CHIEF PSYCHIATRIST APPROVED FORM – FORENSIC 09

SECLUSION (FORENSIC)

Mental Health Act 2013

Sections 92, 94, 96

THCI (Patient ID): _____

Family Name: _____

Given Names: _____

Date of Birth: __ / __ / _____ Gender: ☐ M ☐ F ☐ TG / IT

Address: _____

Telephone: _____ Mobile: _____

AFFIX STICKER HERE

FT21315 5

(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 considered a new episode and can only be authorised by the Chief Psychiatrist (CP) or Delegate of the CP.

Patient *(full name in BLOCK letters)*:

Person authorising seclusion *(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 any or all that apply)*:

- ☐ Facilitate a patient's treatment
- ☐ Facilitate the patient's general health care
- ☐ To ensure the patient's health or safety
- ☐ To ensure the safety of other persons
- ☐ To prevent the patient from destroying or damaging property
- ☐ To prevent the patient's escape from lawful custody
- ☐ To provide for the management, good order, or security of the SMHU
- ☐ To facilitate the patient's lawful transfer to or from another facility, whether in Tasmania or elsewhere

I am satisfied that the seclusion is required for the following reasons:

I hereby 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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SECLUSION (FORENSIC)

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Sections 92, 94, 96

THCI (Patient ID): _____

Family Name: _____

Given Names: _____

Date of Birth: __ / __ / _____ Gender: ☐ M ☐ F ☐ TG / IT

Address: _____

Telephone: _____ Mobile: _____

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FT213155

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

PART B: CLINICAL/MEDICAL OBSERVATIONS

MEMBER OF NURSING STAFF / MEDICAL PRACTITIONER / APPROVED MEDICAL PRACTITIONER TO COMPLETE

Patient *(full name in BLOCK letters)*:

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	*6 hours – Seclusion ceases OR new authorisation made*	

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SECLUSION (FORENSIC)

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Sections 92, 94, 96

THCI (Patient ID): _____

Family Name: _____

Given Names: _____

Date of Birth: __ / __ / _____ Gender: ☐ M ☐ F ☐ TG / IT

Address: _____

Telephone: _____ Mobile: _____

AFFIX STICKER HERE

FT21315 5

(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 another 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 of an adult beyond six (6) hours is considered a new episode and can only be authorised by the Chief Psychiatrist (CP) or Delegate of the CP.

Patient *(full name in BLOCK letters)*:

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 *(full name in BLOCK letters)*:

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)

Unless ceased sooner, the patient's seclusion is to end on: **Date:** DD / MM / YYYY **Time:** 00 : 00

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

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

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 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
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PART A : SECLUSION AUTHORITY – 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 issued by the OCP for further information.

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

A forensic patient may be placed in seclusion if authorised as being necessary for a prescribed reason, if the person authorising the seclusion is satisfied that the seclusion is a reasonable intervention in the circumstances, the seclusion lasts for no longer than authorised, and the seclusion is managed in accordance with any relevant standing orders or clinical guidelines.

"prescribed reason' for applying force to a forensic patient: or placing a forensic patient in seclusion means:

- To facilitate a patient's treatment, or
- To facilitate a patient's general health care, or
- To ensure the patient's health or safety, or
- To prevent the patient from destroying or damaging property, or
- To prevent the patient's escape from lawful custody, or
- To provide for the management, good order or security of the secure mental health unit, or
- To facilitate the patient's lawful transfer to or from another facility, whether in Tasmania or elsewhere, or
- A reason(s) sanctioned by Chief Psychiatrist standing orders.

Seclusion may be authorised for a period of up to three (3) hrs. This period may only be extended once for an additional period of three (3) hrs.– see Part C of this form.

Continuation of the initial seclusion authority may occur once only for an additional three (3) hours. After a maximum of six (6) hours, a new seclusion authority is necessary.

The seclusion authority may be ended at any time by a medical practitioner or approved nurse.

Authorisations cannot be retrospective.

PART B: CLINICAL/MEDICAL OBSERVATIONS

A patient in seclusion must be clinically observed by a member of the Secure Mental Health Facilities nursing staff at intervals not exceeding 15 minutes or at such different intervals as standing order may mandate.

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

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

PART C: CONTINUATION OF SECLUSION

A Forensic patient's seclusion may be continued only once; however, in no circumstances is the period of seclusion continuation to exceed three (3) hours.

The total maximum seclusion time that may be authorised is six (hours), following which, a new seclusion authority must be made if further seclusion is deemed necessary based on assessment of the patient by a medical practitioner.

The period of extension must be authorised in advance by a medical practitioner or approved nurse or in the case of a child, the Chief Psychiatrist or delegate. Authorisation may only be given if the patient has been examined by a medical practitioner immediately prior to the decision to continue the patient's seclusion.

The medical practitioner may impose conditions on any continuation which are to be included on part C of this form.

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

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.

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