health

Nursing observation through engagement in psychiatric inpatient care

Department of Health guideline

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Preamble

This guideline is intended to provide clinicians, services and service users with clear direction regarding the role of, and best practice approaches to, the conduct of nursing observation of people receiving care in Victorian mental health inpatient units. The development of the guideline was instigated in response to the *Chief Psychiatrist's investigation of inpatient deaths 2008–2010*, as well as to the *Coroners Court of Victoria 2011–2012 annual report*. In particular, Recommendation 7 from the Chief Psychiatrist's investigation relates to the need for the Department of Health and health services to ensure that clear and consistent processes and documentation for nursing observation are in place.

Nursing observation is the purposeful gathering of information from people receiving care to inform clinical decision making. It is central to nursing practice, multifaceted and critical to good care. Consideration of nursing observation is complicated by the various understandings of what is meant by the term within service policies and in the literature.

This guideline acknowledges the reciprocity between nursing observation and assessment, where nursing observation informs assessment, while the choice to undertake different forms of observation is guided by assessment.

This guideline highlights not only the opportunity for therapeutic engagement, but also the integral role that person-centred therapeutic engagement plays in enabling nurses to reach a comprehensive understanding of the most pressing issues of people receiving care. The rationale and purpose of formal observation should be one of therapeutic engagement rather than one of surveillance and control, and this understanding is central to this guideline. Nurses' active engagement with people receiving care and their carers means that people's experience of inpatient settings is supportive of recovery, more positive and therapeutic, and will contribute to better outcomes for people and their families.

Observations covered in this guideline include engagement to support people who are vulnerable and require effective therapeutic engagement to ensure their wellbeing. This includes visual observation and physical observation, which should be completed using a therapeutic approach. Of course consistent with this is ensuring effective processes and documentation of nursing care in a person's care plan and progress notes.

Mental health services should develop local policies and procedures for nursing observation that are consistent with these guidelines. This will help services and practitioners to arrive at a common understanding of the purpose of, and best practice approaches to, nursing observation, ensuring that people's rights are upheld and resulting in people having a better experience of care.

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Key message

Although the purposeful observation of people receiving inpatient care is central to nursing practice, definitions of what constitutes nursing observation vary widely. For the purposes of this guideline, nursing observation is considered to be the purposeful gathering of information from people receiving care to inform clinical decision making. Undertaking observation requires nurses to be person centred and to engage therapeutically with those receiving care. Only through talking with people receiving care do nurses gain a comprehensive understanding of their most pressing issues. Underpinning all nursing observation should be the goal of supporting recovery. Implicit in this definition is the promotion of active engagement with people, rather than passively watching them from a distance.

Through engaging with people receiving care and their carers, nurses can provide a more supportive experience within inpatient settings. Being empathic towards people receiving care can contribute to the experience being perceived as positive and therapeutic. The development of strong rapport with carers can help them to feel informed and supported. This is essential as it is carers who continue to be with people outside of the inpatient admission, know them the best and can assist with collateral information that can enable recovery.

Observation is indelibly linked with nursing assessment. Not only does nursing observation contribute information to the assessment of psychosocial functioning, physical health and safety, decisions to undertake different forms of observation are also the outcome of assessment processes. In this way, various forms of assessment and observation are cyclical and should be a continuous feature of the care of people in psychiatric inpatient units.

Nursing observation involves the performance of highly developed skills in several areas of practice, including building therapeutic relationships and attending to psychosocial, physical health and safety needs. As such, experienced nurses and those with access to adequate mentoring are well suited to performing purposeful observation.

Background

Psychiatric inpatient units provide care for people with serious mental health conditions who can be extremely unwell. Nurses have a responsibility for working with large numbers of people with high acuity in ways that promote recovery and ensure safety from harm. One way in which these outcomes can be achieved is through undertaking observation, during which nurses engage therapeutically with people receiving care and obtain meaningful information on each person's wellness and safety.

A recent Chief Psychiatrist investigation revealed that observation practices varied among services. An aspect of practice that was particularly concerning was that observations were not consistently carried out as documented or expected. During certain times (that is, at night and when there was increased ward activity) levels of observation were reduced. The Chief Psychiatrist investigation panel emphasised the need for nurses to engage therapeutically with people rather than relying on risk assessment tools and prescribed observation levels. They commented that the practice of observation should extend beyond the checking of presence and safety to the ongoing assessment of mental and physical state. The panel recommended (p. 31) 'that the Department of Health and health services ensure there is a clear and consistent process and documentation for nursing observations, and that any change in required observation level is made after suitable discussion and consideration. The frequency of observations over the night shift should be congruent with daytime observations unless otherwise decided and documented'.

Purpose

The purpose of this document is to provide guidance to mental health services for developing local policies and procedures with respect to nursing observation and people receiving care in inpatient mental health facilities.

Scope

The guideline applies to all mental health services with inpatient facilities in Victoria.

About the Department of Health guideline

The information provided in this guideline is intended as general information and not as legal advice. Senior mental health nurses, nurse unit managers and mental health service managers should ensure that procedures are developed and implemented consistent with the purpose and intent of the guideline.

Icon key

The following icons highlight important points in the guidelines.

Reflection questions can be for individual reflection or to prompt discussion in group reflection.

Key principles are translated into useful **practice tips**.

Managers and senior staff need to keep in mind certain **key considerations** that when developing **mental health service policies.**

Core principles of nursing observation

Engaging with people during purposeful observation contributes to nurses fulfilling their duty of care.

Nurses demonstrate duty of care through performing nursing interventions that are consistent with recognised standards of practice. They clarify care responsibilities with other members of multidisciplinary teams preventing harm to people for whom they are providing care, and undertake nursing interventions based on comprehensive and accurate assessments (Australian Nursing and Midwifery Council, 2006). With respect to observation, nurses fulfil their duty of care through therapeutically engaging with people and working with them on their paths towards recovery. Fulfilling their duty of care also means that nursing assessments and interventions are performed while engaging with people.

There are several core principles that underlie the practice of nursing observation. The principles hold that:

- nursing observation is multifaceted
- observation and assessment are interrelated
- observation is grounded in therapeutic engagement with the person
- nurses appreciate how inpatient environments influence behaviour
- observations are communicated between colleagues
- there is a clear process of documentation that is timely and descriptive.

Nursing observation is multifaceted

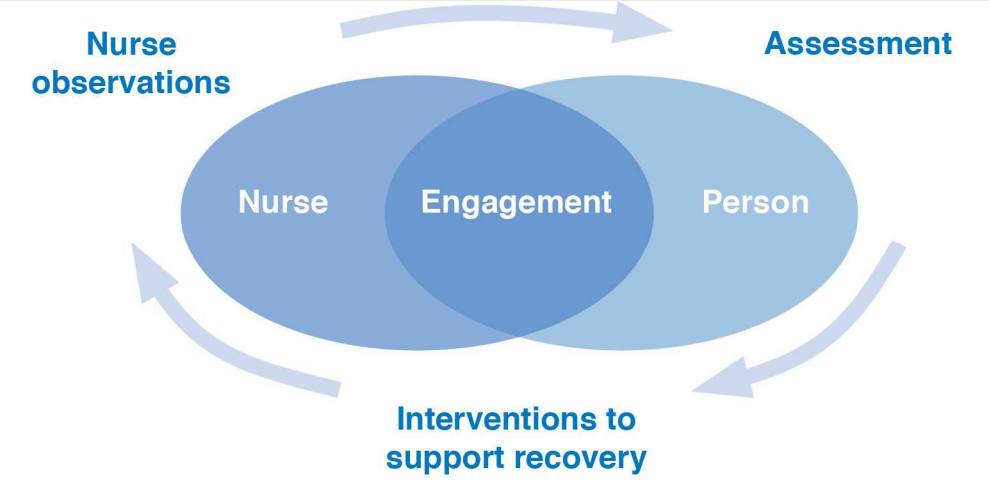
Nursing observation means the purposeful gathering of information from people receiving care to inform clinical decision making. The word *purposeful* implies that observation is undertaken with the intent of obtaining specific information, and distinguishes this skill from passive surveillance. Observation involves the collection of both objective and subjective information about people. Nursing observation is not restricted to the visual medium; observation, in this sense, equally applies to what is heard (that is, what and how people communicate with nurses and others). Reasons for observing people include, but are not limited to, engaging with people who are unwell and obtaining information on their psychosocial wellbeing, physical health and safety. This information can then be used to inform and enhance the development of care plans.

Nursing observation occurs through direct contact with people, including sitting with them, listening to them, understanding their non-verbal and verbal indicators or cues, asking them pertinent questions and developing an understanding of the most pressing issues in their everyday lives. Care involves understanding how people might react to the stress of hospitalisation and all that is occurring in that environment.

Observation and risk assessment are interrelated

Nursing observation both informs risk assessment and is an outcome of the assessment process. Nurses will contribute to the identification of risk through engaging with people receiving care in the completion of evidence-based assessments, and making clinical judgements about their mental health, psychosocial functioning, physical health and safety. These assessments inform judgements on appropriate types of ongoing observation for each person. In this way, a cycle of assessment (through both structured and unstructured means) and observation should be a continuous feature of inpatient admissions. This process is depicted in Figure 1. In this figure, the activities of nursing observation, assessment and interventions to support recovery ensure the nurse has interaction with the person. It is through that intervention and purposeful nursing behaviour that engagement can occur.

Figure 1: The association between observation and risk assessment in psychiatric inpatient care



Source: Beaton, Davies, Szczygielski and Ramsay (2013)

Observation is grounded in therapeutic engagement

To ensure individual care is consistent with a person's needs, nurses must take the opportunity to understand what matters to the person with whom they are working. For this understanding to occur nurses have to spend time with people in meaningful ways using therapeutic skills and thoughtful enquiry. Understanding how things are for people makes it easier to be responsive to their needs.

Engagement requires a series of actions that include establishing a relationship (a person-to-person connection) and conveying acceptance of different views and hearing, listening and understanding (Cutcliffe and Barker, 2002). Engagement means that people are active in the management of their health, which can lead to improved health outcomes. In the context of observation, engagement means:

- collaborating with people receiving care and their carers during periods of assessment, evaluation and review
- discussing with people the reasons why they are being observed and how those observations will occur
- inviting feedback on observation methods and integrating people's responses into how this practice is performed
- conducting observation in a way that fosters meaningful relationships between nurses and the people for whom they care.

Nurses are able to convey care and understand how things are for people by:

- fully informing a person about the observation process
- fully informing a person about their observation status and why
- asking what people might need when they are more vulnerable
- asking people how to best provide observation, understanding that people may not be receptive to observation or find it intrusive.

As much as this document focuses on nurses' observation of people receiving care, it should also be recognised that people make their own observations about nurses. Based on these observations, people make decisions about, for example, whether they trust nurses (or some more than others), whether nurses can keep them safe and whether nurses can help them move past the difficulties they are currently facing in their lives. Nurses who are able to build rapport with people are in stronger positions to foster positive therapeutic outcomes. Nurses can build rapport with people through therapeutically engaging with them and practicing in ways that are appreciative of their unique histories, strengths and hopes for the future.

Nurses who ground their clinical practice within a recovery framework can form supportive and productive relationships with the people for whom they provide care. Mental health recovery can be defined as 'an overarching philosophy that encompasses notions of self-determination, self-management, personal growth, empowerment, choice and meaningful social engagement' (Victorian Department of Health, 2011a). To ensure that care is provided using a recovery-oriented approach, nurses should ensure that their practices are consistent with the principles promoted in the *Framework for recovery-oriented practice* (Victorian Department of Health, 2011a). In this framework, the following aspects of recovery-oriented care are emphasised:

- promoting a culture of hope
- promoting autonomy and self-determination
- collaborative partnerships and meaningful engagement
- focusing on strengths
- holistic and personalised care
- family, carers, support people and significant others
- community participation and citizenship
- responsiveness to diversity
- reflection and learning.

See Appendix A for a summary of how these domains are related to observation practices. Nurses are encouraged to reflect upon how they interact with people and people's experience of care.

Nurses appreciate how inpatient environments influence behaviour

People typically adapt their behaviours for the settings and circumstances in which they find themselves. Being admitted to inpatient units can have many meanings for people and prompt varying emotions. Some people may feel relieved to be receiving care, some may not want treatment and care, while others may feel anxious. Features of inpatient units (for example, care from staff, the appearance and behaviours of other people receiving care or physical surrounds) are also likely to influence how people behave. Furthermore, whether people are admitted voluntarily or involuntarily may impact on how they perceive their inpatient experiences.

There is a natural tendency to attribute people's behaviours to their own dispositions and to overlook the effect of the environment. This tendency may be particularly strong when people are exhibiting behaviours that are not congruent with social norms. Nurses can assist people receiving care through having an appreciation of how inpatient environments may influence behaviour. Through engaging with people receiving care, nurses can come to understand their experiences of being in psychiatric inpatient settings. This, when done well, may create the opportunity for people to experience care differently.

Observations are communicated between colleagues

For nursing observation to be of maximum potential benefit to people receiving care, it needs to be clearly communicated to other nurses and health practitioners within interdisciplinary teams. Sharing knowledge of people's experiences and providing information about their progress and clinical presentation (as is obtained, for example, through nursing assessments) can help other healthcare professionals to improve the interventions they provide. That is, through conveying what is learnt through observation, nurses can help their colleagues to know better the people for whom they are caring. Communication can occur formally and informally.

Formal communication

Making reports during nursing handovers and multidisciplinary meetings and making entries into people's case notes are some of the ways in which nursing observation should be shared with colleagues. Staff in mental health services seeking to improve the effectiveness of handovers within their organisations can refer to the Australian Commission on Safety and Quality in Health Care's (ACSQHC, 2010) *OSSIE guide to clinical handover improvement*. To facilitate communication between colleagues, mnemonics such as ISOBAR (see Table 1) are useful.

Services will have a structure and policy for observation. Nurses will take leadership in defining what is possible and necessary to communicate to ensure safe, timely and effective observation and care for people in the environments they work in. There will be a clear process for communicating observation status, including how this is changed or altered. Nurses will ensure people on frequent observation are known to all nursing staff on duty.

Where a person is being formally observed, documentation is to be completed at the time of the observation by the nurse responsible for that observation practice.

What are the strengths of the communication practices on the wards where you work?

What opportunities may there be to enhance communication practices on your ward?

Informal communication

Supporting strong professional relationships between members of the interdisciplinary team has the potential to enhance the care provided to people admitted to inpatient settings. Because not all that is known about a person can be efficiently communicated using formal mechanisms, clinical staff are encouraged to collaborate when making decisions about people's care. Such collaborations may be enhanced through working with nurses who have been the primary contacts for people receiving care. There is also much to be gained from case managers engaging with the nursing staff in the inpatient unit to ensure collateral information is available about the person admitted.

Mental health service policies need to consider:

- how observations are communicated to the person placed on observation and how their carers are involved
- the benefits of enhancing communication within multidisciplinary teams weighed against the cost of nurses having less time to engage with people
- how observations are to be documented and detailing the timeliness of documentation
- how observations are to be documented and continued when a person leaves the service with a carer or another clinician (for example, medical leave or unplanned required leave). It is essential there is a handover of how observation is to be conducted particularly at points of transfer (either to another clinician, to a carer or in a different environment)
- processes whereby people can make requests associated with observation that are considered and treated with respect
- how to encourage shared decision making and appropriate ways for communication to occur accurately across multidisciplinary teams, and how clear lines of authority are provided.

Table 1: Information communicated using the mnemonic ISOBAR

Definitions	Information communicated
I = Identification	The identity of the person through multiple means including name, date of birth and medical record number.
S = Situation and status	The person's current clinical status (for example, whether the person's condition is improving, deteriorating, or stable), person-centred care needs, advance directives and prospects for discharge or transfer.
O = Observation	The latest observations of the person including how the person is finding them.
B = Background and history	What is known about the person including presenting issues, current issues, experiences and findings from physical and psychological assessments. Also includes current diagnosis, management to date and the effectiveness of that treatment.
A = Assessment and actions	All tasks to be undertaken to support people during their recovery. A plan for the management and escalation of care may include: • a shared understanding of the most pressing issues for the person receiving care • the tasks to be performed • issues identified through mental state examinations, physical health checks, and assessments of risk of suicide, self-harm, aggression or absconding (including recommendations, an agreed plan and contact person should a problem arise) • a plan for communicating with the person in charge • accountability for actions.
R = Responsibility and risk management	Details of who is responsible for each person receiving care. In the context of handover, responsibility is transferred to the incoming team, who need to accept the tasks that require undertaking. Risk management strategies should be communicated when risks have been identified.

Note: Adapted from the *OSSIE guide to clinical handover improvement* (ACSQHC, 2010).

To what extent are these core principles consistent with how you practice?

What are the system issues that may need to vary to incorporate these core principles into clinical nursing practice?

How will you embed these principles into your practice?

Which aspects of your observation practices may need improvement? How might you develop your practice?

Appreciation of people's experiences

By appreciating people's histories and preferences nurses can facilitate a positive and therapeutic experience.

Observation of the behaviours of others, both formal and informal, occurs routinely in many different settings. Sometimes being observed is welcomed, whereas at other times it can be an unsettling experience. Just as for people in wider society, being observed produces a broad range of reactions from people receiving care for mental health conditions. It is important to understand how a person's history or past experiences might impact on the experience of being observed.

What did you think inpatient wards were like before your first visit to one?

Have your impressions of inpatient wards changed over time? If so, how?

What do you think it might be like being observed?

Nurses can help people feel comfortable within inpatient mental health units. Inpatient mental health units can be confronting environments. By reflecting on their initial assumptions and perceptions, nurses can develop empathy for what it may be like for people to be admitted to an inpatient unit.

As part of the observation process nurses should assess how people are finding the inpatient environment. They should assist people to adjust to the inpatient environment by:

- addressing any perceptions people may have about what it is like in an inpatient ward
- explaining the ward environment and routine
- orienting the person to the environment
- assessing how the environment is impacting on the person and supporting them within it.

Asking open-ended questions about previous exposure to inpatient settings (for example, discussions with friends, reading novels or from movies) can be useful in identifying misconceptions, which can then be addressed. Nurses should be prepared to answer the questions of people receiving care as they arise during the course of their admission.

Nurses also need to be empathetic of what it is like to be observed. For some people receiving inpatient care, nursing observation can be a positive and therapeutic experience (Cardell and Pitula, 1999, Pitula and Cardell, 1996). While being observed for safety reasons, some people have reported feeling safe (for example, increased confidence that they would not act on destructive impulses under observation) and more confident they could resolve feelings of hopelessness and worthlessness. Others have indicated that they experienced reduced anxiety, dysphoria and suicidal thoughts when being observed. Nursing behaviours that contribute to observations being perceived as positive and therapeutic include:

- acknowledging that all people are unique
- being optimistic about the situations in which people find themselves and their prospects for recovery
- providing emotional support
- distracting people with activities and conversation.

Many people receiving care, especially those at risk of suicide, may prefer to be observed by nurses they know and who will talk with them (Jones et al., 2000b). In the company of such nurses, people may be more likely to feel safe, reassured and cared for than they would if they were being observed by nurses who they do not know and who will not talk with them. With nurses they know, people may find observation less intrusive and may be less likely to become frustrated with the process. Nurses who are unknown to people they are observing need to ensure they engage and develop a rapport with the person.

Gender-sensitive care

Gender-sensitive care is informed by an awareness of the different needs and experiences of women, men and people who identify as transgender and intersex, and how these differences manifest in mental health settings. There are differences between genders in terms of the causation, prevalence, causes and treatment of mental health conditions. Underpinning these differences is a wide range of biological, psychological, social, cultural and economic factors. To ensure that gender-sensitive care is provided during observations, nurses should refine their practices in accordance with the *Service guideline on gender sensitivity and safety* (Victorian Department of Health, 2011b). Nurses should pay particular attention to the gender-specific issues that people may be experiencing, and how they may manifest in an inpatient environment. Through engaging with people, nurses have opportunities to understand people's gender-specific issues and develop ways to ease their discomfort. With respect to observation, the gender of nurses performing observation may be facilitative or detrimental to providing quality care for certain people, especially when observation is performed on a one-to-one basis. For some people, having a nurse of a different gender observe them may make them feel uncomfortable and compromise their recovery.

A key feature of ensuring gender-sensitive care is to monitor and observe the environment and how people interact with each other. This means understanding and considering how you will work with people identified as vulnerable because of past trauma. It is important that nurses develop rapport and ask people how observation might assist in ensuring their gender-specific needs and care.

Culturally sensitive practice

Culturally sensitive care requires recognising people's shared attitudes, goals, practices, and values and practicing in a manner that is consistent with these. The provision of culturally sensitive care is positively associated with positive health outcomes. To ensure that care is provided in a culturally sensitive manner, nursing practices should be consistent with those promoted in the *Cultural responsiveness framework: guidelines for Victorian health services* (Victorian Department of Health, 2009) and the *Cultural diversity plan for Victoria's specialist mental health services 2006–2010* (Victorian Department of Health, 2006).

Caring for people in a way that respects their culture may mean that additional time needs to be spent on explaining why observation is occurring. The services of an accredited interpreter may need to be provided.

To ensure that people's cultural needs are respected, nurses should discreetly enquire about their requirements.

Observation may need to be modified to ensure it is congruent with a person's cultural beliefs.

Trauma-informed care

Many people who receive care within the mental health system have experienced trauma. For a number of these people, some forms of observation may be further traumatising. Observation should be conducted with care and in consideration of people's history of trauma to maintain therapeutic relationships. Through practicing trauma-informed care, nurses have opportunities to enhance the care that people receive. Trauma-informed care involves:

- recognising that all people could have trauma histories
- being aware of people's trauma histories and using the information in holistic and integrated treatment planning
- using understandings of the roles of victimisation and violence in the lives of people seeking care to inform the design of service systems that accommodate people's vulnerabilities and facilitate their participation in treatment (Harris and Fallot, 2001).

To ensure that observation practices are consistent with the principles of trauma-informed care, nurses should:

- be aware of people's trauma histories and how re-traumatisation during periods of observation could be prevented
- help people to understand why certain forms of observation have been prescribed (for example, for safety reasons)
- talk to people about what observation practices are planned and seek feedback on whether modifications to the practices need to be made for their comfort (for example, if people are displaying signs of hypervigilance, nurses may consider discussing with them how they could be approached while they are sleeping).

Nurses can ensure observation practices are consistent with the principles of trauma-informed care by being aware of how re-traumatisation can be prevented and helping people to understand why observation occurs.

How do you discuss observation practices with people?

How does the assumption that all people could have trauma histories impact on how you carry out observation?

Observation practices

Observation practices vary considerably among mental health services, both in terms of their purpose and the way they are conducted (for example, frequency, intensity, duration and engagement versus watching from a distance). Although the presence of identified risk factors may influence decisions to initiate, change, and remove observation, risk and observation are not synonymous. There are circumstances when determining the need for observation may be desirable for reasons other than for managing perceived risk. Observation can be initiated for several reasons, including when people:

- may benefit from periods of concentrated therapeutic engagement
- have physical health issues that need to be managed
- pose a risk to themselves or others.

Nurses have the responsibility to work within the clinical governance and management structures within their organisations to ensure that observation policies, procedures and guidelines do not compromise the rights of people receiving care and to advocate for changes when they do (Australian Nursing and Midwifery Council, 2006).

Levels of observation

All services should have explicit policies on observation types and frequencies and communication of observations. Since observation, assessment and interventions are interlinked, nurses sighting people and talking with them is implicit in describing levels of observation. One possible model with four defined levels of observation is outlined below.

- Constant (arm's length) – periods of one-to-one nursing observation, with the person within an arm's length of an experienced nurse at all times
- Constant (visual) – periods of one-to-one nursing observation, with the person within the vision of an experienced nurse at all times
- Intermittent – an experienced nurse (or mentored, less experienced nurse) engages with a person at regular intervals. The identified risk factors and purpose of observation will determine the frequency (for example, several times per hour) and pattern of observations (for example, equal or random lengths of time between observations)
- Negotiated – nurses negotiate the frequency of engagement with people who do not have identified risk factors requiring intermittent or constant observation

Examples of reasons why people may be assigned to these levels of observation are provided in Table 2.

Table 2: Situations in which different levels of observation may be required

Purpose	Negotiated	Intermittent	Constant
Psychosocial wellbeing	No identified risk factors likely to result in harm to self or others	Person is at risk of absconding, which might result in detrimental effects, but is not acutely suicidal	Person is at high risk of sexual disinhibition
Physical health	No known physical conditions	Person has poorly managed diabetes with recent incidents of collapse due to hypoglycaemia	Person is at high risk of falling
Safety of people receiving care and others	Person is at low risk of suicide or self-harm	Person is at medium risk of suicide or self-harm	Person is at high risk of suicide or self-harm

At the beginning of observation, nurses inform the person they are on observation, the purpose of observation and how it will occur. Changes to observation should also be communicated, and regular discussion should occur with the person about how they are experiencing the observation.

Whenever possible, nurses should invite people to suggest ways in which observation can be undertaken. For example, nurses could ask people, ‘How should we catch up?’

Nurses should document the physical sighting as well as the information from interacting with the person.

Remember, observation is not just sighting. Nurses should speak with the person throughout the different shifts.

Health services should provide clarity on the levels of observation and the documentation required.

Initiating and changing observation

Mental health service policies need to provide a clear framework for observation practices, including initiating or changing observation.

Mental health service policies need to:

- facilitate nursing models of care that support people's recovery efforts
- determine how the frequency, intensity and duration of observation is decided upon
- articulate the role of nurses in initiating and changing observation practices
- describe processes that support nurses to engage with people, and are not just about visual sightings
- ensure documentation is the end product of observation and not the purpose
- ensure documentation occurs as observation is conducted, not after the fact
- ensure documentation records decisions regarding initiating or changing observation
- when visual sightings are required to ensure safety, ensure the responsible nurse documents observations when they occur
- ensure the appropriate skill mix in units to undertake observation
- formally encourage collaborative decision making between medical and nursing staff
- involve people receiving treatment in the decision-making team.

Night-time observation

The observation levels that have been decided upon should be maintained throughout day, evening and night shifts. When deciding upon observation levels, however, senior nurses and treating psychiatrists should determine whether it may be appropriate to use lower levels of observation. In some situations less intrusive forms of observation may enable better sleeping patterns in people who are hypervigilant and who may awaken or be startled. If observation levels are dependent on the time of the day or the activities of people (for example, awake or asleep), such details should be adequately recorded and nurses should be made aware of the observation requirements.

Whatever the clinical indicators suggest, the person being observed should be aware of what type of observation will occur at night.

Observation in intensive care areas

Intensive care areas are often referred to as high dependency units (HDU). For the purposes of this guideline, and understanding that nursing care and interventions require engagement, the people admitted into this area should not be considered as ‘dependant’ but rather as requiring specific and detailed attention to their mental health needs.

The purpose of intensive care areas is to provide an environment where people who have been assessed as being of high risk to themselves or others can receive care. People admitted to intensive care areas will have been assessed as needing a different environment with a higher level of observation and engagement. Therefore, there should be a constant nursing presence in the intensive care area. The permanence of this observation should be discussed with people being admitted to intensive care areas in the same way as for people in less restrictive areas of mental health services.

Skilled observation is a paramount consideration given the intensity of interventions and managing the milieu in ways that facilitate better care of and responsiveness to people. Engagement with people requires a high degree of competence and this should be considered a priority in resource allocation.

A key consideration for area mental health services is determining how the intensive care areas are utilised. This should be dynamic as the environment needs to be conducive to improving people’s wellbeing.

Observation and seclusion

Although the discontinuation of seclusion practices is strongly encouraged, seclusion rooms remain in use in mental health services. Seclusion rooms are the most restrictive environments in mental health services. Experienced nursing staff need to make use of opportunities to engage with people in seclusion and discuss with them the observation practices that are occurring.

People in seclusion require vigilant visual observations and any observation must comply with Victoria’s *Mental Health Act 1986* and the Chief Psychiatrist guideline *Seclusion in approved mental health services*. Services must have policies that clearly outline what they will do as a minimum for those people in seclusion.

If a person has been restrained, or a physical restraint has been used in order to place them in seclusion, a registered nurse must ensure the person is closely observed once in seclusion. This observation will require monitoring of breathing, movement and levels of agitation.

Observation and restraint

Physical and mechanical restraint requires specific attention. The Mental Health Act provides clarity with regards to mechanical restraint. Reporting and recording of restraint should occur and be consistent with the required legislative guidelines.

Nurses have specific responsibilities for the physical monitoring of a person in any form of restraint. This involves monitoring vital signs and physical integrity. It includes but is not limited to:

- blood pressure
- pulse
- temperature
- movement
- breathing
- skin integrity
- nutrition and elimination.

In physical restraint, prone restraint is of particular concern. The use of prone restraint is to be avoided. If in the course of a restraint a person is put in a prone position then this must cease as soon as practical and is not to exceed three minutes.

The physiology of restraint-related deaths is difficult to determine as the actual numbers are small and classifications of deaths vary from place to place. Theories of causation include:

- the position a person is held in and in particular use of the prone position
- acute behavioural disturbance and excited delirium
- stress-related cardiomyopathy
- alcohol and drug use.

Positional asphyxia occurs when a person being restrained is placed in a position that compromises their breathing and as a result they do not get enough oxygen. A lack of oxygen can lead to disturbance in cardiac rhythm and death may result (Duxbury, 2011).

A key consideration for area mental health services is an appropriate governance structure and robust executive oversight, as well as ensuring that restraint practices are commonly understood among all parties involved.

The use of prone restraint is to be avoided. If in the course of a restraint a person is put in a prone position then this must cease as soon as practical and is not to exceed three minutes.

A registered nurse is required to be responsible for monitoring the person's vital signs and ensuring their chest area is not compressed.

All staff should be educated in the use of restraint and the risks associated with restraint.

A suitably qualified health professional should be in charge of the restraint process.

Services should develop policies that support the use of restraint in positions other than the prone position

All staff should be educated in the use of restraint and the risks associated with restraints.

A suitably qualified health professional should be in charge of the restraint process

Speaking with people about observation

Nurses are responsible for helping people to experience observation as a positive aspect of their journey towards recovery. Nurses should consider how people receiving care may experience observation and explain to them why they are being observed and the form that observation will take (for example, details of duration and frequency). Where possible they should accommodate people's preferences with respect to how observations should occur. Nurses are encouraged to develop their own ways of discussing observation with people. Possible conversation starters are shown in Table 3.

Table 3: Examples of ways to speak with people about observation

Example A	Example B
Hi Riley, I'm concerned about you more so today. I wondered if it would be OK for me to be with you today. How does that sound?	Hi Cameron. I noticed that you seem to be on edge at the moment. I'm concerned that you might try to hurt yourself. Are you concerned? I have had a chat with the medical staff and we decided that it would be a good idea for me to pop in and see you more regularly throughout the day. Is that okay?

How would you speak to someone about starting observation?

How would you ask someone about their concerns in regard to observation?

Observation during routine care

Nurses can take advantage of opportunities during routine care to engage and develop rapport with people. Subjective assessments are largely dependent on the quality of the relationships that nurses have with people. By getting to know the people they work with, nurses can gain a rich understanding of people's histories and experiences.

The first opportunity to develop rapport is when people are first admitted into inpatient facilities. At this time, nurses begin engaging with people and make initial observations about their health and wellbeing. This will include a mental state assessment, history, risk assessment and physical health assessment. Examples of conversation starters with people when they are first admitted to inpatient units are provided in Table 4.

Table 4: Examples of conversation starters to engage with people admitted to inpatient units

Example A	Example B	Example C
Hi Jessie. Welcome to the ward. My name is Sam. What brings you to hospital, Jessie?	Hi Alana. This is ward A and I am Sally. Welcome, can I show you around? And while I am doing that maybe you could tell me why you are here.	Welcome to the ward Sean. My name is Bill and I will be working with you today. Is there anything I need to understand about what you might need while you are here?

Once observation is determined for a person, the responsibility for undertaking observation lies with the nursing staff of the unit. There must be clear dissemination to nursing staff of the type of observation required for each person, including:

- type
- frequency
- responsibility
- rationale
- duration
- special requests and information
- review plans.

Nursing staff must ensure this work is allocated and undertaken as determined to support a person's treatment and care within the inpatient setting. Moreover, the person and their carer(s) should be informed of the decisions about observations.

Physical health

Nurses have a key role in contributing to people's physical health.

Given their extensive clinical training, nurses are well positioned to make a positive contribution to caring for the physical health of people receiving inpatient care. As part of their contribution to multidisciplinary teams, nurses have a responsibility to collect data on the physical health of people using relevant evidence-based assessment frameworks (Australian Nursing and Midwifery Council, 2006).

With support from mental health services, nurses:

- have an opportunity to contribute to the physical health of people receiving care
- have the skill mix and experience to perform physical health assessments and respond with an appropriate action
- should seek specialist advice from medical staff
- facilitate greater collaboration between mental health staff and staff from other medical or surgical settings to provide assessment and treatment.

Inpatient units represent one component of the broader healthcare system. They share the responsibility for meeting people's physical healthcare needs with other specialist clinical mental health services, community mental health support services and community health providers (Ministerial Advisory Committee on Mental Health, 2011). Inpatient unit staff can ensure continuity of care, for example, by integrating physical and mental health assessments and plans with those that people's general practitioners have developed, and by making supported referrals to community health providers.

Compared to people in the general population, people who experience mental illness:

- typically have poorer physical health
- are at greater risk of dying prematurely (Jones et al., 2004, Lambert et al., 2003, Lawrence et al., 2001)
- experience higher rates of asthma, diabetes, gastrointestinal disorder, heart disease, hypertension, malignant neoplasm and skin infection (Jones et al., 2004).

Additionally, certain behaviours such as smoking, drinking alcohol, using drugs, sedentary living and poor nutrition (Australian Bureau of Statistics, 2006, Australian Bureau of Statistics, 2007, Diaz et al., 2009, Stokes and Peet, 2004); some types of medication (Lambert and Chapman, 2004, Zimmermann et al., 2003) and inadequate healthcare (Dale et al., 2008, Mackin et al., 2007) contribute to the high prevalence of medical comorbidities among people with mental illness.

To what extent do people within the ward where you work receive physical healthcare?

How could you enhance the physical healthcare of people on your ward?

Are you competent in providing physical health observation and care for people with coexisting mental and physical illness?

Where would you get training to support your skill development in this area?

Assessment and physical health

To assist healthcare staff, clinical guidelines comprising an assessment and monitoring package are available for the physical care of people with mental health conditions (Stanley and Laugharne, 2011). These evidence-based guidelines focus on five dimensions of physical health, with each dimension having several components and recommended forms of assessment (see Table 5).

The dimensions of physical health call for three main forms of assessment: medication monitoring, physical investigations and lifestyle and psychosocial assessment.

Medication monitoring

Each medication administered has implications for physical health monitoring. Many medications that are prescribed for people receiving care have potentially serious side effects. Some of these side effects produce reactions in people's bodies that they may not have experienced before in their lives (for example, extrapyramidal reactions, impotence or twitching) and may find difficult to articulate to those providing care. The side effects of the medications people are taking may not have been explained to them and they may not have been adequately monitored (Barnes et al., 2008, Stanley and Laugharne, 2010c).

People who are fully informed about the benefits and adverse side effects of the medications they are taking are better positioned to have an active role in their recovery. Knowledge of the potential side effects of medications provides people with the language to express what they may be experiencing in ways that are understandable to those providing care.

Nurses should routinely assess people for the presence of side effects, especially when their medications are changed. To ensure nurses have current knowledge of the potential adverse effects of medications, they should refer to the most recent editions of the *Australian medicines handbook* or MIMS resources. Nurses should use the information in these references to guide the assessment of the adverse effects of medication in people for whom they are providing care.

Nurses can enhance the care people receive through discussing with them the potential effects of medication (both beneficial and adverse).

Although people may have been taking medications for some time, they may not have had the potential side effects explained to them or had these effects adequately monitored. Sometimes the seriousness of potential side effects may have been downplayed.

Table 5: Dimensions, components and recommended assessments of physical health

Dimensions	Components	Recommended assessments
Medication	• Antidepressants • Anxiolytics • Mood stabilisers or anticonvulsants • Antipsychotics	*General assessments* • Blood pressure (mmHg) • Fasting blood glucose levels (mmol/L) • Glucose tolerance test • Liver function test • Vitamin D • Urea and electrolytes • Electrocardiogram *Additional assessments for specific medications* Antipsychotics or mood stabilisers • Abnormal Involuntary Movement Scale (facial–oral, extremities, trunk and global) • Prolactin Valproic acid • Full blood picture • Prothrombin time • Serum valproic acid Lithium Carbonate • Full blood picture • Urinalysis • Thyroid stimulating hormone • Serum lithium Carbamazepine • Full blood picture • Thyroid stimulating hormone • Serum carbamazepine Clozapine • Full blood picture (monthly) • Troponin T • Echocardiogram • Temperature • Pulse

Dimensions	Components	Recommended assessments
Lifestyle	• Exercise • Diet • Smoking • Dental • Cholesterol • Sexual activity	Exercise • Weight (kg) • Body mass index (kg/m^2) • Abdominal girth (cm) • Activity level Diet • Nutritionist • Eating guide Smoking • Yes/no Dental • Last appointment Cholesterol • Total cholesterol • Triglycerides • High-density lipoprotein cholesterol • Low-density lipoprotein cholesterol Sexual activity • Contraception • Pregnancy test
Physical conditions and allergies	• HIV/AIDS and STIs • Hepatitis B and C • Cancer • IBS or gastrointestinal disorders • Type 2 diabetes • Cardiovascular and respiratory disease • Pregnancy	• HIV / STIs • Hepatitis B and C • Pregnancy test
Alcohol and illicit drug use	• Alcohol • Other drugs	Alcohol • Alcohol Use Disorder Identification Test (AUDIT) • Severity of Alcohol Dependence Questionnaire (SADQ-C) Other Drugs • Drug Abuse Screening Test (DAST-10) • Severity of Dependence Scale (SDS)
Psychosocial supports	• Familial relationships • Social and community • Socioeconomic status and employment • Culture and religion	• Familial support • Social support • Socioeconomic status and employment • Culture

Note: Adapted from Stanley and Laughame (2010c, 2011). Tools available to support the use of these recommended assessments include: general screening forms, additional screening forms for medications, tools for lifestyle, psychosocial, and alcohol and illicit drug use assessment and guidelines to facilitate interpretation of results (Stanley and Laugharne, 2010a, 2010b, 2010c).

Physical health assessment

People receiving inpatient care should receive physical examinations to identify the presence of previously undiagnosed physical health conditions and to monitor those that are pre-existing. Specific attention should be paid to investigating for the presence of conditions that are common among people with mental health conditions including asthma, diabetes, gastrointestinal disorders, heart disease, hypertension, malignant neoplasm and skin infection (Jones et al., 2004).

Lifestyle and psychosocial assessment

Assessment of lifestyle and alcohol and illicit drug use is helpful in revealing factors that may have an adverse impact on physical health. For example, sedentary behaviour, unhealthy eating and being overweight can contribute to the cluster of conditions that comprise metabolic syndrome. Identifying the emergence or presence of these factors is important in determining treatment options.

The assessment of psychosocial supports assists in understanding people's perspectives on their lives, conditions and hopes for the future. The identification of supports in people's lives (for example, people who will encourage and support behaviour change or provide transport to healthcare providers) assists healthcare staff in clarifying which treatment options may be suitable for each person.

Mental health service policies need to consider:

- revising physical health assessment practices to be consistent with those that are recommended
- incorporating lifestyle and psychosocial assessment to reveal factors that may impact a person's physical health.

Older people

Providing care for people over the age of 65 may mean that there are additional assessment and observation needs. Specific issues relevant to the physical health assessment of people over 65 include:

- falls
- malnutrition
- multiple medication use
- musculoskeletal limitations and pain
- constipation
- pressure areas in people with reduced mobility (Lawrence et al., 2000).

One area of care in which observation can be useful is in the prevention of falls. For guidance on how to prevent falls service providers and healthcare staff should refer to *Preventing falls and harm from falls in older people: best practice guidelines for Australian hospitals* (ACSQHC, 2009). Observation should be considered as one component of multifactorial fall prevention programs. Increased levels of observation may need to be provided for older people who have cognitive impairment (for example, agitation, delirium or dementia) and who experience difficulties with transfers. Frequent engagement with these people would mean that they could be provided with timely assistance when required. One-to-one observation may be needed for older people who have mobility and cognitive impairments, and who impulsively attempt to get out of their beds or chairs without assistance.

Medication adherence

Medication adherence can be considered a special case of observation, because the actions of nurses are focused on checking that a behaviour has occurred (the taking of medications) rather than the prevention of some behaviours occurring (for example, suicide attempts, self-harm or absconding). Medication refusal can lead to several poor outcomes such as threats of assault, actual assault, seclusion, restraint, longer hospitalisations (Owiti and Bowers, 2011), relapse and readmission to psychiatric facilities (Happell et al., 2002). It is important to note that seclusion and restraint are not recommended responses to a person declining medication within Victorian mental health inpatient units.

There are many factors that contribute to decisions to refuse medications, including:

- the mental illness (for example, illness denial or delusions)
- perceived effects of medication and treatment (for example, side effects or fear of poisoning or contamination)
- the exercise of rights and individual motivations (for example, exercising the right to refuse medication)
- systemic and structural factors (for example, non-regular staff on wards)
- the initiation of special observations (Owiti and Bowers, 2011).

Although checking patients' mouths is a common method for determining medication adherence, such a practice is not infallible and may do little to enhance relationships between nurses and the people for whom they provide care. Enhancing medication adherence may require nurses to use their broader skill sets to engage with people receiving care. Greater engagement would see nurses forming therapeutic relationships with people, finding out why they do not wish to take their medications and using the information obtained to develop strategies to facilitate adherence.

Psychosocial functioning

The visual observation of people's behaviours, while important, can only elicit partial information about what they could be experiencing at any point in time. Many behaviours (for example, sitting quietly) can have several plausible explanations. The environments in which people are observed (for example, the restrictive settings of inpatient units) may greatly affect their behaviours.

To understand what people may be thinking or feeling it is important to recognise the core function of a therapeutic manner that provides the platform for nurses to:

- speak with people in a manner that is encouraging, engaging, non-judgemental and genuine (refer to Appendix B for useful techniques)
- engage with people to identify the most pressing issues at that time
- undertake mental state examinations to obtain information about current difficulties and establish a platform for further engagement and planning
- consider the outcomes of mental state examinations in continuing or modifying the level or intensity of observation
- reflect on their own practice and seek opportunities to receive training or mentoring to develop their own communication skills
- provide support to less experienced nurses to develop their communication skills.

Safety

Nursing observation can contribute to ensuring that inpatient settings are safe places for people receiving care, healthcare staff, and visitors.

Making purposeful observations informs nursing decisions about how to respond when people may be at risk of suicide, self-harm, aggression or absconding. There are two types of risk factors of which nurses should be aware:

- Static factors – these risk factors are unlikely to change throughout the course of admission and should be identified through assessment soon after a person is admitted into inpatient care.
- Dynamic factors – these risk factors can fluctuate throughout the course of care and require regular monitoring through observation and engagement with people receiving care.

Both subjective clinical judgements and structured assessment instruments should be used in making assessments of risk. To make informed assessments, nurses should be aware of the static and dynamic risk factors for suicide, self-harm, aggression or absconding.

What should you do if you think a person could be at heightened risk of suicide, self-harm, aggression, or absconding?

How do you articulate and document your concerns – often described as intuitive (but usually based on experience and knowing the person) – when a person says they are not at risk but you are still concerned they are?

Suicide

The suicide of a person receiving inpatient care is a tragic occurrence. Unfortunately, it is impossible to predict accurately which people may attempt suicide. There are, however, several factors that can be identified at the time of admission (static factors) that may contribute to a greater likelihood that people may attempt suicide while receiving inpatient care (see Table 6). Although the presence of one or several of these factors may increase the risk of suicide, they do not represent an exhaustive list of factors that contribute to inpatient suicide. The presence or absence of these factors should not be the only consideration in determining a person's potential for suicide.

Table 6: Static factors that are associated with increased risk of inpatient suicide

Dimensions	Factors
Demographic and social factors	• Social or relationship problems
Historical factors	• Prior suicide attempt or deliberate self-harm • Family history of suicide • Multiple prior psychiatric admissions • Family history of mental illness
Behaviour and symptoms in relation to admission	• Depressed mood • Feelings of worthlessness, inadequacy or guilt • Hopelessness • Suicidal ideas • Suicide attempt at time of admission • Agitation or anxiety
Psychiatric diagnosis	• Schizophrenia • Affective disorder
Psychiatric treatment	• Prescribed antidepressants • Longer length of hospital stay • Admitted under mental health legislation

Note: Sourced from Large et al. (2011).

Dynamic factors may fluctuate during admissions, raising or lowering a person's risk of suicide. Like factors identifiable at the time of admission, identification of the presence or absence of dynamic factors does not allow healthcare staff to predict accurately which people will attempt suicide. The following factors, however, may increase a person's risk of suicide:

- panic attacks and severe psychic anxiety, anhedonia, worry and agitation
- suicidal intentions
- clinical improvement, particularly during the mixed state of bipolar disorder
- insight (particularly in people with schizophrenia) into the need for treatment, the social consequences of disorders and negative symptoms and delusions
- deterioration of relationships between inpatients, staff and others (Cassells et al., 2005).

To enhance their care for people who may be at risk of suicide, nurses should be familiar with guidelines published by the Victorian Department of Health on working with the suicidal person. Both *Working with the suicidal person: clinical practice guidelines for emergency departments and mental health services* and *Working with the suicidal person: quick reference guide* (Victorian Department of Health, 2010a) (Victorian Department of Health, 2010b) are available online at <www.health.vic.gov.au/mentalhealth/publications/index.htm>.

Self-harm

Predicting which people may be at risk of self-harm is difficult. Few static and no dynamic factors have been consistently associated with self-harm. The strongest predictors of self-harm seem to be:

- previous episodes of self-harm
- the presence of personality disorders (Stewart et al., 2012).

People with histories of self-harm still require appropriate assessment for risk of suicide. The presence of personality disorder should not limit the mental state assessment as people with this condition can have acute and chronic suicidal ideation.

Aggression

Calm environments can help people on their journey towards recovery. One of the challenges to maintaining peaceful and safe environments, however, is that there are few factors that differentiate people who are, and those who are not, likely to engage in aggressive behaviour during their inpatient admissions. The most salient static predictors of inpatient aggression are:

- previous violence
- involuntary admission
- illicit drug use (Bowers et al., 2011).

People with histories of previous violence and illicit drug use were also more likely to have been repeatedly aggressive and violent. With regard to dynamic factors, the most common antecedents to aggressive and violent behaviour are provided in Table 7. The fluidity of aggression risk means that staff need to assess risk on an ongoing basis.

Table 7: Dynamic factors contributing to aggression and violence in psychiatric inpatient settings

Dimensions	Examples of factors
Person–person interaction	• Physical contact • Intrusion into personal, psychological or physical space • Reaction to sexual approach • Miscommunication • Victim doing something person wanted stopped • Competition • Retaliation • Teased or bugged • Unspecified provocation, conflict or interaction
Staff–person interaction	• Limiting a person's freedoms • Medication-related containment (including medication administration, staff requesting that a person take medication or disputes over medication) • Any other containment (including restraint, seclusion, de-escalation or electroconvulsive therapy) • Any other staff–person interaction (including unspecified provocation, ordering a person, intervening in a fight or argument, caring for a person, searching a person, negative staff attitudes, physical contact, miscommunication, staff being too permissive or staff error)
Person's conflict behaviours	• Absconding attempt • Substance misuse • Verbal aggression • Threatening behaviour • Self-harming
Structural issues	• Environmental issues (limited personal space, confined environment, noisy ward or a person finding weapons) • Regime issues (staffing levels, a person admitted, transferred or discharged, excessive sensory stimulation or lack of stimulation)
Person's behavioural cues	• Agitation • Attention-seeking behaviour • Increased motor activity • Boisterousness • Confusion
Person's symptoms	• Past history • Difficulty with conflict resolution

Note: All but 'Person's symptoms' was sourced from Papadopoulos et al. (2012). All dimensions were implicated in 10 per cent or more of the aggressive or violent incidents. In one-third of incidents there was no clear cause.

Although the characteristics of people receiving care (for example, their mental health conditions) and of service settings (for example, staffing levels or high throughput) contribute to the risk of aggressive behaviour, neither set of factors adequately predicts if and when aggressive behaviour will occur (Drach-Zahavy et al., 2012). Furthermore, focusing on people's mental health conditions and suboptimal aspects of service settings as explanations for aggression can create a false impression that aggressive behaviour is inevitable. Although such factors do contribute to the risk of aggression, so too does the extent to which health professionals perceive that they and those for whom they care have control over aggressive behaviours.

Nurses' perceptions of, and behaviour when faced with, aggressive encounters may depend upon the extent to which they perceive that they can modify or prevent aggressive encounters and the degree to which they perceive that people receiving care are able to control their own behaviour (see Figure 2). When faced with aggressive encounters, the most positive outcomes occur when nurses perceive that they have high levels of control (that is, that they can assist to modify or prevent the aggression) and people receiving care have low levels of control over the aggressive behaviour (that is, because of their mental health conditions). In such circumstances, communication and de-escalation strategies are likely to be most useful.

Conflicts do occur between people. It is important to consider the behaviours of all people involved in a conflict rather than focusing solely on the people receiving care. The implications for nursing observation of understanding aggressive behaviour as an outcome of an escalated conflict between people is that nurses need to pay attention, not only to people who could potentially be aggressive, but also to their own behaviours and the behaviour of others who may (inadvertently or otherwise) contribute to conflicts escalating. That is, nurses need to be aware of how their own behaviour (for example, imposing rules that may be perceived as unfair or being dismissive of people's concerns) and those of colleagues and other people may produce or escalate conflicts.

Similarly, nurses need to be observant of the behaviour of people receiving care, and intervene to de-escalate situations that may become problematic. Skilled nurses note the behaviour before it escalates and negotiate different ways of responding, such as providing a calm presence, asking to spend time with a person and moving them from the situation, assessing and determining the concern for the person that has led to the conflict and looking at solutions for its resolution. This may also be an indicator for increasing observations. Behaviours that may be precursors to aggressive episodes include agitation, loudness, voice and general behaviour.

Nurses' behaviours have a significant influence on the risk of aggression in psychiatric inpatient wards.

Nurses create and maintain safe environments through being aware of people's behaviours, attending to particular situations (before they escalate) and the flow of activities around the ward, caring for people and connecting with them (Delaney and Johnson, 2006).

Establishing engaging and therapeutic relationships with people is central to reducing the likelihood of people becoming aggressive.

Figure 2: Outcomes related to nurse attributions of the extent to which nurses and people receiving care have control over aggressive behaviour

	Nurse's high controllability	Nurse's low controllability
A person's high controllability	**Power struggle encounter** *Negative emotions towards the person* • Sense of professionalism • Perception that the person's aggression can be handled • Relying on traditional treatment methods: restraint or tranquillisers	**Inverse power encounter** *Negative emotions towards the person* • Negative emotions towards oneself • Harm to one's sense of professionalism • Perception that the person's aggression cannot be handled • Post-traumatic stress disorder, avoiding the person or refusing to treat the person
A person's low controllability	Therapeutic encounter Positive emotions towards the person • Sense of professionalism • Perception that the person's aggression can be understood and handled • Provider–person communication and de-escalation strategies	Victim-to-victim encounter Positive emotions towards the person • Negative emotions towards oneself • Harm to one's sense of professionalism • Perception that the person's aggression cannot be handled • Loss of professional discretion

Note: Adapted from Drach-Zahavy et al. (2012).

Absconding

With approximately one-quarter of people who abscond from inpatient care committing suicide (Bowers et al., 2010), efforts need to be made to prevent people taking unplanned leave from mental health services. Unfortunately, there is minimal evidence on either the static or dynamic factors that may assist in predicting who may be more likely to abscond. People with schizophrenic disorders (Carr et al., 2008, Mosel et al., 2010, Muir-Cochrane et al., 2011) and those with bipolar disorder or drug and alcohol disorder (Carr et al., 2008) may be at greater risk of absconding than people with other diagnoses. Having a prior inpatient admission may also put people at greater risk of absconding (Carr et al., 2008). Absconding appears unrelated to whether the ward is locked or not (Muir-Cochrane et al., 2011)

Final points

Nurses are the health professionals with whom people receiving inpatient care spend most of their time, and they can make a significant contribution to people's health and wellbeing. By engaging therapeutically with people nurses can help them feel comfortable within inpatient environments and support them in their recovery. While doing so, nurses have opportunities to promote the physical health, psychosocial functioning and safety of people receiving care.

Purposeful observation is central to the care nurses provide. Core principles underlying nursing observation are as follows.

Nursing observation is multifaceted – Purposeful observation is undertaken to inform subsequent decision making and includes:

- objective and subjective information
- attending to what is heard (for example, during conversations), as well as what is seen
- information about, for example, a person's psychosocial wellbeing, physical health and safety.

Observation and assessment are interrelated – Purposeful observation forms part of a continuous cycle whereby observation contributes to risk assessments and these assessments inform the modification of care, the effectiveness of which is determined through observation. Observation not only contributes to risk assessment, it is also an outcome of this process (for example, changes to, or maintenance of, observation levels).

Observation is grounded in therapeutic engagement – Nurses develop strong and supportive relationships with people receiving care, during which they come to understand each person's most pressing issues. Engaging people and understanding what they are experiencing helps nurses to be responsive to their needs.

Nurses appreciate how inpatient environments influence behaviour – Inpatient settings are unique environments, which are dissimilar from the places where people usually spend their time. Nurses understand that the characteristics of inpatient settings influence people's behaviours and use this knowledge to help people feel comfortable and to promote recovery.

Observation is communicated between colleagues – Care is enhanced when observation is shared between the staff who are responsible for working with each person. The communication of observations between colleagues facilitates common understandings of people receiving care. This must occur both verbally and in written documentation. Documentation must be timely.

Nurses appreciate that admission to an inpatient setting can have many meanings for different people and may generate a range of emotions. Admission also comes at a time when people are acutely unwell and may not be best placed to understand these thoughts and emotions. Routine nursing practices such as initial interview, assessment and observation may also prompt a range of reactions in people receiving care. Through engaging with people and coming to understand their experiences, nurses become well placed to help people feel comfortable within inpatient settings.

Nursing observation practices vary widely among mental health services. Nurses are responsible for working within the clinical governance and management structures of their organisations to ensure that observation policies, procedures and guidelines do not compromise the rights of people receiving care and to advocate for changes when they do. Observation policies, procedures and guidelines should be consistent with the principles outlined in this guideline.

Nurses are well positioned to contribute positively to addressing the physical health, psychosocial functioning and safety needs of people receiving care. Making purposeful observations when engaging with people contributes to the formulation of comprehensive assessments. Nurses assess the physical health of people using evidence-based frameworks. Nurses use mental state examinations during each therapeutic encounter to assess psychosocial functioning. Nurses are alert to static and dynamic factors that may place people at an elevated risk of suicide, self-harm, aggression or absconding.

Mental health services can assist nurses in conducting observations that are consistent with the guidance within this document. In particular, they can promote the development of nursing observation practices through:

- evaluating and if necessary improving handover practices within their services
- developing observation policies that provide guidance on (a) the frequency, intensity, and duration of observations (b) the process for initiating, changing and removing observation
- emphasising that:
  - observations require engagement with those receiving care rather than visual sighting only
  - documentation is one of the end products of observation and not the purpose of this practice
  - specific details of observation should be in policy and procedure documentation and be provided to clinical staff in orientation.

Appendix A: Observation practices consistent with a recovery framework

Domain	Examples of good observation practices
Promoting a culture of hope	• Note behaviours and events that indicate positive signs of recovery and remind people receiving care and others of these occurrences.
Promoting autonomy and self-determination	• Engage people in ongoing dialogue and enquiry about their needs, wishes and experiences. • Discuss with people about the need for observation and how it will occur. • Invite feedback on how these practices could be modified to enhance care. • Avoid practices that people may experience as traumatic.
Collaborative partnerships and meaningful engagement	• Demonstrate empathy and respect in all interactions with people and their significant others. • Use person-centred humanistic language, rather than identifying people as their diagnosis. • Elicit people's preferences and give them maximum choice in big and small decisions, and be accommodating and flexible in responding to their preferences. • Work to understand what is important to people. • Support people to make sense of their experiences and to find positive meaning. • Acknowledge and respond to people's views, understandings and experiences. • Work with people in a way that supports their cultural identity and values. • Work to understand people's triggers for episodes of 'unwellness' and what they find works well for them in their recovery efforts. • Use inquisitive and active listening and personalised, supportive, positive and hopeful language. • When people do not express their points of view, actively seek their viewpoint through gentle enquiry. • Use aspects and examples from one's own life and experiences to create a friendly, professional relationship. • Use professional skills and expertise to provide people with optimal choice and tailored support.
Focus on strengths	• Ask people about their strengths, what they have done well and what they have found easy. • Use enquiry that emphasises solutions to situations rather than just the problems. • Assist people to tap into existing strengths and resilience by considering what has worked well for them in the past. • Encourage self-sufficiency in accordance with people's wishes and goals. • Assist people and their significant others to assess their own needs and to choose how those needs are met. • In history taking and reflections with the person, include recognition of areas of functioning where there are no problems and times in their lives when they did cope well. • Emphasise successes and achievements prominently at first contact. • Encourage people to take personality strengths that are causing problems in one area and use them to improve functioning in another (for example, a young client can find drugs at any time in any part of town – can that tenacity and resourcefulness be focused on obtaining housing?) • Support people to approach new challenges or to revisit old challenges.

Domain	Examples of good observation practices
Holistic and personalised care	• Routinely enquire about people's wishes, support needs, goals, values and interests and use this information to personalise care. • Support people to enjoy full physical health and to address health concerns when they present.
Family, carers, support people and significant others	• Talk with families and significant others about how things are for them, how they understand the needs of the person with mental illness and how they can support what is needed for that person.
Community participation and citizenship	• Be aware of the cultural, social and historical factors that limit people's access to resources and opportunities.
Responsiveness to diversity	• Understand how cultural differences affect people and their experiences. • Understand different cultural communication styles and use respectful ways of communicating. • Use non-technical language and use the services of an interpreter when necessary. • Recognise that different people have different understandings and experiences of community and that community has different significance for different people. • Respectfully enquire about the backgrounds and cultural needs of people. • Use innovative practices to meet the different needs of people. • Understand and demonstrate respect in relation to different understandings and meanings attributed to mental health across different cultures. • Recognise the diverse family and kinship structures across different cultures and the need for family work to accommodate these. • Be aware of personal values that may unintentionally affect practice. • Develop knowledge of concepts of Aboriginal and Torres Strait Islander social and emotional wellbeing and the historical and contemporary factors that impact on Aboriginal and Torres Strait Islander Australians' wellbeing.
Reflection and learning	• Reflect on whether one's professional practice is aligned with a recovery approach. • Reflect on one's own values, development needs and limitations.

Note: Adapted from the *Framework for recovery-oriented practice* (Victorian Department of Health, 2011a).

Appendix B: Some helpful techniques for eliciting information about psychosocial wellbeing

Technique	Description
Ask open-ended questions	Open-ended questions have the potential to elicit more information about people's thoughts and feelings than closed questions that encourage brief responses. Obtaining more information through open-ended questions means that people may need to answer fewer questions, which may reduce the chances of them feeling interrogated. Requests for information, for example, 'Please tell me about your morning', may yield more useful responses than the ubiquitous 'How are you?' to which many people are conditioned to give a brief, positive reply.
Listen and attend to body language	The words people use do not usually represent the whole message that they are trying to convey. Nurses should pay attention to how words are spoken, as well as other aspects of body language (for example, proximity of person to nurse, facial expressions, nodding, positions of arms and legs or the direction in which the person is facing). The words 'I'm fine' can have different connotations for a person who is relaxed, comfortably sitting on a chair, and maintaining eye contact with a nurse than for someone who is sitting on the floor, hugging their legs and staring at the floor. Equally, nurses' non-verbal communication can affect how people perceive them and the richness of the information that may be disclosed during interactions. Nurses with open postures, who speak calmly, who show genuine interest in people through verbal utterances and non-verbal gestures, and who demonstrate empathy, even when people introduce challenging material to conversations, may be more likely to make more insightful observations than nurses who, for example, appear rushed and uninterested.
Use paraphrasing and reflections	Paraphrasing is restating someone else's words in other ways. Nurses who wish to paraphrase what people have said may begin a sentence with, for example, 'So, what I hear you're saying is ...' More broadly, reflections involve not only restating what has been said, but also feeding back other observations, such as how people appear to be feeling or their behaviour. A nurse may say, for example, 'You seem quite sad when we talk about this part of your life.' Paraphrasing and reflecting on people's responses are ways that nurses can help people to feel heard and may elicit more information without having to ask further questions. These techniques enable nurses to demonstrate they have understood what people have said. They can also be used to move a person's attention to topic areas on which a nurse wishes to develop richer understandings of people's lives and what they are experiencing.
Summarise	Summarising what people have said at or near the end of an observation encounter can be a powerful way of demonstrating that people have been heard and understood. It also provides people with the opportunity to correct any misunderstandings.

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