Controlled Document

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| **Target Audience** | Approved Treatment Facilities under the Mental Health and Related Services Act |
| **Jurisdiction** | Northern Territory |
| **Document Owner** | Chair Mental Health and Related Services Act Approved Procedures and Quality Assurance Committee |
| **Approval Authority** | Chief Executive |
| **Author** | Approved Procedures and Quality Assurance Committee |

# Purpose

To guide health care clinicians through the process of using seclusion on patients in line with requirements of Section 62 of the *Mental Health and Related Services Act 1998* (the Act).

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| **Note**  All services within NT Health are required to comply with the requirements of the NT Health Seclusion and Restraint Policy, which is located on the staff intranet (PGC). The NT Health policy calls upon this Approved Procedure for the seclusion of patients under the *Mental Health and Related Services Act 1998* in an approved treatment facility |

# Procedure Summary

Refer to Appendix A - Procedural flowchart for seclusion for an overview of this procedure (located at the end of this procedure).

# Definition

Section 62(16) of the Actdefines seclusion as being the confinement of a patient at any time of the day or night alone in a room or area from which free exit is prevented.

In this case, patient means a person who is being assessed or receiving treatment under the Act in an approved treatment facility.

# Introduction

Seclusion is an intervention of last resort used when other options have failed to maintain safety for the person experiencing distress, staff or others.

Reducing the use of seclusion and restraint has been identified as a major practice change initiative for Australian mental health services. The National Mental Health Seclusion and Restraint Project (NMHSRP) involved collaboration between State and Territory Governments and the Commonwealth to reduce and, where possible, eliminate the use of seclusion and restraint in public mental health services.

The objects of the *Mental Health and Related Services Act 1998* (the Act) is for all care and treatment to be consistent with the United Nation’s Principles for the Protection of People with Mental Illness and the Improvement of Mental Health Care (UN Principles). Principle 11 of the UN Principles requires informed consent to treatment except in the case of a prescribed plan of treatment given to an involuntary patient who lacks the capacity to consent and that physical restraint and involuntary seclusion be employed only if necessary to prevent imminent or immediate harm to the patient or others.

This Approved Procedure aligns with Principle 11 as enacted through the Act.

The United Nation’s Principles for the Protection of People with Mental Illness and the Improvement of Mental Health Care (UN Principles) are available from:- <https://www.who.int/mental_health/policy/en/UN_Resolution_on_protection_of_persons_with_mental_illness.pdf>

## Pre seclusion

The primary focus of clinicians working within an inpatient setting is to assist patient recovery, and seclusion is considered the very last resort for management of a patient’s behaviour. To avoid the use of seclusion, staff should actively implement interventions based on a comprehensive assessment and planning process resulting in a clearly articulated Individual Care Plan (ICP) documented in the patient’s clinical record. The ICP should be developed as early in the admission as possible and for all patients. Discussion and planning with the patient must take place to ensure the ICP incorporates action to taken should the patient’s behaviour and/or mood significantly deteriorate (noting that this may not always be possible in the acute phase, depending on presentation).

Staff are to be familiar with relevant strategies to defuse and de-escalate potentially or actual volatile situations. Management of patients is expected to incorporate appropriate behavioural management strategies to reinforce the desired behaviour and reduce incidents that may eventuate in the patient’s seclusion.

Where a patient’s behaviour is becoming increasingly disturbed, clinical staff will:

* Regularly monitor the patient’s mental state and undertake appropriate risk assessment;
* Actively engage with the patient to discuss their situation and feelings;
* If patient speaks a language other than English, ensure an interpreter is booked and used wherever possible for daily nursing interactions, medical reviews and debriefings;
* If the patient is Aboriginal, engage the assistance of an Aboriginal mental health worker, as able;
* Provide diversionary activities, as appropriate;
* Regularly review the patient’s management and medication regime i.e. discussion of patients at handover and ward rounds and clear and accurate documentation of the plan;
* Timely and judicious use of prescribed medication;
* Consider moving the patient into a less stimulating area of the ward, and offer the patient an opportunity for voluntary ‘time out’;
* Engage with the patient’s primary carer or people identified by the patient to identify strategies that may assist.

However it is acknowledged that clinical emergencies can arise quickly that endanger a patient and others including staff and this entire list of clinical interventions may not be able to be implemented before seclusion is indicated as per section 62 (3).

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| **Practice Note**  The *National Standards for Mental Health Services* require that no patient is disadvantaged on the basis of their culture and that services are accessible and equitable for all. Staff should work knowledgeably and sensitively with people from different cultural backgrounds who may display unfamiliar behaviours and responses when in situations that are confusing, distressing or frightening to them.  In the absence of a staff member who can speak the language of the patient and provide support, it would be helpful for patients from culturally and linguistically diverse backgrounds to be provided with written or audio information in their own language relating to their rights and responsibilities as patients of the ATF. Utilisation of the Aboriginal Interpreter Service (AIS) or Telephone Interpreter Service (TIS), or a sign language interpreter for deaf patients, to provide verbal information to patients relating to their own ICP should also occur.  Provision of culturally sensitive service as outlined above may well ameliorate difficult situations and prevent the need to use seclusion. |

# Procedure

## Requirements under the Act for an approved treatment facility

### Requirements for keeping a patient in seclusion

Section 62(1) and (2) of the Act state that a patient must not be kept in seclusion, except where they are being kept in accordance with the provisions of Section 62 of the Act and this approved procedure.

Section 62(3) allows for a patient to be kept in seclusion in an approved treatment facility (ATF) where no other less restrictive method of control is applicable or appropriate and it is necessary for the:

1. purpose of the medical treatment of the patient;
2. prevention of the patient from causing injury to himself or herself or any other person;
3. prevention of the patient from persistently destroying property; or
4. prevention of the patient from absconding from the facility.

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| **Practice Note**  Currently the Northern Territory has two ATFs, these being Alice Springs Hospital (ASH) and Royal Darwin Hospitals (RDH). This includes all departments within ASH and RDH campus, for example the Emergency Department where a person may be assessed under the Act.  The circumstances related to the use seclusion may differ, for example an acute response to Acute Severe Behavioural Disturbance to a progressive escalation of behaviours of concern. Depending on the circumstances, de-escalation techniques and multiple risk assessments may be undertaken. Irrespective of the circumstances, risk assessments must show evidence that the patient is at risk of harm to self or others and be fully documented in the patient’s clinical record. The risk of harm to self or others must be imminent, foreseeable in the immediate future.  The principles of the Act requires that, as far as practicable and appropriate, family members are consulted and involved in the patient's treatment and care. If possible, clinicians should endeavour to contact the carer or other suitable family member prior to a seclusion event to discuss the situation and need for seclusion.  If a patient is sleeping, they do not meet the criteria for seclusion. As such, seclusion should be ceased when a patient is asleep in the seclusion room. Two successive 15 minute observations of the patient sleeping should be used to determine whether the patient is asleep.  If this is found to be the case, nursing staff should unlock and open the door/s wide, and continue 15-minute observations until the patient awakens. The patient must then be informed that they are no longer required to remain in seclusion and can be offered the choice of returning to a bed on the ward. The patient will then continue to receive care and treatment under the provisions of the Act after the episode of seclusion. If the patient again meets the criteria for seclusion, it may be initiated again, according to the requirements of the Act and this approved procedure. |

### Approval of seclusion

Seclusion must be approved by an authorised psychiatric practitioner (APP) or in the case of an emergency, by the senior registered nurse on duty (RNOD) prior to application under the provisions of section 62(4).

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| **Practice Note:**  An emergency situation is one where there is an immediate risk of traumatic experience and/or injury for the patient or any other person. |

Section 62(5) then requires that if the senior RNOD has approved a patient being kept in seclusion, they must notify an APP as soon as practicable after approval.

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| **Practice Note**  Upon approval of seclusion, the person approving it must complete **Form 22 Seclusion**.  The approval for seclusion must be based on a face-to-face clinical review of the patient and this review must occur even if consecutive approvals are made by the same authorised clinician.  If the senior RNOD has approved the seclusion, and the patient remains secluded after one (1) hour, the senior RNOD must contact the APP to review the patient (if the senior RNOD hasn’t previously notified the APP of the seclusion, this may be done simultaneously to the request for the review). When the APP reviews the patient, they are assessing them to determine whether or not they continue to meet the criteria for seclusion. They will also consider other treatments that may assist the patient, in order to reduce the time in seclusion or to cease it. If the APP determines that seclusion is no longer required, the patient must be released from seclusion without delay.  The review by the APP should be undertaken ‘as soon as practicable’, which for the purposes of this procedure should be interpreted to mean no more than three (3) hours from the time that the APP is contacted by the senior RNOD. This will effectively mean seclusion approved by a senior RNOD can continue for a maximum period of four (4) hours, depending on when the APP was contacted after seclusion commenced.  If, within the period from when the APP is contacted to when the review is undertaken the senior RNOD determines that seclusion is no longer required, the senior RNOD must remove the seclusion order and notify the APP. |

### Duration, breaks in, and release from seclusion

Section 62(6) states that the period the patient is to be kept in seclusion must be determined and noted in the patient's case notes by the APP or senior RNOD who approves it. However if it has been approved by the senior RNOD it is required to be reviewed and, if necessary, re-determined by an APP and noted in the patient's case notes as soon as practicable afterwards.

A patient admitted as a **voluntary patient must not be kept in seclusion for longer than a continuous period of 6 hours** under the provisions of section 62(10).

Section 62(11) requires that if a medical practitioner, senior RNOD or an APP determines that the patient no longer satisfies, the requirements for seclusion under subsection (3), they must, without delay, release the patient from seclusion.

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| **Practice Note**  The authorised ‘duration’ of seclusion must refer to a length of time not a behaviour. For example it is not appropriate to indicate a duration of ‘until settled’ or ‘until no longer a risk to others’.  The APP must state the maximum period that the patient may be kept in seclusion but cannot make a plan to keep a person in seclusion for a nominated time. It is suggested that a patient should spend no longer than a maximum period of 4 hours in seclusion especially if they have been adequately medicated. If a patient has been in seclusion for longer than 4 hours, the APP must consult a level 1 APP.  A “break” in seclusion occurs when a patient is removed from seclusion and has free access to all the same facilities as other patients located in that clinical area or if the patient is sleeping, the room is unlocked to enable the patient to have free exit on waking.  Enabling the patient to access: toilet facilities food and drink or physical and psychological care is not considered a “break” in seclusion.  NOTE: It is inadequate to leave the door to the seclusion room unlocked and thus state that seclusion was broken.  **Upon release from seclusion, the patient must be made aware that free exit is available immediately on unlocking the door of the room or when the patient wakes.**  Where someone other than an APP releases the patient from seclusion (prior to an APP review) an APP must review the seclusion with a multi-disciplinary group of staff within the following 24 hours. This must include a review of the patient’s ongoing management so as to prevent further episodes of seclusion where possible and the ICP updated as required. |

### Patient consent, review and observation requirements

Section 62(7) allows for a patient to kept in seclusion without their consent and 62(8) requires that a patient kept in seclusion is to:

1. be visited by a registered nurse at intervals not longer than 15 minutes;
2. be examined by a medical practitioner at intervals specified in approved procedures;
3. be reviewed by an authorised psychiatric practitioner in accordance with approved procedures;
4. be supplied with bedding and clothing that is appropriate in the circumstances;
5. be provided with food and drink at appropriate times;
6. have access to adequate toilet facilities; and
7. be provided with any other psychological and physical care appropriate to the patient's needs.

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| **Practice Note**  Once in seclusion, for the safety of the person, a Registered Nurse must visit the patient at intervals not longer than every 15 minutes. Where possible, staff are encouraged to engage with a person in seclusion. For people at higher risk during the intervention, more frequent and additional monitoring may be indicated, for example where acute sedation has been used.  Clinical monitoring must include vital signs (respiratory rate, blood pressure, temperature and pulse rate). The frequency of monitoring vital signs must be determined by the clinical team, parameters set and reviewed when required.  It may not be possible to monitor all of the vital signs if, by doing so, safety of the staff or person being secluded is compromised. However, in those circumstances**, continuous visual observation** is required to ensure safety. If vital signs cannot be taken, staff must ensure the reasons are documented in the Health Care Record.  Clinical visual observations must be conducted in person and must not be undertaken using closed circuit television (CCTV). The observing NT Health staff must consult with the relevant clinical team in response to any escalation of the person where there are indicators that the person is becoming highly distressed and/or appears to be deteriorating in wellbeing or health.  Security staff are not to replace NT Health medical practitioners for clinical observation of a person.  Any variation to the frequency and type of observations and the reason why the variation occurred must also be documented.  Visual observation may be at a point adjacent to the seclusion room/area and each time a patient is observed it is to be done with the intention to ensure the patient is safe and well, and also to ascertain whether the mental and or behavioural state of the patient is such that seclusion can be terminated. Assessing a patient’s suitability for ceasing seclusion cannot be done comprehensively without an attempt to engage and interact (where safe and possible). Not interacting/engaging with patients may result in a longer seclusion than necessary.  A nurse should be readily available within sight and sound of the seclusion area at all times throughout the period of the patient's seclusion. In general, a nurse should be interacting where possible with the patient, seeking to assess if seclusion can be ceased.  The nurse(s) allocated the duty of regularly observing the secluded patient must   * Record in the patients clinical record, the exact times of their observations and any relevant information including the provision of care, bedding, clothing, food, drink, toileting, medical reviews and observations of the patient’s condition. * Make note of the position of the person. * Consult with the senior RNOD if observations indicate that seclusion can be ceased, in order that the patient is released from seclusion without delay, s62(11). * If a person has been lying/sitting quietly within the seclusion room/area for 30 minutes or more, imminent cessation of the seclusion should be considered and appropriate documentation completed. Reasons for not ceasing the seclusion under these circumstances are to be documented in the patient’s clinical record. * If a person currently or previously in seclusion has not moved for 15 minutes(sooner, if clinically indicated), breathing pattern, rate etc., skin colour and other signs of hypoxia should be checked for. If medication has been used, an immediate review should be implemented where observations may indicate a significant and potentially dangerous level of sedation has occurred. * Provide a summary of the patient’s time in seclusion in the patient’s clinical record:   + prior to each review by an APP or medical officer; and   + at the end of the period of seclusion; or   + at the end of the nursing shift,   whichever comes first.  Throughout the entire period in which the patient is in seclusion, they must also be reviewed at a minimum every three (3) hours by a medical practitioner who has been trained appropriately to undertake this task.  The senior RNOD must also request a medical review at any time if they are concerned about the patient’s physical or mental deterioration. Every attendance by a medical practitioner and their review must be documented.  All details are to be recorded in event reports, patient clinical notes and a seclusion register in a manner and format approved by the PIC of the relevant ATF in line with the approved procedures. |

### Register and event record to be kept

Subsection (12), requires a Person in Charge (PIC) of an ATF to ensure that a record is kept of the:

1. the reasons why a patient was kept in seclusion; and
2. the name of the person who approved the patient being kept in seclusion; and
3. the name of the person who kept the patient in seclusion; and
4. the length of time the patient was kept in seclusion.

The PIC must also ensure that a copy of the record kept under subsection (12), is placed on the patient's medical records (subsection(13)) and the principal community visitor must ensure that this record is inspected by a community visitor at intervals not longer than 6 months (subsection(14)).

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| **Practice Note**  All details are to be recorded in event reports, patient clinical notes and a seclusion register as soon as possible in a manner and format approved by the PIC of the relevant ATF in line with the approved procedures. |

### Notifying the adult guardian

If a patient who is kept in seclusion has an adult guardian or decision maker, the person-in-charge of the ATF must ensure that the adult guardian or decision maker is notified of the following as soon as practicable after the seclusion under the provisions of section 62(15):

1. that the patient was kept in seclusion;
2. the reasons why the patient was kept in seclusion; and
3. the length of time the patient was kept in seclusion.

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| **Practice Note**  An email notification may be sufficient if the adult guardian or decision maker has agreed to this form of communication in advance, on admission of the patient. Some adult guardians or decision makers may wish to receive a notification via telephone call (and subsequently may elect to only make this between certain times).  **Form 56 Adult Guardian Notification** has been developed to assist with communications between the ATF and Adult Guardians. |

## Operational requirements not prescribed by the Act

### Initiating seclusion

ATF policy documents detailing the clinical processes relating to seclusion should be followed when undertaking an episode of seclusion. It should also be noted that the broader policy objectives both nationally and locally are to facilitate a reduction in the use of seclusion in mental health facilities.

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| **Note**  Planned seclusion is not approved by, or consistent with, the Act. Once a person is secluded, it must be recorded as such, regardless of whether it was only for a very short period of time i.e. 5 minutes |

If there is no alternative other than to seclude a patient, seclusion must be undertaken in a safe, secure and appropriately designated area, where the patient cannot harm him or herself, accidentally or intentionally. The area should have:

* adequate air conditioning and ventilation;
* natural light available if possible, so the person can more readily orientate themselves. Lighting should be determined by the individual’s request; and
* a clock viewable by the person.

However the following provisions of the Act must also be met. The person must:

* be provided bedding and clothing that is appropriate in the circumstances;
* have access to toilet facilities;
* be provided food and drink at appropriate times; and
* be provided psychological and physical care appropriate to the patient’s needs.

Although the area should provide a quiet environment, it should not be soundproofed. Staff should be able to hear and see the patient and the patient must be able to be heard by staff.

The area should offer observation from the outside, while also affording the patient privacy from other patients. Any CCTV monitors must be seen by nursing staff but not by any member of the public or by other patients.

Removing or reducing stimulation may increase agitation and distress in some people through sensory deprivation, isolation and exacerbation of their sense of loss of control. The patient must have a means of calling for assistance or attention. It is especially important that this is explained to all patients secluded and most especially any patient who is deaf or hearing impaired.

Staff must ensure that the seclusion area is available and safe to use and sufficient staff should be available to effect the seclusion safely. Where necessary the assistance of security and or police support may be obtained.

Objects such as jewellery, belts, braces and shoes, which could cause harm to the patient or staff, must then be removed. Generally the seclusion area must be provided with non-tear bedding and where necessary, alternative clothing for the person. Removing a patient’s clothing is a traumatic event and can compromise their dignity. If the removal of a patient’s clothing is required, staff undertaking this should be an appropriate sex and/or culture. If a non-tear gown is required, a full explanation of the reasons for this must be included in the patient’s clinical record.

When escorting, placing and leaving a patient in seclusion, staff must be guided by the training provided by the ATF as to how to exit the area safely.

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| **Practice Note - Entry and Exit**  High risk times for injury during seclusion are during times of entering and exiting the seclusion room.   * On entering seclusion, the person is placed face down on a covered mattress (this is the only time where prone restraint may be purposely initiated). Where possible, this is to occur for a maximum of three minutes and is to allow administration of any indicated intramuscular medication and safe exit for staff.   When people are in a prone position for a prolonged (2-4 minutes) there is potential for them to experience difficulties with breathing (i.e. asphyxia).  In these circumstances clinicians should be looking for signs and symptoms such as the following:  - the person having difficulty breathing,  - the person being unable to breathe (has blueish tint to the skin, irregular heart rate), and/or  - the person becoming weak/experiencing a seizure.   * When staff are exiting the seclusion room following restraint, wrapping a blanket around the person’s legs to temporarily limit their movement will reduce the incidence of harm when closing the seclusion room door. |

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| **Practice Note - Prone Position**  Placing people in the prone position entails a significantly increased risk of harm to the person. There have been instances of sudden death, often associated with the administration of parenteral medication while in prone restraint.  NT Health staff should avoid prone restraint. Where prone restraint cannot be avoided, the Prone Safety Notice (Attachment 5 of the NT Health Seclusion and Restraint Policy) must be followed if prone restraint is used. |

### Post seclusion activities

Post seclusion strategies should be engaged within 4-8 hours of patient’s release from seclusion.

After a seclusion episode:

* Offer the person a drink, an opportunity to go to the toilet or some space to themselves for a while. It can take 60 to 90 minutes for the adrenaline release that occurs during a distressing incident to dissipate and for the person to regain physical control of themselves. (Note: certain patients, such as those with autism spectrum disorder or an acquired brain injury, may take longer to return to baseline)
* The patient should consent and not be coerced into a debriefing session. It should be voluntary and the episode should also be allowed to be discussed at a future stage if desired.
* Counselling should be offered to the patient, carers, family members and peer support workers after the episode if appropriate.

Seclusion is a traumatic time for all involved and strategies need to be implemented as soon as a seclusion incident ceases to ensure that everyone has an opportunity to discuss the incident.

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| **Practice Note**  The trauma experienced by a person who is of the belief that they have been secluded should be managed equally to a person who has undergone a period of seclusion. |

The day after an episode of seclusion, the senior RNOD (who should as appropriate, not be the same nurse that initiated the use of seclusion) will conduct a planned debrief with the patient. The timing of this discussion needs to be planned, and dependent on the patient’s mental state. If the patient speaks a language other than English, an interpreter will be booked and used for the debrief, wherever possible.

The patient debriefing discussion can usefully explore how the patient perceived the events, and ask for suggestions about how this could be avoided in the future when staff are supporting the patient. If appropriate, and the patient requests an explanation, the senior RNOD could provide the patient with an understanding of the reasons why seclusion was used.

The primary carer of the patient will be notified of the seclusion, unless the patient specifically requests otherwise. Family members or friends of a patient may be distressed or confused by the use of Seclusion as will other patients who may have witnessed the incident. Explanation and debriefing should be offered as appropriate, within the limits of confidentiality.

The senior RNOD at the time of the incident is responsible for debriefing nursing staff following the use of seclusion. This provides an opportunity to explore the distress that may arise from being exposed to disturbed patients and to physical danger or criticism, for reflection on how Seclusion was managed and what can be learnt from it, and for review of training needs that may come to light.

The treating team should review every episode of seclusion with the intention of identifying how the patient secluded could be better managed so as to avoid further Seclusion incidents. Outcomes of this discussion and the management plan to avoid the use of seclusion should be documented in the patient’s clinical record.

## Seclusion of children

The seclusion of a patient under the age of 18 years is a serious decision. Seclusion is known to be a traumatic event, and for a child (or adult) it may compound trauma and lead to avoidance of mental health services in the future.

Patients under the age of 18 will be observed continuously/constantly to ensure that seclusion can be ceased at the earliest possible opportunity.

Every effort will be made to eliminate the use of seclusion on patients under the age of 18. In recognition of this, the following additional procedures are to put in place:

* A person under the age of 18 may be kept in seclusion only where it is approved:

(a) by an authorised psychiatric practitioner; or

(b) in the case of an emergency, by the senior registered nurse on duty.

* While in seclusion, engagement should occur with the patient, where possible, to determine and implement strategies that may have helped them in the past.
* Unless imminent danger exists to the patient or another person, a patient under the age of 18 is to spend no longer than a maximum period of four (4) hours in seclusion.
* Seclusion is to cease immediately upon observation of sleeping or calm behaviour.
* All patients under the age of 18 who have been secluded will be reviewed by a medical officer or APP as soon as practicable after the cessation of seclusion.
* A patient under the age of 18 is to be allowed to have contact with their primary carer as soon as practical after cessation of seclusion (or after waking, if seclusion has ceased upon observation of the patient being asleep).

## Family/carers

If the patient has nominated family members or carers to be involved in their care, the PIC of the ATF must ensure that the family member or carer is notified of the following as soon as practicable after an episode of seclusion initiated on any person under the provisions of the Act:

* that the person was secluded;
* how the person was secluded;
* the reasons why they were placed in seclusion; and
* the period of time that the person was in seclusion.

# Other relevant and regulatory requirements

The requirements and protections of the *Mental Health and Related Services Act 1998* apply to all patients including prisoner patients and those in police custody. However, provisions of the following legislation may at times override the requirements for the seclusion of patients under the Act, as they relate to safety and good order*:*

* *Correctional Services Act 2014*;
* *Youth Justice Act 2005*; and
* *Police Administration Act 1978.*

## National Disability Insurance Scheme (NDIS) participants and restrictive practices

Refer to the National Disability Insurance Scheme (NDIS) participants and restrictive practices - A guide for NT Health Mental Health Clinicians factsheet, available on the staff intranet at:

<http://internal.health.nt.gov.au/pgc/dm/Documents/Policy%20and%20Strategy/MHAOD/Policy%20Planning/NDIS/National%20Disability%20Insurance%20Scheme%20(NDIS)%20participants%20and%20restrictive%20practices.DOCX> (NT Health internal staff access only).

The NT Health Seclusion and Restraint Policy also provides further information for NT Health staff on the use of restrictive practices for NDIS participants.

<http://internal.health.nt.gov.au/pgc/dm/Documents/Public%20Health/Clinical%20Quality%20Patient%20Safety/Seclusion%20and%20Restraint%20NT%20Health%20Policy.docx> (NT Health internal staff access only).

## Education and training

The PIC of the ATF is to liaise with relevant personnel within the organisation regarding the training of staff in what constitutes seclusion, the prevention and application of seclusion and associated risks.

A trained response team should be used to place a person in seclusion and be available for reviews of the person during the seclusion episode.

## Quality assurance

All episodes of seclusion and debriefing sessions are to be recorded in the person’s Health Care Record in proportionate detail to enable a review of practice.

Patient records may include:

* Incident number (where seclusion is part of a reportable incident);
* Frequency of observations;
* Antecedents;
* Any physical injury;
* Adherence to prevention strategies;
* Notification of family or carer;
* Alternative least restrictive interventions trialled or considered;
* Clinical examinations undertaken and outcomes;
* Reason for seclusion;
* Food and fluid intake;
* Staff who initiated the use of seclusion;
* Staff who approved the use of seclusion;
* Start and finish time of seclusion;
* Cultural background of the person;
* Active practices to reduce duration;
* Identification of future prevention and intervention strategies;
* Debriefing, including service user and family/carer feedback, right of appeal and complaints;
* Location of seclusion episode;
* Authorisation;
* Medication offered or administered;
* Multidisciplinary review;
* Reviews by senior members of clinical team and authorised clinicians; and
* Review of care plan.

The following data should also be recorded in a seclusion register, which is routinely reviewed for quality improvement purposes:

* Incident number (where seclusion is part of a reportable incident);
* Date of seclusion episode;
* Name of the person;
* Age and cultural background of the person;
* Whether the seclusion was approved/not approved under the Act i.e. it would not be authorised under the Act in the case of seclusion being required at the request of NT Police or Corrections staff under their legislation;
* Reasons for episode of seclusion;
* Strategies used to prevent seclusion;
* Name of the person who initiated the episode of seclusion;
* Name of the person who approved the seclusion. If authorised by a senior RNOD, the name of the APP confirming seclusion order;
* Time commenced;
* Time concluded;
* Clinical examinations undertaken and outcomes, including the name of staff undertaking the examinations;
* Details of any variations in the interval at which the patient was examined; and
* Patient’s behaviour during period of seclusion e.g. banging on wall, engaging in conversation, use of the room.

Routine audits of seclusion practices, record keeping and notification requirements should be undertaken. This information will ensure that practices are consistent with policy and legislative requirements and all relevant details and entries are being entered in clinical records, on appropriate forms and appropriately signed, dated and time stamped. This will provide a valuable source of information used to improve practices and in so doing contribute to reducing the use of seclusion.

The PIC of the ATF should, in collaboration with the Clinical Nurse Manager and other key staff, monitor and regularly review the use of seclusion and identify any patterns and trends, which should be raised with Approved Procedures and Quality Assurance Committee in the context of periodic reporting.

# Document Quality Assurance

|  | **Method** | **Responsibility** |
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| **Implementation** | Document will be accessible via the MHARS Act internet and intranet pages and the PGC. | Senior Compliance and Clinical Policy Co-ordinator MHAOD Branch |
| **Review** | Document will be reviewed within a period of 4 years. | Approved Procedures and Quality Assurance Committee |
| **Evaluation** | Document will be informally evaluated at time of review. | Approved Procedures and Quality Assurance Committee |

# Key Associated Documents

All related material produced by the Northern Territory Department of Health is available from: <https://health.nt.gov.au/professionals/mental-health-information-for-health-professional>

Mental Health and Related Services (MHARS) Act 1998 – available from: [https://legislation.nt.gov.au/en/LegislationPortal/Acts/By-Title#](https://legislation.nt.gov.au/en/LegislationPortal/Acts/By-Title)

World Health Organization. (‎2019)‎. Strategies to end seclusion and restraint: WHO Quality Rights Specialized training: course guide. World Health Organization. <https://extranet.who.int/iris/restricted/handle/10665/329605>

# Definitions and Search Terms

| **Preferred Term** | **Description** |
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| **AIS** | Aboriginal Interpreter Service |
| **APP** | Authorised psychiatric practitioner |
| **ATF** | Approved treatment facility |
| **ICP** | Individual Care Plan |
| **MHARS Act** | *Mental Health and Related Services Act 1998* |
| **NDIS** | National Disability Insurance Scheme |
| **Patient** | A person who is being assessed or receiving treatment under the *Mental Health and Related Services Act 1998* |
| **PIC** | Person in charge |
| **Seclusion** | The confinement of a patient at any time of the day or night alone in a room or area from which free exit is prevented.  In this case, patient means a person who is being assessed or receiving treatment under the *Mental Health and Related Services Act 1998.* |
| **Senior RNOD** | Senior registered nurse on duty |
| **TIS** | Telephone Interpreter Service |

#### Alternative Search Terms

# Appendix A - Procedural flowchart for seclusion

**Is the person a child?**

Proceed

Decision required

Release from seclusion

Refer to another procedure/flowchart

YES

**Release from seclusion**

NO

YES

**Person is visited by a RN every 15 minutes and examined by a medical officer every 3 hours**

**APP to review patient within 3 hours**

**Does the APP confirm the seclusion order?**

**Does the person still meet the criteria for seclusion under section 62(3)?**

**Senior RNOD informs the APP of release from seclusion**

**Continue Seclusion**

**Has the patient been in seclusion for an hour?**

**Does the person still meet the criteria for seclusion under section 62(3)?**

**Senior RNOD to arrange for a review by an APP**

**Release from seclusion**

**Is this episode of continuous seclusion less than 4 hours?**

If the APP is a Level 2 APP they must consult with Level 1 APP regarding continued seclusion

**Release from seclusion**

NO

YES

**Is this episode of continuous seclusion less than 6 hours?**

**Release from seclusion and APP to assess for involuntary admission**

**Refer to procedures and flowcharts for Involuntary Admission**

**Is the person a voluntary patient?**

YES

**Person is assessed as requiring seclusion**

**Is it an emergency?**

**If an APP is not immediately available, seclusion may be approved by senior RNOD**

**Seclusion approved by APP**

**Senior RNOD notifies the APP following seclusion commencement**

APP – Approved Psychiatric Practitioner

ATF – Approved Treatment Facility

PIC – Person in Charge

RN – Registered Nurse

RNOD – Registered Nurse on Duty

NO

YES

**Person is visited by a RN every 15 minutes**

**Person is secluded**

**Person is secluded**

YES

NO

NO

YES

YES

NO

NO

NO

NO

**Release from seclusion and review by a medical officer unless imminent danger exists to the child or another person**

YES