CLINICAL RESOURCE AND AUDIT GROUP

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ENGAGING PEOPLE

OBSERVATION OF PEOPLE WITH ACUTE MENTAL HEALTH PROBLEMS:

A Good Practice Statement

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FOREWORD

This report has been prepared by a group of mental health professionals and service users from a broad range of disciplines who have an interest in improving the quality of acute psychiatric care including the crucial role of observation. The group has consulted widely with Trust Chief Executives, service users, nursing and other staff and has developed a good understanding of the main issues in observation. As a result, I believe that this report will have an impact on the areas where improvements can be made whilst continuing to support the good practice that has been identified as already being in place.

One of several crucial elements identified by the group in this revision is the emphasis on ensuring that observation is experienced as a *therapeutic experience* by the recipient. For this to be achieved staff must have adequate support and training but also must operate within a service culture where there is an acknowledgement of the paramount importance of a caring engagement with service users. Since the publication of the original report much good practice has developed in this area. However, it is now timely to revise, review and reflect on the changes in mental health care that have occurred. I hope this report assists those who provide and receive psychiatric care in this process.

David Bertin
Chair, Observation of Acutely Ill Patients in Psychiatric Hospital Review Group
June 2002

EXECUTIVE SUMMARY

"Engaging People" is a revision of the CRAG document "Nursing Observation of Acutely Ill Psychiatric Patients in Hospital" (1995) and is relevant to all who provide or receive acute psychiatric care. The general principles of the document can also be adapted to support care of other client groups requiring comparable care.

This report is a key document and should be made available to all staff who provide care in an acute psychiatric setting.

The report recommends three levels of observation:

General The staff on duty should have knowledge of the patients' general whereabouts at all times, whether in or out of the ward.

Constant The staff member should be constantly aware of the precise whereabouts of the patient through visual observation or hearing.

Special The patient should be in sight and within arm's reach of a member of staff at all times and in all circumstances.

After much discussion the group agreed that **timed observations do not contribute** to the safety of the observation process although being aware of a patient's whereabouts contributes to good general nursing practice.

It is clearly not good practice to simply "watch or guard" patients. Observation of patients is a **therapeutic engagement**; all staff involved in the process should be suitably trained in psychological intervention skills and risk assessment to maximise this process. The report lists the appropriate skills required to undertake observation. Excessive use of untrained temporary staff can impede the patient's progress and can increase the vulnerability of everyone involved in the observation process.

Whilst general observation is a multi-professional task, constant and special observation should be managed by named members of nursing staff who have 24-hour contact with the patient plus the clinical understanding of their condition. **Relatives, carers and other professionals can be involved in observation** at a general level and can often provide a helpful insight into the patient's condition. The report recommends **some practical suggestions** as to how to improve the observation process.

All local Trusts should develop **local policies** based upon the new national guidance; local observation systems should be flexible and patient-centred; the environment that observation is carried out in must be fit for purpose.

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Patients undergoing observation should be kept informed at all times; **written patient information** should be made available for all patients and relatives involved. Local user groups should be encouraged to be involved in the drafting of such documents.

Following consultation with the Royal College of Psychiatrists about procedures for the reduction of observation level, it has been agreed that out-of-hours a named senior nurse can reduce the observation level in consultation with the junior on-call doctor, providing a written patient-specific plan is pre-agreed with the Senior Medical Officer.

Recording systems should provide a complete clinical picture and enable audit trails to monitor the effectiveness of the intervention and, if necessary, support Critical Incident Reviews (CIRs) and Fatal Accident Inquiries. The effectiveness of observation is also a key issue for **Clinical Governance Committees**.

KEY STANDARDS

- Each local service should have a system of observation practice in place that is flexible and responsive to patient need and based upon Millan's ten principles.

- Policies implementing each component of observation practice should be clear and unambiguous in terms of:

    - role
    - responsibility
    - reaction
    - reporting

  to safeguard all those involved in the observation process.

- The environment in which observation practice is carried out should be shown to be safe and suitable through a system of regular audit within the Trust's risk management and clinical governance processes.

- Staff should be trained in the skills and competencies required to practise observation and be supervised in their practice of this therapeutic activity. An understanding of both risk assessment and psychological interventions is required by all staff, and the Trust should be able to demonstrate that this is regularly reviewed and attended to.

- A system of recording must be in place that enables clear communication between staff members and ensures regular assessment and recording of risk. The system must allow immediate comprehension of the process as it applies at any moment to an individual and support an audit trail which enables the review of clinical incidents.

- Written patient information on the principles and practice of observation should be drawn up locally and provided to each patient.

1 INTRODUCTION

1.1 This is a revision of the CRAG Good Practice Statement "Nursing Observation of Acutely Ill Psychiatric Patients in Hospital" (1995). It sets out guidance on the care of people with acute mental health problems who require observation and special care. The guidance will be relevant to NHSScotland Trusts (including the State Hospital) who provide acute psychiatric care, staff (of all disciplines), users and carers. Much of the content will be of use to other providers of mental health care.

1.2 The focus of this document is on the clinical practice within acute psychiatric settings. However, patients may become acutely ill in other types of wards or facilities, or in the community. If someone requires care and observation due to acute psychiatric illness then the suggestions and principles contained within this document apply. The review group did not **specifically** examine the issues of observation of people with learning disabilities or patients suffering from dementia, but believes much of this document would have relevance for these clinical conditions. The management of mental health patients in general hospitals and the management of patients in general hospitals awaiting referral to mental health services have not been addressed in this report.

1.3 Apart from guiding clinical practice this document will assist organisations to comply with the standards produced by the Clinical Standards Board for Scotland (CSBS) and the Quality Indicators from the Scottish Health Advisory Service (SHAS, 2001). It is relevant specifically to Standard 1 (Patient Focus) and Standard 2 (Safe and Effective Clinical Care) within the CSBS Generic Standards and Standard 5 (Transferring Care) within the CSBS Schizophrenia Standards, and to Quality Indicator 2 (the Delivery of Care) from SHAS.

1.4 The report focuses on the practice of observation of the patient but it must be recognised that observation policies and procedures are only **one** aspect of caring for people during periods of high distress. It is clearly not enough to simply observe people. The process must be both safe *and* therapeutic. People who need this level of help are going through a *temporary* period of increased need. Whatever the cause of this need they, at that moment, require safety, compassion, understanding and appropriate treatment. They must still be engaged in a positive and therapeutic relationship with staff after observation levels return to normal.

1.5 This document examines the issue of who should take the major role in observation. With the emphasis on multi-disciplinary and multi-agency working and with the increased role of users and carers in contributing to service delivery, it is timely to develop the observation role into a process in which many disciplines, carers and users have a role to play. However, it must be acknowledged that nurses, and particularly the nurses in charge of wards, remain the major professional players involved.

1.6 *This document outlines both clinical and policy issues for consideration, debate and implementation at a local level. It is prescriptive only where clear, unambiguous guidance is seen to be appropriate.*

2 BACKGROUND

2.1 In May 2000 the Mental Health & Well-Being Support Group invited CRAG to revise the CRAG Working Group on Mental Illness document entitled "Nursing Observation of Acutely Ill Psychiatric Patients in Hospital". The original document published in 1995 had been well received by the Service and the principles of good practice were largely adopted. However, some work was required to bring it in line with current clinical practice and policy developments.

2.2 A working group was established to carry out the review. The full remit of the group is given in Annex 1 and membership is listed in Annex 2. This group met on eight occasions and an editorial subgroup met twice. To ensure that the work of the group was based on the experience of the Service, three preparatory exercises were undertaken:

- a review of Trust observation protocols
- a survey on the impact and barriers to implementing the original good practice statement on observation
- a brief survey of Service users' experiences of observation.

2.3 The information and views received through these consultations were added to the main group discussion and many are incorporated into the document. The details of these consultations are given in Annex 3.

2.4 The original report was prompted by several issues including a comment within the Annual Report from the Mental Welfare Commission for Scotland in 1992, which noted that considerable variation existed in the definition and application of observation levels throughout Scottish hospitals. The original CRAG document attempted to standardise these levels. A review, undertaken by the current working group, identified that the recommended three levels of observation are now in use in the vast majority of Trusts in NHSScotland. Furthermore, it is clear that the report is well known, generally well integrated into care and many of the changes suggested in the responses by clinicians and users around Scotland were, in fact, already largely referred to in the original text.

2.5 These findings supported the strong opinion within the group that the original report had strong validity within clinical practice, the good practice described within it was still largely relevant, and the report would be revised only if the amendments would add strength and depth to the document. The working group identified several key issues requiring attention:

- to move from observation being seen as a purely nursing responsibility to a multi-disciplinary model
- to clarify the role of relatives and other non-clinicians in observation
- to make links to current service issues such as establishing and implementing standards, continuing quality assurance, and risk management within clinical governance processes
- to review relevant literature and clinical practice to establish if a change was required to the three levels of observation
- to review and suggest training needs
- to highlight need and methods for observation to be therapeutic
- to clarify the process for the increase/decrease of observation levels and how it is to be recorded.

3 ELEMENTS OF GOOD PRACTICE

3.1 Purpose of Observation

3.1.1 The key purpose of observation is to provide a period of safety for people during temporary periods of distress when they are at risk of harm to themselves and/or others. It is essential to ensure this period is therapeutic and, although it may be perceived as not needed at the time, that it will generally be seen as a positive experience by the patient in time. It can also be used to provide an intensive period of assessment of a person's mental state. Acute admission facilities and intensive psychiatric care settings are the areas most involved in the practice of raised observation.

3.1.2 It has been reported in recent years that acute environments have seen a significant change in the profile of patients within their care. This would seem to indicate that most acute admission facilities are dealing with a patient population that is generally staying for a shorter duration than in the past but is more acutely ill or distressed. The implications of this are that more patients at any point in time may need raised levels of observation and therefore the need for clear guidance and policies on this issue may be even more essential than previously.

3.1.3 Formal observation systems should not be seen as inflexible and rigid and it is important that policy and clinical practice developments are not restricted. It is essential that clinical services feel able to develop new methods of engaging with high-risk patient behaviour. However, it is essential that such **developments are carefully designed and researched** to assist in developing the evidence base for dealing with this complex issue. The Chief Scientist Office, Nursing and Midwifery Practice Development Unit and CRAG may be able to support such projects.

3.1.4 It must be remembered that the process of observation can be distressing for patients and can be considered an imposition on their freedom and dignity. It has an impact on the use of the available staff resource, and thus on the care of other patients. Clinical teams should not hesitate to use increased levels of observation when their judgement indicates it is needed. However they should be clear about its purpose and aware of the wider effects of this decision.

A general principle is that observation should be set at the least restrictive level, for the least amount of time within the least restrictive setting.

3.1.5 In its review of the Mental Health (Scotland) Act (2001), the Millan Committee offered ten principles that have equal relevance and importance to this document. The ten principles are set out in full in Annex 6. The principles of participation and respect would lead us to involve patients in decisions regarding levels of observation and give clear, comprehensive answers to questions and requests. The principle of reciprocity should ensure that if we restrict patient freedom (because of observation requirements) then we are obliged to give high quality care and engagement with the patient.
At the time of preparation of this report the exact content of the forthcoming mental health bill, based on the Millan Report, is not known.

3.1.6 It is important that all involved in the practice of observation comply with the principles of the European Convention on Human Rights, especially Article 5, which states that

"5.1 Everyone has the right to liberty and security of person. No-one shall be deprived of his liberty save in the following cases, and in accordance with a procedure prescribed by law . . .
(e) The lawful detention of . . . persons of unsound mind

5.4 Everyone who is deprived of his liberty by arrest or detention shall be entitled to take proceedings by which the lawfulness of his detention shall be decided speedily by a Court and his release ordered if the detention is not lawful".

In practice, the issue is that observation must take place on the basis of engagement and dialogue with the patient consenting, as long as that individual is capable. If the basis for such agreement no longer holds, then informal coercion on the basis of what staff members see as the immediate risks may contravene Article 5. Recourse to the provisions of the Mental Health (Scotland) Act 1984 will have to be considered if the relevant criteria can be met.

3.1.7 Spending time with patients, whether engaged in activity, discussion or simply being with them *may* allow close assessment and monitoring of behaviour and mental state. It therefore may meet many of the needs of observation but is not adequate in itself. At times it is essential to have a clear, unambiguous instruction regarding a patient's need for close or special procedures. Formal, standardised observation systems ensure clarity of the process for both patient and staff.

3.1.8 *The key issue is to devise systems and processes that balance patient safety and well being with their therapeutic needs. It must be seen as unacceptable if adequate, caring, patient contact is only achieved by the utilisation of a formal observation system.*

3.2 General Principles of Observation

3.2.1 The process of observation must not be seen as a low-level or less-skilled "task". It requires considerable skill and effort and can be most demanding and tiring for both parties. Therefore it is essential that there is:

- staff with competence in a broad range of clinical skills
- a suitable environment
- a broad range of available activities
- a culture that values and respects the role of observation
- a clinical supervision process for staff
- a good planning of staff breaks
- access to full written explanations of the process for patients/carers
- access to advocacy for patients who may feel discontent with the level or process of observation
- a clear system for Critical Incident Reviews in the event of mishap
- an audit trail on the use of observation procedures.

3.2.2 Observation should be seen as a partnership between the multi-disciplinary team and the patient and carers. It must not be punitive or custodial. To assist in achieving this partnership both the reasons *for*, and the process *of*, observation should be transparent to all parties and discussed openly.

3.2.3 A mechanistic approach to the observation process, which may be seen as "watching the doors" or "guarding the patient" is totally inadequate. Observation of patients who are acutely ill must be seen as a skilled task involving assessment of the patient's mental state and the development of a rapport and therapeutic relationship with the person being observed. The process should be open, transparent and well communicated. All staff who undertake observation should be specifically trained to do so, understand the importance of the duty they are carrying out and have the skills to deliver brief psychological and practical interventions to benefit the patient. Excessive use of temporary and casual staff can impede the development of good rapport between staff and their patients and the quality of treatment afforded.

3.2.4 Research into the use of untrained nursing staff in the process of observation has demonstrated that, as staff changed on an hourly basis, patients were repeatedly asked the same questions (Duffy 1994). Lessons can be learned from this that can improve the quality of care, e.g. handover reports should be carried out before and after every period of observation. This will avoid unnecessary duplication and improve continuity of care. The observational task can be delegated to unqualified members of staff, but the qualified nurse delegating this duty must ensure that the unqualified colleague knows why they are observing the patient and what the purpose of the observation is. The nurse in charge of a particular shift is responsible for ensuring that individuals requiring extra observation are allocated a member of staff skilled to undertake this duty.

3.2.5 For staff, one specific and skilled element of observation, in relation to protecting oneself and others, is the detection of signs of impending aggression. The close proximity inherent in observation and the risk of patients feeling aggrieved or anxious during prolonged periods of observation may increase the probability of violence.
It is therefore essential that all staff should receive training in techniques for the detection, de-escalation and management of aggression prior to being involved in raised levels of observation. (This requirement is detailed within the CRAG Good Practice Statement on "The Prevention and Management of Aggression", 1996.)

3.3 Making Observation Work

3.3.1 To ensure the distress and discomfort that may be felt during raised levels of observation is minimised, a careful balance of activity, silence or privacy must be obtained. This balance will differ for each person and will vary across time. The availability of music, creative activities, magazines/newspapers, board games, jigsaws, etc., as well as somewhere appropriate for using them is helpful. Activities can also

offer an effective method of observing an individual's level of functioning, as is the chance to assess someone's mental state from the general conversation that often occurs around such activities. Being left alone in as private a setting as possible is also appropriate. A careful selection of the available activities is essential and should involve patient choice where appropriate.

3.3.2 Some practical suggestions are as follows.

On-Ward Activities:

- Activities of Daily Living – assist individuals to maintain self-care, maintaining some responsibility and dignity. Assist with bed-making, tidying room and doing personal laundry. As appropriate write letters, make telephone calls.
- Social Interaction – respect a patient's right for silence. If a patient wishes to talk don't only talk about symptoms but introduce general conversation topics. Remember the habit of talking at the patient may be due to a staff member's personal difficulty with silence.
- Clinical Interaction – a spell of uninterrupted contact allows time for brief psychological interventions, focused on negative or intrusive thought patterns, reality-checking and problem solving, or self-harming thoughts. There is much therapeutic self-help written material available now, and it can be helpful for the patient to have some guidance in working through it (see paragraph 10.2).
- Ask the patient what would be helpful to **them at that moment in time**. Is there anything in the patient's history which could be discussed further with benefit?
- Respect a patient's wishes within safety boundaries, and the level of observation in force. Open the door or sit outside the room if the patient's mental state is deteriorating as a consequence of the close proximity and constant observation that is in force.
- On-ward occupational therapy to assist patients in engaging in activities during the time of an acute onset.
- Nurse management systems should be aimed at increasing direct patient contact by ensuring staff are available to patients as much as possible. Appointment systems for named nurse sessions can ensure planned contact and give patients a chance to discuss concerns and frustrations.

Off-Ward Activities:

- Engage in occupational therapy/other therapeutic opportunities.
- Walks around grounds or visiting hospital shop/social centre/chaplain/ welfare department (assuming risk assessment allows).

Spending time with patients, whether engaged in activity, discussion, or simply being with them, allows close assessment and monitoring of behaviour and mental state. It is the basis of all good clinical practice and can meet many of the needs of observation, but may not be adequate in itself to reduce risk. At times it is essential to have a clear, unambiguous instruction regarding a patient's need for close or special procedures. Formal, standardised observation systems ensure clarity of the process for both patient and staff.

3.4 Involvement and Engagement

3.4.1 "Building relationships" is a generally accepted premise upon which psychiatric care is based, and high-quality care is considered to be that which takes note of the individual needs of patients (Altschul 1972, Cormack 1976, Reynolds 1985, Beck *et al* 1988 and Peplau 1988). Caring for acutely-ill psychiatric patients is no different in this respect, and the research evidence shows that promoting a therapeutic environment and culture is crucial in the care of "at risk" and suicidal patients. As the Mental Welfare Commission stated, the challenge for the psychiatric nurse (and other professions) is "to create a balance between care and control" (Mental Welfare Commission, 1993).

3.4.2 Observation of a patient is clearly patient-centred, but should be seen as part of an overall "holistic approach" to care. Multi-disciplinary teams should take the lead in determining the style and content of staff-patient interaction, making every attempt to create an environment which is therapeutic and which treats patients with respect and dignity. While intensive levels of observation may be unavoidably restrictive, observation must never become a form of *de facto* detention for voluntary patients. As far as possible, the team should seek the consent and understanding of the patient being observed.

3.5 The Context and Setting of Observation

3.5.1 As previously stated, observation policy and practice is only one element of acute psychiatric care. Having policies and procedures that ensure safety alone is not sufficient. Acute psychiatric care is challenging and demanding both for staff and patients alike. To achieve a high-quality, comprehensive service, acute units need to address many issues including the following:

– clarity of purpose
– philosophies that are patient-focused
– systems of supporting and developing clinical practice
– management systems that provide clear leadership to the Service
– robust communication between clinical team members
– range of therapeutic evidence-based treatments available
– practices which identify sources of risk and minimise them proactively
– respect for, and involvement of, patients and their carers
– consistent, skilled multi-disciplinary staff who feel valued and supported
– appropriate physical environments with space and privacy.

The physical environment in which observation occurs can influence both the frequency and intensity of its usage. Poor ward design and layout can lead to problems of carrying out *General Observation* leading to increased levels of observation. Inadequate or inappropriate facilities may well be a clinical governance issue for services to consider. Even in older buildings, the ward manager should have the opportunity to work with the Estates Department (or similar) to reduce any obvious hazards. The environment must be made to be fit for purpose, therapeutic, and all environments must be specifically audited for availability of ligature points as detailed in recent Safety Notices (reference no. SAN(SC) 98/49 & SAN(SC) 01/21).

3.5.2 It is the case that on occasion patients in need of raised levels of observation may be cared for in an Intensive Psychiatric Care Unit (IPCU). These wards generally have increased staff:patient ratios and locked doors and can offer an extra level of safety and care. The fact that these ward doors are locked should not mean patients are denied appropriate engagement and one-to-one staff attention. The therapeutic component of observation must be in place whatever the setting.

3.5.3 The locking of any ward doors outwith an IPCU must only be done within clear local protocols and subject to frequent, regular review and audit. Locking of doors would only be required in exceptional circumstances. The Mental Welfare Commission (1999) recommends that a local protocol is developed which requires authority from senior clinical staff and hospital managers and ensures that clear information is made available to patients and their relatives. There are practice implications too, arising from the European Convention on Human Rights, for other patients whose freedom is restricted unnecessarily (see paragraph 3.1.5).

3.5.4 Observation is used for patients who require extra monitoring. Patients under observation are either very ill and/or distressed and are thought at that point in their care to pose a significant risk to themselves or others. It therefore follows that there will be a risk to a patient leaving a ward area even with staff in attendance. However, there are times when the patient may wish to simply get fresh air or attend a department outwith the ward. It must be acknowledged that the feeling of containment felt by some patients under observation may lead to deterioration in their behaviour if

their needs are not addressed. However, like all risk assessment decisions this judgement must consider the risks and benefits of all options. It is unlikely that a rigid policy regarding patients leaving the ward would meet individual needs.

3.5.5 Outwith a hospital setting the need for formal observation is less relevant. However, it is essential to consider two key areas where increased vigilance is needed. The first is at the time of the organisation of an admission to hospital where the patient has been assessed and it is agreed that inpatient care is required. This decision often happens in a primary care, day care or domiciliary setting, where staff or carers may not be so prepared for constant observation practice. Mental health services must ensure there are clear protocols on managing these situations including, where needed, providing training and support to primary care or in other community settings in which people may wait pending admission arrangements being made. The other risk time is within the immediate period after discharge or leave of absence. The *Safety First* Report (2001) from the Confidential Inquiry into Suicide and Homicide by People with Mental Illness highlights the risk of self-harm in this period. It recommends follow-up for patients within seven days of discharge (where the patient suffers from severe mental illness or has a history of self-harm within the previous three months). Clear discharge plans that allow community services time to organise a response are essential in minimising this risk.

4 RISK (Assessment, decision making and recording)

4.1 The decision to use an increased level of observation is based on a variety of factors. Central to it must be the risk assessment of that patient's mental state at that moment in time. Risk assessment/management is a complex process involving both **objective** data (such as patient history, behaviour, etc.), data from **third parties**, and the **judgement** of the clinicians involved. The recently published report "Risk Management" (2000) offers comprehensive guidance on this subject and also acknowledges that the process is difficult and may have to be repeated frequently if the patient's clinical state is fluctuating.

4.2 It is important to note that in the original report it was observed that:

"Few, if any, properly validated risk assessment tools are available and the group sees an urgent need to conduct audit and research into the most clinically effective ways of assessing risk and prescribing the appropriate level of nurse observation."

It is relevant to note that this position, in many ways, has not fundamentally changed in that any value of formal rating scales and check lists must be tempered by the central role of clinical judgement of an experienced professional. Simple checklists of questions/prompts are valid in guiding less-experienced staff in carrying out a risk assessment. An example is given in the "Risk Management Report" and is included in Annex 5 of this report. The key issue in sound risk assessment is that there is open and in-depth dialogue between all members of the clinical team and with appropriate others including relatives, carers and the patient themselves and that risk assessment is a dynamic process that requires constant review.

4.3 Ideally a multi-disciplinary team should always make these decisions. However, on many occasions (particularly at weekends and evenings) decisions may have to be made by a doctor and the ward nursing team. Such decisions should always be reviewed at the first available opportunity with a larger number of the full team.

4.4 Local policies must clarify the procedure for **increasing** levels of observation in emergencies. This decision should be able to be made by the senior nurse in charge of the unit on their own initiative but followed up by consultation with appropriate medical staff as soon as possible. Staff must feel empowered to raise levels of observation and be supported in this action (even if this increase is subsequently reduced following a broader team discussion). Teamwork and trust between team members are essential to safe decision making and safe practice.

4.5 The **reduction** in the level of observation should ideally be a team decision. To ensure patients are not left on an increased level inappropriately it is recommended that teams plan ahead, particularly at weekends, clarifying the circumstances that would enable a reduction in observation level. As part of this process there should be a clear local policy on the acceptability of the authority of the nurse in charge to reduce observation levels. There should be a **generic** policy at Trust level, which sets out the

broad principles including a clear statement of support for nursing staff implementing these decisions. There must also be a **specific** plan for each patient, which outlines the agreed changes in behaviour that would facilitate a reduction in observation level and the exact procedure for this decision to be actioned. It must detail the role of duty medical staff or senior nurses in this process. It may be appropriate for the policy to differentiate between the procedure for the reduction of the observation level from special to constant compared to a reduction from constant to general.

The following guidance from the Royal College of Psychiatrists clarifies the role of medical staff in the decision-making process regarding levels of observation:

> *Deciding on observation levels should be a process in which the multi-disciplinary teams should all contribute. The Scottish Division of the Royal College of Psychiatrists state (consultation response, January 2002) that they see no problem in non-medical members of the team being able to reduce observation levels as long as (the circumstances which would allow) a future reduction in observation levels could be specified at (multi-disciplinary) ward rounds and documented in the case notes in advance. Nursing staff usually know the patients better and are in quite a strong position, for instance, at weekends to decide if observation levels can be reduced. The on-call junior doctor should be involved in examining the patient's mental state and discussing the risk with the senior nurse on duty before the decision to reduce observation is made. Where there is any doubt the decision should be discussed with the on-call consultant or postponed until the next opportunity when the full team, including the patient's Responsible Medical Officer (RMO), is present. The RMO retains final responsibility.*

4.6 There should always be a record of decisions regarding observation kept within the patient's notes including an explanation as to why an increased level is used. It is recommended that a simple record is kept to allow auditing of the frequency, level and duration of increased levels of observation as well as the clinical reason(s) behind the choice. The record must clearly show the perceived risks which led to the decision, who was involved in the decision, and the patient's opinion of the need for increased observation. This audit trail provides key information both in monitoring the frequency of the usage of raised levels of observation and in Critical Incident Reviews (see paragraph 12.3).

5 LEVELS OF OBSERVATION

5.1 One of the key areas of clinical practice in acute psychiatric care is deciding what intensity of care is needed for individuals. The original document refers to three levels:

- general
- close
- special.

In three NHSScotland Primary Care Trust policies we examined, reference is made to the use of a fourth level. This involves the use of a specified time period (such as every 15 minutes) at which the whereabouts of the patient must be "checked". The group gave this issue considerable debate and sought views from outwith the group as it is clearly a contentious issue and one on which a clear unambiguous statement must be given.

5.2 A summary of the points for and against is given below.

Positive:

- allows an intermediary level between intense one-to-one observation and general observation (particularly when **reducing** the level of observation)
- is less intrusive for person being observed
- is less staff-intensive
- may be used to comply with general observations requirements.

Negative:

- high risk as patient able to carry out risk behaviour during gaps in observation
- maybe used as "easier" option when constant observation is really indicated
- encourages a mechanistic process of care
- does not fulfil the purposes of observation.

5.3 The group decided that the original three levels of observation are still the most appropriate and that on balance the risks inherent within "timed checks" outweigh the possible benefits. This view is upheld within "Safety First" (5-Year Report of the National Confidential Inquiry into Suicide and Homicide by People with Mental Illness, 2001) which highlights the risks inherent within "timed" or what they term "intermediate" observation. It recommends that "alternatives to intermediate level observations be developed for patients at risk" referring to intermediate-level observations as "of unproven benefit". Being aware of the patients' whereabouts supports good nursing practice but should not be considered part of the observation process.

5.4 *The "timed check" form of observation is seen by the group as unsafe and should not be used as a means of meeting a need for an increased level of observation.*

5.5 It was clear that the majority of Trusts and staff consulted considered that the original recommendations regarding levels of observation were well implemented, useful and well integrated into the care package; comments received by the group during consultation were supportive of this view. There seemed no requirement therefore to alter terminology or the major aspects of clinical practice. The three levels of observation suggested in the original report remain valid and should continue to form the basis of local policy.

5.6 With this in mind, we continue to recommend that the following categories of observation be used:

General Constant Special

5.7 **General Observation**

The general level of observation is intended to meet the needs of most patients for most of the time. It should be compatible with giving patients a sense of responsibility for their use of free time in a carefully planned and monitored way. The staff on duty should have knowledge of the patients' general whereabouts at all times, whether in or out of the ward. This could be achieved by establishing a patient allocation system whereby the nurse in charge is kept informed of each patient's whereabouts. Patients on general observation are considered not to pose any serious risk of harm to self or others and are unlikely to leave the ward area or other treatment departments without prior permission, escort, or at least informing staff of their planned destination. Any limits set should be determined in conjunction with the patient, documented and updated in the care plan as necessary.

5.8 Gournay & Bowers (2000) offer a useful description of general observation:

> *"General Observation can be thought of as the observation and monitoring of the physical geography of the ward and as a component of constant review of safety in the light of the opportunities the ward and its contents provide for harm to come to patients. This general observation should be an established part of the ward routine and followed rigorously and regularly by nurses, as part of their everyday practice to maintain the safety of the patients."*

5.9 **Constant Observation**

The constant level of observation should be used for patients considered to pose a significant risk to self or others. **An allocated member of staff should be constantly aware at all times of the precise whereabouts of the patient through visual observation or hearing**. The method and purpose of maintaining observation must be clearly determined and stated at the time of review. Respect for privacy should be an important consideration, but a balance should be struck on the side of safety in all matters such as escorting to the toilet, bathroom, or public telephone, etc. In some

circumstances the patient may be permitted to leave the ward or other clinical area in the company of an escorting nurse, other informed professional worker or appropriate relative. This decision must be part of the risk assessment process and the comments referred to in the previous section should be noted. Appropriate members of the multi-disciplinary team (generally a minimum of the nurse in charge and duty doctor) should review the need for constant observation at least every 24 hours.

5.10 Special Observation

The special level of observation will generally be rarely prescribed. The patient should be clinically assessed as requiring intensive and skilled intervention as a consequence of their very serious mental and/or physical state. **The patient should be in sight and within arm's reach of a member of staff at all times and in all circumstances**. Considerations of privacy would be subordinated to those of safety. In some situations more than one staff member may be required. In the event of the patient leaving the ward an appropriate number of escorts should accompany the patient. As this form of observation is potentially very intrusive, it should only be used when judged strictly necessary by the clinical team, and this level of observation should be subject to frequent review (at least every 24 hours) involving appropriate members of the team. A system should be in place for dealing with the increased demand on staff resources which special observation creates. Only staff familiar with the condition of the patient on special observation should normally be deployed on this demanding work.

6 ROLE OF THE PROFESSIONS IN OBSERVATION

6.1 It must be acknowledged that it is primarily psychiatric nurses who provide 24-hour care and who will, therefore, carry the majority of the responsibility for the observation of the patients. However, with the emphasis on multi-disciplinary team-working and the increasing role of users and carers, consideration should be given to the role of these groups within this area of care. It seems correct that in appropriate situations other professionals (apart from nurses) should be involved and have responsibility for the observation of a patient. Indeed, it is clear from our consultation that this practice is already in use to some degree and that guidance on it would be welcomed.

6.2 For non-nursing staff to be involved in observation the following issues must be addressed:

- there must a fool-proof system of staff knowing **who** is responsible for the observation of a patient at all times
- there must be a simple way of communicating between staff members all **changes** in the level of observation
- **all** staff must accept the responsibility for carrying out the observation to local standards
- **all** staff must receive appropriate training in this role especially staff for whom this role is new.

7 ROLE OF THE NURSE IN CHARGE

7.1 As the only profession which has 24-hour contact with patients, nurses are in a key position to ensure robust safety and therapeutic care. As stated, it is still nurses who will remain the staff group predominantly involved in observation and their experience in this skilled task must be recognised and utilised by the other professions. The nurse in charge of the ward or unit should retain responsibility for co-ordination of decisions regarding observation levels. For clarity only one individual must be charged with this duty and be seen as the person who should always know both **who** is being observed (at a raised level) and **which** staff member is responsible for a given time period. That person is the nurse in charge.

8 ROLE OF USERS AND CARERS

8.1 Caring for someone in distress is not a process to which only professionals can contribute. Anyone with a suitable approach and awareness can, at times, help and may, on occasions, be more appropriate than the professional. Clearly it is neither safe nor fair to expect a carer or fellow patient to shoulder the full responsibility of caring for someone in severe distress. However, in many settings the patient being observed may welcome the company of a relative, friend or fellow patient and it **may** not be appropriate to have a staff member present during such occasions.

8.2 During general observation there would appear to be no conflict, whereas during special observation it would not be appropriate to leave a patient without a member of staff present. However, constant observation is more complex. There will be situations where it is reasonable and appropriate, and others where it would be unsafe and unfair. The risk assessment process and subsequent multi-disciplinary team discussion must include decision making; agreement should be reached on the appropriate level of observation and who can offer the greatest level of support to the patient.

9 INFORMATION FOR PATIENTS

9.1 Patients and their carers/relatives should be informed of the observation policies and procedures in use within the service. If observation is to be a true partnership then clear, honest and open dialogue must take place regarding the reasons for an increased level of observation. Written information regarding observation policies and practice must be given to **all** patients. Specific information regarding a patient's current level of observation must also be given. It is recommended that this information is developed in conjunction with local service user groups.

9.2 Although it is not appropriate for a formal "appeal" (as in the Mental Health Act) patients should have access to an advocacy service to assist and guide them in disagreements about any restrictions on their freedom that observation may lead to. Written explanations should be given to both patient and carer/relative about the level of observation in use and its purpose. Patients should also be offered an opportunity to discuss their concerns with a senior member of staff.

9.3 If the process is designed to be truly collaborative and crucially "feels" this way to the patient then the chances of the patient disagreeing with the decision are reduced. Patients must have the right to discuss formally their views on their observation level with staff and, if they desire, involve someone (such as from an advocacy service or friend/relative) in these discussions. To facilitate this collaborative process local user groups should be encouraged to become involved in the development of local observation policy, written information and staff training.

10 TRAINING AND SUPERVISION

10.1 The need for high-quality training was highlighted in the original document. It would appear from our review that training in the practice of observation is still seen by many as an issue requiring more attention. The specific need for training non-nurses in observation responsibilities has already been referred to in this document. It should be noted that although nurses are traditionally the profession most closely associated with observation it would appear that few have received specific training. The review group was not aware of any current formal courses but recommend that local services develop training plans for all staff involved in observation. This training should include input from users and should explore both the practicalities of the local observation procedure and the philosophy underpinning it.

10.2 The training must also include clinical skill training as needed to enable staff to have the necessary "tool-box" of psychological and practical interventions to help patients cope with their distress and illness. Skills such as distress tolerance, suicide thought reduction, psychotic thought management, problem solving and anxiety management are appropriate to include. These two elements of the training should be aimed at ensuring the process of observation is therapeutic and safe.

10.3 The recent Leadership Development Programme is one route through which to identify key players in implementation of local observation protocols. Reference should be made to "Learning Together – A Strategy for Training and Lifelong Learning" (1999).

10.4 Training must not be seen as a "one-off" as, apart from ongoing updates, all staff working in psychiatric units need continuing organisational support in their clinical work. This may be through a system of clinical supervision, mentorship or preceptorship. The recent Nursing Strategy "Caring for Scotland – The Strategy for Nursing and Midwifery in Scotland" (2001) emphasises the important role of clinical supervision in nursing. The need for clinical supervision applies to all professional groups and must be seen as an integral part of good quality care and not an optional extra. It is also part of supporting the process of learning or reflective practice that comes from both formal audit and critical incident reviews and contributes to the continuing professional development that is essential to all professionals.

11 CRITICAL INCIDENT REVIEWS

11.1 Much can be learned through careful analysis by the multi-disciplinary team of the management of particular incidents which should not have occurred. Critical Incident Reviews (CIRs) are considered to be a valuable learning tool for staff, as well as a supportive forum. All wards/units caring for acutely-ill patients should adopt the practice of carrying out reviews when untoward incidents occur (the "critical" applies to the seriousness of the event for the organisation's overall purpose and not to an expressed intent to pin the "blame" on somebody). Although CIRs are associated with the investigation of suicides, suicide attempts and incidents of violence and aggression, the process is mentioned here as a means of looking at "near-misses". By these are meant any failure of systems or failures to apply the correct procedures. Therefore, when an event occurs which constant or special observation was designed to avert, it is worth examining to see how in future the team (and the organisation) can ensure a better outcome. A protocol for conduct of the CIR is described in "Risk Management". To ensure they are useful learning tools, CIRs should be conducted in a learning mode, separate from and not linked to disciplinary procedures, and should be carried out in a manner that facilitates development both on a personal and organisational level.

11.2 If CIRs occur frequently then there may be something wrong with the organisation's ability to learn and incorporate lessons into its risk management processes. More can be gained from looking honestly at occasions when things did not go well, but there is a delicate balance of formal and informal systems applied in a human context. This issue is explored within "An Organisation with a Memory – Report of an expert group on learning from adverse events in the NHS" (Department of Health 2000) and the follow-up document "Building a Safer NHS for Patients" (Department of Health 2001).

12 AUDIT AND CLINICAL GOVERNANCE

12.1 Clinical Governance is defined as "corporate accountability for clinical performance". A key purpose of Clinical Governance is to improve quality of care and to ensure that wherever possible poor performance is identified and addressed. Locally, Trust Clinical Governance Committees are expected to ensure that their organisations put in place systems to allow for learning from complaints or critical incidents. It is essential that observation practice, along with the risk management inherent within it, is seen as a key mental health issue for examination through the Clinical Governance process.

12.2 Simple auditing of the frequency and duration of observation practice across wards is an essential tool in monitoring the effectiveness and usage of this procedure. For an example of this approach see Porter, McCann & Kettles (1998). The audit process must also ensure that feedback from users is gathered and used to shape both policy and training.

12.3 Recording systems must be designed to allow a clear audit trail. The record must be simple and quick to complete but should include: the level of observation used, the presenting clinical picture, who is involved in these decisions, the views of the patient and carer, information given to the patient and carer, and any specific plans for possible reduction of level of observation. Pending the development of electronic recording of practice data, a simple paper record will suffice. Such records are essential components in the discussions at Critical Incident Reviews and in the defence of professional practice in the event of a Fatal Accident Inquiry.

13 SUMMARY

13.1 Caring for people experiencing periods of acute mental illness or distress is challenging and demanding – experiencing it must be even more difficult. Comprehensive care involves **both** ensuring the patient's safety and offering therapeutic help and support. One without the other is incomplete. The risk is that services pay considerable attention to the safety component but perhaps less to making the observation experience healing and compassionate. To ensure **both** are achieved staff must feel valued and supported and given the time and skills to truly engage with the patient. The process **must** be a partnership approach between staff and patient where the needs of the patient are recognised and respected. There is much one group may learn from the other in how safe, therapeutic observation can be developed and delivered.

ANNEX 1

REMIT OF WORKING GROUP

The Group was established in July 2000 with the following remit:

To develop a framework of practice for clinical teams in acute inpatient units to set and implement patient observation levels in ways that

- reduce the risk of untoward incidents to both patients and staff
- combines the practice of observation levels with the proper assessment, treatment and therapeutic engagement with patients
- maintains a balance between the patient's dignity and the need to ensure that he/she does not come to avoidable harm.

Aims:

- to encourage the integration of observation practice into good quality inpatient ward therapeutic care
- to provide standards for clinical practice, enabling the processes of:
    - audit
    - skill definition
    - training
    - supervision
    - quality improvement to occur.

Objectives:

- to review the development of policy and practice as it has occurred over the last five years since the publication of Nursing Observation of Acutely Ill Psychiatric Patients in Hospital (1995)
- to incorporate recent policy developments and practice into a revised good practice guideline to facilitate:
    - clinical governance
    - clinical risk management
    - continuous organisational learning through examination of practice such as critical incident reviews.

ANNEX 2

WORKING GROUP MEMBERSHIP

Mr David Bertin (Chairman)
Clinical Nurse Manager – Lomond and Argyll Primary Care Trust

Mrs Susan Bishop
Chief Pharmacist – Forth Valley Primary Care Trust

Ms Joan Blackwood
Practice Development Facilitator/Research Associate – Mackinnon Unit, Stobhill Hospital

Dr Keith Brown
Consultant Psychiatrist –Forth Valley Primary Care Trust

Ms Moira Cossar
Clinical Nurse Manager – Crichton Royal Hospital

Dr Tim Dalkin
Consultant Psychiatrist – Royal Edinburgh Hospital

Mr Bob Gillies
Intensive Psychiatric Care Unit – Gartnavel Royal Hospital

Mr Michael Hughes
Ward Manager – State Hospital

Ms Elaine Hunter
Trust Advisor in Occupational Therapy – Royal Edinburgh Hospital

Ms Ruth Lockwood
CRAG Secretariat – Scottish Executive Health Department

Dr John Loudon
Principal Medical Officer – Scottish Executive Health Department

Mr Jamie Malcolm
Nursing Officer – Mental Welfare Commission for Scotland

Ms Jackie Meikle
Ward Manager – Royal Edinburgh Hospital

Mrs Alison Meiklejohn
Head Occupational Therapist – Royal Edinburgh Hospital

ANNEX 2 (continued)

Ms Corinna Penrose
Senior Advocacy Worker – Advocacy Matters

Dr Linda Pollock
Nursing Director – Lothian Primary Care NHS Trust

Mr Colin Poolman
Royal College of Nursing Professional Officer – RCN Scottish Board

Mr Robert Samuel
Nursing Adviser – Scottish Executive Health Department

Mr Mark Simpson
Clinical Nurse Manager – Royal Dundee Liff Hospital

Mrs Frances Smith
Director of Nursing and Quality – Clinical Standards Board for Scotland

Ms Lesley Wilkes
Adviser, Mental Health, Scottish Health Advisory Service

ANNEX 3

CONSULTATION PROCESS

To ensure that the work of the group was based upon the experience of the Service three consultation exercises were undertaken:

- a review of Trust observation protocols
- a survey on the impact and barriers to implementing the original good practice statement on observation
- a brief survey of service users' experiences of observation.

1 REVIEW OF TRUST PROTOCOLS

In October 2000 Chief Executives of Primary Care Trusts were invited to submit their current protocols to enable the group to develop an understanding of the impact on observation of the 1995 "CRAG Nursing Observation of Acutely Ill Psychiatric Patients in Hospital" report. Comments were invited on the original publication and implementation issues.

The vast majority of protocols refer to three levels of observation and were broadly in line with the suggestions in the original document although different terminology had developed; some policies referred to "close" observation as opposed to "constant" and some referred to "intensive" observation as opposed to "special". Three documents made specific recommendation to a fourth level of observation that sat between "general" and "constant" observation. One reply indicated that this level of observation had been left in due to a resistance from staff to alter this practice.

Recurring themes requiring greater clarity were: guidance on the observation role of other professionals and relatives, training, recording, post-incidence reviews and supervision, risk assessment, patient rights, and the therapeutic nature of observation.

2 OBSERVATION OF ACUTELY ILL PSYCHIATRIC PATIENTS IN HOSPITAL QUESTIONNAIRE

In December 2000, a questionnaire was sent out to Chief Executives of every Primary Care Trust seeking responses from senior nurses in acute wards and IPCUs. A total of 80 responses was received representing every Primary Care Trust. The purpose of the questionnaire was two-fold:

(a) to understand the impact and obstacles to implementing the 1995 nursing observation good practice statement

and

(b) to ensure that the views and experience of the Service were incorporated into the revised document.

In regard to the three levels of observation recommended, does your service policy broadly fall in line with these?

Virtually all respondents stated that their observation levels corresponded with the CRAG recommendations. 5/15 respondents commented that they used a fourth level of observation that tended to be "general with conditions".

What type of training, if any, has been carried out for staff regularly involved in observation of patients?

Training varies from Trust to Trust; 25% had received some training in observation as part of an induction package; 10% noted some awareness training and two noted on-going training courses and regular team discussions. Only 6% were required to reach a competence level before being considered competent to carry out observation and 15% reported no training at all.

What particular problems have there been with implementing your observation policy and procedure?

Resource implications. Almost half of the respondents reported staffing problems, in particular low and decreasing numbers of trained staff and untrained bank staff unfamiliar with the ward. This leads to no cover during nurse breaks. Some concern was expressed that staffing restraints led to custodial rather than therapeutic care that compromises patients' privacy and dignity. Low staffing can have a negative impact upon other ward activities if there are high numbers of patients under observation. Others identified environmental issues as particular concerns. 16% reported problems with recalling medical staff to carry out medical reviews/reduce levels, particularly at weekends. Two respondents expressed concern that the observation policy is misused. Concerns were also expressed at the use of other professionals (mainly Occupational Therapists) to observe acutely-ill patients. 11% reported no problems.

What are the current issues and concerns within your own area at the moment regarding observation of patients?

Major problems are resource implications and lack of qualified staff. 14% reported difficulties contacting medical staff to approve lowering of observation levels. Several respondents highlighted issues of risk and risk assessment – lack of training and lack of confidence, anxieties that individual staff will be blamed/involved in legal actions if problem occurs. Staff fatigue working full time on observation. Seven respondents reported local environmental issues. Only four reported no problems or concerns.

If observation was to be moved from a purely nursing responsibility to one that could be shared among other professionals and potentially relatives, what would your views be on this and what concerns or issues would you like the group to address?

One-fifth reported that shared observation is already happening although not all wards extend this to relatives and carers. A third would welcome future involvement of other professionals, more than half of this group would also welcome some involvement with relatives but cautioned that training and guidelines would have to be provided to ensure observation retained its therapeutic role. Many were concerned about relinquishing responsibility and decision making on behalf of the patient. Only 10% would not welcome the involvement of other professions and relatives stressing that observation was a skilled nursing intervention based upon professional experience.

Any other concerns, questions or information that you feel would influence the group?

There was a great interest in more tailored training to support nursing staff – topics identified were risk management, symptom identification, team working, record keeping and liability. There was a call for additional research/audit and a request for a sample audit tool to support new guidance. It was noted that returning responsibility to patient can be disruptive – this should be dealt with sensitively.

3 SURVEY OF USERS' VIEWS

Question One: During either your current stay in hospital or on a previous occasion, have you been placed on a "Nursing Observation Level"?

Question Two: Were you given a clear and understandable verbal explanation of:

- Why you were being observed?
- How it would be carried out?
- By whom?
- For how long?
- Your rights?
- Told of any restrictions on your movements?
- Were you given written information?

Question Three: Can you recall what type of observation level had been prescribed for you?

ANNEX 3 (continued)

Question Four: Describe what happened during the observation?

- Did the nurses talk with you?
- Did you have an opportunity to talk about how you were feeling?
- Could you leave the ward?
- Could you attend planned activities, OT, or participate in group work with other service users?
- Did you remain in your room or generally within the ward area?

Question Five: In your own words describe how you felt whilst on an observation level?

Question Six: What, if anything, could have made this experience better for you?

ANNEX 4

BIBLIOGRAPHY

Adams, B (2000) Locked Doors or Sentinel Nurses? *Psychiatric Bulletin* 24, 327 – 328

Altschul A (1972) Patient–nurse interaction: a study of interaction patterns in acute psychiatric wards. Edinburgh: Churchill Livingstone

Beck C B, Rawlins R P and Williams S R (1988) Mental Health – Psychiatric Nursing. A holistic life-cycle approach. Missouri: CV Msoby Co.

Cormack, D (1976) Psychiatric Nursing Observed: a descriptive study of the work of the charge nurse in acute admission wards. London: Royal College of Nursing

CRAG Working Group on Mental Illness (1996), The Prevention and Management of Aggression – a good practice statement. Scottish Executive Health Department, Edinburgh

CRAG/SCOTMEG Working Group on Mental Illness (1995), Nursing Observation of Acutely Ill Psychiatric Patients in Hospital – A good practice statement. Scottish Executive Health Department, Edinburgh

Department of Health (2000) An Organisation with a Memory – Report of an expert group on learning from adverse events in the NHS

Department of Health (2001) Building a Safer NHS for Patients

Dick, S and Keppie, M (1995) User Consultation Project – Observation Policy – Royal Edinburgh Hospital (unpublished)

Dodds, P and Bowles, N (2000) Dismantling Formal Observation and Refocusing Nursing Activity in Acute Inpatient Psychiatry: a case study. *Journal of Psychiatric and Mental Health Nursing* **8**, 183 – 188

Duffy, D (1994) Report to the original good practice group

Duffy, D (1995) Out of the shadows: a study of the special observation of suicidal psychiatric in-patients. *Journal of Advanced Nursing*, 21 pp 944 – 950

Fletcher, R F (1999) The process of constant observation: perspectives of staff and suicidal patients. *Journal of Psychiatric and Mental Health Nursing*, **6**, 9 – 14

Gillion, A (1999) Review of UK evaluative literature on clinical supervision in Nursing and Health Visiting, UKCC: London

Gournay, K and Bowers, L (2000) Suicide and self-harm in in-patient psychiatric units: a study of nursing issues in 31 cases. *Journal of Advanced Nursing,* **32(1)** 124 – 131

Health Department (2000) Risk Management. Mental Health Reference Group, Scottish Executive

Health Department (2001) Caring for Scotland – the Strategy for Nursing and Midwifery in Scotland

Jones, J *et al* (unpublished) A study of psychiatric inpatients' experience of formal observation in acute inpatient settings – Executive Summary

Learning Together – A Strategy for Training and Lifelong Learning (1999)

Mental Welfare Commission (1992) Annual Report 1991/1992 Edinburgh HMSO

Mental Welfare Commission (1993) Annual Report 1992/1993 Edinburgh HMSO

Mental Welfare Commission for Scotland (2001) General Hospitals and the Mental Health (Scotland) Act, 1984 Guidance circulated to Chief Executives of Trusts

Mental Welfare Commission for Scotland (1999) Locked Doors in Hospital – Survey. Annual Report, Visiting Programme 1998 – 1999

National Confidential Inquiry into Suicide and Homicide by People with Mental Illness – Review of Progress 1996 – 2000

National Confidential Inquiry into Suicide and Homicide by People with Mental Illness Safety First (2001)

Neilson, P and Brennan, B (2001) The use of special observations: an audit within a psychiatric unit, *Journal of Psychiatric and Mental Health Nursing*, **8**, 147 – 155

Peplau, H (1988) Interpersonal relations in nursing 3rd edition. London: Macmillan

Pitula C R and Cardell, R (1996) Suicidal Inpatients' Experience of Constant Observation, *Psychiatric Services* Vol. 47, No 6, 649 – 651

Porter, S, McCann, I. and McGregor Kettles, A (1998) Auditing Suicide Observation Procedures. *Psychiatric Care*, 5 (1) 17 – 21

Reynolds B (1985) Issues arising from teaching interpersonal skills in psychiatric care for the suicidal patient. *Journal of Advanced Nursing*, Chapter 13 of Kagan C (ed)

Scottish Health Advisory Service (1999) Mental Health Standards – Edinburgh

Scottish Health Advisory Service (2001) Quality Indicators and Self Assessment Framework. Edinburgh

Standing Nursing and Midwifery Advisory Committee (1999) Mental Health Nursing: "Addressing Acute Concerns" Report by the Department of Health

ANNEX 5

THE ASSESSMENT OF RISK
(ROYAL COLLEGE OF PSYCHIATRISTS COUNCIL REPORT CR53 (1996))

The essentials of this report are as follows.

There are four general principles:

- information from a single source is never going to be enough to assess risk, and corroboration will always have to be sought;
- similarly one person alone cannot perform an adequate risk assessment, and access to the network of people surrounding an individual is crucial;
- people who present a risk to others are also likely to be vulnerable to self-harm, self-neglect or exploitation; (in other words the perception of others should not be allowed to blot out the possibility of that individual also needing protection);
- factors such as age, gender and ethnicity are unreliable predictors of risk to harm to others.

In the history taken from an individual being assessed, certain items must be sought:

- previous violence or suicidal behaviour;
- "social restlessness" – few relationships, frequent changes of address or employment;
- evidence of poor engagement with mental health services;
- presence of substance misuse;
- a social background promoting violence;
- any precipitants or changes in mental state or behaviour that have occurred prior to previous episodes of violence or relapse;
- recent change in any of these risk factors;
- evidence of recent severe stress, especially major losses;
- evidence that medication has recently been discontinued.

It is important to identify potential victims, particularly those who figure in abnormalities in the patient's mental state (for example, the focus of delusions or the apparent source of hallucinations). In the patient's mental state the emotionality with which the patient presents (for example irritability, anger, hostility or suspicion) is important, as are specific threats made by the patient. Also, beliefs of threat, or persecution or control of mind or body by external forces are noteworthy.

In recording the assessment the following points have to be noted:

- how serious is the risk?
- is the risk specific to one person or situation, or is it general?
- how immediate is the risk?
- how volatile is the risk?
- what potential factors increase the risk, and what might decrease it?
- what specific treatment, and which management plan can best reduce the risk?

In managing risk, there are two basic principles:

- a person working within a mental health service, having identified the risk of dangerous behaviour, has a responsibility to take action with a view to reducing that risk and managing it effectively; and
- in managing risk, the emphasis should be towards safety. That starts by engendering a relationship with the patient which makes him or her feel safer and less distressed.

Considerations for managing risk include:

- does he or she require admission as an inpatient?
- should he or she be detained under the Mental Health (Scotland) Act 1984?
- what level of physical security is likely to be needed?
- what level of observation is required?
- what medication should be used?
- it should be understood clearly by ward staff how the medication is to be employed;
- if there is another episode of violence, how should it be managed?

If the patient is being managed in the community, other questions come to the fore:

- is there a place for the Care Programme Approach?
- can the Mental Health (Scotland) Act be used, or is there a case for a community care order?
- what community supports are available, how effective might they be, and how can they best be assisted?
- do the carers and family have access to appropriate support and help?
- have the carers – in the family, and in other agencies – been adequately informed about the situation, how it is likely to develop, and what help they can expect to receive?

ANNEX 5 (continued)

Fundamental to the management of any situation is:

- the plan of management clearly recorded in an accessible place, in legible writing;
- the date for review of the assessment and management plan should be set down, after agreement with all those involved. That date needs to be passed on to all those who need to know;
- the patient's general practitioner must be informed;
- individuals who should or are entitled to receive information should be identified and responsibility assigned to carry this out;
- the threshold for breaching confidence to ensure public safety has been defined;
- if responsibility for the management of a plan of action is being passed on to another team or individual, it must be accepted explicitly. The information passed on must include all relevant details.

Responsibilities

The Clinician

- to respond as rapidly as possible when concern is expressed by a colleague or member of staff from a partner agency about an increased risk from a patient;
- always to make a systematic assessment;
- always to consult as widely as is possible and appropriate;
- not only to make a decision on what needs to be done, but to make explicit the reasons for that decision and to write them down;
- to make a management plan based on the assessment;
- to record details of the management plan;
- to share the management plan as appropriate with all those who have a legitimate concern with its implementation;
- to make no assumptions about what other people will do – if their co-operation is required in carrying out a management plan, make sure that there is explicit consent;
- to make an appropriate arrangement for monitoring the management plan, making sure that a date is set and kept for subsequent review.

Clinical Teams

- should have an agreed protocol for responding to patients showing significant risk. This protocol should identify:

  – the appropriate senior clinicians to be contacted to conduct assessment or re-assessment;
  – the means by which they should be contacted must be clear;
  – if the identified person is not contactable, a subsidiary route should be available;
  – to have agreed protocols for follow-up and review of patients;
  – to establish and maintain links with other agencies, based on mutual respect for the contribution which can be made, to involve them in the care and management of patients who present a significant risk.

Service Managers

- the effective assessment and management of people presenting increased risk of harm should be of the highest priority for allocation of resources;
- risk assessment and clinical risk management is time-consuming and expensive. The appropriate resources should be made available;
- proper assessment and management of clinical risk cannot take place in an unsafe environment or within inadequate facilities;
- senior staff must be expected always to be available to take responsibility for decisions about assessment and management of risk;
- training must be supported and adequately resourced;
- alliances and partnerships with other agencies should be maintained, and mechanisms put in place to ensure their maintenance.

ANNEX 6

MILLAN'S TEN PRINCIPLES
(from "New Directions": Report on the Review of the Mental Health (Scotland) Act* 1984)

1. **Non-discrimination**
   People with mental disorder should, whenever possible, retain the same rights and entitlements as those with other health needs.
2. **Equality**
   All powers under the Act* should be exercised without any direct or indirect discrimination on the grounds of physical disability, age, gender, sexual orientation, race, colour, language, religion or national or ethnic or social origin.
3. **Respect for Diversity**
   Service users should receive care, treatment and support in a manner that accords respect for their individual qualities, abilities and diverse backgrounds and properly takes into account their age, gender, sexual orientation, ethnic group and social, cultural and religious background.
4. **Reciprocity**
   Where society imposes an obligation on an individual to comply with a programme of treatment and care, it should impose a parallel obligation on the health and social care authorities to provide appropriate services, including ongoing care following discharge from compulsion.
5. **Informal Care**
   Wherever possible care, treatment and support should be provided to people with mental disorder without recourse to compulsion.
6. **Participation**
   Service users should be fully involved, to the extent permitted by their individual capacity, in all aspects of their assessment, care, treatment and support. Account should be taken of their past and present wishes, so far as they can be ascertained. Service users should be provided with all the information necessary to enable them to participate fully. All such information should be provided in a way which renders it most likely to be understood.
7. **Respect for Carers**
   Those who provide care to service users on an informal basis should receive respect for their role and experience, receive appropriate information and advice, and have their views and needs taken into account.
8. **Least Restrictive Alternative**
   Service users should be provided with any necessary care, treatment and support both in the least invasive manner and in the least restrictive manner and environment compatible with the delivery of safe and effective care, taking account where appropriate of the safety of others.
9. **Benefit**
   Any intervention under the Act* should be likely to produce for the service user a benefit which cannot reasonably be achieved other than by the intervention.
10. **Child Welfare**
    The welfare of a child with mental disorder should be paramount in any interventions imposed on the child under the Act*.

* The Act refers to the new Act, which will arise from the report, not the existing 1984 Act.

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