Observation Levels
- Addiction & Mental Health Program -

Corporate Policy & Procedures Manual
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Approved by:
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Purpose
- To facilitate patient*, staff and visitor safety by assigning observation levels/times for admitted mental health patients.
- To promote a therapeutic environment for patients within Addiction & Mental Health inpatient units.

Policy Statement
On admission, patients shall be assigned an Observation Level*. An order* indicating the Observation Level shall be based on an assessment of the patient’s emotional, physical, cognitive, behavioural and neurological status as determined by the most responsible health practitioner* with specific consideration as to the risk posed to themselves or others. Patients will continue to be assessed and monitored during their treatment to ensure observation levels are appropriate.

Applicability
This policy and procedure applies to all Covenant Health acute inpatient mental health programs, and the staff and members of the medical staff working within those programs.

Responsibility
Covenant Health’s administrative and medical leaders will demonstrate commitment to the safety of all patients by supporting the elements of defined observation levels for patients.

Ongoing assessment and monitoring of patients within Observation Levels will be the responsibility of the designated health care professional*.

The designated health care professional may assign other health care providers* (eg. an aide) to directly observe the patient, document, and report the observations to him/her.

Principles
Identification of appropriate observation levels are essential to help keep patients safe while at the same time providing a healing environment. Patients have a right to the least restrictive care, based on their level of responsible functioning, and the right to information regarding their levels of observation. Observation levels will be assigned, communicated, documented and acted upon to support all patients. Observation rounds will be conducted and documented without exception.

* see Definition
Procedure

1. On admission, the patients will be assigned an Observation Level by the most responsible health practitioner. Should a patient be admitted to the unit, and an Observation Level has not yet been documented, a minimum of a Q15 minutes observation level will be implemented until such time as an order for an Observation Level is written.

2. Observation Levels can be increased or decreased by an order.

   2.1 The patient’s health care professional shall inform patients of their observation level (and the rationale for same) as soon as clinically appropriate.

      a) Formal patients*, their alternate decision–maker* (eg. 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.

      b) Consent is not required to disclose to the alternate decision-maker of formal or voluntary patients.

      c) For voluntary patients, the patient’s consent must be given prior to disclosing information related to the observation level to others, unless otherwise authorized by the Health Information Act.

3. Health care professionals may increase the frequency within an Observation Level without consulting the physician of record to facilitate patient safety based on clinical assessment and judgement. Any change made in this manner must be communicated as soon as practical to the most responsible health care provider, nurse in charge, the care team, and the patient. The change will also be documented appropriately.

4. Requests from the interdisciplinary team for decreases in observation levels shall be reviewed by the most responsible health practitioner.

5. Patients and, as appropriate, their family(ies)* and/or alternate decision maker will be informed of the Observation Level assigned to them and the rationale for the level of observation assigned.

6. Ongoing monitoring of patients within ordered observation levels is the responsibility of a health care professional authorized to perform a restricted psychosocial intervention. However, the task of conducting observations may be delegated to other health care providers or security/Protective Services persons who will report the observations to the health care professional.

7. Observation Levels (see 'Definitions'):
   The following observation levels shall be utilized in all Addiction & Mental Health inpatient units:
7.1 **Constant Observation**

a) At least one health care provider will be present with the patient at all times and observe and maintain uninterrupted close visual contact and monitoring of the patient. If constant observation is being provided by a member of Protective Services, a health care professional must still conduct an observation at a minimum of every 15 minutes.

b) For patients at risk for suicide, constant observation requires a new order every 24 hours. For non-suicide risk patients on Constant Observation who have remained on Constant Observation for 14 days or greater, a renewal of the order can then take place once every seven days.

c) The patient will not leave the unit unless for medical investigation (emergent), and under such circumstances an assessment of the patient’s risk, including risk of elopement, will be undertaken prior to the patient leaving the unit. The health care professional responsible for ongoing assessment and monitoring of the patient will (with the physician of record where possible), determine the numbers of staff and skill set required to accompany the patient safely.

7.2 **Every 15 minutes (Q15)** - means observing the patient at least every 15 minutes for the duration of the order.

7.3 **Every 30 minutes (Q30)** - means observing the patient at least every 30 minutes for the duration of the order.

7.4 **Every 60 minutes (Q60)** – or General Observation - means observing the patient at least every 60 minutes for the duration of the order.

7.5 In order to promote patient dignity and sleep hygiene, the physician, in collaboration with the interdisciplinary team, may consider differentiating observation levels for daytime and nighttime.

a) In the case of a patient who appears to be sleeping, monitoring of at least three regular respirations (eg. direct observation 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.

b) If the patient is on constant observation and appears to be sleeping, monitoring of at least three regular respirations shall be done every 15 minutes.

8. **Documentation of Observation**

8.1 Documentation of all observation will be completed in the health record* at least once per eight hour shift.

a) Documentation verifying observation for a patient on Constant Observation will occur at least once per hour (by use of a checklist or observation
These observations shall be summarized in the patient’s health record at least once per eight hour shift by the health care provider or their delegate.

8.2 Documentation will include, but not be limited to, a record of the patient’s assigned Observation Level, an assessment of the patient’s condition, behaviour, affect, activity and location, any changes in Observation Level, the rationale for the initiation and continuation of the observation level and the ongoing assessment of the patient. Any relevant points of the discussion with the patient around their observation level shall be noted.

8.3 The health care professional responsible for the patient will reassess the patient throughout the shift and respond to observations reported by other health care providers (e.g., aide) assigned to directly observe the patient. Reassessment and verification of patient status will be recorded on the patient health record by the health care professional.

8.4 Any Observation Records or Checklists used to document observation of patients at the required intervals will be retained in the patient’s health record as per site Record Retention and Disposition policy.

9. Observation Levels and Parameters for Issuing Passes & Privileges – refer to Covenant Health policy #VII-B-217, Privileges & Passes

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, specific decision-maker, a minor’s legal representative, a guardian, a ‘nearest relative’ in accordance with the Mental Health Act, an agent in accordance with a Personal Directive, or a person designated in accordance with the Human Tissue and Organ Donation Act.

Family(ies) means one or more individuals identified by the patient as an important support, and who the patient wishes to be included in any encounters with the health care system, including, but not limited to, family members, legal guardians, friends and informal caregivers.

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 of Alberta.

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 practices within scope and 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 Covenant Health.
**Health record** means the Covenant Health legal record of the patient’s diagnostic, treatment and care information.

**Most responsible health practitioner** means the health care professional who has responsibility and accountability for the specific treatment/procedure(s) provided to a patient and who is authorized by Covenant Health to perform the duties required to fulfill the delivery of such a treatment/procedure(s), within the scope of his/her practice.

**Observation Levels** means a frequency or intensity of observation assigned to a patient during which a regulated professional, or their designate, will observe a patient. The approved observation levels assigned within acute inpatient psychiatric units are:

- **Constant observation level** means an assigned staff member is with the patient at all times with uninterrupted close contact.
- **Every 15 minutes (Q15) observation level** means observing the patient at least every 15 minutes for the duration of the order.
- **Every 30 minutes (Q30) observation level** means observing the patient at least every 30 minutes for the duration of the order.
- **Every 60 minutes (Q60) observation level** means observing the patient at least every 60 minutes for the duration of the order.

**Order** means a direction given by a regulated health care professional to carry out specific activity(-ies) as part of the diagnostic and/or therapeutic care and treatment, to the benefit of a patient. An order may be written (including handwritten and or electronic), verbal, by telephone or facsimile.

**Patient** means all persons who receive or have requested health care or services from Covenant Health and its health care providers. With respect to mental health patients, this pertains to both formal and informal patients equally, unless explicitly stated.

**Physician of record** means the one who has primary responsibility and authority for the medical care of a patient. In community settings, this will likely mean the family physician or general practitioner; in acute care settings, this may mean the admitting and/or following physician, or a hospitalist. As a patient flows through the continuum of care, the physician of record may change with the type of service provided.

Related Documents

- Covenant Health policy #VII-B-230, Transfer or Discharge of Patients
- Covenant Health policy #VII-B-217, Privileges & Passes

Revisions

- December 8, 2014
- September 28, 2012