‘More than a sitter’: a practice development project on special observation in acute general hospital care

Project team: Deidre Connors and Beverley Mills
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Project background

The project was undertaken in a district general hospital in East Sussex, south-east England. It was triggered by a number of patient safety incidents that resulted in significant harm, findings from a literature review on special observation and improvement factors identified from an audit. While special observation is a common nursing activity used with older people with dementia and/or delirium, there appears to be an inadequate evidence base and a lack of clarity about its use, what it means and how it is experienced.

Aims and objectives

A number of aims and objectives for the project were identified. The key aims were to:

- Introduce person-centred and evidence-based special observation into a trial ward
- Transfer the approach more widely across the trust

The related objectives were to:

- Enhance nursing assessment of the need for special observation
- Develop expertise in knowing what type of special observation is needed and empower staff to initiate and review levels of observation with the multidisciplinary team when required
- Enhance the team’s skills and competence in working with people who have mental health needs and require special observation
- Enhance the documentation of special observation to include assessments, reassessments and (de)escalation as required

Implications for practice

- Patient safety issues can be an important trigger for person-centred approaches to improvement projects and help place focus on cultural issues rather than just policy development
- Project teams need to identify a range of strategies to enable ongoing project engagement, as operational issues can distract attention from the project focus
- Continuing evaluation of progress is important to ensure that all staff have the appropriate knowledge and skills to engage in the project and to create opportunities to put new learning into practice
- A range of approaches to information dissemination may be necessary to encourage wider implementation of best practice

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Online

Further information about the project can be accessed from: fons.org/library/report-details?nstid=71703

Key activities and outcomes

• Identification of project management group and implementation group

A small project management group was set up to meet monthly. A core group of staff on the trial ward formed the implementation group; this group was made up of all grades of ward staff so as to provide a ‘bottom up’ approach that would encourage ownership of the project.

• Collection of baseline evidence on the trial ward

The project leaders and implementation group collected baseline evidence of current practice on the trial ward using quantitative and qualitative data.

• Staff education and development

A review of the evidence identified staff education needs. Following discussions with learning and development and with mental health liaison, a training session was developed around therapeutic engagement for all members of the ward team to attend. After attending a session participants were invited to identify a change they would make in their practice or in the ward environment – for example, the creation of rummage or reminiscence boxes.

• Promoting better understanding of trust policy

Baseline evidence indicated team members found the trust’s special observation policy difficult to understand. A flowchart aimed at simplifying the implementation process was therefore created and trialled on the ward. It was intended to act as a guide to enable staff to implement the correct level of observation in a timely and effective way. Feedback and evaluation of the flowchart was gathered via questionnaires. This revealed there was still some confusion about the level at which to commence special observation. Consequently a special observation risk assessment tool was created by adapting the National Patient Safety Agency risk matrix (tinyurl.com/NPSA-risk). The tool was trialled on the ward and informal feedback indicated it was well received.

• Trustwide implementation

To enable the transfer of good practice across the trust, a PowerPoint presentation and accompanying narrative have been developed to go alongside the policy, flowchart and risk assessment. All have been shared on the trust intranet and communicated through the usual channels. However, encouraging staff to engage with this information has proved challenging and there are ongoing initiatives to ensure trust policies are understood and implemented in relation to special observation. A more face-to-face approach is being adopted, with team members going to the wards to meet with staff to talk about the policy and how it can be implemented locally.

• Project evaluations

Staff felt more positive about their role, having a fuller understanding of the use of special observation and feeling more confident in assessment and implementation of the special observation policy and practice. Ongoing education has been identified as essential to maintain skills, knowledge and confidence, and to ensure special observation is prioritised.