Observation Policy

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<td>Quality Committee</td>
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<td>Date ratified:</td>
<td>April 2016</td>
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<tr>
<td>Name of originator/author:</td>
<td>Lorraine Sunduza and Claire Mckenna</td>
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<td>Name of responsible committee/individual:</td>
<td>Safety Committee and Quality Committee</td>
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<td>Circulated to:</td>
<td>Borough Lead Nurses, Deputy Director of Nursing, Director of Nursing and Quality, Safety Committee Quality Committee,</td>
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<tr>
<td>Date issued:</td>
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<td>April 2018</td>
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<td>Target audience:</td>
<td>All clinical staff – in-patient</td>
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## Version Control Summary

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<td>Launa Rolf, Duncan Gilbert</td>
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<td>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. Night time and bath/bed room directions 6. Template reflects care plan arrangements 7. Use of vision panels and night lights</td>
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<td>April 2016</td>
<td>Lorraine Sunduza and Claire Mckenna</td>
<td>Final</td>
<td>Removal of separate care plan as this should be part of inpatient care plan</td>
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1. Introduction

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.

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.

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. Purpose of Policy

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.

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.

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 Restraint
- Policy for Searching Service Users, Visitors and their Property
- Admission Policy (Seclusion Policy)
- Local Fire and Evacuation Policy and Procedure
- Safe Guarding Children Policy
3. Definition

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.

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.

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. 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

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:

1. The observation must be part of the inpatient care plan with the plan being agreed by the Multi-Disciplinary Team (MDT) and, where possible, 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 from the outside?
   • Should the nurse enter the bedroom at night to check on the service user or can this safely be employed from outside the room?

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

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

3. 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

4.1. General Supportive Observation
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. Each service user’s whereabouts and well-being will be checked 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.*

Hourly observation should be regarded as a minimum standard throughout 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.

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 their 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.

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.

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.

### 4.2. Intermittent Supportive Observation

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.

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.

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.

### 4.3. Continuous Supportive Observation – within Eyesight

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.

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

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.

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.

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. Close Supportive Observation – within Arm’s Length

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.

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.

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.

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.

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.

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.

In mother and baby unit (MBU observations are based on MDT risk assessment of mother. (Appendix 3)

5. Deciding the Level of Intervention, Review and Changes in Observation Levels (Process for observations - please refer to the flowchart appendix 2)

Admission

Assessing levels of observation is an integral part of the admission process; all service users should be allocated a level of observation as soon as they arrive on the ward by the shift co-ordinator. On admission the shift coordinator must initiate at least intermittent supportive observations of a new service user as soon as they arrive on the ward. The level of observation must be based on the services users’ reason for admission, clinical presentation and known history. A clinical member of staff on the admitting ward must remain with the service user at all times until they have had a mental state examinations and risk assessment by the admitting doctor which informs specifically what observation the service user will be on. This should be documented accordingly.

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.

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.

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.

6. **Staff Allocation**

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 plan 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. **Handover**

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 staff 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.

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.

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.

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.

The care plan should be completed in collaboration with the service user wherever possible and the service user should receive a copy of the care plan, where necessary translated into their own language.

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.

8. Review

The service user’s intermittent observations must be reviewed at a minimum every 24 hours by two Registered nurses and 72 hours by the doctor. The nursing staff can also request any further reviews should they deem the presentation of the patient to have changed significantly.

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.

All supportive observations must also be reviewed at the Clinical Team Meeting (Ward Round) by the Responsible clinician/consultant (or designated deputy) and multidisciplinary team. These reviews must be documented in the service user’s progress note which will be reflective of inpatient care plan and observation notes. Discussions and reasons for initiating/increasing/decreasing/ continuing with observations must be documented.

Any amendments and changes with the care plan must be discussed within the team and where possible with the patient

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).

For close (arms 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.

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.

Decisions to continue/reduce/increase the level of supportive observation will normally be taken jointly between the service user’s MDT. 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. 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.

There should be a graded reduction of close (arms 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.
9. Support for Staff

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.

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

10. Documentation

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.

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 user's 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.

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.

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

11. 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 base on the particular service needs, physical layout and service user numbers.

12. Enhanced Supportive Observation - Documentation/Record Keeping

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. (Appendix 4)

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 4)

13. Legal Status

In the event of a service user in hospital on an informal basis being deemed to require intermittent, continuous or close observation, the care team should seek to ensure that the
service user is not objecting. If the service user is objecting, the team should consider initiating an assessment for detention under the Mental Health Act 1983. Consideration may need to be given to the use of holding powers under sections 5(2) or 5(4) in the meantime.

14. Competency

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.

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). This for both permanent and bank members of staff. The assessor of permanent ward staff has to be of band 6 and above. The modern matron or PIN must deem permanent band 5 nurses competent to assess any bank nurse out of hours.

The Modern matron will have a system in place on the ward to ensure that every member of staff has read the policy and is aware of their responsibility to follow it and address any concerns they may have.

For non nursing disciplines they must be assessed by their professional manager. The competencies must be given to the Modern Matron of the clinical area and agreed that they can undertake observations.

The competency checklist (Appendix 5) must be completed prior to any member of staff being asked to undertake supportive observation. This will also apply to non-permanent / bank nursing staff (registered and non registered). There should be a file on the ward that contains the signed competency forms. All staff who carry out observations are to have their competencies assessed once a year or where they may be a concern relating to ability/competency in clinical area as appropriate.

If any member of staff fails the assessment this should 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.

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

15. Training Strategy

The Trust will provide training on the content of this policy

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

Modern Matrons should audit the implementation and compliance of the policy on a monthly basis (first Tuesday of each month). Appendix 7. Compiled results will then be sent to the central Audit Team within the Assurance Department who will formulate an annual report based upon findings.
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<th>Lead</th>
<th>Tool</th>
<th>Frequency</th>
<th>Reporting Arrangement</th>
<th>Actions on recommendations and leads</th>
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<td>The Safety Sub Committee will receive and discuss the report and monitor the action plan</td>
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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.
17. 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.

18. References

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

Bibliography


Department of Health (2001) Safety First: National Confidential Inquiry into Suicide and Homicide by People with Mental Illness.
(Appendix 1)

Guidelines of when to initiate/increase observations

The prescription of enhanced observations MUST be agreed by the MDT and clearly documented on the individualized inpatient care plan

Risk Assessment

This section should be read in conjunction with Trust policy on clinical risk assessment and management.

- Indication for enhanced levels of supportive observation should be informed by Trust risk assessment practice, knowledge (or lack of) of the individual service-user and known warning signs and triggers.

- Wherever possible risk assessment, and in particular decision making around levels of supportive observation, should be a multi-disciplinary and dynamic process. SNAMC (1999) practice guidelines suggest the following indications for enhanced levels of observation:
  - History of previous suicide attempts, self-harm or attacks on others
  - Hallucinations, particularly voices suggesting harm to self or others
  - Paranoid ideas where the service user believes that other people pose a threat
  - Thoughts and ideas that the service user has about harming themselves or others
  - Specific plans or intentions to harm themselves or others
  - Past problems with drugs or alcohol
  - Recent loss (bereavement)
  - Poor adherence to medication programs

This list should not be considered exhaustive and all risk assessments should be based on all available knowledge of the individual.

Other circumstances/risks to consider are:

- risk of escape,
- bullying (perpetrator or victim )
- New admission to services (The Department of Health (2001) “Safety First” report highlights the increased risk of suicide for those newly detained and those in their first 7 days in hospital during evening and night time.)
  - new transfer to an unfamiliar ward/unit,
  - unsuccessful tribunal/managers hearing and changes in legal status
  - impending day in court/interview with police ,
  - difficult social visit,
  - loss of section 17 leave,
  - concerns for physical health
  - self control is reduced making a service user vulnerable to exploitation/harm from others, e.g. sexual behaviour
  - Service users experiencing command hallucinations with the intent of acting on them
  - In rare occasions patient under 18 years in an adult facility
  - Cognitive impairment
  - Risk of falls
  - Recent loss e.g. divorce /access to children / accommodation /finances /employment
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
- Close (arms length) observations

Potential risk of suicide/serious concerns about physical health
- Continuous (within eye sight) Where concerns about risk to others consider 2:1

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
- Intermittent observation

No specific concerns about services users safety or safety of others. Service user does not require constant/frequent monitoring
- 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 observations, including one qualified staff in every three
- Handover patient risks and details and requirements of observations to allocated members of staff
- Update service user risk assessment document
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 Doctor

Continuous (within eye sight) observations:
- 1 review every 24 hours during working hours by MDT. Minimum 1 RMN and a Doctor

Intermittent observations:
- 1 review every 24 hours by 2 RMNs
- Minimum 1 review every 72 hours by 1 Doctor. Doctor to review patient by 5pm before weekend and holiday with another review on first working day after holiday

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 24 hours

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 24 hours

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
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 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 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.
# Observation Record Sheet

<table>
<thead>
<tr>
<th>Service users Name:</th>
<th>Primary Nurse:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Consultant:</td>
<td>RIO Number:</td>
</tr>
</tbody>
</table>

**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

<table>
<thead>
<tr>
<th>Date</th>
<th>Time</th>
<th>Record of events</th>
<th>Allocated staff name print &amp; designation</th>
<th>Sign (including senior staff at end of each shift)</th>
</tr>
</thead>
<tbody>
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</tbody>
</table>
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 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, behaviour, 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:
# Observation Policy Implementation Audit

## DATA COLLECTION FORM

<table>
<thead>
<tr>
<th>Directorate:</th>
<th>Ward:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Auditor Initials:</td>
<td>Date of Audit:</td>
</tr>
</tbody>
</table>

## Standards to be measured

<table>
<thead>
<tr>
<th>Standards to be measured</th>
<th>Yes</th>
<th>No</th>
<th>N/A</th>
<th>Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td>Observation on admission</td>
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<tr>
<td>1 Level of observation on admission is identified (minimum level – intermittent)</td>
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<td>2 Any changes in observation level since admission have been documented in the notes</td>
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<td>3 There is evidence in the notes that these changes have been communicated to the service user</td>
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<td>Initiation of observations subsequent to admission</td>
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<td>4 Reason for initiating enhanced level of observation is documented in the notes</td>
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<tr>
<td>5 Evidence of MDT discussion of observation level in the notes</td>
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<tr>
<td>6 There is evidence in the notes that changes in observation level have been communicated to the service user</td>
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<tr>
<td>Staff allocation</td>
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<tr>
<td>7 There is a ward rota for undertaking observations present for the current shift</td>
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<tr>
<td>8 No staff are undertaking enhanced observations for more than 1 hour</td>
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<tr>
<td>Care planning</td>
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<tr>
<td>9 An observation care plan has been completed</td>
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<tr>
<td>10 There is evidence of service user involvement in the observation care plan</td>
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<tr>
<td>Observation review</td>
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</tbody>
</table>
Reviews are documented at required intervals (24hrs for continuous observations, and 72hrs for intermittent)

**Record Keeping – completion of the observation record**

<p>| | |</p>
<table>
<thead>
<tr>
<th></th>
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</thead>
<tbody>
<tr>
<td>12a</td>
<td>Patient’s name</td>
</tr>
<tr>
<td>12b</td>
<td>Primary nurse</td>
</tr>
<tr>
<td>12c</td>
<td>Consultant</td>
</tr>
<tr>
<td>12d</td>
<td>RIO number</td>
</tr>
<tr>
<td>12e</td>
<td>Date &amp; time commenced</td>
</tr>
<tr>
<td>12f</td>
<td>Level of observations</td>
</tr>
</tbody>
</table>
| 12g | Record of events –  
|     |   | Dates and times all present  
|     |   | No gaps  
|     |   | Name and designation printed  
|     |   | Signed |