental Illness or Mental Disorder Detained under the Mental Health Act 2015* |
|  |  |

## Attachment 1 – Seclusion flow chart

