Leicestershire Partnership NHS Trust

Supportive Observation and Engagement of Mental Health, Learning Disability and Autism Inpatients Policy

The purpose of the Supportive Observation and Engagement of Inpatients Policy is to provide guidance for observation for patients in mental health, learning disability and autism 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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1.0 Quick Look Summary

The opportunity for people to be safe whilst receiving care, treatment is important to the Trust and implementing supportive observations and engaging with the patient as described in this policy minimises the risks to patients and/or others.

This policy provides practical guidance for staff undertaking supportive observations.
Supportive observation and engagement involve 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.

The use of increased observation levels should never be regarded as routine practice but must be based on assessed and current needs. 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 for re traumatisation and suggested therapeutic interventions/activities.

PLEASE NOTE THAT THIS IS DESIGNED TO ACT AS A QUICK REFERENCE GUIDE ONLY AND IS NOT INTENDED TO REPLACE THE NEED TO READ THE FULL POLICY

1.1 Version Control and Summary of Changes

Version number	Date	Comments
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	Further amendments to forms following staff feedback.
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 multi-disciplinary team (MDT). • Use of Nerve Centre Observation electronic recording tool. Superseded by Bridgid App electronic recording tool.

Version 12 and 12.1 (combined comments from feedback)	November 2023-February 2024	Amendments made from learning from local and national incidents: • Clarity on the nurse in charge role in ensuring observations are completed appropriately. • Provision of immediate training and competency assessment for bank/ agency staff. • A change to level 1– general observation recording forms to one form for all patients to check they are on the ward, safe and well. • Confirmation that all sites will use paper forms except the Agnes Unit and Short Break Homes which will use Bridgid.
Version 12.2	February and September 2024	• Reformatting and additional sentence added to section 10 and appendix 1, Nurse in Charge duties for clarity.
Version 12.3	June 2026	• Extension agreed at governance group to allow full review
Version 12.4	Sept 2026	• Ext until November 2026 agreed at PSIG • Further ext agreed until Jan 27 in November Safety Forum)

1.2 Key individuals involved in developing and consulting on the document.

Name	Designation
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Representatives	Supportive Observation and Engagement Improvement Group
Wider consultation:	Deputy Heads of Nursing, Matrons and Ward Sister/ Charge Nurses of Inpatient Wards in DMH and FYPC/LDA
	Members of Patient safety and Improvement Group (PSIG)
	LPT Safeguarding Team
	Associate Medical Director and Clinical Directors DMH and FYPC/LDA
	Policy Trust expert group

1.3 Governance

Level 2 or 3 approving delivery group	Level 1 Committee to ratify policy
Patient Safety Improvement Group	Quality and Safety Committee

1.4 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. If you require this document in another format please contact the Corporate governance team.

1.5 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 6) of this policy

1.6 Definitions that apply to this Policy

Patient	Patient refers to a person (adult) who is in receipt of health care services from LPT.
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.
Brigid APP	A SystmOne clinical app that links directly to a patient's clinical care records. The app enables staff to see and record patients' health information, including observations 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.
Staff	The term used to describe all staff that may carryout observation duties- Health Care Support Workers, Nurses, Nurse Associates, Therapy staff.

2.0. Purpose and Introduction

2.1 Purpose

The purpose 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.

2.2 Introduction

Leicestershire Partnership Trust (referred to thereafter in this document as 'the Trust') recognises that some people may be at risk of harming themselves or others whilst receiving a period of care and treatment in a Trust ward/ home. The opportunity for people to be safe whilst receiving care, treatment is important to the Trust and implementing supportive observations and engaging with the patient as described in this policy minimises the risks to patients and/or others.

This policy provides practical guidance for staff undertaking supportive observations.
Supportive observation and engagement involve 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.

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

The Department Health (DOH) (2014), Positive and Proactive Care; 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.

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.

Patients in seclusion should be observed using the paper seclusion records.

Observation is undertaken at the following levels:

Level 1 General Observation – Here and Well Check (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 able to manage risk to themselves or others. Their location, wellbeing and safety will be visibly checked at a minimum of hourly intervals and wellbeing assessed via a short conversation with the patient.

The intended whereabouts of patients who are on leave from the ward should also be known at all times, all other patients receiving level 2-4 observations will also be included in the level 1 here and well checks.

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 may find it difficult to manage potential risk but are not at immediate risk. The specified frequency of observation should be recorded in the patient's 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 and may be varied to reduce predictability within the specified timescale but should not go beyond the agreed timespan. For example, a patient on 10-minute observations was observed at 08.05, 08.15, 08.22, 08.30, 08.37, 08.47….

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 a number of patients using specified zones within the ward area but each patient's individual behaviour and activities during the observation period will be recorded separately.

Level 3 Continuous within eyesight – this means a nominated staff member will be allocated to each patient 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. To ensure staff can intervene appropriately the distance that staff keep a patient in eyesight should be arm's length and 4/5 steps back.

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 the patient immediately by being within the staff members' arm's length. This is for patients who are unable to manage risk harm towards themselves or others, and it has been determined that this level of risk can only be managed by the close proximity of staff with the patient. 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 assessed needing the most support to prevent harm to themselves or others. The patient is kept within the eyesight of 2 or 3 staff members and at arm's length of at least 1 staff member.

3.0 Policy requirements

This policy has been written considering the following guidance and legislation:

- Mental Health Act Code of Practice
- LLR Safeguarding Policy and Procedures including Mental Capacity and Deprivations of Liberty

This policy should be read alongside the Trust Clinical Risk Assessment Policy Equality Diversity and Human Rights Policy, Searching of patients and their property policy, Chaperone Policy for Adults and Children and the use of Bridgid Standard Operating Policy (SOP).

4.0 Principles of Observation and Engagement

Observation must be safe and therapeutic. Consideration could be given to the use of activity, discussion and distraction processes; however, recognition should also be made of the need for silence where appropriate 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 explain to the patient why they are receiving observations and discuss how they can work together to reduce the observation level, giving supporting information where required. The discussion with patients should be recorded in their electronic record; if they refuse to discuss observations and engagement this should also be recorded. For some patients this may increase anxiety, or they may not have the mental capacity for this discussion, in these cases it should be recorded in the patients' electronic record and how and when observations will be reviewed with them or their circle of support/ advocates.

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, unless they are engaging in a therapeutic activity with the patient during that time. 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 for example, disability, race, religion and belief, sex (gender), sexual orientation and consider neurodiversity, 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 along with any known trauma or triggers that may affect the patient's mental wellbeing 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; this should be documented in their care plan.

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 (where you are within arm's reach) 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 the weekend/ Bank Holiday to ensure the ward team is aware of changes if required over the weekend/ Bank Holiday. 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 patient's 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.

4.1 Levels of Observation

Observation can be defined as a 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. The level of observation will be overseen by the nurse in charge and discussed with the multidisciplinary team. Observation on admission will be at the appropriate level to manage patients' safety and risks and a minimum of level 2 15 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 considered 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 'S*earching of patients and their property policy'.*

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

4.1.1 Level 1 Observations 'Here and well check' – 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. Their location, wellbeing and safety will be visibly checked at a minimum of hourly intervals and wellbeing assessed via a short conversation with the patient.

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 who are not subject to detention under the Mental Health Act. 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 carry out this check should be clearly recorded. Approaches to support the hourly checks should be considered, for example 'Intentional Rounding'.

At each shift handover the nurse in charge should check the number of patients on the ward/area and ensure each patient's level of observation is handed over and documentation is complete.

Level 1 here and well checks 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.

Please note the Agnes Unit and LD Short Break Homes use a different template for recording Level 1 only.

4.1.2 Level 2 Observation - intermittent observation

Observation on admission will be at the appropriate level to manage patients' safety and risks and a minimum of level 2 15 minutes during the initial assessment period. This should be reviewed each shift to minimise unnecessary restriction for the patient.

Any patient who has returned from leave or appears to have consumed illicit drugs and / or excessive amounts of alcohol whilst on the ward must be placed on at least level 2 10-minute observations and be assessed by a doctor. The reason for this must be clearly explained to the patient when deemed appropriate.

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 7 Recording). The frequency of these observations will be determined and agreed by the nurse in charge, doctor and MDT and will be dependent upon the level of risk exhibited by the patient and considering the patients and any family/ carers views. Oobserving 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 and should be varied to reduce predictability within the specified timescale, however, should not go beyond the agreed timespan. For example, a patient on 10-minute observations was observed at 08.05, 08.15, 08.22, 08.30, 08.37, 08.47….

This should be detailed in the risk assessment and individual patient care plan with the minimum frequency of observation written on the individual patient care plan and clinical record.

When carrying out Level 2 observations, the staff member must have full sight of the patient within close proximity and communicate with the patient, to ascertain 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 4.2 - Observation of patients who are in bed or sleeping, and Section 7 - Recording.

4.1.3 Level 3 Observation – continuous (within eyesight) including full sight of the whole body.

The patient must be in full sight of the staff member at all times within close proximity. The staff member needs to be close enough to the patient to enable effective

intervention at any time if required. To ensure staff can intervene appropriately the distance that staff keep a patient in eyesight should be arm's length and 4/5 steps back.

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 where possible to include the patients views 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 or the door is held ajar and the nurse can hear and speak to the patient. A staff of the same sex should be provided to observe this activity.

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. This would also apply if patients were accessing other clinical areas with staff escorts outside of our trust including other physical health hospitals.

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 using a personal alarm system.

Observations should be rotated within the team where possible, ensuring cultural diversity and gender are considered. **Good practice describes 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 able to continue, and either a change of observation or a brief comfort break **must** be offered. If staff are concerned about adequate breaks, they should raise this with the nurse in charge initially and if not resolved then ask to speak to the Ward Sister/ Charge Nurse/Matron or out of hours the Clinical Duty Manager or coordinator. Staff escorting patients outside of the trust should refer to the Escort Policy for guidance on breaks and maintaining patient observations.

Please read this section in conjunction with Section 4.2 - Observation of patients who are in bed or sleeping, and Section 7 - Recording.

4.1.4 Level 4 Observation - constant observation (within arm's length) including full sight of the whole body.

The aspects detailed for level 3 are applicable, however, the patient must be in sight of the staff member at all times and within arm's 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 4.2 - Observation of patients who are in bed or sleeping, and Section 7 - Recording.

4.2 Observation of patients who are in bed or sleeping.

Patient Safety Incident investigations have demonstrated that observing patients who are presenting with high risks in bed or sleeping is a skilled task. Staff members must maintain vigilance whilst patients are, or appear to be, asleep. Staff must be aware of the risks presented by bedding, 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 and that their safety is a priority. This is applicable for level 2,3 and 4 observations.

Observation must include **going into a patient's bedroom** to check for regular breathing patterns, observing at least the rise and fall of the chest 4 times and staff must refer to the Physical assessment and examination of service users admitted to Mental Health Unit for further guidance if they have any concerns about physical wellbeing. **Staff should not rely on observing a patient through viewing windows in bedroom doors unless the patient has a specific care plan detailing this practice.**

Consideration must be given to the environment in which the observation of sleeping patients takes place. For example, where possible, 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, or where available other electronic tools may be considered, for example mobile phones.

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 regarding observation whilst the patient is sleeping, within the patient's clinical record and care plan (see section 8 – Management of observation). This allows flexibility of observation according to individual need, for example, reduced observation for patients suffering from sleep deprivation. Any special arrangements for a patients' observation levels should be handed over at each shift change.

5.0 Leaving the Ward

All staff responsible for escorting a patient off the ward who is under observation **must** have completed an observation competency assessment. Staff should continue to record observations on paper forms if attending another LPT site or another hospital site.

All patients, whether detained under the MHA 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 patient's risks and possible psychological effects of leave.

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

5.1 Leaving the ward when on 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, consider the guidance in the Escort Policy.

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.

5.2 Leaving the ward when on Level 2 observations.

If a patient on level 2 observations leaves the ward under staff 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.

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.

5.3 Leaving the ward when on Level 3 and 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 staff member 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.

5.4 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.

5.5 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, however, it should be recorded that prior to the patient leaving the ward an assessment of their wellbeing must be made and outcomes documented.

6.0 Management of observation

Clinical 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 the trust Clinical Risk Assessment Policy should be used to explain this, and the responsible clinician will detail the special arrangements within the patient's clinical record. This must also be recorded on any ward summary board/ handover document.

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.

6.1 Decision to increase or decrease observation levels.

The multi-disciplinary team should always make decisions about the need for observation. However, on many occasions (particularly at weekends, Bank Holidays 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 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 the risk 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.

All discussions and decisions to increase or decrease levels of observations MUST be recorded in the patient's electronic records and the level of observation changed on all relevant systems that support staff being aware of patient's levels of observations, for example Patient Ward Boards, electronic records, care plans, handover documentation.

6.2 Care planning supportive observation and engagement.

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

i. Where possible being written in the first person
ii. Signposting to any associated advanced statement or directive
iii. Signposting to any Personal Safety plan/*crisis contingency plans*
iv. A working formulation related to the behaviour/presentation creating the requirement for increased observation/engagement.
v. Consider any physical health needs/Communication needs.
vi. Use of trauma informed principles
vii. Frequency of safety checking including at nighttime.
viii. Frequency of observation/engagement recording
ix. Any items withheld from the service user with rationale.
x. 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)
xi. Any delegation of responsibility to change observation levels and under what circumstances.
xii. Any gender specific requirements
xiii. The recording requirements
xiv. The engagement requirements
xv. Activities that have been collaboratively agreed and where necessary escort requirements to accommodate same.
xvi. Relapse signs.

xvii. Trigger factors.
xviii. Any agreed private time or unsupervised time with family/carers
xix. Frequency of review

The care plan should be made in collaboration with the patient and/or family where appropriate and how the patient was made aware of any changes documented in their electronic patient records. The care plan should be referenced at each handover and staff made aware of where to find/ access it. 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.

6.3 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 the review and any changes in the patients' 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 consider 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.

7.0 Recording

The doctor or nurse should record all decisions regarding observation levels in the patient's electronic record on the designated tools provided and amended on the ward patient information board and handover records. 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 Brigid App, when paper records are being used or in times where the Brigid system in unavailable and the paper forms are used as a contingency. Please refer to the Brigid Standard Operating Procedure (SOP).

Forms shown in appendix 2 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 Brigid electronic system and the level of observation expansion form.
- **When using the paper forms or as 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.**
- Where paper forms are in use, this must be uploaded onto the Electronic Patient Record (SystmOne) by the next working day except for Learning Disability Service short breaks homes where this will be upon discharge.
- Staff should receive a verbal handover when taking over a level of observation from another staff member.

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.

8.0 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, nurse in charge 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.

9.0 Patient Consent

Clinical staff must ensure that informed 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.

If the patient's capacity to consent is in doubt, the nurse in charge 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.

Where the patient does not have mental capacity to consent a best interest decision will be required involving the patients next of kin, family, carers, friends and professionals involved in their care.

10.0 Duties within the Organisation

Policy, Guideline or Procedure / Protocol Author

To ensure the policy is review in accordance with identified timescale and implementation of monitoring and effectiveness has been planned and is reviewed by the Directorates and appropriate governance group.

Lead Director - 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. They have a responsibility for ensuring there is an appropriate and adequate infrastructure to support the observation and engagement of patients safely, and their equality and human rights are not compromised.

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 into patient's current care plans and observational requirements and provide advice when uncertainty arises regarding the 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.

Clinical Duty managers (CDM)/ Coordinators

Support wards and nurse in charge to review observation levels out of hours when needed.

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 (staff) to safely deliver this Policy on their wards and ensure that further resources are acquired to meet the required needs.

- 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.

Teams must consider how enhanced observation can be undertaken in a way which reduces 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 reduces any distress. 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 ensuring the appropriate staffing resource is available to carry out the required levels of observations on their shift. 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.

Further guidance for the Nurse in Charge role is included in appendix 1.

All patients receiving observations at levels 2, 3 or 4 should have a registered nurse discuss and record their observations with them at least once per 24-hour period to review and reassess their need for observation. For some patients this may increase anxiety, or they may not have the capacity for this discussion, in these cases it should be recorded in the patients' electronic record and how and when observations will be reviewed with them or their circle of support. 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, during the shift and handing this over to the next Nurse in Charge.

All Registered inpatient clinical staff (including nursing associates) 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.

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.

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.

11. Training

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 directorates will monitor local training through their Directorate Management Teams and the governance group responsible for monitoring the training is the Patient Safety Improvement Group.

Staff must be trained in the skills and competencies required to undertake observations and engage therapeutically and appropriately with patients. The Trust will ensure that all relevant staff (both registered, students and non-registered) are trained and their competence is assessed.

New staff joining the trust will receive supportive observation training prior to carrying out observations with patients, the training consists of a theory session delivered on MS teams an assessment of knowledge on ulearn and a competency assessment on the ward. Only when the competency assessment has been graded through ulearn will staff training go to green. This policy should be included in all new starters' service induction / preceptorships.

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.

The competency assessment for substantive and bank staff is graded through our Ulearn system by either a PDN or clinical trainer and completion will be seen as per staffs training compliance. As a minimum, training will be updated on a 3-yearly basis or following any changes to the policy. A copy of the competency assessment must also be offered to the bank nurse, who may wish to take it to their next ward for review.

All temporary (Bank or Agency) staff undertaking Mental Health observation will at minimum have read & understood the Supportive Observation and Engagement of Inpatients – Handover briefing for new, bank or agency staff and Nurse in Charge role and have had their Supportive Observation and Engagement of Inpatients – Handover briefing Competency Assessment completed (Appendix 1).

Training for staff using the Brigid App is available via the HIS Learning Management System as face-to-face training or via guidance documents, and/or identified trainers on wards.

12.0 Monitoring Compliance and Effectiveness

12.1 Compliance with this policy will be overseen by the LPT Patient Safety and Improvement Group. The purpose of monitoring is to provide assurance that the agreed approach as set out in this policy in relation to mental health observations. Our monitoring will therefore be proportionate, achievable and deal with specifics that can be assessed or measured.

Ref	Minimum Requirements	Evidence for Self-assessment	Process for Monitoring	Responsible Individual / Group	Frequency of monitoring
1	Clinical staff are trained in observation and assessed as competent to carry out the duty.	Training Reports.	Compliance with this policy will be monitored through directorate Management Teams training reports.	The training compliance will be reported to the Patient Safety and Improvement Group.	Monthly.
2	Patient observations levels are reviewed as a minimum daily.	Documentation in patient electronic record.	Directorate Quality and Safety meeting.	The audit will be received at the Patient Safety Improvement Group.	Nurse In Charge Duty Annual Audit completed in November.

13.0 References and Bibliography

This policy was drafted with reference to the following:

- Safeguarding and Public Protection Policy and Procedures
- Clinical Risk Assessment and Management Policy
- Incident Reporting and Management Policy,
- Mental Health Act Code of Practice, 2015

- Physical assessment and examination of service users admitted to Mental Health Unit
- Positive and Proactive Care: reducing the need for restrictive interventions, Department of Health, 2014
- NICE (NG10 2015) Violence and aggression: short-term management in mental health, health and community settings.
- Searching of patients and their property policy

https://www.leicspart.nhs.uk/about/policies/

Appendix 1

Supportive Observation and Engagement of Inpatients – Handover briefing for new, bank or agency staff and Nurse in Charge role.

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.

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. This is for patients who pose a potential, but not immediate risk. Observing patients at predictable times can provide patients with the opportunity to plan or engage in harmful activities. 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.

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.

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.

Level 3 Continuous (within continuous eyesight) –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 or for treatment monitoring. 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, unless the patient's multidisciplinary team have risk assessed and agreed a different care plan). It is important patients' gender/identity are considered to maintain dignity when allocating staff for level 3 observations. The multidisciplinary Team will consider the environment and any items available to the patient that may be used to harm themselves or

others and agree any restrictions to support patient safety and detail this in the patient's care plan.

Level 4 Continuous (within arm's length) –observe the patient in close proximity; able to reach immediately within the staff members arm's 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. It may also be used for treatment monitoring where there are risks, for example pulling out feeding tubes. 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. The patient must be at arm's length and in full sight of the nurse at all times by day and by night (including whilst using the toilet and bathroom, unless the patient's multidisciplinary team have risk assessed and agreed a different care plan). It is important patients' gender/identity are considered to maintain dignity when allocating staff for level 4 observations. The multidisciplinary Team will consider the environment and any items available to the patient that may be used to harm themselves or others and agree any restrictions to support patient safety and detail this in the patient's care plan.

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.

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, unless engaged in a therapeutic activity with the patient. Involved staff must be familiar with the ward, ensure they have read available information regarding the patient – patient profiles, care plans etc. and be aware of potential risks in the environment, the ward emergency procedures and have a staff safety alarm on them that has been tested.

Staff should ensure that they hand over to the incoming staff taking over the observation a description of the patient's presentation and behaviour. Staff should not leave patients who are on level 3 or 4 unobserved at any time. If a staff member carrying out level 3 or 4 observations requires assistance, speak to the nurse in charge or through activation of their staff safety alarm.

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. If the patient has no wristband or photo the nurse in charge will ensure the patient is identified and confirmed with the observing staff member at the time, they commence observation.

Staff must be aware of the patient's observation care plan and the risks presented by bedding, other clothing or objects and the need to maintain a full view of the patient's head, neck, arms and hands whilst in bed. 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.

If you have any questions, please speak to a Registered Nurse.

Whilst undertaking observation, if you feel unwell, tired, or sleepy, please speak to the Nurse in Charge.

Nurse in Charge Responsibilities:

At the start of the shift check how many staff have completed the LPT MH obs training and competency assessment. Check the number of staff trained and competency assessed is adequate for the number and frequency of patient observations required.

If the numbers do not meet the need for patient observations inform the Clinical Duty Manager/ Coordinator who will look to swap staff between wards for adequate cover.

If swapping staff is not possible the Nurse in Charge will carry out the brief training and complete the competency assessment.

If staff have completed the training but not been competency assessed, allocate a staff to observe the staff carrying out a period of supportive observation and engagement with a patient during the 1st hour of obs.

If the staff has been assessed as non-competent, please do not allocate to undertake MH obs, and check whether a swap can be undertaken with another ward if required.

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, during the shift and handing this over to the next Nurse in Charge.

Supportive Observation and Engagement of Inpatients – Handover briefing Competency Assessment

The Registered Nurse will be satisfied that member of staff carrying out Mental Health supportive & engagement observation is competent in the following areas:

		Yes	No	Further Comments
1	Supportive Observation and Engagement of Inpatients – Handover briefing is read, and staff member can describe why patients have observation and principles of observation and engagement			
2	The staff member can describe the four levels of observations within the Handover Briefing & relevant forms to complete.			
3	The staff member can demonstrate they understand the rationale for enhanced supportive observations (i.e. monitoring mental state, self-harming, suicidal, physical health concern etc.).			
4	The staff member can explain specific service user details relating to this episode of enhanced supportive observations (i.e. mood, mental state, behaviour, physical health etc.).			
5	The staff member can describe their responsibilities regarding documentation and can demonstrate completion of the paper and or Bridgid observation form/			
6	The staff member demonstrated their handover to the incoming staff taking over the observation a description of patient's presentation and behaviour.			
7	The staff member did not leave patients who were on level 3 or 4 unobserved at any time or were able to describe why this was important.			
8	The staff member was able to describe why there is a need to maintain full view of the patient's head, neck, arms and hands whilst in bed			
9	The staff member was able to describe some examples of when they may need assistance when carryout out observations and how to summon assistance if required			

Assessor:…… (Print Name) …… (Signature)
Designation:……
Staff Member:……(Print Name) …… (Signature)
Designation:……
Please ensure the staff member understands that they will still need to complete the MH Observation training on Ulearn.

Ward: Date:

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

Patient Name – Print or for rooms not used put not occupied or N/A where more rooms than the ward	Bed Room	Legal Status	OBS level	Staff member to initial - please print name and initials on staff on duty log												
				07:00	08:00	09:00	10:00	11:00	12:00	13:00	14:00	15:00	16:00	17:00	18:00	19:00
	1															
	2															
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	24															

Date and Time	**Nurse in Charge Handover Ward:**											**Signature**				
Day shift to night shift																

Level 1 Here and Well Check

Ward: **Date:**

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

Patient Name – Print or for rooms not used put not occupied or N/A where more rooms than the ward	**Bed Room**	**Legal Status**	**OBS level**	**Staff member to initial - please print name and initials on staff on duty log**										
				20:00	**21:00**	**22:00**	**23:00**	**00:00**	**01:00**	**02:00**	**03:00**	**04:00**	**05:00**	**06:00**
	1													
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Date and Time	**Nurse in Charge Handover Ward:**	**Signature**
Night Shift to day shift		

Fix Patient Sticker

All patients on level 2 observations should have neck visible and arms outside of sheets when asleep.

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

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



Fix Patient Sticker

All patients on level 3 observations should have neck visible and arms outside of sheets when asleep.

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

Location	ENGAGEMENT					MOOD AND AGITATION					VIOLENCE AND AGGRESSION					SELF-HARM / SUICIDE					NEGATIVE BEHAVIOURS					EXPLOITATION				POSITIVE BEHAVIOURS							VISIBLE ARMS IN BED		CONFIRMED		SLEEP						
To add location key	Engaging positively with others	Engaging therapeutically/Activities	Self-isolated	Unengaged	Uncommunicative	Calm	Tearful/Emotional	Pacing/Hand wringing	Expressing racing thoughts	Rapid Talking	Responding to unseen stimuli	Violent thoughts	Damage to property	Damage to building	Physical violence	Threatening behaviour	Verbally abusive	Physical violence attempted	No violence or aggression	Thoughts of self-harm	Actual self-harm	Attempting self-harm	Suicidal thoughts	Attempting suicide	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	Not Visible	Visible	Patient not in bed	No	Yes	Awake	Restful Sleep	Restless Sleep	date	time	Observer

Fix Patient Sticker

All patients on level 4 observations should have neck visible and arms outside of sheets when asleep.

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

| Location | ENGAGEMENT | | | | | | | | MOOD AND AGITATION | | | | | | | VIOLENCE AND AGGRESSION | | | | | | | | SELF-HARM / SUICIDE | | | | | | | | NEGATIVE BEHAVIOURS | | | | | | | | EXPLOITATION | | | | | | | | POSITIVE BEHAVIOURS | | | | | | | | VISIBLE ARMS IN BED | | | CONFIRMED | | SLEEP | | | | | |
|---|---|---|---|---|---|---

Fix Patient Sticker

All patients on level 1 observations AGNES UNIT and SHORT BREAKS ONLY

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

Location	ENGAGEMENT					MOOD AND AGITATION						VIOLENCE AND AGGRESSION							SELF-HARM / SUICIDE						NEGATIVE BEHAVIOURS						EXPLOITATION					POSITIVE BEHAVIOURS							VISIBLE ARMS IN BED			CONFIRMED		SLEEP				
To add location key	Engaging positively with others	Engaging	Self-isolated	Unengaged	Uncommunicative	Calm	Tearful/Emotional	Pacing/Hand wringing	Expressing racing thoughts	Rapid Talking	Responding to unseen stimuli	No violence or aggression	Physical violence attempted	Verbally abusive	Threatening behaviour	Violent thoughts	Damage to property	Damage to building	Physical violence	No evidence of self-harm/suicide	Thoughts of self-harm	Actual self-harm	Attempting self-harm	Suicidal thoughts	Attempting suicide	No negative behaviours	N/C Ward boundaries	Under influence drugs/alcohol	Refuses support/treatment	Sexually inappropriate	Attempting to abscond	No exploitative behaviours	Exploiting/Financial	Exploiting /Sexual	Exploiting Grooming	Bully others	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	Awake	Restful Sleep	Restless Sleep	date	time	Observer

Observation Expansion Sheet Level 2/3/4 (circle level)

Ward:		Patient Name:	
Date and Time of observation	Information staff wish to expand on		Staff: Sign and initial

Appendix 3

Supportive Observation Descriptors Guidance Level 2 – 4 Observations (level 1 for Agnes and Short Breaks ONLY)

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 i.e. 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 behaviour	
	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 behaviour	
	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 describe 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 peer's 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 behaviour
	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, noncompliance with diet/fluid or hygiene.
	Uncommunicative	Patient is silent or only speaking in one-word responses

Training Needs Analysis

Training topic:	MH Supportive Observation Training
Type of training: (see study leave policy)	☐ Mandatory (must be on mandatory training register) ☑ Role specific ☐ Personal development
Directorate to which the training is applicable:	☑ Mental Health ☐ Community Health Services ☐ Enabling Services ☑ Families Young People Children / Learning Disability Services ☐ Hosted Services
Staff groups who require the training:	Direct clinical staff – nurses, associate nurses, health care support workers
Regularity of Update requirement:	3 yearly.
Who is responsible for delivery of this training?	Heads of Nursing
Have resources been identified?	Yes, provided by Clinical Trainers/ Matrons
Has a training plan been agreed?	Training already taking place.
Where will completion of this training be recorded?	☑ ULearn ☑ Other (please specify) Agency staff register
How is this training going to be monitored?	Directorate Management Team – workforce agenda

- 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	✓

Section 1	
Name of activity/proposal	Supportive Observation and Engagement Policy
Date Screening commenced	Previously commenced in 2021 and re-screened in 2024
Directorate / Service carrying out the assessment	Enabling Services
Name and role of person undertaking. this Due Regard (Equality Analysis)	Michelle Churchard-Smit Deputy Director of Nursing

Give an overview of the aims, objectives and purpose of the proposal:

AIMS: The purpose 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.

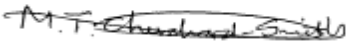
OBJECTIVES: This policy provides practical guidance for staff undertaking supportive observations. Supportive observation and engagement involve a named member of staff being allocated to observe the patient attentively whilst attempting to minimise the extent to which the patient feels he or she is 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.

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

Section 2	
Protected Characteristic	If the proposal/s have a positive or negative impact, please give brief details
Age	No impact expected on any protected characteristic however it is important to note that based on an individual patient risks their privacy and dignity may be impacted when on level 3 and 4 observations require a patient to be observed at all times.
Disability	
Gender reassignment	
Marriage & Civil Partnership	
Pregnancy & Maternity	
Race	
Religion and Belief	
Sex	
Sexual Orientation	
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.	
Yes	**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:

Discussed at Trust Patient Safety Improvement Group as part of policy review.			
Signed by reviewer/assessor		Date	20/02/2024
Sign off that this proposal is low risk and does not require a full Equality Analysis			
Head of Service Signed		Date	20/02/2024

Data Privacy impact assessment (DPIAs) is 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 Observation and Engagement Policy	
Completed by:	Michelle Churchard-Smith	
Job title	Deputy Director of Nursing and Quality	**Date 20/02/2024**

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	**Unless access is required by the Local Authority or Police for safeguarding concerns as part of the current data privacy sharing agreement**
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?	**No**	
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.	**No**	
8. Will the process require you to contact individuals in ways which they may find intrusive?	**No**	

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:	**N/A**
Date of approval	

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