

Rules Governing the Use of Seclusion

Issued Pursuant to Section 69(2)
of the Mental Health Act 2001-2018.

September 2022

PREAMBLE¹

Section 69(2) of the Mental Health Act 2001-2018 ('the 2001 Act') obliges the Mental Health Commission to make Rules providing for the use of seclusion on a patient.

The Mental Health Commission prepared Section 69(2) Rules which came into force on 1 November 2006. Following on from a review in 2009, this document represents the second substantial review and update of the Rules. There have been significant and progressive developments in mental health care in the intervening years. International developments around human rights, the advancement of person-centred care, and evidence demonstrating that restrictive practices can have harmful physical and psychological consequences, have changed how these practices are viewed. This document is informed by these developments and, in particular, emphasises the need for services to adopt a rights-based approach to mental health care.

These Rules are being issued following an extensive stakeholder engagement process and consideration of national and international evidence and best practice. The Mental Health Commission consulted with people who have experienced restrictive practices, as well as staff and clinicians in mental health services. (Copies of the Consultation Report and Evidence Review are available on the Mental Health Commission's website, www.mhcirl.ie)

The Mental Health Commission considers that these Rules will encourage continual efforts to avoid, reduce and, where possible, eliminate restrictive practices. Each service provider will be required to demonstrate how they are achieving this. The Rules emphasise the importance of strong governance and oversight mechanisms as key to successful reduction and elimination strategies. Although the Rules aim to direct practice, they do not purport to be all-encompassing and providers of mental health services have a duty to ensure that they regularly review and update policy and practice in this area.

The date of commencement of these Rules is 1 January 2023, following which, the Inspector of Mental Health Services will begin assessing compliance with the revised Rules.

The Mental Health Commission shall review these Rules as required in terms of any relevant case law and/or amending legislation, but no later than five years from the date of commencement of these Rules.

¹ The preamble provides an explanation and context to the Rules Governing the Use of Seclusion. It is not part of the Rules.

SECTION 69(2) RULES

RULES GOVERNING THE USE OF SECLUSION

These Rules have been made by the Mental Health Commission in accordance with Section 69(2) of the Mental Health Act, 2001-2018. A person who contravenes these Rules shall be guilty of an offence.

TABLE OF CONTENTS

Preamble	1
Glossary	4
Part 1: Principles Underpinning the Use of Seclusion.....	8
Part 2: Definitions	9
Part 3: Use of Seclusion	10
Appendices	21

GLOSSARY

APPROVED CENTRE

A “centre” means a hospital or other inpatient facility for the care and treatment of persons suffering from mental illness or mental disorder. An “approved centre” is a centre that is registered pursuant to the Mental Health Act 2001-2018. The Mental Health Commission establishes and maintains the register of approved centres pursuant to the Mental Health Act 2001-2018.

BREAKAWAY TECHNIQUES

A set of physical skills to help separate or break away from an aggressor in a safe manner. They do not involve the use of restraint.

CHILD

A person under 18 years of age other than a person who is or has been married.

CLINICAL FILE

A record of the person’s referral, assessment, care and treatment while in receipt of mental health services. This documentation must be stored in the one file. If all relevant information is not stored in the one file, the file must record where the other information is held.

CLINICAL GOVERNANCE

A system for improving the standard of clinical practice including clinical audit, education and training, research and development, risk management, clinical effectiveness and openness.

CLOSED CIRCUIT TELEVISION (CCTV)

Any monitoring device which captures a person’s image, either for recording or live observation.

CONSULTANT PSYCHIATRIST

Means a consultant psychiatrist who is employed by the HSE or by an approved centre or a person whose name is entered on the division of psychiatry or the division of child and adolescent psychiatry of the Register of Medical Specialists maintained by the Medical Council.

CONTINUOUS OBSERVATION

Ongoing observation of the person by a registered nurse and registered medical practitioner, who is within sight and sound of the person at all times, which may include the use of electronic monitoring e.g. CCTV.

DE-ESCALATION

The use of techniques (including verbal and non-verbal communication skills) aimed at defusing anger and averting aggression.

DIGNITY

The right of an individual to privacy, bodily integrity and autonomy, and to be treated with respect as a person in their own right.

DIRECT OBSERVATION

Ongoing observation of the person by a registered nurse who is within sight and sound of the seclusion room at all times but is outside the seclusion room. The observation of a person via electronic monitoring (e.g. CCTV) does not constitute “direct observation”.

DUTY CONSULTANT PSYCHIATRIST

The consultant psychiatrist on the on-call duty rota.

INDIVIDUAL CARE PLAN

A documented set of goals developed, regularly reviewed and updated by the person’s multidisciplinary team, so far as practicable in consultation with each person receiving care and treatment. The individual care plan must specify the treatment and care required which must be in accordance with best practice, must identify necessary resources and must specify appropriate goals for the person. For children, individual care plans must include education requirements. The care plan is recorded in the one composite set of documentation.

PERSON

All references to ‘person’ in this document shall be taken to mean a voluntary or involuntary patient or resident, as defined in the 2001 Act.

PERSON-CENTRED

Person-centred focuses on the needs of the person; ensuring that the person’s preferences, needs, and values guide clinical decisions or support; and providing care that is respectful and responsive to them.

POLICY

Written statement that clearly indicates the position of the organisation on a given subject.

POSITIVE BEHAVIOUR SUPPORT

Positive behaviour support involves assessments that look beyond the behaviour of a person and seek to understand the causes or triggers of the behaviours. These causes may be social, environmental, cognitive, or emotional. The approach is one of behaviour change as opposed to behaviour management.

REGISTERED MEDICAL PRACTITIONER

A person whose name appears on the General Register of Medical Practitioners.

REPRESENTATIVE

An individual chosen by the person who is being cared for (e.g. friend, family member, advocate) or a legal professional appointed by the person, statutory organisation or court to represent the person.

RIGHTS-BASED APPROACH

Integrating human rights norms and principles in the design, implementation, monitoring and evaluation of policies and programmes. The principles of equality and freedom from discrimination are central.

RISK ASSESSMENT

An assessment to gauge risk in relation to the person, designed and recognised for use in mental health settings.

TRAUMA-INFORMED CARE

Trauma-informed care is an approach which acknowledges that many people who experience mental health difficulties may have experienced some form of trauma in their life. A trauma-informed approach seeks to resist traumatising or re-traumatising persons using mental health services and staff.

UNSAFE BEHAVIOUR

When a person acts in such a way that they may injure themselves or others.

MENTAL HEALTH ACT 2001-2018

SECTION 69

BODILY RESTRAINT AND SECLUSION

Section 69

- (1) *A person shall not place a patient in seclusion or apply mechanical means of bodily restraint to the patient unless such seclusion or restraint is determined, in accordance with the rules made under subsection (2), to be necessary for the purposes of treatment or to prevent the patient from injuring himself or herself or others and unless the seclusion or restraint complies with such rules.*
- (2) *The Commission shall make rules providing for the use of seclusion and mechanical means of bodily restraint on a patient.*
- (3) *A person who contravenes this section or a rule made under this section shall be guilty of an offence and shall be liable on summary conviction to a fine not exceeding £1500.*
- (4) *In this section “patient” includes –*
 - (a) *a child in respect of whom an order under section 25 is in force, and*
 - (b) *a voluntary patient*

PART 1: PRINCIPLES UNDERPINNING THE USE OF SECLUSION

The following general principles must underpin the use of seclusion at all times. These principles are informed by a rights-based approach to mental health care and treatment. They are applicable to all approved centres where seclusion is used.

1. Approved centres must recognise the inherent rights of a person to personal dignity and freedom in accordance with national and international human rights instruments and legislation.
2. The use of seclusion may increase the risk of trauma and may trigger symptoms of previous experiences of trauma. Therefore, it must only be used in rare and exceptional circumstances as an emergency measure.
3. Persons who are secluded must be treated with dignity and respect at all times before, during, and after the seclusion.
4. Persons who are secluded must be fully informed and involved in all decisions regarding their care and treatment to include all matters relating to the use of seclusion. The views of persons who are secluded must be listened to, taken into account and recorded.
5. As seclusion compromises a person's liberty, its use must be the safest and least restrictive option of last resort necessary to manage the immediate situation, be proportionate to the assessed risk, and employed for the shortest possible duration. Its use must only occur following reasonable attempts to use alternative means of de-escalation to enable the person to regain self-control.
6. Communication with persons who are secluded must be clear, open and transparent, free of medical or legal jargon, and staff must communicate with empathy, compassion and care. Persons who have a sensory impairment may experience an increased level of trauma during seclusion and staff must address the additional communication needs of these persons.
7. The views of family members, representatives and nominated support persons, must be taken into account, where appropriate.
8. Cultural awareness and gender sensitivity must be taken into account at all times and must inform the approved centre's policies and procedures for the use of seclusion.
9. Seclusion must be used in a professional manner and its use must be based within a legal and ethical framework.

PART 2: DEFINITIONS

2. DEFINITIONS

2.1 Definition of Seclusion

2.1.1 For the purposes of these Rules, seclusion is defined as *“the placing or leaving of a person in any room, at any time, day or night, such that the person is prevented from leaving the room by any means.”*

2.2 Exclusions

2.2.1 If a person is locked in their bedroom in the High Secure Unit at night in the National Forensic Service (Central Mental Hospital) as part of their individual risk assessment and management plan for the purposes of enhanced security, this does not constitute seclusion under these Rules.

PART 3: USE OF SECLUSION

Please read Part 1 of the Rules: Principles Underpinning the Use of Seclusion and Part 2 of the Rules: Definitions.

3. ORDERS FOR SECLUSION

- 3.1** The seclusion of any person must only be initiated by a registered medical practitioner or the most senior registered nurse on duty in the unit/ward.
- 3.2** Seclusion must only be initiated following as comprehensive an assessment of the person as is practicable. This must include a risk assessment, the outcome of which must be recorded in the person's clinical file. A copy of the risk assessment must be made available to the Mental Health Commission on request.
- 3.3** The registered medical practitioner or registered nurse must record the matter in the clinical file and on the seclusion register.
- 3.4** Where seclusion is initiated by a registered nurse, a registered medical practitioner must be notified of the seclusion episode as soon as is practicable, and no later than 30 minutes following the commencement of the episode.
- 3.5** There must be a medical examination of the person by a registered medical practitioner as soon as is practicable and, in any event, no later than two hours after the commencement of the episode of seclusion. This must include an assessment and record of any physical, psychological and/or emotional trauma caused to the person as a result of the seclusion.
- 3.6** As soon as is practicable, and no later than 30 minutes following the medical examination, the registered medical practitioner must contact the person's consultant psychiatrist or the duty consultant psychiatrist to inform them of the episode of seclusion. The consultant psychiatrist must discontinue the use of seclusion unless they order its continued use.
- 3.7** The registered medical practitioner must record this consultation in the clinical file and indicate on the seclusion register that the consultant psychiatrist ordered or did not order the continued use of seclusion.
- 3.8** If the consultant psychiatrist orders the continued use of seclusion, they must advise the duration of the order. The registered medical practitioner must record this information on the seclusion register. A seclusion order must not be made for a period of time longer than four hours from the commencement of the seclusion episode.
- 3.9** The order of the consultant psychiatrist must confirm that there are no other less restrictive ways available to manage the person's presentation.
- 3.10** The consultant psychiatrist must undertake a medical examination of the person and sign the seclusion register within 24 hours of the commencement of the seclusion episode. The examination must be recorded in the person's clinical file.

- 3.11** The person must be informed of the reasons for, likely duration of, and the circumstances which will lead to the discontinuation of seclusion, unless the provision of such information might be prejudicial to the person's mental health, well-being or emotional condition. If informed of the reasons, a record of this must be recorded in the person's clinical file as soon as is practicable. In the event that this communication does not occur, a record explaining why it has not occurred must be entered in the person's clinical file as soon as is practicable.
- 3.12 a)** As soon as is practicable, and if it is the person's wish in accordance with their individual care plan, the person's representative must be informed of the person's seclusion and a record of this communication must be entered in the person's clinical file. In the event that this communication does not occur, a record explaining why it has not occurred must be entered in the person's clinical file.
- b)** Where it is the person's wish in accordance with their individual care plan that the person's representative is not to be informed of the person's seclusion, no such communication must occur outside the course of that necessary to fulfil legal and professional requirements. This must be recorded in the person's clinical file.
- 3.13** The Registered Proprietor must notify the Mental Health Commission of the start time and date, and the end time and date of each episode of seclusion in the format specified by the Mental Health Commission, and within the timeframes set by the Mental Health Commission.

4. DIGNITY AND SAFETY

- 4.1** Seclusion of a person with a known psycho-social/medical condition, in which close confinement would be contraindicated, must only be used when all alternative options have been implemented and proven unsuccessful and following an appropriate risk assessment.
- 4.2** The clothing worn in seclusion must respect the right of the person to dignity, bodily integrity and privacy. The person must be secluded in their own clothing. If, in exceptional circumstances, the decision is made to use any other clothing (e.g. tear-proof clothing, or other clothing that is not the person's), this must only occur following a specific and documented risk assessment which is regularly reviewed no less frequently than at each renewal order. If the person's own clothing is not worn, the reason must be documented in the person's individual care plan.
- 4.3** A person in seclusion must not have access to hazardous objects.
- 4.4** Bodily searches must only be undertaken in the most exceptional circumstances, following a risk assessment (the outcome of which must be recorded in the person's clinical file). Bodily searches must be undertaken in the presence of more than one staff member, and respect the right of the person to dignity, bodily integrity and privacy. Gender and cultural sensitivity and the preferences of the person must be respected when undertaking a bodily search.
- 4.5** All staff members involved in the use of seclusion must have undertaken appropriate training in accordance with the policy outlined in section 11.2.

5. THE MONITORING OF THE PERSON DURING SECLUSION

- 5.1** A person placed in seclusion must be kept under direct observation by a registered nurse for the first hour following the initiation of a seclusion episode.
- 5.2** After the first hour, a registered nurse must keep the person under continuous observation and be within sight and sound of the seclusion room. This observation may be completed in person or with CCTV (or other electronic monitoring).
- 5.3** A written record of the person must be made by a registered nurse at least every 15 minutes. This must include a record of:
- i.** the person's level of distress;
 - ii.** the person's behaviour (what the person is doing and saying);
 - iii.** the person's level of awareness;
 - iv.** the person's physical health, especially with regard to breathing, pallor or cyanosis;
 - v.** whether elimination/hygiene needs were met; and
 - vi.** whether hydration/nutrition needs were met.

If the person's unsafe behaviour has abated, the ending of the episode of seclusion must be considered.

- 5.4** Following a risk assessment, a nursing review of the person in seclusion must take place every two hours, unless the risk assessment indicates that to do so would place the person or staff at a high risk of injury. During this review, a minimum of two staff members, one of whom must be a registered nurse who was not directly involved in the decision to seclude (where possible), will enter the seclusion room and assess the person to determine whether the episode of seclusion can be ended. This assessment and decision must be recorded.
- 5.5** A medical examination must be carried out by a registered medical practitioner every four hours. This examination must take account of the records of the nursing observations and any previous medical examination(s). The decision to end or continue seclusion must be recorded.
- 5.6** Where a person is sleeping, clinical judgement needs to be used as to whether it is appropriate to wake the person for a nursing review or medical examination. In such instances medical examinations may be suspended. Nursing reviews must continue every two hours. However, the nature of the nursing review may be such that the person is not woken. A registered medical practitioner must be on call to carry out a medical examination during the night, should the need arise.
- 5.7** Upon commencement of an episode of seclusion, a Seclusion Care Plan for the person must be developed by a registered nurse. A Seclusion Care Plan must include as a minimum:
- i.** personal details;
 - ii.** known clinical needs (including mental and physical considerations);
 - iii.** how de-escalation strategies will continue to be used;
 - iv.** the person's preferences in relation to seclusion, where known (e.g. access to music or reading material while in the seclusion room), and take into account outcomes of any previous debrief with the person, if applicable;

- v. recognising signs where the person's behaviour is no longer deemed an unmanageable risk towards themselves or others, e.g. evidence of tension reduction, improved communication etc;
- vi. how potential risks may be managed;
- vii. reference to specific support plans for the person and details of how the person's mental health needs will continue to be met while in seclusion;
- viii. meeting of food/fluid needs;
- ix. meeting of needs in relation to personal hygiene/dressing;
- x. meeting of elimination needs (with specific reference to how privacy and dignity will be managed);
- xi. medication reviews (in consultation with a registered medical practitioner);
- xii. monitoring of physical observations; and
- xiii. a strategy for ending seclusion; indicating the criteria required for this to be reached.

6. RENEWAL OF SECLUSION ORDERS

- 6.1** A seclusion order may be renewed by an order made by a registered medical practitioner under the supervision of the consultant psychiatrist responsible for the care and treatment of the person or the duty consultant psychiatrist following a medical examination, for a further period not exceeding four hours to a maximum of five renewals (24 hours) of continuous seclusion.
- 6.2** If the person's seclusion order is to be renewed beyond the initial 24 hours of continuous seclusion, the consultant psychiatrist responsible for the care and treatment of the person or the duty consultant psychiatrist must undertake a medical examination of the person, and this must be recorded in the person's clinical file.
- 6.3** If the person's seclusion order is to be renewed beyond 72 hours of continuous seclusion, the consultant psychiatrist responsible for the care and treatment of the person or the duty consultant psychiatrist must undertake a medical examination of the person, and this must be recorded in the person's clinical file. Following the medical examination, the consultant psychiatrist must discontinue the use of seclusion unless they order its continued use.
- 6.4** If a decision is made by the consultant psychiatrist responsible for the care and treatment of the person, or the duty consultant psychiatrist acting on their behalf, to continue to seclude a person for a total period exceeding 72 hours, the Mental Health Commission must be provided with additional information to include:
- i. a record of the reasonable attempts and outcomes to use alternative means of calming and de-escalation to enable the person to regain self-control; and
 - ii. the reasons why continued seclusion is ordered.
- 6.5** If a person has four or more distinct seclusion episodes over a period of five consecutive days, the Mental Health Commission must be provided with additional information, to include the following:
- i. a record of the reasonable attempts and outcomes to use alternative means of calming and de-escalation to enable the person to regain self-control; and
 - ii. the reasons why seclusion has been repeatedly ordered.

7. ENDING SECLUSION

- 7.1** Seclusion may be ended:
- i.** by a registered medical practitioner at any time following discussion with the person in seclusion and relevant nursing staff; or
 - ii.** by the most senior registered nurse in the unit/ward, in consultation with the person in seclusion and a registered medical practitioner.
- 7.2** Where seclusion is ended by a registered medical practitioner or the most senior registered nurse on duty in the unit/ward, the consultant psychiatrist responsible for the care and treatment of the person, or the duty consultant psychiatrist acting on their behalf, must be notified.
- 7.3** The person must be informed of the ending of an episode of seclusion.
- 7.4** Leaving seclusion for a toilet break, or for a medical examination does not constitute the end of an episode of seclusion.
- 7.5** The time, date and reason for ending seclusion must be recorded in the person's clinical file on the date seclusion is ended.
- 7.6** An in-person debrief with the person who was secluded must follow every episode of seclusion. This debrief must be person-centred and must:
- i.** give the person the opportunity to discuss the seclusion with members of the multidisciplinary team involved in the person's care and treatment as part of a structured debrief process;
 - ii.** occur within two working days (i.e. days other than Saturday/Sunday and bank holidays) of the episode of seclusion unless it is the preference of the person who was secluded to have the debrief outside of this timeframe. The person's preferences regarding the timing of the debrief must be recorded;
 - iii.** respect the decision of the person not to participate in a debrief, if that is their wish. If the person declines to participate in the debrief, a record of this must be maintained and recorded in the person's clinical file;
 - iv.** include a discussion regarding alternative de-escalation strategies that could be used to avoid the use of restrictive interventions in the future;
 - v.** include a discussion regarding the person's preferences in the event where a restrictive intervention is needed in the future e.g. preferences in relation to which restrictive intervention they would not like to be used;
 - vi.** give the person the option of having their representative or their nominated support person attend the debrief with them, and, if the person's representative or nominated support person does not attend the debrief, a record of the reasons why this did not occur must be recorded in the person's clinical file.
- 7.7** Where multiple episodes of seclusion occur within a 48-hour timeframe, these episodes may be reviewed during a single debrief in accordance with point 7.6ii.
- 7.8** A record must be kept of the offer of the debriefing, whether it was accepted and the outcome. The person's individual care plan must be updated to reflect the outcome of the debrief, and in particular, the person's preferences in relation to restrictive interventions going forward.

- 7.9** A record of all attendees who were present at the debrief must be maintained and be recorded in the person's clinical file.
- 7.10** Where a person's representative has been informed of the person entering seclusion, the person's representative must be informed of the ending of the episode of seclusion as soon as is practicable. A record of this communication must be entered in the person's clinical file. In the event that this communication does not occur, a record explaining why it has not occurred must be entered in the person's clinical file.
- 7.11** Any use of a restrictive intervention may be traumatic for the person who experiences it. Appropriate emotional support must be provided to the person in the direct aftermath of the episode. Staff must also offer support, if appropriate, to other persons who may have witnessed the seclusion of the person.

8. SECLUSION FACILITIES

- 8.1** Seclusion facilities must be furnished, maintained and cleaned in such a way that ensures the person's inherent right to personal dignity and ensures that the person's privacy is respected.
- i.** The construction of the seclusion room must be designed to withstand high levels of violence with the potential to damage the physical environment e.g. walls, windows, doors, locks.
 - ii.** There must be no ligature points or electrical fixtures.
 - iii.** There must be an anti-barricade door.
 - iv.** The room must allow for staff to be able to clearly observe the person within the seclusion room.
 - v.** Seclusion rooms must have externally controlled heating and air conditioning, which enables those observing the person to monitor the room temperature.
 - vi.** The seclusion room must include limited furnishings which must include a pillow, mattress, and blanket or covering, all of which must meet current health and safety requirements.
 - vii.** The room must be large enough to support the person and team of staff who may be required to use physical interventions during transition to seclusion.
 - viii.** The person must have sight of a clock displaying the time, day and date.
 - ix.** As far as is possible, the seclusion room must be in an area away from communal sitting rooms and sleeping accommodation, but not isolated.

In addition, the below requirements are applicable to all new seclusion facilities where construction is commenced after 1 January 2023:

- x.** The seclusion room must have a window which provides the person in seclusion with a clear view of the outdoor environment.
- xi.** The seclusion room must not be visible to unauthorised persons from the outdoor environment.

- 8.2** The person who is secluded must have ready access to sanitary facilities and sanitary items (unless there is a clearly documented reason recorded in the Seclusion Care Plan).
- 8.3** All furniture and fittings in the seclusion room must be of such a design and quality as not to endanger the safety of the person in seclusion.
- 8.4** Seclusion facilities must not be used as bedrooms.
- 8.5** Bedrooms must not be used as seclusion facilities.
- 8.6** Subject to the outcome of a documented, suitable risk assessment, the person must be permitted periods of access to secure outside areas. A record of daily outdoor access must be maintained.

9. RECORDING OF SECLUSION EPISODES

- 9.1** All uses of seclusion must be clearly recorded in the person's clinical file.
- 9.2** All uses of seclusion must be clearly recorded on the Register for Seclusion (see Appendix 2) in accordance with Rules 3.7, 3.8 and 3.10.
- 9.3** A copy of the Register must be placed in the person's clinical file and a copy must be available to the Mental Health Commission upon request.

10. CLINICAL GOVERNANCE

- 10.1** Seclusion must never be used:
 - i.** to ameliorate operational difficulties including where there are staff shortages;
 - ii.** as a punitive action;
 - iii.** where mechanical means of bodily restraint is also in use;
 - iv.** solely to protect property;
 - v.** as a substitute for less restrictive interventions.
- 10.2 a)** Each approved centre must have a written policy in relation to the use of seclusion which must include sections which identify:
 - i.** who may initiate, and who may carry out, seclusion;
 - ii.** the provision of information to the person which must include information about the person's rights, presented in accessible language and format; and
 - iii.** the safety, safeguarding and risk management arrangements that must be followed during any episode of seclusion.
- b)** The approved centre must maintain a written record indicating that all staff involved in the use of seclusion have read and understand the policy. The record must be available to the Mental Health Commission upon request.
- c)** The approved centre must review its policy on seclusion as required and, in any event, at least on an annual basis.

- 10.3** Each episode of seclusion must be reviewed by members of the multidisciplinary team involved in the person's care and treatment and documented in the person's clinical file as soon as is practicable and, in any event, no later than five working days (i.e. days other than Saturday/Sunday and bank holidays) after the episode of seclusion. The review must include the following:
- i.** the identification of the trigger/antecedent events which contributed to the seclusion episode;
 - ii.** a review of any missed opportunities for earlier intervention, in line with the principles of positive behaviour support;
 - iii.** the identification of alternative de-escalation strategies to be used in future;
 - iv.** the duration of the seclusion episode and whether this was for the shortest possible duration;
 - v.** considerations of the outcomes of the person-centred debrief, if available; and
 - vi.** an assessment of the factors in the physical environmental that may have contributed to the use of seclusion.
- 10.4** The multidisciplinary team review must be documented and must record actions decided upon, and follow-up plans to eliminate, or reduce, restrictive interventions for the person.
- 10.5** Every approved centre that uses, or permits the use of, seclusion must develop and implement a reduction policy which must be published on the Registered Proprietor's website. This policy must:
- i.** clearly document how the approved centre aims to reduce or, where possible eliminate, the use of seclusion within the approved centre;
 - ii.** address leadership, the use of data to inform practice, specific reduction tools in use, development of the workforce, and the use of post incident reviews to inform practice;
 - iii.** clearly document how the approved centre will provide positive behaviour support as a means of reducing or, where possible eliminating, the use of seclusion within the approved centre.
- 10.6** The Registered Proprietor has overall accountability for the reduction policy. The Registered Proprietor must appoint a named senior manager who is responsible for the approved centre's reduction of seclusion.
- 10.7** All information gathered regarding the use of seclusion must be held in the approved centre and used to compile an annual report on the use of seclusion at the approved centre. This report, which must be signed by the Registered Proprietor Nominee, must be made publicly available on the Registered Proprietor's website within six months of the end of the calendar year and be made available, upon request, to the public. The annual report must contain:
- i.** aggregate data that must not identify any individuals;
 - ii.** a statement about the effectiveness of the approved centre's actions to reduce or, where possible, eliminate the use of seclusion;
 - iii.** a statement about the approved centre's compliance with the rules governing the use of seclusion;

- iv. a statement about the compliance with the approved centre's own reduction policy; and
- v. the data as specified in Appendix 3.

All approved centres must produce and publish an annual report on their use of seclusion. Where seclusion has not been used in the relevant 12-month period, then points i and ii above must only be reported on.

10.8 A multidisciplinary review and oversight committee, which is accountable to the Registered Proprietor Nominee, must be established at each approved centre to analyse in detail every episode of seclusion. The committee must meet at least quarterly and must:

- i. determine if there was compliance with the rules governing the use of seclusion for each episode of seclusion reviewed;
- ii. determine if there was compliance with the approved centre's own policies and procedures relating to seclusion;
- iii. identify and document any areas for improvement;
- iv. identify the actions, the persons responsible, and the timeframes for completion of any actions;
- v. provide assurance to the Registered Proprietor Nominee that each use of seclusion was in accordance with the Mental Health Commission's Rules; and
- vi. produce a report following each meeting of the review and oversight committee. This report must be made available to staff who participate, or may participate, in seclusion, to promote on-going learning and awareness. This report must also be available to the Mental Health Commission upon request.

10.9 The Registered Proprietor has overall accountability for the use of seclusion in the approved centre.

11. STAFF TRAINING

11.1 All staff who participate, or may participate, in the use of seclusion must have received the appropriate training in its use and in the related policies and procedures.

11.2 Each approved centre that uses seclusion must implement a policy and have procedures in place for the training of all staff involved in seclusion. This policy must include, but is not limited to, the following:

- a) Who will receive training based on the identified needs of persons who are secluded and staff
- b) The areas to be addressed within the training programme, including training in:
 - i. alternatives to seclusion;
 - ii. trauma-informed care;
 - iii. cultural competence;
 - iv. human rights including the legal principles of restrictive interventions;
 - v. the prevention and therapeutic management of violence and aggression (including "breakaway" and de-escalation techniques);

- vi. positive behaviour support including the identification of causes or triggers of the person's behaviours including social, environmental, cognitive, emotional, or somatic.
- c) The identification of appropriately qualified person(s) to give the training; and
- d) The mandatory nature of training for those involved in seclusion.

11.3 A record of attendance at training must be maintained.

12. THE USE OF CLOSED-CIRCUIT TELEVISION (CCTV)

12.1 Where CCTV or other monitoring devices are installed in seclusion rooms their use is in addition to and does not replace the provisions of Section 5 'The Monitoring of the Person during Seclusion'.

12.2 Where CCTV or other monitoring devices are used, the approved centre must:

- a) Ensure viewing is restricted to designated personnel as per approved centre policy;
- b) Ensure that it is evident and clearly labelled;
- c) Ensure that it is incapable of recording, is incapable of storing a person's image in any format, and is incapable of transmitting images other than to the monitoring station being viewed by the staff member responsible for the care and treatment of the person;
- d) Stop using it if the person starts to act in a way which compromises the person's dignity; and
- e) Have a clear written policy in relation to its use.

12.3 An approved centre must ensure that it discloses the existence and usage of electronic monitoring (e.g. CCTV) to persons being cared for and/or their representatives and the Mental Health Commission during the inspection of the approved centre or at any time on request.

13. CHILDREN

In addition to sections 3-12 which apply to all persons, the following rules apply in approved centres providing care and treatment for children. Children are particularly vulnerable to trauma and harm as a result of restrictive interventions. Seclusion can have particularly adverse implications for the emotional development of a child. These points must be taken into account in any decision to seclude a child.

13.1 Upon admission to an approved centre that uses seclusion as a restrictive intervention on children, a documented risk assessment must be carried out by a registered medical practitioner or registered nurse. This must show that careful consideration has been given to the potential effects of secluding a child or adolescent, having regard to the physical status and emotional development of the child, and their particular vulnerability to trauma and harm as a result of restrictive interventions. The outcome of the risk assessment shall determine if seclusion can be safely used or not.

- 13.2** Children must have the reasons for, likely duration of, and the circumstances which will lead to the discontinuation of seclusion explained in a way that the child can understand and in a format that is appropriate to their age. A record must be maintained of this communication and clearly outline how it met the child's individual communication needs.
- 13.3** An approved centre secluding a child must ensure the child's parent or guardian is informed as soon as possible of the child's seclusion, and the circumstances which led to the child being secluded. The child's parent or guardian must also be informed when the episode of seclusion has ended.
- 13.4** An approved centre secluding a child must have in place child protection policies and procedures in line with relevant legislation and regulations made thereunder.
- 13.5** An approved centre secluding a child must have a policy and procedure in place addressing appropriate training for staff in relation to child protection.

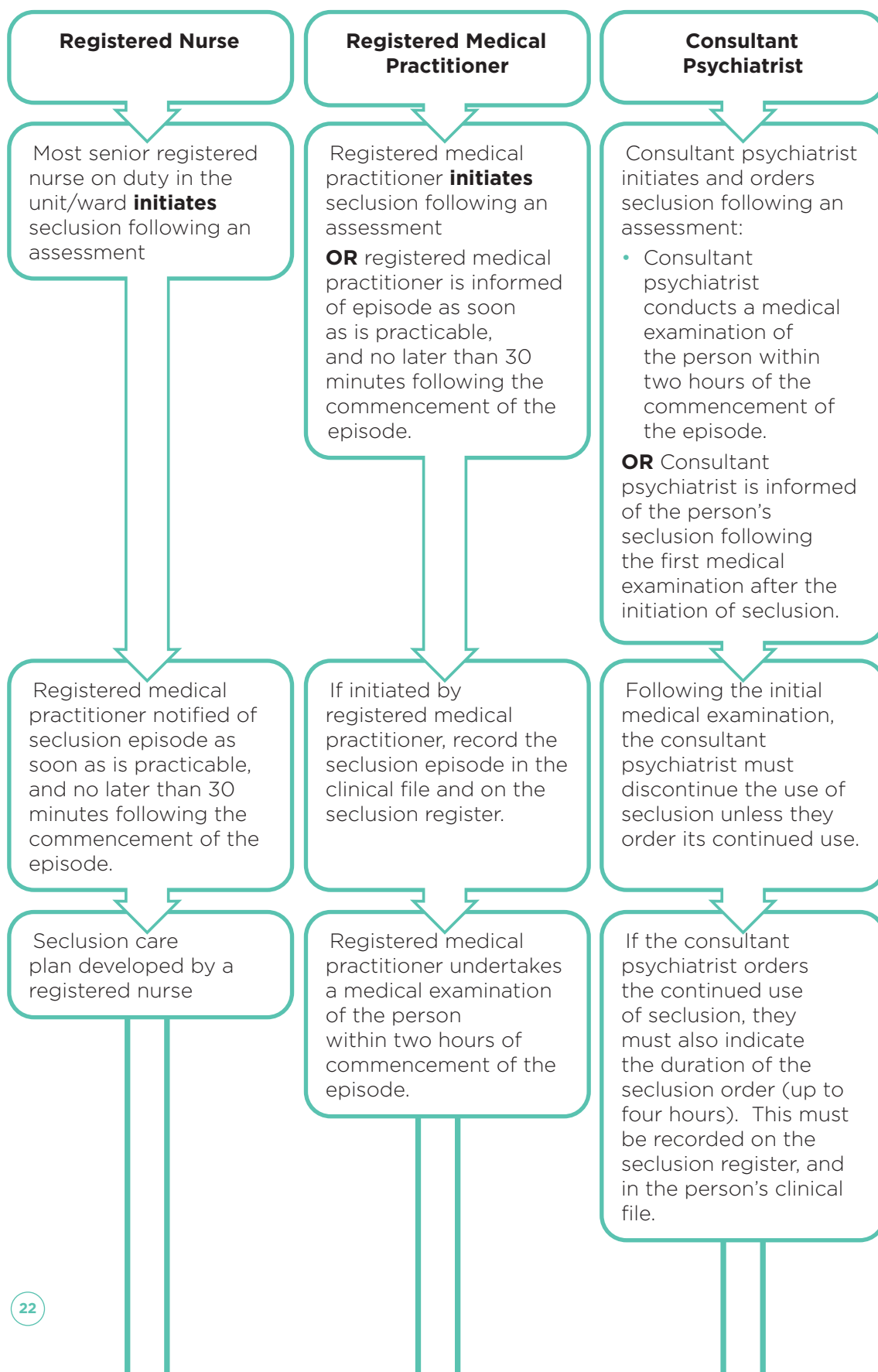
APPENDICES

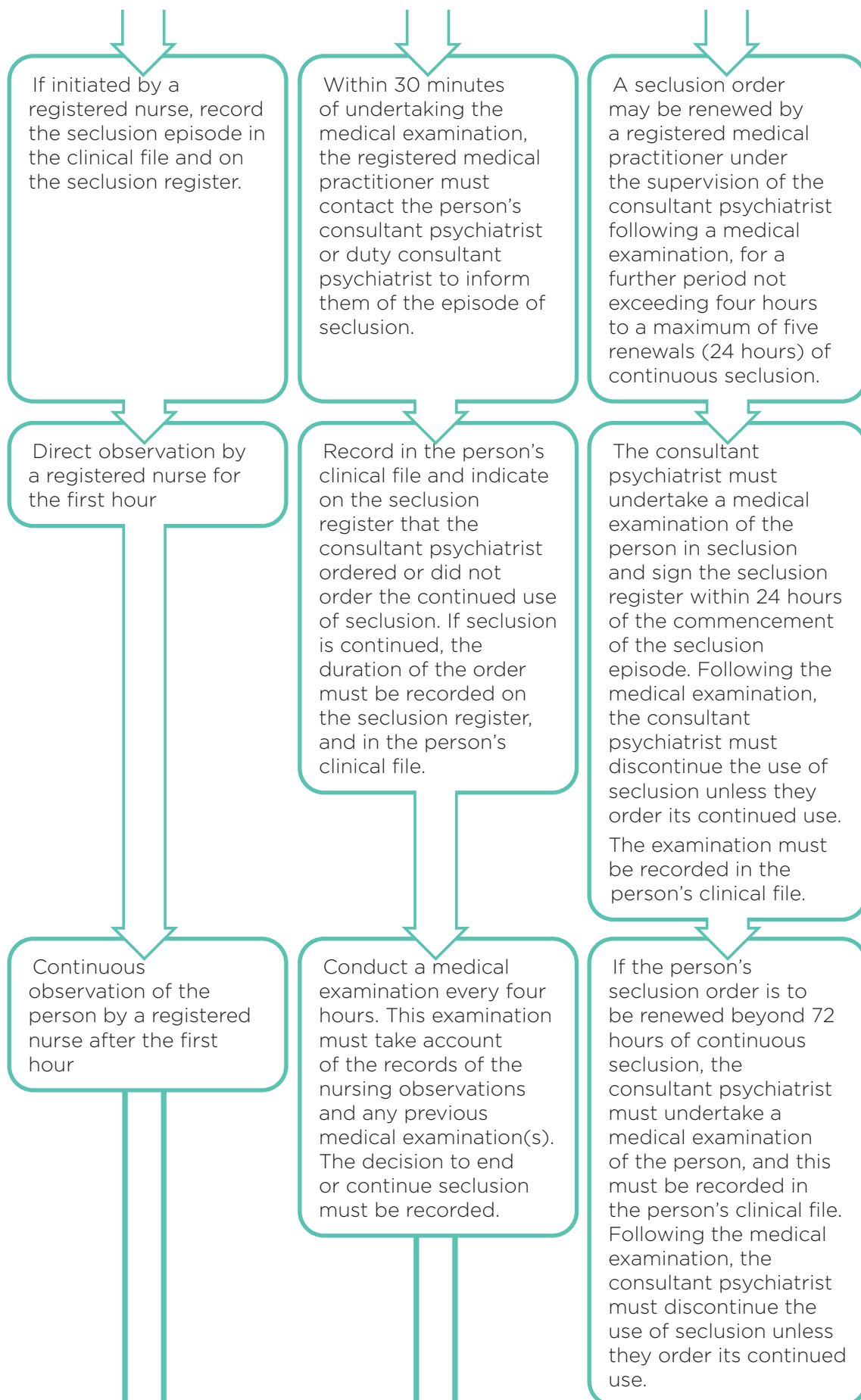
Appendix 1 Key Steps in the Seclusion Process

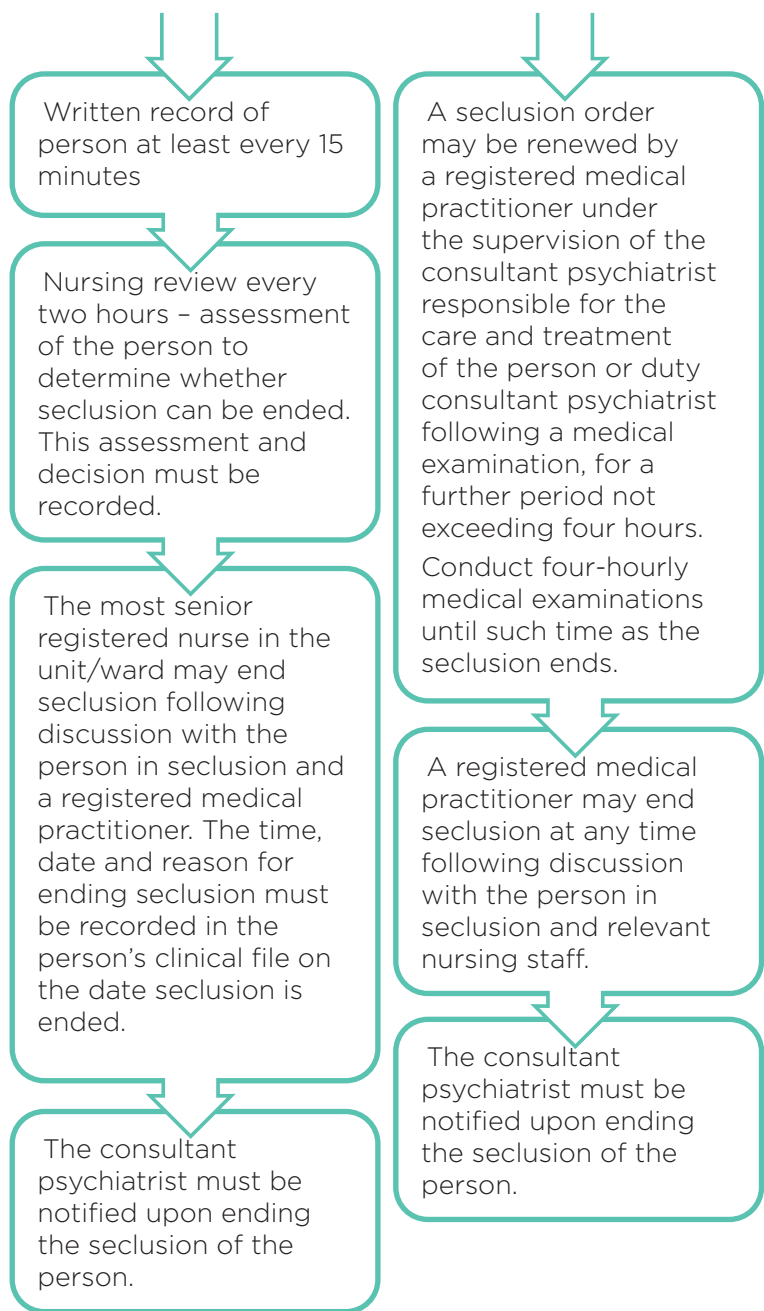
Appendix 2 Register for Seclusion

Appendix 3 Data required for the Annual Report

APPENDIX 1 KEY STEPS IN THE SECLUSION PROCESS (BY ROLE)







APPENDIX 2 SECTION 69 - REGISTER FOR SECLUSION

Person's Details	
1. First Name:	2. Surname:
3. Date of Birth: ____/____/____ (dd/mm/yyyy)	4. Gender: Male <input type="checkbox"/> Female <input type="checkbox"/> Other <input type="checkbox"/>
5. Person's Medical Record Number:	

Location	
6. Approved Centre Name:	7. Unit/ward Name:

Seclusion Details	
8. Seclusion Order Type:	First seclusion order <input type="checkbox"/> Renewal order* <input type="checkbox"/>
<p>As per Rule 3.8, a seclusion order shall last for a maximum of four hours. A renewal order must be made if it is necessary to renew the episode of seclusion beyond four hours.</p> <p><i>*If renewal order, please complete sections 9-10, 12 and 23-25 only. 23 is applicable to renewal orders only.</i></p>	
9. Date seclusion episode commenced: ____/____/____ (dd/mm/yyyy)	10. Time seclusion episode commenced: ____:____ (24hr clock e.g. 2.41pm is written as 14.41)
11. Who initiated seclusion:	
Name (print): _____ Job title (print): _____	
Signed: _____	

12. Why is seclusion being ordered or renewed?

Immediate threat of serious harm to self

Actual harm caused to self

Immediate threat of serious harm to others

Actual harm caused to others

Other (please specify) _____

Please provide further details on the above:

13: Did the medical examination of the person take place within two hours of the commencement of the seclusion episode?

Yes No

If yes, please complete the following:

Name of the registered medical practitioner who conducted the medical examination:

Date and time of medical examination:

Date: ____/____/____ at ____hrs ____mins

Date and time that the consultant psychiatrist was contacted following the medical examination:

Date: ____/____/____ at ____hrs ____mins

**If no*, please provide further details:*

14. Alternative means of de-escalation attempted prior to the use of seclusion:

Verbal Intervention Medication offered/administered
Time Out/One to One Nursing/Observation Physical restraint
No alternatives attempted

Other (please specify) _____

Please provide further details on the above:

15. Was the person secluded in their own clothing?

Yes No

If no, please explain the reasons why this did not occur and what clothing was provided to the person:

16. Was a seclusion care plan developed and implemented for the person?

Yes No

If no, please explain the reasons why this did not occur:

17. Was the person's representative informed of the person's seclusion?

Yes No

If no, please explain the reasons why this did not occur:

Use of physical restraint/mechanical means of bodily restraint for immediate threat to self or others

18. Was mechanical means of bodily restraint used?

Yes No

If yes, complete the Register for Mechanical Means of Bodily Restraint for Immediate Threat to Self or Others

19. Was physical restraint used?

Yes No

If yes, complete the Clinical Practice Form for Physical Restraint

Initiation of seclusion by the most senior registered nurse in the unit/ward or a registered medical practitioner

20. Initiation:

Initiation of seclusion by the **most senior registered nurse** in the unit/ward **or a registered medical practitioner**:

If seclusion is initiated by the most senior registered nurse on duty in the unit/ward, or a registered medical practitioner, they must complete this section.

I _____ have assessed/examined _____ on

Date: ____/____/____ at ____ hrs ____ mins and I initiated the use of seclusion from

Date: ____/____/____ at ____ hrs ____ mins

Name (print): _____ Signed: _____

21. Order:

To be completed by the consultant psychiatrist responsible for the care and treatment of the person or the duty consultant psychiatrist

I _____ have been informed of the outcome of the medical examination of _____ on

Date: ____/____/____ at ____hrs ____mins and I order/do not order the use of seclusion from Date: ____/____/____ at ____hrs ____mins for no later than ____hrs ____mins

Name (print): _____ Signed: _____

Date: ____/____/____ at ____hrs ____mins

Initiation of seclusion by a consultant psychiatrist:**22. Initiation and Order:**

I _____ have assessed/examined _____ on

Date: ____/____/____ at ____hrs ____mins and I initiated and ordered the use of seclusion from

Date: ____/____/____ at ____hrs ____mins for no later than ____hrs ____mins

Name (print): _____ Signed: _____

Renewing/Ending Seclusion***Applicable to a renewal order only:*****23. The seclusion order has been renewed and ordered under the supervision of the:**

Please tick as appropriate and sign below:

Consultant psychiatrist responsible for the care and treatment of the person

Duty consultant psychiatrist

Name (print): _____ Signed: _____

Date: ____/____/____ at ____hrs ____mins

24. Seclusion ended **Seclusion renewed***

Who ended or renewed seclusion:

Name (print): _____ Signed: _____

Date seclusion ended / renewed: ____/____/____ (dd/mm/yyyy)

Time seclusion ended / renewed: ____ : ____ (24 hr clock e.g. 2.41pm is written as 14.41)

** If seclusion is renewed, a new entry on the Register for Seclusion and an Order must be completed.*

To be completed by the person who ended/renewed seclusion

25. Did the seclusion episode result in any injury to the person?

Yes No

If yes, please provide further details:

APPENDIX 3

DATA THAT IS REQUIRED TO BE PUBLISHED AS PART OF THE APPROVED CENTRE'S ANNUAL REPORT ON THE USE OF SECLUSION

- 1 The total number of persons that the centre can accommodate at any one time*
- 2 The total number of persons that were admitted during the reporting period*
- 3 The total number of persons who were secluded during the reporting period*
- 4 The total number of seclusion episodes
- 5 The shortest episode of seclusion
- 6 The longest episode of seclusion

**Where this number is five or less the report must state "less than or equal to five"*



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