THERAPEUTIC SUPERVISION OF MENTAL HEALTH PATIENTS: OBSERVATION CARE LEVELS

PRACTICE GUIDELINE©

DOCUMENT SUMMARY/KEY POINTS

- This guideline pertains to the management and care of mental health patients throughout the Sydney Children's Hospital Network
- Children and adolescents may be admitted to the hospital for assessment and management of acute emotional distress, behavioural disturbance, and/or psychiatric disorders.
- There may also be concerns for the patient's safety or the safety of those around the patient. These patients urgently require the least restrictive safest environment during a period of assessment, stabilisation, and initiation of treatment.
- The principles of therapeutic supervision are to provide the patient with the highest level of safety within the least restrictive, therapeutic environment.
- Therapeutic supervision is a nursing intervention to manage young people who are distressed or at risk of harm to themselves or others.
- The levels utilised are based on a numerical code system with the highest supervision being Care Level 1 and the lowest being Care Level 4 (Refer to Table 2).
    - The level of supervision is decided by a Mental Health Clinician in consultation with the treating Psychiatrist (or delegate).
    - A Registered Nurse can initiate or increase the level of supervision if the patient's condition deteriorates and there are safety concerns whilst awaiting review by a Mental Health Clinician. They cannot reduce the Care Level.
- Care Levels are to be implemented for mental health patients in any setting throughout the hospital (eg emergency department, inpatient unit, general ward)

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CHANGE SUMMARY

- Use of guideline specifically for Mental Health Patients
- Change of language across SCHN to “Care Level”. Was previously referenced as Therapeutic Supervision Level (SCH) and a colour coded system (CHW)
- Amalgamation of Care Level’s across the network and within hospital departments.

RELATED DOCUMENTS

- Protecting People and Property - NSW Health Policy and Standards for Security Risk Management in NSW Health Agencies - http://www.health.nsw.gov.au/policies/manuals/Documents/prot-people-prop.pdf
- Security CHW policy - http://chw.schn.health.nsw.gov.au/o/documents/policies/policies/2006-8216.pdf

READ ACKNOWLEDGEMENT

- All SCHN clinical staff caring for patients requiring therapeutic supervision of mental health patients in hospital should read and acknowledge this document.

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1 Rationale

Children and adolescents may be admitted to the hospital for assessment and management of acute emotional distress, behavioural disturbance, and/or psychiatric disorders. There may also be concerns for the patient's safety or the safety of those around the patient. These patients urgently require the least restrictive safest environment during a period of assessment, stabilisation, and initiation of treatment.

The principles of therapeutic supervision are to provide the patient with the highest level of safety within the least restrictive, therapeutic environment.

Increased Care Levels may be required when a patient is:

- Actively self-harming or suicidal
- Requiring medical treatment for a suicide attempt
- In acute psychosocial/psychological distress
- Acutely intoxicated
- Acutely psychotic or delusional
- Pharmacologically sedated due to mental health concerns
- Disruptive and/or aggressive

2 General Principle

Definition

Therapeutic supervision is a nursing intervention to manage young people who are hospitalised with mental health concerns. Care Levels refer to the level of supervision required. The degree of supervision (i.e., Care Level) is dependent on the level of distress or risk of harm to self/others displayed by the young person on assessment. The care levels implemented are based on a tiered level system.

- The levels utilised **for Mental Health Patients** are based on a numerical code system with the highest being Care Level 1 and the lowest being Care Level 4 (Table 1 & Table 2).
- These levels are utilised for **all** Mental Health patients throughout the hospital, including mental health units, general medical wards and emergency departments.
- The Care Level is decided following a clinical assessment performed by a member of the Mental Health Clinical Team in consultation with the Attending Child & Adolescent Psychiatrist (or delegate).
- The "Member of Mental Health Clinical Treating Team" could be a the Medical Officer, Allied Health Clinician, or senior nurse
- The member of the Mental Health Clinical Team will document the young person's Care Level following the clinical assessment and discussion with Attending Psychiatrist

- When changes are made to Care Levels, this will also be documented by the individual making the change. Changes in Care Levels are generally done in consultation with the Attending Psychiatrist (or delegate) except in cases outlined below.
- Nursing staff are encouraged to contribute to the decision about which Care Level is recommended based on their own observations of the patient/situation
- All clinical staff may increase the Care Level following their assessment that a young person's risk has increased. They must notify the Clinical Team of this as soon as possible.
- Decreasing care level can only occur following review in consultation with the treating team

Aims

- To maintain the safest yet least restrictive and supportive environment for the patient, the family / carer, other patients and families, and staff.
- To establish a therapeutic relationship through empathy, active listening, open communication and respect.
- To provide a sense of safety and containment for the patient
- To assist the patient to regain a sense of personal control and autonomy by clarifying negative statements and cognitions.
- To respect confidentiality.
- To enhance the assessment phase through close observation.

Process

Following a clinical risk assessment and discussion with the Child & Adolescent Psychiatrist a member of the Mental Health Clinical Team (i.e. Medical Officer or individual Therapist) orders the Care Level as part of a treatment plan and records the level in the patient's medical record.

- The level may be increased by a Registered nurse if there is a change in the patient's condition, but not reduced.
- The psychiatrist (or delegate) must be notified as soon as possible if the level is increased to arrange review of the patient's mental state if required and confirm the change in supervision level.
- Other relevant nursing and clinical staff should be notified of a change in the Care Level and the resulting staffing needs and deficits or potential deficits in resources.
- Decisions regarding bed placement will be influenced by safety and best clinical care for all concerned, and should afford maximum observation while regarding the patient's need for privacy and limited stimulation. Other environment measures to assist in maintaining safety may include searching and/or restricting access to personal and other items that may present a risk.

- Increasing the Care Level, through the corresponding patient's sense of restriction, loss of autonomy, loss of privacy and limitations on therapeutic activities may result in patient frustration and escalation of risk, particular to others. This must be taken in account during any risk assessment and decision with regard to therapeutic supervision needs, particularly any order requiring 1:1 nursing supervision - (Level 1A or 1B).
- Any order requiring 1:1 nursing supervision must be confirmed by the treating Psychiatrist (or delegate) to ensure all others ways to reduce risk have been explorer and appropriate measures implemented.
- All patients requiring 1:1 nursing supervision must be reviewed, at least, daily, and their risk level and therapeutic needs reassessed and the need for ongoing 1:1 nursing confirmed in consultation with the treating Psychiatrist (or delegate).

Observations

Close nursing observation and documentation in progress notes provide valuable data for mental health clinicians in terms of diagnosis, monitoring and discharge planning, and should include:

- Mood, affect, behaviour, engagement.
- Expression of self-harm or suicidal throughs or urges, or their absence
- Activities undertaken or their refusal.
- Social interactions.
- Appetite and eating patterns.
- Sleep patterns.
- Level of self-care.

Safety Issues

1. A search of the patient's belongings will be necessary if there is concern that a patient may have concealed objects that may be of harm to themselves or others. See Searching Patients' Belongings Practice Guideline.

2. Potential high risk situations and reactions to high stress times may vary from individual to individual. Some may be:
    - Transition times such as admission and discharge
    - Receiving "bad news"
    - Following family/carer contact such as visits and phone calls
    - After therapeutic sessions, e.g. family meetings, individual sessions
    - Medical interventions, e.g. blood tests
    - As the patient's mood lifts the energy for suicidal behaviour may return

Management Issues

Consideration will need to be given to:

- Appropriate levels of stimulation.
- Continuity of education.

- Developing a collaborative Safety Plan with the patient.
- Visitor and phone contact.
- Care planning within the interdisciplinary team.
- Assisting colleagues during procedures, escorting patients for tests or transferring patients between wards.

Admission checklist

- Has a physical examination been conducted and recorded?
- Has a mental state examination been conducted and recorded?
- Has a risk assessment and level of therapeutic supervision been documented by the clinical team in consultation with the AMO?
- How often will the patient be reviewed and by whom?
- What is the patient's legal status under the Mental Health Act 2007?
- Does the young person have a history of self-harm, substance use, depression or violence?
- Has the patient, their belongings and room been checked for potential implements used for harm to self or others?
- What arrangements are being made and by whom about discharge planning and ongoing care?
- Have all the members of the care team been orientated to management plan and therapeutic supervision?

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Table 1: SCHN Levels of Care for all Mental Health Patients

CARE LEVEL 1
1:1 SPECIALLED

Clinical indicators	Description
• Patient is assessed as a **high level of immediate risk** to themselves or to others • Patient cannot be safely managed in a less restrictive fashion. • All possible appropriate environmental safety measures such as limiting access to room, bathroom, belonging, providing low stimulus time-out environment are in place but high risk remains and is ongoing. • All possible appropriate clinical measures have been taken such as reviewing medication, behavioural management strategies, utilising sensory tools to decrease urge and level of risk, distraction and other strategies have been reviewed, are in place. • Less frequently a patient presenting a high, immediate, and ongoing high risk of violence, aggression or extreme behaviours that are seriously emotionally or psychological disturbing to other patients may require Care Level Red 1:1 supervision. • Assessment needs to balance staff risk and other protective environmental, behavioural and therapeutic measures must be in place with risk continuing. • Patient requires daily review.	• Patient is to be nursed on a 1:1 basis (specialled). • Nurse is to be in close proximity to patient and have direct line of sight at all times. • Patient is to be checked for signs of life (eg spontaneous respiration) every ten minutes and these must be documented. Ensure head and neck visible at all times whilst patient asleep. • Individual observations chart kept as part of patient's medical record. • Minimum of daily CNC or Medical Officer (MO) reviews of risk, need for ongoing 1:1 supervision, and review of clinical plan including behavioural, sensory, environmental and other therapeutic strategies. • Daily consultation with MO confirming ongoing need for 1:1 nursing • Clinical team, in consultation with nursing staff, should attempt to minimise exposure to potential triggers • Consideration should be given of relational dynamics in discussing visiting and phone contact guidelines with family/carers. • Clear risk management plans and rationale should be documented by clinical team if AMO assesses child's safety and ongoing wellbeing would benefit attending a therapeutic activity off the ward • Patient may be visited by immediate family/carers, 2 visitors at a time and for periods as documented by the clinical team in consultation with the AMO. • Ward phone access as per clinical team • No leave **Care level 1 is divided into two categories. The Medical Officer /MHCNC? must specify which care level the patient is to be managed:** **CARE LEVEL 1A** • Patient is to be nursed on a 1:1 basis (specialled). • Patient in safe room, single room if available • Nurse must be within arm's reach at all times. • Supervision includes all bathroom use **CARE LEVEL 1B** • Patient is to be nursed on a 1:1 basis (specialled). • Patient to be within visual observation at all times. • Patient may use the bathroom for brief periods only with the nurse in close proximity (foot in the door whilst standing outside)

CARE LEVEL 2

Clinical indicators	Description
• Patient is assessed as a **medium risk** of suicide or self-harm. • Patient cannot be safely managed in a less restrictive fashion. • Patient is at risk of absconding. • There is a significant risk to the patient's personal reputation, financial affairs or sexual safety.	• Minimum of 10 minute observations (24 hours) by nursing staff with appropriate documentation. Check for spontaneous respirations during the night as part of the observations. • Individual observations chart kept as part of patient's medical record. • Patient must be escorted by a member of the Mental Health Team when out of the ward. *An Enrolled Nurse could be used at the discretion of the Nurse in-charge.*

	• Attendance at any off-Ward activity must be approved by the AMO and clearly documented by the clinical team. • School attendance, if approved by clinical team, at discretion of teacher and dependent on class activity, milieu, staffing and likely therapeutic benefit. • No leave unless otherwise ordered by treating psychiatrist **Hall Ward Only** • Maximum of two patients on Care Level 2 at school • An additional RN to attend to school for any patients on Care Level 2 • Limit of 3 patients on Care Level 2 to attend same school session to ensure safe nursing levels in classroom and Hall Ward. • May not attend off the ward activities
CARE LEVEL 3	
Clinical indicators	**Description**
• Patient is assessed as a **lower level of risk*** of suicide or serious self-harm. • Patient cannot be safely managed in a less restrictive manner. • Patient has compromised ability to maintain appropriate or acceptable behaviour.	• Minimum of 30 minute visual observations (24 hours) by nursing staff with appropriate documentation. Check for spontaneous respirations during the night as part of the observation • Individual observations chart kept as part of patient's medical record. • Patient may attend school and therapeutic activities off the ward if escorted by a delegated staff member and clearly documented by the clinical team. • Leave status and conditions are made on an individual case basis by the treating team in consultation with the MO and needs to be documented by the treating team in the patient's medical record. **Hall Ward Only** • Patient may attend hospital school and other therapeutic activities off the ward as documented by the clinical team in liaison with MO
CARE LEVEL 4	
Clinical indicators	**Description**
• Patient is at a **lower level of risk*** of suicide, serious self-harm risk or absconding. • Patient is not actively suicidal or engaging in serious self-harm. • Patient does not pose a threat to others.	• Patient has hourly observations (24 hours) by nursing staff with appropriate documentation. Check for spontaneous respirations during the night as part of the observation. Observations may be recorded on a group observation sheet • If the patient is not on the ward there is a reason documented in the patient's Medical Record to include where he/she is and when return is expected. • Leave status and conditions, including overnight leave arrangements, are made on an individual case basis by the treating team in consultation with the AMO, and needs to be documented by the treating team in the patient's medical record. • Appropriate discussion and written leave plan is to be provided to the patient and parent/carer in accordance with Transfer of Care Policy - http://www0.health.nsw.gov.au/policies/pd/2012/pdf/PD2012_060.pdf

** When assessing level of risk, it is important to note that a variety of factors are taken into account, including protective factors (e.g. level of supervision by parent or carer), and access to means of self-harm.*

***Note:** Decisions around Care Level are independent of a patient's status under the Mental Health Act. As young people under 16 years may be treated under their parents' consent, status as involuntary or voluntary under the Mental Health Act 2007 NSW are not necessarily indicative of patient risk or therapeutic care level needs. The decision of the treating psychiatrist that a person under 16 years is best cared for as an involuntary patient is complex and again not indicative that the child will necessarily require 1:1 supervision on a medical ward (though likely) – this is a clinical decision.*

Table 2: Care Levels Guide

SCHN	Mental Health Patients
Care Level 1	Care Level 1A 1:1 Within arm's reach and with bathroom supervision
	Care Level 1 B 1:1 With continual visual observations and foot in bathroom door.
Care Level 2	Care Level 2 10 minute observations
Care Level 3	Care Level 3 30 minute observations
Care Level 4	Care Level 3 Hourly observations

Note: *As young people under 16 years may be treated under their parents' consent, status as involuntary or voluntary under the Mental Health Act 2007 NSW are not necessarily indicative of patient risk or therapeutic care level needs. The decision of the AMO that a person under 16 years is best cared for as an involuntary patient is complex and again not indicative that the child will necessarily require 1:1 supervision on a medical ward (though likely) – this is a clinical decision*