OBSERVATION POLICY

KEY AREAS

- The primary aim of observation is to engage positively with the patient; observation should be seen as an integral part of a therapeutic care plan. The purpose of observation is to ensure the safe and sensitive monitoring of the patient's behaviour and mental well being, enabling a rapid response to change, whilst at the same time fostering therapeutic relationships between staff and patient.

- This policy is based upon recommendations from NICE Guideline 25 (2005) and is intended to address the mental health needs of patients who are considered to be vulnerable or at risk of suicide, self harm or harm to others.

Staff Responsibilities

- Registered staff have a responsibility to:
  - Complete observation care plan for their named patient and for other patients in their care as the need arises.
  - Inform each patient of the level of observation they have been identified and the reasons for this.
  - Review any patient's level of observation based on clinical need/risk assessment (increase/decrease).
  - Ensure that the observation care plan is implemented.
  - Review the care plan on a regular basis as identified in the care plan.
  - Complete documentation as specified.

Staff Responsibilities

- Non registered staff have a responsibility to:
  - Be familiar with and implement to the observation care plan for each individual in their care.
  - Complete documentation contemporaneously as specified.
  - Report any relevant information to assist the effective review of patients' level of observation.

Categories Of Observation

- Nice Guideline 25 (2005): “the short term management of disturbed / violent behaviour in psychiatric inpatient settings and emergency departments’, recommends that the following terminology should be adopted across England and Wales.
- Northumberland Tyne & Wear NHS Trust will adopt this terminology.
  - General Observation
  - Intermittent Observation
  - Within Eyesight Observation
  - Within Arms Length Observation

Categories Of Observation (cont'd)

- In line with NICE Guidance 25 (2005) observation above a general level should be considered if any of the following are present:
  - History of previous suicide attempts, self-harm or attacks on others.
  - Hallucinations, particularly voices suggesting harm to self or others.
  - Paranoid ideas where the patient believes that other people pose a threat.
  - Thoughts or ideas that the patient has about harming themselves or others.

Categories Of Observation (cont'd)

- Self control is reduced.
- Past or current problems with drugs or alcohol.
- Recent loss.
- Poor adherence to medication programmes or non-compliance with medication programmes.
- Marked changes in behaviour or medication.
- Known risk factors including absconding from hospital (going missing from the ward).
- Patient under age of 18 must be placed within eyesight observation.

General Observation

- This is the minimum level for all patients. It will therefore apply to the majority of patients who are considered to be **at minimal risk** of vulnerability, suicide, self harm or harm of others.

- The patient's care plan and medical notes should specify the time frame at which the general observation should be carried out both during the day and at night **e.g. hourly, two hourly, mealtimes.**

Intermittent Observation

- This level is appropriate for patients '**potentially, but not immediately'**, at risk of disturbed/violent behaviour, vulnerability, suicide, self harm and may include those who have previously been at risk but are in the process of recovery.

- A specific observation care plan is required that details the exact intervals at which the observations should be carried out.

- The staff member responsible for carrying out intermittent observations over the prescribed period will have an awareness of the patients

Intermittent Observation (cont'd)

- Whereabouts at all times and will observe the patient at specified intervals ranging from 15 to 30 minutes and document this accordingly.

- Intrusion should be minimised and positive engagement with the patients should take place.

- Leave outside of the ward area should be considered in relation to Northumberland, Tyne & Wear NHS Trust Leave of Absence Policy, however responsibility for observations of the patient remains with a member of Trust staff at all times.

Within Eyesight Observation

- This level would usually be prescribed when the patient is felt to be a **significant risk** of vulnerability, suicide, self-harm or violence towards others and / or at risk of going missing from the ward.

- A specific observation care plan is required. The staff member responsible for carrying out the prescribed observations over the period must document an hourly brief summary of the patient behaviour and mental state.

- Issues of privacy and dignity, gender and environmental dangers should be discussed and incorporated into the care plan.

Within Eyesight Observation (cont'd)

- The care plan must stipulate what the observing nurses are required to do to support the individual during these situations.

- Consideration should be given to whether the patient may only require 'within eyesight observation' at specific times or within specific environments, e.g. meal times, using the bathroom and toilet within specific areas of the ward. This should be based on clinical risk assessment and incorporated into the patient's care plan.

- A designated nurse will provide one to one intervention throughout the whole period of prescribed 'within eye sight observation'.

Within Eyesight Observation (cont'd)

- The responsibility for within eyesight observation must under no circumstances be transferred to family members or friends.

- Leave outside of the ward area should be considered in relation to Northumberland, Tyne and Wear NHS Trust Leave of Absence Policy, however the patient will be escorted at all times by a member of Trust staff.

- If patients under 18 years of age are admitted to an adult environment they must be placed within eyesight observation or a higher level of observation on admission and for the duration of their stay (as per young people admitted to adult wards policy).

Within Arms Length Observation

- This level will be prescribed for patient's at the **highest levels of risk** of harming themselves or others and thus need to be nursed in close proximity.
- A designated nurse will provide a minimum of one to one intervention throughout the whole period of 'within arms length observation'. On specified occasions more than one member of staff may be necessary to carry out this level of observation. The care plan will stipulate the number of nurses required.
- A specific observation care plan is required. Issues of privacy, dignity and the consideration of gender in allocating staff, and environmental risks need to be discussed and incorporated into the care plan. The staff member responsible for carrying out the prescribed observations over the period must document an hourly brief summary of the patient behaviour and mental state.

Within Arms Length Observation (cont'd)

- Consideration should be given to whether observations can be reduced to 'within eyesight' once the patient has retired to bed and is asleep. This should be fully documented in the care plan.

- Leave outside of the ward area should be considered, only in exceptional circumstances in accordance with the appropriate risk assessment in place, in relation to Northumberland, Tyne and Wear NHS Trust Leave of Absence policy however the patient will be escorted by a member of Trust staff at all times.

General Principles

- Observation is an intervention that is used both for the short-term management of disturbed / violent behaviour and to prevent self harm (NICE Guidelines 25 2005). The key to all levels of observation is safety and protection from vulnerability.

- The least intrusive level of observation that is appropriate to the situation should always be adopted so that due sensitivity is given to a patient's dignity and privacy whilst maintaining the safety of the patient and / or those around them.

Observation at night

- Night time can be a high risk period for some patients and nationally there have been concerns raised about in-patients wards failing to address this period adequately (Rae 2010).
- Where observation levels are to be reduced during sleep, nursing staff must ensure that there is an appropriate assessment of the patients' sleep pattern and sleep behaviour so that the transition from sleeping to waking can be appropriately monitored, as can attempts to feign sleep. These issues should be discussed openly with patients as part of the risk assessment.
- Each individual patient should be assessed for the level of observations to be carried out at night time and this should be recorded on the patients risk management plan/care plan.
- Patients on general observation should be checked at least every hour during the night unless otherwise specified on their care plan. It is unfortunately not unknown for patients to harm themselves or kill themselves 'quietly' in bed during the night.

Observation at night?

- The consequences of safe observation practice will need to be explained and discussed with the patient who may be disturbed by the observing clinician entering their room or bedspace however this may be necessary in some cases as staff must ensure themselves that the patient is safe and well.

- Whilst it may be experienced as intrusive, staff should always check that they know that the patient is alive and not at immediate risk (e.g. from a ligature or serious injury), remembering that patients have also been known to die unexpectedly of physical causes at night.

- Discussion - How do we best seek a balance in maintaining patient safety at night whilst enabling patients to get a good night's sleep?

When Should Observation Levels Be Set

Assessing levels of observation is an integral part of the admission process, however all patients should be allocated level of observation as soon as they arrive on the ward.

Informing the Patient

Every effort should be made to inform and explain the level and procedure of observations using a variety of resources, any restrictions, why it is felt necessary and how long it is likely to be maintained to the patient concerned and, where appropriate, be communicated with the patient approval to the to the nearest relative/carer/friend. Patients should be offered a copy of their care plan detailing observations and this should also be communicated with the patient approval to the to the nearest relative/carer/friend

Record Keeping

- The observation levels prescribed must be recorded by both medical and nursing entries into the patient record. An individualised care plan should also be drawn up with the involvement of the patient where appropriate.

Who Should Carry Out the Observation

- It is the responsibility of the nurse-in-charge to ensure that observations are carried out according to the agreed level.
- The staff member responsible for carrying out within eyesight and within arms length observation will usually:
  - Be a Registered Nurse or a Support Worker or a final year student nurse who has been deemed competent by the Nurse in Charge. Appendix C must be completed for all bank / agency staff in all cases.
  - The patient views and needs should be taken into account when allocating staff to undertake observations

Reviewing Levels of Observation

- Where a patient is subject to a level of observation above general, the continued need for this should be reviewed at a minimum of every 24 hours, or more frequently if required by the nurse-in-charge and a doctor and documented in the patient's notes.

- For arms length observation there should be three reviews a day by nursing staff, two during the day and one at night and this will be documented in the patients notes.

- Any decision to increase levels of observation should be made by the multidisciplinary team wherever possible, however where necessary qualified nursing staff have the authority (and professional duty) to increase the level of observations in response to urgent changes in need, state, or condition. The increase in the level of observation should be communicated to the patient psychiatrist/on call doctor as soon as possible.

Reviewing Levels of Observation (cont'd)

- Decisions to reduce the level of observation will normally be taken jointly between the patient's Consultant Psychiatrist (or designated deputy) and a first level Registered Nurse.
- However if there has been prior documented agreement between the multidisciplinary team, then a registered nurse who has undertaken a competency based assessment can decide to reduce the level of observation with a clear rationale for this decision being given should be documented.

Reviewing Levels of Observation (cont'd)

- Whenever the level of observation has been reviewed a rationale should be recorded in the patient's notes by a member of the multi disciplinary team and the patient's individualised care plan by the nurse-in-charge.
- Wherever the level of observation changes, a new Observation Record should be used and a record of review documented in the patients notes. The nurse-in-charge should also ensure the rest of the care team are informed of the change in the level of observation.

Competency Assessment Observation