Canterbury District Health Board
Te Poari Hauora ō Waitaha

Inpatient Close Observation – Hospital Aide and Security Officer Policy

Contents

Purpose

- To provide:
- A safe standard of care and supervision for patients who require an increased level of visual observation and supportive care to ensure their safety and that of others whilst undergoing treatment
- Clear guidelines and procedures for staff when utilising formal levels of visual observation and supportive care.

Policy

Formal visual observation and supportive care are vital factors in the clinical management of patients at risk to themselves and/or others to the extent where increased visual observation, support and de-escalation or distraction interventions are required to maintain safety.

This policy includes all patients admitted into a patient care setting, who require visual observation and supportive care by healthcare staff or security staff. The Registered Nurse (RN) caring for the patient will undertake an initial risk assessment upon the patient's arrival to the area, or if the patient's behaviour changes, to identify the visual observation and supportive care requirements for the patient and to determine the level of personnel required – Hospital Aide Special or Security Officer.

The initial risk assessment is documented on the Inpatient Observation Record. During the episode of visual observation and supportive care, the patient is to be reassessed every eight hours by the RN caring for the patient. The results of the reassessment will determine whether the visual observation and supportive care episode is to continue or formally discontinued, and whether the level of personnel is correct. The reassessment results are to be documented on the Inpatient Observation Record.

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Clinical, evidenced based, safe and effective treatment options will be provided by:

- Accurate clinical risk assessment undertaken by RN to determine the level of visual observance required.
- Risk assessment will determine the level of risk management actions using the Inpatient Observation Record.
- Documented rationale, goal and intended outcome will be identified within the clinical record by the multidisciplinary team. Wherever possible, this should be done in conjunction with the patient and their family/whanau.
- Ensuring the environment is safe, identifying and managing potential hazards.
- The provision of trained staff to carry out visual observations, supportive care and de-escalation/distraction techniques as directed by the RN.
- Consideration of restraint minimisation assessment following CDHB Restraint Minimisation & Safe Practice Policy. If restraint is planned or undertaken, completion of a Use of Restraint Form and Safety 1st entry is required with an ongoing plan to reduce and end the restraint to be documented.
- Where bed rails are in use as an enabler, the rationale and ongoing risk assessment during their use must be documented in the care plan, Low beds can be ordered to maintain patient safety when mobilising in or out of bed as required.

The level of visual observation should be at the least restrictive level, for the least amount of time within the least restrictive setting.

Scope/Audience

Excludes SMHS Clients in ED.

Excludes patients requiring a RN special.

Visual observations should be undertaken within the CDHB by a Hospital Aide (HA)/Health Care Assistant (HCA) or Security personnel under the direction and delegation of a Registered Nurse (RN).

Definitions

Observation is the action of watching or noticing something. For the purposes of this policy, it is performed by a suitability trained Hospital Aide, Health Care Assistant or Security Staff member.

Supportive care is the provision of nursing delegated & directed personal, psychological and social care by a suitably trained nurse/Hospital Aide/HCA.

Determining the level of Visual Observation and Supportive Care Required

Factors to support the decision for visual observation and supportive care may include but are not limited to:

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- Risk of harm to self or others
- Level of unpredictability
- Degree of impaired judgement or insight
- Agitation, arousal or unknown risk e.g. unknown patient
- Risk of absconding
- Risk of falling/collapse
- Vulnerability e.g. physical, gender, developmental, inter-personal or other
- Environmental factors such as ward environment should also be considered.

Levels of Visual Observation and Supportive Care

In emergency situations, where there is immediate risk to the individual, other patients, staff or property, the staff member should ring 777 to get immediate help.

Aggressive Patient policy enactment if appropriate.

Level 1: Within arm's length (one to one observation

- Level 1 may be required for the patient assessed to be at extreme or high risk of sudden and/or unpredictable or impulsive behaviour that presents a danger to themselves or others in the context of their illness and the environment.
- The patient must be within arm's reach and in clear sight of the staff member at all times due to the presence of immediate and impulsive risk behaviours. This includes bathroom and toilet areas. All attempts to maintain the person's dignity must be made, including ensuring gender appropriateness.
- Transfer of care must take place in the presence of the patient. The new Observer and the patient must be introduced.
- Visitors should be negotiated for set periods of time and the Observer must remain constantly present during the visit.

Level 2: Within line of sight (constant observation

- Level 2 may be required for the patient assessed as high or increasingly high risk in the context of their illness and their environment.
- The patient remains in unobstructed sight of the assigned Observer on a 1:1 basis at all time. In some instances, it may be clinically identified that the assigned Observer is to remain the same room as the patient at all times. This must be clearly documented on the Inpatient Observation Record.
- Includes constant supervision in bathroom and toilet areas, unless the door is able to be left ajar and the Observer is able to access the room immediately. All attempts to maintain patient dignity must be made.
- Transfer of care must take place in the presence of the patient. The new Observer and the patient must be introduced.

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- Visitors should be negotiated for set periods of time and the Observer must remain constantly present during the visit.
- Level 2 observations may be undertaken by the family/whanau, in which case it is the responsibility of the RN caring for the patient, to document observations on the Inpatient Observation Record.

Level 3: Cohort

- Level 3 may be required for the patient assessed with mental state deterioration or a potential risk.
- Level 3 is for patients who require a high level of proactive management of risks and/or distress but do not require constant presence.
- Transfer of care and observation may take place following usual handover procedures. Both Observers and RN's must sight the patient and the new Observer and the patient must be introduced.
- Level 3 observations may be undertaken by the family/whanau, in which case it is the responsibility of the RN caring for the patient, to document observations on the Inpatient Observation Record.

Authorisation for observation levels

Initiating or increasing a level of observation

- The RN caring for the patient is responsible for undertaking the assessment that will inform the level of observation required after discussion with the appropriate personnel e.g. ambulance, police, family, patient, CNM/NIC/ACNM and medical staff.
- Authorisation and changes to a level of observation must be recorded on the Inpatient Observation Record.

Reducing and ending levels of observation

- Decisions to reduce levels of observation are made by the RN/NIC/CNM/ACNM.
- The rationale for reduction/discontinuation must be documented on the Inpatient Observation Record.

Assigning Duties – Delegation and Direction

- The decision to delegate is a professional judgement, guided by the NCNZ Guide to Direction and Delegation. Delegation of Observation is made by a RN/NIC/CNM/ACNM following the process outlined in the NCNZ document and must include a health status assessment of the patient prior to delegation. Prior to delegating the Observation role to another staff member, the RN/NIC/CNM/ACNM delegating will take into account; prior rapport with and knowledge of the patient; the level of knowledge, skills and experience

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required' the patient's degree of unwellness and complexity, the context of care provision and gender or cultural concerns.

- The RN/EN caring for the patient must check the person delegated the Observation role is checked hourly, or more regularly as required.
- Staff involved in carrying out observation must be familiar with ward or location specific protocols or practices which relate to this policy.

Security

- In an emergency, staff requiring Security should call 777.
- For non-emergencies:
    - During weekdays excluding public holidays, the ACNM/CNM/NIC will authorise Security if required (except in an emergency) and contact the Security Office directly to deploy staff.
    - After 4pm weekdays, weekends and public holidays, the ACNM/NIC will discuss assessment with the Duty Nurse Manager (DNM) who will authorise Security if required (except in an emergency), the DNM will contact the Security Office directly to deploy staff.

Hospital Aide Specials

- The RN caring for the patient after discussion with CNM/ACNM/NIC will contact the Duty Office directly if required, to deploy staff. After 4pm weekdays, weekends and public holidays, contact the Duty Nurse Manager (DNM)

Roles and Responsibilities

The RN caring for the patient maintains overall responsibility and accountability for:

- Undertaking the assessment that will inform the level of observation required including agitation score.
- Formulating the plan of nursing care and the evaluation of the patient response.
- Ensuring the Inpatient Observation Record is completed, including documentation of continuing risk and changes in health status i.e. deterioration/improvement.
- Sighting the patient hourly and receiving a verbal update from the Observer.
- Signing off Observer documentation.
- Ensuring that support, guidance and direction are provided for the Observers.
- Documenting and communicating activities the HA should provide e.g. help with toileting.
- Ensuring care requirements and directions are communicated and documented for Observers.
- Following up with the delegated observer, and obtaining patient care updates.

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- Being available, or ensuring a RN colleague is available in their absence, for advice on nursing requirements.
- Discuss ongoing level of care required with Observer.
- Liaising with the CNM/NIC/ACNM in relation to review.
- Provide a transfer of care to the observer with clear directions related to patient care and safety
- Liaise with the CNM/NIC/ACNM in relation to the reassessment of the patient and the requirement for ongoing visual observation, level of ongoing observation or the ending of visual observation.
- Document condition reassessment at the end of each shift.
- Providing a patient centred handover (with the patient and/or family) to the observer between shifts.

The Observer is responsible for:

- Working within their scope/job description, under the direction of the RN.
- Undertaking visual observation as per the direction related to the Level of Visual Observation, or no less frequently than hourly.
- Contributing to the Inpatient Observation Record.
- Ensuring relevant information or concerns about the patient are communicated to the RN caring for the patient.
- Maintaining line of sight visual observation and reporting to the RN any change in health or psychological status.
- Documenting observed activities and interactions as they occur or a minimum of every hour if inactive on the Inpatient Observation Record.

Associated Documents

CDHB documents,

- Inpatient Observation Record C280128
- Emergency Department Observation (including specialling) Policy for SHMS Clients.
- Emergency Department Observation Record
- Restraint Minimisation & Safe Practice Policy
- CDHB Approved Restraints document
- Fall Prevention Policy
- Policy for managing Aggressive patients

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Documentation

- The Inpatient Observation Record should be completed at the commencement of a formal level of observation and retained in the clinical file after page completion, end of observation, or end of shift.
- Ongoing observations are to be written on the Inpatient Observation Record.

Reassessment

- Reassessment of the ongoing level of observation required, must be completed every 8 hours minimum, or more often as clinically justified/warranted by the RN caring for patient. The decision to alter the required level of visual observation is in discussion between the RN and the CNM/NIC/ACNM/Medical staff. This discussion is to be documented using the risk assessment section of the Inpatient Observation Record.
- If the person has had increased observation for longer than 24 hours, assessment and evaluation must be carried out by the CNM (normal hours) or NIC (after hours) and a new Inpatient Observation Record commenced.

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