## PURPOSE

To ensure appropriate levels of observation for tāngata whai ora / service users whilst an inpatient in Mental Health & Addiction Services (MH&AS) care which is aligned to the level of acuity and unpredictable, aggressive, self-harm or risk to others' behaviour, vulnerability and / or medically compromised. Health and safety is paramount and specific to meet the needs.

Nursing observations refer to the intensity and frequency of nurse monitoring and are based on the mental state and physical health of tāngata whai ora / service users and risk to self or others which aligns to Te Whare tapa whā – holistic care approach. All observations must be completed by a Registered Nurse (RN), Enrolled Nurse (EN) or Health Care Assistant (HCA) under delegated authority of the RN.

## STANDARDS TO BE MET

All tāngata whai ora / service users within MH&AS inpatient facilities will receive an appropriate level of observation and care.

Person centred care, including engagement with the tāngata whai ora / service user and their family / whānau and nursing observation / assessment aims to reduce the factors which contribute to an individual tāngata whai ora / service user's risk to themselves and / or others.

Observation level for tāngata whai ora / service user should include therapeutic engagement with tāngata whai ora / service user and the therapeutic use of self, good interpersonal skills, active listening and activities where appropriate and the utilisation of sensory modulations.

This protocol outlines the levels of observation which may be indicated for a tāngata whai ora / service user during hospital admission.

Observation levels can be commenced by RN, Senior Medical Officer (SMO) and should be assessed upon admission and articulated clearly in the clinical documentation indicating level of observations to be implemented and rational, risk assessment should also be updated accordingly.

A reduction of levels of observation should be completed after clinical review and assessment of risk for tāngata whai ora / service user and in conjunction with input from tāngata whai ora / service user, family and whānau.

### 1. Open Ward Observations

| ACTION | RATIONALE |
|---|---|
| **Level One** | |
| • Low risk<br>• Hourly observations minimum level assigned to inpatients | • Tāngata whai ora / service users considered low risk must be monitored at irregular intervals of up to 60 minutes apart at a minimum of once within a 60 minute time frame. |
| **Level Two** | |
| • Increased risk<br>• Observations between 15 and 30 minutes | • Tāngata whai ora / service users considered low moderate risk must be monitored at irregular intervals of up to 15 - 30 minutes apart. |

| ACTION | RATIONALE |
|---|---|
| **Level Three – High Risk** | |
| • Constant observation and person within sight | • For tāngata whai ora / service users who are requiring on-going observations. The designated staff member is able to respond immediately to any changes of at-risk behaviour to safely mitigate any harm from occurring. |
| **Level Four – High Risk** | |
| • Constant observation and person in the same room within arm's reach | • For tāngata whai ora / service users who are requiring on-going observations. The designated staff member is able to respond immediately to any changes of at risk behaviour to safely mitigate any harm from occurring for tāngata whai ora / service users deemed to be at high risk to self. |

**2. IPC or LSA Observations**

| ACTION | RATIONALE |
|---|---|
| Transition observations from IPC / LSA to open ward – level 3 observations | • Tāngata whai ora / service users who are engaging in therapeutic transitional activities will be accompanied by a RN or HCA under delegated authority of the RN. |
| Significant risk – 10-minute Observation | • Tāngata whai ora / service users who require more frequent monitoring must be monitored at irregular intervals of up to 10 minutes. |
| Seclusion observations | • Observation of tāngata whai ora / service users in seclusion shall be constant observations. These are of the same order of observation as level three observation but with the expectation that the staff member is outside the room. |

**3. Reviewing of Observation Levels**

| ACTION | RATIONALE |
|---|---|
| • The required level of observation must be reviewed q24h and the team should consider in advance and at each change of shift, to review behaviours which could indicate that the level of observation could be reduced. | • The decision to reduce level 2 through to level 1 observations must be made by two RN's.<br>• The decision to reduce to Level 3 or 4 observations must be made by a Senior Medical Officer (SMO) and RN.<br>• The clinical rationale for increase or decrease of observation levels is to be documented in the tāngata whai ora / service user's clinical notes and risk assessment updated accordingly. |

| ACTION | RATIONALE |
|---|---|
| • Decisions about the appropriate level of observation should be made together with the tāngata whai ora / service user and / or family / whānau and healthcare team members wherever possible. | • Tāngata whai ora / service users and / or next of kin are often able to make a judgement as to their vulnerability and need for observation.<br>• The tāngata whai ora / service user and / or their next of kin have the right to have the level of observation explained to them and the opportunity to ask questions.<br>• In some cases, the family / whānau may choose to stay with the tāngata whai ora / service user to mitigate any additional risks. |

## 4. Additional Observations

4.1 Assessment of people with existing or potential cognitive impairment (e.g. delirium) who require additional observations – consider use of assessment tools (i.e. 8474 Cognitive Impairment and Delirium 4AT Screening tool and FM.A20.1 Abbey Pain Scale) to document additional observations that the patient may be unable to articulate. In addition, 7672 Inpatient Bowel Management chart and 7410 Food and Drinks record are recommended for people who are unable to recall this information due to cognitive impairment.

4.2 Duress Alarm

a) All staff are to ensure that they have a personal alarm with them at all times.

## REFERENCES


- Ngā Paerewa Health & Disability Service Standards NZS 8134:2021
- Enhanced Engagement and Observation: A paper to inform the development of engagement and observation policies and procedures in inpatient units New Zealand Directors of Mental Health Nursing May 2015


## ASSOCIATED DOCUMENTS

- Te Whatu Ora Hauora a Toi Bay of Plenty policy 7.104.1 protocol 1 Care Delivery – Caring As A Team Nursing Guidelines
- Te Whatu Ora Hauora a Toi Bay of Plenty policy 7.104.1 protocol 2 Care Delivery – Nursing and Midwifery Shift Handover
- Te Whatu Ora Hauora a Toi Bay of Plenty policy 7.104.1 protocol 4 Care Delivery – Nursing / Midwifery Plan of Care
- Te Whatu Ora Hauora a Toi Bay of Plenty policy 7.104.1 protocol 5 Care Delivery – Nursing / Midwifery Assessment Standards
- Te Whatu Ora Hauora a Toi Bay of Plenty policy 7.104.1 protocol 8 Care Delivery – Physiological Observation Standards for Inpatients
- Te Whatu Ora Hauora a Toi Bay of Plenty policy 7.104.5 Safe Staffing
- Te Whatu Ora Hauora a Toi Bay of Plenty policy 6.3.5 protocol 1 Falls – Risk Reduction and Management of Inpatient Falls
- Te Whatu Ora Hauora a Toi Bay of Plenty policy 6.5.1 Transfer of Care (Discharge)

Planning - Inpatient

- Te Whatu Ora Hauora a Toi Bay of Plenty policy 2.5.2 Health Records Management
- Te Whatu Ora Hauora a Toi Bay of Plenty protocol 6.2.3 P12 Variance Response Management (VRM)
- Te Whatu Ora Hauora a Toi Bay of Plenty protocol 6.2.3 P14 SOP - Acute Patient Journey - ED, Inpatient Teams, Bed Management and Wards - Tauranga Only
- Te Whatu Ora Hauora a Toi Bay of Plenty protocol 6.2.3 P15 SOP - Acute Patient Journey - Diagnostics, Allied Health and Support Services
- Te Whatu Ora Hauora a Toi Bay of Plenty protocol 6.2.3.P16 SOP - Acute Patient Journey - Daily Operations Management
- Te Whatu Ora Hauora a Toi Bay of Plenty Clinical Practice Manual protocol CPM.M5.27 Seclusion - MHAS
- Te Whatu Ora Hauora a Toi Bay of Plenty Form FM.A20.1 Abbey Pain Scale

*All the below Forms are viewable only and musted be ordered through Design & Print Centre*

- Te Whatu Ora Hauora a Toi Bay of Plenty Form Safe Care Companion Documentation of Shift (8103)
- Te Whatu Ora Hauora a Toi Bay of Plenty Incident Management form
- Te Whatu Ora Hauora a Toi Bay of Plenty Form Cognitive Impairment and Delirium 4AT Screening tool (8474)
- Te Whatu Ora Hauora a Toi Bay of Plenty Form Inpatient Bowel Management chart (7672)
- Te Whatu Ora Hauora a Toi Bay of Plenty Form Food and Drinks Record (7410)
- Bay of Plenty District Health Board Form Adult Admission, Assessment and Plan of Care Form (8341)
- Bay of Plenty District Health Board Form Adult Repeated Risk Assessment (8341A)
- Bay of Plenty District Health Board Form Adult Continued Plan of Care (8341B)