Title:	**Observation Levels**		
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Key Words: Constant Observation, Enhanced Observation, Routine Observation, Monitoring, Observer, Restraint, Involuntary Form, Care and observation			
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POLICY:

This policy defines the levels of observation and procedural guidelines for any patient who poses a risk of harm to self or to others, or risk of elopement.

Heightened levels of observation (Appendix A) are required for patients with unstable psychiatric illness, patients with restraints in use, and patients at risk of elopement or harm to self or others.

Observation may be provided by an unregulated care provider (e.g. Security Guard, Patient Care Assistant, or Care and Observation Role) in accordance with the algorithm detailed in Appendix B.

DEFINITIONS:

Heightened Level of Observation: Any level of observation that exceeds the routine, hourly observation for patients (refer to Appendix A).

Involuntary patient: a person who is detained in a psychiatric facility under a certificate of involuntary admission, a certificate of renewal or a certificate of continuation under the Mental Health Act (2015)

Non-Secured Unit: Any patient care area where access to and from the department is not restricted or locked.

Restraint: (Excerpt from Mackenzie Health Policy: "Least Restraint Policy")

> Restraint: any physical, chemical, or environmental measure used to control the physical or behavioural activity of a person or a portion of the person's body.
>
> Physical restraint: any physical or mechanical device that involuntarily limits a patient's movement and cannot be easily removed by the patient. Examples include: holding a child for procedures, bed rails, chair with secure lap belt or tray , or a soft wrist restraint (e.g. Posey ® Econo Limb Holder).
>
> Chemical restraint: any psychopharmacologic medication administered as an immediate response to control behavior or movement, such as agitation, or threatening or assaultive behaviour. Medications used as routine care to treat illness, are not considered a chemical restraint.
>
> Environmental restraints: a barrier or monitoring device that limits the locomotion or mobility of a patient, thereby confining them to a specific geographic area or location. Examples of environmental restraints include: seclusion room, patient wandering system, bed rails, chair with a secured lap belt or tray, furniture placement.

Unregulated Care Provider: A person who assists with or performs some aspects of care and is not regulated under the *Regulated Health Professions Act.* UCPs are not governed by a regulatory body and have no legally defined scope of practice or regulated practice standards. UCPs may include personal care attendants, security personnel, clinical externs and family members.

Violence:

> **Violent behaviour:** Acts of physical force such as, but not limited to, choking, punching, hitting, shoving, pushing, biting, spitting, groping, pinching, kicking, throwing objects, shaking fists; attempts to exercise physical force or a statement/behaviour which leads one to believe physical force will be used. (from Mackenzie Health *Patient Behavioural Risk Assessment and Flagging Procedures* Policy)

Remote Monitoring: Use of assistive devices such as security cameras for the purpose of patient observation and involves continuous physical presence of a staff member in the same environmental vicinity as the patient.

PROCEDURE:

For a patient that requires heightened level of observation:

1. The nurse/Most Responsible Nurse (MRN) will complete the pre-observer screening checklist in the Electronic Medical Record (EMR) to ensure alternative strategies to managing high-risk behaviors are considered.
2. The Patient Care Manager (PCM) or designate (Shift Manager/Patient Care Coordinator (PCC) /Clinical Utilization Coordinator (CUC)/MRN) will contact the staffing office to coordinate additional personnel if required within the department to support the heightened level of observation:
    a. If constant or enhanced observation is required and observation by assigned nurse is not feasible, a delegate (regulated or unregulated care provider (UCP) will be arranged to support observation based on patient needs.
        i. For units with a Patient Care Assistant (PCA) or other unit resources available, consideration would be given to utilize the PCA/other resources as a Care and Observation (C & O) role, if safe to do so.
        ii. For units with a C & O role or Security Guard already assigned, consider co-horting patients that require observation, if safe to do so.
        iii. Consider the use of family members or external UCPs for observation, if available.
    b. If constant or enhanced observation is required and observation by assigned nurse and/or delegate is not feasible, then a strategy to manage the patient needs to be put in place and reasons documented
    c. Refer to Appendix B as a guide to determine which UCP is required and most appropriate to support observation (i.e. Security or C & O role).
    d. For patient inter-department transfers, sending/receiving team to collaborate to have resources available for the required observation level in receiving care area prior to transfer, include bed flow team (if appropriate). Consult manager/shift manager/manager on-call for alternative strategies as needed.
3. The assigned nurse will (according to Appendix A):
    - Ensure appropriate level of observation are in place including during patient transport, as indicated.
    - Notify MRP of any significant change in patient's condition, requiring escalation or de-escalation of observation level.
    - Explain the level of observation to the patient/SDM when appropriate to do so.
    - Assist patient into hospital attire (gown and hospital pants), if indicated
    - Complete hourly assessment and documentation as per guideline below.
    - If observation will be provided by an UCP, the assigned nurse will ensure the UCP:
        – Is competent to perform their duties, by demonstrating understanding of the extent of their responsibilities and ongoing effectiveness in their interventions.
        – Knows when and who to ask for assistance, and
        – Knows when, how, and whom to report the outcome of the procedure, and

- Knows not to leave duties until responsibilities are transferred to the next assigned person.

4. For all patient care areas (except Mental Health): the decision for level of observation would be based on nursing assessment (see Appendix A for guidance). The Most Responsible Physician (MRP) may also enter an order for level of observation if indicated by clinical assessment.
5. Mental Health Program Only: The Most Responsible Physician (MRP) or on-call physician will:
    a. Enter an order for level of observation, including street attire and/or passes if indicated. Refer to *In-patient Unit Passes/Weekend Passes* policy (i.e. involuntary patient);
    b. Reassess constant observation order every 24 hours
    c. Reassess any observation order with significant change in patient's condition
6. For the Behavioural Mental Health (BMH) area in Emergency Department (ED) and Behaviors and the Acute Care of the Elderly (BACE) unit, remote/video monitoring may be utilized for patient safety purposes.

Documentation Guideline

As per practice standards and the *Electronic Clinical Documentation* policy, documentation should occur as close to the time care was provided or an event occurred. The nurse is expected to ensure adequate level of observation is in place based on patient's clinical status and presentation. If there is a dedicated Unregulated health care professional involved in the care and observation and/or involved in the documentation of the patient status through BSO DOS tool, the nurse will conduct routine observation and review the observation documentation every four hours and/or as needed with the care and observation provider.

Documentation in the patient's electronic medical record should include:

a. Observation Level
b. Care and Observation Role (i.e. nurse, patient care assistant, extern, security)
c. Clinical indication for heightened level of observation (as per Appendix A)
d. Person informed (Patient /SDM) of the Heightened observation and/or use of restraint and reason for it.
e. Care and Observation documentation if utilizing the Behavioural Supports Ontario-Dementia Observation System (BSO-DOS©) tool for responsive behavior and follow up with LOFT Behavioural Support, Psychogeriatric and/or Geriatric services.
f. Documentation of violence assessment risk/behavioural care plans and restraint assessment if applicable

Mental Health Program Only: A physician order for level of observation, including orders for street attire and/or passes (if indicated) must be present in the patient's electronic medical record.

Reassessment of Observation and Discontinuation of Observation

- Observation levels and need for care and observation provider are required to be reassessed daily.
- The pre-observer checklist and observation documentation may be utilized to determine if escalation/de-escalation of observation level or discontinuation is appropriate if the need for heightened observation and/ utilization of dedicated person for care and observation is no longer indicated based on clinical assessment.

Documentation of Observation

If patient is referred to LOFT Behavioural Support, Psychogeriatric and/or Geriatric services:

- Care providers (regulated or unregulated) will document care and observation of the patient using the BSO-DOS© tool at a minimum of one-hour intervals and determine individualized interventions. Refer to the electronic medical record for the BSO-DOS© tool.
- Incoming and outgoing nurse and care and observation provider to conduct handover in the patient room through review of the BSO-DOS© tool and IPASS.
- For care providers in the role of Care and Observation who do not have access provision to the electronic BSO-DOS© tool, a paper format would be provided for completion and primary nurse will review the information and input data or scan document into the EMR (i.e. agency personnel).

If patients require heightened observation and *not* referred to LOFT Behavioural Support, Psychogeriatric and/or Geriatric services:

- Follow the required documentation as per patient status and complete the relevant risk assessments and flowsheets such as: violence risk screening, falls risk screening, restraint assessment and respective interventions and care planning

Additional documentation is required if restraints are in use (as per *Least Restraint* policy) and if a Code Yellow is initiated (as per *Code Yellow Missing Patient* policy).

Unit and/or Off-unit Passes

Passes are permitted in accordance with the level of observation (Appendix A) unless otherwise ordered by a Physician. Individual orders that contradict the level of observation should be used sparingly.

If the patient will be accompanied for an off-unit pass, the designated supervisor will not be a Mackenzie Health employee and should be stated in the physician's order. Refer to *In-patient Unit Passes/Weekend Passes* policy.

REFERENCES:

Alberta Health Services. (2018). Restraint as a last resort toolkit. Health Professions Strategy and Practice. Retrieved from: https://www.albertahealthservices.ca/info/Page15702.aspx

Cambridge Hospital. (2015). Least restraints (physical, environmental, chemical). Interdisciplinary Clinical Manual, Policy No. 1-264. Cambridge, Ontario.

Centre for Addiction and Mental Health. (2016). Emergency use of chemical restraint, seclusion, and mechanical restraint. Policy No. PC 2.E.2. Toronto, Ontario.

College of Nurses of Ontario. (2013). *Working with unregulated care providers.* Practice Guideline Pub No. 41014. Retrieved from: http://www.cno.org/globalassets/docs/prac/41014_workingucp.pdf

Emanuel LL, Taylor L, Hain A, Combes JR, Hatlie MJ, Karsh B, Lau DT, Shalowitz J, Shaw T, Walton M, eds. (2017). The Patient Safety Education Program – Canada (PSEP – Canada) Curriculum. Module 13d. Retrieved from: http://www.patientsafetyinstitute.ca/en/education/PatientSafetyEducationProgram/PatientSafetyEducationCurriculum/MentalHealthModules/Pages/Mental-Health-Care-Seclusion-and-Restraint.aspx

Elsevier Clinical Skills. (2018).

Government of Ontario. (1996). *Health Care Consent Act (S.O. 1996, c.2).* Retrieved from: https://www.ontario.ca/laws/statute/96h02?search=health+care+consent+act

Government of Ontario. (1990). *Ontario Mental Health Act (R.S.O.* 1990, c.M.7). Retrieved from http://www.e-laws.gov.on.ca/html/statutes/english/elaws_statutes_90m07_e.htm

Government of Ontario. (2001). *Patient Restraints Minimization Act (S.O. 2001,c.16)* Retrieved from http://www.e-laws.gov.on.ca/html/statutes/english/elaws_statutes_01p16_e.htm

Health Sciences North. (2016). Restraints. Corporate Clinical Policy. Sudbury, Ontario.

Hospital for Sick Children. (2008). *Least Restraint Policy.* Toronto: Canada

Lakeridge Health. (2014). Restraint prevention, application, and management. Policy and Procedure. Oshawa, Ontario.

Markham Stouffville Hospital. (2014). Restraint Minimization Policy. Policy No. 210.914.914.005. Markham, Ontario.

Ministry of the Solicitor General of Ontario. (1992). *Verdict of coroner's jury, Excited delirium and Use of Restraints*. No. 636. Toronto: Author

Ministry of the Solicitor General of Ontario.(n.d.) *Verdict of coroner's jury No. 14519*. Toronto: Author.

North York General Hospital. (2010). Policy of Least Restraint. Policy No. II-137. Toronto, Ontario.

Office of the Chief Coroner. (2017). Inquest into the death of Nokolaos Mpelos. Ottawa, Ontario: Queen's Printer for Ontario.

Rouge Valley Health System. (2013). Restraint Use – Protective devices. Practice Standards Manual, Policy No. R 0004-B. Ajax, Ontario.
Royal Victoria Hospital. (2013). Least Restraint (physical, environmental, chemical restraints). Corporate Clinical Policy & Procedure. Barrie, Ontario.
Southlake Regional Health Centre. (2016). Restraint(s) – Use of for patients admitted under the Mental Health Act (MHA). Policy No. I R019. Newmarket, Ontario.
The Salvation Army Toronto Grace Hospital (2016). Least Restraint. Interprofessional policy and procedure manual, Policy No. I-11. Toronto, Ontario.
Trillium Health Partners. (2017). Restraint minimization policy.

Appendix A: Levels of Observation and Clinical Indications Guideline

*Please Note: Involuntary (i.e. MHA Forms) and mental health patients may have additional physician orders that supersede the below levels of observation. Please refer to *In-patient Unit Passes/Weekend Passes*, and other mental health program policies.

Observation Levels	Definition	Clinical Indications

Constant Observation	A patient in the observer's line of sight at all times.	• Involuntary admission (Form 1/3/4) to inpatient unit, when there is a risk of elopement in a non-secured unit
		• Any patient admitted to Emergency Psychiatric Unit (EPU) and/or Psychiatric Intensive Care Unit (PICU)
		• Physical restraint at **three** or more points (or less if clinically indicated)
		• **Consistent demonstration** of high-risk behaviours that may require involvement of an observer may include (but are not limited to):
		  • Elopement and Exit-seeking behaviours with risk for harm to self or others such as wandering and leaving the hospital/unit alone when unsafe to do so.
		  • Self-risk behaviours (removing lifesaving equipment including tubes and drains, or attempting self-harm)
		  • Impulsive and unsafe ambulation/movements (Exiting the bed or chair when unsafe to do so independently, entrapment in bedrails etc.)
		  • Behaviour that puts others as risk such as verbal or

		physical threats • Escalating behaviours with risk of harm to self or others including acute onset delirium, increasing responsive behaviours

Enhanced Observation
 	
Q 30 mins
	A patient whose mental and/or physical status requires observation of whereabouts, condition, and/or behaviours that is not continuous.	• Use of any chemical, environmental, or physical restraint at two or less points (Aim for initial observation with application is q 15 mins for the first hour, q 30 mins for the second hour and every hour afterwards or more frequent as per clinical assessment, refer to *Least Restraint Policy*).
		• High Falls risk identified (i.e. Morse falls score ≥ 45, MEDFRAT score ≥3) with universal and high-risk fall prevention strategies in place with enhanced monitoring to support interventions if alternative strategies not effective.
		• Behavioural trend of **escalating** high-risk behaviours
		  • Elopement and Exit-seeking behaviours with risk for harm to self or others such as wandering and leaving the hospital/unit alone when unsafe to do so.
		  • Self-risk behaviours (removing life-saving equipment including tubes and drains, or attempting self-harm)
		  • Impulsive and unsafe ambulation/movements (Exiting the bed or chair when unsafe to do so independently, entrapment in bedrails etc.)
		  • Behaviour that puts others as risk such as verbal or physical threats

		• Escalating behaviours with risk of harm to self or others including acute onset delirium, increasing responsive behaviours
Routine Observation Q60 mins or more frequently for clinical monitoring requirements	Routine monitoring by care provider.	• All patients • No identified high-risk behaviours • Stable medical and psychiatric condition
Remote/Video Monitoring	Use of assistive devices such as security cameras for the purpose of patient observation and involves continuous physical presence of a staff member in the same environmental vicinity as the patient.	• For areas with video monitoring devices to enhance patient safety (i.e. BMH area in ED, BACE unit)

Appendix B: Care and Observation Calling Algorithm