

# **PRACTICE GUIDANCE**

## **SAFE AND SUPPORTIVE OBSERVATION OF PATIENTS AT RISK**

### **Mental Health Nursing “Addressing Acute Concerns”**

***STANDING NURSING  
AND MIDWIFERY ADVISORY COMMITTEE***

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# **SUMMARY OF PRACTICE GUIDANCE**

## **SAFE AND SUPPORTIVE OBSERVATION OF PATIENTS AT RISK**

Observation is an important skill for all nurses, but in the acute phases of mental illness, some patients become a risk to themselves or others. The aim is then to prevent potentially suicidal, violent or vulnerable patients from harming themselves or others. Observation is not simply a custodial activity. It is also an opportunity for the nurse to interact in a therapeutic way with the patient on a one-to-one basis. These guidance notes underscore the importance of nursing observation and provide some advice as to how observation should be implemented.

### **WHAT IS OBSERVATION?**

Nursing observation can be defined as “regarding the patient attentively” while minimising the extent to which they feel that they are under surveillance. Encouraging communication, listening, and conveying to the patient that they are valued and cared for are important components of skilled nursing observation.

### **WHAT CHALLENGES ARE ASSOCIATED WITH NURSING OBSERVATION?**

Observing a patient who is deeply distressed and potentially suicidal is one of the most difficult and demanding tasks that a nurse can undertake. Observation calls for empathy and engagement, combined with readiness to act. Whereas most nursing interventions are intended to help patients achieve their own goals, observation is deliberately designed to frustrate the patients' aims. Consequently, patients who are being observed may be very angry with staff, or may experience the process as custodial and dehumanising.

### **WHO IS RESPONSIBLE FOR DECIDING THAT A PATIENT SHOULD BE OBSERVED?**

Where possible decisions about observation should be made jointly by the medical and nursing staff. If a nurse becomes aware that a patient is having suicidal thoughts or difficulty with impulse control, he or she should report to the senior nurse in the ward who will decide whether, and at what level, observation needs to be implemented. The patients' psychiatrist must be informed of any decision as soon as possible. Hospital managers must also be made aware so that adequate numbers and grades of staff can be made available for future shifts.

### **HOW DO WE ASSESS RISK?**

Risk assessment includes an interview with the patient and carers, careful study of the patients history, use of simple risk assessment tools and must take into account the assessments of other professionals, e.g. psychiatrists, CPNs or CMHT. The patient's thoughts, feelings and wishes with regard to suicide, self-harm and harm to others should be approached using direct and respectful questions. This can be a relief to patients who may not have been able to share this information with anyone else. The patient's notes are a vital source of information about past behaviour, as are relatives, friends and carers. A previous history of suicidal attempts or of attacks on others suggest that the patient should be observed until a full assessment can be carried out. When reading the history or gathering information from relatives or carers, it is important that the nurse gets as much detail as possible. There are also a number of simple and reliable tools that have been developed to appraise risk and these can form a useful adjunct to other methods of gathering information.

### **ARE THERE ANY SIGNS THAT INDICATE THE NEED FOR OBSERVATION?**

- 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 and ideas that the patient has about harming themselves or others.
- Specific plans or intentions to harm themselves or others.
- Past problems with drugs or alcohol.
- Recent loss
- Poor adherence to medication programmes.

#### **FOUR LEVELS OF OBSERVATION**

In order to facilitate communication, care planning and training, the following classification in the level of observation is recommended.

Level I: *General observation* is the minimum acceptable level of observation for all in-patients. The location of all patients should be known to staff, but not all patients need to be kept within sight. At least once a shift a nurse should sit down and talk with each patient to assess their mental state. This interview should always include an evaluation of the patients mood and behaviours associated with risk and should be recorded in the notes.

Level II: *Intermittent observation* means that the patient's location must be checked every 15 to 30 minutes (exact times to be specified in the notes). This level is appropriate when patients are potentially, but not immediately, at risk. Patients with depression, but no immediate plans to harm themselves or others, or patients who have previously been at risk of harm to self or others, but who are in a process of recovery, require intermittent observation.

Level III: *Within eyesight* is required when the patient could, at any time, make an attempt to harm themselves or others. The patient should be kept within sight at all times, by day and by night and any tools or instruments that could be used to harm self or others should be removed. It may be necessary to search the patient and their belongings whilst having due regard for patients legal rights.

Level IV: *Within arms length* Patients at the highest levels of risk or harming themselves or others, may need to be nursed in close proximity. On rare occasions more than one nurse may be necessary. Issues of privacy, dignity and consideration of the gender in allocating staff, and the environmental dangers need to be discussed and incorporated into the care plan.

#### **HOW CAN OBSERVATION BE MADE SUPPORTIVE?**

- Ideally nurse and patient should know each other and the nurse should be familiar with the patient's history, social context, and significant events since admission.
- The nurse should be aware of the needs assessment and the overall plan of care drawn up by the multi-disciplinary team.
- Observation is an opportunity for one-to-one interaction. The nurse must show the patient positive regard. If a patient is uncommunicative, the nurse can initiate conversation and convey a willingness to listen. Self-disclose and the therapeutic use of silence are important skills of the expert mental health nurse.
- Some patients will prefer to be active, or may just want to pass the time. It is important that the nurse elicit the patient's preferences, for example, in music, TV, reading, and attempt to provide these.
- The patient is entitled to information about why they are under observation, how long it will be maintained, and what may happen. If possible, information should be provided in a

written form and translated, if necessary, into the patient's own language. For some patients, a written contract stating the roles and expectations of staff and patient might have some therapeutic potential.

- Aims and level of observation should be communicated, with the patient's approval, to the nearest relative, friend or carer.
- The nurse may need to review his or her own thoughts, feelings and attitudes about observation to ensure that they can convey the supportive and therapeutic role of intervention to the patient. In addition the multi-disciplinary team must provide an open and supportive environment to enable members of staff to discuss their feelings about participating in observation.

### **WHO SHOULD BE RESPONSIBLE FOR THE OBSERVATION OF PATIENTS?**

It is impossible to stipulate exactly who should carry out this task, but it is clearly undesirable for someone who does not know the ward or the patient to be responsible for observing a patient who is suicidal, vulnerable or violent.

Ideally the nurse responsible for carrying out observation will:

- know the patient well, including their history, background, and specific risk factors
- be familiar with the ward, ward policy for emergency procedures, and potential risks in the environment
- have received formal training in observation and in the management of violence

It is important to note that the registered nurse remains accountable for the decision to delegate observation to a support worker or student in training and ensuring they are sufficiently knowledgeable and competent to undertake the role.

### **WHAT SHOULD THE NURSE LOOK FOR IN THE ENVIRONMENT?**

The patient should be given the opportunity to use as much of the ward environment as possible and not be confined to a single room. However, acute care settings are often far from ideal in architecture and design. Windows may not be appropriately glazed or the ward layout may make unobtrusive observation difficult. All staff should be aware of environmental dangers but the ward manager must review the ward environment regularly. Staff must assume that the environment is constantly changing and that new dangers may be introduced quite inadvertently.

### **HOW OFTEN, AND BY WHOM SHOULD OBSERVATION, AT LEVELS II AND ABOVE, BE REVIEWED?**

Observation status should be reviewed by the Responsible Medical Officer and the primary nurse or the ward sister/charge nurse at least daily (including weekends). For arms length observation (Level IV), there should be three reviews, two during the day and one before the night shift. Decisions to shift the level of observation should always be taken jointly between medical and nursing staff, except in an emergency.

### **HOW SHOULD DECISIONS BE RECORDED?**

All decisions regarding observation should be recorded by the doctor or nurse in the patient's main medical/clinical notes. Records should include:

- Current mental state
- Current assessment of risk
- Specific level of observation to be implemented
- Clear directions regarding therapeutic approach i.e. occupation, therapy sessions
- Timing of next review

Detailed records of observation should be kept by staff responsible for carrying out observation, including:

The name of the person responsible and the time that they commenced and concluded their period of observation.

A detailed record of the patient's behaviour, mental state and attitude to observation every 15 minutes.

#### **HOW DOES ONE ENSURE CONTINUITY?**

Observation may involve a number of nurses, with care being handed over at hourly intervals. Excellent communication among staff must be maintained by, for example:

A group briefing of all staff to be involved in observing a patient at the beginning of each shift, during which the patient's status is reviewed, potential dangers enumerated and attitudes to the process discussed.

Before taking over the patient's care, each nurse should have familiarised themselves with the patient's background and recent clinical notes.

If possible, the hand over from one nurse to another should involve the patient. Though difficult, involving the patient **can increase their sense of autonomy and encourage the development of trust**. The patient has a right to information about their care and about what might happen in the future.

#### **HOW LONG SHOULD ONE MEMBER OF STAFF BE RESPONSIBLE FOR OBSERVING A PATIENT?**

No period of observation by a member of staff should be longer than 2 hours except in very exceptional circumstances. At the end of each observation period, the nurse should have a break from observation of at least half an hour. Ward managers need to support staff involved in this difficult and demanding task.

##### *Limits to observation*

Should a more intensive level than general observation continue for more than one week a review by the full clinical team should be triggered.

##### *Auditing observation*

Observation is a frequent and significant event in acute inpatient settings and should be audited at 6 monthly intervals. A minimum data set would include:

- reason for observation
- specific level, or levels of observation
- length of time observed
- any untoward incidents

Coding system so that full information can be extracted from patients clinical records demographic data such as age, sex, ethnic origin, principal diagnosis and Mental Health Act status

Observation audits can be facilitated by the preparation of a simple coding sheet for each patient.

Patients' views of the process of observation and nurses' views of the process should be collected regularly and used to improve the implementation of observation.

Random samples of observation records should be examined from time to time

## **WHAT DO WE DO WHEN OBSERVATION GOES WRONG?**

When observation fails, patients die, come to serious harm or cause harm to others. Failure can be due to problems with the individual or the system. Nurses may fail to follow the care plan, or the system may break down because of lack of resources. Sometimes everything was done that could be done. Post-incident reviews are the central method by which practice can be improved. Without such reviews, standards are in danger of being compromised, and individual staff members are in danger of being damaged by the process. Reviews should be guided by a number of principles:

The responsible medical officer and clinical manager should ensure a comprehensive clinical and management review takes place.

Honest reviews cannot be conducted in a culture of blame. The climate must be safe and supportive. It must be emphasised that the purpose of the review process is as a learning experience for all staff and is aimed at improving practice.

If the review reveals serious lapses in individual performance then managers should implement normal procedures.

All members of the team, including medical staff and other professionals connected with the patient's care should attend the review meeting.

Responsibility for collating the results of a review should be given to one person.

In instances where a patient has come to harm the family must be given appropriate information and support.

## **TRAINING FOR OBSERVATION**

Observing patients at risk is a highly skilled activity. Every Trust should ensure that nursing staff (qualified, unqualified, other clinical staff and bank and agency staff) are appropriately trained. Essential components of adequate training include:

- Risk assessment
- Management and engagement of patients at risk of harming self and others
- Factors associated with self harm/harm to others
- Indications for observation
- Levels of observation
- Attitudes to observation
- Therapeutic opportunities in observation
- Roles and responsibilities of the multi-disciplinary team in relation to observation
- Making the environment safe
- Recording observation
- The use of reviews and audit

Footnote:

The SNMAC Practice Guidance is intended to be a template for local services to use in developing protocols and practice