

# Adverse Events



## INTRODUCTION

Suicide research has led to standard predictors of risk by several authors. As many as 78 percent of psychiatric inpatients denied suicidal ideation at their last communication, 51 percent were on 15-minute checks or one-on-one observation, and 28 percent had a “no suicide contract” in effect.<sup>1,2</sup> Factors that are root causes of suicide have been described as related to the environment,<sup>2</sup> failure to evaluate patient characteristics, and regular evaluations of risk. Both Busch et al<sup>1</sup> and Hermes et al<sup>4</sup> recommend assessment of anxiety and agitation as critical factors to be assessed. Tools used to assess risk have failed to predict risk in the short run.<sup>3,4</sup>

Problems encountered in documentation of 15-minute checks that warrant their discontinuation include the high use of nursing resources, difficulty in documentation because of other responsibilities, and poor communication with other team members about patient behaviors. Among problems noted in the use of 15-minute checks are the lapses in documentation, completed suicide during their use, and wide variation in the use of terminology and practice.<sup>5-7</sup> Also, when several patients on a unit of service are placed on 15-minute checks by different treating teams, the realistic time needed to check on each patient would require a full-time equivalent of nursing or more. With other unit demands needing nursing attention, such as therapeutic interactions, running groups, dispensing medications, coordinating meetings, and communicating with colleagues, both conducting and documenting such checks may be neglected.<sup>7</sup>

Although observation of psychiatric inpatients is a fundamental nursing skill, with

## The Utility and Effectiveness of 15-minute Checks in Inpatient Settings

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### ABSTRACT

Implementing harm reduction is among the administrative tasks used for maintaining a safe unit for psychiatric in-patients. Such harm may be potentially caused by patients themselves or others. Included in nursing procedures implemented for observing suicidal patients is the practice of 15-minute checks. In reviewing the standard forms used for such procedures in several major hospitals across the United States, we noticed a wide variation in the format and use of 15-

minute checks, as well as poor guidelines for their termination. We recommend that the observation practice of 15-minute checks be eliminated from the repertoire of nursing protocols for suicidal patients who are assessed to be at imminent risk for self harm on inpatient units.

### KEYWORDS

15-minute check, psychiatric hospital, suicide, suicide risk, patient observation, suicide prevention protocol

present-day economic challenges in unit management, such duties are often delegated to trained observers, nurse extenders, and ancillary staff.<sup>8</sup> The skill level of observers varies with the institution, level of training, and exposure to psychiatric patients. Degrees of intrusiveness and lack of privacy imposed by the practice of observation may guide the decision to place a patient on 15-minute checks.<sup>7</sup>

## METHODS

Prior to a formal evaluation at a monthly meeting of nursing and attending physician staff of an observation protocol regarding 15-minute checks, nursing staff called three major academic centers and three community hospitals and requested copies of their 15-minute check policies. Forms were made available by Duke University Hospital (Durham, North Carolina); Massachusetts General Hospital (Boston, Massachusetts); and NewYork-Presbyterian/Weill Cornell Medical Center (New York, New York). We requested but did not obtain a form from Stanford University Hospital (Palo Alto, California). Among community hospitals, we obtained forms from Howard County General Hospital (Columbia, Maryland); Inova Fairfax (Falls Church, Virginia); and Hartford Hospital (Hartford, Connecticut). We reviewed the forms for indications for 15-minute checks, documentation requirements, and reasons for its discontinuation.

Also, nurses called and interviewed the nursing staff of Massachusetts General Hospital, Duke University Hospital, University of Maryland Hospital (Baltimore, Maryland), the Mayo Clinic (Rochester, Minnesota), Case Western Reserve University Hospital (Cleveland, Ohio), Bellevue Hospital (Bellevue, New York), and Vanderbilt

University Hospital (Nashville, Tennessee) regarding the use of close observation, its prescription and discontinuation, shift assignments, and deployment of 15-minute checks.

The questions focused on staff assignments, use of observers/sitters, responsibility to prescribe and discontinue 15-minute checks, and other observation methods or step-down procedures for patient safety.

## RESULTS

Orders were written by physicians, but the discontinuation policies were not uniform and often vague. In some hospitals, physician assistants or nurse practitioners could initiate an order.

Units ranged from locked to step-down, open-door units and private to semi-private rooms. Both in-house and agency observers were used in hospitals. State laws governed the use of agency observers.

In our brief survey, we noted that some of the forms included check boxes for indications for restraints and seclusion included with 15-

compromising patient safety. The forms were lengthy in some cases, difficult to read, and cumbersome to use. No hospital had a form just for 15-minute checks. Family members were not to be used for observation as noted by one hospital. The meaning of checks varied from direct observation of the patient to patients checking in with nurses every 15 minutes. These checks were used by one hospital for routine monitoring at admission for all patients; at times, 25 percent of the patients were on such an observation.

Fifteen-minute checks were permitted by one hospital for patients who may “elope, act out sexually, violently, or other acting out behaviors.” Only one community hospital clearly spelled out the need for exchange of information between nurse and physician and the frequency of such a communication.

In 2009, we performed a Failure Modes Effects Analysis of close observation, with a view to standardize practice and to identify critical areas of possible failure in the flow of communication as well as

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minute checks. Some had no clear forms, but had brief narratives for observation levels, and the documentation varied from a detailed notation every 15 minutes on a flow sheet with activities noted, to a prescription of clinical indicators for their use, to the use of close observation by an observer for all patients at risk of varied behaviors

practice. Nurses verified that 1) they did not communicate with observers in a standardized fashion; some nurses did not communicate adequately with observers regarding specific instructions on a patient's risky behaviors; 2) observers had different skill levels and were often distracted when patients were inactive and in bed; 3) dedicated,

well-trained observers were limited; 4) timing issues interfered with adequate handoffs to the next shift; and 5) observers had no vehicle to communicate their observations, which may have been helpful to the treating team.

While performing a Failure Modes Effects Analysis of close observation, the consensus of all disciplines from doctors to observers resulted in the identification of the nurse observer interface as the most susceptible to breakdown and lack of proper handoffs.<sup>8</sup>

Fifteen-minute checks are among the protocols implemented on inpatient units to protect patients. The definition of this practice, the indications for use, its implementation, and its application to various levels of illness severity begs for an examination of the most frequently used psychiatric procedure—observation of patients.

## DISCUSSION

Regardless of practice, factors that influence inpatient suicide risk are related to improper treatment of anxiety and agitation, therapeutic relationships with patients, the treatment environment, and lack of a comprehensive evaluation of the patient's behavior, such as hopelessness and other factors.<sup>1,2,4,9,10</sup>

Although scales appear to have the potential to predict risk, as does experience and a thorough clinical assessment, the final pathway to managing at-risk patients is the practice of observation. Regardless of patient characteristics, environment, disease, or behavior, the common practice of observation is only as effective as the training, attitude, and skill of the observer. Distractibility, fatigue, boredom, and watching several patients at one time

to decrease costs could all interfere with such a practice.

Critical to the use of 15-minute checks is the identification of the behaviors that indicate its implementation. Team leadership and communications among team members is the key to the effectiveness of the protocol. The benefits of placing the patient on 15-minute checks versus the risk of not doing so must be spelled out in a clinical risk assessment in the psychiatrist's notes. Also, the changes in the patient's behavior

must be documented as well. The role of acute psychosocial stressors must be documented and evaluated: For example, a phone call from a loved one or acrimony between the patient and his lawyer or landlord can tip the scales.<sup>9</sup>

No national guidelines exist for 15-minute checks in the United States. Similarly, authors in England and Wales found a wide variation in terminology and practice, increasing the potential for confusion and risk to patients.<sup>6</sup> We noticed a similar wide variation in existing policies and practices in the United States as well. One author found that among 98 hospitals surveyed, 15-minute checks were the most frequently used type of observation, ranking first or second in the survey. Increased need for staffing was the most frequently cited reason for not

using one-on-one observation. In one audit of 31 cases of completed suicide or serious self harm in inpatients who were under observation of some sort, Gournay, a forensic expert in England, called for the setting of national standards, having noted a wide variation in observation policy and practice.<sup>11</sup> A proactive approach is used at the Elmhurst hospital in New York and at Johns Hopkins Hospital in Baltimore, Maryland,<sup>12</sup> which includes placing patients on observation at the nurses' own discretion if a psychiatrist's evaluation is still pending. Risk-monitoring studies also show that tools and practices recommended earlier in the literature lack the sensitivity to assess risk for individual patients at specific points in their care.<sup>13-15</sup>

## CONCLUSIONS

Fifteen-minute checks are among the protocols implemented on inpatient units to protect patients. The definition of this practice, the indications for use, its implementation, and its application to various levels of illness severity begs for an examination of the most frequently used psychiatric procedure—observation of patients. The practice of using observers, the least trained among nursing caregivers, is fraught with pitfalls. Given that the prediction of suicide is difficult at best and noting that suicides often occur while patients are placed on 15-minute checks, we strongly recommend the avoidance of its use for suicidal patients. We recommend the use of close observation (one certified observer to one or more patients), one-to-one observation (one certified observer to one patient), or observation by skilled nursing staff when a patient must be within an arm's reach of the observer. We also recommend adequate training of observers, the

use of a standardized patient data support sheet identifying target patient behaviors, and the eliciting of systematic feedback from observers at each shift in a methodical manner.

## REFERENCES

1. Busch KA, Fawcett J, Jacobs DG. Clinical correlates of inpatient suicide *J Clin Psychiatry*. 2003;64:14–19.
2. Lynch MA, Howard PB, El-Mallakh P. Assessment and management of hospitalized suicidal patients *J Psychosoc Nurs Ment Health Serv*. 46;45–52.
3. Grant JE. Failing the 15-minute suicide watch: Guidelines to monitor inpatients *J Fam Pract*. 2007;6:41–43.
4. Hermes B, Deakin K, Lee K, et al. Suicide risk assessment-6 steps to a better instrument. *J Psychosoc Nurs Ment Health Serv*. 2009;47:45–49.
5. Proulx F, Lesage AD, Grunberg F. One hundred in-patient suicides *Br J Psychiatry*. 1997;171:247–250.
6. Bowers L, Gournay K, Duffy D. Suicide and self-harm in inpatient psychiatric units: a national survey of observation policies. *J Adv Nurs*. 2000; 32:437–444.
7. Neilson P, Brennan W. The use of special observations: a audit within a psychiatric unit. *J Psychiatr Ment Health Nurs*. 2001;8:147–155
8. Janofsky JS. Reducing inpatient suicide risk: Using human factors analysis to improve observation practices. *J Am Acad Psychiatry Law*. 2009;37:15–24.
9. Kettles AM, Moir E, Woods P, et al. Is there a relationship between risk assessment and observation level? *J Psychiatr Ment Health Nurs*. 2004;11:156–164
10. Cheung P. Suicide precautions for psychiatric inpatients: a review. *Aust N Z J Psychiatry*. 1992;26:592–598.
11. Green JS, Grindel CG. Supervision of suicidal patients in adult inpatient psychiatric units in general hospitals. *Psychiatr Serv*. 1996;47:859–863.
12. Sullivan AM, Barron CT, Bezmen J, et al. The safe treatment of the suicidal patient in an adult inpatient setting: A proactive preventive approach. *Psychiatr Q*. 2005;76:67–83.
13. Temkin TM, Crotty M. Suicide and other risk monitoring in inpatient psychiatry. *J Am Psychiatr Nurses Assoc*. 2004;10:73–80.
14. Powell J, Geddes J, Hawton K, et al. Suicide in psychiatric hospital inpatients: Risk factors and their predictive power. *Br J Psychiatry*. 2000;176:266–272.
15. American Psychiatric Association. Psychiatry online. Practice Guidelines. Accessed May 2010. [www.psych.org](http://www.psych.org)

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