



TITLE

INPATIENT OBSERVATION LEVELS

SCOPE

Provincial: Addiction & Mental Health Inpatient Units

DOCUMENT #

AMH-01-01

APPROVAL LEVEL

Vice-President

SPONSOR

Addiction & Mental Health

INITIAL EFFECTIVE DATE

November 23, 2011

CATEGORY

Patient Safety

REVISION EFFECTIVE DATE

April 1, 2016

PARENT DOCUMENT TYPE & TITLE

Policy Level 2: Use of Observation, Privileges and Passes

NOTE: The first appearance of terms in bold in the body of this document (except titles) are defined terms – please refer to the Definitions section.

If you have any questions or comments regarding the information in this procedure, please contact the Policy & Forms Department at policy@albertahealthservices.ca. The Policy & Forms website is the official source of current approved policies, procedures, directives, and practice support documents.

OBJECTIVES

- To facilitate patient, staff, Physician, and visitor safety at Addiction & Mental Health inpatient units.
- To promote therapeutic intervention and care in the least restrictive manner.

APPLICABILITY

Compliance with this procedure is required by all Alberta Health Services employees, members of the medical and midwifery staffs, Students, Volunteers, and other persons acting on behalf of Alberta Health Services (including contracted service providers as necessary) working in Addiction & Mental Health Inpatient Units.

PROCEDURE ELEMENTS

1. Assignment and Review of Observation Levels and Communication to Patients

- 1.1 Upon admission, all patients shall be assigned and ordered an observation level by a Physician or a Nurse Practitioner, based on the patient's known risk of harm to self or others. Decision-making shall use communication from the Emergency Department if available, and when possible, be done in collaboration with the interdisciplinary team and the patient, when clinically appropriate.

- a) For any patient admitted to the unit without an order for an observation level, the patient's **health care professional** shall implement a minimum of an every-15-minutes observation level until such time that an order for an observation level is determined and documented by a Physician or Nurse Practitioner.
 - b) The patient's health care professional shall inform patients of their observation level and the rationale for the frequency of the observation level as soon as clinically appropriate. The patient's health care professional shall document relevant points of the discussion in the **health record**.
 - (i) **Formal patients**, their **alternate decision-maker** (e.g., **guardian, agent, nearest relative**), and others per the patient's consent, shall be informed of the patient's observation level and **privilege** and **pass** level, and the rationale.
 - (ii) Consent is not required to disclose to the alternate decision-maker of formal or voluntary patients.
 - (iii) For voluntary patients, the patient's consent must be given prior to disclosing information related to the patient's observation level to others, unless otherwise authorized by the *Health Information Act*.
- 1.2 The documentation of any change(s) in observation levels and the rationale for the change(s) shall be immediately recorded within the "*Physician Orders*" section of the chart.
- a) In the event the patient's health care professional increases an observation level, the appropriate Physician or a Nurse Practitioner shall be informed within a reasonable time frame.
- 1.3 Requests from the interdisciplinary team for decreases in observation levels shall be reviewed by the Physician or Nurse Practitioner within 24 hours.

2. Observation Levels and Observations

- 2.1 The following observation levels shall be utilized in all Addiction & Mental Health inpatient units:
- a) Constant observation – at least one staff member shall be present with the patient at all times and observe and maintain uninterrupted, close visual contact and monitoring of the patient. Nursing observation of patients on security constant shall be conducted, at a minimum, every 15 minutes.
 - b) Every 15 minutes – observations shall be made at least every 15 minutes for the duration of the order.

- c) Every 30 minutes – observations shall be made at least every 30 minutes for the duration of the order.
 - d) Every 60 minutes – observations shall be made at least every 60 minutes for the duration of the order.
 - e) Every two (2) hours – observations shall be made at least every two (2) hours for the duration of the order – this level is only for Addiction & Mental Health rehabilitation and brain injury units (per Addiction & Mental Health *Psychiatric Unit Count* master document).
- 2.2 Ongoing monitoring of patients within observation levels shall be the responsibility of a health care professional authorized to perform restricted psychosocial interventions and may encompass observations and such activities as inquiry into emotional, physical, cognitive, behavioural and neurological status. The patient's health care professional may assign and direct other **health care providers** and security/Protective Services staff to observe the patient and report the observations to the patient's health care professional.
- 2.3 The patient's health care professional in section 2.2 may increase an observation level based on clinical observations of the patient. The change in observation level shall be communicated to the Physician, other health care providers, and security/Protective Services if appropriate, and documented as specified in section 1.2.
- 2.4 The patient's health care professional in section 2.2 shall review monitoring information with the interdisciplinary team and discuss a recommended decrease in observation level with the Physician or Nurse Practitioner.
- a) If the decision was made via verbal or telephonic order from a Physician or Nurse Practitioner, the health care professional shall document the decision in the health record.
- 2.5 In the case of a patient who appears to be sleeping, monitoring of at least three (3) regular respirations (e.g., direct visualization of chest movement or clear sounds associated with sleep such as snoring or deep breathing) shall be done at a frequency equivalent to the patient's observation level, with this exception:
- a) If the patient is on constant observation and appears to be sleeping, monitoring of at least three (3) regular respirations shall be done every 15 minutes.
- 2.6 The patient's health care professional in section 2.2 shall reassess the patient throughout the shift and respond to observations reported by other health care providers and security/Protective Services staff assigned to directly observe the patient.

- 2.7 For patients on any observation level who require off-unit emergency medical services, the patient's health care professional in section 2.2 shall (with the Physician or Nurse Practitioner where possible) determine the number of staff and skill set required to accompany the patient. (See *Addiction & Mental Health Inpatient Privileges and Passes Procedure*.)

3. Re-ordering of Constant Observation

- 3.1 For patients at risk of harm to self or others, constant observation requires a Physician or Nurse Practitioner to review and re-order every 24 hours.
- 3.2 For patients on constant observation for non-suicide risk, and who have remained on constant observation for 14 days or greater, a review and renewal of the order may then take place once every seven (7) days.

4. Documentation of Observations

- 4.1 Documentation of all observations shall be summarized in the patient's health record at least once per eight (8) hour shift or at least twice every 12 hour shift by the patient's health care professional.
- a) The patient's health care professional shall increase the frequency of documentation when warranted by the patient's clinical condition.
 - b) For patients on constant observation, a checklist or observation record shall be used to document observations at least once per hour and these observations shall be summarized in the patient's health record at least once per eight (8) hour shift or at least twice every 12 hour shift by the patient's health care professional.
- 4.2 Any observation records or checklists used to document observation of a patient at the required intervals shall be retained in the patient's health record per the Alberta Health Services *Records Management Policy* and *Records Retention Schedule*.
- 4.3 Clinical documentation shall include, but not be limited to: (re)assessment of the patient's condition; description of the patient's activity(-ies) and location(s); a record of the patient's assigned observation level and any changes; and the rationale for the initiation and continuation of the observation level.
- 4.4 Reassessment and verification of a patient's observation level shall be recorded in the patient's health record by the patient's health care professional.

DEFINITIONS

Agent means the person(s) named in a Personal Directive who can make decisions on personal matters according to the wishes expressed by the patient.

Alternate decision-maker means a person who is authorized to make decisions with or on behalf of the patient. These may include a specific decision-maker, a minor's legal representative, a guardian, a 'nearest relative' in accordance with the *Mental Health Act* (Alberta), an agent in accordance with a Personal Directive, or a person designated in accordance with the *Human Tissue and Organ Donation Act* (Alberta).

Formal patient means a patient detained in a designated mental health facility under two admission certificates or two renewal certificates, in accordance with the *Mental Health Act* (Alberta).

Guardian means where applicable:

For a minor:

- a) as defined in the *Family Law Act* (Alberta);
- b) per agreement or appointment authorized by legislation (obtain copy of the agreement and verify it qualifies under legislation) (e.g., agreement between the Director of Child and Family Services Authority and foster parent(s) under the *Child, Youth and Family Enhancement Act* (Alberta); or agreement between parents under the *Family Law Act*; or as set out in *Child, Youth and Family Enhancement Act* regarding guardians of the child to be adopted once the designated form is signed);
- c) as appointed under a will (obtain a copy of the will; also obtain grant of probate, if possible);
- d) as appointed in accordance with a Personal Directive (obtain copy of Personal Directive);
- e) as appointed by court order (obtain copy of court order; e.g., order pursuant to *Child, Youth and Family Enhancement Act*); and
- f) a divorced parent who has custody of the minor.

For an adult: An individual appointed by the court to make decisions on behalf of the adult patient, when the adult patient lacks capacity.

Health care professional means an individual who is a member of a regulated health discipline, as defined by the *Health Disciplines Act* (Alberta) or the *Health Professions Act* (Alberta), and who practises within scope or role.

Health care provider means any person who provides goods or services to a patient, inclusive of health care professionals, staff, Students, Volunteers and other persons acting on behalf of or in conjunction with Alberta Health Services.

Health record means the Alberta Health Services legal record of the patient's diagnostic, treatment and care information.

Nearest relative means, in the *Mental Health Act* (Alberta) and in this document, with respect to a formal patient or a person who is subject to a Community Treatment Order:

- a) the adult person first listed in the following list, relatives of the whole blood being preferred to relatives of the same description of the half-blood, and the elder or eldest of two or more relatives being preferred, regardless of gender:
- spouse or adult interdependent partner;
 - son or daughter;
 - father or mother;
 - brother or sister;
 - grandfather or grandmother;
 - grandson or granddaughter;
 - uncle or aunt;
 - nephew or niece;

OR

- b) any adult person the Alberta Health Services Governing Body designates in writing to act as nearest relative if there is no nearest relative within any description as above, or if, in the opinion of the Alberta Health Services Governing Body, the nearest relative would not act or is not acting in the best interest of the formal patient or the person subject to a Community Treatment Order.

Pass(-es) means that the patient is allowed to leave the premises or facility grounds for a specified period of time, either accompanied or not.

Privilege means, for the purposes of this document, that the patient is allowed to leave the unit and remain on premises or facility grounds for a specified period of time, either accompanied or not.

REFERENCES

- Alberta Health Services Governance Documents:
 - *Consent to Treatment/Procedure(s)* Policy (#PRR-01)
 - *Consent to Treatment/Procedure(s) Formal Patients and Persons Subject to Community Treatment Orders Under the Mental Health Act* Procedure (#PRR-01-04)
 - *Inpatient Privileges and Passes* Procedure (Addiction & Mental Health) (#AMH-01-02)
 - *Records Management* Policy (#1133)
 - *Records Retention Schedule* (#1133-01)
 - *Safe and Supportive Transfers and Discharges* Procedure (Addiction & Mental Health) (#AMH-03-03)
 - *Use of Observation, Privileges and Passes* Policy (Addiction & Mental Health) (#AMH-01)
- Alberta Health Services Forms:
 - *Acknowledgement of Responsibility for Certified/Formal Patient* Form (#18211)
- Non-Alberta Health Services Documents:
 - *Mental Health Act* (Alberta)

VERSION HISTORY

Date	Action Taken
November 23, 2011	Initial approval/effective
December 02, 2015	Revision approved
April 1, 2016	Revision effective date
March 16, 2017	Non-substantive change
December 2018	Scheduled for Review