NHS
East London
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REPORT TO THE QUALITY ASSURANCE COMMITTEE

November 2020

Title	Cross Cutting Themes Deep Dive: Observations and Inpatient Safety
Author	Andy Cruickshank, Director of Nursing (London Mental Health)
Accountable Executive Director	Lorraine Sunduza, Chief Nurse

Purpose of the report

This report describes the learning from serious incidents where observation prescription and practice have been a contributing factor in inpatient deaths.
The purpose and frequency of observations have led to a diminished rigour in their completion to the required standard and a reliance on a process that has systemic flaws.
Inpatient safety is a key area of focus across London MH Trusts and a strategy to address this has been developed. (see driver diagram)

Summary of key issues

Inpatient safety encompasses a broad range of concepts including safeguarding, violence and aggression, how teams communicate and deliver care, medicines, groups, relationships and engagement. Observation practice is a key part of this.

Observations are heavily relied upon within our inpatient services. The most commonly utilised type of observation in mental health services is intermittent observations. These are used for a list of concerns ranging from an individual's risk of self-harm, aggression, risks of absconding, physical health concerns and not engaging with assessment/treatment. They are frequently used on admission when clinical staff do not know the individual very well.

The higher the volume of intermittent observations, the more prone they become to failure. Factors that influence this are:

- The observing nurse being distracted by a call, incident or request.
- The observing nurse having several patients to observe – often simultaneously.
- Lack of clarity about the purpose of observations
- Prolonged prescription of observations
- Confusion/lack of clarity about who was undertaking the observations
- Long gaps between the observation and documentation

Several SI reports involving inpatients in the last 3 years have identified failures to follow the policy on observations. These failures have been judged to be contributing factors in a lack of or slow response to emergencies.

All identified either missed observations when the incident is likely to have occurred to observations not being undertaken as prescribed over protracted periods.

Whilst individuals are accountable - particularly registered practitioners – for any obvious negligence; many of these failures can be considered as possible by the way in which observation practice has developed over recent years.

Engagement across services through webinars for all staff and service users to discuss observations has revealed some common themes. These are:

1) Observations can be perfunctory – they are so frequent that they often do not assist in engagement but can feel like policing and can make some service users feel alienated and reinforce unhelpful impressions of control rather than care.
2) They are often prescribed as an automatic rather than clearly formulated response to concerns – so their purpose can be misunderstood or not articulated clearly and potentially undervalued.
3) The reviews rely on at least medical and nursing input which can result in certain wards having large numbers of intermittent observations to contend with whilst awaiting review.
4) Observations are not always a constructive use of nursing time and other approaches to engagement and care should be considered as viable alternatives in the use of nursing resources.
5) It is easy to miss an observation or forget to write it down at the time.

Using a QI approach, teams have developed ideas to test to simultaneously reduce the volume of observations and increase engagement. These ideas are:

A) The process of prescribing and review
B) Who undertakes observations
C) Viable alternatives to observations and how this is measured and evaluated

Teams are actively developing and testing these ideas with testing of A and B being undertaken across several teams. C will commence testing in November.

The use of electronic observations (to reduce reliance on paper systems that sit outside the electronic patient record) will be tested over the next 6 months – although a whole system change to electronic observations (both mental health and physical) will take some time longer due how complex this will be.

Further to this there will be a major revision of policy and practice on observations. Each directorate will continue to hold regular webinars to help refine the development of change ideas to test and measure. First revision to be completed by the end of December 2020.

Strategic priorities this paper supports *(please check box including brief statement)*

Improved population health outcomes	☐	
Improved experience of care	☒	More engagement can improve the experience of care and tailor clinical responses to risks through formulation.
Improved staff experience	☒	Less reliance observations and more focus on engagement can improve the quality of work experience.
Improved value	☐	

Committees/meetings where this item has been considered

Date	Committee/Meeting
	Clinical Ethics Committee discussion – July 2020
	Quality Assurance Committee – November 2020

Implications

Equality Analysis	
Risk and Assurance	This report outlines actions taken following investigations to improve the safety of patients and quality of care we provide.

Service User/Carer/Staff	
Financial	
Quality	Reductions in observations, which can be construed as restrictive, can positively affect attitudes and experiences of giving and receiving care.

Supporting documents and research material

a. Driver Diagram – London Safety in Inpatient MH Services
b.

Glossary

Abbreviation	**Obs - observations**
	ACEs – Adverse Childhood Experiences

1.0 Background/Introduction

Inpatient safety encompasses a broad range of concepts including safeguarding, violence and aggression, how teams communicate and deliver care, medicines, groups, relationships and engagement, security and so forth. Observation practice is a key element of this.

Observations are not by their nature focussed on engagement. They are a supportive activity that promotes but cannot always guarantee safety. Observations can help to give cues and clues about how someone's behaviour may be influenced by their state of mind and can, in some instances, prevent harm.

From frank discussions with a wide range of nurses it's clear that they are prone to fail if used too often combined with a vague sense of purpose. Even though our current policy is very clear about their use, it has become commonplace for them to be relied upon for a broad variety of concerns – mostly because of uncertainty around the risks a service user may pose. This can mean that the frequency of prescription is correlated with how well someone is known to a team – so a team dealing with higher admission volumes will use them more frequently and find themselves in a cycle of monitoring. The therapeutic value of these is often unclear.

Service users have frequently expressed that they find them intrusive and alienating – that being watched is a form of intrusion that is often hard to understand and see the value of. This does not mean they are unhelpful but that they need to have a clear purpose to mitigate the levels of intrusion and restriction they can entail.

There is evidence that structured activity around engagement – which includes observations – can help. This is described by Bowers et al (2011, 2012) as a key factor in maintaining safety and reducing conflict on wards. It is conceptually ascribed as being "caringly vigilant". This works on the supposition that at an individual practitioner level – but also to a large extent at a team and managerial level – there is an awareness around risk, around patterns of behaviour and divergence from this that can indicate a change in

someone's state. The evidence about the efficacy of observations is limited to a few studies but all point towards observations being of both some use but also cost in terms of service user experience, reinforcing custodial nursing roles, intrusion and lack of autonomy for both service user and nursing staff. It is therefore a surprise that they have been so uniformly adopted as an approach to care without greater study of their worth and viable alternatives.

Training and monitoring of observation practice is a key element of our assurance but does not address the wider problems and failings that have emerged in practice.

2.0 Report Content

2.1 Key Messages:

Observations are heavily relied upon within our inpatient services. The most commonly utilised type of observation in mental health services is intermittent observations. These are used for a list of concerns ranging from an individual's risk of self-harm, aggression, risks of absconding, physical health concerns and not engaging with assessment/treatment. They are frequently used on admission when clinical staff do not know the individual very well.

Several SI reports involving inpatients in the last 3 years have identified failures to follow the policy on observations. These failures have been judged to be contributing factors in a lack of or slow response to emergencies.

All identified either missed observations when the incident is likely to have occurred or that observations had not been undertaken as prescribed, over protracted periods.

Whilst individuals are accountable - particularly registered practitioners – for any obvious negligence or falsification of records; many of these failures can be considered as possible by the way in which observation practice has developed over recent years.

2.2 Problems and failures of observation practice

The higher the volume of intermittent observations, the more prone they become to failure. It is also likely that the more observations inadvertently fail without consequence; then they are increasingly less likely to be properly managed. Factors that influence this are:

i. The observing nurse being distracted by a call, incident or request.
ii. The observing nurse having several patients to observe – often simultaneously.
iii. Lack of clarity about the purpose of observations
iv. Prolonged prescription of observations
iv. Confusion/lack of clarity about who was undertaking the observations
v. Long gaps between observing and documentation

It is essential to balance the value of an intervention with the costs of implementing it. In this case, intermittent observations are costly, in terms of the volume of them and the human resource to undertake them, their reliability and proneness to failure, and the experience of service users and nurses.

Disentangling the value here is hard mainly because they are a highly prescribed activity. The inference is that they are successful because more people do not come to harm but this may overestimate their efficacy.

There is evidence that being curious and inquisitive can save lives but it is harder to reconcile the act of prescribing observation with these concepts when it is implemented on a large scale within busy wards. There is every likelihood that this gives a false sense of assurance – an assumption is that through checking, one is more likely to detect harm but if checking is dogmatic and cursory then this act may not be welcome and worse, cast the service users and staff in roles that may feel a long way from helpful or therapeutic.

This may be amplified by the number of observations, who is carrying them out, their understanding of the risks and concerns, their level of knowledge and experience, confidence and attention and so on. The added complexity of Covid and PPE may make the experience even stranger for the recipient. Repetitive and unfocussed checking is often subordinated to some of our most junior and inexperienced staff.

Training and monitoring go some way to ensuring that there is compliance with process and policy but this does not necessarily address the questions of intrusion; surveillance and associated restrictions.

3.0 Redesign and Testing Changes

Several elements of observational practice need attention for change and improvement.

These are:

1)The process of prescribing and review

2)Who undertakes observations

3)Viable alternatives to observations and how this is measured and evaluated

1) The main elements of prescribing are about formulation – what is happening for someone that means they are vulnerable to or likely to cause harm. Social factors always play a part in this – so how able a person is to engage, their behaviour generally, how able they are to comprehend what is happening and the nature of their symptoms.
Issues such as previous history – including ACEs and trauma – need to be thought about as core and interacting factors with current symptoms, understanding, engagement and behaviour. Actuarial risk is important in objectively balancing these factors. The prescription of physical observations needs to factor into this – this is particularly important as a result of Covid.

Any decision to implement enhanced observations needs a framework of review that can increase or reduce the level of observation.

In Newham, a 6hour review by 2 RMNs for all admitted service users – who currently automatically go onto intermittent observations – is being structured so that it focuses on formulation and future planning. Developing a rationale for continuing or reducing the level of observations requires further testing with nurses and multi-disciplinary support.

Update December 2020: This has been modified and testing is to start on Lea Ward in Tower Hamlets

2) Current practice is such that often the least trained or experienced staff undertake most of the observations. This is deeply problematic – not least because it subordinates a

crucial activity to some of our most junior staff who are often not in a position to question the task and may not be aware of some of the most essential elements of observation as described by Bowers above.

In this case, enhanced observations need to be tested with registered staff only (Nursing Associates or Registered Nurses). This will undoubtedly impact resourcing but may also increase the review process and help nurses think about other ways of engaging service users. This will be a key policy change.

Update December 2020: This change is being tested on Lea Ward in Tower Hamlets

3) Viable alternatives are largely based on providing an enhanced or extra level of care to those we don't know very well or are concerned who would usually be prescribed observations. An argument here is that if we use our nurses in a more focused way around this form of engagement; then there is a good chance that care will be more tailored and co-produced.

A key question, to at least check the process of prescribing observations is "What are the viable alternatives to help keep this person safe and engaged in their care?".

Of note – if observations are thought to be the most helpful intervention then these can be prescribed alongside extra care – one does not negate the need for the other.

Update December 2020: This is also being tested on Lea Ward and fits within the frame of the decision making process around obs review.

4.0 Recommendations

1) To continue with and the role-out of nurses undertaking the process of prescribing and review post-admission, with a clear framework for rationale and alternatives.

2) The development of the prescription of alternatives (extra care) and develop these ideas with nursing staff and service users.

3) Full testing of registered staff only undertaking enhanced observations.

4) The first stage testing of e-obs

5.0 Action Being Requested

4.1 The Committee is asked to:

RECEIVE and **DISCUSS** the findings of the report