Leicestershire Partnership NHS Trust

Safe and Therapeutic Observation of Inpatients Policy

The purpose of the Safe and Therapeutic Observation of Inpatients. Policy is to provide guidance for robust observation for inpatients in mental health and learning disability wards and homes. Observation should provide a period of safety for patients during temporary periods of distress when they are at risk of harm to themselves and/or others, or are at risk from others. It can also be used to provide an extensive period of assessment of a person's mental state.

Key words:	Observation,	
Version:	V10, October 2016	
Adopted by:	Quality Assurance Committee	
Date adopted:	17 November 2015	
Name of author: (owner of policy)	Claire Armitage, Lead Nurse, Adult Mental Health Services Vicky McDonnell, Patient Safety Lead	
Name of responsible committee:	Clinical Effectiveness Group	
Date issued for publication:	24 November 2015	
Review date:	1 May 2018	
Expiry date:	1December 20	
Target audience:	All staff in inpatient Mental Health and Learning Disability areas and relevant Community Hospital Wards.	
Type of Policy (tick appropriate box)	Clinical √	Non Clinical

CONTRIBUTION LIST

Name	Designation
Claire Armitage	Lead Nurse, AMHS and LDS
Vicky McDonnell	Patient Safety Lead
Michelle Churchard- Smith	Head of Nursing, AMHS and LDS

Circulated to the following individuals for consultation

Name	Designation
Adrian Childs	Chief Nurse
Bal Johal	Head of Quality & Professional Practice
Steve Walls	Local Security Management Specialist
Dr Kumar	Medical Director
Dr Hiremath	Clinical Director – LD Division
Dr Al-Uzri	Clinical Director – AMH Division
Dr O'Kelly	Clinical Director – CHS Division
Helen Burchnall	Clinical Director – FYPC Division
Neil Hemstock	Lead Nurse – FYPC Division
Members	Patient Safety Group and Clinical Effectiveness Group
Vyv Wilkins	Equality and Human Rights Team
Claire Rashid	Clinical Effectiveness Lead
Diane Postle	Lead Nurse, Enabling Services
Kathy Feltham	Lead Nurse, MHSOP
Emma Wallis	Lead Nurse, CHS
Vicki Spencer	Clinical Governance Lead, FYPC
Jacquie Burden	Clinical Governance Lead, AMHS and LDS
Heather Darlow	Clinical Governance Lead, CHS
Joan Hawkins	Policy Lead
Jaya Keshwala	Clinical Audit Officer

With grateful acknowledgement to Jo Hulme, Charlotte Peel, Amanda Cox and members of the South Leicestershire College Healthcare Support Workers Development Course, Group 3 (March 2014 cohort) for their ideas and input.

Contents

Section		Page
11	Professional Accountability of all staff	21
12	Skills, Training and Competence	21
13	Reporting Incidents	22
14	Links to Standards/Performance Indicators	22
15	Dissemination and Implementation	23
16	Monitoring Compliance and effectiveness of this policy	23
17	References	23
18	Associated Documentation	24
Appendices		
Appendix 1	Safe and Therapeutic Observation recording documents	25
Appendix 2	Competency Assessment	29
Appendix 3	Due Regard Equality Analysis Initial Screening Template	33
Appendix 4	Policy Training Requirements	36
Appendix 5	NHS Constitution Checklist	37

Version Control and Summary of Changes

Version Control	Date	Comments (description change and amendments)
Version 1	25th March 2014	Review of August 2012 policy, including development of: • Section 6.6 - Observation of patients who are in bed or sleeping • Section 7 – Leaving the ward • Section 9 – Recording • Section 11 – Professional/staff accountability • Section 12 – Skills and training • Review of competency assessment • Review of recording forms • Addition of Learning Disability Service appendix
Version 2	7th April 2014	Due Regard Equality Analysis Initial Screening Template added Further amendments to: • Section 7 – Leaving the ward • Section 11 – Professional/staff accountability • Section 12 – Skills and training • Review of recording forms
Version 3	14th May 2014	
Version 4	3rd June 2014	Monitoring Compliance and Effectiveness of this Policy – section condensed following comments from the Patient Safety Group
Version 5	17th October 2014	Updated to reflect new format for policies
Version 6	3rd February 2015	6.4 clarification that 'full sight' includes the whole body, and that this includes whilst using the toilet or bathroom. Clarification of maximum time staff should spend on observation. 6.5 clarification that 'full sight' includes the whole body 6.6 Observation of patients who are in bed or sleeping – section strengthened Competencies – Number 12 – staff breaks, strengthened Number 16 – question added re use of the toilet and bathroom
Version 7	May 2015	• Summary added • Removal of Learning Disability Service appendix • Requirement for contemporaneous recording further strengthened
Version 8	July 2015	• Amendments made following discussion at the Clinical Effectiveness Group, 8th July 2015
Version 9	July 2015	• Amendments made to address the requirements of the NICE violence and aggression guidelines (2015)

Version 10	October 2016	Amendments made to address the recommendations from serious incidents, specifically: • Section 5, Engagement – new paragraph added to give further guidance on maintaining privacy and dignity for patients and listening to their views about how they can be supported to feel safe. It is now specifically stated that the door of a bedroom or quiet area must be left open or ajar when undertaking level one observations. • Section 6.4, Level 1B observation – amendments to the guidance for staff on the length of time they may be allocated to undertake observations. • Section 6.6, Observation of patients who are in bed or sleeping – statement added to clarify that observation must include ongoing awareness of the need to check for regular breathing patterns.

All LPT Policies can be provided in large print or Braille formats, if requested, and an interpreting service is available to individuals of different nationalities who require them.

Did you print this document yourself? Please be advised that the Trust discourages the retention of hard copies of policies and can only guarantee that the policy on the Trust website is the most up-to-date version.

For further information contact:
Quality and Patient Safety Lead or Lead Nurse, Adult Mental Health Services

Definitions that apply to this Policy

Safe and Therapeutic observation	Observation is a nursing practice that aims to prevent patients from becoming a risk to themselves or others. It involves a named member of staff being allocated to observe the patient attentively whilst attempting to minimise the extent to which the patient feels he or she is under surveillance.
Statutory legislative requirements	What the law says we must do.
Cultural Diversity	Ethnic variety, as well as socioeconomic and gender variety, in a group or society.
Engagement	Participating in an activity or discussion, or otherwise relating with staff.
Observation	Observation involves a named member of staff being allocated to observe the patient attentively. The member of staff must have full sight of the patient in order to be able to assess his or her mental and physical wellbeing.
Contingency planning	A plan to deal with a particular problem if it occurs. A back up plan if the original plan does not work.
Deprivation of Liberty Safeguard Authorisation (DOLs)	The Deprivation of Liberty Safeguards is an important protection for people in hospitals and care homes who may need to be deprived of their liberty in order to protect them from serious harm. DoLS do not apply if a person is detained in hospital under the Mental Health Act 1983.
Due Regard	Having due regard for advancing equality involves: • Removing or minimising disadvantages suffered by people due to their protected characteristics. • Taking steps to meet the needs of people from protected groups where these are different from the needs of other people. • Encouraging people from protected groups to participate in public life or in other activities where their participation is disproportionately low.
Intentional Rounding	The implementation of hourly checks on patients to engage with them and ensure their fundamental care needs are met.

Due Regard

The Trust's commitment to equality means that this policy has been screened in relation to paying due regard to the Public Sector Equality Duty as set out in the Equality Act 2010 to eliminate unlawful discrimination, harassment, victimisation; advance equality of opportunity and foster good relations.

Measures in place throughout this policy ensure that respect for the dignity of patients, carers and service users is maintained during the application of this policy. Please refer to the Trust Equality, Diversity and Human Rights Policy available on the intranet. To mitigate any adverse impact on relevant protected characteristics, the following examples can be provided;

- Interpretation and translation services are available to ensure all service users receive up to date relevant accessible reference to accessible format, alternative languages etc.
- Religion and belief are recognised in the policy as an essential criteria to ensure dignity, respect and cultural competency is assured.
- Training and development of staff applying this policy will ensure that equality, diversity and human rights is an essential learning and development requirement.

In addition to the examples highlighted above, equality monitoring of all relevant protected characteristics to whom the policy applies will be undertaken. Robust actions to reduce, mitigate and where possible remove any adverse impact will be agreed and effectively monitored.

This policy will be continually reviewed to ensure any inequality of opportunity for service users, patients, carers and staff is eliminated wherever possible.

Please see appendix 5 - Due Regard Equality Analysis Initial Screening Template

Please see appendix 7 - Core Principles of the NHS Constitution

Equality Statement

Leicestershire Partnership NHS Trust (LPT) aims to design and implement policy documents that meet the diverse needs of our service, population and workforce, ensuring that none are placed at a disadvantage over others.

It takes into account the provisions of the Equality Act 2010 and advances equal opportunities for all.

This document has been assessed to ensure that no one receives less favourable treatment on the protected characteristics of their age, disability, gender reassignment, marriage and civil partnership, pregnancy and maternity, race, religion or belief, sex (gender) or sexual orientation.

In carrying out its functions, LPT must have due regard to the different needs of different protected equality groups in their area.

This applies to all the activities for which LPT is responsible, including policy development and review.

Summary

The aim of the Safe and Therapeutic Observation of Inpatients Policy is to provide guidance for the planning and implementation of high quality, consistent and robust care for service users with an assessed need for observation. The policy has been revised, taking into account lessons learnt from a number of serious incident investigations in recent years. It applies to inpatients in mental health and learning disability wards and homes.

Observation should provide a period of safety for patients during temporary periods of distress when they are at risk of harm to themselves and/or others, or are at risk from others. It can be used to provide a period of assessment of a person's mental state. The physical health of patients should also be considered during observation.

Observation can be defined as a nursing practice that aims to prevent patients from becoming a risk to themselves or others. It involves a named member of staff being allocated to observe the patient attentively whilst attempting to minimise the extent to which the patient feels he or she is under surveillance. Encouraging communication, listening and conveying to the patient that they are valued and cared for are important components of skilled observation.

Observation is undertaken at the following levels:

- **Level 3 Observations – minimum of hourly checks**

This is the minimum acceptable observation for all inpatients and should include: location of patients, safety, wellbeing, they are not showing any signs of ill health and the consideration of potential risks.

- **Level 2 Observation - intermittent observation**

This level of observation requires that the patient should be observed at intermittent intervals. The frequency of these observations will be determined and agreed by the multi-disciplinary team and will be dependent upon the level of risk exhibited by the patient.

- **Level 1B Observation – constant observation within Close Proximity**

The patient must be in full sight of the nurse at all times, and the nurse needs to be close enough to the patient to enable effective intervention at any time if required.

- **Level 1A Observation - constant observation within Arm's Length**

The patient must be in full sight and within arm's length of the nurse at all times, and the nurse needs to be close enough to the patient to enable effective intervention at any time if required.

Detailed standardised records of observations must be kept on an ongoing basis by staff responsible for carrying out observation. This must include a record of the patient's behaviour, mental state, identified risks and attitude to observation within a given shift period. It must also be documented that the clinician has handed over responsibility for observations at the end of the span of observations.

1 Introduction

This policy has been revised, taking into account lessons learnt from a number of serious incident investigations in recent years. It is for use with those patients who require observation either because of a combination of an assessed mental health problem, or a potential mental health problem awaiting assessment and it being in the interests of the safety of the patient to minimise risk.

2 Purpose

The purpose of the Organisation wide Policy for the observation of Inpatients is to provide guidance for the planning and implementation of high quality consistent and robust care for service users with an assessed need for observation.

Observation should provide a period of safety for patients during temporary periods of distress when they are at risk of harm to themselves and/or others, or are at risk from others. It can also be used to provide an extensive period of assessment of a person's mental state. The physical health of patients should also be considered during observation.

Formal observation systems should be flexible and not rigid, it is important that policy and clinical practice developments are not restrictive.

3 Duties

3.1 Trust Staff

It is the responsibility of the **Trust Board** to provide the appropriate level of support, guidance and or training to meet the needs of this policy and statutory legislative requirements.

The **Chief Nurse** has overall responsibility to ensure the safety and well being of patients in the care of the Trust. This includes ensuring that a robust policy for appropriate levels of observation is in place and that monitoring systems are identified to ensure the effectiveness of practice.

It will be the responsibility of the **Lead Nurse / Senior Matron / Ward Matron** within trust services to ensure this policy is followed and monitoring arrangements reflect the standards outlined in this document and appropriate systems are in place to ensure the handover of care between shifts.

The **Clinical Director** will ensure that this policy is followed by medical staff and there is regular multidisciplinary review of each patients care and progress as reflected in the standards of this policy.

It is the responsibility of **all clinical staff** to participate in observations if required within ward environments or whilst attending therapeutic activities and record these observations in accordance with the standards in this policy.

3.2 Approval of the Organisation Policy for the Observation of Inpatients / Service Users

The policy has been reviewed by the Patient Safety Group, and has been agreed as an organisation wide policy by the Clinical Effectiveness Group.

4 Communication and Cultural Diversity

It is essential that all members of the multidisciplinary team caring for patients are aware of the level of observation being used and this is detailed in the patient's care plan. The individual care plan ensures consistency of the team's approach in supporting a patient requiring observation. Please refer to Staff Multi faith resource.

Cultural diversity must be respected and must be carefully considered when observation of a patient is required. Wherever possible cultural needs should be discussed with the patient and their relatives/ carers, so that information and advice can be obtained, for example regarding the gender of the staff carrying out observation duties or ability to have private time and space to carry out religious worship.

The patient and / or carer if appropriate should be informed of the process starting, why observation is felt to be necessary and be given information as appropriate as well as the opportunity to discuss any concerns or questions they have with an appropriate member of the multi-disciplinary team. Different languages and communication methods should be considered to ensure the information is given appropriately (refer to Trust interpretation and translation services). The needs of service users with a learning disability must be considered.

5 Engagement

Observation must be safe and therapeutic. Consideration could be given to the use of activity, discussion and distraction processes, but recognition should also be made of the need for silence and as much privacy as is safely achievable.

At least once per shift, a nurse should set aside time to engage positively with the patient, recognising that patients may find the process of observation intrusive, and seeking their views and feedback. The nurse should give the patient information about why they are under observation, and discuss how they can work together to reduce the observation level.

Staff carrying out observation should not engage in other activities whilst carrying out this duty, for example, reading, watching television or using a mobile telephone. Involved staff must be familiar with the ward, potential risk in the environment and the ward emergency procedures.

Due regard will always be given to each relevant protected characteristic including disability, race, religion and belief, sex (gender), sexual orientation etc. to maintain dignity and respect throughout the care giving and observation process. For example, a female nurse must be designated to observe a female patient who wishes to attend to her personal hygiene needs. It is acknowledged that it will not always be possible to allocate a staff member of the same gender to observe each patient, however, the nurse in charge must consider privacy and dignity needs when allocating staff to undertake observations. Discussions must be held with patients, wherever possible, to determine their preferences, special needs and any measures that would assist them to feel safe. Proximity to supervised areas (such as the ward office or day room) must be considered when allocating bedrooms or observing patients on level one. The door of a bedroom or quiet area must be left open or ajar when undertaking level one observations. Please refer to the Trust's Equality Diversity and Human Rights Policy and the Chaperone Policy for Adults and Children.

Where appropriate carers and family members will be engaged and involved throughout the process to ensure patients are given the most appropriate support.

If the patient being observed is visited by friends or family, the observation level continues regardless of their presence and this is documented on the recording form.

Staff carrying out observation duties must be able to identify the appropriate patient by either using their identification wrist band or checking their photo identification, used in areas where wrist bands are not appropriate.

6 Levels of Observation

6.1 The Principles of Observation

Observation can be defined as a nursing practice that aims to prevent patients from becoming a risk to themselves or others. It involves a named member of staff being allocated to observe the patient attentively whilst attempting to minimise the extent to which the patient feels he or she is under surveillance. Observation at levels one or two will only be used after positive engagement with the patient has not been able to dissipate assessed risks. The least intrusive level of observation necessary will be used, balancing the needs for safety with the needs for privacy and dignity. Encouraging communication, listening and conveying to the patient that they are valued and cared for are important components of skilled observation.

Any patient who has fallen or is deemed at risk of falling should be assessed in line with the Falls Pathway and may not require observation inline with this

policy. The physical health of patients should also be considered during observation.

Any patient who has fallen or is deemed at risk of falling should be assessed in line with the Falls Pathway and the use of therapeutic observation must not be seen as a specific rationale to prevent falls, therefore patients may not require observation in line with this policy unless indicated by other risks to self or others. The physical health of patients should also be considered during observation.

The observation needs of patients during restrictive practices such as seclusion and rapid tranquilisation must be considered, and staff should refer to the relevant policy for further guidance.

It may be necessary to search the patient and their belongings whilst having due regard to the patients legal rights. For more information, please see the Searching of Inpatients within mental health and learning disability areas.

Observations must be undertaken by the nominated staff member, and patients' observations must not be left to relatives or visitors.

Within LPT, observation is defined and undertaken at three levels.

6.2 Level 3 Observations – minimum of hourly checks

The general level of observation is intended to meet the needs of most patients most of the time. It should be compatible with giving patients a sense of responsibility for their use of free time in a planned and monitored way. This is the minimum acceptable observation for all inpatients and should include: location of patients during each shift, safety, wellbeing, they are not showing any signs of ill health and the consideration of potential risks. Documentation should illustrate the risk assessment and contingency planning.

Some patients may only require general observation but due to levels of risk or vulnerability, may need to be restricted from leaving the ward or units, a Deprivation of Liberty Safeguard Authorisation (DOLs) may be considered appropriate for some patients. Documentation for this intervention should reflect the reason for the patient to be placed on this restriction and the reason fully explained to the patient and / or carer as appropriate.

All patients on this level of observation must be observed at least every hour and the staff requested to carryout this check should be clearly documented on a ward/area general observation recording sheet.

Approaches to support the hourly checks should be considered, for example 'Intentional Rounding' and areas should ensure they have an appropriate record sheet to document hourly observations. At each shift handover the staff in charge should check the number of patients on the ward/area and ensure each patients level of observation is handed over.

Level 3 observations will contribute to:

- Good communication between staff and patients regarding care and treatment
- Assurance that patients are receiving appropriate care in accordance with the care plan
- Accurate assessment of patients' health, wellbeing and behaviour
- Staff knowledge of patients whereabouts and general ward acuity
- Improved management of the risk of absconsion, self-harm and risk to vulnerable patients

6.3 Level 2 Observation - intermittent observation

Any new admission to the ward / area must be on at least level 2 observations for 24 hours to support the assessment process.

Any patient who has consumed illicit drugs and / or excessive amounts of alcohol must be placed on at least level 2 observations and be assessed by a doctor.

This level of observation requires that the patient should be observed at intermittent intervals of either 5, 10, 15, 20 or 25 minutes (see section 9 Recording). The frequency of these observations will be determined and agreed by the nurse and doctor / MDT and will be dependent upon the level of risk exhibited by the patient. This should be detailed in the risk assessment and individual patient care plan. The minimum frequency of observation should be written on the individual patient care plan, in the clinical record and on the observation record sheet.

When carrying out Level 2 Observations, the nurse must have **full sight of the patient within close proximity**, to ascertain the patient's location, safety and wellbeing, they are not showing any signs of ill health and potential risks are considered during each intermittent check.

Please read this section in conjunction with Section 6.6 - Observation of patients who are in bed or sleeping, and Section 9 - Recording.

6.4 Level 1B Observation – constant observation within Close Proximity including full sight of the whole body

The patient must be in full sight of the nurse at all times but not necessarily at arms length. The nurse needs to be close enough to the patient to enable effective intervention at any time if required. The patient must be in full sight of the nurse at all times by **day and by night (including whilst using the toilet and bathroom)** and any tools or instruments that could be used to harm self or others should be removed.

The decision whether the patient will use the bath/ shower and toilet in private should be discussed and risk assessed by the MDT and specified in the

individual patients care plan, for example, the patient can use the toilet as long as the staff observing can see the patient's body fully through a door held ajar and can hear and speak to the patient. Where the level of risk is such that the use of the bath/ shower and toilet must be observed then a designated toilet/ bathroom should be identified and a staff of the same sex should be provided to observe this activity. The use of bath / showers and toilets must be documented clearly in the care plan and handed over to each shift so there is no doubt what actions the observing staff should take during these activities.

Staff are responsible for assessing their own health and safety when observing a patient closely and should not put themselves at risk should the patient become aggressive. Staff must be able to summon help in the appropriate method used in the ward/area, for example personal alarm system.

Good practice dictates that staff should not be asked to undertake level 1 or 2 observations for a continuous period of more than two hours (NICE, 2015). The nurse in charge of the ward must aspire to achieve this, however, it is acknowledged that in circumstances when acuity on the ward is high, staff may need to undertake further observations. In such cases, a check must be made to ensure that the staff member is equipped to continue, and either a change of observation or a brief comfort break must be offered.

Observations should be rotated within the team where possible, ensuring cultural diversity and gender are considered.

Please read this section in conjunction with Section 6.6 - Observation of patients who are in bed or sleeping, and Section 9 - Recording.

6.5 Level 1A Observation - constant observation within Arm's Length including full sight of the whole body

The aspects detailed for level 1B are applicable but the patient must be in sight of the nurse at all times and within arms length. The nurse needs to be close enough to the patient to enable effective intervention at any time if required. The patient must be at arm's length and **in full sight of the nurse at all times by day and by night** and any tools or instruments that could be used to harm self or others should be removed.

Please read this section in conjunction with Section 6.6 - Observation of patients who are in bed or sleeping, and Section 9 - Recording.

6.6 Observation of patients who are in bed or sleeping

Serious Incident investigations demonstrate that observing patients who are in bed or sleeping is a high risk and skilled task. Staff must maintain vigilance whilst patients are, or appear to be, asleep. Staff must be aware of the risks presented by bedding, other clothing or objects and the need to maintain full view of the patient's head, neck, arms and hands. This should be explained

and discussed with the patient, so that he or she understands the need for staff to have **full sight of their head, neck, arms and hands**.

Observation must include ongoing awareness of the need to check for regular breathing patterns, and staff must refer to the Physical Health Observation policy for further guidance if they have any concerns about physical wellbeing.

Following a full risk assessment, this policy makes provision for the psychiatrist or designated medical officer to detail any appropriate special arrangements within the patient's clinical record (see section 8 – Management of observation). This allows flexibility of observation according to individual need, and any special arrangements must also be recorded on the patients' observation record chart.

Consideration must be given to the environment in which the observation of sleeping patients takes place. For example, beds and chairs may be arranged to facilitate full observation and promote patient dignity. Lighting should be conducive to sleep and balanced with safe observation, and torches may need to be provided.

These principles apply equally to level one and two observations.

7 Leaving the Ward

All staff responsible for escorting a patient who is under observation **must** have completed an observation competency form.

All patients, whether detained or informal, must be reassessed prior to leaving the ward, in line with the dynamic on going nature of risk assessment. All re-assessments must be clearly documented in the patients' clinical record (although for long-stay informal patients, and at the discretion of the nurse in charge, documentation of re-assessment may not be necessary on every occasion the patient leaves the ward).

Please note that within the low secure unit, the term 'leaving the ward' refers to patients leaving the confines of the air lock.

Level 1A and 1B observations

It is expected that generally speaking, patients on level 1A and 1B observations will not have leave from the ward other than for urgent medical appointments or interventions.

However, on rare occasions patients on level 1A and 1B observation may have leave from the ward with the written agreement of the multi-disciplinary team. This may be for patients who are at risk from others whilst on the ward, or who it is felt may benefit from a therapeutic activity. In such cases, staff must be identified to continue observation whilst the patient is off the ward. The multi-disciplinary team must consider the number and grades of nursing staff required to safely escort the patient.

A patient who is on level 1B observation due to their own vulnerability (for example, a pregnant patient) may leave the ward unescorted with the express written agreement of the multi-disciplinary team.

Level 2 observations

If a patient on level 2 observations leaves the ward under escort, **any change in the member of staff undertaking observations must involve clear communication regarding any risks and handover of relevant documentation**, e.g. observation recording form. It is good practice to involve the patient in any discussions during the handover if possible.

On rare occasions, and following a full assessment, it may be deemed appropriate for a patient on level 2 observations to leave the ward unescorted - this must be agreed and documented by the multi-disciplinary team.

Level 3 observations

If a patient on level 3 observations has been assessed as requiring an escort when leaving the ward, this must be communicated to all staff that care for the patient. The member of staff delegated the responsibility of escorting the patient must remain with the patient at all times. **If the patient is to be handed over to the care of another department or professional, full details of the patient's status must be communicated to the receiving department/professional.** At no time should the patient be out of the sight of staff when not on the ward.

7.1 Detained patients

This applies to all patients detained under the Mental Health Act in Mental Health and Learning Disability services.

Detained patients should not be permitted to leave the ward whilst on Level 1A, Level 1B or Level 2 observations without prior permission from the responsible clinician and documentation to this effect must be made within the clinical notes. Leave will only be authorised when the appropriate Section 17 leave forms have been completed. Detained patients may access the ward garden whilst on observations in line with the restrictions identified in the observation care plan. It is anticipated that if a patient requires leave from the ward during such times, it will only be in unusual circumstances (i.e. to attend appointments in another hospital) or as part of an agreed therapeutic care plan. It is the responsibility of the ward matron or the nurse-in-charge in their absence to ensure that appropriate numbers of adequately skilled staff escort the patient on such occasions and that a full risk assessment has been undertaken in agreement with the multi-disciplinary team.

7.2 Informal patients

This principle should also apply to informal patients but they should not feel coerced into remaining on the ward with implied threats to use the Mental

Health Act if they are unwilling to do so. Entries in the clinical notes should make it clear that if an informal patient attempts to leave the ward against clinical advice then their mental health state should be reassessed at that time and appropriate action taken. A Deprivation of Liberty Authorisation (DOLs) may be considered appropriate for some patients.

The phrase 'Not to leave the ward' must not be used within patients' records, but it should be recorded that prior to the patient leaving the ward an assessment of their wellbeing must be made and outcomes documented.

8 Management of observation

Risk assessment will determine the individual observation needs of each patient. On occasions it may be appropriate for patients to be on different levels of observations at different times of the day and be restricted from some areas or activities. In circumstances where this is relevant a full risk assessment must be completed, and the responsible clinician will detail the special arrangements within the patient's clinical record. This must also be recorded on the patients' observation record chart.

For example: A patient is being observed on level 1B due to the risk of him misinterpreting the actions of others and reacting aggressively towards them. He does not present a risk to himself or others when he is alone in his bedroom. The nurse will sit outside the bedroom ensuring no one enters, and if the patient leaves the room they will then observe him as per Level 1B. This has been agreed by the MDT and documented in the healthcare record and on the observation chart.

8.1 Decision to increase Observations

The multi-disciplinary team (MDT) should always make decisions with regard to the need for observation. However, on many occasions (particularly at weekends and evenings) decisions may have to be made by a doctor, the nurse in charge and the ward nursing team.

A nurse can initiate observation or increase the level of observation based on professional judgement and a risk assessment of the situation. Such decisions should always be discussed at the first available opportunity with a doctor or a larger number of the MDT.

Within the Learning Disability Service short breaks homes, the decision to initiate observation will be nurse led. This will be discussed at the first available opportunity with the Home Manager or nominated deputy. The full rationale will be entered into the electronic record and reflected in the care plan.

8.2 Review of Observation Levels

Observation levels should be reviewed at least daily and communicated in the handover between shifts. The nurse should evaluate the impact of the patient's mental state on the risk of violence and aggression, and record any risk in the notes.

Where observation at level one or two continues for one week or more, multi-disciplinary review must take place on a weekly basis as a minimum.

When reviewing the level of observation required, staff will take into account the patient's current mental state, current assessment of risk, the effects of any prescribed or non- prescribed medications and the views of the patient, as far as possible.

8.3 Decreasing Observation

The multi-disciplinary team (MDT) should always make decisions with regard to decreasing observation levels. However, on many occasions (particularly at weekends and evenings) decisions may have to be made by a doctor, the nurse in charge and the ward nursing team.

The decision to reduce observation must always be based on clinical need and risk assessment of the individual concerned and should never be made in response to reduced staffing levels. Any concerns about staffing levels needed to provide safe care must be raised with the relevant service manager.

Observation levels will only be reduced by nurses within normal working hours after discussion with the patient's psychiatrist and/or other members of the MDT. However, at weekends or out of hours, this responsibility is delegated to the senior nurse on duty and doctor on call. This decision should always be made in the presence of, and with the agreement of, a member of staff who knows the patient.

The decision to decrease observation must be documented in the healthcare record, along with the rationale and the identification of staff involved in the decision.

Within the Learning Disability Service short breaks homes, the decision to decrease observation will be nurse led. This will be discussed at the first available opportunity with the Home Manager or nominated deputy. The full rationale will be entered into the electronic record and reflected in the care plan.

9 Recording

The doctor or nurse should record all decisions regarding observation levels in the patient's main clinical notes and treatment plan. Records must be updated every shift and include:

- Rationale for observation
- Current mental state
- Current assessment of risk
- The agreed level of observation to be implemented
- Timescales and review
- Clear direction regarding therapeutic approach
- Patient's compliance
- The care plan should include the agreed interventions which may be used to engage with the patient
- Names and titles of staff involved in making the decision

Detailed standardised records of observations must be kept on an ongoing basis by staff responsible for carrying out observation on the forms shown in Appendix 1 including:

- The name of the person responsible and the time that they commenced and concluded their period of observation. It must also be documented that the clinician has handed over responsibility for observations at the end of the span of observations

- A detailed record of the patient's behaviour, mental state, identified risks and attitude to observation within a given shift period.

- Under no circumstances should observation timings, recordings or signatures be recorded in advance of the observation. For level 2 observations, observing staff must immediately document the actual time the patient is observed. Staff must not sign for observations that they have not personally completed.

The phrase 'Not to leave the ward' must not be used within patient records, but it may be recorded that prior to a patient leaving the ward an assessment of their wellbeing must be made and outcomes documented (see section 7.2).

Note: For patient safety reasons, observation recording forms must be printed on coloured paper as follows:

- Level 1 A and B use pink observation charts.
- Level 2 (5 minutes) use cream observation charts
- Level 2 (10 minutes) use blue observation charts
- Level 2 (15 minutes) use yellow observation charts
- Level 2 (20 minutes) use lilac observation charts
- Level 2 (30 minutes) use green observation charts

This system of colour coding observation forms applies to all inpatient mental health and learning disability areas and relevant community hospital wards as per the scope of this policy.

10 Risk Assessment

A current risk assessment and management plan must be used to inform decisions regarding the appropriate level of observation for each patient and the staffing requirements for the ward must reflect that observations can be carried out safely in accordance with the policy. The number and level of patients requiring observation must be reviewed on every shift to ensure that the ward/area is staffed appropriately. Any concern around the number of patients in a ward requiring level 2 and 1 observation and the staffing levels to meet the needs must be raised with the matron or appropriate manager immediately and recorded appropriately. If the situation is not resolved, an electronic incident form (eIRF) must be completed.

11 Professional Accountability of all Staff

All staff are accountable for their own practice, and when carrying out patient observations must do so in accordance with this policy.

The nurse in charge is responsible for ensuring that a rota of staff nominated to undertake observations during the course of the shift is in place and communicated to all staff. Any changes to the rota must only be made following discussion with the nurse in charge.

The nurse in charge will delegate observation tasks to team members, taking into consideration the acuity of the ward, the best interests of the patients and the skills, knowledge and workload of all staff.

Staff undertaking observation must be appropriately briefed about the patient's history, specific risk factors and individual needs.

It is the responsibility of all staff members to raise any concerns about their capacity or competence to safely undertake delegated observations. Such concerns must be discussed with the nurse in charge. Patient safety is paramount, and it is also the responsibility of all staff members to raise any concerns about poor or unsafe practice that they witness.

12 Skills, Training and Competence

There is a need for training and competence assessment identified within this policy. In accordance with the classification of training outlined in the Trust Human Resources and Organisational Development Strategy, this training has been identified as **essential to role training**.

The governance group responsible for monitoring the training is the Clinical Effectiveness Group.

Observing patients at risk is a highly skilled activity. Staff must be trained in the skills and competencies required to undertake observations, and they must be supervised in their practice of this therapeutic activity as they would with any other form of treatment.

The trust will ensure that all relevant staff (both qualified and unqualified) are trained and their competence is assessed.

Student health professionals in their second year of training and beyond can undertake level 1, 2 or 3 observations with the appropriate training and supervision. Consideration should be given to observing and working alongside students as part of the competency assurance process.

Identified staff will be trained by the ward matron or their delegated deputies, and the Competency Assessment in Appendix 2 must be successfully completed. This will be held in the staff's personnel record and will be reviewed at the discretion of the supervisor. As a minimum, training will be updated on a three yearly basis or following any changes to the policy.

The competencies must be completed for all new starters to the ward and all bank staff and students who will be undertaking observation duties.

All staff should be given the opportunity to read the Trust Policy on Safe and Therapeutic Observation and receive training before completing the assessment. Should the staff member be unable to successfully complete the competencies they must **NOT** undertake observations, and an action plan must be agreed with timescales set to achieve the required competencies.

A copy of each bank staffs' competency assessment must be sent to LPT Bank. A copy must also be offered to the bank nurse, who may wish to take it to his or her next ward for review.

Observation cards have been developed to assist ward staff to ensure that all staff who are asked to undertake observations are competent, and have a full understanding of how to protect patients by safely working within the policy. The cards aim to act as an aide memoire and a handy reference source for staff. They can be used with staff as part of training and competency assessment, preceptorship and induction and re-launch of the observation policy. Observation cards are available from ward matrons and managers.

13 Reporting Incidents

Any incidents pertaining to the observation of a patient must be reported in line with the Trust Incident Reporting policy.

14 Links to Standards/Performance Indicators

This policy document links to Care Quality Commission (CQC) Outcomes as follows:

Specific to;	Outcome 4: Care and welfare of people who use services
In support of;	Outcome 16: Assessing and monitoring the quality of service provision Outcome 21: Records

Outcome 1: Respecting and involving people who use services

TARGET/STANDARDS	**KEY PERFORMANCE INDICATOR**
Monitoring effectiveness will include review of observation recording forms by ward matrons.	Consistent completion of observation recording forms.
There will be an annual Trust-wide audit to identify key learning and areas requiring action.	Identification of compliance and areas requiring action.

15 Dissemination and Implementation

This policy will be disseminated into all inpatient areas, and it will be posted on the LPT Intranet. Communication of the policy will be via management structures and the Lead Nurses and Senior Matrons.

The implementation of this policy will be accompanied with training which will be available via the ward matrons.

16 Monitoring Compliance and Effectiveness of this Policy

Monitoring of compliance and effectiveness of this policy will be managed through an ongoing programme of annual clinical audit led by the Clinical Audit Team to include the following:

i) Review of staff trained in observation.

ii) Audit of daily risk assessment and review of service users on observation

iii) Audit of staffing levels in line with the requirements of service users on observation.

17 References

References used in the production of this document

- LPT Incident Reporting Policy, 2014
- Mental Health Act Code of Practice, 2015
- Positive and Proactive Care: reducing the need for restrictive interventions, Department of Health, 2014
- Violence and aggression: short-term management in mental health, health and community settings, NICE, 2015
- LPT Deprivation of Liberty Safeguards Policy, 2012

- LPT Absence without Leave and Missing Patient Policy, 2013

18 Associated Documentation

Acknowledgement: Cambridgeshire and Peterborough Mental Health Partnership NHS Trust policy on therapeutic observation.

Appendix 1

Leicestershire Partnership NHS
NHS Trust

Attach Patient Label

Safe and Therapeutic Level 1 A or B Observation Recording Form

Date		**Type of Observation (A or B)**	**A** ☐ within arm's length **B** ☐ within close proximity
Rationale for Level of Observation			
Special instructions / restrictions, e.g.: Observation during personal care *(Please refer to doctors instructions in patients clinical record)*			

An individual treatment plan must be in place that reflects the appropriate interventions, patient preferences and engagement during periods of observation. All staff carrying out observations must introduce themselves to the patient and ensure they understand the observation rationale.

Time	**Comments** i.e. mental / physical health, general behaviour, mood & attitude, interactions activities with others, risks. Movement during sleep	Name and Signature Observing Staff*	Handed over to Name and Signature Staff*
00.01 – 01.00			
01.00 - 02.00			
02.00 – 03.00			
03.00 – 04.00			
04.00 – 05.00			
05.00 – 06.00			
06.00 – 07.00			
07.00 – 08.00			
8.00 – 09.00			

Observation Record Continuation Sheet. Date: …….. Sheet No: ……..

Time	**Comments** i.e. mental / physical health, general behaviour, mood & attitude, interactions activities with others, risks. Movement during sleep	Name and Signature Observing Staff*	Handed over to Name and Signature Staff*
09.00 – 10.00			
10.00-11.00			
11.00-12.00			
12.00 – 13.00			
13.00 -14.00			
14.00 -15.00			
15.00 – 16.00			
16.00 -17.00			
17.00 -18.00			
18.00 – 19.00			
19.00 – 20.00			
20.00 – 21.00			
21.00 – 22.00			
22.00 – 23.00			
23.00 – 24.00			

*Name and signature of staff carrying out observations confirming that they have carried out the period of observation. Name and signature of staff taking over next period of observation -staff to check previous hour fully completed.
Please note: photocopy this form on pink paper; names must be written legibly
For sleeping or resting patients, staff must be aware of the risks presented by bedding, and the need to maintain full view of the patient's head, neck, arms and hands.

Leicestershire Partnership NHS
NHS Trust

Attach Patient Label

Safe and Therapeutic Level 2 (intermittent) Observation Recording Form

Date		**Type and frequency of Observation**	
Rationale for Level of Observation			
Special instructions / restrictions, eg: Observation during personal care *(Please refer to doctors instructions in patients clinical record)*			

An individual treatment plan must be in place that reflects the appropriate interventions, patient preferences and engagement during periods of observation. All staff carrying out observations must introduce themselves to the patient and ensure they understand the observation rationale.

For sleeping or resting patients, staff must be aware of the risks presented by bedding, and the need to maintain full view of the patient's head, neck, arms and hands.

Times must not be pre-entered – immediately document the time the patient is actually observed.

Time (use 24 hour clock)	**Comments** i.e. mental / physical health, general behaviour, mood & attitude, interactions activities with others, risks. Movement during sleep	Name and Signature Observing Staff*	Handed over to Name and Signature Staff*

Observation Record Continuation Sheet. Date: ……………… Sheet No: …………

Time (use 24 hour clock)	**Comments** i.e. mental / physical health, general behaviour, mood & attitude, interactions activities with others, risks. Movement during sleep	Name and Signature Observing Staff*	Handed over to Name and Signature Staff*

* Name and signature of staff carrying out observations confirming that they have carried out the period of observation.
Name and signature of staff taking over next period of observation – staff to check previous hour fully completed.
Please note: <u>names must be written legibly</u>
<u>Photocopy as follows:</u>
5 mins – cream, 10 mins – blue, 15 mins – yellow, 20 mins – lilac, 30 mins - green

Leicestershire Partnership NHS
NHS Trust

Appendix 2

Safe and Therapeutic Observation of Inpatients – Staff Competencies

Competence: "The state of having the knowledge, judgement, skills, energy, experience and motivation required to respond adequately to the demands of one's role and for some professional responsibilities" (adapted from Roach, 1992)

The following competencies must be completed for all new starters to the ward, and all bank staff and students who will be undertaking observation duties.

Should the staff member be unable to successfully complete the competencies, they must **NOT** undertake observations and an action plan must be agreed with timescales set to achieve the required competencies.

A copy of each bank staff's competency assessment must be sent to LPT Bank.

All staff should be given the opportunity to read the Trust Policy on Safe and Therapeutic Observation and receive training before completing the assessment.

Name of staff……..**Band**…….

Name of Assessor……**Band**……..

Date of Assessment……**Ward/Area**…….

	Question	Criteria to meet	Achieved *Please circle*
1	Has the staff member attended training and read the policy?	Can demonstrate attendance at training, locate the policy and reports they have read it.	YES/NO
2	Define the purpose of observation.	Staff member can explain that observation minimises risk of harm to a patient and/or others and monitor mental state.	YES/NO
3	Outline the different levels of observation?	The staff member is able to accurately describe levels of observation 1a, 1b, 2 and 3.	YES/NO
4	Who agrees the patient requires observation and how often should it be reviewed?	The MDT (doctor and nursing staff) agree observation and it should be reviewed daily or when staff note a change in mental health.	YES/NO

	Question	Criteria to meet	Achieved *Please circle*
5	How should any change to observation be documented?	In the patient notes, in their care plan, in observation records on patient status boards	YES/NO
6	How can observation be made therapeutic/ supportive?	Informing the patient of the reason and level of observation, considering any cultural needs, introducing self. And engaging in interactions or activities.	YES/NO
7	Who is responsible for the observation of patients?	All team members have general responsibility but individual staff may be allocated to patient observation for a specified time.	YES/NO
8	When carrying out observations what environmental risks should be considered?	Staff can give examples, such as blind spots, ligature points, damaged equipment, bedding etc.	YES/NO
9	What should be documented whilst undertaking observations?	Mental and physical health, food and drink taken, medication offered/taken, interactions and activities.	YES/NO
10	What else should clearly be documented?	Patients name, hospital number, the staff observing name and the timespan of observation	YES/NO
11	How can continuity of observation be maintained?	An individual patient care plan is in place, levels of observation are handed over at every shift and to each observing staff.	YES/NO
12	How long should you observe a patient for without a break?	One hour for level 1 observation, after which you may be asked to undertake up to one further hour on level 2 observations.	YES/NO
13	If a patient has taken excessive alcohol or illicit drugs, what level of	Level 2	YES/NO

	Question	Criteria to meet	Achieved *Please circle*
	observation should be considered as a minimum?		
14	If you notice someone who is not on observation is missing from the ward, what should you do?	Report it to the nurse in charge and conduct a thorough local search, discuss with the unit coordinator, carry out the missing person's procedure, inform relatives and the police.	YES/NO
15	What should you do with any information gained through conversations during observation?	Report to the identified nurse and document in the patients' notes. Ensure any relevant info is handed over to the nursing team.	YES/NO
16	What should you consider when observing a patient on level 1A or 1B who is using the toilet or bathroom?	Refer to any specific instructions for observation in the patient's care plan, as agreed by the MDT. Discuss the need for **full sight** of the patient, and check clothing and objects the patient has to assess risks. Staff of the same gender should be identified to observe this activity.	
17	What should you consider when observing a patient who is in bed?	Explain to the patient the need for observation, ensure arms, hands, neck and head are visible.	
18	What would you need to consider if a colleague asked you to undertake observations that have been allocated to them?	Has this been agreed with the nurse in charge? Only sign for observations you have undertaken yourself.	
19	What do you need to consider when handing over responsibility for observation from one staff member to another?	Staff member to handover to the next staff member, ensuring the documentation is completed and up to date. Both staff members to sign.	

Note: For new staff a shorter review date (less than 3 years) may be agreed at the discretion of the supervisor / assessor.

Next review date:	

Adapted from the assessment developed by the Releasing Time to Care Team on Beaumont and Cedar wards.

Reference - Roach. MS (1992) The Human Act of Caring. Ottawa, Ontario: Canadian Hospital Associated Press.

Appendix 3

Leicestershire Partnership NHS Trust

Due Regard Equality Analysis

Initial Screening Template

Introduction

This document forms part of the Trusts Due Regard (Equality Analysis) toolkit which can be accessed here.

Leicestershire Partnership NHS Trust has a legal requirement under the Equality Act 2010 to have '' due regard'' to eliminate discrimination. It is necessary to analysis the consequences of a policy, strategy, function, service or project (referred to as activity) on equality groups in respect of service users, patients and staff.

The analysis has to consider people's 'protected characteristics 'age, disability, gender reassignment, marriage / civil partnership, pregnancy and maternity, race, religion / belief, sex, sexual orientation. We also include other vulnerable groups who may not be protected under the Equality Act but their needs should be considered.

There are several tangible benefits in conducting equality analysis prior to making policy decisions, including:

- Higher quality decisions as a result of more complete management information
- Reduced cost as a result of not having to revisit policy that is not fit for purpose
- Enhanced reputation as an organisation that is seen to understand and respond positively to diversity.

Most importantly, through equality analysis we are able to take into account the needs of our different equality groups of staff and patients. Changes being proposed through policy, strategy, transformational programmes or other methods need to be analysed from an equality perspective and the results considered before decisions are made. Where negative impacts are identified, ways to mitigate or minimise them must be put in place.

Before starting if you are unfamiliar with doing an Equality Analysis contact the Equality and Human Rights Team for guidance or visit the Due Regard section on the Trust Intranet here.

Below is the Due Regard Screening Template which aims to assess the likelihood of a negative impact on an equality group/s. For example, a policy change in financial management systems may be considered major but has no negative impact.

The initial screening form needs to be completed to decide if a full Due Regard (Equality Analysis) * should be undertaken. An overview of the various option available are

highlighted in a Due Regard fact sheet which includes top tips and a flow chart which can be accessed here.

*A full Due Regard (Equality Analysis) makes sure that any negative impacts have been considered and ways to minimize the impact are specified. Further guidance is available here.

Due Regard Screening Template

Section 1	
Name of activity/proposal	Observation of inpatients in MH and LD
Date Screening commenced	April 2014
Directorate / Service carrying out the assessment	Adult Mental Health and Learning Disability Division
Name and role of person undertaking this Due Regard (Equality Analysis)	Claire Armitage, Lead Nurse
Give an overview of the aims, objectives and purpose of the proposal:	
AIMS: The purpose of the Organisation wide Policy for the observation of Inpatients is to provide guidance for the planning and implementation of high quality consistent and robust care for service users with an assessed need for observation.	
OBJECTIVES: Observation should provide a period of safety for patients during temporary periods of distress when they are at risk of harm to themselves and/or others, or are at risk from others. It can also be used to provide an extensive period of assessment of a person's mental state. The physical health of patients should also be considered during observation.	
PURPOSE: To provide clear guidelines and standards for staff to work within.	

Section 2		
Protected Characteristic	**Could the proposal have a positive impact Yes or No (give details)**	**Could the proposal have a negative impact Yes or No (give details)**
Age Disability Gender reassignment Marriage & Civil Partnership Pregnancy & Maternity Race Religion and Belief Sex Sexual Orientation Other equality groups?	Measures in place throughout this policy ensure that respect for the dignity of patients, carers and service users is maintained during the application of this policy (see section 4, Communication and Cultural Diversity, section 5 Engagement, section 6.6, Observation of patients who are sleeping and section 14, Due Regard).	

Section 3	
Does this activity propose major changes in terms of scale or significance for LPT? For example, is there a clear indication that, although the proposal is minor it is likely to have a major affect for people from an equality group/s? Please <u>tick</u> appropriate box below.	
Yes	**No ✓**

High risk: Complete a full EIA starting click here to proceed to Part B		Low risk: Go to Section 4.	

Section 4

It this proposal is low risk please give evidence or justification for how you reached this decision:

Throughout the development of this policy, careful consideration has been given to ensure that respect for the dignity of patients, carers and service users is maintained.
See for example:
Section 4, Communication and Cultural Diversity
Section 5 Engagement, section 6.6, Observation of patients who are sleeping
Section 14, Due Regard).
These considerations should be set in the context of a high risk activity where patient safety is paramount.

Sign off that this proposal is low risk and does not require a full Equality Analysis:

Head of Service Signed:
Date:

Appendix 4

Policy Training Requirements

The purpose of this template is to provide assurance that any training implications have been considered

Training topic:	Observation
Type of training:	☐ Mandatory (must be on mandatory training register) ☑ Role specific ☐ Personal development
Division(s) to which the training is applicable:	☑ Adult Learning Disability Services ☑ Adult Mental Health Services ☑ Community Health Services ☐ Enabling Services ☑ Families Young People Children ☐ Hosted Services
Staff groups who require the training:	*All clinical staff who undertake therapeutic observations*
Update requirement:	Every three years
Who is responsible for delivery of this training?	Ward matrons
Have resources been identified?	Yes – training pack, competency checklist and prompt cards are available
Has a training plan been agreed?	Yes
Where will completion of this training be recorded?	☑ Trust learning management system ☐ Other (please specify)
How is this training going to be monitored?	Annual clinical audit

Appendix 5

Leicestershire Partnership NHS
NHS Trust

The NHS Constitution

NHS Core Principles – Checklist

Please tick below those principles that apply to this policy

The NHS will provide a universal service for all based on clinical need, not ability to pay.
The NHS will provide a comprehensive range of services

Shape its services around the needs and preferences of individual patients, their families and their carers	☐
Respond to different needs of different sectors of the population	☐
Work continuously to improve quality services and to minimise errors	x☐
Support and value its staff	☐
Work together with others to ensure a seamless service for patients	x☐
Help keep people healthy and work to reduce health inequalities	☐
Respect the confidentiality of individual patients and provide open access to information about services, treatment and performance	x☐