Patient Observation Procedure

Effective: 13 December 2016

1. Guiding Principles

1.1 The Broome Mental Health Unit (BMHU) / Mabu Liyan aims to provide safety for patients, visitors and staff, within the least restrictive environment.

1.2 This procedure provides information in relation to mental health risk assessment and observation categories for patients.

1.3 The decision regarding the category of observation assigned must be based on a clinical need and risk assessment. The Risk Assessment and Management Plan (RAMP) SMHMR 905 is used to inform the allocation of the observation category.

1.4 Patients must be observed at intervals that are sufficient to address needs identified in the risk assessment and subsequent care plans.

1.5 Based on the risk assessment, the observation of a patient through a bedroom door panel may not be sufficient to ensure patient safety.

1.6 Where possible, explain to the patient and carer why a particular level of observation is required and involve the patient in care planning.

1.7 Legal requirements for patients detained under the *Mental Health Act 2014* (MHA 14) must be adhered to at all times including patient observation where the patient is restrained or placed in seclusion.

1.8 Where a patient is restrained every thirty (30) minute medical assessment must occur as per the MHA 14.

1.9 Staff are to remind patients that night time, observations occur throughout the night.

1.10 Staff are to be mindful that when conducting night time observations, patient sensitivity may cause reaction and restimulate past trauma.

1.11 For all patients and or/carers including those who are of Aboriginal[1] origin or Culturally and Linguistically Diverse backgrounds, understanding is to be facilitated where appropriate by:

- 1.11.1 utilising leaflets/signs
- 1.11.2 using approved interpreter service
- 1.11.3 involvement of Aboriginal Mental Health Worker (AMHW)
- 1.11.4 involvement of carer, close family member or other personal support person.

1.12 There are four categories of patient observations. Consultation with the medical team must occur as soon as practicable where category variation is required. Individual clinical staff can, based on their professional judgement of patients presenting with risk factors, increase the frequency of observation. The Shift Coordinator must be consulted regarding the change of category and the rationale for the change as soon as possible.

[1] Within Western Australia, the term Aboriginal is used in preference to Aboriginal and Torres Strait Islander, in recognition that Aboriginal people are the original inhabitants of Western Australia. No disrespect is intended to our Torres Strait Islander colleagues and community.

1.13 The four categories are:

1.13.1 Staff must sight and observe the patients mental/physical presentation no less than every 60 minutes. Risk Assessment and Management Plan indicates low risk.

1.13.2 Staff must sight and observe the patients mental/physical presentation no less than every 30 minutes. Risk Assessment and Management Plan indicates moderate risk.

1.13.3 Staff must sight and observe the patients mental/physical presentation no less than every 15 minutes. Risk Assessment and Management Plan indicates high risk.

1.13.4 '1:1 Special' - Staff must sight and observe the patients mental/physical presentation continuously on a 1:1 basis. Patients under 18 years always require this category of observation until reviewed by Psychiatrist. Risk Assessment and Management Plan indicates high risk.

1.13.5 There are two '1:1 Special' categories. Both categories may be with or without toilet privileges. Staff are expected to engage the patient whilst a '1:1 Special' is in action. Categories are:

- In visual range
- At arm's length

These categories may be with or without toilet privileges.

2. Procedure

2.1 On admission, all patients are automatically placed on 15 minute observation until assessment is conducted by the Consultant Psychiatrist.

2.2 Patient Physical Observations

2.2.1 All patients are to have physical observations recorded on Adult Observation and Response Chart daily unless otherwise directed by the medical team. Any deviations from normal parameters must be reported to the medical team as soon as practicable and a management plan developed and documented in the patient health record.

2.3 Patient Visual Observations

2.3.1 Considerations When Allocating Visual Observations
Patient observation is a tool used for effective ongoing assessment of patient clinical presentation and dynamic factors associated with risk. The following examples are neither exhaustive nor prescriptive in content:

Mental presentation:

- Agitation
- Anger
- Anxious
- Responding to hallucinations
- Blunt affect
- Depressed mood
- Elevated mood

Physical presentation:
- Skin colour
- Breathing
- Sweating
- Movement
- Pacing
- Unsteady
- Signs of over sedation
- Staring
- Unusual body movements

- On admission, following clinical and risk assessment, the patient is assigned an observation category. Generally this will be Category 2 observations until reviewed by the medical team unless otherwise prescribed by the psychiatrist.
- Where a change is noted in the patient's mental /physical state, category observation level is to be reviewed and any change to the level is to be documented in the patient health record.
- The Shift Coordinator may increase the category level of observation following risk assessment but any reduction can only occur in consultation with the psychiatrist or delegate.

2.3.2 Process

- Initial category observation status is documented in the patient's health record and on the Mabu Liyan /BMHU Patient Journey Board
- Category observation is reviewed daily at the multidisciplinary team handover, and as required. These changes will be reflected in the patient's health record and on the Mabu Liyan /BMHU Patient Journey Board. Review of a patient's observation status also occurs:
  - when an adverse event takes place
  - when there is a deterioration /improvement in the patient's mental state
  - prior to being granted leave
  - prior to discharge.

2.3.3 Visual Observation Chart (BMHU MRK 7146)

- The visual observation chart is to include:
  - a description of the clothing worn by the patient, legal status and
  - observation category level
  - date, time, clinical state (e.g. awake, aggressive, calm etc.) and respiratory rate (when asleep or lying down resting)
  - any special requirements and /or notable events e.g. patient being interviewed.
- At commencement of shift, the allocated staff member is to note on the Visual Observation form, his/her full name (printed) and sign off each observation of the patient
- At shift change, both staff are to make their first and last observation together.

2.4 Observation Categories

2.4.1 CATEGORY '1' (observations at no less than 60 minute intervals; with restrictions to leave)

Risk assessment indicates no immediate or foreseeable danger to self or others. Staff must be aware of the patient's whereabouts, and sight the patient no less than 60-minute intervals, where the patient has not been granted leave, during both day and night time hours. If there is an alteration in level of risk, frequency of observation must be increased to reflect that risk.

The following examples of **Risk factors** are neither exhaustive nor prescriptive in content:

- Voluntary status with moderate evidence of risk
- Conversation and/ or behaviour suggest there may be some risk or danger to self or others
- Patient's physical status requires regular monitoring
- Intellectually impaired
- Near completion of a withdrawal regimen.

Staff actions

- Staff must physically sight the patient and observe the patient's mental/physical presentation unless the patient has been granted leave which is to be documented on the observation form.
- Staff may negotiate a verbal/written contract of personal safety if appropriate.

Patient Leave

- Patient leave, either for an external appointment or other commitment, is to be negotiated with the medical team for all patients.

2.4.2 CATEGORY '2' (observations at 30 minute intervals; restricted to Mabu Liyan /BMHU)

Risk assessment indicates moderate risk to self and others. Staff must be aware of the patient's whereabouts, and sight the patient no less than 30 minute intervals during both day and night time hours. If there is an alteration in level of risk, frequency of observation must be increased to reflect that risk.

Risk Factors are both static and dynamic. The following examples of **Risk factors** are neither exhaustive nor prescriptive in content and may include:

- Involuntary status
- Increased vulnerability to exploitation by others
- Angry about hospitalisation and treatment plan
- Ambivalent about hospitalisation and treatment plan
- Ambivalent about providing commitment to verbal/written contract regarding personal safety

- Disinhibited behaviour that may be a potential risk to patient
- Thought disordered
- Acute psychosis
- Cognitive impairment
- Patients physical status requires increased monitoring e.g. adverse effects to medication
- Undergoing a withdrawal regimen
- First 24 hrs following admission.

Staff Actions:

- Staff must physically sight the patient and observe the patient's mental/physical presentation.
- Where possible, staff may negotiate a verbal/written contract of personal safety at least twice daily if appropriate

Patient Leave:

- Patient leave, either for an external appointment or other commitment, is to be negotiated for all patients with the medical team.
- No leave is to be granted until the patient is reviewed by the medical team.
- During any leave granted, the patient must be accompanied by a staff member or carer.

2.4.3 **CATEGORY '3' (observations no less than 15 minute intervals)**
All HDU patients are placed under Category 3 observations or higher as clinically indicated. Risk assessment indicates increased risk to self or others. Staff must be aware of the patient's whereabouts, and sight the patient no less than 15 minute intervals during both day and night time hours. If there is an alteration in level of risk, frequency of observation must be increased to reflect that risk.

Risk Factors are both static and dynamic. The following examples of **Risk factors** are neither exhaustive nor prescriptive in content and may include:

- Involuntary or voluntary status with increased personal risk
- Verbalising thoughts of self-harm/ suicidal ideation/ harm to others with no plan
- Previous self-harm/ suicide attempts
- History of violence
- Recent losses e.g. bereavement, relationship breakdown
- Command hallucinations
- Risk of absconding
- Floridly psychotic and reluctant to respond to simple requests
- Physical status requires close monitoring
- High level of emotional distress/hopelessness

- Unwillingness for treatment and hospitalisation
- Cognitive impairment
- High level of disorganisation.

Staff Actions:

- Staff must physically sight the patient and observe the patient's mental/physical presentation.
- Safety contract is to be established where possible.
- Where the patient is sleeping, the respiratory rate is to be monitored and recorded on the visual observation form.
- Belts, shoelaces, plastic bags and any other items that may be used for self-harm purposes are removed and placed into safe keeping.
- Staff are to ensure that the patient is reviewed daily by the psychiatrist where possible.

Patient Leave:
Where a patient has escorted leave, they are to be accompanied by a staff member.

2.4.4 CATEGORY '4' (1:1 Special – Continuous Observation)

Risk assessment indicates that there is significant risk of danger to self or others. Patient has 1:1, 'arm's length' contact with assigned staff at all times. The assigned staff have no other duties.

Risk Factors are both static and dynamic. The following examples of **Risk factors** are neither exhaustive nor prescriptive in content and may include:

- Verbalising thoughts of self-harm/ suicidal ideation/ harm to others with plan.
- Sense of hopelessness about the future.
- Serious recent self-harm behaviour.
- Recent history of violence.
- Refusal to participate in treatment plan.
- Made attempts to abscond and is reluctant to remain in the unit.
- Patient's physical status continues to deteriorate and requires constant monitoring.
- Patient's mental state has deteriorated to the point where the patient is at significant risk from others.

Staff actions:

- A 1:1 special may be initiated by the Shift Coordinator, Clinical Nurse Specialist, Clinical Nurse Manager, medical officer or psychiatrist
- The Shift Coordinator is responsible for implementing the request for a 1:1 special as soon as practicable.

- The decision and its rationale must be documented in the patient's health record.
- To initiate a staff special, a comprehensive mental state assessment, including a risk assessment is to be completed.
- Mood, behaviour and any changes in mental status is to be recorded on the Visual Observations form.
- Where the patient is sleeping the respiratory rate must be monitored and recorded on the Visual Observation form

The criteria for a 1:1 special may include:

- risk of self-harm or suicide
- risk of absconding
- risk of exposure to environmental dangers
- risk of harm to others
- sexual vulnerability
- risk related to disorganised behaviour

Patient leave:

- Patients are only able to leave Mabu Liyan /BMHU in exceptional circumstances e.g. patient requires a CT Scan. This is determined by the clinical team. Two staff are to escort the patient.

1:1 Special

The following principles are to be adhered to when providing 1:1 special:

- The patient is to be observed by a designated staff member who does not have responsibilities for the observation or care of any other patient on the unit.
- The patient must be in close range at all times, or at a distance sufficiently close to be able to intervene to prevent or minimise harm or undesirable behaviour, with due regard to a patient's rights to privacy and dignity.
- The patient must remain on 1:1 special during staff handover, staff meal breaks and ward disturbances.
- Where risk assessment allows, the patient may be out of direct view on specified occasions, e.g. when using toilet and shower facilities. The staff member must remain outside the unlocked door and maintain verbal contact with patient.
- The staff member is not to leave the patient at any time, unless another staff member relieves them.
- The patient may only leave Mabu Liyan /BMHU under exceptional circumstances. Necessity for leaving Mabu Liyan /BMHU is to be decided by the clinical team. Two staff members are to escort the patient.

The allocated staff 1:1 special is responsible for:

- Remaining vigilant to:
  - any opportunities for the patient to engage in harmful behaviours
  - the potential of absconding
  - their own personal safety
  - maintaining the level of observation when the patient has visitor(s).
- Reporting any changes in the patient's mental or physical state that are of concern to the Shift Coordinator, who is to inform the medical team.
- Documentation in the patient health record including patient response to the 1:1 special.
- Self-monitoring their capacity to perform 1:1 special and communicating concerns to the CNS or Shift Coordinator.
- Providing handover to the incoming 1:1 special including:
  - current mental and physical state
  - identified problems
  - specific risk factors
  - prescribed nursing actions.

Resourcing

- The need for a 1:1 special is to be reviewed at least once every 24 hours by the psychiatrist. The decision to continue or cease 1:1 special is to be documented in the patient health record.
- In an effort to maintain patient dignity, appropriate gender allocation must be considered when the patient is engaged in personal care e.g. showering.
- Where possible, cultural needs and gender are to be considered when allocating staff to 1:1 specials.
- The requirement for increased staff or utilisation of existing staff resources is to be determined by the Shift Coordinator after consultation with the CNM /CNS or After Hours Manager.

3. Definitions

Sight	Staff must physically sight the patient and observe the patient's mental/physical presentation. Staff must have a clear visual view of the patient with nothing obscuring their observation. For example: a closed door or blanket.
Special	Special is defined as "… an increased level of observation and supervision in which continuous one to one monitoring techniques are utilised to assure the safety and wellbeing of an individual or others in a patient care environment" (Moore et al 1995, p46)

4. Roles and Responsibilities

The **Clinical Director** has overall responsibility for ensuring that services are delivered in accordance with this procedure.

The **Consultant Psychiatrist** is responsible for the medical management of patients in accordance with this procedure.

The **Clinical Nurse Manager** is responsible for the implementation of this procedure.

All Staff are required to work within this procedure to make sure Broome Mental Health Unit is a safe, equitable and positive place to be.

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 Misconduct 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

This procedure is to be reviewed every five years.

7. Standards

National Safety and Quality Health Care Standards: 1.5.2; 1.8.1; 1.8.2; 1.8.3; 1.18.1
EQuIPNational Standards: 12.3.1; 15.13.1; 10.4.5
National Standards for Mental Health Services: 1.1; 1.2; 1.9; 2.6; 2.13; 10.1.2
National Standards for Disability Services: 1.1; 1.4; 6.2

8. Legislation

WA Mental Health Act 2014

9. References

Australian Commission on Safety in Quality in Health Care Clinical Communications program - iSoBAR
Mental Health Division, WA Department of Health (2008) WA Clinical Risk Assessment and Management (CRAM).
Monitoring the Physical Health of Mental Health Patients – Dr Johnathon Laugharne 2012
BMHU Patient Observation Chart

10. Related Policy Documents

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

Patient Admission Procedure - Broome Mental Health Unit (Mabu Liyan)

BMHU Patient Admission to High Dependency Unit Procedure (change of title from Admission to Secure Area – under review)

11. WA Health Policy Framework

Clinical Governance, Safety and Quality Policy Framework

Mental Health Policy Framework

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

Contact:	Senior Project Officer (M.Vandale)		
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