Observation Policy

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1.0	Sept 2008	Launa Rolf, Duncan Gilbert	Final	Revised policy
1.0	Dec 2008	Duncan Gilbert	Final	Revision of para 8.2 re documentation standards for intermittent observations
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6.0	March 2018	Day Njovana and Daisy Mudoni	Final	1. Addition of MSORT guidance on observation reviews 2. New care plan template 3. Addition of review template 4. Review Guidance and addition of Rio Codes 5. OLM competency assessments
7.0	September 2022	Claire McKenna	Final	Minor amendment to make reference to Mental Health Unit – Use of Force Act Policy. Approved extension to March 2023 to enable further update on completion of Observations QI Project

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1.0. Introduction

1.1. The contents of this policy are to address the mental health needs for service users who are considered to be vulnerable or at risk of suicide, self harm or harm to others. In addition the policy sets out the responsibilities of Trust employees who may be required to observe service users and sets out the process and procedures for guiding practitioners in making decisions to ensure a safe and therapeutic environment, to facilitate the assessment and management of in-patient's level of observation and the rationale for supporting those decisions. The primary aim is to ensure the safe and sensitive monitoring of the patient's behaviour and mental well being. This will enable the Multi Disciplinary Team (MDT) to rapidly respond to any changes.

1.2. The least intrusive level of observation that is appropriate to the situation should always be adopted so that due sensitivity is given to the service user's dignity and privacy whilst maintaining the safety of those around them.

1.3. Observation with a service user, including the observation, reporting and recording of mental state and behaviour is an important part of mental healthcare. It is, however, only one aspect of the wider process of care delivery. Observations should be in keeping with the East London NHS Foundation Trust commitment to ensuring the safety of service users in in-patient units.

1.4. Supportive observation will be seen as an integral part of the inpatient care plan that will contribute to the management and reduction of risk. The purpose of supportive observation is to ensure the safe and sensitive monitoring of the service user's behaviour, mental state and physical health well being, enabling a rapid response to any change, whilst at the same time fostering positive therapeutic relationships between staff and service users. This will be achieved by establishing good rapport with service users, promoting their coping skills and being aware of their individual needs. All verbal interactions must be document as set in this document. As such all staff engaged in the activity of supportive observation should have received adequate training, have the required experience, and be identified as competent to do so.

2.0. Purpose of Policy

2.1. The purpose of the policy is to provide direction and guidance for the planning and implementation of high-quality supportive observation procedures for the Trust. This would provide a safe environment for service users thereby maximizing the opportunity for successful therapeutic interventions.

2.2. The policy aims to secure therapeutic observation between Trust staff and service users. The policy provides a framework for enhanced levels of supportive observations when service users are considered to be at risk of harm to themselves or others.

2.3. The purpose of this policy is to ensure that all in-service users' level of observation within East London Foundation Trust be allocated appropriate to their mental and physical health care needs. The clinical risk assessment is the basis for determining levels of observation and applies to both informal and detained service users

Please refer to the following Trust policies for further guidance as and when required:

- Clinical Risk Assessment and Management Policy
- Policy on the use of Physical Holding Skills
- Policy for Searching Service Users, Visitors and their Property

- Admission Policy
- Seclusion Policy
- Local Fire and Evacuation Policy and Procedure
- Safe Guarding Children Policy
- Safeguarding Policy
- Mental Health Units Use of Force Act Policy

3.0. Definition

3.1. High quality observation will incorporate listening and fostering interaction, rapport building and collaboration with the service user and conveying to the service user that they are valued and cared for.

3.2. A commonly employed definition observation of service users ought to be seen as a partnership between the multi- disciplinary team and the service user and their carers. It should not be delivered in a way that is, or is perceived as, custodial or punitive.

3.3. As a general principle the level of supportive observation should be set at the least restrictive level, for the least amount of time in the least restrictive setting possible

Please note that when the document refers to the shift coordinator this is referring to a registered nurse. All decisions regarding observations are to be made by the most senior nurse on the ward at that time.

A 'Senior' member of staff refers to the shift coordinator

4.0. Process

4.1.0. Levels of Supportive Observations

There are four levels of supportive observation within the policy:

1) **General supportive observation**
2) **Intermittent supportive observation**
3) **Continuous supportive observation – within eyesight**
4) **Close supportive observation – within arm's length**

4.1.1. The term **enhanced** level of supportive observations refers to intermittent, continuous and close level of observations.

When all enhanced levels of observations are undertaken the following MUST apply:

4.1.2. The observation must be part of the observation care plan (appendix1)with the plan being agreed by the Multi-Disciplinary Team (MDT) and, the service user, if not agreed with service user, reasons for this should be clearly documented on the care plan. The care plan will be imbedded within rio progress notes and also available with the observation records for staff and service users to reference. A copy of the care plan must be given to the Service user.

It will give specific instructions for the observing nurse to follow. These could include the following:

- Should the nurse allow the service user to use the toilet or bathroom with or without the nurse physically going into the room?
- When the service user is in their bedroom should the nurse sit inside the room or is it deemed safe for the nurse to observe form the outside?

- Should the nurse enter the bedroom at night to check on the service user or can this safely be employed form outside the room?

NB See also MSORT guidance on for consideration in the care planning process and discussion with service user (Appendix 2)

*The inpatient care plan **MUST** be attached to the **Observation Record Sheet** (appendix 5)*

4.1.3. A qualified member of staff – including bank employees must undertake a minimum of one third of the observations within the shift

4.1.4. A 'senior' member of staff – including a bank employee if they are the shift coordinator agrees and approves that the observations have been completed and signs off the form appropriately

4.2.0. General Supportive Observation:

4.2.1. General supportive observation is the minimum acceptable level of supportive observation for all in-patient units. The location of all service users should be known to staff, but not all service users will need to be kept within sight. Service users subject to general observations will normally have been assessed as being a low-risk to themselves or others. If a service user is deemed to present a risk that cannot be managed by general observations up to and including concerns about physical health, suicide ideation, vulnerability etc, the shift coordinator should escalate and increase the observations to enhanced observations for better support of the patient. General observations are meant to support staff in knowing the whereabouts of and well-being of each service user. General observations must be completed visually and (if necessary) verbally by an allocated member of staff on an hourly basis. This will obviously differ for those service users on leave or absent from the ward and this should be documented accordingly. ***This documentation will also be used in case of an evacuation due to an emergency, e.g. fire, for the purposes of accounting for all service users.***

4.2.2. Hourly observation should be regarded as a minimum standard through out the trust. Local areas can increase the frequency as necessary due to the nature of the environment e.g. PICU, Forensic Services, Older Persons' Services etc.

4.2.3. At the beginning of each shift it is the responsibility of the incoming shift coordinator to ensure that a 'visual handover' has been received from a designated staff member from the outgoing shift. Identifying all of the service users on the ward and being aware of there whereabouts, and accounting for the service users who are not present on the ward. This should be undertaken by a staff member who is familiar with all the service users on that ward.

4.2.4. Any significant changes or concerns arising from hourly checks must be passed on to the shift coordinator and documented in the service user's progress notes at the earliest opportunity.

4.2.5. These observations can be undertaken by any clinical member of staff who is familiar with both the ward environment and every patient on the ward.

4.3.0. Intermittent Supportive Observation:

4.3.1. This level of observation is appropriate when service users are potentially, but not immediately, at risk of seriously harming themselves or others or there are concerns about their physical health which requires them to be checked at specific times. Observation must be carried out even when the service user is asleep in bed. The interval between observations must be clearly identified by the person who has

prescribed the observations. This may vary according to the MDT's assessment of need, but will usually be between 10 – 30 minutes. Observations should be carried out at least at the time intervals stated.

4.3.2. It may be appropriate for service users prescribed intermittent supportive observation to leave the ward environment e.g. for fresh air, internal therapeutic activities. Provision for leaving the ward must be incorporated into the care plan, such a decision must be made by the MDT and based on an up to date risk assessment. This plan should clearly state the minimum staffing and designation of the escorting member of staff. A further decision must be made by the nurse in charge based on current presentation at the time it is proposed to leave the ward. The service user must be accompanied by a member of staff at all times in the event of leaving the ward.

4.3.3. If a ward has more than four service users on intermittent observations, the shift coordinator must escalate to the Clinical nurse manager or Matron and consideration to increase staff and should be made. It is important that a datix is completed to highlight safety concerns to the directorate in these circumstances.

4.3.4. These observations can be undertaken by any clinical member of staff who is familiar with both the ward environment and the service user on supportive observations.

4.4.0. Continuous Supportive Observation – within Eyesight:

4.4.1. Continuous (within eyesight) supportive observation is required when the service user could potentially attempt suicide or there are serious concerns about the service user's physical health. If there is an attempt/concerns of harm others then considerations should be made about the risk to the member of staff who will be allocated to carry out the observations. Medication, use of seclusion and in rare occasion's observations must be considered where there is a risk to others. The service user will be kept within sight at all times, by day and by night, by an allocated member of staff. The supportive observation prescription must state if the service user does not require observation whilst using the toilet/taking a bath.

4.4.2. Gender issues are to be considered regardless of whether the service user is observed or not when using the bathroom/toilet.

4.4.3. It may be necessary to search the service user and their belongings, whilst having due regard for the service user's legal rights. Trust policy on the searching of service users and their property must be adhered to.

4.4.4. These observations can be undertaken by any clinical member of staff who is familiar with the ward environment and the service user who they have been allocated.

4.4.5. A service user who is prescribed level **continuous** should be mainly ward based given the level of risk identified. Fresh air should be facilitated on Hospital grounds in an internal courtyard area. It should be clearly documented in the care plan the length of time, the designation of the staff and the number of staff needed to facilitate the fresh air. In case of ward emergency the observing member of staff is to stay with the service user as they evacuate the ward. Service users on continuous observations can be escorted to general hospital for medical emergencies/procedures. For emergency procedures the nurse in charge has to ensure that they have adequate staff attending with the service user, the Duty Senior Nurse, RC, if out of hours the duty doctor has to be informed. For routine/known appointments this has to be care planed and conditions are agreed in advance.

4.4.6. Sometimes continuous supportive observations are used where the risk is more general than specific - e.g. a patient aged under the age of 18 admitted to an adult

ward. In such a scenario leave from the ward and observation around using the shower etc. would not be an issue. Please follow local protocols in the directorate for guidance in these observations.

4.5.0. Close Supportive Observation – within Arm's Length:

4.5.1. Close (within arm's length) continuous supportive observation will be used when a service user is considered to be in need of the very highest level of observation i.e. the service user is considered to be at an immediate or high level of risk of suicide or there are serious concerns regarding their physical health. The service user will therefore be nursed in close physical proximity of an allocated member of staff, with due regard to safety, privacy, dignity, gender and environmental dangers.

4.5.2. It may be necessary to search the service user and their belongings, whilst having due regard for the service user's legal rights (again Trust policy on the searching of service users and their property must be adhered to). It is likely that there will be circumstances when it is necessary for a staff member to accompany a service user into the toilet or bathroom. In such circumstances female staff should accompany female service users and male staff should accompany male service users.

4.5.3. If there is a risk of harm to others this level of observation must not be prescribed using one member of staff. On rare occasions it may be necessary for reasons of safety for more than one nurse to carry out this level of supportive observation. This is when there is a risk to others.

4.5.4. A service user who is prescribed level **close** supportive observation should be mainly ward based given the level of risk identified. Fresh air should be facilitated on hospital grounds in an internal courtyard area. It should be clearly documented in the care plan the length of time, the designation of the staff and the number of staff needed to facilitate the fresh air. In case of ward emergency the observing member of staff is to stay with the service user as they evacuate the ward. Service users on continuous observations can be escorted to general hospital for medical emergencies/procedures. For emergency procedures the nurse in charge has to ensure that they have adequate staff attending with the service user, the Duty Senior Nurse, RC, if out of hours the duty doctor has to be informed. For routine/known appointments this has to be care planed and conditions are agreed in advance.

4.5.5. Close supportive observations are the highest level of observations. These observations can only be undertaken by clinical member of staff who is familiar with the ward environment and the service user they have been allocated.

4.5.6. Some services may deem it appropriate for service users on enhanced supportive observations to leave the ward unaccompanied by clinicians (e.g. a young person being allowed to leave the ward with their parents), this is where the risk being considered less when the service user in outside the ward environment (observations may have been due to conflicting relationships on the ward/bullying etc). This has to be agreed by the local service DMT with a unit specific protocol. The decisions have to be care planned with an up to date risk assessment.

4.5.7. In mother and baby unit (MBU observations are based on MDT risk assessment of mother. **(Appendix 4)**

5.0. Admission

5.1. Assessing levels of observation is an integral part of the admission process; however, **all newly admitted service users should be allocated a minimum level of intermittent observation until the service user been examined and assessed. In cases where the person is unknown to services and/or the level of risk has not**

been determined; a clinical member of staff must remain with the service user at all times until a mental state examination and risk assessment is duly completed and the required level of observation has been specified . The level of observation must be based on the services users' reason for admission, clinical presentation and known history. A. This should be documented accordingly.

5.2. A shift coordinator can and may initiate enhanced supportive observation, and in such circumstances will inform the Responsible clinician/consultant (or designated deputy) at the earliest opportunity. The Responsible clinician/consultant (or designated deputy) will conduct a mental state examination and consider changes to treatment plan. If an admissions out of hours this should be communicated to the admitting duty doctor. When a clinician/team initiates enhanced levels of observations, the overall treatment plan must be reviewed i.e. medication, section 17 leave, legal status. Social visits should be reviewed. If service users have access children and young people during visits considerations to be made about the impact of the service users distress/presentation on children and young people during and after a visit.

5.3. Levels of observations should never be determined by staffing levels. They should be always be based on the service user's presentation and clinical risk assessment. Ideally the initiation of an enhanced level of supportive observation should be decided by the multi disciplinary team following discussion of the service-user's current risk assessment and management care plan.

5.4. The clinician who initiates/increases/decreases any observations must inform the service user of these changes. The nurse in charge must ensure that the observations are reflected in the care plan detailing the specifics about the observations. Where English is not the service users first language and a service user needs to be on an enhanced level of supportive observation then interpreting services should be obtained as soon as practicable to explain the decision to the service user and facilitate a more detailed assessment of mental state. Similarly an interpreter should be employed during team review of the supportive observation level to ensure that the service user remains involved in decision making and to facilitate the most accurate and comprehensive assessment possible.

NB: See guidance Appendix 3 for new admissions and deciding Level of intervention.

6.0 Initiation of Observation – RIO code - RCODE OBSVN01: Observation Authorisation

6.1. The decision to introduce or increase the frequency of observations may in the first instance be appropriately taken by a registered nursing staff or mental health practitioner, when possible in conjunction with medical staff, and in response to an assessed risk. Wherever possible, decisions about the level of supportive observation required by an individual service user should be jointly made by the multidisciplinary team.

6.2. If a decision is made to initiate observation by the shift coordinator, at the earliest opportunity, a Doctor should be made aware to support in completing a risk assessment. It is important that the patient is seen and reviewed by a Doctor at the earliest opportunity.

6.3. As part of an initial assessment prior to initiating observations, clinical staff will need to consider the following areas:

- CPA information and contemporary risk assessment;
- Information available from care co-ordinator if known to services;

- Expressed intentions;
- Information shared by relatives and carers;
- Implied intentions;
- Past history including previous suicide attempts, self-harm or assaultive behaviour;
- Hallucinations suggesting harm to self or others;
- Paranoid ideas that pose a threat to self or others;
- Recent loss or bereavement;
- Past or current problems with drugs or alcohol;
- Poor adherence to prescribed medication;
- Marked changes in behaviour or medication;
- Risk of falls;
- Risk of physical vulnerability.
- Safeguarding issues

NB: Also refer to MSORT guidance Appendix

6.4. A care plan should be completed in collaboration with the service user and the service user should receive a copy of the care plan, where necessary translated into their own language. The care plan template (appendix) will need to be imbedded within the rio progress notes.

6.5. The care plan should include the reason(s) for commencing an enhanced level of supportive observation, the level of observations prescribed, the goal(s) of observation, the MDT plan for the period of the enhanced observation, the service user's views and their plan for the period of enhanced observation with a review period. It should also be specific in detailing what has been agreed by the MDT such as access to fresh air, number and designation of staff allocated, use of toilet/bathroom facilities, visitors (both social and legal). For consistency the care plan must be as explicit as possible. Advance directives are to be used when formulating the care plans. The service user must be given a copy this care plan.

6.6. The Care plan should be viewed as a high intensity engagement plan, explaining what, when & why it should consider/include:-

- Where possible being written in the first person
- Signposting to any associated advanced statement or directive
- Signposting to any Personal Safety plan
- A working formulation related to the behaviour/presentation creating the requirement for increased observation/engagement
- Use of trauma informed principles
- Frequency of safety checking including at night time
- Frequency of observation/engagement recording
- Any items withheld from the service user
- What should happen during times usually associated with privacy (use of toilet, bathing etc.) (Inconsistency reported as frustrating for the service user with the potential to create conflict)
- Any delegation of responsibility to change observation levels and under what circumstances
- Any gender specific requirements
- The recording requirements
- The engagement requirements
- Activities that have been collaboratively agreed and where necessary escort requirements to accommodate same.
- Relapse signs
- Trigger factors
- Any agreed private time or unsupervised time with family/carers (however please note comment above)

- Frequency of review

NB: All patients on enhanced observations should have a care plan (appendix1) in their rio progress notes on rio and should use the initiating enhanced observations template with rio code : RCODE OBSVN01: Observation Authorisation

7.0. Staff Allocation

7.1. Once observations have been prescribed the shift coordinators will draw up a rota at the commencement of every shift to ensure that the observations are distributed fairly and according to competence. Rota must be formally documented on the wards shift planner and should be readily available as and when required. Any changes/swaps in the rota must be documented and countersigned by the shift coordinator. Observation may involve a number of staff, with care being handed over at hourly intervals. The shift coordinator may allocate observation levels to non-nursing clinicians who are familiar with the ward environment, have had their competency to carry out observations and are breakaway trained.

7.2. Clinical staff are expected to observe and record service users functioning, behavioral presentation, mental state. It is not acceptable to simply note the location of service users. When undertaking any level of observation, the staff tasked with undertaking observation, should, if the patient is awake, not otherwise occupied, or contra indicated in the care plan, be making an attempt to engage meaningfully with the service user.

8.0. Handover

8.1. No period of observation by a member of staff will be longer than 1 hour. At the end of each observation period, the member of staff will have a break from each observation of at least 30 minutes. This break must be a clear break from any observations. Every effort should be made to allocate staff who know the service user. Due to some staff working long days the nurse in charge must consider the impact of staff carrying out observations at regular intervals during the course of their shift.

8.2. The allocated staff prior to undertaking observations will be handed over the service user's social context, care plans, risk assessment and management care plans, warning signs and triggers and significant events since admission. A group briefing will take place at the beginning of each shift, of all staff to be involved in observing a service user, during which the service user's mental state is reviewed, potential risks highlighted and attitudes to the process discussed. Before taking over the service user's care, each member of staff will have familiarized themselves with the service user's background, recent clinical notes and care plans.

There will be a detailed handover of the mood, behaviour and interactions with the service user from the member of staff completing the period of observation to the member of staff who would be commencing the observation.

8.4. Considerations must be made to the location of the service user's bedroom; where possible it should be closer to the nursing office. Where there are concerns about the risk to others this location should be based on the location of potential vulnerable victims.

8.5. It is the responsibility of the shift coordinator to ensure that they hand over the specific of the observations i.e. level of observations, reason for observations and access to fresh air, visitors, bathroom facilities, and actions in case of an

emergency (how to summon for help when observing a service user and what to do in case of an evacuation of the ward) etc. All staff who undertake supportive observations are to report any relevant information to assist the effective review of service users' level of observation.

9.0. Reviews

9.1. The review process should include the service user at all times. If unable to have service user views in the review process, this should be documented in the review template (Appendix 4) using the appropriate rio code and imbedded within the progress notes. Shift coordinators and medical staff have the responsibility of reviewing enhanced observations. Any enhanced observations initiated without medical support must be reviewed by the senior nurse on duty in the area with medical staff at the earliest opportunity.

9.2. Intermittent Supportive Observation: **RCODE OBSVN02: Intermittent Observations 24 hour nursing review: RCODE OBSVN03: Intermittent Observations 72 hour Doctor review**

9.3. The service user's intermittent observations must be reviewed at a minimum every 24 hours by two Registered nurses. The nursing staff can also request any further reviews should they deem the presentation of the patient to have changed significantly. A medical assessment is required every 72hours following a patient being placed on intermittent observations.

9.4. The ward doctor must review the patient at 5pm before a weekend/bank holiday and again on the first working day after a holiday. During an extended public holiday and weekend period the on call doctor must be used.

The documentation of observation review should include an outline of the conditions and observed behaviors that prompted the increase in observation level and should aim to facilitate a prompt reduction in observation levels :RCODE OBSVN02: Intermittent Observations 24 hour nursing review- DR review

9.5. Continuous Supportive Observation – within Eyesight – RCODE OBSVN04: Continuous eyesight Observations 24 hours Doctor and Nurse review

9.6. Continuous (eyesight) supportive observation must review by a registered Nurse and ward Doctor at a minimum of every 24 hours. During the weekend the duty doctor must review the patient with the shift coordinator (registered nurse).

9.7. Close Supportive Observation – within Arm's Length- **RCODE OBSVN05: Continuous arms- length Observations 24 hours Doctor and Nurse review (1) : RCODE OBSVN06: Continuous arms- length Observations 24 hours Doctor and Nurse review (2)**

9.8. For close (arm's length) supportive observation there should be two reviews a day completed by the MDT. At the weekend there should be two reviews in 24 hours by the duty doctor and a registered nurse.

9.9. Enhanced observations after a Week: **RCODE OBSVN07: Weekly independent enhanced observation review**

9.10. If a service user remains on enhanced observation for a week and there either remain concerns about the service user or there are disagreements within the team on whether to increase/decrease/remain the same considerations should be

made for an independent review or an assessment of the service user's appropriateness of their placement/treatment.

9.11. Termination of Observations: **RCODE OBSVN08: Termination of enhanced observation**

9.12. At a minimum the decision to discontinue observations must be by the shift coordinator and a doctor. A decision to reduce the observations should have an immediate action and agreed at least by shift coordinator and Responsible clinician/consultant (or designated deputy.

9.13. In case of the weekend the ST4-6 on call should be consulted. The decision to discontinue observations should have an immediate action and should not have a projected date of discontinuing.

9.14. There should be a graded reduction of close (arm's length) and continuous (eyesight) supportive observations to general observation. All close and continuous observation should initially be graded to the next level down for at least 24 hours. There should be another review prior to further reducing the observations at each level of supportive observations.

10.0. Support for Staff

10.1. The multi-disciplinary team must provide an open and supportive environment, to enable members of staff to discuss their feelings about participating in supportive observation.

10.2. A post supportive observation reflective interview with the service user should take place at the end of any episode of enhanced observations.

11.0. Documentation

11.1. All levels of observations have specific documents that have to be completed. Records of all decision making, progress and review of enhanced levels of supportive observation should be documented in detail in the service user's progress notes.

11.2. A summary of the service user's behaviour and mental state must be entered in the service user's notes at the end of each shift. Any changes/deterioration/concerns regarding service users physical health state observed during any level of observation regardless of reason the observations were initiated should be documented in the notes and where appropriate recorded on care plan. These concerns/changes must be communicated to the shift coordinator. Physical health observations (BP, temp, pulse, etc.) must be completed recorded and escalated as appropriate.

11.3. Termination of enhanced supportive observation must be recorded in on the care plan and the service user's notes. The observation records must be completed by the clinician who has been allocated and has undertaken the observation. The date and time, and the name and designation of the staff undertaking the observation should be clearly apparent in all documentation. These must be signed off by the 'senior nurse'. Entries made by unregistered staff should be countersigned by a registered member of the team from the same professional group.

11.4. If a service user leaves the ward with a member of staff, it is their responsibility to remain with the service user and to document on the observation record sheet. Where service users leaves the ward with a relative (e.g. CAMHS), the shift coordinator must document on the observation record sheet as they leave and recommence the observations as soon as they arrive back on the ward. An assessment has to be made based on the handover of mental state/ mood and behaviour as to if the observation needs to remain/increase/decrease.

12.0 General Supportive Observation - Documentation/Record Keeping

The undertaking of general supportive observation should be recorded hourly. The whereabouts of the service users is recorded using codes. The template is based on the particular service needs, physical layout and service user numbers.

13.0. Enhanced Supportive Observation - Documentation/Record Keeping

13.1. During intermittent supportive observation a record of the service user's behaviour and whereabouts must be recorded at the time the supportive observation is undertaken, i.e. if the supportive observation is prescribed as every 10 minutes then there should be a record of progress every 10 minutes. **(Appendix6)**

13.2. During continuous and close supportive observations the allocated member of staff should document a summary of mental state, mood and behaviour after the allocated hour of observations. **(Appendix 6)**

14.0. Legal Status

14.1. At times, it will be clinically necessary to place an informal patient on Enhanced levels of observations in order to meet their needs and manage their risks. In these instances, staff must consider if this leads to the person being deprived of their liberty. In order to prevent this, the staff team must consider:

- If the patient has capacity and consents to the restrictions they will not be deprived of their liberty

- If the patient lacks capacity to consent to the observations then the MDT must consider the effect and duration of the observations, alongside the other type of restrictions on the person and if the cumulative effects amounts to a deprivation of liberty, take steps to reduce the restriction so they do not deprive the person of their liberty or seek to authorise these under the Mental Health Act.

15.0. Competency

15.1. Modern Matron's have to ensure that all nursing staff are made aware of this policy and receive appropriate training in its application and implement it appropriately and identify/manage and deploy resources to meet service requirement.

15.2. It is the responsibility of the Modern Matron to ensure that every member of nursing staff on their ward is assessed as competent to undertake supportive observations on the ward(s).

15.3. Every member of staff should read the policy and must be aware of their responsibility to follow it and address any concerns they may have. All trust clinical members of staff (Permanent and Bank) are expected to complete the OLM Therapeutic observations module before they undertake any observations.

15.4. The competency checklist should be completed for Agency staff members (**Appendix 7)** prior to being asked to undertake supportive observation. All shift coordinators are expected to ensure that bank and agency staff have completed competency assessment prior to assigning them to undertake observations. There should be a file on the ward that contains the signed competency forms for agency staff. All staff who carry out observations are must complete the OLM therapeutic observations once a year or where they may be a concern relating to ability/competency in clinical area as appropriate.

15.5. If any member of staff fails the assessment this should will be recorded and there should be a specific date set for the next assessment. The member of staff should not undertake any observations until they are deemed competent to do so. Supervision should be used to assist the member of staff prior to the next assessment. Where the member of staff is a bank member of staff the Trust Bank office are to be informed immediately. Bank members of staff who have been deemed incompetent should not undertake observations anywhere in the trust even if they are deemed competent in other areas.

15.6. Where staff fails the assessment twice the Capability Policy and Procedure is to be considered.

16. Training Strategy

The Trust will provide training on the content of this policy.

Each Directorate will facilitate restrictive practice training to incoporate observation Policy

17. Process for Monitoring Compliance with and the Effectiveness of this Policy

17.1. Modern Matrons should audit the implementation and compliance of the policy on a monthly basis. The audits should be submitted to their Borough lead Nurse. They should also carryout periodic adhoc checks on policy compliance (**Appendix 7).**

17.2. The Audit results should be discussed in the ward governance forums at least once every quarter and have action plans attached if appropriate. The audits should also be discussed and actions implemented in the directorate governance forums.

17.3 The lead Nurses should discuss the audits in the lead nurses meeting on a quarterlybasis.

17.4. Every year a report on compliance will be should be submitted to the Trust Quality Committee

NHS LA Standard	Name	Element to be monitored	Lead	Tool	Frequency	Reporting Arrangements	Actions on recommendations and leads	Change in practice and lessons to be shared
Observation Policy								
6.5	Observation & Engagement of Service users	Duties **Observation at differing levels** How the organisation trains staff, in line with the training needs analysis **How the observation is recorded**	Deputy Director of Nursing	audit	annual	The Deputy Director of Nursing receives the audit report	The Deputy Director of Nursing will formulate action points and timescales for each Directorate where there is evidence of non-compliance within two weeks of the audit	The Safety Sub Committee will receive and discuss the report and monitor the action plan
6.6	Dual Diagnosis not assessed							

It is important for individuals, teams and the organisation to learn when things go wrong. When serious incidents occur during supportive observation it is essential that there is a review of the incident, appropriate action is taken and any learning is appropriately disseminated. This process will be coordinated by the Assurance Department

18. Process for Reviewing, Approving and Archiving this Policy

Dissemination, implementation, and access to this policy.

This policy should be implemented and disseminated throughout the organisation immediately following ratification and will be published on the Trust's intranet site. Changes in policy and procedure will be introduced locally via Matrons and Team Leaders. Access to this document is open to all.

A Supportive Observation Policy Implementation Plan can be found in **Appendix 8.**

19. References

Standing Nursing and Midwifery Advisory Committee (1999) Safe and supportive observation of service users at risk – practice guidance

Bibliography

NHS Scotland Clinical Resource and Audit Group (2002) Engaging People: Observation of people with acute mental health problems – a good practice statement.

National Institute for Mental Health in England (2003) Preventing Suicide: A toolkit for mental health services.

Department of Health (2001) Safety First: National Confidential Inquiry into Suicide and Homicide by People with Mental Illness.

(Appendix 1)

Therapeutic Observation Care Plan

Patient Name:	Ward:
Consultant:	Date of Birth:
Legal Status:	
Observation Level:	Date/Time started:

Does the patient understand what 'observation' is and why it is necessary for them? YES / NO

If No – Please state the reason for this:

Reason for initiation of increased observations:

Include recent incidents, history if relevant, and presenting risks:

Observation Care Plan

This should include expected level of engagement with staff, length of time without specific incidents, what they need to do to have their level of obs reduced, use of medication if necessary etc.

Service User Views:

Agreed time of first review:

Staff members present:

(Appendix 2)

MSORT guidance to care planning for enhanced observations.

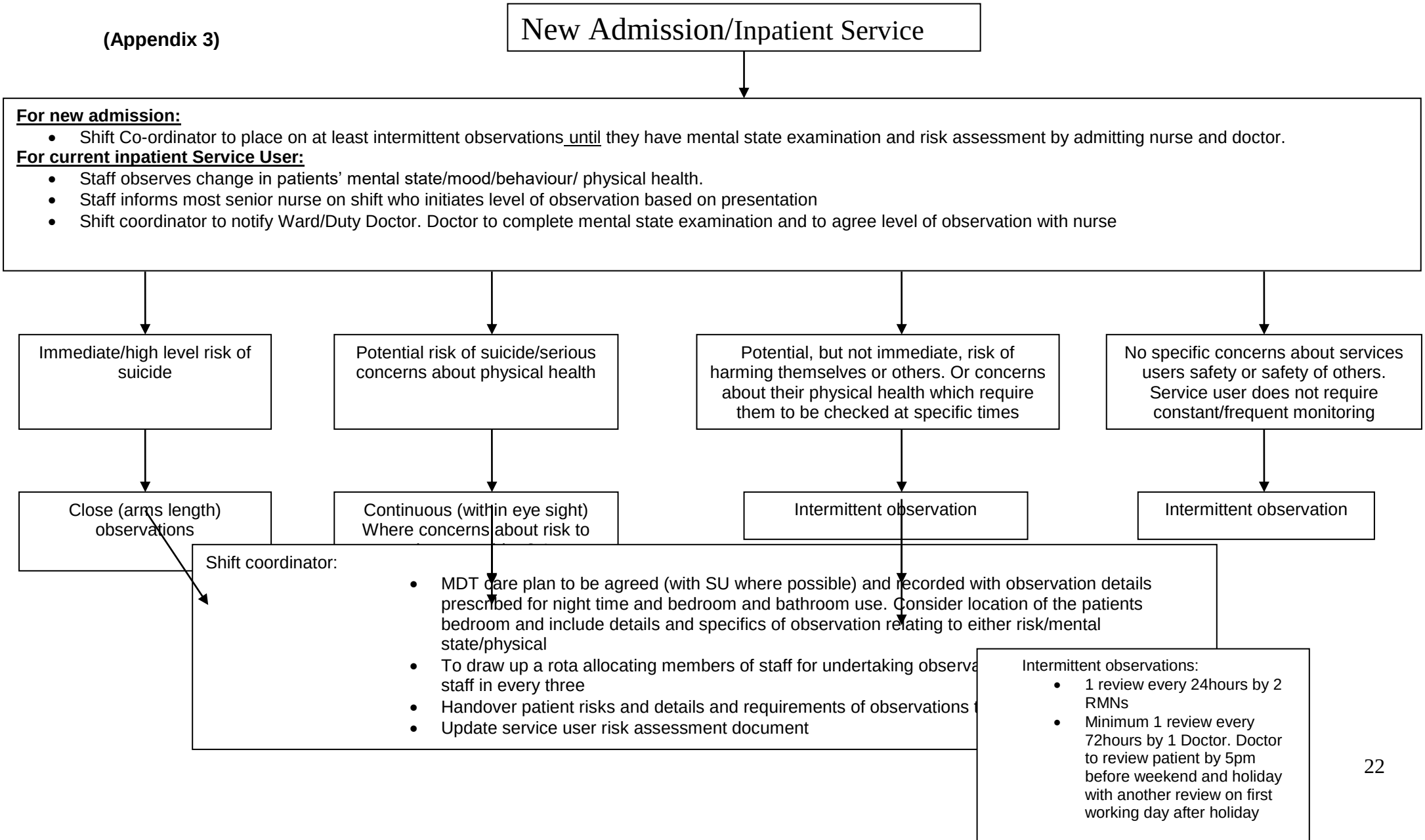
Please note the examples provided in the guidance are not the only examples of behaviour from that item rather they are suggestion of areas to consider.

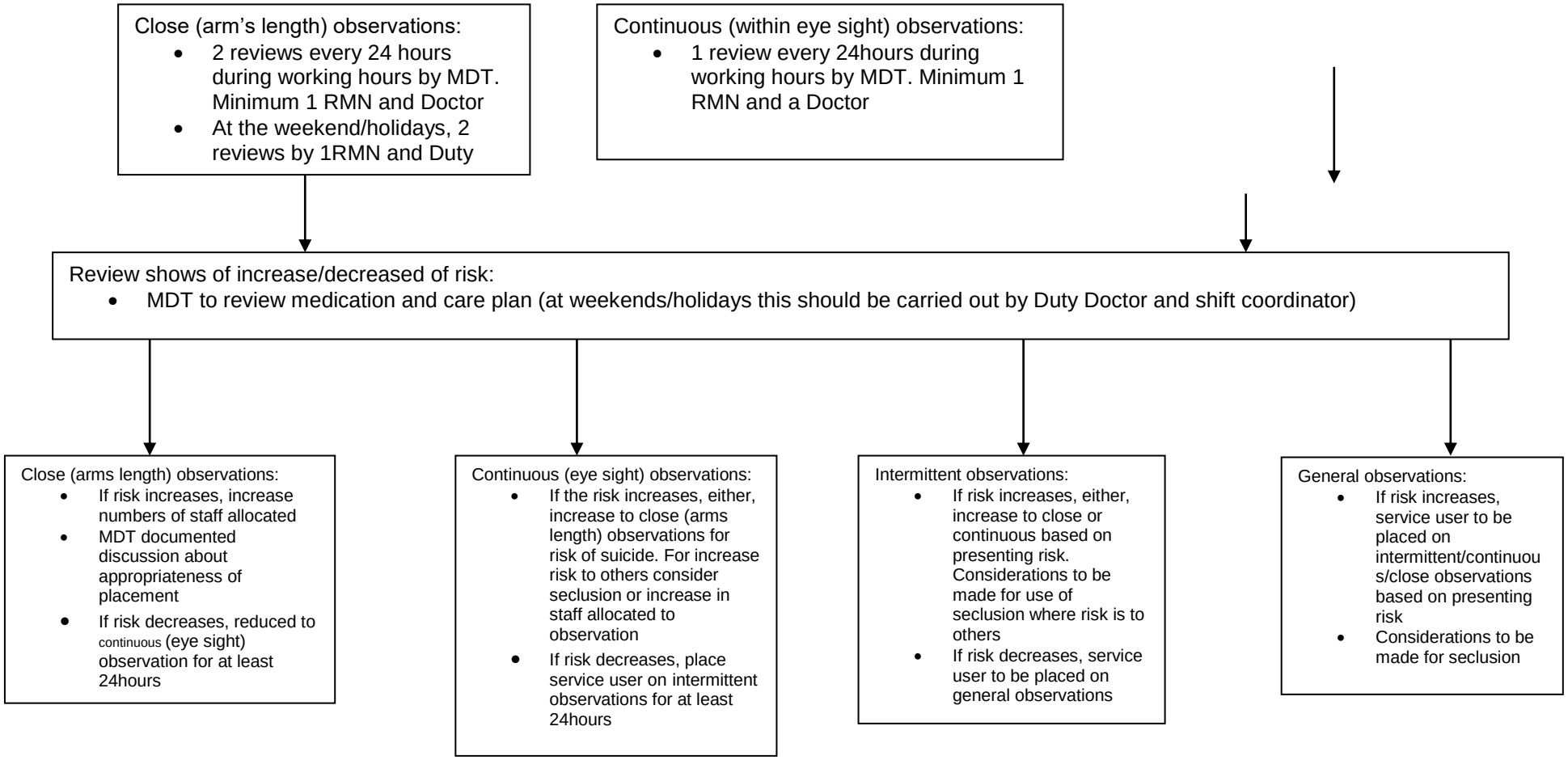
CATEGORY	ITEM	GUIDANCE
SLEEP	1. Peaceful sleep	Continuous, restful sleep
	2. Restless/interrupted sleep	The patient is unable to rest, such as tossing and turning, or the sleep is disrupted.
POSITIVE FACTORS	3. Used coping strategies	Any positive methods used by the patient to manage their thoughts, feelings and/or behaviour.
	4. Accepted support	Accepted support from staff or maybe sought support from staff to discuss their difficulties, communication to staff of increased stress.
	5. Compliance with care	Accepted medication and are working towards their personal recovery and treatment goals.
	6. Therapeutic engagement	Engaged therapeutically with staff such as discussing their situation/difficulties and showed insight into why they were on observations or in psychiatric care.
	7. Positive engagement	Engaged positively with staff and peers, engaged in any form of positive activity, attended workshops.
	8. Stable presentation	Calm, engaging in their normal routine, accepting diet and fluid, attending to their personal and environmental hygiene.
DISENGAGEMENT	9. Non-compliance with care	Not accepting their medication or working towards their personal treatment goals.
	10. Hopelessness	Displaying or communicating no hope for the future,

		despair, and low self-worth.
	11. Disengaged	Avoidance of or disengagement from staff, peers or activities that the patient usually engages in, non-compliance with diet/fluid or hygiene.
NEGATIVE BEHAVIOURS	12. Bullying	Influencing someone else's behaviour, intimidation.
	13. Grooming	To prepare someone to engage in a particular activity, to influence or manipulate someone else's actions.
	14. Subversion	Not complying with the rules and procedures such as engaging in substance misuse, attempting to abscond, and swapping possessions.
	15. Active Resistance	Communicated or demonstrated no intention of wanting to become well or move on that.
SELF-HARM/SUICIDE	16. Expressed suicidal thoughts	Communicated suicidal thoughts
	17. Expressed thoughts of self-harm	Communicated thoughts or ideas of self-harm
	18. Actual/Attempted self-harm	Engaged or attempted any form of self-harm including hitting body parts against the wall
	19. Facilitating self-harm	Actions that will help them to self-harm such as obtaining objects to self-harm with, hiding body parts from staff in order to self-harm on, potentially refusing diet and fluid in order to harm self.
	20. Facilitating suicide	Actions that may indicate a build up to a suicide attempt, such selling or giving away possessions, or actions that will help them commit suicide.
VIOLENCE	21. Actual/Attempted physical violence	Any form of physical violence, such as hitting, pushing and swinging at others.
	22. Threatening behaviour	Demonstrating hostile or threatening behaviour. This may be verbal or through use of body language.
	23. Thoughts of violence	Communicated plan or intention to harm others
	24.	
	25. Property damage	Caused damage to personal,

		hospital or a peers property, such as a magazine, TV, walls etc.
AGITATION	26. Sexually inappropriate behaviour	Demonstrated verbal or physical sexually inappropriate behaviour.
	27. Use of PRN	Requested the use of PRN to help to manage their agitation.
	28. Instability in thoughts	Communicated or demonstrated a sense of feeling threatened or paranoid.
	29. Instability in behaviour	Displayed increased agitation or behaviour which is unpredictable and inconsistent with their normal presentation.
	30. Instability in emotion	Heightened positive or negative emotional state compared to normal presentation, such as feeling low or manic, or a high changeability in mood.
INDIVIDUAL	31.	This space is to include specific relapse indicators or risk factors for the patient that have been observed/need to be monitored.

(Appendix 3)


New Admission/Inpatient Service
For new admission:
Shift Co-ordinator to place on at least intermittent observations until they have mental state examination and risk assessment by admitting nurse and doctor.
For current inpatient Service User:
Staff observes change in patients' mental state/mood/behaviour/ physical health.
Staff informs most senior nurse on shift who initiates level of observation based on presentation
Shift coordinator to notify Ward/Duty Doctor. Doctor to complete mental state examination and to agree level of observation with nurse
Immediate/high level risk of suicide
Potential risk of suicide/serious concerns about physical health
Potential, but not immediate, risk of harming themselves or others. Or concerns about their physical health which require them to be checked at specific times
No specific concerns about services users safety or safety of others. Service user does not require constant/frequent monitoring
Close (arms length) observations
Continuous (within eye sight) Where concerns about risk to
Intermittent observation
Intermittent observation
Shift coordinator:
MDT care plan to be agreed (with SU where possible) and recorded with observation details prescribed for night time and bedroom and bathroom use. Consider location of the patients bedroom and include details and specifics of observation relating to either risk/mental state/physical
To draw up a rota allocating members of staff for undertaking observa
staff in every three
Handover patient risks and details and requirements of observations
Update service user risk assessment document
Intermittent observations:
1 review every 24hours by 2 RMNs
Minimum 1 review every 72hours by 1 Doctor. Doctor to review patient by 5pm before weekend and holiday with another review on first working day after holiday


Close (arm's length) observations:
2 reviews every 24 hours during working hours by MDT. Minimum 1 RMN and Doctor
At the weekend/holidays, 2 reviews by 1RMN and Duty
Continuous (within eye sight) observations:
1 review every 24hours during working hours by MDT. Minimum 1 RMN and a Doctor
Review shows of increase/decreased of risk:
MDT to review medication and care plan (at weekends/holidays this should be carried out by Duty Doctor and shift coordinator)
Close (arms length) observations:
If risk increases, increase numbers of staff allocated
MDT documented discussion about appropriateness of placement
If risk decreases, reduced to continuous (eye sight) observation for at least 24hours
Continuous (eye sight) observations:
If the risk increases, either, increase to close (arms length) observations for risk of suicide. For increase risk to others consider seclusion or increase in staff allocated to observation
If risk decreases, place service user on intermittent observations for at least 24hours
Intermittent observations:
If risk increases, either, increase to close or continuous based on presenting risk. Considerations to be made for use of seclusion where risk is to others
If risk decreases, service user to be placed on general observations
General observations:
If risk increases, service user to be placed on intermittent/continuous/close observations based on presenting risk
Considerations to be made for seclusion

(Appendix 4)

Levels of Support/Supervised Care for Babies on the MBU

Close Continuous Supportive Engagement – within Arm's Length (RED)

This occurs when risks assessed by the MDT and where an infants health/safety maybe at significant risk due to the mother's mental state, taking into consideration the needs and risks associated with infant or with mother.

Staff maintain full care of the baby and constant supervision of the mother whilst she is with the baby. Staff must be within arms length of the baby at all times. Baby has own allocated member of staff separated from allocated member of staff observing mother.

*When allocating member of staff to care for baby, consideration is to be given as to suitable/appropriate discipline, experience level and previous knowledge of infant. Allocated worker should maintain care of the infant throughout the shift to promote consistency for the infant. Staff to also consider use of the nursery in caring for the baby, however baby will still be cared for by own allocated member of staff.

Staff should whilst maintaining infant's health/safety, allow the mother to have maximum access to her baby to encourage and enable bonding and to maintain their relationship.

Continuous Supportive Engagement – within Eyesight (ORANGE)

This occurs when risks assessed by the MDT and where an infants health/safety maybe at significant risk due to the mother's mental state, taking into consideration the needs and risks associated with infant or with mother.
Constant supervision, so infant is within sight of staff at all times, remaining in the same room as baby and mother but allowing the mother independence to carry out baby care but staff are able to provide intervention and support needed to maintain the safety/health of the infant.

Intermittent Supportive Engagement (YELLOW)

This occurs when the MDT assesses the mother and there are concerns about capability to care safely for infant independently. The team would be aiming to increase confidence and enable development of safe nurturing relationships between mother and infant.
Intermediate supervision allows the mother to have an increased responsibility in carrying out care for their baby therefore building the mother's confidence levels in caring for her baby and in developing a nurturing relationship. Staff should be making regular 15 minute checks to maximize flexibility of support available and adapt to changes in the mother's mental state – reviewing level of support as needed.

General Supportive Engagement (GREEN)

This occurs when the MDT assesses the mother and there are no immediate concerns about capability to care safely for infant independently

Mother will have unsupervised care of infant both day and night - when all the infants' needs are capable of being met by the mother and mother has been assessed as being able to assume that responsibility.

Mother carries out all needs of her baby unsupervised - has home/overnight leave and is preparing for discharge back into the community can be reviewed at any time following a risk assessment.

All levels to be reviewed by Multi Disciplinary Team on a regular basis or if there are any changes in the mother's presentation or mental state. Decision to change levels of observation can be made by two members of the multidisciplinary team.

(Appendix 5)

Review of Enhanced therapeutic observations template

Patient Name:	Ward:
Review date/time:	No. of days on close obs:
Staff members involved in review:	

Handover of engagement during period of observations:

Refer back to care plan, has the care plan been met?

Since the last review has any of the following occurred:

Aggression towards staff or anther service user: YES / NO If yes, Verbal ☐ Physical ☐

Experiencing hallucinations, particularly voices suggesting harm to self or others: YES / NO

Having paranoid thoughts where they believe others to pose a threat: YES / NO

Incidents of self-harm: YES / NO If yes, by what means:

Reported thoughts of self-harm and/or suicide: YES / NO

A physical health condition which is causing significant risk to physical health: YES / NO

Significant recent life event (such as bereavement) that may cause them to be a risk to self: YES / NO

If yes to any of the above, please provide a brief summary of the risk/s identified

Details: (have the risks changed since initiation of close observations)

Can the identified risks be managed without enhanced observations? YES / NO

If no, why? If yes, what is the new management plan?

Agreed level of observation following review:

Date/time of next review

(Appendix 6)

Observation Record Sheet

Service users Name:	**Primary Nurse:**
Consultant:	**RIO Number:**
Date & Time Observation commenced:	
Level of Observation:	

- **inpatient Care Plan - completed and attached including reference to use night time observations and use of bedroom and bathroom**
- **One third of observation responsibility to be undertaken by a registered nurse**
- **Senior staff member to sign off form at end of each shift**

Date	Time	Record of events	Allocated staff name print & designation	Sign (including senior staff at end of each shift)

(Appendix 7)

Supportive Observations Competency Checklist

The Manager (Band 8a, 7 or 6) will be satisfied that member of staff they line manage to undertake supportive observation is competent in the following areas:-

- Supportive Observation Policy read and understood.
- Seclusion policy read and understood (if patient to be observed is in seclusion)
- Responsibilities regarding documentation and timing of same read and understood
- Understanding the four levels of observations within the policy
- Understanding the rationale for enhanced supportive observations (i.e. self-harming, suicidal, physical health concern etc.).
- Understanding specific service user details relating to this episode of enhanced supportive observations (i.e. mood, mental state, behavior, physical health etc.).
- Understanding when and how to summon assistance if required
- Understanding of the importance of the service users care plan and receipt of formal hand over from the shift coordinator and being introduced to the patient prior to commencement of any period of observation
- Understanding their responsibilities in the event of an emergency on the ward (i.e. fire, serious incident etc.).

When this document has been read and understood, please sign below:-

Assessor:…… (Print Name)

…… (Signature)

Designation:……..

Staff Member:…… (Print Name)

…… (Signature)

Designation:……..

Able to assess bank staff out of hours Y / N

Comments:

(Appendix 8)

Observation Policy Implementation Audit

DATA COLLECTION FORM

Directorate:	**Ward:**
Auditor Initials:	**Date of Audit:**

	Standards to be measured	Yes	No	N/A	Comments *Please use to flag up any quality issues and explain any fails or N/As*
	Observation on admission				
1	Level of observation on admission is identified (minimum level – intermittent)				
2	Any changes in observation level since admission have been documented in the notes				
3	There is evidence in the notes that these changes have been communicated to the service user				
	Initiation of observations subsequent to admission				
4	Reason for initiating enhanced level of observation is documented in the notes. The initiation process used Rio codes				
5	Evidence of MDT discussion of observation level in the notes				
6	There is evidence in the notes that changes in observation level have been communicated to the service user				
	Staff allocation				
7	There is a ward rota for undertaking observations present for the current shift and on the shift planner				
8	No staff are undertaking enhanced observations for more than 1 hour				
9	Registered staff are completing one third of the observations in a shift				
	Care planning				
10	An observation care plan has been completed				
11	There is evidence of service user involvement in the observation care plan				

Observation review					
12	Reviews are documented at required intervals (*24hrs for continuous observations, and 72hrs for intermittent)*				
Record Keeping – completion of the observation record					
12a	Patient's name			[redacted]	
12b	Primary nurse				
12c	Consultant				
12d	RIO number				
12e	Date & time commenced				
12f	Level of observations				
12g	Record of events – ▪ *Dates and times all present* ▪ *No gaps* ▪ *Name and designation printed* ▪ *Signed*				