CHIEF CIVIL PSYCHIATRIST APPROVED FORM 9

TASMANIA'S MENTAL HEALTH ACT
Rights, Respect, Recovery

SECLUSION (INVOLUNTARY)

Mental Health Act 2013
Sections 56, 58

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

AFFIX STICKER HERE

FT21315O

PART A : AUTHORISATION OF SECLUSION

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

Patient's name: _____

Approved hospital in which patient is being detained:

☐ NWRH (Burnie) ☐ LGH ☐ RHH ☐ Roy Fagan Centre ☐ Millbrook Rise Centre

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

Only the CCP (or delegate) may authorise a child patient's seclusion.

Name/Identity Card Number/Payroll Number of person authorising seclusion:

_____

Status of person authorising seclusion:

☐ Chief Civil Psychiatrist or delegate ☐ Medical Practitioner ☐ Approved nurse

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 for a prescribed reason; if the person authorising the seclusion is satisfied that the seclusion is a reasonable intervention in the circumstances; if the seclusion lasts for no longer than authorised; and if the seclusion is managed in accordance with any relevant standing orders or clinical guidelines.

*Seclusion may be authorised for a period of **up to three (3) hrs.** This period may be extended – see Parts C and D of this form.*

I **am satisfied** that it is necessary to seclude the patient named above (*tick any or 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 hereby authorise seclusion for a period of: _____ Hours and _____Minutes

commencing on Date: / / at Time: _____:_____(24 hrs)

Date and time of authorisation: Date: / / Time: _____:_____ (24 hrs)

Is the person authorising seclusion completing this form?

☐ **Yes – person authorising to sign here:** _____

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

We confirm that seclusion has been authorised for the patient named above, for the reasons given above:

Dr/Nurse Name/Payroll/ID Number 1: _____ Signature: _____

Dr/Nurse Name/Payroll/ID Number 1: _____ Signature: _____

COPY TO: ☐ Patient ☐ CCP (if authorised by a delegate, medical practitioner or nurse) ☐ Tribunal ☐ LOC ☐ If patient is a child or if there is consent - copy to parent/support person/representative **OTHER:** ☐ Statement of rights to patient ☐ Explanation to patient in language and form that patient can un4derstand

CONTACT DETAILS: MHT: Phone: (03) 6165 7491 Email: mht.applications@justice.tas.gov.au
CCP: Phone: (03) 6166 0781 Fax No: (03) 6230 7739 Email: chief.psychiatrist@dhhs.tas.gov.au

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FT213150

PART B: CLINICAL/MEDICAL OBSERVATIONS

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

Patient's name: _____

Approved hospital in which patient is being detained:

☐ NWRH (Burnie) ☐ LGH ☐ RHH ☐ Roy Fagan Centre ☐ Millbrook Rise Centre

Date and time seclusion commenced: Date: / / Time: ____:____ (24 hr)

Date and time seclusion ceased: Date: / / Time: ____:____ (24 hr)

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 examined by a medical practitioner or approved nurse at intervals not exceeding four hours to see if the seclusion should continue or be terminated.

A patient in seclusion must also be examined by an Approved Medical Practitioner (AMP) at intervals not exceeding 12 hours.

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.

The shaded rows are a reminder for a medical practitioner or approved nurse that the patient must be examined at intervals not exceeding 4 hours

Date of observation/ examination	Time of observation/ examination (24 hrs)	Comments/Observations	Name/Identity Card/Payroll Number & Status	
			Name/ ID Card/Payroll Number	Status (Nurse/MP/ AMP)
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COPY TO: ☐ CCP ☐ LOC

CONTACT DETAILS: CCP: Phone: (03) 6166 0781 Fax No: (03) 6230 7739 Email: chief.psychiatrist@dhhs.tas.gov.au

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Family Name: _____
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Address: _____
Telephone: _____ Mobile: _____

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FT2131150

PART C: EXTENSION OF SECLUSION – INITIAL

CHIEF CIVIL PSYCHIATRIST / DELEGATE TO COMPLETE

Patient's name: _____

Approved hospital in which patient is being detained:

☐ NWRH (Burnie) ☐ LGH ☐ RHH ☐ Roy Fagan Centre ☐ Millbrook Rise Centre

Date and time seclusion first commenced: Date: / / at Time: ____:____(24 hr)

Date and time seclusion will cease, if not extended: Date: / / at Time: ____:____(24 hr)

A period of seclusion may be extended.

The period of extension must be authorised by the CCP or delegate and authorisation may only be given if the patient has been examined by a medical practitioner immediately prior to the decision to extend the patient's seclusion.

An involuntary patient's seclusion may be extended more than once; however ***in no circumstances is the period of extension to exceed three (3) hrs.***

The CCP (or delegate) may impose conditions on any extension.

Name of Chief Civil Psychiatrist/delegate authorising the extension of seclusion:

_____

I **confirm** that the patient named above was examined by *(insert name of medical practitioner)*

_____ on Date: / / and Time: ___:__ (24 hr)

and **hereby extend** the period for which the patient named above may be secluded for an additional period of _____ Hours and _____ Minutes.

Unless subsequently extended or sooner ceased, the patient's seclusion is to cease on:

Date: / / Time: _____:_____ (24 hr)

Conditions imposed on extension *(if applicable)*:

_____

_____

Date and time of extension: Date: / / Time: _____:_____ (24 hr)

Is the person extending the seclusion completing this form?

☐ **Yes – CCP/delegate to sign here:** _____

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

We confirm that the CCP/delegate named above has authorised an extension of the period for which the patient named above may be secluded, for the period referred to above, subject to the conditions (if any) specified above:

Dr/Nurse Name/Payroll/ID Number 1: _____ Signature: _____

Dr/Nurse Name/Payroll/ID Number 1: _____ Signature: _____

COPY TO: ☐Patient ☐CCP (if authorised by delegate) ☐ Tribunal ☐ LOC ☐ If patient is a child or if there is consent - copy to parent/support person/representative **OTHER:** ☐Statement of rights to patient ☐ Explanation to patient in language and form that patient can understand

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Telephone: _____ Mobile: _____

AFFIX STICKER HERE

FT213150

PART D: EXTENSION OF SECLUSION – SUBSEQUENT

CHIEF CIVIL PSYCHIATRIST / DELEGATE TO COMPLETE

Patient's name: _____

Approved hospital in which patient is being detained:

☐ NWRH (Burnie) ☐ LGH ☐ RHH ☐ Roy Fagan Centre ☐ Millbrook Rise Centre

Date and time seclusion first commenced: Date: / / Time: ____:____(24 hr)

Date and time seclusion extended: Date: / / Time: ____:____(24 hr)

Date and time seclusion will cease, if not subsequently extended: Date: / / Time: ____:____(24 hr)

A period of seclusion that has already been extended may be further extended.

The further period of extension must be authorised by the CCP or delegate and authorisation may only be given if the patient has been examined by a medical practitioner immediately prior to the decision to further extend the patient's seclusion.

An involuntary patient's seclusion may be extended more than once; however ***in no circumstances is the period of extension to exceed three (3) hrs.***

The CCP (or delegate) may impose conditions on any extension.

Name of Chief Civil Psychiatrist/delegate authorising the subsequent extension of seclusion:

_____

I **confirm** that the patient named above was examined by *(insert name of medical practitioner)*

_____ on Date: / / and Time: ____:____ (24 hr)

and **hereby further extend** the period for which the patient named above may be secluded for an additional period of _____ Hours and _____ Minutes.

Unless subsequently extended or sooner ceased, the patient's seclusion is to cease on:

Date: / / Time: _____:_____ (24 hr)

Conditions imposed on extension *(if applicable)*:

_____

_____

Date and time of extension: Date: / / Time: _____:_____ (24 hr)

Is the person extending the seclusion completing this form?

☐ **Yes – CCP/delegate to sign here:** _____

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

We confirm that the CCP/delegate named above has authorised an extension of the period for which the patient named above may be secluded, for the period referred to above, subject to the conditions (if any) specified above:

Dr/Nurse Name/Payroll/ID Number 1: _____ Signature: _____

Dr/Nurse Name/Payroll/ID Number 1: _____ Signature: _____

COPY TO: ☐Patient ☐CCP (if authorised by delegate) ☐Tribunal ☐LOC ☐If patient is a child or if there is consent - copy to parent/support person/representative **OTHER:** ☐Statement of rights to patient ☐Explanation to patient in language and form that patient can understand

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