1. PURPOSE

1.1. To ensure individuals receiving acute inpatient care or crisis services in the WRHA Mental Health Program are observed at intervals determined by their risk of harm to self, others, or environment.

1.2. To ensure that individuals receiving acute inpatient care or crisis services in the WRHA Mental Health Program are observed through practice that is grounded in therapeutic engagement and conducted as a method to build a relationship with an individual rather than as a purely monitoring activity.

2. PRACTICE OUTCOMES

2.1. Individuals will have a documented observation level and therapeutic engagement plan that addresses their unique level of risk, related needs, and interventions.

2.2. Interdisciplinary teams will develop observation and therapeutic engagement strategies that address times when staff may be less available on the unit such as during shift changes, team meetings, and at night.

2.3. Consistency across the WRHA Mental Health Program in how observation is conducted, communicated, and documented.

2.4. Consistent communication of an individual’s risk to other service providers, and family as appropriate.

3. DEFINITIONS

3.1. **Family**: Is defined by the individual and includes all those persons that the individual considers to be family. In the case of individuals under 18 years of age, family consists of any legal guardian, custodial parent, and non-custodial biological parent.

3.2. **Individual**: A person receiving services from the Mental Health Program in an inpatient or crisis service setting.

3.3. **Risk assessment**: Is a complex process involving objective data (such as individual history, behaviour, etc.), subjective data (provided by the individual), data from third parties, and the judgment of the clinicians’ involved (NHS Scotland, 2002).

3.4. **Observation**: Ongoing assessment of the individual’s mental and physical health status to identify and subvert any potential problems (Austin & Boyd, 2008).

3.5. **Therapeutic engagement**: Is about building a trusting relationship, and is a “purposeful, goal directed relationship that is directed at advancing the best interest and outcome of the individual” (RNAO, 2006). “Therapeutic engagement involves healthcare professionals spending quality time with individuals and aims to empower the individual to actively participate in their care” (Pereia and Woolastan, 2007).
4. GUIDING PRINCIPLES

4.1. Observation and therapeutic engagement strategies are developed in collaboration with the individual and in accordance with the WRHA Mental Health Program (2013), Involving Families Clinical Practice Guideline and implemented based on the individuals’ assessed level of risk.

4.2. The practice of observation and characteristics of inpatient settings contribute to unique environments and are understood to influence people’s behaviours. Mental health care professionals can use this knowledge to help individuals feel comfortable and to promote recovery (Victorian Department of Health, 2013).

4.3. Just as for people in wider society, being observed produces a broad range of reactions from people receiving care for mental health conditions. It is important to understand how a person’s history or past experience might impact on the experience of being observed. It is important to consider (amongst other factors): gender sensitive care; culturally sensitive practice; and trauma informed care. (Victorian Department of Health, 2013).

4.4. Observation should be set at the least restrictive level, for the least amount of time within the least restrictive setting, given that the process of observation can be considered an imposition on an individuals’ freedom and dignity. When possible, the interdisciplinary team should seek the consent and understanding of the individual (or substitute decision maker where applicable). Refer to WRHA Policy (110.000.005) Informed Consent (for Procedures, Treatments, and Investigations).

4.5. Observation and assessment are interrelated and form part of a continuous cycle. Observation contributes to risk assessments and these assessments inform the modification of care. The effectiveness of care is determined through observation. (Victorian Department of Health, 2013).

4.6. Respect for privacy is an important consideration, and should be balanced with safety of the individual. Decisions about escorting individuals to the toilet or shower, for example, are part of the overall risk assessment process conducted by the team.

4.7. Observation is undertaken to inform subsequent decision making and includes:

- Objective and subjective information
- Information about a person’s psychosocial wellbeing, mental and physical health, and their potential risk areas to harm self or others including elopement, suicide, violence, behavioural issues, and falls.

5. PROCEDURES

5.1. All individuals admitted to inpatient or crisis service settings will be assessed for observation level upon admission, at regular intervals, and as needs change.
5.2. The individual and their family (as appropriate and when possible) are informed about what observation means, the purpose of the observation, and how it will occur over a 24 hour period. Feedback is invited on observation methods and individual’s responses are integrated into how this practice is performed.

5.3. As part of the observation process the interdisciplinary team assesses how individuals are responding to the inpatient/crisis service environment and assist with adjustment by:

- Addressing any perceptions individuals may have about what it is like in an inpatient unit/crisis service;
- Orienting the individual to the unit environment and routine on admission and ongoing as appropriate;
- Recognizing and negotiating the right for privacy, relaxation, and rest;
- Assessing how the environment is impacting the person and supporting them with it;
- Encouraging engagement in unit based activities when appropriate;
- Reviewing on a daily basis how the observations and environment is impacting the individual; and
- Conducting observation with more than one staff member for reasons of staff safety.

5.4 In an emergent situation, when an individual’s clinical presentation necessitates, a heightened observation level/therapeutic engagement plan may be implemented without the individual’s involvement in developing the plan. Individual involvement with the plan will occur as soon as possible.

5.5 Observation Levels:

5.5.1 **Constant Observation** (care) is an increased level of observation requiring one-to-one supervision at all times by a designated staff. This level of observation is potentially the most intrusive and should be determined in collaboration with the interdisciplinary team. Constant observation is used only when assessed to be strictly necessary and is subject to frequent review every 24 hours. Treatment teams should consider the following when planning constant care:

- Type of 1:1 care provider: security, HCA, or other;
- Preference for familiar staff;
- Proximity of care provider (i.e. within arm’s length or within eyesight of the individual.)

5.5.1 **Frequent 15 Minute Observation** is an increased level of observation for individuals assessed at a higher risk of harm to self or others because of physical or mental health status. It is
<table>
<thead>
<tr>
<th>Practice Guideline:</th>
<th>Observation and Therapeutic Engagement Levels</th>
</tr>
</thead>
<tbody>
<tr>
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<td>8</td>
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</table>
| Approved By:        | Dr. Jitender Sareen, WRHA Regional Medical Director, Mental Health  
|                     | Susan Chipperfield, WRHA Regional Program Director, Mental Health  
|                     | Signed off by Professional Advisory Council October 27, 2017 |
| Approval Date:      | November 1, 2017                              |
| Supercedes:         |                                                |

5.5.2 **Routine Hourly Observation** is the least restrictive level of observation provided for all patients who are at a minimal risk of harm to self or others.

5.5.3 See Appendix A: Observation Practice Standards

5.5.4 See Appendix B: Unit Rounds & Observation Option A & B

5.5.5 See Appendix C: Important Tips About Observation in Mental Health

5.6 **Information Transfer**

5.6.1 Communication about observation levels occurs verbally and in written documentation at transition points in care in accordance with WRHA Mental Health Program (2016) *Ensuring Information Continuity Clinical Practice Guideline.*

5.6.2 An individual's observation level will be verbally stated during each shift to shift report.

5.6.3 An individual’s previous observation level(s) and current observation level will be discussed at minimum weekly at team rounds.

5.7 **Documentation**

5.7.1 Nurses or Physicians may determine the appropriate level of observation following an assessment. The order for the level of observation will be recorded as either a Nursing Order or a Physician order on the order sheet.

5.7.2 Reason for change of Observation Level will be documented in the Integrated Progress Notes (IPN).

5.7.3 The observation level will be noted on the Unit Rounds and Observation sheet (see Appendix B) and the level will be confirmed with the new staff on the log sheet.

5.8 **Therapeutic Engagement Plan:**

5.8.1 In addition to the team assessed observation level (see item 5.5), the nurse/crisis service worker develops (in collaboration with the individual, family and other interdisciplinary team members as appropriate) a written individualized care plan for how and when meaningful engagement will occur for each shift with assigned nurse/crisis service worker. Existing tools such as the Patient Care Plan or Patient Safety Plan (for example) should be modified to include a plan. It is recognized that sometimes individuals may not wish to engage in meaningful interactions with staff members. This does not preclude staff members from:

- Attempting to engage the individual again at a later time;
- Ensuring the individual’s basic needs are met;
• Objectively assessing and reviewing a person’s mental state and general behaviours.

6. CORRESPONDING GUIDELINES AND POLICIES


6.8 WRHA Mental Health Program (2016, September). Ensuring Informational Continuity Clinical Practice Guideline. Retrieved from

6.9 WRHA Mental Health Program (2016, draft). Care of the Patient with Disinhibited Sexual Behaviour Clinical Practice Guideline.

6.10 WRHA Mental Health Program (2017, draft). Trauma-Informed Care Clinical Practice Guideline.

7 SOURCES/REFERENCES

WRHA MENTAL HEALTH REGIONAL PROGRAM PRACTICE GUIDELINE

Practice Guideline: Observation and Therapeutic Engagement Levels

Approved By:
Dr. Jitender Sareen, WRHA Regional Medical Director, Mental Health
Susan Chipperfield, WRHA Regional Program Director, Mental Health
Signed off by Professional Advisory Council October 27, 2017

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Approval Date: November 1, 2017

Supersedes:


8 PRIMARY AUTHOR
8.1 Regional Observation and Therapeutic Engagement Levels Working Group.

9 ALTERNATE CONTACT
9.1 Co-Chairs, Regional Mental Health Program Practice Guidelines Coordination Committee

10 APPENDICES
10.1 Appendix A: Acute Care Practice Standards
10.2 Appendix B: Unit Rounds & Observation sheet Option A & B
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<tr>
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10.3 Appendix C: Important Tips About Observation in Mental Health
## APPENDIX A: OBSERVATION PRACTICE STANDARDS

<table>
<thead>
<tr>
<th>Observation Component</th>
<th>Constant</th>
<th>Frequent 15 minutes</th>
<th>Routine Hourly</th>
</tr>
</thead>
<tbody>
<tr>
<td>Frequency of visual observation</td>
<td>continuous</td>
<td>Q 15 minutes</td>
<td>Q 1 hour</td>
</tr>
<tr>
<td>Process to initiate level of observation</td>
<td>Upon Nurse or Manager’s assessment (requires managerial approval to increase staffing) or as ordered by MD. *Specify within eyesight or within arm’s length.</td>
<td>Upon Nurse assessment or as ordered by MD.</td>
<td>All individuals on hourly at minimum</td>
</tr>
<tr>
<td>Process to discontinue level of observation</td>
<td>Upon Nurse or Manager’s assessment. MD order required only if order initiated by MD.</td>
<td>Upon Nurse assessment. MD order required only if order initiated by MD.</td>
<td>All individuals on hourly at minimum</td>
</tr>
<tr>
<td>Frequency of reassessment of Observation status</td>
<td>Every 24 hours</td>
<td>Determined by changes in mental and/or physical status</td>
<td></td>
</tr>
<tr>
<td>Communication of Observation status</td>
<td>On Order Sheet; Unit Rounds &amp; Observation Sheet; Individual Constant/Seclusion Observation Record.</td>
<td>Verbally stated each shift change during shift to shift report.</td>
<td>Minimum weekly review at full team meeting of previous week’s level(s) and current observation level.</td>
</tr>
<tr>
<td>Observation status explained to individual and family</td>
<td>Yes, completed by the Nurse. The meaning, purpose of the observation, and how it will occur are included in the explanation.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Documentation</td>
<td>- Order Sheet (physician &amp; nurse) - Integrated Progress Note -Assessment/Intervention Record Part A &amp; B -Constant Care 24-hour monitoring flow record -Unit Rounds &amp; Observation Sheet - Completed q 15 minutes or pm</td>
<td>- Order Sheet (physician &amp; nurse) -Integrated Progress Note -Activity Flow Sheet -Unit Rounds &amp; Observation Sheet - Completed q 15 minutes</td>
<td>- Order Sheet (physician &amp; nurse) -Unit Rounds &amp; Observation Sheet - Completed once per hour</td>
</tr>
<tr>
<td>Requirements for off-unit activity</td>
<td>Per assessment of the team: Must be accompanied by a staff member who remains with individual at all times</td>
<td>As assessed by the Nurse. MD order required for passes.</td>
<td></td>
</tr>
<tr>
<td>Individual bed assignment</td>
<td>Team assesses unit population, location, and proximity to the nursing desk.</td>
<td>Team assesses unit population.</td>
<td></td>
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<tr>
<td>Individual’s personal belongings: locked/secured or given to family</td>
<td>Upon Nurse’s assessment</td>
<td></td>
<td></td>
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<tr>
<td>Individual/belongings/environment searched for harmful items.</td>
<td>Yes – if located items are removed and/or secured</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Clothing requirements</td>
<td>Individual’s personal clothing preferred unless rationale for Hospital issue</td>
<td></td>
<td></td>
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<tr>
<td>Other: Visitor restrictions, Activity restrictions, Frequency of vital signs…</td>
<td>Upon Nurse’s assessment or as ordered by MD.</td>
<td></td>
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<td>Observation performed by:</td>
<td>RN/RPN; UA, NA; HCA/UCA, AC, Security or delegate</td>
<td>RN/RPN; UA, NA; HCA/UCA, AC, or delegate</td>
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*Signed off by Professional Advisory Council October 27, 2017*

**Approval Date:**

November 1, 2017

**Supercedes:**

APPENDIX B: Unit Rounds & Observation sheet