CHIEF PSYCHIATRIST APPROVED FORM – CIVIL 09

SECLUSION (INVOLUNTARY)

Mental Health Act 2013
Sections 56, 58

THCI (Patient ID): _____
Family Name: _____
Given Names: _____
Date of Birth: __ / __ / __ Gender: ☐ M ☐ F ☐ TG / IT
Address: _____
Telephone: _____ Mobile: _____

AFFIX STICKER HERE

FT213150

(Tick ☑ as appropriate, format time as 00:00 (24 hour) and date as DD/MM/YYYY)

PART A: AUTHORISATION OF SECLUSION

CHIEF PSYCHIATRIST / DELEGATE / MEDICAL PRACTITIONER / APPROVED NURSE TO COMPLETE

This authority is applicable for up to three (3) hours seclusion. Only the Chief Psychiatrist (CP) or Delegate of the CP may authorise seclusion of a child. Consecutive episodes of seclusion of an adult beyond six (6) hours is a new episode and can only be authorised by the Chief Psychiatrist (CP) or Delegate of the CP.

Patient *(full name in BLOCK letters)*:

Name of the approved facility where the patient is located: ☐ Millbrook Rise (South) ☐ Roy Fagan (South) ☐ Royal Hobart Hospital (South) ☐ Launceston General Hospital (North) ☐ North West Regional Hospital (Burnie)

Person authorising *(full name in BLOCK letters)*:

Status of person authorising: ☐ Chief Psychiatrist or Delegate ☐ Medical Practitioner ☐ Approved Nurse

I **am satisfied** that it is necessary to seclude the patient named above *(tick all that apply)*:

☐ To facilitate the patient's treatment ☐ To ensure the patient's health or safety ☐ To ensure the safety of other persons ☐ To provide for the management, good order or security of the approved hospital.

I am satisfied that the seclusion is a reasonable intervention in the circumstances for the following reasons:

I authorise seclusion for a period of: **hours** **minutes** (maximum 3 hours, unless ceased sooner)

Commencing on: **Date:** DD / MM / YYYY **Time:** 00 : 00

Authorised on: **Date:** DD / MM / YYYY **Time:** 00 : 00

Is the person authorising the seclusion completing this form?

☐ **Yes – authorised person to sign here:** _____
(CP/Delegate/Medical Practitioner/Approved Nurse signature)

☐ **No – two members of nursing/medical staff to complete below**

We confirm seclusion has been authorised by the person named above for the patient named on this form.

1. Name Dr/Nurse *(full name in BLOCK letters)*:

ID Card/Payroll/Registration number:	**Date:** DD / MM / YYYY
Signature:	**Time:** 00 : 00

2. Name Dr/Nurse *(full name in BLOCK letters)*:

ID Card/Payroll/Registration number:	**Date:** DD / MM / YYYY
Signature:	**Time:** 00 : 00

COPY TO: ☐ Patient ☐ Chief Psychiatrist ☐ TASCAT ☐ Legal Orders Coordinator

OTHER:
☐ If there is consent – copy to patient support person/representative
☐ If patient is a child – copy to parent/support person/representative
☐ Statement of Rights provided to patient
☐ Explanation to patient in a language and form that the patient can understand

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PART B: CLINICAL/MEDICAL OBSERVATIONS

MEMBER OF NURSING STAFF / MEDICAL PRACTITIONER TO COMPLETE

Patient *(full name in BLOCK letters)*:

Name of the approved facility where the patient is located: ☐ Millbrook Rise (South) ☐ Roy Fagan (South) ☐ Royal Hobart Hospital (South) ☐ Launceston General Hospital (North) ☐ North West Regional Hospital (Burnie)

Date and time seclusion commenced: Date: DD / MM / YYYY Time: 00 : 00

Date and time seclusion ceased: Date: DD / MM / YYYY Time: 00 : 00

Date of Observation/ Assessment	Time of Observation/ Assessment	Comments/Observations	Name/ID Card/Payroll Number and Status (Nurse/MP)
DD/MM/YYYY	00 : 00		
DD/MM/YYYY	00 : 00		
DD/MM/YYYY	00 : 00		
DD/MM/YYYY	00 : 00		
DD/MM/YYYY	00 : 00		
DD/MM/YYYY	00 : 00		
DD/MM/YYYY	00 : 00		
DD/MM/YYYY	00 : 00		
DD/MM/YYYY	00 : 00		
DD/MM/YYYY	00 : 00		
DD/MM/YYYY	00 : 00		
DD/MM/YYYY	00 : 00	*3 hours – Seclusion ceases OR continues (see Part C)*	
DD/MM/YYYY	00 : 00		
DD/MM/YYYY	00 : 00		
DD/MM/YYYY	00 : 00		
DD/MM/YYYY	00 : 00		
DD/MM/YYYY	00 : 00		
DD/MM/YYYY	00 : 00		
DD/MM/YYYY	00 : 00		
DD/MM/YYYY	00 : 00		
DD/MM/YYYY	00 : 00		
DD/MM/YYYY	00 : 00		
DD/MM/YYYY	00 : 00		
DD/MM/YYYY	00 : 00	*6 hours – Seclusion ceases OR new authorisation made*	

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Family Name: _____
Given Names: _____
Date of Birth: __ / __ / __ Gender: ☐ M ☐ F ☐ TG / IT
Address: _____
Telephone: _____ Mobile: _____

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(Tick ☑ as appropriate, format time as 00:00 (24 hour) and date as DD/MM/YYYY)

PART C: CONTINUATION OF SECLUSION

CHIEF PSYCHIATRIST/DELEGATE/MEDICAL PRACTITIONER/APPROVED NURSE TO COMPLETE

Continuation of seclusion for up to three (3) hours must be authorised *before* the end of the first three (3) hours of seclusion. Only the Chief Psychiatrist (CP) or Delegate of the CP may authorise seclusion of a child. Consecutive episodes of seclusion for an adult beyond six (6) hours is a new episode and can only be authorised by the Chief Psychiatrist (CP) or Delegate of the CP.

Patient *(full name in BLOCK letters)*:

Name of the approved facility where the patient is located: ☐ Millbrook Rise (South) ☐ Roy Fagan (South) ☐ Royal Hobart Hospital (South) ☐ Launceston General Hospital (North) ☐ North West Regional Hospital (Burnie)

Date and time seclusion first commenced: **Date:** DD / MM / YYYY **Time:** 00 : 00

Date and time seclusion will cease if not continued: **Date:** DD / MM / YYYY **Time:** 00 : 00

Person authorising continuation *(full name in BLOCK letters)*:

Status of person authorising: ☐ Chief Psychiatrist or Delegate ☐ Medical Practitioner ☐ Approved Nurse

I confirm that the patient named above was assessed by *(name of medical practitioner who assessed patient)*:

Assessment completed on: **Date:** DD / MM / YYYY **Time:** 00 : 00

I authorise the continuation of seclusion for an additional period of: _____hours_____minutes
(maximum 3 hours unless ceased sooner)

Seclusion is to end on: **Date:** DD / MM / YYYY **Time:** 00 : 00

Continuation authorised on: **Date:** DD / MM / YYYY **Time:** 00 : 00

Conditions imposed on continuation of seclusion *(if applicable)*:

Is the person authorising the seclusion CONTINUATION completing this form?

☐ **Yes – authorised person to sign here:** _____
(CP/Delegate/Medical Practitioner/Approved Nurse signature)

☐ **No – two members of nursing/medical staff to complete below**

We confirm that the person named above has authorised a continuation of the period for which the patient named on this form must be secluded, for the period referred to above, subject to the conditions (if any) specified above:

1. Name Dr/Nurse *(full name in BLOCK letters)*:	
ID Card/Payroll/Registration number:	**Date:** DD / MM / YYYY
Signature:	**Time:** 00 : 00
2. Name Dr/Nurse *(full name in BLOCK letters)*:	
ID Card/Payroll/Registration number:	**Date:** DD / MM / YYYY
Signature:	**Time:** 00 : 00

COPY TO: ☐ Patient ☐ Chief Psychiatrist ☐ TASCAT ☐ Legal Orders Coordinator

OTHER:
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PART A: AUTHORISATION OF SECLUSION – INSTRUCTIONAL INFORMATION

The Chief Psychiatrist (CP) (or delegate), a medical practitioner or an approved nurse may authorise an adult patient's seclusion.

Only the CP (or delegate) may authorise a child patient's seclusion. See fact sheet for further information.

Seclusion means the deliberate confinement of an involuntary patient, alone, in a room or area that the patient cannot freely exit.

An involuntary patient in an **approved hospital** may be placed in seclusion if authorised as being necessary to:

- To facilitate the patients treatment;
- Ensure the patient's health and safety;
- Ensure the safety of other persons;
- To provide for the management, good order or security of an approved hospital.
- The person authorising the seclusion is satisfied that it is a reasonable intervention in the circumstances; and
- The seclusion lasts no longer than authorised.

Seclusion must be managed in accordance with Chief Psychiatrists Standing Orders and Clinical Guidelines issued for this section.

Seclusion may be authorised for an initial period of **up to three (3) hours.**

Before the end of the initial period of seclusion, a medical practitioner must assess the patient to see if the seclusion should continue or cease. If the medical practitioner considers that seclusion is still necessary, continuation of the seclusion authority may occur once only for an additional three (3) hours resulting in a maximum seclusion of six (6) hours. (See part c of this form) After a maximum of six (6) hours, seclusion must end.

Following a maximum of six (6) hours, consecutive periods of seclusion are only to occur in accordance with the Chief Psychiatrist Standing Orders issued.

Whether or not to end a period of seclusion is a clinical decision made by clinical staff. If clinical staff on duty believe that the seclusion is no longer necessary, then it must be ceased immediately by a medical practitioner or approved nurse.

A patient may not be placed in seclusion as a means of punishment or for reasons of administrative or staff convenience.

Authorisations must be made prior to commencement of seclusion and cannot be retrospective.

PART B: CLINICAL/MEDICAL OBSERVATIONS

A patient in seclusion must be clinically observed by a member of the approved facility's nursing staff at intervals not exceeding 15 minutes or at such different intervals as standing order may mandate.

A patient in seclusion must be assessed by a medical practitioner at intervals not exceeding three hours to see if the seclusion should continue or be terminated.

Regardless of authorisation, seclusion must not be maintained to the obvious detriment of the patient's mental or physical health.

A patient's seclusion is not taken to have been interrupted or terminated by reason of scheduled observations, examination or assessment or the giving of necessary treatment or general health care.

If clinical staff on duty believe that the seclusion is no longer necessary, then it must be ceased immediately by a medical practitioner or approved nurse.

PART C: CONTINUATION OF SECLUSION

A period of seclusion may be continued once only. I**n no circumstances is the period of seclusion continuation to exceed three (3) hours.** Therefore, the total maximum seclusion time is 6 hours. Following the maximum 6 hours seclusion, a new authorisation must be made.

The period of continuation must be authorised in advance by a medical practitioner or approved nurse before the initial period of seclusion ends. Authorisation may only be given if the patient has been assessed by a medical practitioner immediately prior to the decision to continue the patient's seclusion.

Consecutive episodes of seclusion of an adult beyond six (6) hours can only be authorised by the Chief Psychiatrist (CP) or Delegate of the CP in accordance with Clinical Guidelines and Standing Orders.

The Chief Psychiatrist (or delegate) may impose conditions on the seclusion of the patient at any point during the period of seclusion.

Clinical assessment to determine if continuation of seclusion is needed must be done in person.

CONTACT DETAILS:

Chief Psychiatrist:	Phone: (03) 6166 0778	Email: chief.psychiatrist@health.tas.gov.au
TASCAT – Protective Stream:	Phone: (03) 6165 7491	Email: applications.mentalhealth@tascat.tas.gov.au