

Seclusion under the Mental Health (Compulsory Assessment and Treatment) Act 1992

Citation: Ministry of Health. 2010. *Seclusion under the Mental Health
(Compulsory Assessment and Treatment) Act 1992*.
Wellington: Ministry of Health.

Published in February 2010
by the Ministry of Health
PO Box 5013, Wellington 6145, New Zealand

ISBN 978-0-478-33942-0 (Print)

ISBN 978-0-478-33943-7 (Online)

HP 4972

This document is available on the Ministry of Health website:

<http://www.moh.govt.nz>



Preface

The purpose of these guidelines is to identify best practice methods for using seclusion in mental health acute inpatient units, in alignment with the specifications set out in the *Health and Disability Services Standards*. The intention of the revised guidelines is to, over time, limit the use of seclusion and restraint on mental health patients. Seclusion may be legally implemented under the conditions set out in the Mental Health (Compulsory Assessment and Treatment) Act 1992, but only during situations in which other methods of clinical management cannot safely be used, or as a last resort when other interventions have been used without success. The legal basis of seclusion for patients under the Mental Health Act is set out in section 71 of the Act (see appendix two). Seclusion should be used for as short a time as possible. The decision to seclude should be an uncommon event, subject to strict review.

The decision to use seclusion should be based on the duty of care required for the individual patient, or for other patients. Seclusion should only be used when no other safe and effective intervention is possible. Appendix three provides a template form for clinicians considering the use of seclusion. Seclusion should not occur as part of a routine admission or therapeutic procedure, or be administered as discipline, or as a replacement for adequate levels of staff or resources. The Mental Health (Compulsory Assessment and Treatment) Act 1992 requires that, except in an emergency, seclusion shall be used only with the authority of the responsible clinician. If the responsible clinician cannot be involved in the immediate decision, the responsible clinician must be informed of the seclusion as soon as appropriate, at least at the start of the next working day, and should review the decision. The specificity of the review shall be appropriate to the level of risk and likelihood of harm occurring to the patient. Wherever practicable, the two suitably qualified clinicians involved should be the patient's own nurse and doctor.

These guidelines reflect an ongoing Ministry of Health commitment to promote a culture wherein, over time, seclusion usage by the mental health sector will gradually decrease. I endorse these guidelines.

Stephen McKernan
Director-General of Health

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Seclusion under the Mental Health (Compulsory Assessment and Treatment) Act 1992

Outcome

The organisation ensures the principles of this document are applied to seclusion usage, and a regular review occurs in order to consider the appropriateness of the technique, to ensure safety, and to identify preferred alternative interventions.

Criteria

The criteria required to achieve this outcome include the organisation ensuring the following:

Commencing seclusion requirements

- 1.1 The *New Zealand Health and Disability Services Standards* from which these guidelines have arisen define seclusion as ‘where a consumer is placed alone in a room or area, at any time and for any duration, from which they cannot freely exit’.¹
- 1.2 A period of seclusion will commence when the patient² enters the conditions of seclusion. The seclusion period is deemed to have ended when the patient leaves the conditions of seclusion without the expectation of return, and in any case, if the patient has been out of seclusion for more than one hour. A template for recording seclusion is attached as appendix three.
- 1.3 When considering the use of seclusion, the potential physical and psychological effect to the individual, and the consequential effect on all involved as a result of its use, or not, shall be carefully deliberated.
- 1.4 Preferred alternative interventions have been used in a timely manner to prevent or minimise the use of seclusion until all other practical options have been considered or tried.
- 1.5 The specific cultural needs of patients are recognised throughout seclusion and relevant cultural advice is sought in order to maintain cultural safety.
- 1.6 Individual service delivery plans that identify proactive alternative interventions (eg, behavioural support and de-escalation techniques) ensure seclusion is only used where it is required, following comprehensive assessment and can be fully justified.
- 1.7 The safety of patients, service providers and others is enhanced through comprehensive assessment, risk and quality management systems during seclusion.
- 1.8 The requirements of legislation, patient rights, current standards and relevant professional codes of practice are met throughout the seclusion process.

¹ New Zealand Standards. *Health and Disability Services Standards*. Ministry of Health. 2008.

² Note any person subject to seclusion must be compulsorily detained as a ‘patient’ or ‘proposed patient’ under the Mental Health (Compulsory Assessment and Treatment) Act 1992.

Specific Observation and Assessment Requirements

(Normative)

Adapted from *Procedural Guidelines for the Use of Seclusion*. Revised Edition. Ministry of Health. 1995.

2 Continuous observations³

- 2.1 Observation shall be continuous or as frequent as possible. The longest interval between recorded observations shall be 10 minutes. (The interval should vary within the 10 minute interval, without being longer than 10 minutes.)
- 2.2 The minimum observations within the 10 minute interval include but are not limited to general condition, colour (for example cyanosis, pallor), breathing, position, activity and behaviour. This will require physical observation and interaction with the patient and cannot be achieved through electronic surveillance. For a checklist of seclusion care requirements see appendix four.

3 Two-hourly assessments

- 3.1 An attempt should be made by a suitably qualified clinician⁴ at least once every two hours to enter the room to assess the physical wellbeing of the patient. If an attempt to enter the room is unsuccessful, the reason why should be recorded on the observations form.
- 3.2 An assessment of the patient's mental state by a suitably qualified clinician shall be made at this time. Further assessment of physical state should be carried out as clinically indicated.
- 3.3 Safety precautions should be taken when entering the room. The number of service providers required to enter the room should be appropriate to manage the potential risk involved. This should be determined prior to entry or detailed in local protocols.
- 3.4 Each entry to the seclusion room is an opportunity to assess the readiness of the patient to reintegrate back into the ward.

³ In emergency situations, if a patient requires restraint or to be kept within constant reach to prevent harming behaviours, then this would not qualify as seclusion. For more information on restraint and harm minimisation see the New Zealand Standard guideline, *Health and Disability Services Restraint Minimisation and Safe Practice Standards*.

⁴ A suitably qualified clinician is either a registered nurse or a medical practitioner.

4 Eight-hourly assessments and care

- 4.1 During the period of each shift an ongoing programme of care and assessment must be provided and recorded. Responsibility for care delivery and observations during seclusion is that of the registered nurse. In particular they are responsible for ensuring the following:
- (a) Observations and care as described above are undertaken (10-minute and two-hourly observations).
 - (b) Clinical consultation with the responsible clinician occurs and is documented
 - (c) Communicating all care requirements both verbally and via the patient's plan to the following shift, for example:
 - (i) food/fluid intake
 - (ii) personal care/hygiene/toileting arrangements
 - (iii) medication requirements
 - (iv) exercise/physiotherapy
 - (v) visitors (chaplain, advocates, family).
- 4.2 Wherever practicable, care should be carried out predominantly by staff of the same gender and culture as the patient.
- 4.3 It is mandatory that a suitably qualified clinician shall psychiatrically assess the person in seclusion at least once every eight hours. A record of this assessment is documented.
- 4.4 Before the completion of an eight-hour period, when a decision is taken to extend seclusion, confirmation should be provided by the initiating and supporting clinicians or another suitably qualified nurse and doctor if the original clinicians are not available. The responsible clinician should be notified, at an appropriate time.

5 Prolonged seclusion

- 5.1 If over the course of one admission, the cumulative hours of seclusion exceed 24 hours in a four-week period, reassessment in the form of a case management conference should occur.
- Cumulative hours of seclusion should not include hospital standing orders of seclusion or night seclusion.
- 5.2 If the patient is unresponsive to alternative treatment modalities, consultation about the use of prolonged seclusion should occur with the Clinical Director, or another delegated senior clinician.

6 Reintegration for patients undergoing seclusion

- 6.1 A planned and graduated process of reintegration into the ward may be required, particularly after a prolonged period in seclusion.
- 6.2 Reintegration should start with the door open and move to integration during times of least stress and disruption.
- 6.3 An assessment of reintegration attempts should be taken into account when making a decision whether or not to continue seclusion.

7 Ending seclusion

- 7.1 If the goals for seclusion have been achieved, a decision to end seclusion should be taken by two suitably qualified clinicians, in agreement with the responsible clinician. If the decision is made to end seclusion after hours, the delegated authority must be notified at an appropriate time.
- 7.2 Each episode of seclusion is deemed to have ended if the patient leaves the conditions of seclusion without expectation of return, and in any case, is deemed to have ended if the patient has been out of seclusion for more than one hour. The purpose of this is to allow a short period of evaluation out of seclusion.

8 Recurrent seclusion

- 8.1 If it is necessary to replace an individual back in seclusion after a short period of evaluation, or attempted reintegration, a new seclusion event must be commenced.

9 Recording the use of seclusion

- 9.1 A specific form must be used to record the use of seclusion and must be supported by clinical notes. In addition each service shall develop a method of recording the 10-minute and two-hourly observations.
- 9.2 Recording should start as soon as seclusion has been initiated.
- 9.3 One copy of the seclusion record should be retained on the patient notes and one retained in a central seclusion register (as per section 129 of the Mental Health (Compulsory Assessment and Treatment) Act 1992).
- 9.4 The main purpose of the information is to provide a basis for internal quality assurance as well as review and audit. As in other aspects of the Mental Health (Compulsory Assessment and Treatment) Act 1992, it is expected that District Inspectors will monitor that procedures are properly used.

Appendix One:

General Guidance on Seclusion

The following are situations where, according to the duty of care, seclusion may be appropriate:

- (a) the control of harmful behaviour occurring during the course of a psychiatric illness that cannot be adequately controlled with psychological techniques and/or medication
- (b) disturbance of behaviour as a result of marked agitation, thought disorder, hyperactivity or grossly impaired judgement
- (c) to reduce the disruptive effects of external stimuli in a person who is highly aroused due to their illness
- (d) to prevent harmful or destructive behaviour, using specific indicators of impending disturbance which may be identified by either the individual or the staff, and which should wherever possible be part of an agreed management plan.

Seclusion should be used with extreme caution in the following circumstances:

- (a) where the patient is receiving medication and there is:
 - (i) evidence of altered or fluctuating levels of consciousness, or other neurological side effects
 - (ii) likelihood of respiratory suppression or other cardiovascular side effects
- (b) physical deterioration
- (c) where the patient is in need of intensive assessment and/or observation, especially where there is a history suggestive of significant trauma, ingestion of unknown drugs/substances or organic diagnosis
- (d) presence of physical illness or injury requiring specific physical treatment
- (e) presence or likelihood of self-injurious behaviour
- (f) likelihood of escalation of anxiety, aggression or distress or a previous adverse response
- (g) no demonstrable psychiatric diagnosis
- (h) intoxication with alcohol, or possibility of other drug ingestion.

Seclusion shall be in a room or area designed for that purpose by, or with the approval of, the Director of Area Mental Health Services. The emphasis shall be on providing a safe environment.

As a minimum, the room must have:

- (a) adequate light, heat and ventilation
- (b) means to easily observe the patient that also allows the patient to see the head and shoulders of the observer
- (c) means for a secluded patient to call for attention
- (d) fittings recessed to avoid potential for harm
- (e) furnishings (other than bedding) that are fixed to avoid the potential for harm.

In addition, it is desirable that:

- (a) doors open outwards flush with the walls and the environment should be pleasant and minimally stimulating
- (b) the secluded individual should be allowed as much of their normal clothing as possible within the dictates of safety, and should not be deprived of all their personal possessions
- (c) any items provided be considered on a case-by-case basis to establish the potential for harm and to relate to the indications for seclusion
- (d) assistance be given to provide a means of orientation (time, date, news and other information)
- (e) there is access to toileting, washing and showering facilities in, or adjacent to, the area
- (f) there is access to two-way communication
- (g) there is access to an equally safe external area to assist with reintegration
- (h) there is access to temperature regulation if required.

Appendix Two:

Section 71 of the Mental Health (Compulsory Assessment and Treatment) Act 1992

71. Right to company, and seclusion

- (1) Every patient is entitled to the company of others, except as provided in subsection (2) of this section.
- (2) A patient may be placed in seclusion in accordance with the following provisions:
 - (a) Seclusion shall be used only where, and for as long as, it is necessary for the care or treatment of the patient, or the protection of other patients.
 - (b) A patient shall be placed in seclusion only in a room or other area that is designated for the purposes by or with the approval of the Director of Area Mental Health Services.
 - (c) Except as provided in paragraph (d) of this subsection, seclusion shall be used only with the authority of the responsible clinician.
 - (d) In an emergency, a nurse or other health professional having immediate responsibility for a patient may place the patient in seclusion, but shall forthwith bring the case to the attention of the responsible clinician.
 - (e) The duration and circumstances of each episode of seclusion shall be recorded in the register kept in accordance with section 129(1)(b) of this Act.

Appendix Three: Seclusion reporting template



Unit	Date	Time in	Time out

Patient details (or patient label)

Name	
Date of birth	
Ethnicity	
NHI	
Legal status	
Gender	

Authorisation to initiate seclusion

Initiating clinician	
Name	
Designation	
Date and time	
Supporting clinician	
Name	
Designation	
Date and time	
Responsible clinician (if not initiating or supporting clinician)	
Name	
Designation	
Date and time	

Reason for seclusion

Duty of care for the patient or for others is required because of:

i harmful behaviour that cannot be adequately controlled with psychological techniques and/or medication	Yes/No
ii disturbance of behaviour as a result of marked agitation, thought disorder, hyperactivity or grossly impaired judgement	Yes/No
iii the disruptive effects of external stimuli to a person who is highly aroused due to their illness	Yes/No
iv harmful or destructive behaviour, using specific indicators of impending disturbance which may be identified by either the individual or the staff, and which should wherever possible be part of an agreed management plan.	Yes/No

Detailed account of the event:

Alternative interventions attempted *(Please give details)*

i Biological	
ii Psychological	
iii Environmental	
iv Social	
v Cultural or spiritual	

Authorisation to seclude for more than 8 hours

Details of the decision to continue seclusion:

Initiating clinician	
Name	
Designation	
Date and time	
Supporting clinician	
Name	
Designation	
Date and time	
Responsible clinician (if not initiating or supporting clinician)	
Name	
Designation	
Date and time	

Ending seclusion

If the goals for seclusion have been achieved, a decision to end seclusion should be taken by two suitably qualified clinicians. The responsible clinician should be notified as soon as possible.

Details of the decision to end seclusion:

Initiating clinician	
Name	
Designation	
Date and time	
Supporting clinician	
Name	
Designation	
Date and time	
Responsible clinician (if not initiating or supporting clinician)	
Name	
Designation	
Date and time	

Appendix Four:

Seclusion care requirements checklist

Minimum 10-minute observations

The minimum observations within the 10 minute interval include:

- colour (for example cyanosis, pallor)
- breathing (rate per minute)
- position (lying, sitting, standing)
- activity (sleeping, talking, pacing)
- behaviour (violent, aggressive).

Minimum two-hourly observations

The minimum observations within the two hourly interval include:

- an attempt to enter the room to assess the physical well-being of the patient; if the attempt is unsuccessful a record of why must be noted on the reporting form
- an assessment of mental state
- observations and care as described in the 10 minute observations.

Minimum eight-hourly observations

The minimum observations within the eight hourly interval include:

- documented clinical consultation with the responsible clinician
- communication of all care requirements both verbally and via the patient's plan to the following shift
- psychiatric assessment of the patient at least once every eight hours
- observations and care as described in the 10 minute and two hourly observations.