Policy: Nursing Observation through Engagement within Tiaho Mai

Background/Overview

The primary aim of the service is to engage positively with the service user. This involves a two-way relationship, established between a service user and a staff member, which is meaningful, grounded in trust, and therapeutic for the service user.

There are several core principles that underlie the practice of nursing observation. The principles hold that:

- Nursing observation is multifaceted
- Observation and assessment are interrelated
- Observation is grounded in therapeutic engagement with the person
- Nurses appreciate how inpatient environments and observation itself influence people's behaviour
- Observations are communicated between colleagues
- There is a clear process of documentation that is timely and descriptive.

Purpose

The purpose of the policy is to describe the levels of observation that will be used in Tiaho Mai. All service users admitted to Tiaho Mai will be assigned a level of observation based on the individual risks and safety needs.

Note: This policy also needs to be read in conjunction with:

Guideline – Nursing Observation through Engagement within Acute Mental Health Services

Procedure - Nursing Observation and Engagement within Tiaho Mai

Risk Assessment

Scope

This policy is applicable to all CMDHB employees, (full-time, part-time and casual (temporary) including contractors, visiting health professionals and students working in Tiaho Mai.

Policy

Therapeutic engagement and observation is an integral part of all inpatient treatment.

- Therapeutic engagement and observation will be used continuously as part of the ongoing assessment of risk and needs of individual service users.

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- Service users will be assigned a level of observation appropriate to their risk profile and safety needs.
- The periods of observation are part of the overall treatment plan and are structured to support a positive experience by the service user.
- Engagement and observation are components of the ongoing assessment of a person's mental state.

Levels of Observation

There are four levels of observation:

- Hourly Observation
- Intermittent Observation
- Continuous Visual
- Constant within arm's reach

Definitions

Terms and abbreviations used in this document are described below:

Term/Abbreviation	Description
Observation	Locate, check, engage, supervise and critically observe a service user on a regular basis.
Therapeutic Engagement	Involves healthcare professionals spending time with service users to collaborate, discuss reasons for observation, invite feedback, and foster meaningful relationships.
Hourly Observation	Is the minimum level of observation in the Acute Adult Mental Health Inpatient Unit. Every service user will be located, visually sighted, engaged with and monitored at least hourly during their admission.
Intermittent Observation	Regular and random observation at intervals between 15-30 minutes. This includes meal times and shift handovers.
Constant Visual Observation (line of sight)	The service user is constantly within eyesight and immediately accessible to an assigned staff member.
Constant within Arm's Reach	Staff are positioned within arm's reach of the service user at all times, responding to their needs as appropriate.

Associated Documents

Other documents relevant to this policy are listed below:

NZ Legislation	Mental Health Act (1969) Mental Health (Compulsory Assessment and Treatment) Act (1992) Mental Health (Compulsory Assessment and Treatment) Amendment Act (1999) Health Practitioner Competency Assurance Act (2003) The Health & Disability Commissioner (Code of Health & Disability Consumer Rights) Regulations (1996) Privacy Act (1993)
CMDHB Policies & Procedures	Deployment of Nursing and Midwifery Staff – Policy Tikanga Best Practice Safe Management and Privacy of Personal Health Information - Policy Informed Consent Policy Therapeutic engagement and observation Procedure Service User and Family Whaanau Participation Policy Watch Procedure
NZ Standards	NZNC Responsibilities for Direction and delegation of care to an enrolled nurse. (2011) NZNC Guideline: Delegation of care by a Registered Nurse to a Health Care Assistant. (2011)

References (Evidence Based Practice)

Te Pou (2009) Working with Services User. Let's Get Real

Te Pou (2009) Working with Families/Whanau. Let's Get Real

National institute for clinical excellence www.nice.org.uk

'Avoidable Deaths' Five year report of the national confidential inquiry into suicide and homicide by people with mental illness (2006) University of Manchester. Bowers L, Flood C, Brennan G & Allan T (2008)

A replication study of the City nurse intervention: reducing conflict and containment on three acute psychiatric wards *Journal of Psychiatric and Mental Health Nursing* 15, 737-742.

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National Institute for Health and Clinical Excellence (2005) *Violence: the short-term management of disturbed/violent behaviour in inpatient psychiatric settings and emergency departments.* Clinical Guideline. 25. London: NICE.

Savage v South Essex Partnerships NHS Trust – (January 2009)

National Institute for Health and Clinical Excellence (2005a) *Violence: managing disturbed/violent behaviour. Understanding NICE guidance – information for patients, their advocates, families and carers, and the public.* London: NICE.

Department of Health, January 2010: "See, Think, Act – your guide to relational security"

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Procedure: Nursing Observation through Engagement within Tiaho Mai

Purpose

This procedure clarifies roles and responsibilities, and clarifies the process for allocating, increasing, decreasing and reviewing levels of observation.

Note: The Nursing Observation through Engagement Guideline sets out the scope and principles for all staff.

Responsibilities

All staff within the scope of this procedure is expected to:

- Comply with the procedure with awareness of the related legal and professional obligations and responsibilities.
- Undertake relevant education/training.

Nurse Unit Manager, Charge Nurse Manager, Associate Charge Nurse Manager or their delegates

- To operationalise this procedure.
- To ensure all staff is informed of their responsibilities associated with this procedure.
- To have an overview of the acuity requirements of the ward and allocate staff to meet that demand.
- To undertake regular audits to monitor compliance with procedure.

Registered Nurses (RN)

- On admission complete a mental health clinical assessment to determine the appropriate observation level using general clinical judgement and tools available e.g. Dynamic Appraisal of Situational Aggression (DASA), Vulnerability Risk Scale (VRS) and Aggression Risk Checklist (ARC). Consider:
  - Mental/Emotional state
  - Physical profile including falls risk
  - Risk Assessment – Alerts, acute admission plans, trauma and risk history, risk to self, risk to others, AWOL risk, aggression, disinhibition, vulnerability, etc.
- Participate in regular review of level of observation as clinically indicated (i.e. ward rounds, handover, MDT etc.).
- Inform any ACNM and/or CNM if the service user is behaving in a manner that causes concern.
- Discuss with the service user and their family/whaanau the rationale and process for assigning observation levels.
- Engage cultural support as appropriate.
- Take on-going responsibility to see that the service user's observation level is maintained and documentation is completed.
- Some tasks related to observation may be directed and delegated to appropriate staff. This requires the delegated staff member to have a clear understanding of the observation rationale, tasks required and service user's treatment plan. The RN retains clinical responsibility.

- When observation tasks have been delegated check with observer hourly, at a minimum, to ensure that requirements are being met and staff member is well supported.
- Document a clinical summary once per shift in the clinical record.

Enrolled Nurse (EN)

- Perform the roles under the direction and delegation of a specific RN.
- Report directly to the RN.
- Maintain regular communication with the RN and other staff through the shift, at least hourly.
- Document on the appropriate observation forms provided.
- Document in the clinical record a clinical summary of the service user once per shift.
- Inform the RN of any changes in the service user's condition.
- Inform any RN if the service user is behaving in a manner that causes concern.

Psychiatric Assistants (PA)

- Perform the roles under the direction and delegation of a specific RN.
- Report directly to the RN.
- Maintain regular communication with the RN and other staff through the shift, at least hourly.
- Document on the appropriate observation forms provided.
- Inform the RN of any changes in the service user's condition.
- Inform any RN if the service user is behaving in a manner that causes concern.

A Care Giver

- To perform the roles under supervision of the RN who retains accountability for the care of the patient if deemed appropriate.
- The RN is responsible for completing all clinical documentation in the clinical record.
- The RN must maintain regular communication with the caregiver and other staff through the shift.
- The caregiver must understand the risks and treatment plan and inform the RN of any changes in the patient's condition
- The caregiver must inform any RN if the patient is behaving in a manner that causes concern

Student nurses

- BN6 students may undertake all observations under close delegation of the RN (as described for EN above).

Note: Only Hourly observations may be undertaken by BN4 students

Resources

- **Watch observations chart**
- **Procedure**

1. **Observation types and indicators**
2. **Assessment**
3. **Observation management and review**
4. **Handover**

Nursing staff must be aware of each individual patient's needs and whereabouts and any likely concerns for their well being in order to ensure that the patient has the right level of observation and that staff are responsive to their needs.

When delegating to the role of the observer the Registered Nurse must consider the following:

- The needs of the patient / service user
- The safety risks
- Cultural and gender appropriateness
- The skill / experience understanding of the person being delegated to

Following a full risk assessment it may at times be appropriate for more than one person to be allocated at a time to the role of the observer

Best practice would indicate that the role of observer is not undertaken for prolonged periods. Ideally the role should be rotated hourly

1. Observation types and indicators

Type	**Definition**	**Indicator.** (Observation levels must be based on regular clinical assessment of individual patients.) **The following list is not limited to but should include:**
General	**Low Dependency Unit (LDU):** Every Service User will need to be located and monitored at least hourly during their stay in the Adult Inpatient Service. **High Dependency Unit (HDU):** Every Service User will need to be located and monitored at least every 15 minutes	All Service Users admitted to the inpatient facility
Intermittent Observations	The Service User is located and observed at intervals of up to 15 minutes apart. All Registered Nurses can implement 15 minute observations and discontinue the same.	**The Service User is assessed as:** - AWOL risk - transitioning from HDU to LDU - risk of self-harm in short term - requiring high physical care and/or assistance - sexually disinhibited or vulnerable
Constant Observation In clear view	When the Service User must be in sight of the staff member Observing at all times.	**The Service User is assessed as:** - acutely psychotic and/or suicidal with impaired judgement - risk of self harm in the immediate future - acute medical presentation - delirium or dementia - high risk to self and/or others

		- high AWOL risk with treatment required urgently - Known recent sexual inappropriateness and or vulnerability
Constant Observation (Within Arms Reach)	When the Service User must be at arms reach of the staff member observing at all times	**The Service User is assessed as:** - acutely psychotic - having the intent and plan to commit suicide - being a high and imminent risk to self and/or others

2. Assessment

Observation Through Engagement Procedure

STAGE	PROCESS	DOCUMENTATION
Admission	Tiaho Mai Safety Assessment completed Analyse the scores from: ➢ Risk Assessment ➢ Aggression Risk Checklist ➢ Violence Risk Checklist ➢ Identify Risks and Strengths	Documentation within the HCC clinical notes and alerts as appropriate
Collateral Information	Contact: ➢ Family/whanau (NOK) ➢ Residual Facility Staff ➢ Support workers ➢ Other service providers	Document in HCC clinical notes
Ward Placement	Decide which ward is appropriate based on service user need and risk: ➢ High Dependency Unit ➢ Low Dependency Unit	Record ward, room and mode allocation and rationale in HCC: ➢ HCC clinical notes ➢ MDT form ➢ SBAR Update the ward, room and mode allocation on: ➢ electronic Whiteboard ➢ observation checklist Commence individual observation form for all service users on Intermittent, Continuous or Constant observations
Room Placement	Consider the specific bed requirement: ➢ Retreat (LSE) ➢ Standard bedroom ➢ Special A bedroom ➢ Special B bedroom ➢ Consider proximity to clinical operations including sub-bases ➢ Consider Gender, current SU placements	
Consider changing building mode configuration	A variety of configurations are available including service user flow and pod options. Refer to the Operational Mode Guide.	If a Mode change is required document as per the Operational Mode Guide.
Allocation of Observation Level	In consultation with the SMO/MOSS/Registrar choose the appropriate observation level either: **1. Hourly** **2. Intermittent** **3. Continuous Visual** **4. Constant within arms reach** Inform the service user, family/whanau and ward staff of the observation type and rationale.	Record decision and rationale: ➢ In HCC clinical notes ➢ SBAR Form ➢ MDT Form ➢ Whiteboard
Allocation of AWOL Status	The medical team assess AWOL risk and assign the appropriate category with rationale	
Allocation of Leave Status	The medical team allocate leave based on assessment ➢ Unescorted leave ➢ Supervised Leave with family/whanau ➢ Escorted Leave ➢ No Leave	
Communicate to the senior nurse on duty	Inform the Nurse in Charge of the allocated observation level. The nurse in charge will allocate an RN for over-all responsibility. Directed & Delegated staff must: ➢ Carry a personal alarm which they know how to use ➢ Discuss the service user profile, rationale for observation and expectations	As the allocated staff member commences observation they sign the observation recording sheet as they accept responsibility for the observation Alarm Allocation recorded
Observation commences	At allocated observation periods: ➢ Visually sight ALL service users ➢ Check breathing ➢ Engage with service users ➢ Respond to needs as appropriate ➢ Complete required documentation ➢ Communicate with team of any issues, concerns, etc	**Hourly** - Complete the ***generic*** checklist form **Intermittent, Continuous & Constant** – each service user assigned to these levels of observation has an ***individual*** observation form to be completed as per instructions on the form.
Ongoing assessment of observation levels	Allocated RN reassess risk and observation level **each shift and with the medical team at CWR each morning.** ➢ Observations may be increased by nursing staff ➢ When decision to increase is made a medical review must be requested ➢ Reduction of observations level must only be in consultation with medical staff Inform the service user and family/whanau and ward staff of any changes and the rationale.	Record ongoing decisions and rationale in HCC clinical notes Update SBAR, MDT Form and whiteboard

3. Observation, Management and Review

Hourly Observation Procedure

This is the minimum level of observation ALL service users in the Acute Adult Inpatient Unit.

STAGE	PROCESS	DOCUMENTATION
Observation Requirements	**Hourly observation requires staff to visually sight the Service User EVERY HOUR PLUS at meal times and shift handover times.** ➢ Inform the service user about the level of observation and the reason. ➢ Visually sight the service user ➢ Check breathing (if sleeping or lying on their bed) ➢ Engage with service users ➢ Respond to needs as appropriate ➢ Record as per the Generic Checklist ➢ Communicate with team of any issues, concerns, etc PLUS ➢ Be aware of service user Leave status ➢ Know the whereabouts of service users ➢ Inform RN immediately a service user's whereabouts are unknown	General Observation Form is commenced and maintained throughout the observation period. Whiteboard/SBAR reflects correct: ➢ Observation level ➢ AWOL Status ➢ Leave Status
Safety	All staff assigned to Houlry Observations must: ➢ Carry a personal alarm & know how to use it ➢ Be well informed of the service user profile ➢ Understand the rationale for observation ➢ Be clear of the RN's expectations ➢ Take regular scheduled breaks from observation	Alarm Allocation recorded
Responsibility	Each duty the service user will be allocated to a specific RN who is responsible for: ➢ Ensuring the Hourly Observation tasks including documentation are completed. ➢ Completing a MH assessment on AM & PM shifts plus PRN on nights ➢ Facilitating regular medical review ➢ Interacting and engaging with the service user ➢ The Direction & Delegation of appropriate tasks to EN's &/or PA's associated with the service user. ➢ Being accessible to support and communicate with delegated staff at all times	• When the assigned staff member commences observation they sign the observation recording sheet assuming responsibility of the observation. • The responsible RN ensures all documentation is accurate • Check the prior observer has completed the form and it is up to date. • If an EN or PA is assigned to observations, the RN is to countersign the forms as the delegate. • Record in the HCC clinical notes all issues and decisions. • Record MH assessment and risk assessment in the HCC clinical notes
Assessment	Allocated RN reassess risk and observation level **each shift and RN or their delegate reassesses situation with the medical team at CWR each morning.** ➢ Observations may be increased by nursing staff ➢ When decision to increase is made a medical review must be requested ➢ Reduction of observations level must only be in consultation with medical staff Inform the service user and family/whanau and ward staff of any changes and the rationale.	• Reviews, plans and mental state are documented in the HCC clinical notes • Ensure that rationale for maintaining, decreasing or increasing observation level is captured in the HCC record. • Update SBAR and MDT Form with any changes to AWOL & Leave status • Record names and relationships of family/whanau/carers who were informed along with their feedback and contact numbers.

Intermittent Observation Procedure

This is an enhanced level of observation intended for service users who may have:

- A compromised ability to maintain appropriate or acceptable behaviour and maybe identified as vulnerable or sexually disinhibited.
- Previously been at risk of harming themselves or others, but who are in a process of recovery.
- Been on a higher level of observation which is reducing, maybe transitioning between wards.
- Potential, but is not immediately, at risk of, or from, disturbed/violent behaviour.

STAGE	PROCESS	DOCUMENTATION
Observation Level	Intermittent Observation requires staff to: ➢ Inform the service user about the level of observation and the reason. ➢ Perform & Record regular & random observation at intervals BETWEEN 15-30 MINUTES as per Dr order as well as at meal times & at shift handovers ➢ Visually sight the service user ➢ Check breathing (if sleeping or lying on their bed) ➢ Engage with service users ➢ Respond to needs as appropriate ➢ Communicate with team of any issues, concerns, etc PLUS ➢ Be aware of service user Leave status ➢ Know the whereabouts of service users ➢ Inform RN immediately a service user's whereabouts are unknown	An Individual Observation Form is commenced and maintained throughout the observation period. Whiteboard/ SBAR reflects the correct: ➢ Observation level ➢ AWOL Status ➢ Leave Status
Safety	All staff assigned to Intermittent Observations must: ➢ Carry a personal alarm & know how to use it ➢ Be well informed of the service user profile ➢ Understand the rationale for observation ➢ Be clear of the RN's expectations ➢ Take regular scheduled breaks from observation	Alarm Allocation recorded
Responsibility	Each duty the service user will be allocated to a specific RN who is responsible for: ➢ Ensuring the Intermittent Observation tasks including documentation are completed. ➢ Completing a MH assessment on AM & PM shifts plus PRN on nights ➢ Facilitating regular medical review ➢ Interacting and engaging with the service user ➢ The Direction & Delegation of appropriate tasks to EN's &/or PA's associated with the service user. ➢ Being accessible to support and communicate with delegated staff at all times	• When the assigned staff member commences observation they sign the observation recording sheet assuming responsibility of the observation. • The responsible RN ensures all documentation is accurate • Check the prior observer has completed the form and it is up to date. • If an EN or PA is assigned to observations, the RN is to countersign the forms as the delegate. • Record in the HCC clinical notes all issues and decisions. • Record MH assessment and risk assessment in the HCC clinical notes
Assessment	Allocated RN reassess risk and observation level **each shift and with the medical team at CWR each morning.** ➢ Observations may be increased by nursing staff ➢ When decision to increase is made a medical review must be requested ➢ Reduction of observations level must only be in consultation with medical staff ➢ Assess the impact of the observations and the suitability of the environment Inform the service user, family/whanau and ward staff of any changes and the rationale.	• Reviews, plans and mental state are documented in the HCC clinical notes • Ensure that rationale for maintaining, decreasing or increasing observation level is captured in the HCC record. • Update SBAR and MDT Form with any changes to AWOL & Leave status • Record names and relationships of family/whanau/carers who were informed along with their feedback and contact numbers.

Continuous Visual Observation Procedure

This is an enhanced level of observation intended for service users who have been determined as being a high level of immediate risk to themselves or others (aggression/violence) They may:

- At any time, make an attempt to harm themselves or others.
- Be experiencing acute psychosis with impaired judgement, an acute medical condition, delirium or dementia and maybe identified as vulnerable or sexually disinhibited.
- Have a degree of impaired judgement and is reducing from a higher level of observation
- The service user is in LSE area

STAGE	PROCESS	DOCUMENTATION
Observation Requirements	Constant within Arm's Reach Observation requires staff to: ➢ Inform the service user about the level of observation and the reason. ➢ Remain in sight and within arm's length of the service user at all times ➢ Engage with service users as appropriate ➢ Respond to needs as appropriate ➢ Complete documentation ➢ Communicate with team of any issues, concerns, etc	An Individual Observation Form is commenced and maintained throughout the observation period. Whiteboard/SBAR reflects correct: ➢ Observation level ➢ AWOL Status ➢ Leave Status
Safety	All staff assigned to Continuous Visual Observations must: ➢ Carry a personal alarm & know how to use it ➢ Be well informed of the service user profile ➢ Understand the rationale for observation ➢ Be clear of the RN's expectations ➢ Take regular scheduled breaks from observation	Alarm Allocation recorded
Responsibility	Each duty the service user will be allocated to a specific RN who is responsible for: ➢ Ensuring the Continuous Visual Observation tasks including documentation are completed. ➢ Completing a MH assessment on ALL shifts ➢ Facilitating a daily medical review ➢ Interacting and engaging with the service user ➢ The Direction & Delegation of appropriate tasks to EN's &/or PA's associated with the service user. ➢ Being accessible to support and communicate with delegated staff at all times ➢ Issues of privacy, dignity & gender appropriateness are considered.	• When the assigned staff member commences observation they sign the observation recording sheet assuming responsibility of the observation. • The responsible RN ensures all documentation is accurate • Check the prior observer has completed the form and it is up to date. • If an EN or PA is assigned to observations, the RN is to countersign the forms as the delegate. • Record in the HCC clinical notes all issues and decisions. • Record MH assessment and risk assessment in the HCC clinical notes
Reassessment	Allocated RN, or their delegate, reassess risk and observation level **am & pm shift & with the medical team at CWR each morning.** ➢ Observations may be increased by nursing staff ➢ When decision to increase is made a medical review must be requested ➢ Reduction of observations level must only be in consultation with medical staff Inform the service user and family/whanau and ward staff of any changes and the rationale.	• Reviews, plans and mental state are documented in the HCC clinical notes • Ensure that rationale for maintaining, decreasing or increasing observation level is captured in the HCC record. • Update SBAR and MDT Form with any changes to AWOL & Leave status • Record names and relationships of family/whanau/carers who were informed along with their feedback and contact numbers.

Constant within Arm's Reach Observation Procedure

This is an enhanced level of observation intended for service users who are:

- **At the highest risk of harming themselves**
- **Are behaving in a manner which is likely to cause imminent harm to themselves**
- **A High category AWOL risk**

This observation may require more than one staff member. Service Users may feel restricted & consideration needs to be given to the possibility of this intervention making the situation worse.

STAGE	PROCESS	DOCUMENTATION
Observation Level	Constant within Arm's Reach Observation requires staff to: ➢ Inform the service user about the level of observation and the reason. ➢ Remain in sight and within arm's length of the service user at all times ➢ Engage with service users as appropriate ➢ Respond to needs as appropriate ➢ Complete documentation ➢ Communicate with team of any issues, concerns, etc	Special Observation Form is commenced and maintained throughout the observation period. Whiteboard reflects correct: ➢ Observation level ➢ AWOL Status ➢ Leave Status
Safety	All staff assigned to, or assisting with, Constant within Arm's Reach Observations must: ➢ Carry a personal alarm which they know how to use ➢ Be well informed of the service user profile ➢ Understand the rationale for observation ➢ Be clear about the RN's expectations and follow instructions ➢ Take regular scheduled breaks from observation	Alarm Allocation recorded
Responsibility	Each duty the service user on Constant Within Arms Reach Observation will be allocated to a specific RN who is responsible for coordinating the care by ensuring: ➢ An RN is always with the service user ➢ Any Direction & Delegation of tasks to EN's &/or PA's associated with the service user are allocated appropriately with support and guidance. ➢ Documentation is completed. ➢ A MH assessment is completed on ALL shifts if asleep i.e. night shift the review can be with the ACNM ➢ A medical review occurs on every shift ➢ There is appropriate interaction/engagement with the service user ➢ Issues of privacy, dignity & gender appropriateness are considered	• When the assigned staff member commences observation they sign the observation recording sheet assuming responsibility of the observation. • The responsible RN ensures all documentation is accurate • Check the prior observer has completed the form and it is up to date. • If an EN or PA is assigned to observations, the RN is to countersign the forms as the delegate. • Record in the HCC clinical notes all issues and decisions. • Record MH assessment and risk assessment in the HCC clinical notes
Reassessment	Each shift the allocated RN, with the medical team reassesses risk and observation level. ➢ Reduction of observations level must be authorised by medical staff Inform the service user, family/whanau and ward staff of any changes and the rationale.	• Reviews, plans and mental state are documented in the HCC clinical notes • Ensure that rationale for maintaining, decreasing or increasing observation level is captured in the HCC record. • Update SBAR and MDT Form with any changes to AWOL & Leave status • Record names and relationships of family/whanau/carers who were informed along with their feedback and contact numbers.

4. Handover:

- The Registered Nurse must handover to the on coming Registered Nurse all information in relation to service user observation levels.
- Staff members sign the service user's specific observation form when the level of observation allocated is intermittent, continuous visual and constant within arm's reach to indicate they have accepted responsibility.
- For service user's allocated intermittent, continuous visual and constant within arm's reach observation levels at each shift handover there must be a full clinical note entered in HCC by the allocated Registered Nurse. This entry will provide a clinical summary of the shift and the benefit/need for level of observation to continue or be discontinued.

Definitions

Terms and abbreviations used in this document are described below:

Term/Abbreviation	Description
Observation	Locate, check, engage, supervise and critically observe a service user on a regular basis.
Therapeutic Engagement	Involves healthcare professionals spending time with service users to collaborate, discuss reasons for observation, invite feedback, and foster meaningful relationships.
Hourly Observation	Is the minimum level of observation in the Acute Adult Mental Health Inpatient Unit. Every service user will be located, visually sighted, engaged with and monitored at least hourly during their admission.
Intermittent Observation	Regular and random observation at intervals between 15-30 minutes. This includes meal times and shift handovers.
Constant Visual Observation (line of sight)	The service user is constantly within eyesight and immediately accessible to an assigned staff member.
Constant within Arm's Reach	Staff are positioned within arm's reach of the service user at all times, responding to their needs as appropriate.

Associated Documents

NZ Legislation	Mental Health Act (1969) Mental Health (Compulsory Assessment and Treatment) Act (1992) Mental Health (Compulsory Assessment and Treatment) Amendment Act (1999) Health Practitioner Competency Assurance Act (2003) The Health & Disability Commissioner (Code of Health & Disability Consumer Rights) Regulations (1996) Privacy Act (1993)

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References

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Office of the Children's Commissioner (2007) "*Pushed in to the shadows-young people's experience of adult mental health facilities".* London.

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Department of Health, January 2010: "See, Think, Act – your guide to relational security" Trystpark, Bellsdyke Hospital, Forth Valley NHS Board Primary Care, Larbert, Stirlingshire, Scotland FK5 4SE, UK. ian.mackay@fvp.scot.nhs.uk

Policy: Open Doors in Acute Adult Inpatient MHS

Introduction

Protecting the human rights of service users, some who may be vulnerable and some who may have limited capacity, is fundamental to providing quality mental health services. Therefore, this policy applies to all acute adult inpatient services.

Purpose

The purpose of this policy is to ensure that inpatients have the best possible experience of mental health services. This includes providing a safe environment and protecting their human rights.

The policy states that CMH standard practise is that ward doors, with the exception of Kuaka Ward, are kept unlocked daily between 9am and 5pm.

A process to identify variances from the Open Door Policy describes areas where it has been considered and agreed that access and egress to and from wards is controlled by the temporary use of a locked door when clinical need dictates.

Note: This policy must be read in conjunction with Open Doors in Acute Adult Inpatient MHS Procedure and Observation in MHS Guideline.

Scope of Use

This policy is applicable to all CMDHB employees working within Acute Inpatient Mental Health Services, (full-time, part-time and casual (temporary) including contractors, visiting health professionals and students working in any CMDHB facility.

Policy

Counties Manukau Health (CMH) operates Ward 22/Tui and Huia Ward with an open door policy.

The management, security and safety of service users should, wherever possible, be achieved by means of the required observation level, appropriate staffing levels, quality care, and supervision.

Staff must give due regard to the NZ Bill of Rights Act 1990, Right 22, the right to liberty. Doors are only locked when a situation is risky enough to warrant this action and that the duration of the period that the door is locked is no longer than is necessary.

The locking of a door must not be used as an alternative to considering whether a service user may need to become subject to the Mental Health (Compulsory Assessment and Treatment) Act 1992 and detained.

Furthermore, it is recognised that on some occasions it will be necessary to temporarily lock wards. The 'Open Door' procedure guides this practise. It clearly identifies any variance and the rationale for why this occurred.

Signage will be in place to ensure:

- Carers, staff and service users are aware of the locked door rationale and our aim to ensure safety without compromising liberty.
- Carers and service users who are not detained and are safe to leave are aware of how to leave the ward.
- Signposting people back to staff if they have any questions or concerns.

Locking a door that is usually 'open' is considered to be an incident, and should be recorded and reported using the CMH Riskpro incident reporting procedure, in order that statistical information can be provided for quality monitoring.

The external and entrance doors to inpatient settings will be locked between 5pm and 9am for general security and safety with the exception of Kuaka Ward which is locked at all times.

References

1. Sussex Partnership NHS Foundation Trust Open Door Policy 22 June 2012.

Definitions/Description

Terms and abbreviations used in this document are described below:

Term/Abbreviation	Description
Open Door	The door is not locked allowing free access and egress without the need to ask to be let out.
CMH	Counties Manukau Health

Associated Documents

Other documents relevant to this policy are listed below:

NZ Legislation /Standards	• Mental Health (Compulsory Assessment and Treatment) Act 1992 • Mental Health (CAT) Amendment 2000 • Intellectual Disability (Compulsory Care and • Rehabilitation) Act 2003 • Criminal Procedures (Mentally Impaired Persons) Act • 2003 • Alcoholism and Drug Addiction Act 1966 • Health and Disability Commissioner Act 1994

CM Health Documents	• Therapeutic Engagement and Observation Policy and Procedure • Open Doors in Acute Adult Inpatient MHS Procedure and Observation in MHS Guideline. • AWOL policy and procedure
Other related documents	

Procedure: Open Doors in Acute Adult Inpatient MHS

Purpose

The purpose of this procedure is to ensure the least restrictive environment is provided to service users of the acute adult inpatient unit after careful consideration of individual service user's rights and risk assessments.

Note: This procedure must be read in conjunction with Open Doors in Acute Inpatient MHS Policy.

Objectives

The entrance door to Adult Mental Health Wards, **with the exception of Kuaka Ward**, will be routinely open between the hours of 9am and 5pm each day as defined in this procedure unless an exception is offered. The procedure for locking doors temporarily when clinical need dictates is set out.

Scope of Use

This procedure is applicable to all CMDHB employees, (full-time, part-time and casual (temporary) including contractors, visiting health professionals and students working in any CMDHB facility.

Roles and Responsibilities

Service Managers and Clinical Heads

Disseminate the policy to all relevant staff.

Nurse Unit Manager (NUM), Charge Nurse Managers (CNM) and Associate Charge Nurse Managers (ACNM)

To ensure the policy is implemented and the incidence of locking doors is monitored and acted upon accordingly.

All clinical staff

To comply with the procedure outlined in the policy.

Resources

Observation within Acute Mental Health Services Guideline

Display notices for doors for use when an exception occurs – Appendix 1

Procedure

1. This procedure is the routine practice standard for all acute adult inpatient MHS, with the exception of Kuaka Ward which remains a restricted environment.

2. Ward 22/Tui and Huia Ward will routinely operate their entrance door with an open door during the hours of 9am – 5pm as defined within the policy unless an exception is identified.

3. The external and entrance doors to inpatient settings will be locked between 5pm and 9am for general security and safety with the exception of Kuaka Ward which is locked at all times.

4. There may be exceptional clinical circumstances where the nurse in charge of a ward will consider locking the entrance door of that ward in the interests of service user safety and security.

5. In assessing the need to lock the door, the nurse in charge of the ward should inform the ACNM of the issues and the following as possible alternatives should be considered:

   - Transfer of a service user(s) to a more suitable environment.
   - The use of additional staffing.
   - Alternative care strategies and / or use of the Mental Health Act.

6. Where these alternatives are either not possible, or not appropriate, the door may be locked.

7. Once the decision has been taken to lock the door the nurse in charge of the ward should:

   - Inform service users and all ward staff of the locked status of the entrance door and the reason for this.
   - Advise all other service users and visitors that they may leave, on request, at any time and ensure that a member of staff is available to unlock the door on request.
   - Display a notice (see Appendix 1) at the ward entrance advising that the door is locked and informing about the means of entrance and exit.
   - Inform the CNM during normal business hours.
   - Inform the ACNM.
   - Ensure that the length of time that the ward entrance is locked is kept to a minimum.
   - CNM to inform the NUM when the entrance door is kept locked for more than 24 hours.
   - Complete an incident form.

7. The use of a locked door must be subject to on-going review from the multidisciplinary team at least once each 24 hours. Consideration must be given to; NZ Bill of Rights Act

1990, Right 22, the right to liberty and Right 9, the Right not to be subjected to torture or cruel treatment.

8. As soon as the clinical situation can be safely managed without the door being locked it should be unlocked.

9. All incidents related to the breech of the 'open door policy' will be reviewed at the weekly Acute MHS Risk Review meeting.

Definitions/Description

Terms and abbreviations used in this document are described below:

Term/Abbreviation	Description
Open Door	The door is not locked allowing free access and egress without the need to ask to be let out.
ACNM	Associate Charge Nurse Manager
NUM	Nurse Unit Manager
CNM	Charge Nurse Manager

Associated Documents

Other documents relevant to this procedure are listed below:

NZ Legislation & Standards	• Mental Health (Compulsory Assessment and Treatment) Act 1992 • Mental Health (CAT) Amendment 2000 • Intellectual Disability (Compulsory Care and Rehabilitation) Act 2003 • Criminal Procedures (Mentally Impaired Persons) Act 2003 • Alcoholism and Drug Addiction Act 1966 • Health and Disability Commissioner Act 1994
CM Health Documents	• Observation in MHS Policy, Procedure and Guideline • AWOL Policy and Procedure • Patient leave Procedure • A safe way of working guideline • Incident Reporting & Management Policy & procedure • Health and Disability Sector Standards • Code of Health and Disability Services Consumers' Rights 1996 • Ministry of Health Guidelines Absent Without Leave, May 1994
Other related documents	• AWOL Absent Causing Concern – Procedure • Informed Consent • Reportable Events

Appendix 1:

Document ID:	A832594	**CMH Revision No:**	1.0
Service:	Acute Mental Health Service	**Last Review Date :**	17/01/2018
Document Owner:	Clinical Head - Acute Mental Health Service	**Next Review Date:**	1/02/2019
Approved by:	Clinical Head - Acute Mental Health Service	**Date First Issued:**	02/02/2018
Counties Manukau Health			

The ward door is currently locked

Please speak to staff using the intercom at the door to gain entry and we will be with you as soon as possible.

Many thanks

Document ID:	A832594	**CMH Revision No:**	1.0
Service:	Acute Mental Health Service	**Last Review Date :**	17/01/2018
Document Owner:	Clinical Head - Acute Mental Health Service	**Next Review Date:**	1/02/2019
Approved by:	Clinical Head - Acute Mental Health Service	**Date First Issued:**	02/02/2018
Counties Manukau Health			

The ward door is currently locked

If you are currently able to leave the ward, please ask a staff member to unlock the door for you.

Apologies for any inconvenience.

Many thanks – the Ward Team

Document ID:	A832594	**CMH Revision No:**	1.0
Service:	Acute Mental Health Service	**Last Review Date :**	17/01/2018
Document Owner:	Clinical Head - Acute Mental Health Service	**Next Review Date:**	1/02/2019
Approved by:	Clinical Head - Acute Mental Health Service	**Date First Issued:**	02/02/2018
Counties Manukau Health			

Policy: AWOL (Absent without official leave) or Absences causing concern.

Introduction

During the course of treatment it is often appropriate and therapeutic for patients to have periods of absence from the usual treatment setting. These absences are ordinarily negotiated between the various parties, including the patient, their family/whaanau and the treatment team.

Purpose

The purpose of this policy is to provide direction for mental health staff when a service user / patient goes missing causing concern without clinical agreement from an inpatient or community setting. It will assist with determining the level of risk for the person or others and the appropriate response and management of their absence.

This Policy is to be read in conjunction with the AWOL Absent Causing Concern - PROCEDURES

Scope

This policy is applicable to all staff of CMH Mental Health Services.

Policy Statements

- Mental Health Services ensure the safety of service users under their care.
- CMDHB needs to ensure every attempt is made for the safe return of service users under their care. This will enable service users to receive the care and treatment they require.
- Mental Health Services will comply with the relevant legal requirements where a service user detained under compulsory processes is absent from the assessment or treatment unit without the permission of the Responsible Clinician.
- Mental Health Services will make every effort to ensure that a service user who is absent is located as soon as possible.
- All matters pertaining to publicity surrounding any missing consumer will be dealt with by the Clinical Director Mental Health in consultation with the senior management team
- Absences from the usual treatment setting are authorised by the Mental Health Compulsory Assessment and Treatment Act at all stages although they are only

strictly defined as leave for patients subject to an Inpatient Compulsory Treatment Order.

- Terms and conditions for absence of any patient must always be documented
- Absences without such documented approval are regarded as Absences without Leave (AWOL) or Absences Causing Concern, if the Service user/patient is informal. Such unauthorised absences should be managed in a consistent manner across all services.
- A formal notification process is in place
- Adequate and appropriate assessment and documentation of risk occurs.

Definitions: Terms and abbreviations used in this document are described below.

Term	Definition
AWOL (Absent Without Official Leave)	The term applies when a consumer (including Special Patient) under compulsory treatment processes absents themselves without authorisation from an inpatient unit or from a specified community placement. This includes when the consumer leaves an escort or does not return from a period of specified leave.
Absent Causing Concern	A person not under the MH Act in an inpatient unit or a service user in a community setting (residential rehab or respite) who either leaves without clinical assent or whose absence from the treatment setting / their usual place of residence, causes concern to the treating team, family or others.
Categories for AWOL / Absent Causing Concern	
Category A	Any service user considered to be a serious or imminent risk to self, identified other(s) or to property. Note: Service users who are categorised as a Special or Restricted patient as defined by the MHA, who are absent without leave or clinical authority are automatically Category A.
Category B	A service user assessed to be no immediate risk to self, identified other(s) or property but whose risk increases if they fail to take prescribed medication; consume alcohol or illegal drugs; or are exposed to circumstances which may trigger inappropriate anti-social behaviour. **Note:** All patients absent without authority from an Inpatient Unit would normally be categorized either **A or B**
Category C	A service user who poses no threat to self or identified other(s) or property

Associated Documents: Other documents that are relevant to this policy are listed below

NZ Legislation	• Mental Health (Compulsory Assessment and Treatment) Act 1992 • Mental Health (CAT) Amendment 2000 • Intellectual Disability (Compulsory Care and Rehabilitation) Act 2003 • Criminal Procedures (Mentally Impaired Persons) Act 2003 • Health Information Privacy Code 1994 • Privacy Act 1993 • Alcoholism and Drug Addiction Act 1966 • Health and Disability Commissioner Act 1994
NZ Standards	• Health and Disability Sector Standards • Code of Health and Disability Services Consumers' Rights 1996 • Ministry of Health Guidelines Absent Without Leave, May 1994
CMDHB Policies / Procedures	• AWOL Absent Causing Concern – Procedure • Informed Consent • Privacy of Patient Information • Access to Patient Information • Reportable Events

Procedure: AWOL or Absences Causing Concern from a Mental Health Inpatient unit

Background / Introduction

During the course of treatment it is often appropriate and therapeutic for service users to have periods of absence from the usual treatment setting. These absences are ordinarily negotiated between the various parties, including the service user, their family/whaanau and the treatment team.

Absences without such documented approval are regarded as Absences without Leave (AWOL) or Absences Causing Concern if the service user is informal. Such unauthorised absences should be managed in a consistent manner across all services.

Purpose

The purpose of this procedure is to provide clear direction of the steps to take when a patient goes AWOL/ Absent Causing Concern from the Acute Inpatient Unit. It also provides the steps to be taken when a service user returns from AWOL/ Absent Causing Concern to the inpatient treatment setting.
This procedure will assist with determining the level of risk for the person, or others, the appropriate response and management of their absence and / or return to the unit.

Roles and Responsibilities

Team Manager
↓
Charge Nurse
↓
ACNM
↓
RN's

This procedure is carried out by the Associate Clinical Nurse Manager (ACNM) or Senior Nurse or delegated nursing staff member.

This procedure is applicable to all CMDHB employees, fulltime part time and casual.

Associated Documents

Document ID:	A160845	**CMH Revision No:**	
Service:	Core Adult Inpatient Mental Health Services	**Last Review Date :**	17/10/2012
Document Owner:	Clinical Director - Mental Health Services	**Next Review Date:**	16/10/2017
Approved by:	Mental Health Clinical Governance Group	**Date First Issued:**	14/07/2011
Counties Manukau Health			

Other documents relevant to this procedure are listed below:

NZ Legislation	Mental Health (Compulsory Assessment and Treatment) Act 1992
NZ Standards	Health and Disability Sector Standards Code of Health and Disability Services Consumers' Rights 1996
CMDHB Policies	AWOL Absent Causing Concern Policy

Terms and definitions used in this document are described below

Term	Definition

AWOL (Absent Without Official Leave)	The term applies when a patient (including Special Patient) under compulsory processes absents themselves without authorisation from the unit or from a specified community placement. This includes when the patient leaves an escort or does not return from a period of specified leave.
Absent Causing Concern	A patient not under the MH Act in an inpatient unit or a patient in a community setting (residential rehab or respite) who either leaves without clinical assent or whose absence from the treatment setting / their usual place of residence, causes concern to the treating team.
Categories for AWOL / Absent Causing Concern	
High Risk	• Likely to take his/her own life, or pose a major risk to the life of another person. • Has made a credible direct or seriously implied threat, to cause serious bodily injury to any other person, or serious damage to other property. **Note:** Patient s who are categorised as a Special or Restricted patient as defined by the MHA, who are absent without leave or clinical authority are automatically Category A.
Medium Risk	• Has a known history from previous admissions of self -harm, harm to others or damage to property or has the potential to do so. • Patients may initially fall into this category and need to be elevated to "High" if not located within a period and have run out of/stopped taking medication. • A service user assesses to be no immediate risk to self, identified other(s) or property but whose risk increases if they fail to take prescribed medication, consume alcohol or illegal drugs, or are exposed to circumstances which may trigger inappropriate anti-social behaviour.
Low Risk	• Poses no threat to themselves, any other persons or property. • Any other patients not falling into the "High" or "Medium" risk category. *Use the AWOCA FORM IN HCC for service users with low risk.*

PROCEDURE

AWOL/ABSENT CAUSING CONCERN of service user from an Inpatient Service

Step	Action
1.	Search the unit to confirm that the service user is absent or 'missing' from the unit.
2.	Determine the category of AWOL/Absent Causing Concern, using definitions above.
3.	**Allocated RN** Notify: • Shift Facilitator • Charge Nurse Manager – within usual business hours • ACNM – at all times • Nurse Unit Manager during usual working hours and Mental Health On-Call Manager when **High Risk category**
4.	**Allocated RN** • Advise service user's medical staff that the service user is AWOL or AWOCA and ascertain AWOL category. **After Hours:** Call the on-call Registrar Consultant Psychiatrist to ascertain AWOL category. • Complete AWOL/ AWOCA form within HCC file and inform ACNM. • Call the Police to inform of AWOL and ascertain job number. • Notify Intake and Acute Assessment team by phone and liaise regarding what follow up is required by them. The plan have to includ the requested frequency of community visits and contact attempts to the service user, family, friends and partners in care. • Inform the service user's Next of Kin. **Note:** If a potential person at risk is known, consideration must be given to notify this person. This must be discussed with the senior medical and nursing staff involved in the care of the patient, or after hours, with the On Call Consultant. This will include consideration of the most appropriate person to inform the person at risk. **Shift Facilitator** • Updates Fire board • Electronic whiteboard • Daily ward Report
5.	**ACNM** • Review AWOL/AWOCA form Ensure that the text box is expanded then print

	and scan into the ACNM Folder. • Email the form to Police on counties.manukau.fmc@police.govt.nz • Print out confirmation from inbox that email has been sent and scan into ACNM folder. • Move confirmation of sent email to the service users HCC folder.
6.	**Allocated RN** Record AWOL/AWOCA in the Incident Management System Incident system.
7.	**ACNM** Contacts next of kin and/or relevant other support people that have been identified at least once per shift to inquire if they have made contact or are aware of the service user's whereabouts. If the location is known then the Intake and Acute Assessment Team is informed of the

Return of AWOL/ABSENT CAUSING CONCERN service user to an Inpatient Service

Service user can be returned to the ward with the assistance of a number of people and professionals including but not limited to: family members, partners in care, Intake and Acute Assessment staff, Police.

Step	Action
1.	**Allocated Nurse** • Allocated Nurse complete nursing assessment. This assessment determines needed ward placement and how urgently a medical assessment need to occur. • Urine screen for illicit substances. • Completes 'Return from AWOL part' of the AWOL form and alerts ACNM. • Completes clinical note. **ACNM** • Review AWOL/AWOCA form Ensure that the text box is expanded then print and scan into the ACNM Folder. • Email the form to Police on counties.manukau.fmc@police.govt.nz • Print out confirmation from inbox that email has been sent and scan into ACNM folder.

	• Move confirmation of sent email to the service users HCC folder. Consultant Psychiatrist/MOSS/Registrar or On Call Registrar • Completes mental health assessment. • Completes clinical note.

Discharge of a service user that is AWOL/ABSENT CAUSING CONCERN service user from an Inpatient Service

Step	Action
1.	If the service user is AWOL and not located within 72 hours the following steps Occur: • The CNM, ACNM and Consultant Psychiatrist discuss the follow up needs for the Intake and Acute Assessment Team. • The ACNM completes a clinical handover to Intake and Acute Assessment with • ACNM completes a note in clinical records • Consultant psychiatrist completes note in clinical records and discharge summary
2.	If the service user is Absent Causing Concern and not located within 24 hours the following steps Occur: • The CNM, ACNM and Consultant Psychiatrist discuss the follow up needs for the Intake and Acute Assessment Team. • The ACNM completes a clinical handover to Intake and Acute Assessment with • ACNM completes a note in clinical records • Consultant psychiatrist completes note in clinical records and discharge summary
3.	ACNM inform Administrator of discharge.

Flowchart - AWOL or Absences Causing Concern from a MH Inpatient Unit