



WACHS Mental Health Seclusion Policy

1. Background

In accordance with the [WA Chief Psychiatrist's Standards for Clinical Care 2015](#), WA Country Health Service (WACHS) is committed to working with consumers and carers to prevent, reduce and eliminate the use of restrictive practices. Early intervention, assessment, crisis management, de-escalation and other alternatives to seclusion are preferred interventions of choice in managing patient care and safety. WACHS recognises however that there are circumstances where seclusion may be necessary to minimise imminent risk to the patient, visitors and/or staff.

2. Policy Statement

WACHS upholds that the dignity and rights of people accessing mental health services must be respected and supported at all times. As such, seclusion is only to be used as a last resort, and for the shortest period of time, when all other less restrictive interventions have been exhausted. The purpose of this policy is to describe safe clinical and documentation requirements should seclusion be required to ensure the safety of the patient, staff or others within WACHS acute psychiatric units.

2.1 Key Principles

- The use of seclusion is not considered a therapeutic intervention and should be avoided wherever possible.
- Seclusion may only be considered when there is an imminent risk of danger to the individual or others and no other safer intervention is identified at the time.
- Seclusion is only to be used for a minimum period of time and must be terminated as soon as it is safe to do so.
- Where there are no appropriate alternatives to seclusion, it is to be administered in the most safe, dignified, compassionate and respectful manner as possible by appropriately trained staff and for the shortest possible duration.
- The use of seclusion creates significant risks for people with mental illness, their carers and staff. These risks may include serious injury, physical harm and /or psychological trauma, loss of dignity, cultural harm and breakdown in therapeutic relationships
- The patient must be examined by a medical practitioner within 2 hours of seclusion commencing.
- Patients, and with consent, their family/carer or nominated Personal Support Person (PSP), will be actively involved in the assessment process and their ongoing care planning and treatment choices.

2.2 Compliance with best practice standards

Compliance with best practice standards will be met by:

- Early identification and risk assessment of individuals who may require seclusion as a safety intervention of last resort
- Implementing a comprehensive management plan, developed in a multi-disciplinary framework and in consultation with the person, their family/carer or nominated PSP, which identify strategies to deal with episodes of violence and aggression
- High quality, active treatment interventions conducted by trained and competent staff who effectively employ individualised alternative strategies to prevent and defuse escalating situations
- Close monitoring and reporting of seclusion as defined by the Mental Health Act (MHA) 2014 legislation and regulations.
- For Aboriginal people, taking into account traditional beliefs and practices and when practicable and appropriate, involving collaboration with health workers, traditional healers and language interpreters from their communities.

2.3 Legislative requirements

Seclusion is only permitted in an authorised hospital and is strictly governed by the MHA 2014. All staff must be aware of statutory requirements, best practice guidelines and reporting requirements in relation to seclusion.

- The use of seclusion must be compliant with National and State policy, procedure and legislation. Seclusion of a patient with a mental illness at an authorised place must be conducted in accordance with the MHA 2014
- In a non-authorised facility, placing a person alone in a room from which they cannot leave may be a breach of the Criminal Code. A person may only be placed in a room from which they cannot leave if there are justifiable and proper reasons for doing so. These may include exercising a duty of care to the patient or others where there is no safer alternative. This is an emergency situation intervention and must be accurately and comprehensively documented in the patient's clinical record.

2.4 Exclusion criteria

- Seclusion must not be used for the purposes of discipline, coercion or staff convenience such as managing inadequate staffing levels.
- As seclusion has been shown not to be particularly effective in preventing imminent self-harming behaviours, seclusion should not be used for this sole purpose. Other strategies to manage self-harming behaviours should be employed.

2.5 Prior to seclusion

- On admission, clinical staff will ensure a risk assessment is undertaken to ascertain the potential for aggression or violence.
- A Psychiatric Services Online Information System (PSOLIS) Management Plan will be completed with the patient and carer/family member as soon as practical on admission, identifying, wherever possible, any precipitating and exacerbating factors which may result in seclusion and outlining a graded series of responses. Patients and their carer/family members must be given sufficient time to read through the Management Plan, offered an opportunity to ask questions, or seek clarification, before being asked to sign the document.
- Multidisciplinary clinical reviews need to be undertaken regularly and the management plan recorded in the patient medical record and in PSOLIS. The management plan should be used and regularly updated with the involvement of the patient, their family/carer or PSP. Where this is not possible the reason will be documented in the patient's medical record.
- Medical Practitioners, mental health practitioners or the person in charge of the ward must explore all least restrictive interventions prior to seclusion being considered. Prevention and early interventions to consider include, but are not limited to:
 - Implementation of the patient's and/or family/carer's documented advice regarding the appropriate strategy to reduce distress and agitation
 - Defusing and de-escalation techniques
 - Peer support involvement, dependent upon consent of the patient and availability of the Peer Support Worker
 - Ensuring a culturally safe environment
 - Diversional activities and sensory modulation
 - Low stimulus environment (e.g. comfort room, outdoor area, dedicated low stimulus zone)
 - Pro re nata (PRN) medication, used in conjunction with other strategies, for the purpose of calming, not sedating

2.6 Authorising Seclusion

- A medical practitioner, mental health practitioner, or the person in charge of a ward may make a seclusion order authorising the seclusion of (s. 214):
 - A person who is a patient admitted to the authorised inpatient unit
 - A person who is referred for examination by a psychiatrist at the authorised inpatient unit
 - A child who is under an order to enable an examination to be conducted by a psychiatrist at the authorised inpatient unit.
- If seclusion is required urgently, either a medical practitioner, mental health practitioner or the person in charge of the ward can make an oral authorisation (Form 11A) or written authorisation (Form 11B) for the person to be placed into seclusion.
- As soon as practicable after an oral seclusion order is authorised, the

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staff member who made the authorisation must record the use of seclusion on the Seclusion Form (Form 11A).

- For those patients who may be physically or medically compromised, (e.g. pregnancy, heavy sedation, active medical illnesses etc), a Medical Practitioner is required to document, as soon as possible after seclusion is commenced, in the Written Seclusion Order (Form 11B) and in the patient's clinical record, that the patient is medically fit to continue seclusion.
- If a person is restrained, and then a decision is made to also place the person in seclusion, then both a decision to restrain and a decision to seclude have been made and both forms need to be completed.
- If reasonable force in the form of physical restraint is needed to get the patient into the seclusion area and an oral or written authorisation has been made, then that is not a separate restraint event and a completion of a restraint form is not required.
- The person who authorised the seclusion must inform the patient's psychiatrist/duty psychiatrist of the seclusion within 2 hours (Form 11C).
- The patient must be examined by a medical practitioner (not necessarily the practitioner who authorised the seclusion) within 2 hours of seclusion commencing.
- Seclusion can be extended (Form 11E) for periods of up to 2 hours. An examination by a medical practitioner is always required before seclusion is extended
- Revoking or expiry of a seclusion order must be recorded on form 11F.
- The most senior registered nurse on the ward (after hours the most senior registered nurse on duty), is to be informed of all seclusion events. This registered nurse will attend, sight the patient and ensure nursing practice and documentation comply with overarching policy, regulation and legislation.

2.7 Patient Management during Seclusion

- All hazardous items such as belts, shoe laces, pens etc. must be removed.
- Patients should retain their own clothing unless there is a serious clinical contra- indication which may compromise safety. Such reasons must be documented in the patient's clinical record. Patients must not be secluded naked or in underclothes.
- To ensure staff safety, staff should never enter a seclusion room without sufficient staff numbers (minimum of three staff members).
- While in seclusion, clinical observations must be performed by a mental health practitioner, registered nurse or enrolled nurse every 15 minutes, and must include monitoring and documentation of the patient's respiratory rate (Form 11D). It is imperative that any change in the patient's physical condition, or sudden deterioration, is promptly recognised and reported.
- The 15 minute clinical observations can be performed outside the room but must be direct observation, not through a closed-circuit television (CCTV) link (if available).
- In addition to the 15 minute observations, CCTV (if available), should be

activated once seclusion has commenced, with the patient observed continuously by a mental health practitioner or a registered or enrolled nurse.

- The nurse in charge of the ward is to ensure that only necessary staff view the CCTV monitor throughout seclusion. The patient will be informed at the commencement of seclusion that CCTV facilities are used in the seclusion process
- If CCTV monitoring is not available, a Mental Health Practitioner or a registered or enrolled nurse must remain outside the seclusion room for the duration of the patient's seclusion.
- Whilst caring for the patient in seclusion, the Mental Health Practitioner or a registered or enrolled nurse should be aware that this duty is a priority. In the event of an emergency, the allocated clinician must ensure that the patient remains under observation whilst in seclusion.
- A medical practitioner must examine the person at least every 2 hours and more frequently when the condition of the patient indicates more frequent medical intervention is appropriate.
- The purpose of the medical practitioner examination is to ensure that the patient's medical condition is satisfactory and to assess whether seclusion should continue or be revoked. Details of these examinations are to be documented on the extending Seclusion Form (Form 11E).
- At any time a medical practitioner, a mental health practitioner or the person in charge of the ward can revoke the seclusion order and the patient must be allowed to exit the seclusion area (Form 11F).
- A risk assessment must be conducted prior to a decision to revoke or the expiry of the seclusion order.
- Where a patient is in seclusion, it is essential to ensure that appropriate provision is made for their basic needs, including bedding, clothing, food, drink and toilet facilities
- In accordance with the patient's consent and management plan, the family/carer or PSP will be informed as soon as practical of the use of seclusion and when the seclusion has been terminated.

2.8 Patient Management Post Seclusion

- Following the release of a patient from seclusion, a medical practitioner will carry out a physical examination within 6 hours to ensure that there is no complication of, or deterioration in, the patient's mental or physical condition that is a result of, or may be a result of the patient being secluded (Form 11G).
- The most senior registered nurse on the ward (after hours the most Senior Registered Nurse on duty) is responsible for ensuring the patient's risk assessment and management plan is reviewed and updated as part of the clinical review process in collaboration with the patient and/or their family/carer or PSPS, as soon as practicable post seclusion.

- Following seclusion, all patients must be offered support and counselling preferably from a person of their choice. Support may also include access to the Mental Health Advocacy Service.
- Aboriginal MH staff should ensure the cultural welfare and safety of the patient following seclusion wherever possible
- A Post Seclusion Interview must be offered to the patient and is to be conducted as soon as practicable by a member of staff chosen by the patient. With the consent of the patient, Peer Support involvement and the patient's family/carer and/or PSP should be included in the review process.
- Patients have a right to refuse to engage in a Post Seclusion Interview but every attempt should be made by staff to engage them in the process. If a patient chooses not to engage in a Post Seclusion Interview, this should be documented in the medical record.
- The information gathered by the Post Seclusion Interview is to be recorded as 'Post Seclusion Interview' in the patient's medical record.

2.9 Staff Debriefing

Line Managers must organise post seclusion debriefing for staff in accordance with local service policies and procedures.

2.10 Documentation

Minimum documentation requirements include:

- The relevant [MHA 2014 Forms](#) must be completed for every occasion of seclusion
- All forms must be checked to ensure they are comprehensively and accurately completed and comply with the MHA 2014 legislative requirements prior to submitting to the Office of the Chief Psychiatrist (OCP)
- A copy of all seclusion forms are to be forwarded to the Nurse Manager or delegate once all of the forms are checked and completed in full.
- A copy of all seclusion forms will be provided to the Chief Psychiatrist, and where applicable the Mentally Impaired Accused Review Board, after any seclusion order.
- A copy of all the forms used in the seclusion process must be given to the patient unless it is determined by the medical officer that to do so may not be in the best interest of the patient or others. If the forms are not provided to the patient, the medical officer will document the reasons for this decision in the patient's medical record
- The patient's medical record must be contemporaneously updated to include:
 - Guidance on when to cease seclusion,
 - Length of seclusion and any breaks in seclusion
 - The face-to-face medical examination of the patient in the 24 hours following seclusion.
 - Patient's post-seclusion presentation

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- Post seclusion review of the Management Plan which includes the review of the clinical observation level.
- What action is required post-seclusion, including completion of necessary documentation
- Identifiable factors which may have contributed to seclusion
- Actions taken by staff prior to seclusion to defuse situation to avoid seclusion
- PSOLIS Alerts and Incidents will be reviewed and updated
- Datix CIMS online notification form must be completed whenever the seclusion has resulted, or may have resulted, in harm to the patient.
- If seclusion is preceded by a restraint then the MHA 2014 Forms pertaining to the restraint are required to be completed in addition to seclusion documentation (see WACHS Mental Health Restraint Policy).
- Transfer and discharge documentation should include triggers that resulted in seclusion and known individual de-escalation and preventative strategies

2.11 Executive Review of Seclusion

An Executive Review of Seclusion by the Clinical Director, Regional Manager (or delegate) and the Nurse Unit Manager must occur within seven days of the event occurring (see Appendix A). Outcomes of each review will be recorded on the relevant WACHS (Region Specific) Seclusion and Restraint database and in the patient's medical record.

Where required, a formal case conference can be coordinated for complex cases, which may include, but is not limited to:

- Patients who have three or more seclusion events within one week
- Any seclusion longer than six hours
- Any event which results in an injury to the patient, staff or others
- If required, the Clinical Director can further escalate complex cases to the Director of Psychiatry and the Coordinator of Nursing Mental Health for an independent review
- The Clinical Director will ensure evidence of local interventions and reviews are available during the independent review.

3. Definitions

Appropriately Trained Mental Health Clinician	This refers to a Mental Health Clinician, working within WACHS MH services, who has within the last 12 months, successfully completed regionally endorsed training in the recognition and management of challenging and aggressive behaviour.
Mental Health Practitioner	A person who is qualified as one of the following and has at least 3 years' experience in the management of people who have a mental illness: <ul style="list-style-type: none">● psychologist;● nurse whose name is entered on Division 1 of the Register of Nurses kept under the Health

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	<p>Practitioner Regulation National Law (Western Australia) as a registered nurse;</p> <ul style="list-style-type: none"> • occupational therapist; • social worker.
Restraint	<p>Bodily restraint is the physical or mechanical restraint of a person who is being provided with treatment or care at an authorised hospital.</p> <p>A person is not being physically restrained when being provided with the physical support or assistance reasonably necessary to enable the person to carry out daily living activities or to redirect the person because the patient is disoriented MHA 2014 (Section 227.). For the purposes of this policy bodily restraint does not include:</p> <ul style="list-style-type: none"> • Physical or mechanical restraint by a police officer acting in the course of duty; or • Physical restraint by a person exercising a power under section 172(2).
Seclusion	<p>The Mental Health Act 2014 (Section 212) defines seclusion as the confinement of a person who is being provided with treatment or care at an authorised hospital by leaving the person at any time of the day or night alone in a room or area from which it is not within the person's control to leave. A person is not secluded merely because the person is alone in a room or area that the person is unable to leave because of frailty, illness or mental or physical disability.</p>

4. Roles and Responsibilities

All levels of leadership and management, both within Mental Health Services and at regional executive level, are to lead the monitoring and reduction of restrictive practices, as per the Chief Psychiatrist's Standards for Clinical Care 2015.

Clinical Leads

Provide strategic leadership, workforce and organisational development to ensure local health systems use least restrictive practice and reduce the use of seclusion and restraint

Managers and Clinicians

- Ensure clinical staff are provided with continuing education and support in least restrictive practice and the use of restraint and seclusion
- Ensure reduction in the use of restraint and seclusion and engage in monitoring of quality care and patient and population health outcomes to inform quality improvement

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- Ensure documentation and reporting requirements of the MHA 2014 and associated regulations are met.
- Provide support, debriefing and opportunities to learn
- Aboriginal Mental Health Workers are to be involved following episodes of seclusion when it is appropriate to follow up the cultural welfare and safety of the patient

Medical Staff

Medical staff must take a proactive role in minimising restrictive practices.

- The treating or on-call Psychiatrist must take an active leadership role in facilitating strategies which reduce restrictive practices
- Comply with the requirements of the MHA 2014 as they pertain to seclusion & restraint
- Medical staff must attend an Acute Psychiatric Unit, at the earliest possible time, when there is evidence of escalating risk not settling with remote support
- Medical staff must take an active decision making role early in the seclusion process to limit duration and maximise safety

Security Staff

In the event Security Personnel attend a potential seclusion event, the role of security staff is to assist the clinical team under the direction of the Mental Health Practitioner or Medical Practitioner, or person in charge of the ward in accordance with local health service protocol.

5. Compliance

Failure to comply with this policy may constitute a breach of the WA Health Code of Conduct (Code). The Code is part of the [Integrity Policy Framework](#) issued pursuant to section 26 of the [Health Services Act 2016](#) (WA) and is binding on all WACHS staff which for this purpose includes trainees, students, volunteers, researchers, contractors for service (including all visiting health professionals and agency staff) and persons delivering training or education within WACHS.

WACHS staff are reminded that compliance with all policies is mandatory.

Seclusion and Restraint data is monitored and reviewed at the WACHS Mental Health Safety, Quality and Risk Steering Committee and by the WACHS Board. All seclusion and restraint forms are provided to the Office of the Psychiatrist for review and monitoring.

6. Records Management

[MHA Forms 2014](#)

7. Evaluation

Evaluation of this policy is to be carried out by the Director of Psychiatry Adult / Older Adult every three years at minimum.

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8. Standards

[National Safety and Quality Health Service Standards](#) - 5.31, 5.32, 5.33, 5.34, 5.35, 5.36, 6.7, 6.8, 6.9, 6.10, 6.11

[National Standards for Mental Health Services](#) - 1, 2, 6, 8, 10

9. Legislation

[Mental Health Act 2014](#)

10. References

[Chief Psychiatrist's Standards for Clinical Care: Seclusion and Bodily Restraint Reduction](#)

[Reporting Seclusion to the Chief Psychiatrist \(Authorised Hospitals\), WA Mental Health Act 2014, Division 6](#)

11. Related Forms

[MHA Forms 2014](#)

12. Related Policy Documents

WACHS Mental Health Restraint Policy

13. Related WA Health System Policies

[WA Health Code of Conduct](#)

[WA Health Consent to Treatment Policy](#)

14. Policy Framework

[Mental Health Policy Framework](#)

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on request for a person with a disability**

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Appendix A: Executive Review of Seclusion

An Executive Review of Seclusion by the Clinical Director, Regional Manager (or delegate) and the Nurse Unit Manager must occur within seven days of the event occurring.

The purpose of the Executive Review of Seclusion is to consider the following questions:

- 1** Could the seclusion have been anticipated?
 - b If so, could any management strategies have been put in place sooner?
 - c Was the risk assessment accurate and contemporaneous?
- 2** a Which staff were involved in the seclusion?
 - b Were all staff involved in the seclusion appropriately trained mental health clinicians*? **This refers to WACHS mental health clinicians, who have within the last 12 months, successfully completed regionally endorsed training in the recognition and management of challenging and aggressive behaviour.*
- 3** Was the seclusion performed safely and in accordance with overarching legislation, policy and standards?
- 4** Did the seclusion result, or have the potential to result, in harm to the patient?
 - a If so, were any immediate health care needs of the patient identified and met?
 - b Was a Datix CIMS online notification completed at the time?
 - c Following this Executive Review of Seclusion, does a CIMS online notification form and subsequent investigation need to be initiated?
- 5** Did the seclusion result in harm to staff or others?
 - a If so, were their immediate health care needs identified and met?
 - b Were the required Occupational Health and Safety forms completed?
- 6** Were cultural considerations taken into account prior to, during and following the seclusion?
- 7** Was all required documentation completed in line with MHA 2014 requirements?
- 8** Was a Post Seclusion Interview offered to the patient?
 - a With consent of the patient, was their family/carer/PSP and Peer Support included in the review process?
- 9** Was debriefing organised for staff following the seclusion?
- 10** What worked well for this patient?
- 11** What could be done differently in the future?
- 12** How will the results of this review be shared with ward/local staff and others?