

Seclusion

Chief Psychiatrist's Guideline

Key message

Seclusion is an extremely restrictive intervention that is subject to minimum statutory requirements defined and prescribed by the *Mental Health Act 1986*.

The clinical decision to seclude a patient should be undertaken only when other less restrictive treatment options have been tried or considered and excluded as inappropriate.

At all times the safety and the personal dignity of the person being restrained must be protected. Any interference with the person's rights, privacy, dignity and self-respect are to be kept to the absolute minimum necessary in the circumstances.

Introduction

Seclusion, while sometimes necessary is very restrictive of a person's liberty. Consequently, the *Mental Health Act 1986* (the Act) defines and prescribes minimum statutory requirements for its use.

This guideline aims to clarify for mental health practitioners and services the underlying principles in the use of seclusion and establishes minimum practice standards. It also answers some common questions and discusses legal and clinical issues. This guideline applies to the use of seclusion in all approved mental health services.

The decision to use seclusion is a clinical one taken after other less restrictive options have been considered, tried or excluded. While seclusion can provide safety and containment for the person, it can also be a source of distress or complaint for patients, family members, friends, other patients and visitors. Particular care needs to be taken when managing the person in seclusion so that their personal safety and dignity are protected.

Once the decision has been made to use seclusion, the person requires careful clinical monitoring, support and review, and the episode must be appropriately recorded and reported. In addition, clinical staff need to be aware of how the person, and others in the inpatient unit, are affected by the use of seclusion. Staff should offer information and the opportunity for the person who has been secluded, or others in the environment to discuss what has occurred.

Each approved mental health service is required to develop local policies and procedures governing the use and management of seclusion. These must incorporate the minimum standards set out in this guideline. It is expected that staff will have a sound knowledge of the policy and procedures and that services will conduct local quality assurance activities related to seclusion practice. Clinical audits should be based on the knowledge and application of local policies and procedures and this guideline.

Definitions

Seclusion

Section 82(1) of the Act defines seclusion as:

the sole confinement of a person at any hour of the day or night in a room of which the doors and windows are locked from the outside.

This includes the confinement of a person alone in any room or space within a building, the exit of which cannot be opened by the person from the inside.

Seclusion applies even if the patient agrees to or requests such confinement. Any confinement of a person, which meets the above definition, must be described as seclusion and not by such terms as 'time out' or 'isolation', and must meet the legal and clinical requirements described in this guideline.

Authorised psychiatrist

The authorised psychiatrist is a qualified psychiatrist appointed under section 96 of the Act as the authorised psychiatrist for an approved mental health service. The authorised psychiatrist may delegate to a qualified psychiatrist any power, duty or function of the authorised psychiatrist other than the power to delegate. For the purpose of this guideline, the term 'authorised psychiatrist' refers to the authorised psychiatrist or delegate.

Without delay

s. 82(2)(b)(ii)

In an emergency situation, the senior registered nurse on duty may authorise the use of seclusion and must notify a registered medical practitioner without delay. This means that the registered nurse must immediately contact a medical practitioner and advise that the person has been placed in seclusion and the circumstances surrounding the seclusion. Most commonly the medical practitioner will be employed by the service and communication will be by telephone or in person as soon as the person has been secluded.

Imminent risk

s.82(2)(a)

If, based on clinical judgement, knowledge and assessment of the person and their behaviour, clinical staff believe that a person is soon likely to significantly harm themselves or put at significant risk the health or safety of another person, and seclusion is the least restrictive treatment response, then this belief is reasonable grounds to seclude the person.

Absconding

s. 82(2)(a)

Absconding means that an involuntary or security patient is absent without permission or leave from the approved mental health service. Absconding should only be used as a reason for seclusion if absconding presents a serious risk to the health or safety of the person or others and seclusion is used as an intervention of last resort once less restrictive measures have been considered or tried.

As soon as practicable s.82(2A)

When seclusion is authorised by the senior registered nurse on duty, the Act requires that the nurse notify the authorised psychiatrist as soon as practicable. This means that if the emergency use of seclusion occurs during ordinary business hours it would be appropriate for the registered nurse to discuss the matter with the authorised psychiatrist almost immediately either directly or by telephone. The emergency use of seclusion outside ordinary working hours should be reported to the authorised psychiatrist as soon as practicable.

Reviewed as clinically appropriate

s. 82(3)(a)

A registered nurse must review the secluded person at intervals of not more than fifteen minutes. If clinical assessment indicates the need for more frequent review, then this must occur. There may be occasions when the person in seclusion will need to be continuously observed by a registered nurse who would, in these circumstances, be stationed outside the seclusion room, observing and monitoring the person through the glass insert in the door. The review process must include a clinical judgement about the need to enter the seclusion room to adequately monitor the person's physical signs and symptoms to ensure the person is physically safe and comfortable and also to assess their mental and physical status and the need for continuing seclusion.

Assessment details to be included in each review shall be specified in the person's management plan and may include:

- **physical observations** – for example respiration, skin colour, posture, level of consciousness, motor activity, blood pressure, pulse and
- **mental status observations** – for example pattern and content of speech, thought content, mood, affect, concentration, attention, level of motor activity.

Examination by a medical practitioner

s. 82(3)(b)

A registered medical practitioner must examine the secluded person at least every four hours. This examination should be as thorough as the circumstances permit. It should cover the person's mental and physical status and include an assessment of the need to continue the seclusion based on the criteria in s. 82(2)(a) of the Act. The first examination should occur as soon as clinically appropriate after the medical practitioner is first notified of the seclusion. The authorised psychiatrist may vary the interval for the medical examination if she or he believes it is appropriate. However, the requirement for a four-hourly review is a minimum standard and the decision to extend the period of time between examinations is a serious one.

A variation extending the four hourly review should not be done if the person has been in the unit for less than twenty-four hours or has received an injectable form of psychotropic medication in the preceding twenty-four hours.

If the authorised psychiatrist varies the interval for medical examination by extension, this must be reported to the Chief Psychiatrist at the end of each month. (for further details see 'What monitoring is necessary?' and 'What documentation is required for the use of seclusion?').

Legal considerations

Who can be secluded?

In an emergency, any person receiving treatment for a mental disorder at an approved mental health service may be secluded. However, if the person is not an involuntary patient, a forensic or security patient, consideration needs to be given as to whether the person meets the criteria for involuntary detention under section 8 (1) of the Act. Whatever the outcome of the review, the rationale for seclusion must be clearly documented in the patient's clinical record and discussed with the medical practitioner and authorised psychiatrist. It would be inadequate, for example, to write that the person required protection from immediate or imminent risk to personal safety. Clinical staff are expected to document how they had formed that opinion.

When can a person be secluded?

Section 82(2) (a) of the Act states that:

a person receiving treatment for a mental disorder in an approved mental health service may be kept in seclusion only if it is necessary to protect the person or any other person from immediate or imminent risk to his or her health or safety or to prevent the person from absconding.

Wherever possible, alternative, less restrictive ways of management should be used and seclusion should be discontinued as soon as less restrictive management becomes possible.

What does the legislation require?

Section 82 requires that:

- The person must be receiving treatment for a mental disorder in an approved mental health service. Seclusion, therefore, cannot be legally applied in a service that is not an approved mental health service, such as a private hospital or supported residential service.
- The person can only be secluded to protect themselves or other persons from immediate or imminent risk to their safety or to prevent the person from absconding.
- Seclusion must be approved or authorised.
- The person is reviewed at intervals of not more than fifteen minutes by a registered nurse.
- A medical practitioner examines the person at not more than four-hourly intervals.
- The person is supplied with appropriate bedding, clothing, food, drink and toilet arrangements.

How is seclusion approved?

s. 82(2)(b)(i)

The authorised psychiatrist approves seclusion. This can occur in the following ways:

- a) The authorised psychiatrist approves the continuing seclusion of a person for a specified period following seclusion in an emergency that was authorised by the senior registered nurse or the authorised psychiatrist is present at the commencement of the patient's seclusion episode and approves seclusion for a specified period, or
- b) The authorised psychiatrist approves seclusion for a specified period as a planned intervention for an individual patient in exceptional circumstances.

How is seclusion authorised?

s.82(2)(b)(ii)

In an emergency, seclusion may be authorised by the senior registered nurse on duty and the period of the emergency seclusion specified. She or he must advise the authorised psychiatrist as soon as practicable. The authorised psychiatrist may then approve the continuing seclusion of the patient for a specified period. Services must have policies that clearly identify the senior registered nurse on each shift.

What monitoring is required?

The Act requires that a secluded person is:

- Reviewed, as clinically appropriate, at intervals of not more than fifteen minutes by a registered nurse. This involves the assessment of physical and mental status.
- Examined by a medical practitioner at four- hourly intervals during the period of seclusion. However, if the person has been newly admitted to the unit or is not well known to the clinical staff, or the need for seclusion represents a significant change in the person's condition, then a medical examination should be conducted without delay.

The examination shall include a physical and mental status examination, risk assessment and the need for continuing seclusion.

What documentation is required for the use of seclusion?

Approval of/authority for use of seclusion MHA 30

An approval of/authority for use of seclusion form (MHA 30) must be completed at the time of seclusion by the person approving or authorising the seclusion. The form must show:

- the commencement, finish and total time for the seclusion episode (at the cessation of an authorised and/or approved period of a seclusion episode)
- the name of the person who authorised and/or approved seclusion
- when seclusion is authorised by the senior registered nurse on duty, the name of the authorised psychiatrist who is notified and the date and time the notification occurred
- the name of the registered medical practitioner and the date and time of notification

- the name of the senior registered nurse who kept the person in seclusion. This must be recorded on the 'Clinical Observations' page of the MHA 30 form (and continued as applicable on the MHA30A form) at each change of shift to reflect responsibility for the nursing care provided for the duration of the shift
- the legal status of the secluded person
- the reason/s for the seclusion and
- in the case of variation to the interval for medical examination, the frequency at which medical examinations are to occur, the reasons for variation, the signature of the authorised psychiatrist and the date.

A record of clinical and medical reviews is to be maintained on the 'Clinical observations page of the MHA 30 and MHA 30A form as applicable.

If the period of seclusion applied in an emergency includes a change of nursing shift, a new authority is to be completed so that accountability and responsibility for the nursing management of the patient in seclusion rests with the senior registered nurse on duty.

Monthly report to the Chief Psychiatrist, seclusion register MHA 31

Section 82(5) of the Act requires that at the end of each month the authorised psychiatrist must send to the Chief Psychiatrist a report of the use of seclusion in the service. Each episode of seclusion should specify the:

- reasons seclusion was used
- name of the person who authorised and approved the use of seclusion
- name of the person who kept the person in seclusion
- period of time of the seclusion and
- reason for varying, by extension, the requirement for a medical examination at four hourly intervals, if that occurred.

It is also expected that all required data for the seclusion episode will be entered onto the RAPID/CMI database by the tenth day of the following month in which the seclusion episode occurred.

The seclusion register MHA 31 must be completed and forwarded to the Chief Psychiatrist by the twentieth day of the following month in which the seclusion episode ceased. Only registers (MHA 31) printed from the RAPID/CMI database and signed by the authorised psychiatrist will be accepted.

This will assist with improved data integrity and the information will be used for statutory monitoring purposes and for comparisons of utilisation of seclusion in Victoria.

Clinical record documentation

To satisfy requirements for good clinical practice, the patient's clinical record should demonstrate that the standards required in this guideline and local policy and procedures are met. These requirements include:

- a patient seclusion management plan
- the rationale for the decision to seclude
- the medical and psychiatric assessment
- a record of observations made during the period of seclusion.

The clinical record should clearly show the specific time the person was observed, any relevant observations and when the seclusion room door was opened to review or observe the patient in seclusion. The review process must ensure the person is safe and comfortable, assess their mental and physical status and the need for continuing seclusion. Assessment details to be included in each review shall be specified in the person's seclusion management plan and may include recording details of:

- the person's behaviour, skin colour and respirations
- a description of the person's medical and psychiatric condition at the commencement of seclusion
- notation of any observable changes
- any medication or treatment provided
- the response to treatment
- when and how much food and fluids were provided
- how and when the person's toilet and hygiene needs were met
- the rationale for any change in the seclusion management plan
- the outcome of any medical reviews including the four-hourly medical review
- if the authorised psychiatrist varied the requirement for the medical review, the rationale for this decision and
- details of second opinions and/or case management reviews.

When should seclusion be ceased?

s.82(3B)

The Act requires that if the registered medical practitioner, the senior registered nurse on duty, or the authorised psychiatrist believes that seclusion is no longer necessary, then it must be ceased immediately.

The end of a period of seclusion is a clinical decision made by clinical staff. Opening the door for toileting, food and fluids, medical examination or exercise does not constitute the end of a period of seclusion. Such breaks must not be used to remove the requirement for a four-hourly medical examination. If a decision has been made to cease an episode of seclusion and subsequent behaviour indicates the need to recommence seclusion, this requires a new approval or authority.

Patients who fall asleep in seclusion

Where a person appears to be asleep in seclusion, clinical staff must be alert to and assess the level of consciousness and respirations of the person to exclude the possibility of an altered level of consciousness and/or respiratory distress.

If a person is asleep following seclusion, clinical staff should assess whether it is appropriate to end the seclusion. It is not necessary to wake the person but leaving the door ajar and unlocked and allowing the person to continue sleeping, if it is safe to do so, would be appropriate. The person should continue to be observed at regular intervals. Only if there is a substantial continuing risk or doubt about the immediate or imminent risk to the person's health or safety or others should the door remain locked and the episode of seclusion continued until the person wakes and can be reassessed.

Seclusion care planning

Seclusion care planning involves planning for the person to be placed in seclusion and subsequent management of the person.

Although seclusion usually occurs in an emergency, its application should be based on well-established and well-understood principles and practice. There may, however, be occasions when staff have some time to plan the management of the event in advance, for example, where the admission of an extremely disturbed person is anticipated and the person is admitted directly into the seclusion room. Whatever the circumstances, the process requires planning, even if the time available for this is brief, and will include:

- The presence of appropriately trained clinical staff in adequate numbers to safely place the person in seclusion. Ideally, managing seclusion of a person who is resisting aggressively would involve staff of both genders. Where a female person is being secluded, it is important that female staff members are present.
- Informing the person of the intention to seclude. Whenever seclusion is used, the person must be informed of the decision, why this decision has been made and how they will be observed, managed and reviewed. This is best done by one staff member talking to the person in a quiet, reassuring, clear and non-threatening manner, explaining what is happening to the patient throughout the procedure.
- Allocating responsibilities among participating staff so each person is aware of their individual and team responsibilities including who will talk to the person, who will be responsible for holding the left and right arm, and who will open the door to the seclusion room.
- Ensuring staff are cognisant of any pre-existing injuries and the medical condition of the patient prior to the application of physical restraint to ensure exacerbation of these conditions are avoided or minimised.
- Ensuring that clothing provided is comfortable, appropriate and provides for the person's self-esteem, dignity and safety. There is no requirement for the person to be clothed in night attire, particularly the traditional hospital gown which makes it difficult to preserve a person's modesty. Under no circumstances is it acceptable to keep a person in seclusion naked. Clothing that is durable and not easily torn is desirable, such as track suits, clothing made of stretch fabric or jeans.

- Removing potentially dangerous items, such as penknives, nail files, cigarette lighters, belts, shoes with laces. These should be stored safely for return to the person as appropriate.
- Providing the person with suitable bedding. This means that there will be, as a minimum, a mattress with sheets, a pillow and sufficient blankets/bedcovers to ensure the person is warm. Under no circumstances is it acceptable to keep a person in seclusion without appropriate bedding.
- Providing the person with adequate toilet arrangements. The most desirable way to manage toileting is to accompany the person to the toilet as often as required. This, however, may not always be appropriate. In these instances, each person in seclusion shall be provided with a pan or urinal and toilet paper. These will be removed and replaced with clean pans/urinals promptly after use, as often as necessary. Where the use of normal pans and urinals are contraindicated for safety reasons, disposable items should be provided. The person in seclusion should have the opportunity to wash their face and hands after toileting. Appropriate arrangements must be made for women in seclusion who are menstruating.
- Ensuring that the person's additional hygiene needs are met. This may be best achieved by accompanying the person to the bathroom and assisting them to bathe or shower as appropriate. In most instances the person should not be left alone in the bathroom during this time.
- Ensuring that debriefing and support are provided to the person during and after the seclusion. Although seclusion is used for sound clinical reasons, it is a potentially dehumanising intervention which requires sensitivity and skill in its management. Debriefing should also be provided to other persons who are aware of the seclusion, for example, other visitors, co-patients and staff.
- Developing a seclusion management plan that covers the primary diagnosis and assessment of the person's clinical needs, treatment objectives and outcomes, with sufficient detail to allow for effective continuing care. The plan should include:
 - * identification of health problems and risks and how they are to be managed (strategies to manage the identified risks might include the use of psychotherapeutic techniques, counselling, specialising and or medication)
 - * the time and frequency for the medical examination and review
 - * details of how the person's dietary needs are to be met (the plan should show that fluid is to be offered to the person at least every two hours and food every four hours, except overnight. It may be appropriate for the person to be supplied with a plastic cup and container of water. A fluid balance chart should be commenced for a person who has been secluded for more than four hours)
 - * details of how the person's hygiene and elimination needs shall be met and
 - * when the treatment plan is to be reviewed.

Clinical considerations

Medical assessment

In an emergency, seclusion may be commenced prior to a medical assessment being completed. However, a medical assessment must be conducted as soon as possible. For the first examination, particular emphasis should be placed on seeking a history of the presentation from the person. The assessment should include information about the possible ingestion of alcohol, illicit drugs and overdose, deliberate or accidental, of prescribed medication administered and any history of suicide attempts by the person and members of her or his family.

The physical and mental state examination should be conducted in the seclusion room and be as thorough as the circumstances allow. The interview and physical examination should include:

- review of physical and psychiatric health status
- assessment of adverse effects of medication
- review of the observations required
- reassessment of the medication prescribed
- assessment of the risk to the person from deliberate or accidental self-harm; and
- assessment of the need for continuing seclusion.

Recently admitted persons

Occasionally a person is admitted to an inpatient unit who is profoundly psychotic, unable or unwilling to give coherent responses to questions and is aggressively opposed to being physically examined. While this makes adequate assessment difficult, as thorough an assessment as possible must take place before medication is administered. Staff should be aware of the possibility that the person may have ingested significant amounts of alcohol or drugs prior to admission and/or may have unrecognised medical conditions such as epilepsy, diabetes or concomitant conditions such as chest infection or head injury which pose a threat to life. Medical and nursing staff responsible for the management of the person who is secluded must be aware of the medical history of the patient and clinical manifestations of alcohol and substance abuse or withdrawal, the cumulative effect of prescribed medication administered prior to seclusion, particularly in recently admitted persons.

Degree of vigilance

Medical and nursing staff vigilance should reflect the seriousness of the intervention. Attention should be focused on the person's safety and dignity and on any change in their physical or mental status that may indicate a change or deterioration in their condition and which may require (increased) clinical intervention.

Whether to use medication

The decision to prescribe medication prior to or during the period of seclusion involves balancing the risks and benefits of administering or not administering medication. In circumstances where assessment is difficult, the risk of adverse effects from medication is greatly increased. Determinants include the safety and well-being of the person, ongoing management, achieving the best treatment

outcomes in the shortest possible time and the safety of the other patients and staff. Close clinical observation is essential following the administration of psychotropic medication. Staff should also be alert for symptoms of respiratory depression, distress or laryngeal spasm.

Principles of prescribing

Medical staff prescribing for persons who are or may be secluded must be familiar with the likely rate of onset and duration of effect of medication prescribed, and the possibility of cumulative effects from repeat administration of medication. Further, doctors prescribing and nurses administering particular medication must be familiar with adverse effects that may occur.

Other principles relevant to prescribing are:

- the use of multiple drugs should be avoided wherever possible
- the use or withdrawal from benzodiazepines may heighten anxiety and aggression in some people and
- the administration of medication as necessary (PRN) prescriptions must specify the precise dose, route of administration, the interval between doses and the maximum dose in a specified period and the indications for use. Consideration may be given to prescribing medication in intramuscular or oral forms to minimise the risk of non-compliance or hoarding.

Observations

The legal requirement is that the seclusion must be reviewed as clinically appropriate for the person's condition. A registered nurse (Division 1 or 3) conducts this review at intervals of not more than fifteen minutes. In some circumstances, the person may need to be continuously observed for the whole or part of the period of seclusion. It is the joint responsibility of the medical and nursing staff to identify the level of observation required in each instance. This decision must be regularly reviewed and should be clinically appropriate to the person's condition.

If large doses of medication are given by injection, the doctor should specify the observations needed to identify potential side-effects. The periodic observation from within the seclusion room of vital signs, muscle tone and level of consciousness is necessary. Staff must be alert to the possibility that the patient who appears to be asleep may actually be unconscious.

Persistently disturbed/treatment resistant behaviour

The care of people who repeatedly behave in a manner which threatens themselves or others and whose symptoms fail to respond to a full range of clinical interventions, pose particular clinical problems that require careful consideration and management. A thorough review of the person's history, treatments attempted and their duration, doses of medication administered and responses should be undertaken. This should be presented to a group of skilled professionals for consideration at a case conference. Subsequently, a detailed management plan should be developed which describes the behaviour in question, identifies, wherever possible, the precipitants and outlines a graded series of responses. The plan should include a strategy aimed at reducing the behaviour and the person's need for such restrictive interventions.

Second opinion

Where seclusion is required for extended periods or is used on a recurrent basis, good clinical practice would indicate obtaining a second opinion or holding a case conference to review the person's management as soon as practicable.

Patients who ask to be secluded

There may be occasions when a person is distressed and requests seclusion because they feel contained and safe when secluded. If the door is locked from the outside, this meets the definition of seclusion and must be recorded and reported as such. If this is considered as clinically appropriate, there is no reason not to agree with this request, however it is expected that this would only occur on rare occasions.

Absconding patients

Absconding should only be used as a reason for seclusion if it presents a serious risk to the health or safety of the person or to others. In the management of absconding patients, seclusion can only be viewed as a short-term strategy and alternative options should be considered prior to its implementation. This may include enlisting the person's cooperation, gaining a therapeutic hold by psychotherapeutic and or medication means, close observation or nursing on a one-to-one basis, nursing in a high dependency area or movement to a more secure environment.

Isolation of a patient out of doors

There may be rare occasions when confining a patient alone in an enclosed outdoor area may be less restrictive and distasteful to the patient than the use of a seclusion room. This should be used as rarely and briefly as possible. It should be part of a written plan of management that:

- includes strategies to reduce or eliminate the need for its use
- is introduced only after appropriate assessment and
- is discussed where possible with the person and their family.

Although there is no legal obligation to report the use of patient isolation, this practice significantly limits the patient's usual freedom of movement and should be reported to the Chief Psychiatrist in the monthly report. If isolation is used, it is strongly recommended that the procedure is approved or authorised in the same way as seclusion and the person is provided with at least the same level of observation and medical review. Careful documentation of events leading to this decision, clinical management of the episode and the outcome should be made.

Quality assurance

Seclusion monitoring should be included in the ongoing quality assurance program of the approved mental health service. Areas targeted for review may include:

- reasons for seclusion, prolonged or repeated use of seclusion, use of seclusion overnight
- risk assessment prior to and during seclusion
- injuries and/or incidents occurring in seclusion
- care planning
- strategies to reduce the need for seclusion
- use of medication
- patient and family perception of seclusion.

The Chief Psychiatrist will monitor and compare seclusion practice on a statewide basis.

Seclusion – key points and processes

Note: The following steps may not occur sequentially.

- Decision is taken to seclude the person and a plan of how this is to be achieved is formulated.
- The person is informed of the decision, why the decision has been made and the level of observation and review that will apply. The person should be reassured that she or he is safe.
- Placing the person in seclusion should involve as many clinical staff, and a mix of genders, as required to ensure the safety of the person, staff and other persons. Where the person being secluded is a female, then female staff should be present.
- The appropriate medical practitioner is notified without delay if seclusion has been used in an emergency.
- The authorised psychiatrist is notified as soon as practicable if seclusion has been used in an emergency.
- An individual management plan is developed covering diagnosis, assessment of clinical need, anticipated outcomes, identified risks and strategies to manage those risks.
- Clothing provided should be comfortable and appropriate and provide for the person's dignity and self esteem. Placing a person in night attire should occur only if this is considered clinically appropriate. No person in seclusion should be without clothing.
- Potentially dangerous items, such as penknives, nail files, cigarette lighters, belts, and shoelaces must be removed and stored safely.
- The person must be provided with adequate food and fluids and appropriate assistance to meet their nutritional needs. A fluid balance chart should be commenced for persons who are in seclusion for longer than four hours.

- The person must be provided with adequate arrangements and assistance for the purposes of elimination and personal hygiene. It is desirable that the person be accompanied to the bathroom for these purposes. Women in seclusion who are menstruating must be provided with appropriate sanitary supplies.
- The person should, as is appropriate, have the opportunity to exercise.
- The person who authorised the seclusion and the authorised psychiatrist must sign the approval and authorisation for seclusion as indicated.
- Clinical documentation must be completed in clear descriptive terms.
- Debriefing of relatives, next of kin/primary carers, co-patients and staff is provided as required.
- A monthly RAPID/CMI generated report signed by the authorised psychiatrist is forwarded to the Chief Psychiatrist by the 20th day of the month following seclusion.

Seclusion – clinical audit

Standard 1: Each agency shall have an established policy and procedures concerning seclusion. Indicators:

- 1.1 There is a written policy and procedure for seclusion, which is informed by the clinical guideline issued by the Chief Psychiatrist.
- 1.2 Clinical staff are able to articulate a sound knowledge of the key principles, legal requirements, guidelines and local policies and procedures relating to seclusion.

Standard 2: An accurate account of each episode of seclusion is recorded in the clinical record, which demonstrates the delivery of effective, humane, efficient and evaluated treatment.

Indicators:

- 2.1 Clinical record documentation of an episode of seclusion contains the requirements of relevant policies and procedures.
- 2.2 Each person has a documented seclusion management plan covering the primary diagnosis, assessment of clinical needs, anticipated outcomes, risk assessment, and strategies to manage those risks.
- 2.3 The rationale for the decision to seclude the person is recorded.
- 2.4 All medical and psychiatric examinations, clinical reviews and treatments are recorded.
- 2.5 The person's response to treatments and interventions is recorded.
- 2.6 The rationale for any change to the treatment plan is recorded.
- 2.7 Details of second opinions and/or case reviews are recorded.
- 2.8 Reasons for variation of the four hourly reviews is recorded and are consistent with this guideline.

About Chief Psychiatrist's Guidelines

The information provided in this guideline is intended as general information and not as legal advice. If mental health staff have queries about individual cases or their obligations under the *Mental Health Act 1986*, service providers should obtain independent legal advice.

Standard 3: Statutory reporting requirements are achieved.

Indicators:

3.1 The Chief Psychiatrist is provided with the Seclusion Register (MHA 31) within 20 days of the following month in which the seclusion episode occurred.

3.2 The report of each episode of seclusion shall include:

- reasons why seclusion was used;
- name of the person who approved and/or authorised the use of seclusion;
- name of the person who kept the person in seclusion;
- period of time of the seclusion and reason for varying the medical examination by extension, if that occurred.

Data for each episode is entered into RAPID/CMI database by the 10th day of the following month in which the seclusion episode ceased.



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