



MENTAL HEALTH SERVICES

POLICY & GUIDELINES FOR THE USE OF OBSERVATION AT FAIRFIELD HOUSE

Standard Statement

All residents are assured a level of supervision and observation appropriate to their presenting needs, and/or perceived level of risk to themselves or others. Residents will be consulted on their level of supervision, which will be care planned and evaluated at prescribed intervals

Department of Health: National minimum standards for independent health care (2002) Standard M30.1

There are written policies and procedures, which are reviewed at least every three years for determining levels of observation, engagement, communication and supervision for inpatients

Definition of observation

Observation and supervision of residents has been described as “regarding the patient attentively” (SNMAC 1999) It is therefore an active process that requires the nurse to attentively listen and engage with the patient combined with a readiness to act. With self injury for example “Observation is deliberately designed to frustrate the patient’s aims” hence the patient may feel angry with the process or the nurse him/herself. It is essential for the nurse to convey to the patient that observation is being undertaken on the basis of care and concern for the individual’s safety.

Who can make decisions about a patient’s level of observation/supervision?

Ideally, this decision should be made jointly by the medical and nursing staff as a proactive measure, and as an outcome of the assessment process. A great many incidents, such as self harm or outbursts of aggression, can be anticipated or reasonably predicted in circumstances where the patient’s history and patterns of behaviour are well known to the team. As part of the clinical risk assessment process, the medical and nursing staff, together with the patient will need to determine at an early stage which level of supervision is appropriate to the patient’s needs. By being well informed and proactive, appropriate application of a specified supervision level can prevent an incident from occurring and thereby reduce harm and risk. In circumstances where it is not possible to have the immediate input from medical staff, or the patient is unable to participate in the decision, the nurse in charge is responsible for ensuring the appropriate supervision level is implemented and communicated to the team and the patient.

Assessing level of risk

A number of sources are to be used when assessing the level of risk.

- Interview with the patient (and carers) exploring patient's feelings, intentions towards others, level of impulse control, thoughts of self harm or harm to others
- Consultation with colleagues on duty or care team
- Reference to notes and daily file
- Observations of patient, mental state and behaviour
- Review of the patient's history
- Use of risk assessment tools

Indicators for enhanced level of observation (examples)

- ❖ History of previous suicide attempts, self harm or harm to others
- ❖ Thoughts and plans for self harm, or harm to others
- ❖ Perceptual disturbance such as hallucinations, including command hallucinations or voices directing the person to harm self or others.
- ❖ Suspicious or paranoid ideas that make the patient feel threatened by others.
- ❖ Poor compliance with medication (include check of treatment cards)
- ❖ Recent loss, bereavement and bad news

Levels of Observation/Supervision

LEVEL 1 – General Observation

This is the minimum level of observation/supervision that a patient can receive. All patients receive a minimum of Level 1 supervision. The location and activities of the patient should be known to staff and visual checks need to be undertaken a minimum of two hourly including at night. If the patient is on unescorted leave away from the unit for longer than 2 hours, clearly it will not be possible to check at the 2 hourly intervals. Level 1 observation does not require the nurse to complete a 'patient observation/recording sheet'. All levels of supervision/observation above the standard Level 1 can be collectively described as 'enhanced levels', and indicate a heightened level of risk.

LEVEL 2 – Intermittent Observation

Intermittent observation requires the allocated nurse to undertake a visual check upon the patient's location and wellbeing every 15 to 30 minutes. The precise frequency of the checks must be documented in the care plan and observation recording sheet.

This level of observation and supervision is used when a patient has been assessed to be potentially, but not immediately, at risk. For example, patients who are depressed but have no immediate plans to harm themselves or others, require intermittent observation. Nurses will be allocated for specified time periods e.g. 2-4pm to undertake patient checks. This is to ensure that the team are clear about who is responsible for observing a patient during a specified period. Nurses must ensure they 'handover' the patient when the allocated nurse changes. The patient observation/supervision sheet' must be completed for the period of allocated observation. Where the patient is determined to need Level 2, 15 minute checks, entries to the recording sheet must be made every 15 minutes. Where the patient is determined to need Level 2 30 minute checks, entries to the recording sheet must be

made every 30 minutes. The observations need to occur both during the day and at night

LEVEL 3 – Constant Care

This requires the allocated observing nurse to remain within sight and sound of the patient. Level 3 is used when there is an imminent risk of the patient causing harm to themselves or others. Staff must consider the patients ease of access to dangerous or harmful objects and the need to remove them as safety requires. Searches of the patient may be required, following guidance protocols, to ensure a safe environment. Level 3 must be documented in the care plan and the 'patient observation/supervision recording sheet' need only be made every 15 minutes. As with Level 2, nurses will be allocated for specified time periods to undertake patient checks. This is to ensure that the team are clear about who is responsible for observing a patient during a specified period. Nurses must ensure they 'handover' the patient when the allocated nurse changes. The observations need to occur both during the day and at night.

LEVEL 4 – Intensive Care

Intensive care requires the allocated nurse to remain within arms length of the patient at all times, and is used for patients who present the very highest level of risk. It may be necessary for more than one nurse to provide safe observation and supervision of the patient. Issues of privacy, dignity and consideration of the gender of allocated staff must be considered by the nursing team, and care planned accordingly. As with Level 3 staff must ensure a safe environment for the patient and minimize the risk of the patient accessing hazardous items with which to harm themselves or others. Nurses will be allocated for specific observation periods and must make entries to the 'observation recording sheet' at intervals no less than every 15 minutes. Nurses must ensure they handover the patient when the allocated nurse changes. The observations need to occur both during the day and at night.

Making Supervision and observation of patients more effective

It is quite possible for the patient receiving enhanced levels of supervision (**Levels 2, 3, and 4**) to experience this as an intrusive process. However, there are many ways that the skilled nurse can minimize these feelings, and use the observation process as a way of expressing empathy and positive regard for the person. As well as being a means to developing a more therapeutic relationship with the patient, observation can also achieve safe outcomes with greater reliability where staff:

- Explain the rationale for the supervision level to the patient and actively seek their engagement in the process
- With the patient's consent, provide this rationale to family or carers
- Ensure that care plans detail risk indicators and those factors mitigating risk
- Care plans specify changes in the patient's thought content and behaviour indicating that a reduction in the level of supervision can be safely achieved i.e. what is expected from the patient in order to consider a change to the observation level
- Use the supervision process as a means of continuous assessment and treatment
- Provide the patient with a copy of their care plan.

Supervision will achieve greater safety for the patient if the member of staff observing knows the patient and their history well – careful consideration needs to be given to whether it is appropriate to ask an agency or bank nurse to supervise the patient, unless he/she is entirely conversant with the needs and history of the patient, the observation policy and emergency procedures on the unit.

Allocated periods of patient supervision

The Registered Nurse in charge of the shift will draw up an observation ‘rota’ identifying who is responsible for implementing supervision over a stated period. No period of undertaking enhanced levels of supervision should exceed 2 hours as it is a difficult and demanding task. Level 1 supervision (minimum standard) can be provided by the shift nurse, without a rota, as part of their normal shift responsibilities.

Frequency and process of reviews

Level 2:

Intermittent observation must be reviewed daily and requires the registered nurses on the outgoing shift and those on the in-coming shift, to discuss the patient’s presentation and behaviour. Handover between shifts is the most effective time for this to take place. The staff will refer to the daily notes and observation sheets when formulating a nursing evaluation of the observation level. The registered nurse must ensure that the decision to continue the existing level of supervision, or to change it (increase or decrease) is clearly documented in the notes including the rationale and the staff present at the evaluation.

Levels 3 and 4

Constant care and intensive care levels are also to be evaluated daily following the same directions as above and must include the input of the Home Manager. Changes to level 4 will require the clinical opinion of the Approved Clinician responsible for the patient.

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