Leicestershire Partnership NHS Trust

Supportive Observation and Engagement of Inpatients Policy

The purpose of the Supportive Observation and Engagement of Inpatients Policy is to provide guidance for 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. Engagement with patients at these times can offer support and provide a period of assessment or treatment.

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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.
Version 11	March – May 2021	Amendments made to bring the policy in line with the National observation template developed by the MH/LD Directors of Nursing Forum and NHSE/I, including following the nationally recommended observational levels 1-4. Changes also reflect learning from serious incidents and the National Enquiry for Suicide Prevention 2019/20 specifically: • Registered staff participation in patient observations • The importance that observation is a therapeutic activity supporting assessment and treatment and communication during observation is important to patient wellbeing. • Registered nurses at band 6 and 7 can decrease observation levels following individual patient agreed criteria set with the Responsible Clinician and MDT.

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For further information contact:
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Definitions that apply to this Policy

Supportive observation	Observation is a clinical 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 – this may form part of assessment or treatment care plans.
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.
Nerve Centre	A computer system developed to support a patients clinical care by recording patients health information entered by a staff member and making this accessible to all staff involved in the patients care immediately via a handset or desk top computer.

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 promotes 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, sex (gender), gender reassignment, sexual orientation, marriage and civil partnership, race, religion or belief, pregnancy and maternity.

Due Regard

LPT will ensure that Due regard for equality is taken and as such will undertake an analysis of equality (assessment of impact) on existing and new policies in line with the Equality Act 2010. This process will help to ensure that:

- Strategies, policies and procedures and services are free from discrimination
- LPT complies with current equality legislation.
- Due regard is given to equality in decision making and subsequent processes.
- Opportunities for promoting equality are identified.

Please refer to due regard assessment (Appendix 3) of this policy

1 Purpose

The policy has been revised, considering lessons learnt from a National Quality Improvement Collaborative aimed at improving observation and engagement in mental health and learning disability inpatient settings and national and local serious incident investigations.

2 Summary and scope of policy

The aim of the Supportive Observation and Engagement of Inpatients Policy is to provide guidance for the planning and implementation of high quality, consistent and robust care for patients with an assessed need for observation.

Observation is a multi-disciplinary practice and 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 and treatment of a person's mental state. The physical health of patients should also be considered during observation.

The Department of Health (DOH) (2014), reducing the need for restrictive interventions provides a framework whereby Adult Health and Social Care providers are obliged to develop a culture where restrictive interventions are only ever used as a last resort and for the shortest possible time. This is also stated in Compliance with Chapter 26 of MHA Code of Practice (2015), Supportive observation and associated practices are potentially highly restrictive.

The use of increased observation levels should never be regarded as routine practice but must be based on assessed and current need.

Enhanced observations should be recognised as a restrictive practice and may be perceived by patients as a coercive intervention. It should therefore only be implemented for initial assessment or after positive engagement with the patient has failed to reduce the risk to self or others, and only used for the least amount of time clinically required.

Supportive observation and engagement 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 aimed at reducing factors which contribute to increased risk and promoting recovery.

All patients assessed as requiring enhanced levels of observation should have a collaborative care plan in place detailing a summary of the patient's condition, risk behaviours and significant events, potential re traumatisation and suggested therapeutic interventions/activities.
Patients in seclusion should be observed using the paper seclusion records.

Observation is undertaken at the following levels:

Level 1 General Observation (hourly) – this is the minimum level of observation for all patients in inpatient areas. Staff should know the location of all patients in their area, but patients need not be kept in sight. Patients subject to general observations will normally have been assessed as being a low risk to themselves or others. Their location, wellbeing and safety will be visibly checked at a minimum of hourly intervals.
The intended whereabouts of patients who are on leave from the ward should also be known at all times.

Level 2 - Intermittent Observation (between 5 and 30 minutes) – this means that the patient's location and safety must be visibly checked at specified intervals. These intervals may range from every five minutes to a maximum of every thirty minutes. This is for patients who pose a potential, but not immediate risk. The specified frequency of observation should be recorded in the patients Care Plan and on the ward patient summary board. Observing patients at predictable times can provide patients with the opportunity to plan or engage in harmful activities. This should be considered when determining the frequency of observation required.

Zonal Observations can be undertaken in level 2 intermittent observations – this is an approach a ward or clinical area may take to enhance observation of a particular group of patients within a specific area of the ward. A staff member may be assigned to observe and engage with individuals using specified zones within the ward area but each patients individual behaviour during the observation period will be recoded separately.

Level 3 Continuous (within continuous eyesight) – this means a nominated staff member will be allocated to each individual being managed on this level of

observation and the patient must be always kept within continuous eyesight. This is for patients who could, at any time, try to harm themselves or others, or where a patient is perceived as being vulnerable.

Level 4 Continuous (within arm's length) – this means a nominated staff member will be allocated to observe the patient in close proximity; able to reach immediately within the staff members arms length. This is for patients who pose the highest level of risk of harm towards themselves or potentially to others, and it has been determined that this level of risk can only be managed by the close proximity of the service user with staff. More than one nurse or member of the multidisciplinary team may be required to implement this level of observation safely, usually used when a patient is at the highest risk of harming themselves or others and needs to be kept within eyesight of 2 or 3 staff members and at arm's length of at least 1 staff member.

3 Introduction

The policy is applicable to all Trust inpatient settings providing care to people with Mental Health needs or Learning Disability and or Autism. The Policy provides guidance to all clinical staff for the planning and implementation of high quality, consistent and robust care for patients with an assessed need for observation.

4 Duties

Trust Board of Directors – is responsible for overseeing the reduction of restrictive practice within its services, recognising enhanced observations should only be used for the least amount of time clinically required. They have a responsibility for ensuring there is an appropriate and adequate infrastructure to support the observation and engagement of patients and that patients are safeguarded and their equality and human rights is not compromised.

Executive Director of Nursing – is accountable to the Trust Board for the development, consultation, implementation and monitoring of compliance with this Policy, which promotes supportive observations, engagement of patients and safeguards against unnecessary use of restrictive practice.

Service Directors/ Managers – have operational responsibility for Directorate's compliance with this Policy and will ensure mechanisms in place within each service for:

- Identifying and deploying resources within the Directorate to safely deliver this Policy.
- Ensuring all clinical staff with responsibility for prescribing and carrying out observation/engagement receive orientation to the content of this Policy.
- Monitoring the Directorates compliance and consistent application of the Policy
- Ensuring that all patients subject to prolonged periods of constant observations are reviewed after 14 days and then at least once per calendar month by clinicians independent of the patient's care.

Responsible Clinician – has a legal and professional responsibility for the care and treatment of the patients. As part of that responsibility, they must have a thorough knowledge of the patients in their care, input to patient's current care plans and observational requirements and provide advice when uncertainty arises regarding level of observation required.

Matrons – are accountable to the Service Director/Head of Nursing for providing assurance that the wards they have designated responsibility for are compliant with the requirements of the Policy.

Ward Sister / Charge Nurses – have overall accountability for the management of their ward and must ensure:

- They understand their role in initiating and reviewing supportive observations.
- Care plans are in place and appropriately identify the required level of observation.
- Documented risk review accompanies the decisions made to change the levels of observation and staff able to increase and decrease observation levels are identified and receive supervision.
- Deployment of the available resources to safely deliver this Policy on their wards.
- Identification, responding and where necessary escalating any areas of non-compliance with this Policy on their wards.
- That Peer review occurs when patients are subject to constant observations for longer than 14 days.

Multidisciplinary Care Team – have a responsibility to understand their role in initiating and reviewing supportive observations. They must balance the potentially distressing effect on the individual of increased levels of observation, particularly if these are proposed for many hours or days, against the identified risk of self-injury or behavioural disturbance. Levels of observation and risk should be regularly reviewed by the Multidisciplinary team and a record made of decisions agreed in relation to increasing or decreasing the observation.

The teams must consider how enhanced observation can be undertaken in a way which minimises the likelihood of individuals perceiving the intervention to be coercive and how observation can be carried out in a way that respects the individual's privacy as far as practicable and minimises any distress. In particular care plans should outline how an individual's dignity can be maximised without compromising safety when individuals are in a state of undress, such as when using the toilet, bathing, showering, dressing etc, detailed in a robust care plan based on identified risk.

When enhanced observations are used for longer than 14 days, the team should use the skills of the entire team to support service user's recovery.

Nurse in Charge – is responsible for identifying the staff (by their profession and grade) who are best placed to carry out enhanced observation and under what circumstances. This selection should take account of the individual's characteristics and circumstances (including factors such as experience, ethnicity, sexual identity, age and gender). They should ensure staff allocated to undertake increased observations have been assessed as competent to do so. It is important to consider

the observation requirements of environments, for example, communal areas and areas where lines of sight are not clear in the allocation of staff duties.
All patients receiving observations at levels 2, 3 or 4 should have a registered nurse discuss their observations with them at least one per 24 hour period to review and reassess their need for observation. Where possible the nurse will complete the observations at this time.

The Nurse in Charge should also be checking observations are undertaken in line with the prescribed observation level, and in accordance with the agreed care plan.

All Registered inpatient clinical staff have a responsibility to:

- Understand their role in initiating, carrying out and reviewing supportive observations/ engagement.
- Carry out that role in line with the Policy.
- Complete the care plan for their named patient.
- Inform each patient of the level of observation they are subject to and the reasons for this.
- Review the level of observation based on recorded clinical need and risk review.
- Ensure the care plan is implemented.
- Ensure the periods of observation are viewed and used as opportunities to build a therapeutic relationship, carryout assessment, or treatment.
- Complete all the required documentation.
- Fully familiarise themselves with the policy and attend training.

Non-registered inpatient clinical staff / Health Care Support Workers have a responsibility to:

- Understand their role in carrying out supportive observations.
- Carry out observations in line with the observation level prescribed.
- Ensure the periods of observation are viewed and used as opportunities to build a therapeutic relationship, support assessment, or treatment.
- Be familiar with, and implement, the patients care plan.
- Complete the required documentation accurately and contemporaneously.
- Report any relevant information that would assist the effective review of the service user's needs.
- Fully familiarise themselves with this Policy and attend training.

Consent

Clinical staff must ensure that consent has been sought and obtained before any care, intervention or treatment described in this policy is delivered. Consent can be given orally and/ or in writing. Someone could also give non-verbal consent as long as they understand the treatment or care about to take place. Consent must be voluntary and informed and the person consenting must have the capacity to make the decision.

In the event that the patient's capacity to consent is in doubt, clinical staff must ensure that a mental capacity assessment is completed and recorded. Someone with an impairment of or a disturbance in the functioning of the mind or brain is thought to lack the mental capacity to give informed consent if they cannot do one of the following;

- Understand information about the decision
- Remember that information
- Use the information to make the decision
- Communicate the decision

5 Communication and Cultural Diversity

All decisions about the specific level of observation should take into account:

- The patient's current mental state and capacity around risk and observation.
- Any prescribed medications and their effects.
- The current assessment of risk should include the patient's ability to perceive potential risk.
- The views of the patient.

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.

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 patients with a learning disability and/ or Autism must be considered.

6 Principles of Observation and 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 24 hour period, 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 risks 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 staff member 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 3 and 4 observation. The door of a bedroom or quiet area must be left open or ajar when undertaking level 3 and 4 observations. Please refer to the Trust's Equality Diversity and Human Rights Policy and the Chaperone Policy for Adults and Children.

It is important to consider the observation requirements of environments, for example, communal areas and areas where lines of sight are not clear in the allocation of staff duties.

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

To ensure observations remain least restrictive the ward team should review patient observations prior to weekend to ensure the ward team aware of changes if required over the weekend. 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. The MDT may agree that a patients observations can be undertaken by family during a visit and if this is felt appropriate the family should be informed of the observation approach for the patient and how to record it on a paper form to be inputted by the staff member who discusses the visit after.

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.

7 Levels 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 on admission will be at level 2 10 minutes during the initial assessment period**, following this observation at levels 2, 3 or 4 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 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 Trust 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 Checking and Searching Policy.

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

7.1 Level 1 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 recorded.

Approaches to support the hourly checks should be considered, for example 'Intentional Rounding'. At each shift handover the staff in charge should check the number of patients on the ward/area and ensure each patient's level of observation is handed over.

Level 1 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.

7.2 Level 2 Observation - intermittent observation

Any new admission to the ward / area must be on at least level 2, 10-minute observations for a minimum of 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 10-minute 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, 25 or 30 minutes (see section 10 Recording). The frequency of these observations will be determined and agreed by the nurse and doctor and 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 and the clinical record.

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 7.5 - Observation of patients who are in bed or sleeping, and Section 9 - Recording.

7.3 Level 3 Observation – continuous (within arm's length) including full sight of the whole body

The patient must be in full sight of the nurse at all times but not necessarily at arm's length to maintain some privacy and dignity. 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 3 or 4 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, there are unfamiliar staff on the ward, staff may need to undertake further observations. In such cases, a check

must be made to ensure that the staff member is equipped and 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 7.5 - Observation of patients who are in bed or sleeping, and Section 10 - Recording.

7.4 Level 4 Observation - constant observation within Arm's Length including full sight of the whole body

The aspects detailed for level 3 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 7.5 - Observation of patients who are in bed or sleeping, and Section 9 - Recording.

7.5 Observation of patients who are in bed or sleeping

Serious Incident investigations demonstrate that observing patients who are presenting with high risks in bed or sleeping is a 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 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 in conjunction with the MDT 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. For example, reduced observation for patients suffering from sleep deprivation.

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, torches may need to be provided.

8. Leaving the Ward

All staff responsible for escorting a patient who is under observation **must** have completed an observation competency assessment. Staff should continue to record observations on paper forms or via Nerve Centre device if attending an LPT site or UHL hospital site.

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.

Patients going on planned leave must have a clear plan of care for observation levels on their return; this may be different from the level prior to leave considering the patients risks and possible psychological effects of leave.

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

Level 3 and 4 observations
It is expected that patients on level 3 and 4 observations will not have leave from the ward other than for urgent medical appointments or interventions.

However, on rare occasions patients on level 3 or 4 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 bands of staff required to safely escort the patient.

A patient who is on level 3 observation due to their own vulnerability (for example, a pregnant patient) may leave the ward unescorted with the express documented 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 3/4 observations

If a patient on level 3/4 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.

8.1 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 2, 3 or 4 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 or ward protocols on the management of the garden areas. 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 sister or charge nurse 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.

8.2 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.

9. 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' clinical record and any ward summary board.

For example: A patient is being observed on level 4 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 3. This has been agreed by the MDT and documented in the healthcare record and on the observation chart.

9.1 Decision to increase or decrease observation levels

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 junior or on call 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.

A senior nurse (band 6, 7 or above) may decrease the level of observation if the responsible clinician and MDT have an agreed and recorded criterion and this has been achieved for the required timespan.

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.

9.2 Care planning supportive observation and engagement

The Care plan should be viewed as a high intensity engagement plan, explaining what, when & why, (wherever possible taking into account patients preferences) it should consider/include: -

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

- Any agreed private time or unsupervised time with family/carers
- Frequency of review

The care plan should be shared at each hand over. If for any reason, engaging the service user in dialogue and activities during supportive observation is not possible, then the reasons for this needs to be clearly recorded.

9.3 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 identified risks and record any changes in the patient electronic record.

Where observation at level 3 or 4 continues for 14 days a multi-disciplinary review must take place on a weekly basis as a minimum.

The MDT should be aware of the risk of dependency developing in those patients subject to constant observations for prolonged periods and consider how this will be sensitively managed.

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, behaviour during observation and the views of the patient, and family.as far as possible.

10 Recording

The doctor or nurse should record all decisions regarding observation levels in the patient's electronic record. 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 and criterion for decreasing observation
- Clear direction regarding the 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 Nerve Centre electronic system or in times where the system in unavailable on the contingency forms shown in the appendices 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 using the observation behaviours listed; additional information can be added on the Nerve Centre electronic system and the level of observation expansion form.
- When using the paper contingency forms, 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.

11 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, 3 and 4 observation and the staffing levels to meet the needs must be raised with the ward sister/ charge nurse or appropriate manager immediately and recorded appropriately. If the situation is not resolved, an electronic incident form (eIRF) must be completed.

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 Training Needs

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 training needs analysis is shown in appendix 1.

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

Observing and engaging with patients at risk is a skilled activity. Staff must be trained in the skills and competencies required to undertake observations and engage appropriately with patients.

The Trust will ensure that all relevant staff (both registered and non-registered) are trained and their competence is assessed.

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

All staff must complete the role essential training on ULearn and assessed as being competent This record 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 Supportive Observation and Engagement 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.

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

TARGET/STANDARDS	**KEY PERFORMANC**E **INDICATO**R
CQC standards 12 Safe Care	Reduced incidents of harm for patients on level 1,2,3,4 of observation.

15 Monitoring Compliance and Effectiveness of this Policy

Monitoring of compliance and effectiveness of this policy will be managed through the following:

Ref	Minimum Requirements	Evidence for Self-assessment	Process for Monitoring	Responsible Individual / Group	Frequency of monitoring
	Clinical staff staff trained in observation and assessed as competent	Reports	Workforce Reports	Directorate Workforce Groups	Quarterly
	Patient observations levels are reviewed as a minimum daily	Report	Audit	Clinical Effectiveness Group	Annual

16 References

References used in the production of this document:

- LPT Incident Reporting Policy,
- 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
- Preventing Suicide in England Report – 4th Report 2020.
- LPT Deprivation of Liberty Safeguards Policy,
- LPT Absence without Leave and Missing Patient Policy,
- LPT Checking and Searching Policy

17 Associated Documentation

Acknowledgement:

Mental Health Directors of Nursing Forum Supportive Observation and Engagement Policy Template and Mersey Care Trust for the evidenced based observation behaviours form - adapted.

Literature Review

Simonfinallitrev.pdf

Appendix 1

Training Requirements

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?	Electronic training on ULearn with optional face to face in teams
Have resources been identified?	Yes – training pack and competency checklist 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?	Directorate Workforce Groups monthly

The NHS Constitution

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	☑
Support and value its staff	☑
Work together with others to ensure a seamless service for patients	☑
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	☑

Appendix 3

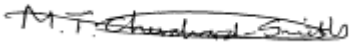
Due Regard Screening Template

Section 1	
Name of activity/proposal	Supportive observation
Date Screening commenced	March 2021
Directorate / Service carrying out the assessment	Mental Health
Name and role of person undertaking this Due Regard (Equality Analysis)	Michelle Churchard-Smith, Head of Nursing
Give an overview of the aims, objectives and purpose of the proposal:	
AIMS: The aim of the Supportive Observation and Engagement of Inpatients Policy is to provide guidance for the planning and implementation of high quality, consistent and robust care for patients with an assessed need for observation.	
OBJECTIVES: Observation is a multi-disciplinary practice and 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.	

Section 2	
Protected Characteristic	**If the proposal/s have a positive or negative impact please give brief details**
Age	No impact
Disability	No impact
Gender reassignment	Consideration of gender of staff members carrying observation included.
Marriage & Civil Partnership	No impact
Pregnancy & Maternity	No impact
Race	Consideration of gender of staff members carrying observation included.
Religion and Belief	Consideration of gender of staff members carrying observation included.
Sex	Consideration of gender of staff members carrying observation included.
Sexual Orientation	Consideration of gender of staff members carrying observation included.
Other equality groups?	

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 tick appropriate box below.			
		No	
High risk: Complete a full EIA starting click here to proceed to Part B		Low risk: Go to Section 4.	

Section 4
If this proposal is low risk please give evidence or justification for how you reached this decision:
Supportive and therapeutic observations have been in place for many years, the new policy

focuses on engagement with patients and maintaining restrictive observations for the least time possible whilst maintaining patient's safety.			
Signed by reviewer/assessor		**Date**	18.05.21
Sign off that this proposal is low risk and does not require a full Equality Analysis			
Head of Service Signed		**Date**	18.05.21

Appendix 4

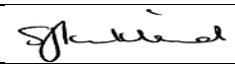
DATA PRIVACY IMPACT ASSESSMENT SCREENING

Data Privacy impact assessment (DPIAs) are a tool which can help organisations identify the most effective way to comply with their data protection obligations and meet Individual's expectations of privacy.
The following screening questions will help the Trust determine if there are any privacy issues associated with the implementation of the Policy. Answering 'yes' to any of these questions is an indication that a DPIA may be a useful exercise. An explanation for the answers will assist with the determination as to whether a full DPIA is required which will require senior management support, at this stage the Head of Data Privacy must be involved.

Name of Document:	Supportive and Therapeutic Observation Policy	
Completed by:	Michelle Churchard-Smith	
Job title	Head of Nursing	Date May 2021.

Screening Questions	**Yes / No**	**Explanatory Note**
1. Will the process described in the document involve the collection of new information about individuals? This is information in excess of what is required to carry out the process described within the document.	No	
2. Will the process described in the document compel individuals to provide information about them? This is information in excess of what is required to carry out the process described within the document.	No	
3. Will information about individuals be disclosed to organisations or people who have not previously had routine access to the information as part of the process described in this document?	No	
4. Are you using information about individuals for a purpose it is not currently used for, or in a way it is not currently used?	No	
5. Does the process outlined in this document involve the use of new technology which might be perceived as being privacy intrusive? For example, the use of biometrics.	No	
6. Will the process outlined in this document result in decisions being made or action taken against individuals in ways which can have a significant impact on them?	Yes	The process of observations may be seen as restrictive in nature.
7. As part of the process outlined in this document, is the information about individuals of a kind particularly likely to raise privacy concerns or expectations? For examples, health records, criminal records or other information that people would consider to be particularly private.	Yes	Describes behaviours of patient when unwell.
8. Will the process require you to contact individuals in ways which they may find intrusive?	Yes	The process of observations may be seen as restrictive and intrusive in nature.

If the answer to any of these questions is 'Yes' please contact the Data Privacy Team via Lpt-dataprivacy@leicspart.secure.nhs.uk
In this case, ratification of a procedural document will not take place until review by the Head of Data Privacy.

Data Privacy approval name:	
Date of approval	**17.05.21**

Acknowledgement: This is based on the work of Princess Alexandra Hospital NHS Trust

Appendix 5

Competency Assessment
Supportive Observation and Engagement

You must now be observed carrying out a period of supportive observation and engagement with a patient. Your assessor must be competent in carrying out this activity and must be a band 6 or above.

Observation standards:	Assessors name: Assessors Job role & band: Ward/ Department: I hereby certify that I have observed (INSERT NAME)_____ (assignment number)_____ successfully carrying out a period of supportive observation & engagement and has met all of the observation standards. Assessors signature: Date:
❑ Is aware of the reasons why the person they are allocated is on observations. ❑ Demonstrated good use of communication skills. ❑ Promoted good food and fluid intake. ❑ Engaged patient in prescribed leisure/ therapeutic activities. ❑ Documented observations correctly. ❑ Observed carrying out observations at the correct time intervals. ❑ Demonstrated an understanding of the different levels of observation through conversation.	

Send a copy of the completed form to:
Clinical Trainers Annie Palmer or Colin Bourne via email.
Please retain a copy for your own evidence and give a copy to your manager.

Appendix 6

Fix Patient Sticker

All patients on level 1 observations

Location Key:	Bedroom - **B**	Toilet - **T**	Garden - **G**	Clinic Room /Treatment Room - **CR/ TR**	Interview room - **IR**	Other – please add note
	Bathroom / Shower - **BS**	Communal Area - **C**	Kitchen - **K**	Seclusion / Extra Care - **S**	Therapy Area - **TA**	

Location	**ENGAGEMENT**					**MOOD AND AGITATION**						**VIOLENCE AND AGGRESSION**								**SELF-HARM / SUICIDE**						**NEGATIVE BEHAVIOURS**						**EXPLOITATION**					**POSITIVE BEHAVIOURS**								**VISIBLE ARMS IN BED**			**CONFIRMED BREATHING**		**SLEEP**					
To add location key	Uncommunicative	Unengaged	Self-isolated	Engaging therapeutically/Activities	Engaging positively with others	Responding to unseen stimuli	Rapid Talking	Expressing racing thoughts	Pacing/Hand wringing	Tearful/Emotional	Calm	Physical violence	Damage to building	Damage to property	Violent thoughts	Threatening behaviour	Verbally abusive	Physical violence attempted	No violence or aggression	Attempting suicide	Suicidal thoughts	Attempting self-harm	Actual self-harm	Thoughts of self-harm	No evidence of self-harm/suicide	Attempting to abscond	Sexually inappropriate	Refuses support/treatment	Under influence drugs/alcohol	N/C Ward boundaries	No negative behaviours	Bully others	Exploiting Grooming	Exploiting /Sexual	Exploiting/Financial	No exploitative behaviours	None of above - add to notes	Asked for PRN appropriately	Used coping strategies	Attended to personal care	Attended Education	Accepted support with care	Engaging with others	Calm	Visible	Not Visible	Patient not in bed	No	Yes	Restless Sleep	Restful Sleep	Awake	date	time	Observer

Fix Patient Sticker

All patients on level 2 observations should have arms outside of sheets when asleep

Location Key :	Bedroom - **B**	Toilet - **T**	Garden - **G**	Clinic Room /Treatment Room - **CR/ TR**	Interview room - **IR**	Other – please add note
	Bathroom / Shower - **BS**	Communal Area - **C**	Kitchen - **K**	Seclusion / Extra Care - **S**	Therapy Area - **TA**	

Location	ENGAGEMENT						MOOD AND AGITATION							VIOLENCE AND AGGRESSION							SELF-HARM / SUICIDE							NEGATIVE BEHAVIOURS							EXPLOITATION							POSITIVE BEHAVIOURS								VISIBLE ARMS IN BED			CONFIRMED BREATHING		SLEEP				
	Uncommunicative	Unengaged	Self-isolated	Engaging positively with others	Engaging therapeutically/Activities		Calm	Tearful/Emotional	Pacing/Hand wringing	Expressing racing thoughts	Rapid Talking			Physical violence	Damage to building	Damage to property	Violent thoughts	Threatening behaviour	Verbally abusive	Physical violence attempted	No violence or aggression	Attempting suicide	Suicidal thoughts	Attempting self-harm	Actual self-harm	Thoughts of self-harm	No evidence of self-harm/suicide	Attempting to abscond	Sexually inappropriate	Refuses support/treatment	Under influence drugs/alcohol	N/C Ward boundaries	No negative behaviours	Bully others	Exploiting Grooming	Exploiting /Sexual	Exploiting/Financial	No exploitative behaviours	None of above - add to notes	Asked for PRN appropriately	Used coping strategies	Attended to personal care	Attended Education	Accepted support with care	Engaging with others	Calm	Visible	Not Visible	Patient not in bed	No	Yes	Restless Sleep	Restful Sleep	Awake	date	time	Observer
To add location key																																																								

All patients on level 3 observations should have arms outside of sheets when asleep

Fix Patient Sticker

Location Key:	Bedroom - **B**	Toilet - **T**	Garden - **G**	Clinic Room /Treatment Room - **CR/ TR**	Interview room - **IR**	Other – please add note
	Bathroom / Shower - **BS**	Communal Area - **C**	Kitchen - **K**	Seclusion / Extra Care - **S**	Therapy Area - **TA**	

Location	ENGAGEMENT					MOOD AND AGITATION						VIOLENCE AND AGGRESSION								SELF-HARM / SUICIDE						NEGATIVE BEHAVIOURS						EXPLOITATION					POSITIVE BEHAVIOURS								VISIBLE ARMS IN BED			CONFIRMED BREATHING		SLEEP					
To add location key	Uncommunicative	Unengaged	Self-isolated	Engaging therapeutically/Activities	Engaging positively with others	Responding to unseen stimuli	Rapid Talking	Expressing racing thoughts	Pacing/Hand wringing	Tearful/Emotional	Calm	Physical violence	Damage to building	Damage to property	Violent thoughts	Threatening behaviour	Verbally abusive	Physical violence attempted	No violence or aggression	Attempting suicide	Suicidal thoughts	Attempting self-harm	Actual self-harm	Thoughts of self-harm	No evidence of self-harm/suicide	Attempting to abscond	Sexually inappropriate	Refuses support/treatment	Under influence drugs/alcohol	N/C Ward boundaries	No negative behaviours	Bully others	Exploiting Grooming	Exploiting /Sexual	Exploiting/Financial	No exploitative behaviours	None of above - add to notes	Asked for PRN appropriately	Used coping strategies	Attended to personal care	Attended Education	Accepted support with care	Engaging with others	Calm	Visible	Not Visible	Patient not in bed	No	Yes	Restless Sleep	Restful Sleep	Awake	date	time	Observer

Fix Patient Sticker

All patients on level 4 observations should have arms outside of sheets when asleep

Location Key	Bedroom - **B**	Toilet - **T**	Garden - **G**	Clinic Room /Treatment Room - **CR/ TR**	Interview room - **IR**	Other – please add note
	Bathroom / Shower - **BS**	Communal Area - **C**	Kitchen - **K**	Seclusion / Extra Care - **S**	Therapy Area - **TA**	

Location	ENGAGEMENT					MOOD AND AGITATION						VIOLENCE AND AGGRESSION								SELF-HARM / SUICIDE						NEGATIVE BEHAVIOURS						EXPLOITATION					POSITIVE BEHAVIOURS								VISIBLE ARMS IN BED			CONFIRMED BREATHING		SLEEP					
To add location key	Uncommunicative	Unengaged	Self-isolated	Engaging therapeutically/Activities	Engaging positively with others	Responding to unseen stimuli	Rapid Talking	Expressing racing thoughts	Pacing/Hand wringing	Tearful/Emotional	Calm	Physical violence	Damage to building	Damage to property	Violent thoughts	Threatening behaviour	Verbally abusive	Physical violence attempted	No violence or aggression	Attempting suicide	Suicidal thoughts	Attempting self-harm	Actual self-harm	Thoughts of self-harm	No evidence of self-harm/suicide	Attempting to abscond	Sexually inappropriate	Refuses support/treatment	Under influence drugs/alcohol	N/C Ward boundaries	No negative behaviours	Bully others	Exploiting Grooming	Exploiting /Sexual	Exploiting/Financial	No exploitative behaviours	None of above - add to notes	Asked for PRN appropriately	Used coping strategies	Attended to personal care	Attended Education	Accepted support with care	Engaging with others	Calm	Visible	Not Visible	Patient not in bed	No	Yes	Restless Sleep	Restful Sleep	Awake	date	time	Observer

Observation Expansion Sheet

Time of observation	Information staff wish to expand on	Sign and initial

Appendix 7

Supportive Observation Descriptors Guidance

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

CATEGORY	ITEM	GUIDANCE
SLEEP	Awake	
	Restful sleep	Continuous, restful sleep, observed signs of life i.e. breathing
	Restless sleep	The patient is unable to rest, such as tossing and turning, or the sleep is disrupted, observed signs of life
POSITIVE BEHAVIOURS	Calm	The patient is quiet and does not appear angry or stressed.
	Engaging with others	
	Accepted support with care	Accepted support form staff or maybe sought support form staff to discuss their difficulties, communication to staff of increased stress
	Attended education	Went to an educational activity.
	Attended to personnel care	The patient carried out their personal care needs such as washing and dressing with minimal support and taking proactive steps to manage Activities of Daily Living ie doing laundry, sorting out bills
	Used coping strategies	Any positive methods used by the patient to manage their thoughts, feelings and/or behaviour
	Asked for PRN appropriately	Requested the use of PRN to help to manage their agitation
	None of the above – add to notes	
EXPLOITATION	No exploitative behaviours	
	Exploiting/Financial	Patient is asking other patients for money, use of bank cards, or items for exchange or sale.
	Exploiting /Sexual	Patient is asking other patients / staff / others for sexual acts or relationships.
	Exploiting Grooming	Patient has been seen to build a relationship with another patient where manipulation or abuse is thought to be taking place.
	Bully others	Patient is seen to be acting towards another patient in a continued negative approach, either verbally physically or emotionally , causing the other patient distress.
NEGATIVE BEHAVIOURS	No negative behaviours	
	Not conforming to ward boundaries, for	For example ward charters or agreements made by the Patient Group / Ward
	Under influence drugs/alcohol	Patient appears to be under the influence of drugs or alcohol
	Refuses support/treatment	Not accepting their medication or working towards their personal treatment goals
	Sexually inappropriate	Sexually disinhibited which may include sexual advances to others, sexual gesturing or stripping of clothing
	Attempting to abscond	Trying to leave the ward by following staff through the main entry to the ward or attempting to scale fences in the garden
SELF-HARM/SUICIDE	No evidence of self-harm/suicide	
	Thoughts of self-harm	Patient describes thoughts of harming themselves
	Actual self-harm	Patient shows staff member self harm or completes self harm in front of staff member / others
	Attempting self-harm	Patients describing how they are going to self harm and may try to self harm in front of staff or others. including body parts against hard surfaces.
	Suicidal thoughts	Communicated suicidal thoughts or ideas to staff or others. Actions that may indicate suicidal thoughts include selling or giving away possessions, or collecting items that may be used for suicide et: objects or medication
	Attempting suicide	Engaged or attempted any form of self harm including hitting body parts against hard surfaces
VIOLENCE AND AGGRESSION	No violence or aggression	
	Physical violence attempted	Communicates thought so physical violence towards others and attempts where intervention is successful
	Verbally abusive	Any form of verbal comments that others may find offensive or upsetting.
	Threatening behaviour	Demonstrating hostile or threatening behaviour. This may be verbal or through use of body language
	Violent thoughts	Communicated plan or intention to harm others
	Damage to property	Caused damage to personal, hospital or a peers property, such as a magazine, TV, walls etc.
	Damage to building	Caused damage to the ward environment
	Physical violence	Any form of physical violence, such as hitting, pushing and swinging at others

MOOD AND AGITATION	Calm	Patient showing no negative behaviours
	Tearful/Emotional	Patient is noticeably distressed/crying/agitated/upset.
	Pacing/Hand wringing	Patient is continually walking and repetitive movements or maybe continually wringing their hands together
	Expressing racing thoughts	Patient describes rapid thoughts running through their mind and maybe verbalising these.
	Rapid Talking	Patient talking very quickly without pause, this may be repetitive.
	Responding to unseen stimuli	Patient is responding to something they are seeing or hearing that is not heard / seen staff.
ENGAGEMENT	Engaging positively with others	
	Engaging therapeutically/Activities	Patient is joining in with conversation with staff members / others on the ward and participating in activities
	Self-isolated	Patient is not responding to staff or others and may be in one location avoiding contact with others.
	Unengaged	Avoidance of or disengagement from staff, peers or activities that the patient usually engages in, non compliance with diet/fluid or hygiene.
	Uncommunicative	Patient is silent or only speaking in one word responses