Cumbria Partnership
NHS Foundation Trust

Policy Title: Enhanced Engagement and Supportive Observations Policy (CPFT)

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Policy On A Page

SUMMARY & AIM

The aim of this policy is to provide guidance and a structured framework for the use of enhanced engagement and supportive observations across Cumbria Partnership NHS Trust.

The policy provides a framework for all in-patients in accordance with their assessed level of risk and identified needs. The aim being to ensure a consistent and effective approach to patient observation, engagement and support within in-patient services across the Trust

This policy will provide in-patient staff with guidance on the standards expected of them in making decisions about observation levels, carrying out observations, documentation and training

TARGET AUDIENCE:

It applies to all clinical staff working on all Adult Acute, Psychiatric Intensive Care unit (PICU), Dementia, Learning Disabilities and Older Adult mental health wards, though will be used primarily by nursing and medical staff

TRAINING:

Trust Mandatory training

KEY REQUIREMENTS

Mental health staff have an overriding duty of care to maintain the safety and wellbeing of service users at all times especially when they pose a risk to their own or others safety. The observation of a patient is one intervention that may help to maintain their safety or to maintain ongoing therapeutic care needs.

All patients will be observed whilst they are on a Mental Health, Learning Disabilities or Dementia Assessment in-patient unit in CPFT. The level of observations will vary according to the individual needs of the patient and will link to their risk assessment and care plans.

Staff will know the levels of observation and how they are implemented, as well as the process for reviewing and documenting any changes or other decisions made in line with the individuals care plan and Risk assessment

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1. INTRODUCTION

Enhanced Engagement and Supportive observations form a key intervention in the delivery of safe and therapeutic in-patient mental health and Learning Disabilities care. The use of supportive observations have been subject to debate with a range of views expressed about their effectiveness in reducing and managing risk and the impact they may have on the privacy and dignity of service users (Bowers and Simpson 2007, Dodds and Bowles 2001). The largest study conducted in England found that intermittent observations were associated with reduced incidents of self-harm on acute wards (Bowers et al 2007). However, there are also a number of incidents each year of patients managing to abscond and commit suicide whilst on continuous observations (Bowers et al 2006). Mental health staff have an overriding duty of care to maintain the safety and well being of service users at all times especially when they pose a risk to their own or others safety. The observation of a patient is one intervention that may help to maintain their safety or to maintain ongoing therapeutic care needs. It should however be seen as one of a range of interventions which all contribute to effective risk management. Staff have to weigh up the need for positive risk taking using the least restrictive practice verses supportive observation

Enhanced Engagement and Supportive observations will be used in this Trust for a range of risk related behaviours such as those listed below

- Risk to self including deliberate and accidental suicide and self-harm, thoughts and plans about harm to self.
- Risk to others including actual attacks, thoughts of harming others, symptoms of mental illness such as paranoid ideas where the patient believes others pose a threat.
- Known risk indicators including escape, absconding and going missing from the ward, vulnerability and exploitation, sexual behaviour and safeguarding issues
- Physical health risks including effects and side effects from medication.
- General risks through activities of daily living e.g. choking, risk of falls, cognitive impairment.
- Monitoring of mental state.
- Where Self Control is reduced
- Recent Loss
- Maintaining a safe environment, and assisting with Activities of Daily Living for those who do not have the capacity to do so for themselves Type here using normal text

1.1 Scope

The aim of this policy is to provide guidance and a structured framework for the use of enhanced engagement and supportive observations across Cumbria Partnership NHS Trust. It applies to all clinical staff working on all Adult Acute, Psychiatric Intensive Care unit (PICU), Dementia, Learning Disabilities and Older Adult mental health wards, though will be used primarily by nursing and medical staff. This policy places enhanced engagement and supportive observations within the risk assessment and risk management process used across the Trust.
(Clinical Risk Policy (POL/001/017).

The policy provides a framework for all in-patients in accordance with their assessed level of risk and identified needs. The aim being to ensure a consistent and effective approach to patient observation, engagement and support within in-patient services across the Trust. This policy is based upon recommendations from National Institute for Health and Clinical Excellence (NICE) NG 10 (2015) and is intended to address the mental health needs of patients who are considered to be vulnerable

2. PURPOSE

This policy will provide in-patient staff with guidance on the standards expected of them in making decisions about observation levels, carrying out observations, documentation and training requirements.

This policy will also aim to encourage the development of therapeutic interaction/ engagement with service users that keeps a balance between intrusion and safety. To justify the level of observation for each service user as proportionate to the degree of risk they pose to either themselves or others.

Effective engagement with service users underpins effective observation.
The policy describes only what is required in terms of service user observation and is not prescriptive in relation to the development of therapeutic interventions and engagement. These should be determined and recorded in individual care plans and support effective risk assessment and management.

3. OBSERVATIONS POLICY

3.1 Principles of Observation

Patients are observed primarily due to risk to self or others or for their general wellbeing and welfare on an in-patient unit. Observation is not a custodial activity, therefore, the act of observing patients should be more than ‘seeing’ them. Observations should be viewed as a therapeutic intervention in which there should be some benefit for the patient. This benefit needs to outweigh the impact of observations on the patient privacy and dignity or where it is counter productive to their recovery and the fact that some patients often see observations as intrusive and unhelpful. Consideration should be given to the

use of activity, discussion and distraction processes, but recognition should also be made of the need for silence and as much privacy as is safely achievable. While the safety of the patient always comes first, the encouragement of communication, listening and conveying to the person that they are valued and cared for are important components of skilled nursing observation. Observing a patient who is deeply distressed is an important task and calls for empathy, engagement and readiness to act in the best interests of the patient.

All patients should be informed of the level of observation which has been assigned to them and where possible they should be engaged in the assessment and decision making process to determine the level of observation. The patient should be told when the observations will be reviewed and what will happen whilst they are being observed e.g. times of staff change-over, access to activities etc. The aims and level of observations should also be communicated to the nearest relative, friend or carer with the patient's approval and in accordance with the MHA 1983 Code of practice (2008). For those lacking capacity the levels of observation will be discussed with the nearest relative, family members or patients advocate.

Using observation

- Use observation only after positive engagement with the service user has failed to dissipate the risk of violence and aggression.
- Recognise that service users sometimes find observation provocative, and that it can lead to feelings of isolation and dehumanisation.
- Use the least intrusive level of observation necessary, balancing the service user's safety, dignity and privacy with the need to maintain the safety of those around them.
- Give the service user information about why they are under observation, the aims of observation, how long it is likely to last and what needs to be achieved for it to be stopped. If the service user agrees, tell their carer about the aims and level of observation.
- Record decisions about observation levels in the service user's Care Plans and clearly specify the reasons for the observation.

When deciding on levels of observation take into account:

- the service user's current mental state
- any prescribed and non-prescribed medications and their effects
- the current assessment of risk
- the views of the service user, as far as possible.

Record clearly the names and titles of the staff responsible for carrying out a review of observation levels and when the review should take place.

Staff undertaking observation should:

- take an active role in engaging positively with the service user
- be appropriately briefed about the service user's history, background, specific risk factors and particular needs
- be familiar with the ward, the ward policy for emergency procedures and potential risks in the environment
- be approachable, listen to the service user and be able to convey to the service user that they are valued.

Human Rights issues

The European Convention on Human Rights (ECHR) has been enshrined in United Kingdom law since 2000. The provisions indicate that everyone has the right to respect for his/her private life (Article 8). No service user should therefore be subject to unnecessarily intrusive observations in a way that would breach this right. In order for this policy to comply with the law observation must be Justified: the ECHR permits breaches of Article 8 that are necessary for one or more of the following reasons:

- The interests of national security, public safety or the economic well-being of the country; or
- The protection of disorder or crime; or
- The protection of health or morals; or
- The protection of the rights or freedoms of others;
- Proportionate: even if the use of observations is considered justified, it will only be lawful if it goes no further than is reasonably necessary in each individual case to achieve the relevant objectives. When operating this policy clinicians will need to make sure that the use of observations remains ‘proportionate’ and that it is no more intrusive – nor continues longer – than is required by the circumstances.

3.2 Clinical Decision Making re Observations

Observation levels should be determined by effective clinical decision making. A summary of the process of clinical decision making, recording and reviews in relation to observations has been presented in diagrammatic form in Appendix 1

When a patient is first admitted to an in-patient unit a member of nursing staff will review the risk assessment, risk management plan, care plans and information received by the CMHT/ ALIS team/ AMHP etc, and following discussion with the admitting team, will determine the patients initial level of observations .

All in-patients will have a risk management care plan formulated on or within the first 4 hours of their admission This will detail the patient's level of observations in addition to other interventions being used to manage/reduce risk. The procedure for increasing/decreasing observation levels is further detailed in section 6.5 and section 6.6.

3.3 Observation Levels

All patients will be observed whilst they are on a Mental Health, Learning Disabilities or Dementia Assessment in-patient unit in CPFT. The level of observations will vary according to the individual needs of the patient and will link to their risk assessment and care plans. Observation levels other than Level 1 (Low level intermittent observations) should only be used if all alternative treatment options considered would not provide adequate safety for the patient.

Observation levels fall into four categories:

Level 1 – Low level intermittent Observations (frequency every 30-60 mins)

Level 2 – High Level intermittent Observations (frequency every 15-30 minutes)

Level 3 – Continuous Observation and Engagement (within eyesight)

Level 3 – Continuous Observation and Engagement (within arms length)

Level 1 - General Observations (Low level observations)

This is the minimum acceptable observation level for all in-patients aged 18 and over. The location of all patients should be known to staff though not all patients will need to be kept in sight.

- At least once per shift a staff member should set aside dedicated time to assess the mental state of the patient and engage positively with them. This should be documented in the patient's clinical records. The aim should be to develop a positive caring relationship with the patient. Assessment should always include an evaluation of the patient's mood, risk related behaviour and general wellbeing.

- The nurse in charge will allocate staff to undertake observations for the duration of their shift. A staff member will be allocated to check on the whereabouts and wellbeing of all Level 1 patients at hourly intervals, on the hour.

- The observations will be recorded on a Level 1 observation record. A template has been provided in Appendix 2. The only variation on the

form will be the numbers of beds on the ward. Once each form is completed they will be filed centrally by the ward administrator/ ward manager and stored on file in accordance with the Health Records Management Policy (POL/002/008).

- If there are any patients not accounted for or any concerns noted this must be reported to the nurse in charge of the shift who is responsible for taking action as appropriate and as specified in the risk management / Care Plan e.g. carrying out a search, implementation of Users Missing/ AWOL Procedure (POL/001/009).

- Patients who are placed on Level 1 general observation following the admission assessment must have their risk management care plan reviewed at the 48 hour review or MDT, or sooner if any changes identified would require a change of observation level

- Following the 48 hour review, patients on Level 1 observations must have a review of their risk and risk management plan/ Care plan at a maximum of 7 day intervals or sooner if there is any change in their presentation, or risk related incidents occur.

- The only patients who will not be managed on Level 1 observations are patients aged 16-17 years old who are admitted to a mental health unit. They MUST be placed on Level 2 or Level 3 observations at all times.

Level 2 - Intermittent Observation and Engagement (High level observations)

Level 2 Intermittent observation is an intermediate stage between Level 1 observation and Level 3 continuous observation. It involves intermittent checks on the patient's exact whereabouts and their well-being, and again the member of staff carrying out this responsibility should seek to engage positively as well as to ensure the safety of the service user and the safety of others. Checks need to be carried out sensitively in order to cause as little intrusion as possible. This level is appropriate when patients are potentially, but not immediately, at risk of disturbed/ violent behaviour.

Patients who have been at risk of harming themselves or others, but who are in a process of recovery/improvement may require intermittent observations.

- Intermittent Observations will take place at intervals of 15 minutes.
- There may be occasions where flexibility is required within these observations and the Care team may need to look at providing a number of visits within the hour of which the duration between each visit will be no longer than 15 minutes. This would be used ,for example, with patients who have had risky behaviour and the team have agreed to reduce observations from level 3 to level 2 for assessment of that risk. The visits will be random e,g 5 mins then 15

mins then 10 mins and this will be documented within the Care plan and times recorded on the Observation sheet

- The nurse in charge of the shift will allocate staff at hourly intervals to undertake Level 2 observations for the duration of their shift.
- Staff engaged in Level 2 Intermittent observation should negotiate with the patient about available ward activities and encourage engagement in these activities wherever it is safe and appropriate to do so.
- Recording of Level 2 observations must be made using the form found in Appendix 3. Individual staff members allocated to observations are responsible for initialling at 15 minute intervals that they have observed the patient, for example signing at 0815hrs will be for the time period between 0800hrs to 0815hrs. In addition the nurse will also complete the required information including the patients presentation and behaviour and any interventions offered or required during those periods. Completed forms must be scanned into RIO
- The same applies to those on flexible intermittent observation where the staff member will initial at the end of the allocated time slot which may be 5, 10 or 15 mins, and record the patients presentation and behaviour and any interventions offered or required during those periods
- All patients have an allocated nurse each shift that is responsible for leading their care and implementing the care-plan across the shift. The shift nurse allocated to patients on Level 2 Intermittent observations must be a qualified nurse. They are responsible for updating the risk management /care plan which includes an evaluation of the patients' presentation and the effect of the observations during that shift, or within the timescale dictated by the care plan.
- If indicated from the evaluation, the allocated nurse must ensure a review of the risk management /Care plan and level of observations carried out, for communicating decision making to the rest of the clinical team on duty and maintaining adequate clinical records.
- The Care plan must be reviewed every 24 hours when the patient is on Level 2 observations or within the timescale dictated by the Care Plan.
- Level 2 observations is the minimum level that a patient aged 16-17 years old can be placed on whilst they are on a mental health unit. They MUST be on Level 3 observations for the first 24 hours and this can only be reduced to Level 2 following a risk review. This is due to their potential vulnerability on an adult ward.

If a patient on Level 2 observations cannot be located, the Missing Persons Procedure must be implemented immediately (POL/001/009).

Level 3 – Continuous Observation and Engagement

This is the highest level of observations and should only be used where there is clear clinical rationale and for the minimum time possible due to the level of intrusion it places on the patient's privacy, dignity and personal autonomy. It is required when the patient could, at any time, make an attempt to harm themselves or others. It may be necessary to search the patient and their belongings, while having due regard for the patient's legal rights and conducting the search in a sensitive way.

On the Psychiatric Intensive Care Unit (PICU), any admission will be immediately placed on Level 3 for at least one hour and then reviewed by the ward team

This level of observation and engagement may also be required when the patient, due to their physical frailty, cognitive impairment or learning disability requires ongoing observations or support to maintain their safety or their Activities of Daily Living

This Level includes 'within eyesight' and 'within arms length' as recommended in the NICE Guidance.

- This level of observation MUST be detailed in the risk management /Care plan to tailor it to the specific risks of that patient. This will include the proximity of the staff member to the patient such as eye sight at all times, within arms length at all times, allowance for privacy whilst using the bathroom or whilst in the company of visitors, access to outside space such as gardens, access to kitchen areas, privacy in bed areas, use of blick response etc.

- If deemed necessary any tools or implements that could be used to harm themselves or others should be removed

- The nurse in charge of the shift will allocate staff at either hourly or half hourly intervals, depending on the needs/ complexities of the patient, to undertake Level 3 observations for the duration of the shift.

- To determine the number of staff required to carry out the observation.

- The allocated staff member is responsible for maintaining constant observations in accordance with the patient's risk management plan/ care plan.

- Individual staff members are responsible for signing at the end of their allocated hour of observations and completing the required information including observed behaviour/ presentation and interventions offered and required on forms within arms length (Appendix 4) and within eyesight (appendix 5). Completed forms must be scanned into RIO.

- Staff should endeavour to establish positive and therapeutic engagement with the patient to minimise the intrusiveness of observations and maximise the benefit for the patient in relation to risk.

- All patients have an allocated nurse each shift that is responsible for leading their care and implementing the care-plan throughout the shift. The shift nurse allocated to patients on Level 3 observations must be a qualified nurse.

- They are responsible for updating the risk management /care plan which includes an evaluation of the patients' presentation and the effect of the observations during that shift, or within the timescale dictated by the care plan.

- If indicated from the end of shift evaluation, the allocated nurse must ensure a review of the risk management / care plan and level of observations is carried out, for communicating decision making to the rest of the clinical team on duty and maintaining adequate clinical records.

- A full risk management review must be completed every 24 hours when the patient is on Level 3 observations. This review should assess the appropriateness of the Level 3 observations and be documented in the clinical record/ Care plan.

- If Level 3 observation continues for more than 72 hours, a review by the full clinical team should take place.

- For those patient who require continuous level 3 observations for the duration of their admission due to frailty, cognitive or learning difficulties, then the review dates will be agreed with the care team and documented in the care plan.

- Patients aged 16-17 years old MUST be placed on Level 3 observations for the duration of their admission unless further assessment has been carried out to determine that they can be safely managed on Level 2 observations.

- Wards which use Seclusion will follow the Trust seclusion policy.

Multi-Professional Continuous Observations (eyesight or 2 or 3 members of staff).

Flexible Observations

- Traditionally, service users who intermittently present with an increased level of risk have been placed on continuous observations by one or more member of the nursing team. This model of observation does not always result in a positive clinical outcome for the service user and staff resources could be utilsed more efficiently

- E.g a frail patient may be on level 3 observations due to risk of falls if they try to get out of their chair however this is not a regular occurrence and they tend to doze off regularly due to frailty, but it can happen when agitated or if ward noisy etc, This does not require the assigned member of staff to be with them constantly using level 3 observations but could be managed differently e.g. chair alarm in situ, or if they are sitting within a group setting e.g. lounge area then another member of staff who is already in that area could be assigned to monitor the patient and to call the member of staff when they are awake.
- A patient with a Learning Disability who is at risk of eating inedible objects such as glass, metal, and batteries for example, could be on level 2 in communal areas, level 3 line of sight in isolated areas such as bedroom/ bathroom and level one once asleep. Risks may be reduced by cutlery being counted, TV remotes stored away, clock in locked cabinet, and having no risk objects/ belongings in the bedroom. There is always a staff member in the communal area of Edenwood due to nature/size of the unit, so whenever the patient is in the communal area and staff present the obs could be reduced to general at this time, and this could be care planned appropriately
- The Nurse in Charge can drop the level of observations to level 2 which would ensure the assigned member of staff is still checking that their patient is safe every 15 minutes and when patient is awake it will revert back to level 3 observations.
- This flexible approach will only be used with the agreement of the Care Team and the Care plan should reflect that flexible observations can be used with the individual using specific criteria

If a patient on Level 3 observations cannot be located/ absconds the Missing Persons Procedure must be implemented immediately (POL/001/009).

Section 17 leave

Patients who are on leave from the ward for either a period of time through the day or on an agreed overnight leave will have specific details related to this period of leave entered onto the leave template on appendix 6. This will also apply for example to service users on Kentmere ward who leave the ward for cigarette breaks outside the ward. If patients do not return to the ward by the agreed time the shift coordinator or nurse in charge of the ward should be informed immediately. A leave care plan should also be formulated in line with trust policies (001/057: Protocol for the management of informal patient's leave from Adult Acute Mental Health wards); (001/005/006: MHA Guidance on section 17 leave of Absence) and (POL 001/009: Policy for the Management of Service Users Missing or Absent Without Official Leave (AWOL)).
The expected date and time of return from leave will also be recorded on the ward's Patient Status at a Glance Board.

Zonal Engagement & Observations

Zonal observations and engagement is an approach a ward or clinical area may take to enhance the observation of a particular group of service users within a specified ward or clinical area. Zonal observations can be plotted against certain times or functions dependent on the ward layout and key tasks relevant to the service user group. Individual needs assessment will inform individual care plans and individual observation levels as detailed in this wider policy. This model is currently being piloted and audited to assess its suitability for use within the Trust.

3.4 Observations at Night

Night time can be a high risk period for some patients and nationally there have been concerns raised about in-patients wards failing to address this period adequately (Rae 2010). However, there is a balance to be sought with enabling patients to get a good night's sleep. Therefore, each individual patient will be assessed for the level of observations to be carried out at night time and this will be recorded on the patients risk management plan/ Care Plan.

The Mental Health Act Code of Practice, (2015) states that: "Staff must balance the potentially distressing effects on the patient of increased levels of observation, particularly if these levels of observation are proposed for many hours.

It is acknowledged that there are reduced natural opportunities to engage within patents during the night and observation levels should be discussed in the evening handover between the staff on the late shift and the staff on the night shift. Night staff carrying out observations should be able to satisfy themselves that they are able to observe the patient to determine their safety and well being in relation to the level of observation appropriate to their needs and care plan.

Consideration will also take place around the use of blick response, bed and chair alarms.

Patients, and where appropriate family, will be informed around what level of observation they are on at night and what that involves. E.g. being checked on every hour as a minimum

The member of staff undertaking the engagement and observation at night and at any time the patient is sleeping, should be able to:

- Observe the patient in the room
- See clearly that the patient is safe e.g. not fallen or self harmed
- See clearly that the patient is breathing normally
- See the patients head and ensure nothing is impeding their breathing

- If the staff member is not assured about the patients safety or breathing they should assess the situation and either enter the room or call for assistance from a colleague and enter together and If there are any concerns about the person's mental state or physical wellbeing a top-toe check may be required to see if the person is moving freely and not restricted in anyway

3.5 Increasing & Reducing Observations and resolving disagreements

When staff are reviewing the observation level of a patient they are reviewing the effectiveness of observations as an intervention to reduce and/or manage risk.

Indicators for increasing observations:

- Change in the patients risk profile and or presentation.
- Current level of observations ineffective at reducing or managing the risk.
- Risk incidents that have occurred.
- Concern by the family or others and therefore observations enable further assessment of these risks.

Indicators for reducing observations:

- Risks for which the observations were implemented have reduced or changed such that the observations are no longer required.
- The use of observations is counter-productive to the patient's mental health and risks.
- Alternative and more effective interventions have been identified.

Good practice suggests that observation levels should be changed based on multi disciplinary decision making.

Safe and supportive observation however is a nursing responsibility and nurses are entitled to and should make decisions about observations based on their own assessment of risk in the absence of the MDT.

In the case of disagreement over the level of observation required for a specific patient the patient should be placed on the higher level until agreement can be reached. A third party should be approached as necessary to resolve disagreements (e.g. ward manager, consultant nurse, medical consultant, or advanced nurse practitioners,).

Any changes to observation levels should only be made following the completion of the risk management and evaluation of the Care Plan

3.6 Standards for Risk Management Reviews

- One to One with Patient by Qualified Nurse (where appropriate)
- Review current risk management plan / Care Plan
- Read clinical notes and identify any risk related incidents.
- Identify any feedback from relatives/ carers or if appropriate contact them for feedback.
- Complete Risk Management plan and care plan and decide on observation levels
- Communicate changes to the patient, the staff on duty and relevant members of MDT.
- Consult with MDT on decision making where there is uncertainty/ where appropriate.
- Set next review date and put in ward diary.
- Ensure Care Plan completed on RIO.
- Ensure risk management plan updated.
- Level 2 and Level 3 observations must be reviewed a minimum of once every 24 hours by a qualified nurse, with the exception of those patient who require continuous level 3 observations for the duration of their admission due to frailty, cognitive or learning difficulties and the agreed review dates will be in the care plan
- Any conflict arising about decisions between members of the multidisciplinary team should be resolved through a joint risk assessment and the outcome documented in the clinical records.

3.7 Documentation of Observation

Documentation and review of Observations will be through the individual care plans on RIO. Choose the care plan relevant to the need for observation within the ‘strength and need’ category
e.g. patient is at risk of self harm due to psychotic thoughts

- strength and needs category - ‘psychosis’
- strength and needs sub category - ‘assessment’
- intervention category – ‘risk management’
- intervention subcategory - ‘prescribed observation level’

The goals, activities and clients views will be documented as well as how often the care plan will be reviewed e.g daily or weekly etc

When writing the progress notes after every shift the person writing the entry will then be able to click on the care plan boxes on the left hand side of the screen to link the entry they are making to the care plan.

The completed individual records of observation will be scanned onto RIO.

3.8 Care after Rapid Tranquilisation

Patients must continue to be observed after Rapid tranquillisation and should be placed on level 2 supportive observations. If the patient becomes sedated and asleep this observation level should be reviewed by nursing and medical staff together with physical monitoring arrangements to maintain patient safety

Monitoring of the service user must take place as per the Rapid tranquilisation policy

4. TRAINING AND SUPPORT

Training required to fulfil this policy will be provided in accordance with the Trust's Training Needs Analysis. Management of training will be in accordance with the Trust's Learning and Development Policy

5. PROCESS FOR MONITORING COMPLIANCE

The process for monitoring compliance with the effectiveness of this policy is as follows:

Aspect being monitored	Monitoring Methodology	Reporting		
		Presented by	Committee	Frequency
What	How	Who	Where	How often
The process of observing service users over a 24 hour period according to their assessed need/risk is evident in practice and clearly documented in RIO	Observational audit of practice, within 4 clinical areas and examination of observation records	Deputy Director of Operations	Care Group Governance meetings Ward meeting	Annual
Those responsible for observing service users	Annual review and report including review of observation activity of Trust staff	Deputy Director of Operations	Care Groups	Annual

Aspect being monitored	Monitoring Methodology	Reporting		
		Presented by	Committee	Frequency
undertake their duties according to the policy				
Staff have completed training associated with this policy in line with TNA	Compliance with training will be monitored in accordance with the Learning and Development Policy			

Wherever the above monitoring has identified deficiencies, the following must be in place:

- Action plan
- Progress of action plan monitored by the *name of relevant committee* minutes
- Risks will be considered for inclusion in the appropriate risk registers

6. REFERENCES:

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The European Convention on Human Rights (ECHR) article 8

7. ASSOCIATED DOCUMENTATION:

POL/001/009: Policy for the Management of Patients Missing or Absent without Official Leave from In-Patient Units (AWOL)

001/057 :Protocol for the management of informal patient's leave from Adult Acute Mental Health wards;

POL/002/006/001 2015 :Incident and Serious Incidents that require Investigation (SIRI) Policy

POL/001/ 004: Trust Seclusion Policy

POL/002/008 : Health Records Management and Policy

POL/ 001/005/006 : MHA Guidance on Section 17 leave of absence

8. DUTIES (ROLES & RESPONSIBILITIES):

8.1 Chief Executive / Trust Board Responsibilities:

The Chief Executive and Trust Board jointly have overall responsibility for the strategic and operational management of the Trust, including ensuring that Trust policies comply with all legal, statutory and good practice requirements.

The Chief Executive has ultimate accountability and responsibility for the safety of patients and staff. This is delegated through organisational structures and accountability frameworks to ensure staff providing direct clinical care are provided with the appropriate tools and training to undertake supportive observations.

The Trust Board will ensure there are appropriate structures in place for the management of risk across the Trust.

8.2 Executive Director Responsibilities:

All policies have a designated Executive Director and it is their responsibility to be involved in the development and sign off of the policies, this should ensure that Trust policies meet statutory legislation and guidance where appropriate. They must ensure the policies are kept up to date by the relevant author and approved at the appropriate committee.

The Executive Director of Operations and Nursing is the accountable Director for this Policy and will be responsible for providing assurance reports to the appropriate committee. The Trust Board will require assurance from the Networks/Localities that appropriate risk management structures are in place and that staff are provided with appropriate training and resources to undertake supportive observations.

8.2.1 Associate Director of Nursing and Associate Medical Director

The Tripartrate is responsible for ensuring this policy is implemented and complied with across their Care Group. This includes compliance with training and record keeping. This activity may be delegated to Network managers where they are in post.

8.3 Managers Responsibilities:

Ward managers are responsible for ensuring all staff within their sphere of responsibility attend training on this policy; that this policy is implemented and documentation is completed. They will ensure this is monitored through audit. They will take action with individual staff where necessary where the policy is not being adhered to and will ensure wards have the appropriate resources to carry out supportive observations.

Ward managers will brief Network Managers, Quality and Safety Leads, and Associate Director of Nursing on any incidents occurring in relation to the implementation of this policy and in accordance with the Trusts Incident and Serious Incidents that require Investigation (SIRI) Policy (POL/002/006/001)

8.4 Staff Responsibilities:

All in-patient staff are responsible for ensuring that they:

- Are familiar with this policy and any associated procedural documents;
- Know where to locate them, i.e. Intranet;
- Keep up to date when any changes are made;
- Attend training or learning events necessary for the implementation of practice associated with this policy;
- Comply with the practices, documentation and reporting arrangements identified within this policy, ensuring they seek assistance where appropriate.

8.4.1 Clinical Staff Undertaking Observations

Staff who carry out the observations have specific responsibilities which will impact on the quality and safety of observations;

Registered professionals

- Staff members should explain to patients why observations are being undertaken and what it means to them. If the patient lacks capacity this should be discussed with the relatives where appropriate
- Staff should actively engage with patients, be approachable, listen and understand the importance of boundaries, and ensure that periods of observation are viewed as opportunities for therapeutic engagement and relationship building as well as assessing their mental state, wellbeing and behavior which is central to the care being provided.
- Observation and skilled engagement enables staff to learn about patients in their care, to assess their needs, work collaboratively and facilitate the development of a therapeutic and meaningful relationship.
- Have a handover/ brief on the patient's history, background, current presentation and risk, risk management and care plan.

Document in accordance with Trust and professional guidelines, in an approved format

- Staff should be familiar with the ward and policy to be followed in an emergency e.g. AWOL, access to ligature cutters etc

- Registered staff will be able to review any patients level of observation based on clinical need/risk assessment (increasing or decreasing observations where clinically indicated) involving the MDT and patient wherever possible

- Staff should only be allocated to level 3 observations for periods of one hour and never for more than a two hour period for an individual unless clinically agreed

- To ensure that positive engagement can take place, consideration needs to be given to the number of patients a staff member is allocated to observe at any one time. Consideration also needs to be given to the physical environment and how positively this lends itself to patient engagement and observation.

- Staff should be aware of male / female preference for each individual and identify if it is possible to provide this within the staff on shift.

- Individual staff will escalate any service user concerns or failure to return from agreed period of leave to the shift coordinator / nurse in charge of the ward immediately.

Non-registered staff

Non-registered staff have a responsibility to:-

- Ensure that periods of observation are viewed as opportunities for therapeutic engagement and relationship building;

- Be familiar with and implement the observation care plan for each individual in their care;

- Complete documentation contemporaneously;

- Report any relevant information to assist in the effective review of patients" levels of observation.

Medical Staff

Medical staff and Responsible Clinicians that form part of the patients multi-disciplinary team should be informed of any decisions concerning observation above the general levels as soon as possible. They should contribute to reviews and decision making regarding observations where it is necessary.

8.5 Approving Committee Responsibilities:

The Chair of the approving committee will ensure the policy approval is documented in the final section of the Checklist for Policy Changes. The committee will agree the approval of the final draft of the policy.

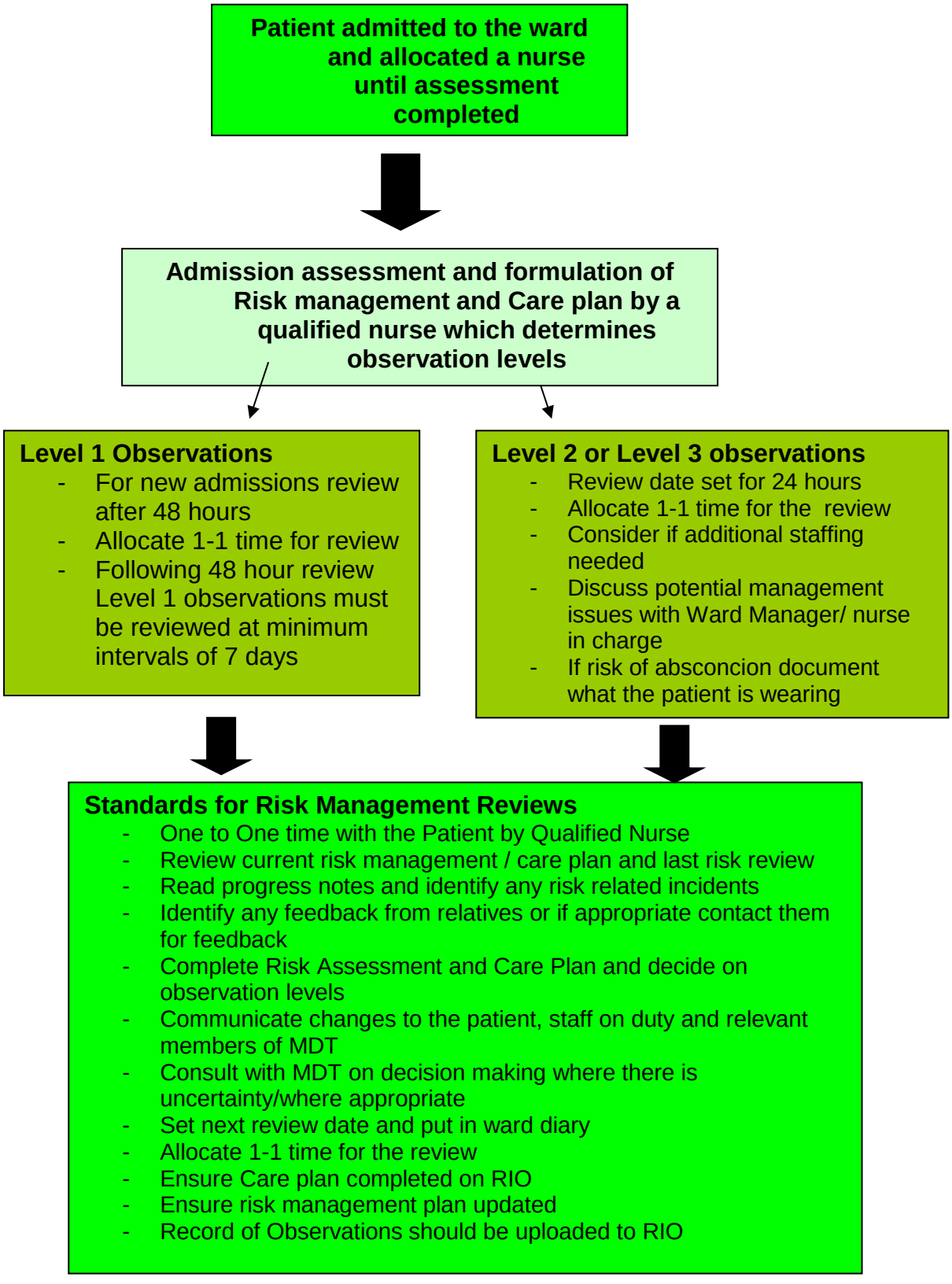
8.5.1 Trust Wide Clinical Governance

The Trust wide Clinical Governance Group will receive assurance from groups such as the Care Groups on incident data and action plans related to the use of supportive observations.

9. ABBREVIATIONS / DEFINITION OF TERMS USED

TERM USED	DEFINITION
Engagement	Therapeutic engagement involves healthcare professionals spending quality time with patients, and aims to empower the patient to actively participate in their care rather than 'having things done to them'. Service users negotiate the level of engagement that will be most therapeutic. (NICE 2005)
Observation	"Regarding the patient attentively while minimising the extent to which they feel that they are under surveillance. Encouraging communication, listening and conveying to the patient that they are valued and cared for are important components of skilled nursing observations" Standing Nursing & Midwifery Advisory Committee 1999. A minimally restrictive intervention of varying intensity in which a member of the healthcare staff observes and maintains contact with a service user to ensure the service user's safety and the safety of others (NICE 2015)

APPENDIX 1 - OBSERVATIONS – FLOWCHART OF CLINICAL DECISION MAKING AND DOCUMENTATION



APPENDIX 2 - LEVEL 1 (OBSERVATION RECORD)

All patients are subject to at least hourly observations and engagement and will never be any less frequent than hourly .

Date		Ward	

Staff Member																								
Patient Name	1am	2am	3am	4am	5am	6am	7am	8am	9am	10am	11am	12pm	13pm	14pm	15pm	16pm	17pm	18pm	19pm	20pm	21pm	22pm	23pm	24pm
Staff signature																								

S =Sleeping DR= Dining Room AR =Activity Room B= Bedroom L= Lounge K =Kitchen C=Corridor VR= Visitors Room OT =At OT G=Garden
BR/ SR- Bathroom/ Shower room T= Toilet WO= Ward Office M=Meeting OL= On Leave AWOL= Absent without leave SEC= Seclusion/ Extra care

APPENDIX 3 - LEVEL 2 OBSERVATION RECORD (INTERMITTENT)

Date…… Ward……

A visual check is made upon the service user every 15 mins or more frequently, if risk assessed and care planned. Time intervals inserted as required especially if using flexible times. (No longer than 15 minute intervals)

Is this referenced in the Care Plan? YES / NO (if no please inform the nurse in charge)

Have reviews taken place and been recorded in accordance with policy/ care plan? YES / NO

Staff Allocation	Time	Location	Observed Activity / Presentation	Intervention (related to care plan)	Staff Signature Grade

Suggested Interventions		
S= Support Given	R= Relaxation	M= Medication Given
A= Encouraged Activity	PMVA= Restraint	OL = on leave
C= Engaged in conversation	DE= De escalation	TA= Encouraged time alone

Patient is wearing ……

A visual check is made upon the service user every 15 mins or more frequently, if risk assessed and care planned. Time intervals inserted as required especially if using flexible times. (No longer than 15 minute intervals)

Is this referenced in the Care Plan? YES / NO (if no please inform the nurse in charge)
Have reviews taken place and been recorded in accordance with policy/ care plan? YES / NO

Staff Allocation	Time	Location	Observed Activity / /presentation	Intervention (related to care plan)	Staff Signature Grade

Suggested Interventions		
S= Support Given	R= Relaxation	M= Medication Given
A= Encouraged Activity	PMVA= Restraint	OL = On leave
C= Engaged in conversation	DE= De escalation	TA= Encouraged time alone

Patient is wearing ……

Patient label or

Surname
Forename
Date of Birth
RNN
NHS no.

NHS
Cumbria Partnership
NHS Foundation Trust

APPENDIX 4- LEVEL 3 OBSERVATION RECORD (WITHIN ARMS LENGTH)

Date…… Ward…… No of Staff ……

The patient is subject to close proximity observation by one or more health care staff. This level of observation is used where risk assessment indicates a high level of self harm or harm to others without this level of observation

Is this referenced in the Care Plan? YES / NO (if no please inform the nurse in charge)

Have reviews taken place and been recorded in accordance with policy/ care plan? YES / NO

Staff Allocation	Time	Location	Observed Activity / Behaviour	Intervention (related to care plan)	Staff Signature Grade
	01:00				
	02:00				
	03:00				
	04:00				
	05:00				
	06:00				
	07:00				
	08:00				
	09:00				
	10:00				
	11:00				
	12:00				

Suggested Interventions		
S= Support Given	R= Relaxation	M= Medication Given
A= Encouraged Activity	PMVA= Restraint	OL = On Leave
C= Engaged in conversation	DE= De escalation	

Patient is wearing ……

Staff Allocation	Time	Location	Observed Activity / Behaviour	Intervention (related to care plan)	Staff Signature Grade
	13:00				
	14:00				
	15:00				
	16:00				
	17:00				
	18:00				
	19:00				
	20:00				
	21:00				
	22:00				
	23:00				
	24:00				

Suggested Interventions		
S= Support Given	R= Relaxation	M= Medication Given
A= Encouraged Activity	PMVA= Restraint	OL = On Leave
C= Engaged in conversation	DE= De escalation	

Patient is wearing ……

Patient label or

Surname
Forename
Date of Birth
RNN
NHS no.

NHS
Cumbria Partnership
NHS Foundation Trust

APPENDIX 5 - LEVEL 3 OBSERVATION RECORD (WITHIN EYESIGHT)

Date…… Ward…… No. of staff……..

The patient is subject to uninterrupted observation by health care staff. The Care Plan stipulates the maximum distance which is permissible between the supervising staff and patient, and whether the supervisor must remain in the same room as the patient (see policy for guidance)……

Is this referenced in the Care Plan? YES / NO (if no please inform the nurse in charge)
Have reviews taken place and been recorded in accordance with policy/ care plan? YES / NO

Staff Allocation	Time	Location	Observed Activity / Presentation	Intervention (related to care plan)	Staff Signature Grade
	01:00				
	02:00				
	03:00				
	04:00				
	05:00				
	06:00				
	07:00				
	08:00				
	09:00				
	10:00				
	11:00				
	12:00				

Suggested Interventions		
R= Reassurance Given	R= Relaxation	M= Medication Given
A= Encouraged Activity	PMVA= Restraint	OL = On Leave
C= Engaged in conversation	DE= De escalation	

Patient is wearing ……

Staff Allocation	Time	Location	Observed Activity / Presentation	Intervention (related to care plan)	Staff Signature Grade
	13:00				
	14:00				
	15:00				
	16:00				
	17:00				
	18:00				
	19:00				
	20:00				
	21:00				
	22:00				
	23:00				
	24:00				

Suggested Interventions		
R= Reassurance Given	R= Relaxation	M= Medication Given
A= Encouraged Activity	PMVA= Restraint	OL = On Leave
C= Engaged in conversation	DE= De escalation	

Patient is wearing ……

APPENDIX 6 -TEMPLATE FOR RECORDING LEAVE FROM THE WARD

NHS Cumbria Partnership NHS Foundation Trust

Patients Name	Date and Time out of ward	Expected date and time of return to ward	Actual date and time of return to ward	Section 17 leave (Yes/No)	Escorted/Unescorted (specify who patient is with)	Staff signature authorising leave	Staff signature confirming return of Patient to ward.

DOCUMENT CONTROL

Equality Impact Assessment Date	n/a amendment to current policy
Sub-Committee & Approval Date	MH governance August 2018

History of previous published versions of this document:

Version	Ratified Date	Review Date	Date Published	Disposal Date
1	2/10/2017	March 2020	10/4/2018	
2	-	March 2020		

Statement of changes made from version

Version	Date	Section & Description
2	29/9/18	• Amendment to Section 6.4
		•
		•

List of Stakeholders who have reviewed the document

Name	Job Title	Date
Has been through each M/H Ward and Governance groups for both Mental Health and Later Life	Various	Aug 2018