Therapeutic Engagement and Observation Policy

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Services	Applicable to
Trust wide	x
Mental Health and LD (Learning Disabilities)	
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Version Control Summary

Version	Date	Author	Status	Comment
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
2.0	Dec 2010	Lorraine Sunduza, Edwin Ndlovu	Final	Revised in light of SUI report recommendations (reference KU090410)
3.0	Oct 2011	Lorraine Sunduza	Final	Revised in light of SUI report recommendations (CT190211). Addition of responsibility to monitor patient's physical wellbeing and escalate as appropriate regardless of reason for initiation observations. Changes: 1. Introduction para 3 2. Purpose of policy para 3 3. Documentation para 2 4. Appendix 5 competency – rational 5. Flow chart – new admission and current service user.
4.0	March 2013	Launa Rolf	Final	Revised in light of Serious Incident recommendations (ref) Clarity with regards observation responsibility, senior nurse approval, qualified nurses' duties, and incident review (ref) directions with regards nighttime observations and room entry. Changes: 1. Definitions – section 4 2. Role of senior staff member 3. Qualified staff responsibilities 4. Introduction of an enhanced observation care plan 5. Nighttime and bath/bedroom directions 6. Template reflects care plan arrangements 7. Use of vision panels and night lights
5.0	April 2016	Lorraine Sunduza and Claire Mckenna	Final	Removal of separate care plan as this should be part of inpatient care plan
6.0	March 2018	Day Njovana and Daisy Mudoni		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
7.1	Oct 2024		Extended	Extended at Quality committee to allow time for full review of policy

8.0	August 2024	Sasha Singh		• Addition of expected standards of engagement and documentation following period of enhanced observations • Addition of expected standards of documentation including process to be followed for observations not undertaken • Addition of Trust wide agreed change ideas to improve therapeutic engagement and observations: - Board relay - Zonal observations - Twilight shift Addition of Honesty in Documentation training as part of observation competency training staff must complete
9.0	November 2025	Sasha Singh		• Amendment of clinical authority to downgrade observations (inconsistent in previous version) • Amendment of R Codes to allow for specific data capture for intermittent and close supportive observations • Amendment of expected level of observation and assessment to be undertaken and recorded by staff of service users on intermittent observations

EXECUTIVE SUMMARY

1. Therapeutic engagement and observations are an integral tool used in the provision of safe and effective care. The main aim is to promote engagement and reduce the risk of harm.

2. Staff allocated to undertake therapeutic engagement and observations must be adequately trained and assessed as competent to undertake this task. Undertaking this task have individual responsibility and are accountable to ensure the task is carried out as prescribed and where this is not possible, incidents of missed or incomplete observations are appropriately escalated, reported and recorded.

3. Therapeutic engagement and observations must have a completed care plan that reflects the interventions necessary to ensure patient safety- these care plans will include service user input as far as possible and where there is consent, can reflect the views and input of families or carers. Any changes to observation care plans must be discussed and agreed by multiple professionals in the team and documented in the progress notes, updated in the care plan and the risk assessment updated if indicated.

4. The task must be completed as prescribed and described in the observation care plan. This is particularly important when completing observations as the frequency and individual arrangements for observation directly link to patient safety. Any deviation from this that is not honestly reported and recorded will be treated as falsification of observations.

5. Therapeutic engagement and observation levels should never be decided based on staffing availability. Where increased number of enhanced observations are required and there is insufficient staffing resource to undertake the required tasks, the nurse in charge is responsible to escalated this to a senior member of the clinical team (including out of hours). Where clinical acuity changes during a shift and tis impacts on resource availability, the same escalation process should follow.

6. Teams should adhere to the principles of the board relay to promote completion of observation, handover of clinical observation and reduce the risk of missed observations. Zonal observations and the twilight shift can be applied based on individual service need i.e. only applied to clinical services where they would be most impactful, are safe to use and reduce risk.

Contents

1.0 Introduction

1.1 The main aim of engagement and supportive observation is to engage positively with each inpatient to reduce risk and prevent harm. This involves a two-way relationship, established between the staff member and service user that is meaningful, based on trust and is therapeutic in nature. Relational engagement includes key components of awareness, presence, mutuality, respect, authenticity, perception, and reflection. Additional investments have gone into all mental health inpatient wards to fund a Life Skills Recovery worker to increase staffing resource and increased access to therapeutic and engagement activities out of hours. See Appendix 7 Life Skills recovery Worker on twilight shift (2-10pm): Standard Guidance. This staff resource is in addition to safer staffing requirements.

1.2 Observations are interventions of varying intensity in which staff observe and maintain contact with a patient to ensure their safety and the safety of others. However, patient's observations and associated practices are potentially highly restrictive. Multi-disciplinary teams need to balance the need for positive risk taking using the least restrictive practice versus the use of enhanced observation.

1.3 Engagement and observation are a required skill for all mental health professionals. This includes competence in the prevention and management of suicide, self-harm and violence along with skills to monitor mental health and evaluate against agreed planned care. The same engagement and observation levels may also be used for people with risks including falls risk, physical health concerns or other presentation where a higher level of monitoring is required. See Physical health policy and Slips Trips and Falls Management (Inpatient) Policy.

1.4 The role of inpatient staff in therapeutic engagement and observation includes the reporting and recording of each inpatient location, mental state, wellbeing, and behavior. Inpatient staff also have a key role in reviewing levels of observations and escalating any changes in presentation appropriately. Any delays in completing scheduled observations or missed observations must be noted on the observation recording sheet, escalated to the nurse in charge of a shift and reported on the Trust InPhase system. Staff must not falsify observation records where observations have not been undertaken or are delayed in being carried out.

1.5 There are four levels of observations applied in the Trust:

- General supportive observation
- Intermittent supportive observation
- Continuous supportive observation – within eyesight
- Continuous supportive observation – within arm's length

2.0 Purpose of the Policy

2.1 The policy's purpose is to provide direction and guidance for the planning, implementation and undertaking of high-quality supportive observation procedures for the service users in receipt of inpatient care. It provides a framework for the care of patients who may be suicidal, at risk of self-harm, harm from or to others; risk associated with physical frailty, or physical or psychotic or cognitive deterioration, increased risk of falls, and sexual disinhibition.

2.2 The purpose of therapeutic engagement and observation is to ensure the sensitive monitoring of the behaviour, mental state and well-being of people receiving inpatient care, enabling a rapid response to any change. This will support preventing inpatients from coming to harm by harming themselves or others.

2.3 The policy will ensure supportive observation practice is therapeutic in nature, is recovery and patient focused and reduces the risk of observations being used in a disproportionately restrictive manner. The policy provides a framework to ensure that all inpatients' level of observation and engagement is tailored appropriately to their individualised needs and risks.

2.4 It ensures colleagues understand their role in making decisions to ensure a safe and therapeutic environment, to facilitate the assessment and management of an inpatients' supportive therapeutic observation, and the rationale for supporting those decisions.

2.5 The policy outlines training and competency expectations for staff. All registered and non-registered nursing staff (including substantive, bank and agency staff) must complete the Inpatient Safety suite training bundle that includes Observations in MH Care and Honesty in Documentation training. Staff must be inducted and orientated to clinical areas as this is integral to undertaking observations. Observations can only be undertaken by a clinical staff member familiar with the ward environment, the service user on close supportive observations and who has completed the Inpatient Safety Suite training bundle.

2.6 The observation care plan must specify the level of engagement and observation for each individual at any given time This should include patient's clinical needs, strengths, and indicators of deterioration and harm, alongside their advance statement, carer's views, and the purpose of their admission to hospital. The policy recommends that personalised care, treatment, and safety planning should be determined and informed by using information from the patient.

2.7 Risk Assessment is an essential feature of engagement and observations. Effective management of risk must focus on reducing or altering harmful behavior by individuals, to enhance their safety and work towards their recovery. The clinical risk assessment and formulation is the basis for determining levels of observation and applies to both informal and detained service users.

2.8 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, Transfer and Discharge Policy
- Physical health policy
- Slips Trips and Falls Management (Inpatient) Policy
- Seclusion Policy

- Local Fire and Evacuation Policy and Procedure
- Safeguarding Children Policy
- Safeguarding Policy
- Use of Force Policy
- AWOL Policy

3.0. Definition

3.1. Observations are an interactive process that promotes relationship building and recovery. High quality observation will incorporate interaction, rapport building and collaboration with the service user. It is intended to be supportive and engage the service user.

3.2. Observation of service users should be seen as a partnership between the multidisciplinary team and the service user and their carers. It should not be delivered in a way that is, or is perceived as, custodial, restrictive or punitive.

3.3. Generally, the level of supportive observation should be set at the least restrictive level, for the least amount of time and in the least restrictive setting possible.

3.4. Staff are deemed competent and able to undertake observations only after they have undertaken and passed the competency tests for Observations in MH Care and Honesty in Documentation training available on the Trust Inpatient Safety Suite on the Learning Academy (ELA).

3.5. All decisions regarding observations are to include the nurse in charge of the ward at that time. Decisions around the use of observations do not solely rely on the presence or absence of incidents. Rationale for changes to levels of observations must be clearly documented in the RiO progress notes and any changes reflected on the risk assessment (if appropriate) and observations care plan.

- The decision to increase or initiate supportive levels of observation can be based on observations by members of the team or noted changes in circumstances likely to increase risk. Collateral information provided by family members or carers should also be considered in the assessment of risk and determining level of observations.

- Any decisions to reduce levels of observation must be taken by 2 registered nurses as a minimum and one of these must be a Senior nursing member at Band 6 or above. Reduction in levels of observations must be based on a clinical assessment of risk and not on staffing resource availability.

4.0. Use of observations

4.1 There are four levels of supportive observation within the policy:

a) General supportive observation
b) Intermittent supportive observation
c) Continuous supportive observation – within eyesight
d) Continuous supportive observation – within arm's length

4.1.1 Staff must only be allocated observations if they have completed the Observations in MH Care and Honesty in Documentation training and have passed both competency tests. They must also be orientated to clinical areas and have knowledge of the service users in the clinical area where observations are allocated.

4.2 General Observations

4.2.1 General observations are the minimum level of observation, these low-level observations are performed intermittently to locate a patient and visually check their well-being. All service users, including those on enhanced levels of observations must be checked and recorded on the general observation sheets.

4.2.2 General observations checks must be completed visually by an allocated member of staff on a minimum hourly basis. Local areas can increase the frequency of general supportive observations as needed due to the environment e.g. PICU (Psychiatric Intensive Care Units), Forensic Services, Older Persons' Services, etc.

4.2.3 General supportive observation does not require all service users to be within sight at all times, however the whereabouts of all service users should be known to staff at all times. For service users on leave or absent from the ward, this should be documented accordingly.

4.2.4 General observations don't always provide a practical opportunity to engage therapeutically with patients. Staff completing these general observations checks are expected as a minimum to observe the location and wellbeing of the patient When performing a general observation, colleagues must as a minimum:

- locate and visibly check that the patient is safe be mindful of and respond accordingly to any signs of deterioration.
- follow up on or delegate appropriately any non-urgent concerns and requests.

4.2.5 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 nurse in charge can make the decisions to increase the observations to enhanced observations and must inform the medical team for review of the care and treatment if indicated.

4.2.6 At the beginning of each shift, it is the responsibility of the incoming nurse in charge to ensure that a 'visual check' has been conducted jointly with a designated staff member from the outgoing shift. Identifying all of the service users on the ward, being aware of their whereabouts, ensuring there are visible signs of life and accounting for the service users who are not present on the ward. This should be undertaken by/with a staff member who is familiar with all the service users on that ward and the expectations of the task. 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. This task may coincide with scheduled general observation checks. If the visual handover occurs outside of the scheduled general observation checks, the general observation checks must still be completed at the appropriate time and accurately recorded.

4.3 **Zonal Observations**

4.3.1 Zonal observations may be used in addition to general supportive observations. Zonal observations do not replace general supportive observations and cannot be prescribed. This allows an alternative method of observation, which involves allocating staff to observe defined areas of the ward zones). Staff allocated to these zones will be able to observe and engage with patients individually and as groups for set periods of time. It does not require the service users in the defined zone to be visible at all times to the allocated member of staff for that zone. The use of zonal observations is better suited to clinical areas where the environment may present challenges in carrying out observations e.g. impaired lines of sight or with service user groups more likely to be dysregulated by the stimulation of an inpatient setting e.g. PICU or Learning Disability services. Staff carrying out zonal observations have a greater opportunity to detect when circumstances change and provide a sooner intervention to avoid or deescalate disruptive or unsettled behaviour. Please see Appendix 6 Zonal Observations Standard Guidance.

4.3.2 Zonal observations can be implemented at certain times or functions dependent on the ward layout and key tasks relevant to the service user group. Ward zones must be designated and specific - these must have explicitly defined rooms, corridors, and spaces within them. The zone should be described clearly with defined boundaries as to where the zone starts and ends. Staff on shift are allocated on the handover sheet in the same way enhanced observations are allocated.

4.3.3 Staff should proactively engage patients in that zone if this does not compromise the staff member's ability to view the whole zone and leave a zone unattended. Individual needs assessments will inform individual care plans and individual observation levels. This means that individual patients could still be managed under existing enhanced observations if deemed necessary.

4.3.4 Allocated staff will:

- know their zone
- know who they are to observe
- be familiar with the observation status of all service users in their observation zone
- be vigilant to monitor safety of ward and be confident to intervene or summon help when needed
- facilitate interaction and communication with the service user
- provide a handover for the nurse taking over from them
- report any changes in the service user's behaviour considered significant to the nurse in charge
- report any concerns to the nurse in charge.

4.3.5 Staff allocated to undertake zonal observation will be required to record their observations and interactions during that period for service users in that defined zone. This does not need to be recorded as individual entries for each service user in that zone, only instances where there has been an actual intervention or interaction. Where there has been no observed activity or direct interaction, this should still be recorded.

4.4 Enhanced Observation

4.4.1 Enhanced observation is a therapeutic intervention intended to reduce the factors that contribute towards increased risk to and from an individual or others. They may also be used for people with risks including falls risk, physical health concerns or other presentation where a higher level of monitoring is required Enhanced observations must focus on engaging the person therapeutically and enabling them to address their care needs constructively.

4.4.2 The term **enhanced** level of supportive observations refers to intermittent and continuous (within eyesight and at arm's length) levels of observations.

4.4.3 Staffing shortages must not influence the decision to initiate or reduce levels of enhanced observations. Local escalation procedures must be followed and consideration should be given to redeploying resources from other clinical areas, non-essential tasks that wards can be exempt from or tasks that can be delayed releasing capacity to carry out observations.

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

a) The level of enhanced observation must be part of the observation care plan with the plan being agreed by the Multi-Disciplinary Team (MDT) and the service user. If the service user disagrees with the observation care plan, staff should and address their concerns and consider reasonable amendments to the care plan. Any reasons for this disagreement and measures taken to address these should be clearly documented on the care plan. The care plan will be embedded in Rio progress notes and 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.

b) The observation care plan will give specific instructions for the observing nurse to follow. These could include the following:

i. Should the nurse allow the service user to use the toilet or bathroom with or without the nurse physically going into the room.
ii. 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 from the outside.
iii. Should the nurse enter the bedroom at night to check on the service user or can this safely be undertaken from outside the room.

iv. Support required at mealtimes to monitor and record food and fluid intake.

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

4.4.6 The observation care plan **MUST** be attached to the Observation Record Sheet (appendix 3) and Dialog+

4.4.7 A registered nurse – including bank employees must undertake at least one third of the observations within the shift (where possible and there are adequate resources). All observations must only be undertaken by staff assessed as competent to do so.

4.5**. Intermittent Supportive Observation**:

4.5.1 This level of observation is appropriate when service users are potentially, but not immediately, at risk. The interval between observations must be clearly identified by the person who prescribed them. 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 and documented as completed at the time the observation was completed.

4.5.2 **Standards for intermittent Observations and engagement:**

a) Observations must be carried out even when the service user is asleep in bed; this applies to day and night time. Any exceptions to this must be documented in the observation care plan formulated by the multi disciplinary team.

b) Observations should be used to visibly check the patient's location, well being and signs of life. Any concerns must be raised by the staff undertaking the observations at that time.

c) Staff allocated to undertake observations must ensure these are completed at the defined intervals and frequencies in the care plan. Where this is not possible and the staff is called away, they must ensure the task is handed over to a colleague. The Trust has implemented a board relay system to support completion of observations where allocated staff to complete observations are responsible for ensuring the physical handover of the board as part of the handover of the responsibility to carry out the observations. Staff must also handover the patient's presentation and any relevant information from their period of observation to the member of staff taking over. Please see Appendix 8 for the Board Relay Standard Guidance.

d) Observations should only be downgraded when clinically appropriate. Where there are additional measures agreed as part of intermittent observations to ensure the safety of the service user, changes or amendments to these plans must also be included in the review of

observations. Examples of this may be decisions to limit access to a service user's bedroom unless under supervision.

4.5.3 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 observation care plan, such a decision must be made by the multidisciplinary team and based on an up-to-date risk assessment. This plan should clearly state the staffing requirement to facilitate leave. A further decision must be made by the nurse in charge based on the current presentation at the time it is proposed to leave the ward to determine if it is appropriate to facilitate leave and the staff appropriate to undertake the escort. The service user must be accompanied by a staff member if they leave the ward.

4.5.4 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 should be made. Out of hours the point of escalation is the Duty Senior nurse and On call Manager. It is important that an InPhase report is completed to highlight safety concerns to the directorate if there are inadequate staffing levels to manage clinical dependency.

4.6 **Continuous Supportive Observation – within Eyesight**:

4.6.1. Continuous (within eyesight) supportive observation is required when there are significant concerns about the service user's safety (this can be linked to mental and/or physical health), or where the service user is vulnerable and there are potential safeguarding concerns. If there is an attempt/concerns of harm to others, then considerations should be made about the risk to the member of staff who will be allocated to carry out the observations. Where there is a decision to increase ratios of staff to service users for safety, this should be reflected in the observation care plan and staff required to undertake observations should be included in the daily review. The observation care plan must state if the service user does not require observation whilst using the toilet/taking a bath(shower). In the event of an emergency on the ward the observing member of staff is to stay with the service user as they evacuate the ward

4.6.2. Gender issues are to be considered when allocating observations as far as possible to uphold the service user's right to privacy and dignity. For specific tasks such as when using the bathroom/toilet, staff of the opposite gender to the service user should seek support from colleagues. Where eyesight observations must be maintained throughout, staff should swap cover for observations if the service user is using the toilet or in the shower.

4.6.3. 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.

4.6.4 A service user who is prescribed continuous supportive observations must be assessed (as part of their risk assessment) for access to fresh air breaks Fresh air breaks should be facilitated on Hospital grounds; this may be more appropriate in an internal courtyard area. The length of time should be clearly documented in the care plan, the designation of the staff and the number of staff needed to facilitate the fresh air. Please see AWOL Policy

4.6.5 Service users on continuous observations can be escorted to appointments including access to the general hospital for medical emergencies/procedures. For emergency general hospital attendance, the nurse in charge has to ensure that they have adequate staff attending with the service user. The Duty Senior Nurse, medical team (if out of hours the duty doctor) has to be informed. For routine/known appointments this has to be care planned and conditions agreed in advance.

4.6.6 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. Such cases will still require an observation care plan.

4.7 **Close Supportive Observation – within Arm's Length**:

4.7.1 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 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.

4.7.2 It may be necessary to search the service user and their belongings dependent on their presenting or known risks, 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). 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.

4.7.3 If there is a risk of harm to others this level of observation must not be prescribed using one member of staff. Where there is a decision to increase ratios of staff to service users for safety, this should be reflected in the observation care plan and staff required to undertake observations should be included in the daily review.

4.7.4 A service user who is prescribed continuous supportive observations must be assessed (as part of their risk assessment) for access to fresh air breaks. Fresh air breaks should be facilitated on Hospital grounds; this may be more appropriate in an internal courtyard area. The length of time should be clearly documented in the care plan, the designation of the staff and the number of staff needed to facilitate the fresh air. Please see AWOL Policy

4.7.5 Service users on continuous observations can be escorted to appointments including access to the general hospital for medical emergencies/procedures. For emergency general hospital attendance, the nurse in charge must ensure they have adequate staff attending with the service user. The Duty Senior Nurse, medical team (if out of hours the duty doctor) has to be informed. For routine/known appointments this has to be care planned and conditions agreed in advance.

4.7.6 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 can occur where the risk being considered is reduced when the service user is outside the ward environment (observations may have been due to conflicting relationships on the ward/bullying etc.). This must be agreed by the local service multidisciplinary team with a unit-specific protocol. The decisions have to be care planned with an up-to-date risk assessment.

4.7.7 In the mother and baby unit (MBU) observations are based on MDT risk assessment of mother and will include consideration of her ability to provide direct care to the child (Appendix 5).

5.0 Initiation of Observation

5.1 Any decision to initiate enhanced observations must be clearly recorded in the RIO progress notes. Entries should be clearly reflect the appropriate R-Code as a header in the entry. The relevant R- codes are:

OBSVN01 INT (to be used for intermittent observations)

OBVSN01 CON (to be used for continuous supportive observations)

Enhanced observations must be recognized as a restrictive intervention and may be experienced by service users as punitive, intrusive, or coercive. They should only be implemented after therapeutic engagement with the patient has not effectively reduced the risk to the individual or to others and this should be for the least amount of time clinically required. Staff should also consider environmental changes they can employ that might reduce the risk and need for use of enhanced observations eg bedroom location, alternative forms of engagement e.g. use of sensory rooms and activities.

5.2 The least intrusive level of observation which is appropriate to the risk being managed should always be adopted; staff must be mindful when prescribing and undertaking observations, of the service user's dignity and privacy whilst maintaining the safety of the service users and those around them. When a clinician/team initiates enhanced levels of observations, the overall treatment plan must be reviewed i.e., medication, section 17 leave, legal status. The team must consider whether social visits are appropriate and where possible should engage service users in this process.

5.3 The decision to initiate or increase the frequency of observations may in the first instance be appropriately taken by the most senior nurse on the ward at that time, in response to an assessed risk. 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 admission occurs out of hours this should be communicated to the admitting duty doctor. However, wherever possible, decisions about the level of supportive observation required by an individual service user should be jointly made by the multidisciplinary team.

5.4 All new patient assessments should be undertaken jointly by medical and nursing staff. All newly admitted service users should be allocated a minimum level of intermittent observation until the service user has been examined and have had a medical and risk assessment completed. Consideration can also be given to the use of close supportive observations until these assessments are completed and the required level of observation has been specified. Where an initial joint assessment has not been possible it is the responsibility of the clinician (nurse or doctor) who initiates changes to levels of observations to verbally handover the agreed plans for care including any levels of observations prescribed.

5.5 After a decision has been made to initiate enhanced observations, a doctor must 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. Equally the treating multi-disciplinary team should be made aware of the individuals escalating risks.

5.6 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
- A patient's advance directive
- A patient's "My safety plan"

NB: Also refer to MSORT guidance Appendix 2

6.0 Observation Care Plan

6.1 An observation 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 will need to be imbedded within the Rio progress notes.

6.2 It should also be specific in detailing what has been agreed by the MDT such as:

- reason(s) for initiating enhanced level of supportive observation,
- the level of observations prescribed,
- the goal(s) of observation,
- the service user's views
- The team's plan for the period of enhanced observation with a review frequency agreed
- The engagement requirements reflecting trauma informed principles
- Signposting to any associated advanced statement or directive
- Signposting to any Personal Safety plan
- Arrangements for access to fresh air
- number and designation of staff allocated
- Gender requirements
- supervision arrangements when using of toilet/bathroom facilities, visitors (both social and legal)
- Any items withheld from the service user
- Activities that have been collaboratively agreed and where necessary escort requirements to accommodate same.
- Relapse signs
- Trigger factors

7.0. Staff Allocation

7.1. The shift coordinator allocating staff to carry out observations has a responsibility to ensure that staff rostered to complete enhanced observations have been assessed as competent, have received an orientation to the ward environment and a handover of service users on the ward including their risks. Staff also have personal responsibility and are accountable for their own practice and must inform the shift coordinator if they have not undertaken training or feel capable of undertaking allocated observations.

7.2. The shift coordinator will draw up a rota at the commencement of every shift to ensure that the observations are distributed fairly and according to competence. The observation rota must be formally documented on the ward's 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. Observations may involve a number of staff, with care being handed over at intervals using the principles of the board relay. The shift coordinator may allocate observation levels to non-nursing clinicians who are familiar with the ward environment and have had their competency to carry out observations assessed and are breakaway trained. Changes to the shift allocations must be made if indicated by changes in levels of observation and communicated directly to the staff on duty.

7.3. Clinical staff are expected to observe and record service users' functioning, behavioral presentation, mental state. This may be completed by allocated staff at the end of their shift.

7.4. For service users on continuous supportive observations, it is unacceptable to only note the location of service users. When undertaking any level of observation, the staff tasked with undertaking observation for their allocated time should record if the patient is awake or not, engaged in any activities or declining interventions as prescribed in their care plan. Continuous attempts must be made to engage meaningfully with the service user.

7.5. Staff carrying out close supportive observations **must not** be distracted by engaging in other activities that would interfere with their ability to carry out observations safely. This includes the use of mobile devices whilst on duty (please see Mobile Phone/Tablet Policy for Service Users , Visitors and Staff (Inpatient)).

8.0. Handover

8.1. A handover will take place at the beginning of each shift, with all staff on the incoming shift present. The handover will include a brief appraisal of all service users on the ward, their mental state and potential risks highlighted. A member of the outgoing shift will conduct an environmental and well-being check with a member of staff from the incoming shift to ensure all service users are accounted for.

8.2. There will be a verbal handover of the mood, behavior and interactions with the service user from the member of staff completing the period of observation to the member of staff taking over observations as well as their observation care plan. To support this process in practice, each clinical area will have a system for 'handing over observations and the service user' demonstrated by a physical token. This process of handing over will be called the board relay (Appendix 8).

8.3 No allocated period of observation by a member of staff should be longer than 1 hour. At the end of each observation period, the members of staff where possible, 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 users.

8.4 In exceptional circumstances where staff undertake periods of observation for longer than 1 hour, this must be reported to the shift co-ordinator and an InPhase report completed before the end of that shift. The shift coordinator is responsible for ensuring they check on the staff completing the observations welfare, consider any potential impact on safety of the staff and service user and plan for them to be relieved as soon as is reasonably practical.

8.5. It is the responsibility of the shift coordinator to ensure that staff on duty are aware they need to familiarize themselves with individual observation care plans i.e. level of observations, reason for observations and arrangements for 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. Reviewing levels of observations

9.1. The review process should always include the service user. If unable to have service user views in the review process, this should be documented in the review template (Appendix 5) using the appropriate Rio code and imbedded within the progress notes. Shift coordinators and medical staff are responsible for reviewing enhanced observations. Any enhanced observations initiated without medical support must be reviewed by the senior nurse on duty with medical staff at the earliest opportunity. 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.

9.1.1. All decisions to review levels of observations must be verbally communicated to the nursing team on duty by the nurse in charge and reflected on the observation care plan. The level of observation must be based on the services users' reason for admission, clinical presentation, and current and historical risk and this should be documented in the clinical records. Changes to the shift allocations must be made if indicated by changes in levels of observation and communicated directly to the staff on duty.

9.1.2 Levels of observations should never be determined by staffing levels. They should always be based on the service user's safety and or that of others, 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. Where there are concerns about staffing resource to undertake observations, this must be escalated to the team manager or Matron and out of hours the Duty Senior Nurse (DSN), and on call manager. An InPhase report must also be completed.

9.2 Intermittent Supportive Observation:

9.2.1 MDT ward rounds should always consider the current plan for any patient requiring more than a general level of observation. The MDT should always plan ahead and have clear parameters outlining conditions and observed behaviors that would facilitate downgrading of enhanced observation at the earliest opportunity. The documentation of observation reviews 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:
RCODE OBSVN03: Intermittent Observations 72 hour Doctor review

9.2.2 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 further reviews should they deem the patient's presentation to have changed significantly.

.

9.2.3 Following a period of assessment of at least 6 hours, two registered nurses can decide whether a patient can be safely stepped down to a general level of observations. This will be guided by the reasons for admissions, current presentation, current and historical risks. This decision must be documented in the clinical notes and record the names of the 2 nurses undertaking the review and agreeing to downgrade observations

9.2.4 A medical assessment is required every 72hours (about 3 days) following a patient being placed on intermittent observations The ward doctor should review the patient by 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.

9.3 Continuous Supportive Observation

RCODE OBSVN04: Continuous eyesight Observations 24 hours Doctor and Nurse review

9.3.1 Continuous (eyesight) supportive observation must be reviewed by a registered Nurse and a Doctor at a minimum of every 24 hours.). During the weekend and bank holidays such reviews may be carried out by a registered nurse and the duty doctor. A record of the discussion between the registered nurse and the doctor must be clearly documented in Rio.

9.3.2 Close Supportive Observation – within Arm's Length-

RCODE OBSVN05: Continuous arms- length Observations 24 hours Doctor and Nurse review

9.2.3 Continuous (eyesight) supportive observation must be reviewed by a registered Nurse and a Doctor at a minimum of every 24 hours.). During the weekend and bank holidays such reviews may be carried out by a registered nurse and the duty doctor. A record of the discussion between the registered nurse and the doctor must be clearly documented in Rio.

9.4 Enhanced observations after a Week:

RCODE OBSVN07: Weekly independent enhanced observation review

9.4.1 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. In Forensic services there may be service users subject to enhanced packages of care where the need for continued close

supportive observations has been agreed as appropriate to their need- these cases will not require an external review. Similarly in all services where a service user may be on extended leave in a general hospital receiving care and treatment, an external review will not be required.

9.5 Amendments to and Termination of Observations:

RCODE OBSVN08: Termination of enhanced observation

9.5.1 At a minimum, the decision to discontinue or downgrade level of observations must be agreed between 2 registered nurses with one nurse being at Band 6. Where a doctor has not been directly involved in the decision to downgrade enhanced observations, the nurse in charge must inform them at the soonest opportunity. A management plan must be agreed and clearly documented on RiO and the care plan and risk assessment (if appropriate) must be updated to reflect the changes. The decision to amend levels of observations must be recorded on the Review of Enhanced Therapeutic and Observations Template Appendix 5.

9.5.2 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.

9.5.3 There should be a graded reduction of close (arm's length) and continuous (eyesight) supportive observations to general observation. All continuous supportive observations 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. However as decisions around initiating observations are patient and risk specific, a graded reduction may not be necessary.

10 .0. Support for Staff

10.1 The training provided to staff is essential to ensure they understand the task and professional accountability and responsibility for observations. Where individual practice falls short of expected standards of practice, managers must facilitate a supportive discussion that enables the individual to reflect and look at any potential opportunities for learning and development. Managers must be transparent where professional conduct and standards of practice have fallen short and are likely to trigger management under the Trust Disciplinary Policy.

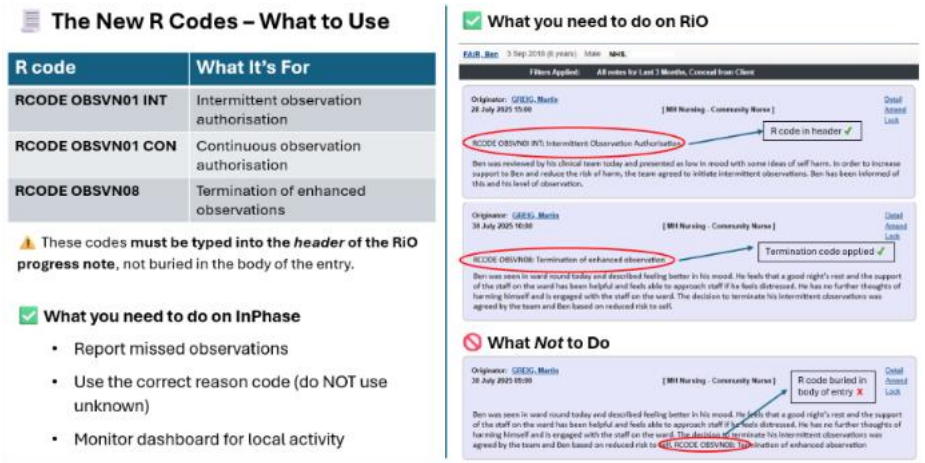
10.2 The multi-disciplinary team must provide an open and supportive environment, to enable members of staff to discuss their feelings about participating in supportive observation.

10.3 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 must be completed. Records of all decision-making process and review of enhanced levels of supportive observation should be documented in detail in the service user's progress notes. Entries should reflect the actual time the observation was completed. Staff must not falsify observation records where this has been missed. Please see Appendix 11 for Observations not undertaken Protocol

11.2. All observation activity related data will rely on the correct application of the R Codes onto RiO progress notes and incident reporting on In Phase for missed observations.



Observations activity data will be available on the Power Bi dashboard Quality- therapeutic Observations folder. Additionally current inpatient enhanced observation activity is visible on the Power Bi ward view pages. Examples of where this observation data might be included in clinical discussions to support learning and improvement are handover/huddles, the Senior Nurses' meetings, Time to Think Forums and weekly safety discussions.

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

11.4. For all patients on enhanced observation, there must be a completed observation care plan. For close supportive observations' hourly documentation, a summary of the patient's presentation (risk behaviors, significant events) and any therapeutic interventions must be recorded in the observation record sheet following each period of completed observation by the allocated member of staff. Documentation must be completed in a timely manner (within 15 minutes of completed close supportive observations) and not left until the end of the shift.

11.5. 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.

11.6. Any changes/deterioration/concerns regarding service users' physical health state observed during any level of observation should be handed over to the nurse in charge and documented in the RiO progress notes. Physical health observations (BP, temperature, pulse, etc.) must be completed, recorded using the RiO NEWS2 forms and escalated as appropriate.

11.7. Termination of enhanced supportive observation must be recorded on the care plan and the service user's RiO progress notes. The termination of enhanced observations R Code must be used to head the entry in the RiO progress notes: **RCODE OBVSN08**

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

11.9. Missed or delayed observations must not be falsified. This constitutes gross misconduct and staff found culpable of this poor practice will be managed under the Trust Disciplinary Policy and procedures. Where observations have been missed or are delayed staff must follow the Observations not undertaken Protocol. Staff must prioritize checking the whereabouts and wellbeing of the service user once alerted to missed observations and inform the nurse in charge. An InPhase report must be completed.

11.10. A summary of the interactions/ interventions with the service user and observed mental state must be entered in the service user's progress notes at the end of each shift.

12.0. Legal Status

12.1 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

amount 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.

13.0. Competency

13.1 It is the responsibility of the Matron to ensure that every member of nursing staff on their ward is assessed as competent to undertake supportive observations on the ward(s). Inpatient Lead Nurses have responsibility for the competency of their workforce and will have established governance structures for oversight of rates of compliance.

13.2 All inpatient registered and unregistered nursing staff staff (Permanent and Bank) are expected to complete the ELA Observations in MH Care and Honesty in Documentation training as part of the Inpatient Safety Bundle. before they undertake any observations. These staff read the policy and must be aware of their responsibility to follow it and address any concerns they may have. Other members of the MDT should familiarise themselves with this policy and must undertake the required training before undertaking observations.

13.4 Where staff fail the assessment twice, their support needs should be considered by their line managers. For bank staff, this will need to be feedback to the bank team for oversight and specific supports to be put in place. In some cases, the Capability Policy and Procedure is to be considered.

14.0 Training and competency

The Trust will provide training on the subject of this policy. The Observation training is included in the Inpatient Safety Suite and is classed as essential for all inpatient clinical staff. Staff must also complete the Honesty in Documentation training within the Inpatient Safety suite. Compliance with training is reported via the Learning Academy platform and reports available to team managers. Matrons and Managers can also directly monitor individual compliance through clinical supervision.

15.0 Process for Monitoring Compliance with and the Effectiveness of this Policy

15.1. Matrons, nurse managers and/or their deputies should monitor compliance with the Inpatient Safety Suite staff training using ELA.

15.2 Unit observation completion data must be collected using Power Bi and discussed with staff in each unit's safety/governance forums. Teams will use the data to inform learning and areas for improvement in observation practice.

15.4 A quarterly overview summary of observation practice and any improvement actions must be fed back to the Directorate management team for oversight and be shared at the Lead Nurses' meeting.

15.5 Service user experience will be captured through PREM data and will be considered as part of service evaluation.

16.0 Process for Reviewing, Approving and Archiving this Policy

16.1 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.

16.2 Changes to this policy can occur outside of the agreed review timeframe if indicated- this can be due to significant changes to practice or introduction of new tools and procedures that impact on therapeutic engagement and observations.

17.0 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

RCODE OBSVN01 INT (or CON): Observation Authorisation
Name of the patient:
MHA (Mental Health Act) Status:

Observation commenced at (time):
Decision to initiate enhanced observation made by (doctor/Nurse):
Level of enhanced observation:
RC informed at (name, time and if by email):
Has the risk assessment been updated?

Care plan
Level of enhanced observation discussed with service user: *(what was discussed, how did the service user respond? e.g. fears, thoughts, feelings etc.)*

Reason for enhanced observation: *(e.g. risks, concerns, assessment, are there physical health concerns?)*

Does service user understand and consent to the reason for enhanced observation? *(What was discussed, how did the service user respond?*

Has the service user contributed to their care plan? *(How did they contribute? do they have any preferences? Do they have capacity? If not has advocacy been considered?*

Does the care plan have specific interventions during enhanced observation? *(What should the observing nurse look out for? What is the escalation plan? Are there any specific things the observer should do each time they check the patient?*

Do the service users have a copy of the care plan?

Has the care plan been uploaded onto RiO?

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 suggestions 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 peer's 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

Observation Record Sheet

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

- **Inpatient Care Plan - completed and attached**
- **One third of observation responsibility to be undertaken by a registered nurse**
- **Senior staff member to sign off form at end of each shift**
- **Any missed observations must be escalated to the nurse in charge and reported on InPhase- staff must not falsify records and enter MISSED on the observation record sheet**
- **Any delayed observations must be correctly recorded reflecting the time undertaken**

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

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 infant's 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 arm's 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 (AMBER)

This occurs when risks assessed by the MDT and where an infant's 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

Zonal Observations Standard Guidance

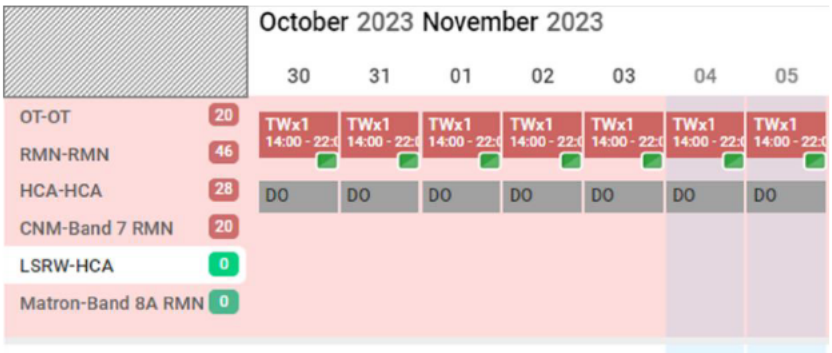
Change Idea - Zonal Observations	
Please describe the change idea	• Zonal observations allows an alternative method of observation, which involves designating the ward into different zones where allocated staff observe and engage with patients individually and as groups for set periods of time. This is to allow for continuous engagement with patients, enhanced monitoring of the environment including interaction and engagement over a 12hour shift. • 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. This means that patients could still be managed under existing enhanced observations if deemed necessary. Staff should proactively engage patients in that zone as long as this does compromise the staff member's ability to view the whole zone and leave a zone unattended. • Zonal Engagement & Observations must be service user focused at all times. The Service has a duty for safety and security to the service users, staff and visitors. This care must be provided in an environment and manner that reflects the least level of restriction possible for the safe and supportive management of the service user. Zonal Observation and Engagement should therefore be seen as one method of reducing risk and enhancing the service user experience. It is integral part of a wider risk assessment and contextual management process. • Zonal observations are undertaken by staff within a shift's safer staffing requirements; it should not be completed using additional staff resource however where this is needed it must be discussed and agreed by a senior clinician.
What is the theory behind this and problem being solved?	• This means patients have equal access to staff resources and are subject to less restrictions. • Greater staff presence in communal areas of the ward or defined 'zones' increases the opportunity for sooner intervention and de escalation and increased opportunities for engagement and relationship building • Increased visibility and opportunities for engagement can enhance the service users' experience of feeling safe on the ward

Standard Work		
What	**Who**	**When**
Specify designated ward zones - these must have explicitly defined rooms, corridors, and spaces within them. The zone should be described clearly with defined boundaries as to where the zone starts and ends.	Ward manager or matron	Before starting
Create a folder for each zone, for allocated staff members to document patient activity in that zone every hour.	Ward manager or matron	Before starting
Staff on shift are allocated on the handover sheet the same way enhanced observations are allocated.	Nurse in charge	Beginning of the shift
Staff are allocated slots for up to one hour at a time. (Staff should remain in a zone for a maximum of two hours at any one time.)	Nurse in charge	Beginning of the shift
Ensure that known and relevant risks are communicated to the observing nurse(s);	Nurse in charge	Beginning of the shift
Allocated staff will: • know their zone; • know who they are to observe; • be familiar with the observation status of all service users in their observation zone; • be vigilant to monitor safety of ward and be confident to intervene or summon help when needed. • facilitate interaction and communication with the service user; • provide a handover for the nurse taking over from them; • report any changes in the service users behaviour considered significant to the nurse in charge; • report any concerns to the nurse in charge.	Allocated staff	During allocated observation period
The documentation has to include any relevant information that contributes to understanding the safety in that zone eg observed altercations, observed changes to presentation, interaction and engagement with service users in that zone. Staff are to ensure that any incidents or concerns are also handed over to the Nurse in Charge and followed up as a Rio entry or InPhase report if indicated.	Allocated staff	During allocated observation period
Zonal observations are reviewed daily in safety huddles with MDT input; teams can review the boundaries of the defined zone and agree changes if needed. This discussion and any agreed changes must be documented on the zonal observation record sheet	MDT	Daily
Teams should review their quantitative (number of reported incidents, use of restrictive practice interventions (RT, seclusion and restraint) and qualitative (service user experience) data to measure impact and usefulness of zonal observations	MDT	Monthly CIG meetings
Discussions are held with service users in Community meetings to explain and review the process.	Ward Manager	Weekly
Measurement		

- Daily observation audit – zonal obs allocation and documentation
- Number of service users on intermittent observations
- Feedback at MDT safety huddle and community meetings
- Datix incidents
- Service user feedback

Appendix 7

Life Skills recovery Worker on twilight shift (2-10pm): Standard Guidance

<table>
<tr><th colspan="2"><u>Change Idea: Life Skills Recovery Workers (LSRW) on twilight shift</u></th></tr>
<tr><td>Please describe the change idea</td><td>LSRWs are to offer therapeutic interventions in the form of activities to service users on the ward. They are an additional resource and not included in safer staffing number of staff required to run the shift. The hours of work can be flexible to cover periods out of hours (after 5PM weekdays and over weekends). Staff covering these shifts can include Band 3 support workers once they have been trained to deliver appropriate interventions and activities.
Staffing Requirements:
There should be a minimum of three hour-long therapeutic interventions per shift, 7 shifts per week
LSRWs will work in collaboration with an MDT (Multidisciplinary Team) of Nurses, OTs, Doctors, and Psychologists to ensure that the therapeutic offering is diverse and well targeted.
Management staff should work collaboratively with LSRWs, using regular meetings and away days to allow for feedback, continuous improvement, and additional support.
Risk should be assessed prior to each session with nurse in charge – discuss the group and its aims, materials, and services users' presentations.
Some wards may benefit from having timetabled activities (e.g., movie evenings or a weekly craft session), but LSRWs should be prepared to be flexible with the activities happening on that day.
LSRWs are supernumerary, they are not counted in the nursing numbers and their work is ring fenced, there is a specific shift on HealthRoster: 

Resources:
Materials should be sourced after planning meeting (£50 per week budget - ward admin to manage the petty cash).
Attendance:
Groups should be open to all service uses and be aimed at all levels (within reason).
Groups should be planned so that the last session of the day promotes good sleep hygiene (i.e.: meditation, mindfulness, pamper session, movie night).</td></tr>
</table>

	• Group activities and their attendance should be recorded locally, this can be brought to HSCG, Managers and Matrons meeting and displayed in the CQC best practice folder. **Example Shift Structure (14:00 – 22:00, 7.5 hours exc. break):** • 2pm – 3pm - Plan the day meeting with service users to identify what sessions the service users would like to see. • 3pm – 4pm – Source materials needed for sessions. • 4pm – 5pm – 1st group • 5pm – 6pm – Notes/support SUs with individual tasks (community leave/1:1 session) • 6pm – 7pm – 2nd group • 7pm – 8pm - Notes/support SUs with individual tasks (community leave/1:1 session) • 8pm – 9pm - 3rd group – Low impact/low intensity group. • 9pm – 10pm – Notes to summarise intervention – using RiO notes structure provided at the end of the document.
What is the theory behind this, and problem being solved?	Originally, we tested LSRWs carrying out 9-5 shifts, however, many incidents occur in the evening when there are less activities on the ward. By bringing more activities and structure throughout the entire day, service users will more engaged with greater potential for a reduction in incidents. Responding to and managing incidents impact on staff time to provide direct care; fewer incidents will release staff time to provide higher quality care and increased opportunities for therapeutic engagement.

Standard Work

What	Who	When
Introduction of new shift pattern to HealthRoster within the 24/7 working directive	DBLN & HealthRoster Team	Before testing change
Train current and new LSRWs on new working pattern	Senior Management Team	Ongoing
Plan with service users and source materials for activities	LSRW & Ward Managers	Beginning of each shift
Carry out risk assessment for all activities	Nurse in charge	Before activity commences
Run three activities per shift	LSRW	Every shift
Record RiO notes for service users, using notes structure below	LSRW	Final hour of shift
Record group type and attendance	LSRW	After each activity or end of shift
Management meeting regarding LSRWs – check in	Managers/Matrons	Once a fortnight

Measurement

- Violence and Aggression Incidents
- Number of interventions per day and what they were
- Service user and staff feedback
- Observation Completion

Changes to infrastructure

- New shift pattern was introduced, this will need reflecting within HealthRoster and require discussions with ward staff to determine acceptability.
- There will need to be designated spaces to carry out the activities on the ward.
- One away day every quarter with senior management and LSRWs to share best practice and continuously improve the work.

Life Skills Recovery Worker RiO notes structure

1. **Title:** 'Life Skills Recovery Session' and then name and duration of session/interaction.
   E.g., Life Skill Recovery Baking Group (9.30am-11am)

   Aim: To encourage and promote therapeutic engagement and activities for service users on the ward.

2. **Intervention:** This section includes whether the service user gave consent to attend the session and how they did this e.g., verbal/written consent. This also includes what was observed within the session/interaction.
   E.g., Intervention: *Name* made multiple requests to prepare himself a light meal which was facilitated upon staff availability. He chose to prepare beans on toast. *Name* appeared orientated in the (room on ward) as he was aware of where to look to find items he required. He expressed some difficulties in using the toaster however managed independently with perseverance. *Name* also took time to work out how to use the microwave but again managed independently eventually.

   Name appeared calm in mood and engaged well in conversation with staff. He expressed that he enjoys eating lighter meals like beans on toast but is not often able to cook them on the ward. He thanked LSRW for facilitating his meal before returning to the ward.

3. **Risk:** This section is where any risk that was observed can be recorded. This is only reflective of risk within the session/interaction.
   E.g., Risk: None observed during the session.

4. **Signed and role identified.**
   E.g., Written by Joe Brown (Life Skills Recovery Worker)

All notes should include:

- Consent is gained and recorded for assessment, intervention, information gathering and sharing.
- The duration of the intervention is captured.
- All entries are signed off and your role is identified.
- Assessments including risk assessments outcome/implication recorded.
- Notes are person centred and service user wishes/goals are recorded.
- All communication/discussion (including third party) and referrals to other services are recorded.
- Records are completed within 24 hours after intervention occurred.

Appendix 8

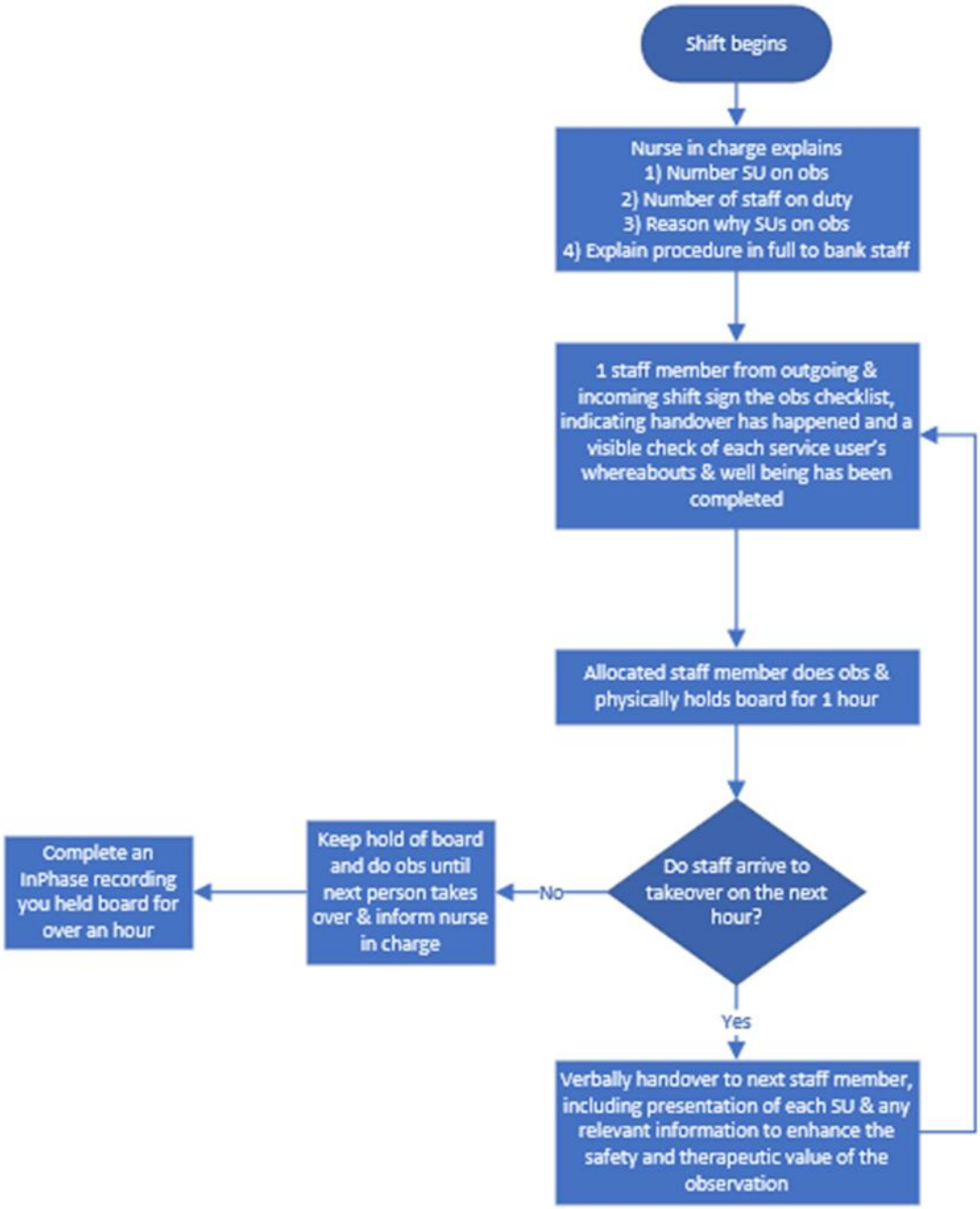
Board Relay Standard Guidance

Change Idea (Board Relay)	
Please describe the change idea	This idea is based on the concept of a baton relay – you never let go of the baton until you pass it onto the next person. The board relay is related to general observations and intermittent observations only (1:1 observations are physically handed over). The process is below and shown in appendix one as a process map. • **Step 1:** At the beginning of each shift, the nurse in charge will explain to the team the number of service users on observations, the number of staff on duty and the reason why people are on observations. They will also explain to bank staff how the board relay works and what is expected of them throughout the shift. • **Step 2:** A designated member of staff from each shift will undertake checks jointly with a designated member of staff from the incoming shift. Staff will hand over the observations board having completed the physical check of the whereabouts and wellbeing of each service user and sign the observation checklist indicating handover has been completed (see Figure 2) • **Step 3:** Staff member who was handed over the board will complete observations and keep hold of the board until the next hour. • **Step 4:** On the next hour they will hand the board over to the next staff member allocated to do observations. This will include a verbal handover of how each service user presented in the previous hour and any important information that will help the next staff member to conduct the observations safely and therapeutically. Both staff members will sign the sheet to say handover has occurred This process will continue throughout the day and night at hourly intervals.

What is the standard work involved in this?		
What	**Who**	**When**
Explain to the team the number of service users on observations, the number of staff on duty and the reason why people are on observations	Nurse in charge	Beginning of each shift
Explain to bank staff how the board relay works and what is expected of them throughout the shift	Nurse in charge	Beginning of each shift
Staff hand over observation board to each other as per shift allocation; this can vary if there are changes within the shift	Registered and non-registered nurses	Every hour

Staff give verbal handover of how each service user presented in the previous hour and any important information that will help the next staff member to conduct the observations safely and therapeutically	Registered and non-registered nurses	Every hour
Staff sign observation sheet indicating observations have been handed over	Registered and non-registered nurses	Every hour
Measurement		
• Number of missed observations • Number of Datix reports related to missed observations. • Number of Datix reports related to staff holding the board for more than an hour.		
Changes to infrastructure (environment, policies, way people work)		
• Put poster about observations on ward wall. • Communications with staff around the importance of observations and the consequences of falsification of observation records. • Change in reporting culture of practice around missed observations and observations not completed		

Flow Chart of board relay



Appendix 9

Missed and Delayed Observation Protocol