Continuous special observation (CSO) is defined as an intervention in which an inpatient staff member is assigned to observe one patient at all times, including while they toilet, bathe and sleep, to prevent violence directed towards self or others. Some patients who are at high risk of suicide and are unable to discuss their suicidal thoughts or impulses do require this level of care. However, most patients can be treated with interventions based on engagement.

Why avoid CSO

CSO is based on control and coercion. CSO restricts a patient’s privacy as well as the ability to make decisions independently of the observing staff. It is considered a containment procedure and is often studied alongside restraints, seclusion and forced injections (Bowers, 2006). CSO is intense and intrusive which often increases the observed patient’s anxiety. Violent patients can become more agitated with increased risk to act on violent impulses. This places the staff observing these patients at high risk to be assaulted. It is for this reason that patients at risk of violence should not be placed on CSO. CSO is also a very time intensive intervention drawing nursing care from the rest of the unit to focus on one individual patient which might have deleterious effect to the rest of the milieu. Finally CSO is a custodial intervention designed to mitigate violence but does not treat the underlying condition and symptoms

Alternative nursing protocols to CSO

Psychiatric Nursing Availability (PNA) designed for suicidal and self-injurious patients.

The therapeutic value of CSO is not in the staff member watching the patient at all times, but in the staff member being available so the patient can talk about the thoughts and feelings that cause the self-directed violent impulses. PNA is based on the concept that the staff partner with the patient in coping with their impulses, so the patient is not alone with his or her struggle. According to Cutcliffe (2007), patients who are suicidal often feel “disconnected from humanity” and nurses can treat the patient’s suicidal thoughts through a relationship based on engagement, which inspires hope and reduces the feelings of isolation. When a patient is placed on PNA, staff are made available to the patient at all times (not to watch them!). The patient’s primary nurse assists the patient in developing the Psychiatric Nursing Availability agreement (below). The nurse helps the patient identify circumstances which lead to the suicidal and self-injurious thoughts and explores coping skills with these violent thoughts or impulses. This Plan is created jointly with the nurse and patient which reinforces the nurse’s partnership in helping the patient cope. The PNA agreement can be adjusted to meet the needs of the patient. The patient’s door is left open to reinforce the connection with the staff, however most patients do not require having a staff member be in the room when using the bathroom so this can be adjusted while creating the agreement. The most important aspect of PNA is the relationship based on engagement not on where the staff is in relationship to the patient.
**Psychiatric Monitoring and Interventions (PMI)** designed for violent, threatening, intimidating, sexually and socially-intrusive, grossly psychotic, those who wandered into other patients’ rooms, or who were elopement risks.

PMI, is used along with intermittent observations to support the individual’s efforts to effectively cope with aggressive impulses and maintain overall safety. Like PNA, the interventions are embedded in a relationship based on engagement. Interventions are implemented in a supportive and caring manner to reinforce this relationship. The concepts supporting PMI are based on Bailey’s (1977) work which identified the following elements that must be present in order for violence to occur: a target, a trigger, a weapon, and a state of arousal. Management of these four elements became the conceptual framework for all interventions. Similar to PNA, staff members are assigned to be available to these violent or impulsive patients. However, unlike PNA, where the patient shared the responsibility for their self-directed violent behaviors, the staff are responsible for manipulating environmental stimuli to remove one or more of the aforementioned triggers, assuring the safety of others. Psychiatric Monitoring and Intervention allows the patient to remain in their assigned room alone with the door closed to decrease stimuli and increase a sense of privacy. The staff remained nearby in the adjacent dayroom, available to respond to sounds of agitation coming from the room, while being available to support the general milieu. The staff monitors the violent or impulsive patient closely when outside the room and offer limits and redirection. The most important aspect of PMI is the care plan created by the nurse to address the individual needs of the patient while maximizing patient participation and stabilization of the milieu.

A detailed description of these protocols can be found in Ray R., Perkins E., & Meijer B. (2011).

Any questions regarding these protocols can be forwarded to rray@nmh.org

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**References**


13 (3) 172-180


Psychiatric Nursing Availability agreement

Psychiatric Nursing Availability is a level of observation used to help you with thoughts or feelings of wanting to harm yourself. A staff member will be assigned to be available to assist you with these thoughts or feelings. It is expected that you will talk to this staff member at any time for help with these issues. In order to share the responsibility of maintaining your safety and the safety of others, the following will occur:

1. You will be expected to attend groups, unless otherwise specified in your treatment plan. A staff member will be available to you during this time.

2. The door will always be open to your room.

3. While you are using the bathroom; the door will be opened/closed. (circle one)

4. Prior to each meal, you and your assigned staff will discuss any necessary changes to your meal arrangements in order to help you maintain your safety.

5. Which personal belongings do you not feel safe having?

   ____________________________________________________________
   ____________________________________________________________
   ____________________________________________________________

6. Identify what activities you can do to help with these thoughts or feelings.

   ____________________________________________________________
   ____________________________________________________________
   ____________________________________________________________
   ____________________________________________________________
   ____________________________________________________________
   ____________________________________________________________

Witness: _______________________  Patient’s signature: _______________________

DATE: _________________________ Time: _________________________________