NHS Greater Glasgow and Clyde

GUIDELINES FOR THE OBSERVATION OF PATIENTS WITH ACUTE BEHAVIOURAL DISTURBANCE IN ACUTE DIVISION WARDS

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1. Introduction

Within the acute (general) ward setting, caring for patients experiencing periods of behavioural disturbance is particularly challenging and demanding. Staff will need to consider additional support measures. Behavioural disturbance in hospital can be aggravated by many underlying conditions including sepsis, head injury, unidentified substance use, mental illness, delirium or dementia. Many factors, including pain and anxiety from being in an unfamiliar environment, can contribute to the patient's stress and distress, which is particularly difficult to manage effectively should the patient have problems verbalising their distress.

The following guideline is based on Scottish Clinical Resource and Audit Group (CRAG) Engaging people: Observation of people with acute mental health problems (2002) and is relevant to all staff who are caring for a patient who requires constant or special observation in the Acute Division. Mental Health Services have a separate policy NHSGGC Mental Health Service: Safe and Supportive Observation Policy and Practice Guidance (2012) which is a useful reference as is the Mental Welfare Commission Good Practice Guide "Rights, risks and limits to freedom (2013)".

An assessment of mental capacity should be carried out and mental health legislation used, where appropriate, to provide the proper safeguards and support effective care planning: (Adults with Incapacity (Scotland) Act 2000 and Mental Health (Care and Treatment) (Scotland) Act 2003). Staff should ensure that the patient has consented to any necessary treatment in accordance with the Consent Policy. For further guidance and supporting documentation see Staffnet page Consent to Treatment.

2. Levels of Observation

Three levels of observation have been highlighted in the CRAG Good Practice Statement. Increased levels of observation required can be either 2. 'constant' or 3. 'special' depending on the level required to support the patient's needs most effectively.
The definition of the third level, special observation, has been adjusted to reflect practice in the Acute Division. NB: it is slightly different to the definition in use in mental health services.

The three levels are:

1. General Observation: where the patient has no particular observation requirements over and above that generally provided to all patients within the ward.

2. Constant Observation: where the patient requires to be kept within sight or sound of an identified member of nursing staff.

3. Special Observation: where the patient requires to be under constant observation on a one to one basis since the patient presents a serious risk of harm to self or others.

3. Practice Guidelines

3a. Introducing Increased Observation

Where the patient in an acute (general) ward requires ongoing medical treatment and there is considered to be a risk of harm to self or others by virtue of their mental state, Increased Observation should be initiated. The nurse in charge of the ward, together with the senior member of the medical staff responsible for the patient's care, should agree on the level of observation.

Observation can be provided by either a registered nurse or a health care support worker, depending on the circumstances. **A team approach, where staff regularly rotate into a period**

of increased observation, is more equitable and sustainable than assigning this duty to one person for a whole shift.

Where a patient has been clinically assessed as requiring constant or special observation (See Flow Diagram Appendix 1 for guidance on measures that should be considered) the nurse in charge of the ward should consider whether there is capacity in the ward staffing to provide this, or if additional staff can be sourced locally from other wards or duties. If local provision is not possible (See Flow Diagram Appendix 2), contact the *Nurse Bank* or the Page holder, or as per local policy, to ensure arrangements are put in place for as long as considered necessary. Ward staff requesting Bank staff should give the Nurse Bank as much information as possible to ensure the best match is provided. This can be added as comments detailing patient presentation, role required to be undertaken (holistic care or psychological care only) and staff grade requested.

3b. Cohorting

Where there is more than one patient with behavioural disturbance being cared for in a ward, cohorting may be successfully used to provide constant observation of this area. However, where more than one patient requires care simultaneously, additional assistance will be needed from other members of staff.

The staff members who are providing constant observation for a cohort of patients also need regular relief from these duties and the Nurse Bank will be using a proforma to collect this information for bank staff.

3c. Rotation of Duties during Increased Observation

Ideally, staff should be those who already know the patient. The staff member providing increased observation will require regular relief and rotation into other duties. Rotation should be hourly, but may be up to 2 hourly depending on local agreement. Staff should also get their meal breaks. The nurse in charge of the ward is responsible for organising relief, which should be arranged in advance. **A team approach is best.**

On finishing a period of increased observation the staff member should discuss any clinical concerns with the nurse taking over care and /or the nurse in charge of the ward.

3d. Role of Staff carrying out Increased Observation

The primary role is to keep the patient safe by observation and therapeutic engagement, with the aim of developing a supportive relationship with the patient. All staff undertaking increased observation (Registered nurses and HCSWs) should receive a handover, describing: the patient's current and underlying condition; any known risk factors or triggers which might precipitate an escalation of behaviour; actions that may help calm the patient.

The family / next of kin / main carer / guardian should be conferred with throughout the admission, including finding out what level of involvement they would like in the patient's hospital stay, e.g. offering familiar reassurance and social activities; and how and when they would wish to be contacted by the ward staff, should any change occur. They should also be encouraged to discuss care and raise any suggestions or concerns they may have.

Use of the tool "Getting to Know Me" will assist and incorporate knowledge from family members about interpreting normal behaviours for patients with cognitive or communication impairments.

For staff who normally work in Mental Health Services, direct clinical care (particularly the more technical elements of care e.g. IV treatment) may be outwith their current competencies, and so in these situations these elements of care must remain the responsibility of acute hospital staff.

Role boundaries and expectations of the bank nurse should be clarified by the ward staff members involved, including responsibilities for documentation of behaviours; supports used; care needed etc., in addition to the verbal handover given to Nurse in Charge.

3e. Referral to Liaison Psychiatry

Where there are concerns about the patient's mental state, risk of harm to self or others or possible mental illness immediate referral should be made to the NHSGGC Liaison Psychiatry Service or out-of-hours to the local Duty Psychiatrist (see Flow diagram, Appendix 3). Consider also referral to other services as appropriate e.g. Falls service using NHSGGC Policy and Guidelines for the Prevention and Management of Adult In-patient Falls.

Until a member of the psychiatric team has assessed the patient and the appropriate level of observation has been determined, it is accepted that constant observation may be required.
Following a systematic assessment and risk screening process the psychiatric team, in discussion with the nurse in charge of the ward, should make decisions regarding the introduction, increase or reduction of special observation with the rationale for such decisions being documented in the patient's clinical record and then discussed as part of the ward safety brief.

Where it has been assessed by the psychiatric service that special observation should be undertaken by a RMN, ward staff are responsible for the patient's observation until the RMN is in attendance.

3f. Reviewing Observation Levels

The level of observation should be reviewed at least every 24 hours by the nurse in charge of the ward. Decisions on observation levels should be recorded in the patient's medical and nursing care plan / notes and, where appropriate, discussed with the patient's family / next of kin / main carer / guardian. Where Special Observation has been initiated by the psychiatric team, the need for this will be reviewed jointly by the nurse in charge of the ward and the psychiatric team each day. When the patient is medically fit to be discharged from the ward, the psychiatric team will advise on any further management.

3g. Increased Observation Documentation

Documentation within the patient's clinical record (medical and nursing) should include:

- Date of commencement of increased observation level
- Details of care requirements / treatment / interventions / control measures identified
- The name and recommendations of the psychiatric team member / psychiatrist (if involved)
- The date of the next scheduled review.

4. Patients with Learning (Intellectual) Disabilities

Patients with a learning disability may already be receiving support from one of the Learning Disability Community Liaison teams or Learning Disability Inpatient Units prior to admission which can be contacted to offer advice to ward staff. In the case of planned admissions to hospital and where the person is known to the Learning Disability Services it is always preferable to involve the learning disability team, so that the sharing of essential information can take place in an effort to minimise behavioural disturbance / distress.
In addition, a 'Hospital Information Booklet for Acute Hospitals' or 'Getting to Know Me' booklet may be in place. The booklet should provide detailed information about the person's disability, the level of support required and the best way to communicate effectively.

Learning Disability Service currently provide an 'Out-of-Hours' (OOH) nursing service at evenings and weekends in Greater Glasgow. Out-of-Hours provision in Clyde is by prior arrangement only. The Out-of-Hours service can provide advice and guidance and, dependent on levels of activity, on-site support and may also be able to access information about individual patients to support care. **LDS OOH (7.30pm to 8am) Contact No. 07768868857 Greater Glasgow, not Clyde**

5. Detention under Mental Health Legislation

For advice on Emergency Detention under the Mental Health (Care and Treatment) (Scotland) Act (2003) see Appendix 3. However for the purposes of these observation guidelines, observation levels and legal status should be considered separately. Many detained patients do not require anything beyond general observation whilst some patients requiring even special observation may be informal. Specific issues relating to detained patients should be raised with the local Liaison Psychiatry team.

6. Patient transferred from Inpatient Mental Health Hospital

Where in-patients of adult mental health services (MHS) are requiring treatment in a general hospital, the decision as to providing staff to carry out increased observation (this is termed "escort" in MHS) will be made by the nursing and medical staff of the patient's own MHS ward following the Mental Health Service structured risk assessment processes. This includes both informal (not detained) patients and patients who are detained under the Mental Health (Care and Treatment) (Scotland) Act (2003) (formal detention).

Consideration will be given to the patient's current level of observation in the Mental Health setting:

- if on general observation nurse escort would not normally be considered necessary;
- if on constant observation it may be appropriate to supply an escort;
- if on special observation it would be normal to escort patients.

However, this would be after proper risk assessment and known history of the patient.

Any specific risks associated with a patient should be discussed between the patient's mental health team and the general ward staff and a management plan should be documented in the patient's case record. The transfer documentation provided from MHS should give a summary of the patient's known needs, triggers and any behavioural management techniques which have proved successful in the past.

7. Restraint

Where there is only one member of staff provided for increased observation (even if they are a Mental Health Nurse trained in restraint), once reasonable persuasion has been exhausted, it is not considered safe practice to even minimally restrain or prevent a patient leaving the ward unless assistance is given by the general ward staff. In these situations, further risk assessment and discussion should take place between both services' nursing and medical staff.

No nurse is expected to take action beyond his or her level of competence. In particular, no nurse is expected to restrain a patient without having undergone appropriate training. In most instances, it is more important to know and report that the patient has absconded rather than putting the patient, other patients', themselves or other staff at risk by attempting to physically restrain or prevent the patient from leaving.

8. Absconded patient

In the event of a patient absconding from the ward, the nurse in charge should follow the NHSGGC Missing Patient Protocol (2014)

Appendix 1:

Guidance for consideration of RMN support in the management of disturbed behaviours when increased supervision is required

Type of behaviour:

- Aggression (Verbal or physical) ☐
- Wandering ☐
- Disinhibited ☐
- Absconding ☐

- Risk of Suicide / Self Harm ☐
- Acute Psychosis ☐

THINK Delirium!

Exclude/ Treat -

Sensory Impairment / cognitive impairment / communication difficulty.

Organic Cause e.g.

- Delirium,
- UTI
- Constipation
- Dehydration
- Pain
- Sepsis
- Substance / Alcohol use
- Head Injury

Signs of Delirium!

Delirium Common if age >65 and acute iIlness / surgery / change in drugs

- Recent change (hours / days) in cognition or other mental function
- History of change from relatives / GP letter / ward staff
- May be withdrawn / unresponsive / drowsy
- May be agitated / uncooperative / suspicious

Consider -

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- Collaborative History (family and significant others)
- Follow 'Guidance for the observation of patients with acute behavioural disturbance'
- Low stimulus environment
- 1:1 Nursing (RMN not always necessary)
- Refer to acute addiction liaison if excess drugs or alcohol use suspected
- Referral to relevant services e.g. AHPs
- Discuss patient care with lead nurse and / or clinical coordinator
- Cohorting (with similar patients in one area)
- Prescribe appropriate medication to control behaviour see Therapeutics Handbook 2013 pp 167-170: escalate promptly to Senior Grade if prescribed medication not effective
- Professional Case Conference (Remember to include & feedback to relatives / advocate)

If still required:

- Refer to Liaison Psychiatry / Duty Psychiatrist for advice / assessment
- Follow recommendation of Duty Psychiatrist / Liaison Psychiatry service (GLPS)
- Consider use of AWIA and /or Mental Health (Care & Treatment) (Scotland) Act

In Extreme Violence, Consider:

- Police Support (**Phone 999**)
- Senior Clinician agreed Rapid Tranquilisation Management Plan
- Additional Staff to support patient. (Not specifically RMN unless directed by GLPS)
- Consider discharge if medically safe
- Use of 'Standards of Behaviour' protocol

Appendix 2: OBTAINING STAFF FOR INCREASED OBSERVATION (ACUTE DIVISION)

Decide: What level of increased observation is required (constant or special)?

If the patient is at risk of Suicide / Self harm, or Acute Psychosis, or assistance is required in the management of Delirium, discuss with Liaison Psychiatry / Duty Psychiatrist for Advice / Assessment – See Guidance, Appendix 1

Decide: Can increased observation be managed with existing staff? – NO: Escalate to Line Manager

Seek staff locally- Are staff available from other areas in unit / hospital?- NO: Escalate to Line Manager

Request additional staff from Nurse Bank as below (Record reasons for need of additional staff, patient condition (e.g. patient with delirium / confused and agitated etc.) and grade of staff requested in notes section of Nurse Bank requesting system)

Record all decisions made & level of observation applied in nursing notes.

Requesting staff for increased observation from Nurse Bank

1. On recommendation of Duty Psychiatrist / Liaison Psychiatry service

2. Significant risk of suicide

In these situations request RMN for Special Observation

If potential need for restraint of patients with acute / temporary cognitive impairment **remember**:

Physical Restraint requires 2-4 persons skilled in safer restraint techniques (depending on level of restraint) and also rapid access to medical assistance and resuscitation facilities.

In all other situations (following assessment) request either:

a) Conflict management trained / mental health experienced HCSW for **constant or special observation**;

Best practice is to use additional staff as part of the ward team and rotate care of patient amongst all staff on shift rather than assign this duty to one member of staff for the shift

Requesting Escort* from Mental Health Services (MHS)

Both of the following conditions need to be met: Patient is currently an in-patient in Mental Health Services (MHS) AND patient is assessed by MHS Risk Assessment as requiring constant or special observation.

In these situations contact hospital / other area where patient has been admitted from.

If issues arise over level of observation required - Escalate to own line manager for resolution

Request additionally qualified / experienced HCSW staff from Nurse Bank (not usually required to be an RMN)

***NB** Escort is the term used in MHS for staff accompanying patient to another area.

Where support is not available from any source at the time required

1. Inform line manager

2. Complete a Datix using the codes:

- Employee Incident,
- Staffing level,
- Inappropriate staffing level

Appendix 3: **Mental Health (Care and Treatment) (Scotland) Act 2003**
Application of an Emergency Detention Certificate (EDC)
within an Acute Hospital Setting

Patient assessed by fully registered Medical Practitioner
Medical Practitioner discusses with an Approved Medical Practitioner (AMP) [(1)]
Mental Health Officer contacted for consent [(2)]

Medical practitioner must complete certificate by midnight of day of examination (if prior to 20:00) or within four hours of examination if after 20:00

Form **DET 1** completed by Medical Practitioner [(Click here for form)]
The certificate must be given to the Clinical coordinator
The EDC authorises detention in hospital for up to 72 hours from the granting of the certificate where the patient has been admitted.
The certificate does not authorise treatment only assessment. [(3)]

Check for advance statement and Named person [(4)]

Where the patient has a certificate granted in the community the point of commencement is prior to admission when the certificate is handed to hospital managers.

The certificate must signed dated / timed by the Doctor and the patient clearly identified.
The criteria for **Emergency Detention Certificate**:

- The patient has a mental disorder,
- and that because of this the patient's ability to make decisions about the provision of medical treatment is significantly impaired
- That it is a matter of urgency to detain the patient in hospital to determine what treatment is required.
- That if the patient were not detained there would be significant risk to the patients health safety or welfare or the safety of others.
- Granting a Short Term Detention Certificate would involve undesirable delay.
- Mental Health Officer consent is granted or state why it was impracticable to get this.

Only an MHO can give consent. If attempts to access MHO are unsuccessful then detention may be granted without consent

Failure to hand over the certificate to hospital managers will invalidate the certificate.
It is the detaining doctor's duty to ensure this happens

<u>Duties following Completion of the Certificate</u>

The **Ward / Unit Senior Charge Nurse** (within Hours) or **Clinical Coordinator** (out of hours)[(5)] must ensure that the following parties have been **informed** that a certificate has been granted within **12 hrs** of receiving it.

- The Mental Welfare Commission on **0131 313 8777**[(6)]
- The nearest relative, or if they do not reside with the patient
- The person who resides with the patient
- The named person if they are none of the above

The patient must also be informed in a manner which they can understand, the consequences of the detention, the review of the detention by a Psychiatric RMO and their right to independent advocacy. This advice is best supported by an information leaflet given to the patient and as soon as is practicable, a copy of this leaflet should be given to the named person.

If psychiatric services have not been contacted, the **Ward / Unit Senior Charge** or **Nurse Clinical Coordinator** must contact services to arrange for examination by an Approved Medical Practitioner as soon as practicable (usually within 24 hrs) for those patients subject to an EDC.

10:00hrs Sun – 17:00hrs Fri Liaison Psychiatry must be contacted.

17:00hrs Fri - 10:00hrs Sun The on call AMP must be contacted via the appropriate psychiatric duty doctor

A Psychiatric Responsible Medical Officer will then be appointed for the patient if they do not already have one

Detention form **DET1** must be forwarded to the Acute Medical Records Office as soon as possible as per local arrangements. The form will be forwarded to local psychiatric medical records.

Psychiatric Medical Records will **notify** within 7 days the nearest relative or person who resides with the patient, named person, Mental Welfare Commission and where MHO consent was not obtained the appropriate local authority of the detention and other relevant information.

1 Approved Medical Practitioner Contact Details

AMP A psychiatrist with further training who is approved by the board to carry out certain functions within the Act

Within working hours contact should be with liaison psychiatry, outwith working hours the duty doctor at the appropriate site:

Southern General & Victoria Infirmary	Leverndale	**0141 211 6400**
Royal Alexandria Hospital	Dykebar	**0141 884 5122**
Inverclyde Royal Hospital	Langhill Clinic	**0147 563 3777**
Glasgow Royal Infirmary	Parkhead	**0141 211 8300**
Western Infirmary & Gartnavel General	Gartnavel Royal	**0141 211 3600**
Vale of Leven	Gartnavel Royal	**0141 211 3600**

2 Accessing a Mental Health Officer

MHO A social worker with further training who carries out functions within the Act

Within working hours

(8:45 am- 4:45 pm Monday –Friday)

Glasgow City	North East Sector	**0141 232 1200**
	South Sector	**0141 276 8735**
	North West Sector	**0791 779 0028**
South Lanarkshire		**0141 531 4117**
Renfrewshire		**0141 207 7878**
Inverclyde		**0147 571 2197**
East Dunbartonshire		**0141 232 8217**
West Dunbartonshire		**0138 973 7020**
East Renfrewshire		**0141 800 7840**

Outwith Working Hours

(5pm – 9am Monday – Friday / all day Saturday & Sunday and public holidays)

Social Work Standby Service	**0141 305 6705**
South Lanarkshire	**0303 123 1008**

3 Urgent/ Emergency Medical Treatment

Patients who are subject to an **Emergency Detention Certificate** cannot be given medical treatment under that certificate. However, in a medical emergency a detained patient may be administered medical treatment without consent for the mental disorder under **section 243** of the Act in order to:

- Save the patient's life
- Prevent serious deterioration in the patient's condition
- Alleviate serious suffering on the part of the patient
- Prevent the patient behaving violently and/or being a danger to themselves or others.

Following such treatment the administering doctor must inform the Mental Welfare Commission (T4 form) of their action within 7 days and inform the patients Responsible Medical Officer.

In medical and psychiatric emergencies for any non detained patient, common law allows treatment to preserve life or function. No certification is needed beyond description of the action in the casefile.

4 **Named Person** someone nominated by a person or appointed under the provisions of the Act to support and protect the patient interests. (Named Person Guidance)

Advance Statement A written, document stating how the person would prefer to be treated (or not treated) if they were to become ill in the future, any doctor treating the patient must have regard to the advance statement. (Advance statement Guidance)

5 The **Ward / Unit Senior Charge Nurse** or **Clinical Coordinators** are acting as hospital managers and must ensure the prescribed functions are carried out. Failure to carry out these functions could lead to a successful appeal against detention and a civil liability for unlawful detention.

6 This may be an answering machine outwith office hours