Constant Observation in the General Hospital: A Review

Sol Jaworowski, MBBS, FRANZCP, David Raveh MD,2 Elisabeth Lobel, MD,1 Arik Fuer,3 Cornelius Gropp, MD,1 and Joseph Mergui, MD1

1 Department of Consultation/Liaison Psychiatry, Shaare Zedek Medical Center, Jerusalem, Israel
2 Unit of Infectious Disease, Shaare Zedek Medical Center, Jerusalem, Israel
3 Department of Security, Shaare Zedek Medical Center, Jerusalem, Israel, affiliated with the Ben-Gurion University of the Negev, Beersheba, Israel

Abstract: The role of Constant Observation (COb) in the general hospital is addressed. The difficulties of managing acute psychological disturbance in the general hospital are described. Concerns about confused behavior and suicidal risk appear to be the most common reasons for ordering COb. Organic brain syndrome is the most common diagnosis made in patients receiving COb. Medico-legal, ethical and therapeutic aspects of COb are noted. To our knowledge there is no research evidence that COb significantly decreases the rate of suicide in the general hospital. It appears that the role of COb is enshrined in the general hospital as a result of medico-legal process in addition to its therapeutic role. Further research in this area is needed.

Introduction:

Constant observation (COb) is an intervention in which continuous one-to-one monitoring is used to assure the safety and well-being of an individual patient or others (1). In the general hospital, COb is most commonly recommended for patients who suffer from delirium (1). Concerns about the patient harming himself or others are further reasons for COb being ordered (2–4).

Management of Acute Psychological Disturbance in the General Hospital

Concerns about patient violence toward self or others generates considerable tension in the general hospital environment. The staff often feel a lack of expertise in dealing with these phenomena and the physical surroundings do not lend themselves to containment of acutely disruptive behavior. The comorbidity of physical and psychiatric pathology in the patient creates frustration in the treating staff particularly where overworked nursing resources are further stretched by needing to supervise patients often confused, who are prone to walk off the ward. There may be escalating confrontation between the patient and the staff leading to staff demands for discharge or transfer of the patient to a psychiatric setting. The patient may react negatively to the perceived rejection by general hospital staff creating further escalation of tension between patient and staff. If there is no psychiatric ward located in the general hospital campus, the process of transferring the patient to a psychiatric ward off campus may be a formidable task involving the patient, his/her family and COb staff. According to Israeli law (5), urgent involuntary psychiatric hospitalization in the Israeli general hospital setting is possible. The examining psychiatrist needs to consult with the District Psychiatrist in order to confirm that the patient's condition fulfils the criteria of altered judgement (mainly psychosis) together with immediate danger to self or others. Involuntary psychiatric hospitalization in Israel is therefore not limited to psychiatric centers.

It may be difficult to distinguish between a patient's transient psychological reaction to physical illness and a more entrenched psychological disturbance which existed prior to the patient's current illness. For example, the patient who voices active suicidal threats after being given unfavorable news of his medical condition places the treating staff in a dilemma: On the one hand, there is a duty of care to maintain the safety of the patient throughout the admission. On the other hand, psychiatric assessment...
in order to evaluate the patient’s risk status may reinforce the patient’s distress by psychiatric stigmatization. Following the assessment, the psychiatrist may resort to COb on a short-term basis if there is an ongoing concern regarding suicide risk. This intervention may cause the patient even further distress.

**Suicide in the General Hospital**

General hospital suicides occur between 2–5 per 100,000 hospital admissions and the most common method is by jumping from a high place (6). Patients who committed suicide during their general hospital admission had been admitted to hospital for treatment of a variety of illnesses including malignancy, chronic obstructive airways disease, cardiovascular disease and abdominal pains. They had also been admitted following attempted suicide (7, 8). Major depression was diagnosed in 66% of patients. Depression and substance abuse were found to be risk factors for patients who committed suicide shortly after having been discharged from a general hospital. Seventy-three percent of the patients suffered from one or both diagnoses (8). Severe anxiety and agitation were found to be acute predictors of inpatient suicide with 70% of patients denying suicidal ideation prior to the suicide (9).

In view of the association between general hospital suicide and clinical syndromes such as depression, agitation and substance abuse, early intervention for diagnosing and treating patients suffering from these high risk conditions are indicated. Reducing patients’ access to hospital windows through the use of window shutters and restricted opening windows is also suggested.

**Violence in the General Hospital**

Violence in the general hospital is most frequently manifested in the emergency room. It has been described in relation to patients’ complaints concerning pain management and ward regulations (10), and prolonged waiting in the emergency room (11). Verbal abuse of clinical staff has been reported as being very common with two-thirds of junior doctors in one study (12) reporting this on a weekly basis. One-quarter reported being physically assaulted. One-third of staff reported that they were preoccupied by the incident after work (11). Emergency room physicians who are less experienced are more likely to suffer verbal and physical abuse than their more experienced colleagues. Female physicians in the emergency room are more likely to suffer more physical abuse than male physicians (13). Various psychiatric diagnoses have been associated with violent behavior: organic mental disorder, personality disorder and substance abuse. Repeated violence by the general hospital patient is associated with high levels of the following psychiatric comorbidity: substance abuse, schizophrenia, personality disorder and bipolar disorder (14). Most violence in general hospitals does not originate in psychiatric disorders but rather from other non-Axis 1 problems.

Prevention programs to help staff avoid the escalating phase of tension between patient and staff have been described (15). The use of violence management teams to manage patients who exhibit violence in the general hospital has also been described (16).

**Role of COb in the General Hospital**

Although studies in the general hospital have confirmed that COb is frequently ordered for management of confusion/agitation (1) and suicide prevention (3) reduction of self harm has not been demonstrated through the use of this intervention. It is very difficult to predict which patient will attempt suicide with any sensitivity or specificity since suicide is such a rare event with multifactorial aetiology.

Substance abuse and personality disorder have high comorbidity in these COb populations. Male gender and single marital status predominate (1). The most frequent psychiatric diagnoses made in patients receiving COb are organic brain syndrome and mood disorder. However, a significant number of COb patients do not attract a psychiatric diagnosis (1).

In a recent study (17), the average duration of COb was 30 hours and the most frequent reason for the COb was concerns about suicide risk. The absence of an inpatient psychiatric unit in the general hospital in which the study was conducted may have created a bias in the use of COb for suicide prevention compared to other studies where organic brain syndrome is a more frequent indication for COb.
The only medical condition which was found to be significantly related to length of COb in this study was ischaemic heart disease.

A variety of COb providers are described in the literature (4) including registered nurses, nursing assistants, family members, security staff and volunteers. Training requirements of providers range from no training to on-going training. Some hospitals use multiple providers. The background of COb providers in major Israeli hospitals is summarized in Table 1.

The use of nursing staff for COb may be less stigmatizing than security staff for the patient and his/her family. However, the professional background of the staff member providing COb may be less relevant than his/her personality and physical characteristics which allow physical and emotional containment for patients at risk of harm to self or others. For example, the authors are aware of one case of COb in which a nurse of slight build was unable to restrain a patient from throwing himself out of a hospital window (personal communication with Dr. Rael Strauss, 2006). The authors consider that COb should include constant eye contact with the patient. The staff member should request another staff member to provide COb if he/she needs to use the toilet.

COb is usually authorized by a physician although a nurse may institute the order with a subsequent confirmatory order by a physician. Discontinuation of a COb order is authorized by a physician only, in the majority of cases (3).

Authorization of COb by a consultation-liaison psychiatrist has been shown to be cost effective (18, 19). Other cost saving interventions have been suggested for COb including consolidating bed space for patients in an intensive nursing area, requiring daily written renewal of the order, bed enclosure devices (20) and use of less expensive providers, including family members (3).

### Medico-Legal Considerations

An Israeli Supreme Court decision in 1999 (21) criticized a general hospital for not providing COb for a patient who was admitted after a serious suicide attempt. The patient subsequently committed suicide during the hospitalization. This decision is in line with other judicial decisions (22) which require the treating hospital to exercise a duty of care towards a patient with a known risk of self harm, such as following a suicide attempt. The Supreme Court interpreted the concept of “duty of care” to include COb.

In situations where there are acute concerns of risk to the patient or others, the general hospital staff...
are faced with the dilemma of ensuring the safety of the patient and having to restrict his/her freedom of movement. For example, the COb provider would be expected to restrain a patient, by force if necessary, from jumping out of a window as an urgent lifesaving intervention, even if the patient was under no compulsory treatment order. However, if the same patient insisted on leaving the hospital against medical advice without evidence of immediate medical or psychiatric risk the staff member could be prosecuted for assault if the patient was forcibly restrained. Adequate familiarization of staff with the mental health legislation is important, as is adequate consultation between the medical staff and the consultation-liaison psychiatrist.

Adequate documentation of decisions particularly where the patient discharges him/herself against medical advice is essential.

Ethical Considerations

The clinician should be guided by the principle of *primum non nocere*: “First do no harm” (23). COB is a coercive intervention which is often ordered for patients who would not satisfy the criteria for involuntary psychiatric treatment according to Israeli mental health legislation (5). COB is ordered in situations where the clinician, in consultation with a psychiatrist, considers that the patient manifests a significant risk of harm to self or others. This risk assessment is usually a dynamic phenomenon and will be affected by a number of variables including the patient's current medical treatment, his/her underlying physical and psychological condition and the level of social supports. It is therefore imperative both from an ethical and a therapeutic point of view that COB is explained to the patient and where appropriate to the patient's family so as to minimize the negative reactions of the patient and family associated with this intervention.

In the assessment of a patient who wishes to end his life in the setting of a general hospital, the psychiatrist needs to determine whether the patient is competent to make such a decision, taking into account the patient's underlying physical and psychiatric condition. This assessment also requires an adequate consultation with medical staff and providing adequate explanation to the patient and family. The patient's freedom of movement may need to be restricted in order to undertake this assessment.

The hospital also has a duty of care toward maintaining a safe working environment for patients and staff. In addition to duress alarms, video monitoring and the presence of security staff, the use of a computer flagging system to identify repetitively disruptive patients significantly reduced violent behavior among this group of patients in one study (24). Recurrent violent behavior of certain patients who present to hospital is described in particular psychiatric diagnoses (14). How can the hospital minimize the predictable risk of violence when staff attend to these patients? The hospital has a responsibility for maintaining confidentiality of patients' treatment among relevant clinical staff. A system of computer flagging patients with past disruptive behavior allows non-clinical staff to have access to the patient's medical management. Although this intervention is justifiable in terms of its aim of reducing the risk of hospital violence, it has ethical implications in relation to placing staff safety above patient privacy and stigmatization.

The role of family members providing COb for a suicidal patient in the general hospital is problematic from an ethical as well as a medico-legal perspective. This arrangement implies that the hospital transfers responsibility for maintaining the patient's safety to the family. It is also problematic from a logistic perspective since this requires adequate manpower operating on shifts with a full explanation of the inherent risks. In the authors' experience, family members who object to COb by hospital staff are amenable to discussion with the liaison psychiatrist away from the patient's bedside.

The scenario of discharging a patient to his/her home after COb often elicits the justifiable reaction from family members: "If you considered our family member to be at risk during the hospitalization so as to require COb, how can you discharge him/her to go home now without any supervision?" Families' concerns are more acute when the family member was hospitalized following a suicide attempt and the patient refuses medical recommendation for psychiatric hospitalization.

A discussion about the hospital's duty of care toward inpatients seen to be at risk and the patient's right to refuse psychiatric hospitalization where he
or she does not satisfy the criteria for urgent involuntary hospitalization does little to allay the family’s anxiety. The liaison psychiatrist may need to say to the patient:

“You tried to kill yourself and you may still have thoughts of killing yourself by jumping from a hospital balcony. I cannot stop you from killing yourself after your discharge from hospital but I will do my best to stop you from killing yourself while you are a patient of this hospital.” This approach of involving the patient, willing or unwilling, in taking responsibility for his/her management requires a consistent approach from the clinical team. The family of the patient should also be recruited to participate in this pragmatic treatment plan. Clearly, the patient’s underlying distress should be addressed in tandem with measures to reduce his/her risk status. The liaison psychiatrist needs to provide an adequate understanding of the patient’s underlying emotional difficulties and resources to the rest of the treatment team and to the patient’s family so as to make recommendations regarding post-discharge management.

**Therapeutic Considerations**

COb should be used as part of the clinician’s patient-centered treatment at a time of crisis. It should be discussed in an open and transparent way both with the patient and where appropriate with the patient’s family.

The staff member providing COb should be seen as part of the therapeutic team and be provided with sufficient clinical information regarding the patient’s current crisis. The primary role of the COb staff is not to provide treatment for the patient but rather to provide containment so as to allow assessment and treatment to take place. However, in the course of such observation, a supportive relationship may develop between the patient and a given staff member. The extent of such a relationship will be affected by patient variables, staff member variables and the nature of the patient’s underlying crisis. For example, in the authors’ experience, adolescent patients following a suicide attempt may be more likely to develop a more significant relationship with one or more staff members.

Simple measures such as allowing a confused, irritable patient to walk out of the emergency room or medical ward under the supervision of COb staff to smoke a cigarette may be very helpful in reducing the patient’s anxiety, for example where nicotine withdrawal may be a factor contributing to the patient’s anxiety.

Staff members need to be aware of patient confidentiality issues. For example they should practice discretion when communicating the patient’s clinical details to their colleague at the end of their shift so as not to broach patient confidentiality in front of other patients.

Concerns about the stigmatizing effect of COb occasionally arise in relation to patients with substance abuse and family members of patients following suicidal behavior. Feelings of anger or distress regarding the patient may be displaced toward the staff member providing the COb. Therefore, it is important that there should be regular workplace discussion of problematic patient interactions with input from psychiatric staff. For example, the authors are familiar with a staff member who complained of acute distress following a dramatic episode of restraining a patient who had attempted to jump from a hospital window. The staff member was diagnosed as suffering from an acute stress reaction. Brief psychological treatment of the staff member was successful in reducing the intensity of the reaction to the point where the staff member could return to work.

Where possible, the COb provider should be of the same gender as the patient, particularly where issues of past sexual abuse or religious modesty are relevant. Otherwise the COb may be perceived by the patient as a further traumatic event.

In one study, 28% of patients rated their COb in negative terms (17). There was a trend for older patients to view COb as punitive, especially in those patients with a history of substance abuse. Younger patients tended to rate COb more positively and some even described the interaction with the COb staff member as a therapeutic experience. The reaction of the patient and provider to COb is a subject that requires further research (25).

**Recommendations**

COb in the general hospital will continue to be a prevalent phenomenon with increasing medico-
legal awareness of the hospital’s duty of care toward patient and staff. General hospital staff is required to care for medically ill patients who suffer from comorbid psychological/psychiatric conditions which may endanger the safety of themselves and/or their surroundings. COb should be used as a therapeutic intervention which is clearly explained to both the patient and his/her family. In most cases, this intervention is only necessary on a short-term basis during the patient’s crisis.

Confusion in the patient is a common reason for ordering COb. Therefore, early assessment and management of patients’ disorientation through the use of night light, pictures or presence of family members may minimize the need for COb (1). Rapid, effective use of psychotropic medication may also be useful in this regard.

COb staff should receive work-based training in managing common psychiatric conditions to improve their communication and interaction with their patients.

COb should be reviewed at least daily by the consultant psychiatrist in order to monitor the patient’s strategies for coping with the crisis and to assess the ongoing need for COb.

There is currently no research data to demonstrate that COb is effective in reducing the prevalence of suicide or violence in the general hospital. Ethical practice prevents the implementation of a study involving random allocation of COb in a clinical setting. However, a study comparing the frequency of critical events of harm to self or others occurring in two general hospitals which differ in COb provision would provide some data to support the efficacy of COb.

Acknowledgements

We would like to acknowledge the devoted secretarial assistance of Mrs. Yedida Ponger.

References


22. ca: McNamara vs. Honeyman, NE 2d 139, Mass. 1989, 146–147, USA.

