Additional Observations of Patients at Risk of Harm Procedure

Effective: 19 December 2016

1. Guiding Principles

The Albany Acute Psychiatric Unit (APU) strives to provide safety for patients, visitors and staff, within the least restrictive environment.

This procedure aims to provide information on the use of additional observations for patients at risk of harm to themselves or others or harm from others on the APU.

The key principles of this procedure are:

- The purpose of additional observations is to recognise, and wherever possible, prevent and therapeutically manage disturbed/violent behaviour.
- Explanation to the patient and Carer why a particular level of observation is recovery focused and involving the Patient and Carer wherever possible in the care planning is required.
- The decision regarding the category of observation assigned must be based on clinical need and documented risk assessment.
- Cultural needs are to be considered when initiating patient observations and the Aboriginal Mental Health workers to be consulted as required.
- In order to maintain a safe environment, staff are to ensure patients are observed at intervals sufficient to address the needs identified in the risk assessment and documented in care plans .
- Additional observations may be perceived as intrusive or custodial rather than a therapeutic intervention, therefore staff should focus on developing rapport and building a relationship with the patient rather than just providing supervision.
- In order to improve assessment of the patient's mood and behaviour, staff should engage positively with the patient. This will assist in identifying any patterns in disturbed and/or violent behaviour as part of treatment planning.
- When formulating decisions regarding individual patient observations, the multi-disciplinary team should balance the need for privacy and dignity (including any gender requirements) with identified safety needs, the needs of others and environmental risks.
- Staff must ensure that legal and reporting requirements for patients detained under the Western Australian *Mental Health Act, 2014* (The Act) are adhered to at all times.

2. Procedure

2.1 Assessment

Risk Assessment

Upon admission and at regular intervals thereafter, patient risk should be formally assessed. Newly admitted patients may require a period of additional observations while they undergo risk assessment.

If the patient presents with an identified risk of disturbed/violent behaviour (to self or others) that has not been sufficiently reduced by positive engagement the behaviour may indicate that additional observations should be considered as part of treatment planning and risk containment. Any decision to increase observations should be balanced with the potentially distressing effect of this outcome.

Environment

Individualised care planning should include consideration of the most suitable environment for the patient's care e.g. removing and storing items associated with risk from the patient or the use of the less stimulating/more secure area.

Legal Authority for Intervention

If a voluntary patient is assessed as needing additional 'within eyesight'/'within arm's length' observations, an assessment under the 2014 Mental Health Act should be considered by the treating team.

Collaborative Care

Wherever possible risk assessment should be carried out by the multi-disciplinary team and include a face-to-face interview with the patient and the involvement of their family/carer and/or nominated person (as appropriate). Where consultation in formulating the initial care plan is not immediately possible, consultation and collaborative care planning should occur as soon as it is safe to do so.

2.2 Assigning and reviewing a level of observation

Assigning an observation level

There are four levels of observation (see section 3, definitions). Decisions on which level to implement are to be made following the completion of a documented risk assessment and input from the multi-disciplinary team:

- General (hourly) observations as a minimum for all patients.
- intermittent observations (randomly a number of times in the hour)
- constant observations – line of sight (within eyesight and accessible at all times)
- or constant observations – within arm's length at all times

The specific requirements of the staff providing the additional observations are to be documented in the care plan.

Increasing the level of observation:

Individual clinical staff can increase the frequency/level of observation at any time it is clinically indicated. This should be based on their professional judgment of the presenting risk of the patient. The Shift Coordinator must be consulted immediately regarding the change of category and the rationale for the change. Consultation with the medical team must occur as soon as practicable.

If the level of observation is increased, an entry must be made in the progress notes detailing the change in observation and the rationale. Any requirement for increased staff is to be determined by the Shift Coordinator after consultation with the APU Nurse Unit Manager (or the bed manager after hours). It is preferable that additional observations are provided by nursing staff rather than external guards unless the threat of potential violence indicates otherwise.

Reviewing / decreasing the level of observation:

The level of observation cannot be reduced without the authorisation of a psychiatrist.

For all patients subject to intermittent or constant observation, documented reviews should take place at the earliest opportunity. Reviews are to occur in response to an event or change in presentation or as a minimum on a daily basis at the multidisciplinary team handover. In exceptional cases where the need for additional observation is ongoing an appropriate review schedule can be planned and documented by the treating psychiatrist.

Reviews are to be documented in the patient's progress notes and if the observation level is changed it is to be documented in an updated care plan. A review of a patient's observation status occurs:

- when an adverse event takes place
- when there is a documented deterioration /improvement in the patient's mental state/level of risk
- prior to being granted leave
- prior to discharge
- no less than every 24 hours.

Environmental restrictions

In addition to the use of additional observation, consideration is to be given to searching the patient and their room/property to remove any items which can be used to harm the patient or others. Where required, staff are to remove and store any potentially harmful objects/property. With the exception of legally prohibited items, staff are to return the objects/property wherever appropriate as risks diminish (see Clinicians Guide to the 2014 Mental Health Act section 4.11 Search and seizure (Part 11, Division 2).

2.3 Care-planning

Collaborative care:

Wherever possible the patient and/or their family/carer and/or nominated person (as appropriate) should be involved in the development of the patient care-plan which includes the level of observation required. Staff are also to consider/take into account any Advance Health Care Directives.

The patient and their family/carer and/or nominated person should be offered the opportunity to indicate their agreement by signing the care plan. If the patient or their family/carer and/or nominated person disagree with the care plan their objections are to be recorded in the care plan and the patient and/or carer and/or nominated person offered a copy.

Legal Authority for Intervention

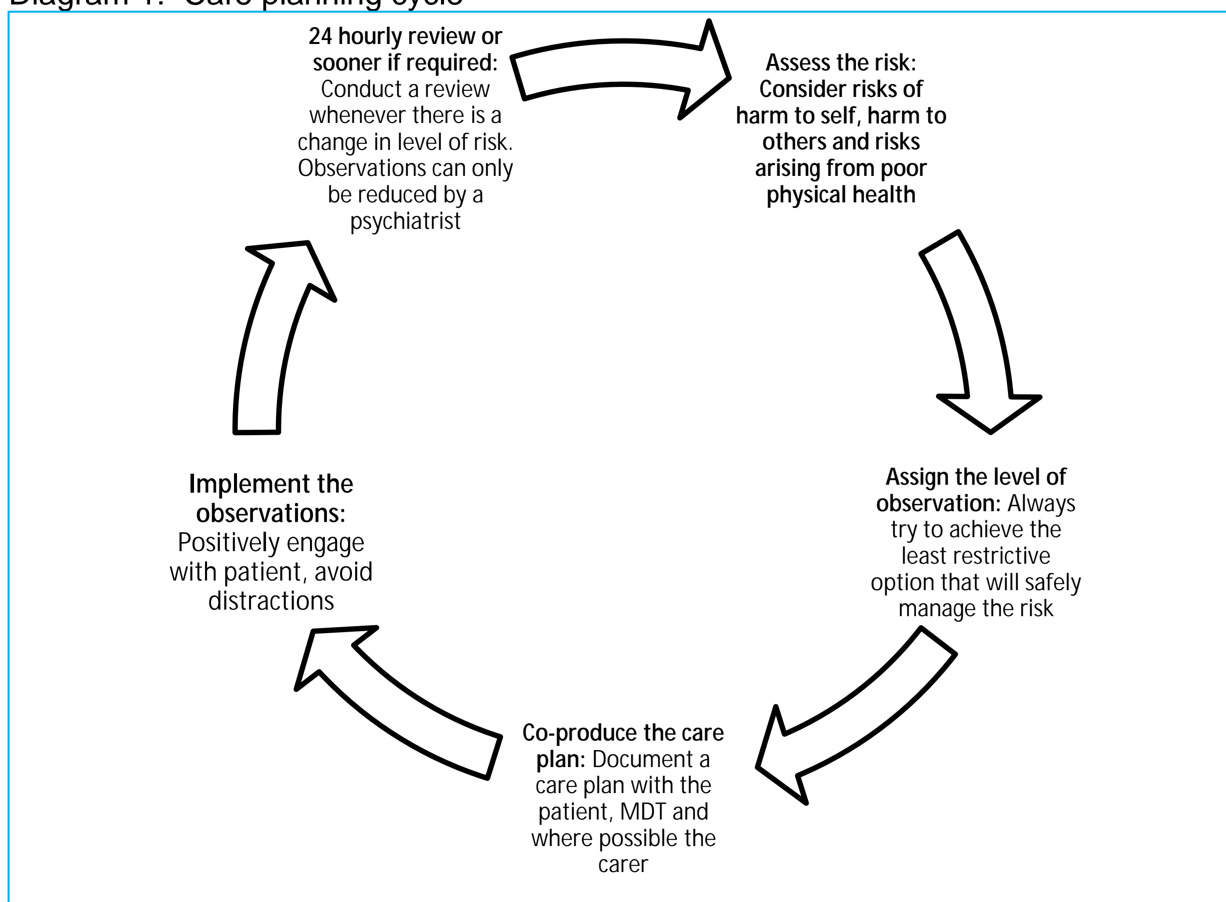
If an involuntary patient does not agree with the use of additional observations as detailed in the care-plan, they cannot refuse the additional observations being carried out. If a voluntary patient does not agree with the care plan, and staff consider there to be at risk without additional observations, a psychiatric review of their status under mental health act should be requested.

Care Plan Contents

The observation requirements documented in the care are to include:

- the number of staff required to observe the patient, and the level of observations each staff member should maintain and the period of duration.
- environmental boundaries (e.g. location within the ward – open/secure area) and the level of observation for activities such as showering/using the toilet etc.
- strategies for engaging the patient in conversation/therapeutic activity
- interventions to reduce/manage risk of self-harm/suicide and disturbed//violent behaviour, including strategies that the patient themselves finds useful sourced from assessment or previous recovery planning documents
- food/fluid, physical health, cultural and spiritual needs
- any situations/factors where a different/variable level of observation has been agreed and documented by the treating team
- date and time of next review (the review should be done sooner than the documented date and time if the patients' presentation changes).

Diagram 1: Care planning cycle



2.4 Undertaking additional observations

Competency assessment

Staff undertaking additional observations are to have completed the additional observations of patients at risk competency assessment with their line manager. See Appendix 1.

Patient engagement

Whilst undertaking additional observations of patients at risk, staff are to engage positively with the patient. It is not therapeutic for staff to sit in the corridor/area ignoring/not engaging with the service user. This should only occur in exceptional circumstances, not as a matter of course. Staff are only to carry out activities related to observation and the care/management of the patient. Staff are not to engage in activities which may distract attention from the observation process or result in the staff member leaving the documented observation setting. This includes during the night when staff should monitor the patients' breathing.

Handing over

The member of staff ending a period of additional observations should give a verbal handover (being mindful of confidentiality) to the staff member assuming the responsibility at shift changeover. Wherever possible this should involve the patient and their family/carer and/or nominated person (as appropriate). At shift change, both staff are to make their first/last General Observation check together.

Night time observations

At night the position of the service user on all levels of observation must be monitored and recorded. If the observation chart indicates that they have not changed position for two (2) hours, staff must consider whether to review the service user's wellbeing. A sleeping patients' respiration is to be observed to assess for normal breathing as per the guidance in the Australian Resuscitation Guidelines. Look, listen and if necessary feel for breathing. In the absence of normal breathing follow the deteriorating patient policy and, if required, treat as a Code Blue emergency.

Missing patients

In the event a patient cannot be located, staff are to inform the Clinical Nurse Shift Coordinator and the Missing or Suspected Missing Person Procedure is to be followed.

2.5 Record Keeping

Risk assessment

Prior to commencement of additional observations a Risk Assessment and Management Plan is to be completed.

Care Plan

The Treatment, Support and Discharge Plan is to be used to record the plan of care developed by the patient, multi-disciplinary team and where possible family/carers and/or nominated person.

Progress notes

Reviews of additional observations are to be recorded in the progress notes.

Visual observation form

Observations are to be recorded on the visual observation chart.

The visual observation form is to include:

- a description of the clothing worn by the patient
- the reason for the observation category and category level
- date, time and patient location
- a summary of the observation during the period of staff allocation
- any special requirements and /or notable events e.g. patient being interviewed
- The allocated staff member is to note on the visual observation form his/her full name and designation (printed) and sign the form.

3. Definitions

General observations	Staff must sight and observe all patients at intervals of no less than 60 minutes. This is the minimum acceptable level for all service users. The patient's location is to be known at all times but they are not necessarily within sight.
Intermittent observations	The patient is to be randomly checked an agreed number of times per hour
Constant observations – line of sight	The patient is to be within eyesight and accessible at all times, day and night (unless otherwise agreed and care-planned by the MDT)
Constant observations – arm's length	Staff are to maintain constant observations within arm’s length (unless otherwise agreed and documented in a care plan by the MDT)

4. Roles and Responsibilities

Manager GSMHS	Responsible for overall management of the service.
Clinical Director	Responsible for overall clinical governance of the service.
Consultant Psychiatrist	Responsible for ensuring that a documented management plan is in place which includes arrangements for the review of additional observations out-of-working hours (including delegates who can reduce observation levels) and circumstances where the level of observation may be varied.
Doctors	Expected to take part in the MDT reviews of additional observation.
Nurse Unit Manager	Responsible for ensuring policy awareness and completion of the Assessment of Competence (Appendix 1) for each staff member and that a list of staff deemed 'competent' to carry out additional observations is maintained and is accessible to CN's.
Clinical Nurse/Shift Coordinator	Responsible for ensuring staff allocated to undertake observations have been assessed as competent to do so.
All APU Staff	Responsible to adhere to this procedure.

5. Compliance

It is a requirement of the WA Health Code of Conduct that employees "comply with all applicable WA Health policy frameworks."

A breach of the Code may result in Improvement Action or Disciplinary Action in accordance with the WA Health Discipline Policy or Breach of Discipline under Part 5 of the *Public Sector Management Act*.

WACHS staff are reminded that compliance with all policies is mandatory.

6. Evaluation

Monitoring of compliance with this procedure is to be reviewed every five years.

7. Standards

National Safety and Quality Health Care Standards : 6.1.2, 6.2.1, 6.5.1, 9.1.1, 9.1.2, 9.3.1, 9.4.1, 9.6.2, 9.7.1, 9.9.1

EQuIPNational Standards : 12.1.112.10.1

National Standards for Mental Health Services : 1.1, 2.1, 2.2, 2.3, 2.6, 2.8, 2.10, 2.11, 3.1, 6.5, 6.7, 6.8, 6.9, 6.10, 6.11, 6.16, 7.1, 7.2, 7.5, 7.10, 7.11, 7.12, 10.4.1, 10.4.2, 10.4.3, 10.4.4, 10.4.5, 10.4.8, 10.5.2, 10.5.5..

8. Legislation

Mental Health Act 2014

9. References

Australian Resus Council Guidelines

Australian Commission on Safety and Quality in Health Care: National Clinical handover Initiative

National Mental Health Standards 2010

National Safety and Quality Service Standards

Clinicians' practice Guide to the Mental Health Act 2014

10. Related Forms

GS MR 148B Visual observation chart

11. Related Policy Documents

Princess Margaret Hospital for Children Clinical Deterioration Response – coverage PMH/WACHS

WACHS Adult Psychiatric Inpatient Services Referral, Admission, Assessment, Care and Treatment Policy

12. Related Policies

WA Health Clinical Deterioration Policy, February 2014. Perth

Mental Health Division, WA Department of Health (2008) Clinical Risk Assessment and Management (CRAM) in Western Australian Mental Health Services: Policy and Standards Perth.

This document can be made available in alternative formats on request for a person with a disability

Contact:	Janette Kostos, Manager, GSMHS		
Directorate:	GS Mental Health Service	TRIM Record #	ED-CO-13-69327
Version:	2.00	Date Published:	20 December 2016

Copyright to this material is vested in the State of Western Australia unless otherwise indicated. Apart from any fair dealing for the purposes of private study, research, criticism or review, as permitted under the provisions of the *Copyright Act 1968*, no part may be reproduced or re-used for any purposes whatsoever without written permission of the State of Western Australia.

Appendix 1

CONFIDENTIAL

APU Assessment of Nursing Competence in Additional Observations

Name of Staff Member being assessed: ______________________Date:____________

Line Manager:_____________________Assessor's Name:________________________

Date of last appraisal in additional observations:_______________________________

Arrangements for clinical supervision in place: Yes / No (please circle) If 'No' note reason:

…………………………………………………………………………………………………

…………………………………………………………………………………………………

If Yes - Clinical Supervisor Name:______________________

If No - Future arrangement for clinical supervision: ……………………………………………

Assessment:

Competency Required	Yes	No	Agreed Action Plan and deadline if answered No
KNOWLEDGE: Staff member has read and understood the following:			
Patient Observation Procedure			
Deteriorating Patient Policy			
Missing or suspected missing inpatient procedure			
RISK IDENTIFICATION: Staff member able to:			
identify environmental risk factors (including ligature points)			
identify potential risk behaviours			
identify how to manage attempts/actual self-harm			
attempts to leave/violence and aggression			
COMMUNICATION: Staff member able to:			
describe what information is required in handing over responsibility for additional observations			
describe what should be recorded in the health record following observation of a service user			

Competency Required	Yes	No	Agreed Action Plan and deadline if answered No
OBSERVATION: Staff member able to:			
identify changes/behaviours and their implications			
describe what and how to assess during observations			
THERAPEUTIC INTERVENTION: Staff member able to:			
identify skills and resources required to perform observation as an intervention			
describe how to reduce the patients' negative perceptions of being observed			
GENERAL (HOURLY) OBSERVATION: Staff member can describe:			
what is meant by 'general observation'			
the correct recording procedure for general observations			
INTERMITTENT OBSERVATION: Staff member can describe:			
what is meant by 'intermittent observation'			
the correct recording procedure for intermittent observations			
the procedure for implementing and discontinuing intermittent observations			
situations in which intermittent observations may be used			
WITHIN EYESIGHT OBSERVATION: Staff member can describe:			
what is meant by 'within eyesight observation'			
the correct recording procedure for within eyesight observations			
the procedure for implementing and discontinuing within eyesight observations			
situations in which within eyesight observations may be used			
WITHIN ARM'S LENGTH OBSERVATION: Staff member can describe:			
what is meant by 'within arm's length observation'			
The procedure for implementing and discontinuing within arm's length observation			
situations in which within arm's length observation may be used			
Overall Competency Confirmed			Date for completion of above actions and competency re-assessment

Signed Assessor: ________________ Signed Staff Member:________________

When complete, place on staff member's personal file and offer the staff member a copy for their portfolio