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ANALYSIS OF CLINICAL OBSERVATION ON ACUTE PSYCHIATRIC WARDS

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SUMMARY

Background: *Clinical observation is very important to manage risk of people who are acutely ill on psychiatric wards. It is always an area of dispute between different specialities and disciplines in serious untoward incidents (SUI). Three levels of observations have been applied on acute psychiatric words. Assessing practice is important to help to identify any area needs improving.*

Methods: *A questionnaire was developed by HN to collect demographics. Medical notes on Westley and Grangewater wards were reviewed. Excel Microsoft Office World Computer Programme was used to analyse the results.*

Results: *57% were men. 62% were above 41 years of age. Majority were suffering from schizophrenia and schizoaffective disorders 61%. 64.28% were admitted as formal patients. 31.42% were on level I observation.62.53 were informal. 54.76% were risk to themselves, 28.57% risk to others. 82.3% were on level II observation, 31.42% formal and 68.50% informal. 21.32% were on level III observation. 66.66% were formal and 66.66% had an incident before this level.*

Conclusion: *This study have shown that patients are assessed properly before they go on any level of care. Some patients need to go on level III as they pose a risk mainly to other people. Regular reviews of patients, especially on high level of observation should be done more promptly, as being on observation is not a comfortable experience to go through and applying the least restrictive practice should always be sought and adopted.*

Key words: *acute ward - clinical observation - serious untoward incidents*

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INTRODUCTION

Patients who are admitted to acute psychiatric wards are usually acutely unwell and pose a risk to themselves through self harming, absconding and getting exploited or may other people lives at risk. Nursing staff do their best to reduce this risk by different measures, one of them is special observation, where patients are monitored by staff. However, there is a lot criticism about clinical observation, in that there is no evidence about its efficacy (Bowers 2005). It has been argued that it shifts risk or postpones it until the observation is ended or to post discharge, having said that, others see clinical observation as having an important preventative role, when the patient is severely depressed or acutely psychotic (Gouray 2000), until he is treated and his observation is terminated. It has been argued that clinical observation infringes the patient's privacy and freedom, it may make patients more irritable, angry and frustrated with mental health care.

Clinical observation has been an area of dispute in serious incidents, where different disciplines have disagreed about the level of observation that the patient was on and whether the risk would have been prevented, had he been on a different level (Bowers 2005).

It has been shown that usage of containment and level of observation varies greatly between hospitals and between countries (Bowers 2005, Forquer 1996, Sourander 2002). Research on manual restraint has shown that this intervention is used more to enforce detention and treatment than to manage violence (Ryan 2006).

South Essex Foundation University Trust's clinical observation policy and procedure states three levels of observation. Level I, this involves knowing the location of all patients, though not all patients need to be kept within eyesight, this is the minimum level of observation for any in-patient. Level II, Intermittent Observation requires directly observing the patient at least five times each hour at irregular intervals. Level III, This level is required when the patient could, at any time, make an attempt to harm themselves or others. The patient must be kept within eyesight at all times, day and night, any objects that could be used to harm themselves or others must be removed.

This audit was conducted to check clinical practice and its adherence to trust policy. It scrutinises documentation and compare practice of different levels of clinicians. It used the trust clinical observation policy and procedure as standards.

METHODS

A retrospective case note review study was conducted on medical notes of patients who were admitted to Westley and Grangewaters acute psychiatric wards at the mental health unit at Basildon hospital for a month. Notes of patients who were put on special observation during that month were reviewed. A data collection form was devised by (HN) was used to collect age, sex, diagnosis, drug and alcohol, forensic history before and after the implementation of the level of observation, and what was patient's and staff views about that level of observation, whether the level of risk had been reduced, and whether incidents followed the re-grading of that level of observation.

RESULTS

24 men and 18 women were admitted. 62% above the age of 41 years. Table 1 shows the demographic characteristic of the sample. Patients who suffer from schizophrenia form most of the sample, table 2 shows the diagnostic categories of the sample.

Patients who were on level I observation were 23, their clinical and behavioural characteristics are outlined in table 3.

Patients who were on level II observation were 33, their observation details and progress are outlined in table 4.

Patients who were put on level III observation were 9. Their details and progress on that level of observation are outlined in table 5.

Table 1. Shows age and sex of patients on Grange-waters and Westley Wards

Clinical Observation of patients on General Adult Psychiatric Wards	
Male	57.00%
Female	43.00%
Age Demographics	
Not Answered	2.00%
18-25	11.00%
26-30	4.00%
31-40	9.00%
41-50	23.00%
51-60	37.00%
61 and over	14.00%

DISCUSSION

Although this is a retrospective study with all its short comings, it showed that documentation was lacking in most of the observation details, although it is not an excuse, documentation got better when the seriousness of incidents increased and when level of observation was increased.

It is surprising that 75% of patients are above the age of 40 years. It is also interesting to note that patients suffering from schizophrenia were 50% of the admissions compared to 35% affective disorders.

Patients who got on level one observation were mostly informal and that was the case with level II observation. Patients on level II were mostly on section and serious incidents were noted more which warranted level III observation.

It is interesting that the information was not documented for level I, II especially regarding the frequency of review and who reviewed the patient, but it was documented properly for level III observation. It is also interesting that all reviews were done by the ward doctor and the consultant at this level.

We always claim that our work is trying to involve and empower patients, while practice, at least in this piece of work, indicated that not only patients, but also staff's views were not sought or were not taken into consideration, as patients and staff views is missing or not documented in most of the observation levels assessments. This practice needs to change as it has been proven that staff factors were significantly related to total conflict and containment rates on the wards (Bowers 2005, Bowers 2009).

Table 2. Shows the diagnostic categories of the sample

Diagnosis		N	%
F01.2	Sub Cortical dementia	1	2.3%
F06.3	Organic Mood Disorder	1	2.3%
F16.0	Mental and Behavioural disorder due to Hallucinogen use	1	2.3%
F19.50	Drug Induced Psychotic Episode (schizophrenia like)	1	2.3%
F20.0	Schizophrenia	20	48.0%
F22.0	Persistent Delusional Disorder	1	2.3%
F23.0	Acute Psychotic Episode (acute polymorphic psychotic disorder)	2	4.7%
F25.1	Schizoaffective Disorder	2	4.7%
F31.0	Bipolar Affective Disorder, current manic episode	3	7.1%
F31.2	Bipolar Affective Disorder, current episode with psychotic symptoms	2	4.7%
F31.6	Bipolar Affective Disorder, with current episode mixed	1	2.3%
F33.1	Recurrent Depressive Disorder	4	9.5%
F42.0	Obsessive Compulsive Disorder (predominantly obsessional thoughts)	1	2.3%
F60.6	Anxious Personality Disorder	1	2.3%
F91.0	Conduct Disorder(confined to family context)	1	2.3%

Table 3. Patients on level I Observation

Legal status		Formal	Informal		
		5	18		
Frequency of the review		Daily	Weekly	Unknown	
		12	7	4	
Reviewed by whom	Nurse	Ward Doctor	Duty Doctor	Consultant	Not Known
	4	7	4	2	6
Duration on Level I	Hours	Days	Months	All Admissions	Not Known
	1	9	3	1	9

Table 4. Patients on level II Observation

Legal status		Formal	Informal		
		11	20		
Frequency of the review		Daily	Weekly	Unknown	
		18	7	4	
Reviewed by whom	Nurse	Ward Doctor	Duty Doctor	Consultant	Not Known
	6	13	5	2	9
Duration on Level I	Hours	Days	Months	All Admissions	Not Known
	10	15	5	2	3
Serious of incidents on Level II		Trivial	Serious	Not Answered	
		5	3	1	
Who/What was involved in the incident		Furniture	Staff	Other Patients	Self Harm
		1	5	2	1
Incident after commencement on level II		Yes	No	Not Known	
		5	3	1	
Change of Legal status after incident		Sectioned	Stayed informal		
		3	2		
Patient's view on level II Observation		Positive	Negative	Not Documented	
		4	7	24	
Staff's View on Level II observation		2	8	25	

Table 5. Patients on level III Observation

Legal status		Formal	Informal		
		6	3		
Frequency of the review		Hourly	Daily	Unknown	
		3	6	0	
Reviewed by whom	Nurse	Ward Doctor	Duty Doctor	Consultant	Not Known
	0	8	0	1	0
Duration on Level I	Hours	Days	Months	All Admissions	Not Known
	1	6	2	0	0
Serious of incidents on Level II		Trivial	Serious	Not Answered	
		3	6	0	
Who/What was involved in the incident		Furniture	Staff	Other Patients	Not Answered
		1	1	5	2
Incident after commencement on level II		Yes	No	Not Known	
		1	8	0	
Change of Legal status after incident		Sectioned	Stayed informal		
		3	2		
Patient's view on level II Observation		Positive	Negative	Not Documented	
		0	1	8	
Staff's View on Level II observation		0	1	8	

CONCLUSION

Close observation is a controversial issue with regards to patients' care in acute psychiatric wards. It is an important and critical aspect of practice, it may create a lot of friction between staff and patients and also between patients. Proper documentation including incidents preceding and following the decision of putting patients on specific level of observation should be documented and explained properly. Time, frequency and who carry out the reviews should be documented properly, in order to make sure that good practice is followed. Staff and patients' views should be taken into consideration and documented properly.

This study made recommendations for changing the incident form and making documentation more clear and accurate.

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