Reflective account of increasing a persons observations

People

Reflective Account of Increasing a Persons Observations on an Acute Mental Health Ward

This essay will discus a decision that was made on a local male acute ward. Using this example, an analysis of the decision making process has been made and a reflective model has been used in order to generate personal knowledge that will inform further practice (Rolfe, 2011a). A pseudonym of Tim has been used for the discussed patient to maintain confidentiality in accordance with the NMC code of conduct (2010a).

Observationis one way in which mentalhealthnurses can protect acutely mentally ill inpatients from harm and is commonly implemented for patients who impose a risk of harming themselves, others and for those who are vulnerable (Bowers et al, 2006). Tim, who was on a local male acute ward, posed a risk of harming himself and became very vulnerable during his stay. On admission he was perceived to be at low risk of harming himself and vulnerability, therefore was observed on the minimum level of observation, general observation, which includes all patients and involves an hourly eyesight check on the patient (DH, 1999; NICE, 2005).

The decision to increase his observation level was jointly taken by the mentor and the author by gathering information from bank support workers about Tim's current presentation. After a noted deterioration in Tim's mental health, it was decided to increase observations to within eyesight of staff. Justification for this was that he was becoming a serious risk of harming himself as he threatened to jump from the ward roof, as he was determined to leave.

Tim was detained under section 2 or the mental health act (DH, 2007). He felt that he needed to leave in order to find his son who he had recently lost contact with. He had been stopped attempting to climb a drain pipe to leave via the ward roof and had been in a very distressed state. Eyesight level of observation is seen as the second highest of four levels and demands intensenursing, only within arms length is higher (DH, 1999; Jones & Eales, 2009; NICE, 2005).

Close observation is an example of decision making which is exclusive to mental health nursing. The Chief Nursing Officer described observation as a key area where good practice is essential and that nurses should ‘ demonstrate an understanding of the benefits and limitations of the use of levels of observation to maximise the therapeutic effect on inpatient units’ (DH, 2006). Additionally NICE (2005) recommends the use of observation in the short-term management of disturbed/violent patients.

The Nursing and Midwifery Council (NMC, 2010a) require nurses to be able to apply knowledge and an appropriate repertoire of skills that is indicative of safe and effective practice and based on the best available evidence. At the time of making the decision it seemed the right course of action. The mentor's final decision was taken for granted as he was an experienced nurse and a lack ofpersonal experiencemeant that the author had limited personal experience to work with. Before undertaking this assignment it could not decided what could be done differently if faced with a similar situation on qualification.

On qualification, such a decision will have to be well informed and made with confidence and one that has to be made in accordance with the NMC code of professional conduct (2010) which requires nurses to be accountable for their own actions and omissions in practice. By using the decision making tool below the advantage of hindsight can be used when analysing this decision to better inform future practice. Pritchard (2006) sees decision making as one of the most difficult processes that a nurse can undertake and one of the most important parts of nursing practice.

Aitkin (2003) concludes that formal decision analysis can improve future decision making. The utilised decision making model, as described by Jasper (2003), asks the questions Who/What/When/Where/Why and How? These questions make a useful contribution to systematic, holistic, clinical judgement and enable evaluation andcritical thinkingabout the made decision to take place Jasper, 2003; Standing, 2011). Tim has a long history of mental illness and was admitted to the ward following a deterioration in his mental illness after he lost contact with his son.

His mood was elevated and he felt very restless and agitated. Prior to admission, he was found police in a very distressed state. Tim was placed on a section 2 of the mental health act (DH, 2007) and was originally observed generally where a member of staff would have to see him face to face on a hourly basis (NICE, 2005). Under section 2 of the mental health act Tim has lost the right to leave hospital at will and his responsible clinician has not granted him section 17 leave. A person can be detained for up to 28 days and treat against their will (DH, 2007).

As Tim was detained it was important for staff to keep him on the ward. Increasing attempts by Tim to leave led to a change in observation level to within eyesight to make sure he did not leave the ward by any means. Staff levels were low, and for that reason it was felt that there was not enough staff to informally observe Tim. In addition there was a general feeling of fear that if Tim left the ward there would be inevitable consequences for the staff. The literature shows that the decision to increase a persons observations is common when faced with the above situation.

Buchanan-Barker ; Barker (2005) are critical at the increase of observations on acute mental health wards following high profile tragedies placing practitioners in defensive mode to stop patient elopements and harm to patients. Organisations have responded to this risk by formalising observation policies to defend themselves against litigation. In addition, it is felt that observation policies dominate practice and reassure distant managers that 'something is being done' (Horsfall ; Cleary, 2000). Equally, nurses use observation in 'defensive mode' in order to prevent harm.

Despite these measures, the effectiveness of observation to reducing patient risk and providing a therapeutic benefit is not at all clear (Mana, 2010). This indicates that observation is driven by riskcultureand defensive practices concerned with physical integrity of the person and do little to address the origin of a person's distress (Cutcliffe & Stephenson, 2008; Buchanan-Barker & Barker, 2005). Tim was finding it hard to cope with the loss of his son and wants to leave the ward to find him. One study found that the most cited reason for ncreasing levels of close observations was the prevention of

absconding from an acute ward which could lead to the patients self-harm, neglect vulnerability andviolence(Dennis, 1997). During Tim's observation staff were tired and unwilling to engage with Tim. Staff were seen to be following Tim from one part of the unit to another which was aggravating him further. The observation was void of conversation which is in contrast to Peplau's (1952) view that clinical observation should be carried out with the nurses attention to the interpersonal relationship with the patient.

Likewise, Rooney (2009) reports that nurses acknowledged that observations were more about prevention than cure and keeping the patient safe was priority. On the other hand, Bowles et al (2002) found that distressed patients need both containment and engagement. In conclusion, there was a need to maintain a therapeutic relationship while considering the management of risk and the empowerment of the patient. The mental Health Act (DH, 2007) requires an appropriate package of treatment to be in place which includes one-toone time with staff which could have helped alleviate Tim'sanxiety.

Short staffing meant that Tim's one-to-one time had not taken place and from a personal view point a package that can only be theoretically provided is not be good enough. Bank support workers had been allocated to observe Tim as the qualified nurse had to complete paperwork. This is in agreement with the findings of Rooney (2009) who reported that observation was usually left to unqualified staff as nurses were often dealing with other matters. In contrast, NICE (2005) states that observation should be

undertaken by registered nurses. Nurses may delegate to competent staff who have had the appropriate training.

It is thought that the bank staff did not have the appropriate level of competence which created a poor skill mix on that shift which Aston et al (2010) see as a barrier to good decision making. In agreement Rooney (2009) found that staff acknowledged therapeutic work could take place during times of observation however, they felt that they lacked the relevant skills. Staff reported that no one had ever explained how to interact with the patient or had received any further guidance beyond the aspects of risk management and containment.

Most nurses who took part in this study had no practical or theoretical preparation for observations. Tim attempts to leave by the door on the ward when it is opened for visitors and he will try several times a day to enter the court yard to leave by climbing onto the roof. The high level of staffing resources taken up by preventing Tim from leaving the ward prevented staff from engaging with other patients who felt that they were being ignored and neglected which in turn added furtherstressto staff.

In agreement are a number of authors who have shown that formal observations consume nursing resources and that the patient being observed receive a disproportionate amount of nurses time (Mana, 2010; Bowles et al, 2002). Bowles et al (2002) argued that the time taken up by the demands of observation was to the detriment of of care of patients that were not seen as a high risk. To reflect on the above experience Rolfe's framework

has been used which poses the questions what? , so what? , now what? (Rolfe, 2001; 2011a).

This type of reflection which is done after and away from the actual event is referred to by Schon (1983) as reflection-on-action and the following discussion focusses on how the author and others did and what changes could be made. Despite this type of reflection being useful reflection-in-action is seen to have far more significance in professional practice. Reflection-in-action looks at the suitability of a particular intervention while it is been carried out. This is one of the distinguishing features as a nurse progresses from qualified status to an advanced practitioner (Schon, 1983; Rolfe, 2011b).

In terms of clinical reasoning and decision making, reflection is seen as an invaluable resource for developing personal practice and learning from other people's perspectives (Aston et al, 2010). In addition to this, reflection can generate knowledge from practice rather than relying on external research findings (Rolfe, 2011a). Rolfe's (2001) framework allows the construction of personal theory and knowledge and how a similar situations outcome might be improved by future actions. The NMC makes it clear that nurses should take part in appropriate learning that helps develop competence and performance (NMC, 2010a).

According to Benner's (2001) novice to expert the author recognises that as a management student working towards qualification he needs to be a proficient performer who looks at situations as a whole rather than their constituent parts. In strong agreement, Aston (2011), who uses a skills

escalator approach, places a management student at level 4 which is a level where a student is expected to demonstrate they can draw on a wide range of resources using an evidence based rational for decisions.

When the author collaborated with staff to assist in making a decision for Tim he felt equally involved in the decision making process however personal contribution was lacking due to limited knowledge at that time. The NMC (2010a) require that care is based on the best available evidence or best practice. The author's personal decision was not based on either. Furthermore, Aston (2010) recommends that confidence in making a decision is developed by a number of factors including relevant past experiences and practising using decision making skills.

Pritchard (2006) argues that the process of decision making is learned gradually through practical experience of caring for patients and observing more experienced colleagues making decisions. Further inhibiting the authors ability to make a decision was a theory practice gap (Aston, 2010). This indicates that the author was practising at Benner's (2001) novice stage, in that he had entered a new clinical area and had a limited contextual understanding. The author was too inexperienced to made the above decision. Tim was placed on eyesight observations and the permanent presence of staff upset him.

Tim was feeling distress and anger. There were no positive outcomes and the intervention was not effective meaning the wrong decision may have been made. Personal decisions and actions were not based on evidence or experience. One of the barriers to future decision making is making mistakes

and reflection is one way of recognising what could have been done better. In addition, in the new clinicalenvironment, the author should have been assisted to practice safely under constant supervision and possibly not able to make such a decision at this stage of nursing training (Aitkin, 2003).

Despite this being the case a thorough theoretical knowledge before working on the ward would have better prepared the author for making the decision. In contrast to this is the notion that a nurse who is experienced in working with theoretical knowledge will find differences in practice that the formal theory fails to express (Benner, 2001). This indicates that a new understanding of the situation has been reached. Despite no real harm coming to Tim the author was not in a position to assist in making the decision. The author should have declined stating that he did not have the relevant knowledge.

It is clear that the author had a low critical thinking capability at that time. It is argued that this is a problem faced by newly qualified nurses. Graduates do not meet expectations for entry level clinical judgement ability (Del Bueno, 2005). Similarly, Deuchester (2009) reports that newly qualified nurses go through a transition shock and have a poor ability to make decisions. Feelings of doubt, loss, confusion and disorientation for newly qualified nurses are reported along with a lack of knowledge that includes practical, theoretical and tacit.

Despite this being the case the NMC (2010b) require students to demonstrate the ability to work as autonomous practitioners by the point of registration. Del Bueno (2005) concludes that newly qualified nurses should

be expected to think critically and use clinical judgement in order to develop it. In conclusion the broader issues that have arose from this are that time needs to be taken to stop and think and consider whether whether the decision is meeting the patients needs.

The main learning, for future practice, is to make sure that the author is exposed to as many situations as possible to gain practical knowledge. In addition, theoretical gaps in knowledge need to be eliminated in future practice. The best attempt to engage with the patient needs to be sought in the future. If observation levels needs to be increased the decision should be weighed up against the patient being allowed to move freely and not feel restricted and Mental Health Act (2007) requirements of offering one to one-to-one sessions.