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Constant Observation The Benchmark Study

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Constant Observation: The Benchmark Study

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Contents

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Executive Summary

Constant observation is defined as “an increased level of observation and supervision which continuous one-to-one monitoring techniques are utilized to assure the safety and wellbeing of an individual patient in the patient care environment. In the hospital setting constant observation has become the most used resource for mental health patients. The use of constant observation has significantly improved patient safety outcomes reducing falls and suicide rates drastically. With one study in Pennsylvania showing a vast improvement in patient safety in simply one-month times. As fall rates decreased from 53,966 falls occurring without the implementation of constant observation to only 323 falls occurring with the implementation of constant observation (Feil & Wallace, 2014). Another study completed in England over a four-year period revealed the impact that constant observation had on decreased self-harm and suicide rates within the hospital setting. With self-harm/suicide rates decreasing from 236 without the implementation of constant observation to a mere 17 with the implementation of constant observation (Janofsky, 2009). Over the years constant observation has proven that it is a remarkable safety intervention and has become the backbone of safe practice for mental health patients reducing the use of physical and chemical restraints.

Despite all the positive reviews from constant observation concerning safety outcomes, there is a disproportionate amount of information about how constant observation affects the patients it is implemented it. There is also an absence of actual therapeutic implementation for this intervention for mental health patients. This is disheartening as this is an intervention commonly used for this patient population and has been named by The Joint Commissions in 2009 as “the primary intervention for mental health patients in the hospital setting” (Sinvani et al., 2019).

1. Rationale for the Project

Constant observation is an intervention that lacks "clarity in the terms used to describe constant observation, who provides constant observation, variability in what the care entails, and the needs of patients requiring this care" (Sinvani et al., 2019). To this day constant observation is without "national guidelines with regard to sitter qualifications, specific components of required education and training curriculum, nor job description and roles (Sinvani et al., 2019). Constant observation can also be implemented by anyone as there are no qualifications to be able to implement this intervention. This intervention can be implemented by "registered nurses, certified nurse assistants, and other nonlicensed paid employees as well as family members and volunteers (Sinvani et al., 2019). When researching what patient population constant observation is implemented on the most psychiatry was found to be the primary diagnostic category and the most common psychiatric diagnoses constant observation is used for are "psychosis, schizophrenia, schizoaffective disorder, bipolar disorder, post-traumatic stress disorder, and mood" (Solimine et al., 2018). The lack of structure for this intervention makes it nontherapeutic and unorganized when implemented. This means that the intervention named to be the primary intervention for mental health patients is not even tailored to actual provide this patient population with any therapeutic benefits. This is a problem as these patients deserve to be able to receive therapeutic care from trained professionals in the hospital setting just like any other patient population.

1.1 Project Goals

The goal of this Benchmark Study is to bring attention to the fact that constant observation is lacking therapeutic properties, protocol, or guidelines. Due to this, the intervention has no foundation or actual beneficial assets when it is utilized. "One in eight emergency

department visits now involves a psychiatric emergency" and to this day mental health patients have a very limited number of resources available to aid in their care even though they account for a large number of patients entering in the ER (Zeller, S. 2018). Constant observation is the number one resource implemented in the hospital setting for mental health patients yet does not provide this patient population with any actual impactful intervention to help improve their mental health. As of now hospitals are unable to give mental health patients any therapeutic care, only safety interventions are provided even though this patient population has increased by more than 50% since 2006 in ER visits (Zeller, S. 2018).

The goal of this program is to create a protocol for constant observation with specific guidelines, training, and education requirements. This will provide constant observation with a foundation as an intervention providing mental health patients with a resource that will give therapeutic benefits. This will allow mental health patients to receive needed care in the hospital setting just as medical patients receive immediate care in the hospital setting.

2. Literature Discussion to Support Project

Twelve articles were reviewed for this Benchmark Study and 3 main themes were discovered during this research:

- How the lack of guidelines and structure effects staff and patient outcomes
- Therapeutic aspects of constant observation
- Nontherapeutic aspects of constant observation

2.1 How the Lack of Guidelines and Structure effect staff and patient outcomes

Many research articles discuss the lack of structure, guidelines, and educational requirements for this intervention and its effects on the staff implementing this intervention. The responsibilities and proficiencies needed for staff members implementing constant observation

are “intervening (responding or taking action during the observation process), maintaining the safety of the patient and others; prevention de-escalation and management of aggression; assessing; communication and therapy” (MACKAY et al., 2005). Research has shown that constant observation “is frequently conducted by less qualified staff” and that there is a pronounced need for “education materials for staff on how to observe patients” (Reen et al., 2020; Stewart & Bowers, 2011). The absence of structure for this intervention leads staff members into a situation unprepared and stressed as they are not equipped to implement this intervention. Studies reveal that staff have verbalized “anxieties about not being skillful enough” to implement constant observation and that this could also “dissuade staff from engaging with patients in a deeper way” (Insua-Summerhays et al., 2018). Staff who have implemented constant observation without proper training and education have declared “a wish for further training to negotiate complicated dynamics that were intensified during one-to-one observation” (Insua-Summerhays et al., 2018). Due to this lack of training to prepare staff to implement constant observation there is a considerable disparity in therapeutic elements occurring with implementation of this intervention. This in turn is negatively affecting patient outcomes and experience with constant observation. Research findings show that therapeutic benefits with this intervention depends heavily on how this intervention is educated to the staff implementing this intervention (MACKAY et al., 2005). In one study an idea was created for constant observation training based on the staff members experiences to incorporate formal therapeutic models such as “cognitive behavioral therapy, mentalization based treatment, and dialectical behavioral therapy” to prepare staff to be able to perform constant observation with therapeutic benefits (Insua-Summerhays et al., 2018). Research also emphasized “that observation alone could not

solve patients' underlying long-term difficulties and should be used in tandem with therapeutic input" (Barnicot et al., 2017).

2.2 Therapeutic aspects of constant observation

Exploration of how staff and patients experience constant observation allowed for therapeutic properties of constant observation to be found. Findings indicate that therapeutic engagement with patients from staff made constant observation a positive experience for both the sitter and the patient and improved patient outcomes (Ashaye et al., 1997; Barnicot et al., 2017; Cardell & Pitula, 1999; COX et al., 2010; Insua-Summerhays et al., 2018; MACKAY et al., 2005; Stewart & Bowers, 2011). With the implementation of therapeutic engagement both staff and patients described feeling companionship, connection, acceptance, protection, emotional attunement, and empathy (Insua-Summerhays et al., 2018, Berg et al., 2017). With the implementation of therapeutic engagement both staff and patients stated that constant observation had "the potential to provide comfort and distraction" along with "being reassuring for those who felt otherwise unsafe, displaced, and alone in themselves" (Insua-Summerhays et al., 2018). Patients and staff also affirmed that through therapeutic engagement patients are able to open up about "their thoughts, emotions, suicidal urges, and symptoms such as auditory hallucinations" (Insua-Summerhays et al., 2018). This lets patients feel a sense of control as they can "gain insight" and learn how to cope with difficulties and symptoms of mental illness (Berg et al., 2017).

2.3 Nontherapeutic aspects of constant observation

Just as therapeutic facets were found during this research study nontherapeutic qualities of constant observation were also found. The leading negative feature of constant observation

was invasion of privacy/personal space (Ashaye et al., 1997; Barnicot et al., 2017; Cardell & Pitula). In one study 23/28 patients and 28 out of 31 staff members "recognized that continuous observation constituted a significant invasions of patients privacy" (Barnicot et al., 2017). Staff have emphasized that constant observation is the most effective "when used for a short time" or using "less intrusive methods such as intermittent observation" (Barnicot et al., 2017). As this helps prevent patients from feeling that their personal space and privacy are being constantly invaded by staff. The next negative finding of constant observation is the lack of therapeutic engagement or interaction from staff members (Ashaye et al., 1997; Barnicot et al., 2017; Cardell & Pitula, 1999; COX et al., 2010; Insua-Summerhays et al., 2018; Jones et al., 2000; MACKAY et al., 2005; Stewart & Bowers, 2011). Without therapeutic engagement staff and patients describe constant observation as "an emotionally detached, risk-management procedure, in which the patient was the object of clinical observation rather than partaking in attuned, reciprocal engagement" (Insua-Summerhays et al., 2018). Leading to "uncomfortable silence" and "sense of awkwardness" between the patient and the observer "characterized by mutual resentment," which leads to poor patient outcomes and destructive consequences to the patient's mental health (Insua-Summerhays et al., 2018). Lack of patient involvement in the decision being under constant observation is another nontherapeutic part of constant observation by patients (Ashaye et al., 1997; Barnicot et al., 2017). Research indicated in one study that 22/28 patients and 10/31 staff expressed that "observation was more likely to be unhelpful when decisions were made without adequate knowledge or involvement of the patient" (Barnicot et al., 2017).

3. Project Stakeholders

There are limited resources available in the hospital setting for mental health patients. Improving the primary intervention used in the hospital for mental health patients will improve patient outcomes and satisfaction rates. Project stakeholders for this benchmark study are the chief nursing officer, regional nurse managers, nurse mangers, nurse educators, registered nurse, certified nurse assistants, and newly hired sitters. These stakeholders can be categorized by upper-level management, mid-level management, low-level management. Upper-level management consists of the chief nursing officer and regional nurse managers. Mid-level management is nurse managers and nurse educators. Low-level consists of registered nurses, certified nurse assistants, and newly hired sitters.

3. Proposed Outcomes

The proposed outcomes for this study include: 1. providing constant observation with guidelines, training, and educational base to give a foundation to this intervention. 2. Establishing therapeutic benefits that derive from constant observation. 3. Hiring staff members specifically to implement constant observation. 4. Providing mental health patients with a beneficial resource and improve mental health patient outcomes in the hospital setting.

5. Evaluation Design

Evaluation of the participants of this study which will include the observers and patients that experience constant observation will include online surveys. There will be two groups in this study Group 1 will be to staff and patients who experienced traditional constant observation with none of the evidence-based recommended changes. Group 2 will be to staff and patients who experience constant observation with the recommended evidence-based changes. See Appendix A and B located at the bottom of the article for sample of survey questions.

6. Timetable/Flowchart

The PICOT Question for this Benchmark Study was developed in August 2020. Evidence-based research was completed for this study from August 2020-August 2021. Revamping of the PICOT Question occurred in January 2022. Change Project integrated into what is now the Benchmark Study in November 2022. Delivery of the Benchmark Study to Senior Management to occur in May 2023.

7. Data Collection Methods

Data was collected for the benchmark study through a review of previous research study articles that implemented their own change projects. Research method, study design, sampling techniques, size, and characteristics were alll reviewed for each study. Ethical considerations and informed consent from participants in the study were also reviewed for each study. Strengths and weakness in each study were also carefully assessed and considered during review. Data for this benchmark study will be collected from surveys completed online.

8. Discussion of Evaluation

This is only a benchmark as there has been no official evaluation of this study at this time. There is not an official evaluation of this benchmark study currently. Delivery of this benchmark study to senior management is planned for May 2023.

9. Costs/Benefits

The overall cost of this project will be $16,500. This includes holding a presentation to the clinical director, chief nursing officer, and CEO, which should cost an average of $500. This will include the price of providing snacks, drinks, preparing the presentation room with professional decorations. $5,000 will go to implementing the change project. This will include having IT upload the surveys on computers and tablet for patient and staff responses to be

recorded, staff educators being hired review research articles and complete another throughout research on the topic, review the change project results and compare them to the research findings, create a constant observation protocol/guidelines/training, and to educate staff on the change project and recommended changes. $10,000 will go to hosting job fairs to hire sitters and hold educational seminars by mentors and staff educators to ensure that sitters will be trained on how to implement constant observation based on evidence-based research findings and results from the change project. $1,000 will be used to provide yearly educational seminars during skill fairs to keep staff educated and up to date on evidence-based best ways to implement constant observation.

The benefits of this benchmark study out way the cost because with constant observation being improved as an intervention and providing therapeutic care patient outcomes will improved and patient satisfaction rates will improve. This means reimbursement rates will increase for the hospital. It has also been proven that hospital admission rates are higher in mental health patients than those without mental health issues and that mental health patients remain in the emergency department longer than any other patient group (Hill et. Al., 2020). By using constant observation to its full potential and providing these patients with therapeutic interventions upon arriving their length of stay can be greatly decreased saving the hospital money.

Conclusion

With this project a protocol, guidelines, and training will be created for the intervention constant observation. Ensuring that there is a therapeutic intervention for mental health patients in the hospital setting will completely change the experience that mental health patients have while in the hospitals and improve patient outcomes. This will help prevent the delay in care that

mental health patients experience daily when they come to the hospital in need of help. This will forever change healthcare and how mental health patients are viewed and treated in the hospital setting. By providing constant observation guidelines the hospital will now be able to implement care on mental health patients just as they implement care on medical patients. The hospital is meant to be a place where everyone can come for help, and this will finally make the hospital truly be the number one resource to provide aid to all patient population groups.

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Appendix A

Evaluation Tool for Patients

Not at all
Somewhat
Almost Completely
Completely

1. Were you informed what constant observation is and why you were put on constant observation?

   Not at all
   Somewhat
   Almost Completely
   Completely

2. Was your sitter kind to you and make you feel comfortable?
   Not at all
   Somewhat
   Almost Completely
   Completely

3. Did your sitter engage in any conversations with you during your observation?

   Not at all
   Somewhat
   Almost Completely
   Completely

4. Did being under constant observation improve your mental state at all?

   Not at all
   Somewhat
   Almost Completely
   Completely

5. Do you feel that your observer improved your mental state?
   Not at all
   Somewhat
   Almost Completely

Completely

6. Did your observer make you feel safe from self-harm/suicide?
   Not at all
   Somewhat
   Almost Completely
   Completely

7. Do you feel like you were involved in your care plan?
   Not at all
   Somewhat
   Almost Completely
   Completely

8. Do you feel that going to the hospital and being under constant observation was beneficial and improved your mental health?
   Not at all
   Somewhat
   Almost Completely
   Completely

9. Did you observer make you feel acknowledged and provide you with emotional support?

   Not at all
   Somewhat
   Almost Completely
   Completely

10. Overall, do you feel that constant observation as an intervention for mental health patients is beneficial for mental health patients for providing safety and therapeutic benefits for mental health?

    Not at all
    Somewhat
    Almost Completely
    Completely

11. Please elaborate any further points on your constant observation experience that made it either a positive or negative experience and if you feel that constant observation is vital resource for mental health patients in terms of improving their mental health?

Appendix B

Evaluation Tool for Staff

Not at all
Somewhat
Almost Completely
Completely

1. Have you ever received education/training on how to implement constant observation?

   Not at all
   Somewhat
   Almost Completely
   Completely

2. Did you know what to expect when implementing constant observation?

   Not at all
   Somewhat
   Almost Completely
   Completely

3. Did you interact or engage in conversation with the patient?

   Not at all
   Somewhat
   Almost Completely
   Completely

4. Do you feel that constant observation provided the patient with therapeutic benefits or improved the patients' outcomes?

   Not at all
   Somewhat
   Almost Completely
   Completely

5. Did you feel prepared to engage in conversation with the patient?

   Not at all
   Somewhat
   Almost Completely

Completely

6. Did you feel anxious about implementing constant observation?

7. Do you feel that you were able to provide therapeutic benefits to the patients through engaging with the patient?

   Not at all
   Somewhat
   Almost Completely
   Completely

8. Do you feel that you were trained and educated enough to implement constant observation?

   Not at all
   Somewhat
   Almost Completely
   Completely

9. Do you believe that staff should be hired specifically to be educated and trained to complete constant observation?

   Not at all
   Somewhat
   Almost Completely
   Completely

10. Please elaborate here on your experience implementing constant observation and what you felt was positive or negative in the experience or what you believe will my constant observation a therapeutic intervention for mental health patients?