Seclusion Procedure – Albany Acute Psychiatric Unit

1. Guiding Principles

Effective: 11 March 2020

There is unequivocal evidence that seclusion is traumatising for the person secluded in both the short and long term. The Great Southern Mental Health Service (GSMHS) is opposed to the use of seclusion and aims to have zero incidents of seclusion occur. This is one of the reasons GSMHS has made the decision that seclusion will not be conducted in the dedicated seclusion room in the secure area of the APU.

The Mental Health Act regulations require that an APU be capable of initiating and managing seclusion, the Great Southern Mental Health Service (GSMHS) allows seclusion to occur safely and legally in the patient's own bedroom or the PICU area, if it should be decided in an individual situation that seclusion is required.

Seclusion in any form is a procedure of last resort not a treatment intervention. Early identification, intervention, assessment, crisis management, de-escalation, individualised treatment programs and other alternatives are preferred interventions of choice in managing patient care and safety. Seclusion is only to be used as a last resort, for the shortest period of time when all other less restrictive interventions have been exhausted.

Any use of seclusion within GSMHS must be consistent with the Mental Health Act 2014 (see legislation below), WACHS Mental Health Seclusion Policy and reported according to the Mental Health Act 2014 and the Office of the Chief Psychiatrist seclusion and restraint reporting guidelines (see references below).

2. Procedure

Seclusion is 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. The statutory definition of seclusion in the Mental Health Act 2014 (s.212 (1)) includes any area, not just a room, where a patient is not able to leave

The criteria for seclusion is that the person needs to be secluded to prevent them from physically injuring himself or herself or another person, or persistently causing serious damage to property and there is no less restrictive way of preventing the injury or damage other than placing them in seclusion.

For the purposes of this procedure, the term seclusion refers to seclusion in the patient's own bedroom or PICU area which is considered an intervention used as a last resort.

The OCP has clarified that any time period where the PICU has no nursing staff present, needs to be recorded as a seclusion event and the OCP notified.

This includes:

- Any event where allocated staff return to office because of imminent risk of harm and whilst a restraint team is being assembled.

- Any time period where a PICU staff member leaves the PICU common area briefly for any reason and there is no other staff in the unit.

If the person needs to be secluded urgently either a medical practitioner, mental health practitioner or the person in charge of the ward can make an oral authorisation for the person to be placed into seclusion.

If it was not the patient's psychiatrist who authorised the seclusion, then the practitioner who authorised the seclusion must inform the patient's psychiatrist of the seclusion within 2 hours. At times when the patient's psychiatrist is not on duty the on call psychiatrist should be informed. It would be good practice for the patient's psychiatrist to be also informed when they are on duty again.

Seclusion events in the patient's own bedroom must be managed as follows:

1. The room must be attenuated to ensure it is safe for the patient to be secluded in their room, consider ligature, self-harm, egress. The bathroom door should be locked when not in use by the patient, with patients offered regular opportunities to use the toilet

2. After the designated seclusion bedroom is stripped of any furnishing and/or equipment which may pose a risk to the patient, the patient is to be escorted into the room in the safest and most respectful manner possible with an appropriate number of WACHS staff members.

3. Appropriate provision will be made for the basic needs of the patient including bedding, clothing, food, drink, toilet facilities and any other care the patient may need.

4. If the patient's ordinary clothing is a self-harm risk then special clothing and bedding should be provided which cannot be used for that purpose. Patients should never be left naked in seclusion.

5. While in seclusion the patient must be observed by a mental health practitioner or a registered or enrolled nurse every 15 minutes. Best practice would be continual monitoring of the patient while in seclusion.

6. In the instance nursing staff have withdrawn from the PICU area during a seclusion event the patient/s must be monitored at all times by CCTV and/or the viewing window.

7. All required MHA 2014 documentation must be completed as soon as practicable.

An essential element to placing a person in seclusion is to provide further treatment and care. At times that treatment may include oral or IM medication. If the person is an involuntary patient then treatment can be provided without consent, though consent should always be sought. If the person is a voluntary patient (including a referred person) and they refuse to consent to treatment then treatment can only be provided as emergency psychiatric treatment (EPT) if they meet the criteria for EPT (Form 9A).

The traumatic nature of the experience is to be held in mind by staff responsible for the seclusion. As soon as a patient is calm enough to leave seclusion they should be allowed to do so, though close observation and contact with staff should be maintained until the patient's calmer mental state is confirmed

Following the release of a patient from seclusion he or she must be provided with a physical examination by a medical practitioner within 6 hours to ensure that there are no complications of, or deterioration in, the patient's mental or physical condition that is a result of, or may be the result of, the patient being secluded. This would also be an opportunity for debriefing for the patient and allowing their perspective to be heard.

A copy of forms used in the seclusion process must be given to the patient.

The carer, close family member and/or nominated person are entitled to be informed and know that a patient has been secluded. There is no requirement to notify them immediately unless they have made a specific request that they are informed immediately.

A copy of all seclusion forms must be provided to the Chief Psychiatrist, who will report in details of the use of seclusion in mental health services

A register of each episode of seclusion must be kept within the APU by the Clinical Nurse Manager. The responsibility for recording seclusion documentation rests with the Clinical Nurse or Shift Coordinator on duty at the time of the seclusion event.

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

The original MHA seclusion forms recording the seclusion event must be included in the patient medical record.

3. Definitions

Seclusion Event	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.

4. Roles and Responsibilities

Clinical Director
Clinically lead the service by ensuring excellence in local clinical governance systems and defining clinical best practice.

Manager, GS Mental Health Service
Provide managerial support to the APU via clear expectations of operational unit role and ensuring that there are adequate resources to meet these. Monitor the team performance against the agreed performance indicators.

Acute Psychiatric Unit Clinical Nurse Manager
Identify and communicate organisational and local ward clinical governance structures. Provide day to day monitoring of the ward clinical governance processes.

Shift Coordinator
The Shift Coordinator will be responsible for supervising, monitoring, delegating, and communicating all operational processes involving the provision of safe and effective nursing care.

Clinical Nurses, Registered Nurses and Enrolled Nurses
Deliver care within the scope of practice for registration and competence. Undertake tasks as delegated or as scheduled by shift coordinator instructions. Escalate to the shift coordinator any clinical, OSH, or security incidents, near misses, and patient complaints. Communicate immediately with the shift coordinator if there is any deterioration in a patient's condition or when the delivery of patient care is outside of the nurse's scope of practice or competence. Liaise with the shift coordinator to communicate the patient's condition and care, including use of discretionary/prn medications

5. Compliance

All episodes of seclusion must be conducted, managed and reported in accordance with the Mental Health Act 2014.

Failure to comply with this procedure 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.

6. Records Management

All WACHS corporate records must be stored in the approved Electronic Documents and Records Management System.

Records Management Policy

Clinical:
Health Record Management Policy

7. Evaluation

Seclusion events are monitored by the Office of the Chief Psychiatrist. All seclusion event outcomes are monitored by the Clinical Director of GSMHS, and identified issues tabled for review at the GSMHS Management Committee Meeting. Regular reviews occur in accordance with WACHS MH Central Office and the Office of the Chief Psychiatrist governance processes. When these occur GSMHS conducts file reviews to ensure all necessary paperwork has been completed with escalation to non-compliant clinicians and/or Clinical Nurse Manager and/or Clinical Director as required for compliance improvement.

8. Standards

National Safety and Quality Health Service Standards - 1.3, 1.7, 1.9, 5.10, 5.11, 5.13, 5.14, 5.33, 5.34, 5.35, 5.36, 6.9, 8.5
National Standards for Mental Health Services - 10.2.2, 10.2.3, 8.10
Chief Psychiatrists Standards for Clinical Care
Chief Psychiatrists Authorised Hospital Standards

9. Legislation

Mental Health Act 2014 (WA)

10. References

Reporting episodes of Seclusion and Restraint
Clinicians Practice Guide to the Mental Health Act 2014
Seclusion Reporting to the Chief Psychiatrist (Authorised Hospitals) Flowchart

11. Related Forms

Mental Health Act 2014 mandated forms

12. Related Policy Documents

WACHS Mental Health Seclusion Policy
WACHS Disturbed Behaviour Management-WACHS Clinical Practice Standard

13. Related WA Health System Policies

Nil

14. Policy Framework

Mental Health Policy Framework
Clinical Governance, Safety and Quality Framework

This document can be made available in alternative formats on request for a person with a disability

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