Dorset HealthCare NHS
NHS Trust

OBSERVATION POLICY

CLINICAL AREA:	Trust Wide (In Patient Services)
POLICY SPONSOR:	Nurse Executive
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APPROVED BY:	Nurse Advisory Committee -19 June 2003 Joint Governance Board - July 2003 Medical Advisory Committee – October 2003 Clinical Governance Sub Committee – February 2004
DISSEMINATED TO:	Chief Executive All Medical and Nursing Consultants Nurse Managers for all in patient units Hospital Managers Modern Matrons/Senior Nurses Medical Staffing manager – for medical induction packs Human Resources Manager – for general induction packs Clinical Governance Co-ordinator

Dorset Healthcare NHS Trust

OBSERVATION POLICY

1 INTRODUCTION

1.1 All patients being cared for in clinical areas are observed by the staff. The purpose of observation is generally to monitor the patients' mental state, behaviour and whereabouts.

1.2 Following the appropriate Risk Assessment, some patients may require more precise and intensive observation. This type of observation is aimed at preventing potentially suicidal, violent or vulnerable patients from harming themselves or others. The purpose of observation for these patients is:

1. To protect them and keep them safe
2. To more intensively monitor changes in their mental state which will guide and support therapeutic intervention.
3. To use the opportunity provided by the observation wherever possible in a therapeutic way in order to facilitate the patient's recovery.

1.3 Although being observed is usually of benefit to the patient, it can be seen as intrusive, or may impede the patient from taking responsibility for their own actions. Unless handled skilfully, observations may be seen as a custodial rather than as a therapeutic intervention.

1.4 This policy has been produced in line with national best practice and standards.

2.0 LEVELS OF OBSERVATION

2.1 Level 1: General Observation

2.1.1 All in-patients will have this as a minimum baseline level of observation. Such observations are to monitor and report on significant changes in the patient's mental, physical and behavioural state

2.1.2 The nurse in charge of the shift will know the whereabouts of all the patients, whether they be on leave, attending an activity within the hospital, or in the Ward/Department.

2.1.3 All newly admitted patients will initially be asked to remain on the ward to allow the nursing and medical staff to make a detailed and informed assessment of their mental state. Many patients will agree to and understand the reason for this decision. If it is thought by staff that the patient will not willingly comply with the request to remain on the ward, a more intensive level of observation may be considered necessary

2.1.4 In order to assist nursing staff in knowing the general whereabouts of all patients, the following should be carried out:

I Handover

Following each nursing handover, the whereabouts of each individual patient should be established. This will normally be carried out jointly by a member of staff from each shift.

II Allocation of Nursing Staff

At the beginning of each shift:-

- The nurse-in-charge will allocate a member of the nursing staff to work with a group of patients for the duration of the shift.
- The allocated nurse should see his/her patients at the beginning of the shift to establish the patient's plans/ movements for the shift and make arrangements for one:one sessions as appropriate.
- This time could also be used to establish if the patient plans to return for meals and to advise the patient to notify the nurse of any changes to his/her plan.
- If a patient notifies the nurse-in-charge that he/she will be off the ward for a period of time, a n entry in the patient records should be made of the time of departure and expected time back, where this leave is approved

III Meal Times

The patient's allocated nurse should notify the nurse-in-charge which of his/her patients have expressed an intention to return for lunch/evening meal. This will allow the nurse-in-charge to inform the member of staff supervising meals which patients to expect. Checks will be made to establish a patient's attendance or otherwise and appropriate action taken

2.2 Level II: Intermittent Observation

2.2.1 A timed observation is when the nurse carrying out the observations makes sight contact with the patient at pre-determined intervals, for example every 10 to 20 minutes. These times can be spaced out e.g. checking the patient four times every hour.

2.2.2 The frequency of the observation is to be carried out should be recorded in the care plan

2.2.3 The purpose of timed interventions is to more closely monitor a patient's mental state and behaviour than is possible using general observations alone. For example, patients at risk of self-harming may be observed becoming more distressed and agitated and hence appropriate interventions can be put in place. Patients thought to be vulnerable can be assessed more closely to determine whether they are engaging in behaviour which are putting them at increased risk

2.2.4 Some patients see timed observations as supportive, indicating a high level of care from the nursing staff and they can be useful as part of "trust exercises" negotiated between the patient and the team.

2.2.5 At least once during a shift the allocated nurse should monitor and assess the patient's mental state, this should include an evaluation of the patient's mood and behaviour and a review of the issues associated with the decision to commence observation and should be recorded in the patient records, as per the patients care plan.

2.3 Level III: Close Observations/within eyesight

2.3.1 Level III observations may be appropriate for patients who are considered to be significant risk to self or others

2.3.2 The designated nurse must be able to see the patient at all times except when using the toilet and bathing

2.3.3 Being mindful of the patient's right for privacy and safeguarding of their dignity, the patient may close but not lock the toilet/bathroom door. The designated nurse remains in attendance outside the door and remains in verbal contact with the patient. If the designated nurse is at all concerned, he/she will enter the toilet/bathroom

2.3.4 Any substances or objects that could be used to self harm or harm others should be removed from the patient. It may be necessary to search the patient and their belongings whilst having due regard for the patient's legal rights. Staff should refer to Policy on Searching of Patients and their Belongings for guidance. Staff need to be aware of potential environmental hazards such as windows see Health and Safety Policy Specific Issue: Windows (Patient Safety).

2.3.5 The designated nurse should use the opportunity provided by this high level of observation not only to closely monitor the patient's behavioural and mental state but also, to provide therapeutic input.

2.3.6 This level of observation must be reviewed every twenty four hours and the team should consider in advance and at each review behaviours which could indicate that the level of observation could be reduced.

2.3.7 At least once during a shift the allocated nurse should monitor and assess the patient's mental state, this should include an evaluation of the patient's mood and behaviour and a review of the issues associated with the decision to commence observation and should be recorded in the patients record, as per the patients care plan.

2.4 Level IV: Very close observations/within arm's length

2.4.1 The patient is observed within arm's reach of a designated nurse at all times without exception, day and night. There are no physical barriers between the patient and the nurse. Patients should not be allowed to shut bathroom or toilet doors without a nurse being present with them.

2.4.2 This is an extremely high and intrusive level of observation which should only be used for patients at imminent risk of suicide or at high risk of harming others

2.4.3 Any substances or objects that could be used to self harm or harm others should be removed from the patient. It may be necessary to search the patient and their belongings whilst having due regard for the patient's legal rights. Staff should

refer to Policy on Searching of Patients and their Belongings for guidance. Staff need to be aware of potential environmental hazards such as windows see Health and Safety Policy Specific Issue: Windows (Patient Safety).

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3.0 CHOOSING THE OBSERVATION LEVEL

3.1 All inpatients are on at least a general level of observation - Level I. The decision about starting a higher level of observation will be made by the clinical team responsible for the patient care or the nurse-in-charge of the ward/unit.

3.2 On admission, the doctor and the nurse who assess the patient should jointly agree on the appropriate level of observations for that patient. The use of the Trust's Risk Screen as part of the assessment will assist the medical and nursing staff in coming to an appropriate decision.

3.3 If a senior doctor has assessed the patient immediately prior to admission to the ward/department he/she should be involved in the decision as to the appropriate level of observation.

3.4 If agreement cannot be reached between the medical and nursing staff admitting the patient as to the appropriate level of observation, the senior doctor and the senior nurse on duty for the site should become involved in assisting the team in making the appropriate decision. Until formal agreement the higher level of observation should be instigated.

3.5 If agreement cannot be reached out of hours between the senior doctor and senior nurse on duty, the higher level of observation being proposed should be instigated. This decision should be reviewed urgently by the patient's own clinical team the next working day

3.6 The decision about the level of observation together with the reasons for that decision should be recorded in the integrated notes/care plan.

3.7 If there are difficulties in providing the required number of staff to carry out the designated level of observation the duty senior nurse for the site should be consulted to assist the clinical team in devising a strategy for dealing with this situation. This should be recorded in the patient's record and Incident Form completed.

3.8 There may be occasions when it is appropriate that the patient is on varying levels of observation e.g. in certain circumstances the patient may be on a reduced level of observation at night time apart from patients on level IV observation and this should be agreed by the clinical and nursing team and documented clearly in the care plan.

4.0 CHANGING THE OBSERVATION LEVEL

4.1 All patients whose behaviour or circumstances have changed in a significant way need a face-to-face re-assessment prior to deciding on the level of observation. Ideally this should be multi-disciplinary and made by those familiar with the patient. Where this is not possible, observation levels should, by way of a holding strategy, err on the side of caution and should be higher than at the time of the adverse event.

4.2 The nurse-in-charge of the ward can make the decision at any time to raise the level of observation if he/she thinks it is clinically necessary. This decision would be reviewed when appropriate by the clinical team at the next Multi Disciplinary Team meeting.

4.3 The decision to decrease a level of observation can often be made in a planned way by the clinical team in charge of the patient.

4.4 The decision can often be made in advance e.g. at the ward round during which specifying clinical behaviours that would indicate that the level of observation could be reduced can be agreed upon.

4.5 At other times, a patient's clinical state may improve such that the nursing staff feel a reduction in observation is appropriate. The decision must involve the medical team for that patient.

4.6 If the nursing staff are seeking another opinion on the level of observations necessary and are unable to contact the team's medical staff, they may ask the duty doctor and Duty Senior Nurse for the site to assess the patient and help with the decision.

4 PATIENTS RESTRICTED UNDER THE MENTAL HEALTH ACT (1983)

4.3 If a patient is detained in the hospital/unit on a Home Office restriction order then the level of observation they are placed on should be determined by the patient's RMO (Responsible Medical Officer) and nursing team in line with the guidance from the Home Office.

5.2 If a patient is subject to a Restriction Order, the decision to decrease the level of observation must be made by the patient's RMO in consultation with nursing staff.

5 ISSUES FOR CONSIDERATION

6.1 Involving the patient

6.1.1 Decisions about the appropriate level of observation should usually be made together with the patient. Patients are often able to make a judgement as to their own vulnerability and need for observation and these considerations should be taken into account by the clinical staff ultimately responsible for the decision.

6.1.2 If an informal patient does not agree to a level of observation that the staff feel is necessary, a decision would need to be taken as to whether use of the Mental Health Act would be appropriate.

6.2 Who carries out the observations

6.2.1 Staff carrying out the observations should be aware of the patient's clinical background and their current mental and behavioural state. The staff should be aware of the reasons for the observation, in particular, any behavioural change

that they need to be observing and therapeutic interventions that they should be attempting to carry out. The majority of observations will be carried out by qualified nursing staff.

6.2.2 In the case of an unqualified staff member being delegated to carry out the observation, the nurse-in-charge will need to make a careful judgement as to whether the staff member:-

- Has a good knowledge of the patient's background and the reasons for observation
- Has been adequately trained
- Is capable and competent to undertake such duty
- Has adequate and appropriate supervision

6.2.3 Medical staff or other members of the multi-disciplinary team may wish to interview a patient in private. If the patient is on Level III or Level IV observations, the nurse-in-charge must make it clear to the colleague making the request that he/she takes full responsibility for maintaining the agreed level of observations. At the end of the interview the colleague accepting the responsibility must hand over the patient's care to the nurse-in-charge of the shift.

6.2.4 In the rare case of a patient's legal representative wishing to interview a patient in private who is on Level III or Level IV observations, the decision as to whether that is appropriate should be made in consultation with the patients RMO in consultation with the multi disciplinary team.

6.2.5 It would not be appropriate for patient's carers to carry out observations for a patient on Level III or Level IV observations, however in Older Peoples Services there can be times where this is appropriate e.g. in the case of a patient who is considered vulnerable. This would need to be agreed by the multi disciplinary team and be clearly documented in the care plan. Consideration should be given to the use of flexible observation as outlined in Section 3.8.

6.2.6 If there is a need for the person doing Level III or Level IV observations to be of a particular gender, every effort will be made to accommodate this.. Staff should be sensitive to patients' wishes and needs.

6.3 Issues related to patients on observation leaving the ward environment

6.3.1 Patients on Level IV observations will not be able to leave the ward. The nurse-in-charge of the ward may agree to patients on Level II (intermittent observations) or more rarely on Level III (close observations), walking in the hospital grounds accompanied by a member of staff following a full risk assessment. Staff members should have means of getting support if required e.g. mobile phone.

6.3.2 The nurse-in-charge of the ward needs to be satisfied that the staff member carrying out the observation is both fully informed as to the clinical state of the patient and also competent to carry out the task.

6.3.3 On occasions, it might be seen as appropriate for a carer to accompany the patient into the grounds of the hospital, for patients on Level II observations as outlined in Section 6.2.5. This decision can be made by the nurse-in-charge of the ward if they have satisfied themselves that the carer is aware of the need and what this entails for observation, and the patient and carer are happy to comply with the instructions from the Nurse in Charge.

6.4 **Personal Searches**

6.4.1 At the start of a period of observation above general observation, it may be necessary to search the patient and his/her belongings for substances and objects which may be used to self harm or harm others.

6.4.2 There should be two members of staff present one of whom should be the same gender as the patient and the property policy should be followed for any property taken into safe keeping

6.4.3 Staff should familiarize themselves with the Policy on Searching of Patients and their Belongings, for further guidance.

6.5 **Potential Hazards**

6.5.1 Staff should familiarise themselves of the environment they are working in of potential hazards, this would include blind spots in rooms doing observations, electrical sockets, potential ligature points.

6.6 **Time Spent on Observation**

6.6.1 The time spent by staff carrying out observation should take into account patients' needs, but wherever possible, not exceed two hours at one time for Level III and Level IV observation. After two hours the designated staff member must take a break from observation duties following a formal handover for a minimum of one hour.

6.6.2 Any variance from this in excess of two hours should be recorded on the daily report to the Senior Nurse Manager for monitoring and review.

6.7 **Transfer from Police Custody**

6.7.1 It would be appropriate for a patient transferred from a Police Station to be on at least Level II observations for an initial period until a formal risk assessment can be carried out and a management plan put in place.

7.0 <u>DOCUMENTATION</u>

7.1 Having completed the Trust risk screen, the level of observation should be decided as part of the appropriate management of that risk. A care plan should indicate the level of observation, the reason for the level of observation and the interventions to be carried out, in addition to the level of observation. The record must include the time of initiation and the time frequency of the observations where appropriate (see also Section 3.6).

7.2 The level and reason for the observation should also be recorded in the patient's notes.

7.3 It should be recorded that the patient has had the level of observation explained to him and that this has been understood. This should include, where appropriate, notifying the next of kin.

8.0 AUDIT

8.1 Audit related to observation of Patients should be carried out on a six monthly basis.

8.2 A minimum data set would include:

- Reason for observation
- Specific level or levels of observation
- Length e.g. time observed
- Any untoward incidents

9.0 TRAINING

9.1 All new Health Care Assistant should complete a one day training session on observation and therapeutic engagement within six months of starting post.

9.2 All qualified in–patient nursing staff should undertake a training session on 'Therapeutic engagement through observation'.

9.3 All Doctors should have a training session on the observation policy as part of their induction.

9.4 The above training packages are currently being developed by a working team of Nurse Consultants, Matron and Senior Nurse/Clinical Training Manager (MH).

10. ENQUIRIES

10.1 Enquiries about this policy should be directed to the Nurse Executive.