

## Therapeutic Observation and Engagement Policy

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**Signed on behalf of the Trust:** .....  
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## **1. Executive Summary**

Supportive observation and associated practices are potentially highly restrictive and 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. A safe, collaborative, and therapeutic culture should be evident for all people receiving treatment whilst living with a mental health condition. However, there may be times when enhanced levels of observation are required for the short-term management of behavioral disturbance or during periods of distress. Enhanced observation should be a therapeutic intervention with the aim of reducing the factors which may have contributed to increased risk to self and others. This intervention should be collaborative, supportive and promote recovery at all times.

## **2. Purpose**

To set out:

- Standards and guidance on the management and practice of therapeutic observations.
- A legal and best practice framework for the practice of observations.
- Requirements for staff training/education and assessment prior to carrying out observations.
- A framework for audit and quality assurance.

## **3. Scope**

This is a Trust wide policy for inpatient areas and applies to all staff working in the Trust who have a responsibility for prescribing and/or undertaking therapeutic observations.

## **4. Key Principles**

Therapeutic observations should aim to engage positively with the patient to reduce identified risk and to prevent harm to self and others. This must involve a two-way relationship, established between the patient and the member of staff, which is meaningful and therapeutic for the patient (NMC, 2008).

The purpose of this policy is to ensure that levels of inpatient therapeutic observation are allocated in response to the individual's mental and physical health needs.

This policy will guide:

- When an increased level of observations might be used.
- Which staff are best placed to carry out observations
- Responsibilities for ensuring observations are used for the least amount of time clinically required.
- Meeting individualized needs of patients.
- Engaging with patients and carers where therapeutic observations are required.
- The process to be followed for assessing the level of risk for each patient, agreeing the appropriate level of observation, review and clinically informative record keeping.

## **5. Duties**

### **Trust Board of Directors**

Responsible for overseeing the reduction of restrictive practice within its services, recognizing 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, AHPs & Quality**

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.

### **Directorate Senior Leadership Team**

Have operational responsibility for Clinical Directorates compliance with this Policy and will ensure mechanisms in place within each service for:

- Identifying and deploying resources within the clinical 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 clinical 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 patients. As part of that responsibility, they must have a thorough knowledge of the patients in their care, contribute to patients' care plans including observational level and circumstances where this can be varied. They will provide advice when uncertainty arises regarding level of observation required and ensure proactive review of observation levels at least daily to reduce restrictive practice at the earliest opportunity.

### **Modern Matron**

Are accountable to the General Manager for providing assurance that their respective wards are compliant with the requirements of the policy.

### **Ward Managers**

Have overall accountability for the management of their ward and must ensure:

- Registered practitioners understand their role in initiating and reviewing therapeutic observations, and maintaining quality controls

- All staff undertaking observations understand the importance of therapeutic engagement and patient/carer involvement in observations.
- Care plans are in place and appropriately identify the required level of observation and detail how staff and patient can reduce these observations.
- Documented risk review accompanies the decisions made to change the levels of observation.
- With the matron ensuring all ward staff undertake full competency assessment and this is reviewed and recorded in-keeping with policy requirements.
- Identification, responding and where necessary escalating any areas of noncompliance with this policy on their wards

### **Person in Charge (PIC)**

Responsible for

- Ensuring the shift staff are always aware of the patient's observation levels on the ward and there are adequate staffing levels to ensure safe and effective care and communicating any deficits to the ward manager, deputy, or matron.
- Ensuring those undertaking observational duties have appropriate understanding of the observation care plan for each patient to enable them to carry out observations safely and effectively.
- Delegating staff to carry out therapeutic observational roles who have been assessed to be competent to do so.
- Checking observations are undertaken in line with the prescribed observation level, ensuring the appropriate documentation is completed and in accordance with the agreed care plan.
- Ensuring patients and family, wherever possible, have been given an enhanced observation information leaflet
- Observation levels must be discussed during ward handover to ensure continuity of care.
- At shift handover the PIC of both the outgoing and incoming shift are responsible to review and sign the observation record ensure documentation is completed and physically see the patients.

### **Multidisciplinary Team**

Will together:

- Ensure effective communication which enables responsive and informed clinical decision making about the use of therapeutic observations.
- Ensure levels of observation and risk are regularly reviewed by the multidisciplinary team and a record made of decisions agreed in relation to increasing or decreasing the observation.

Delivering interventions to patients requiring constant observations should not be restricted to members of the unregistered nursing team. All members of the multidisciplinary team, both registered and unregistered staff should engage in therapeutic interventions intended to aid the patient's recovery and reduce identified risk.

There is an expectation Registered Practitioners will undertake observational duties during their shift.

## All clinical staff have a responsibility to:

- Understand their role in initiating, carrying out and reviewing therapeutic observations
- Carry out that role in line with the policy
- 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 risks
- Ensure the care plan is implemented
- Ensure that observations are viewed and used as opportunities to build a therapeutic relationship
- Ensure the legal status of the patient is considered and the appropriate process followed. Consent is required for informal patients however patients nursed under the mental health act can have these prescribed without consent.

## 6. Definitions

General Observations – Level 1
<p>This is the minimum level of observation for all patients in inpatient areas. Patients subject to general observations will have been assessed as being a low risk to themselves or others. Their location and safety will be visibly checked at least once an hour.</p> <p>Every hour staff should confirm the whereabouts of all patients, and record this on the fireboard/General Observation checklist (Appendix 1). Staff must check patients on general observations hourly and whilst this may be experienced by some patients as intrusive, staff should check that the patient is well and not in immediate risk. The rationale for this needs to be explained and discussed with the patient on admission to the ward area.</p>
Intermittent Observations – Level 2
<p>This level of observation is for patients who pose a potential, but not immediate risk. The duration of Level 2 intervals at which the observations should be carried out is to be agreed by the multidisciplinary Team and/or the Nurse in charge and based on an assessment of the individual risks.</p> <p>Observations need to be carried out sensitively to cause as little intrusion as possible. However, this observation should also be seen in terms of positive engagement with the patient.</p> <p><b>For those likely to carry out risk behaviours, observations should be carried out at irregular intervals in a pattern that cannot be predicted by the patient.</b> This is so the patient cannot predict a pattern that may increase opportunity to plan or engage in harmful activities.</p> <p>Intermittent observations should be recorded on the observation recording form at every interval and not just each hour.</p> <p>Patients should be checked at irregular times but without excessive gaps between observations. For example, a patient likely to carry out risk behaviours and nursed on x 4 observations an hour should not be checked at 07:00hrs, 07:15hrs, 07:30hrs, 07:45hrs but small variations so as there is some unpredictability to reduce risk.</p>

E.g., 10:12hrs, 10:23hrs, 10:38hrs, 10:49hrs, 11:00hrs.

Intermittent observations must not be used to manage high risks posed by patients who are likely to carry out risk behaviours during gaps in engagement and observation and that are likely to encourage a mechanistic process of care or place “unrealistic” expectations on the clinician undertaking the engagement and observation. Level 2 intermittent observations Therefore, should not be used with patients presenting as suicidal and, in these cases, Level 3 or Level 4 observations may be warranted.

Clinical teams who practise intermittent engagement and observation should be aware of the risk that gaps in engagement and observation present to patients at high risk and be clear that they have considered this issue as part of their decision-making process.

It is acknowledged that moving from Level 3 or Level 4 observations to general observations may leave the patient feeling unsupported. In these circumstances, it is felt that intermittent observations could be used in the context of a risk management plan which involves and engages patients in planned activities (NCI, 2015). This is appropriate when patients are potentially, but not immediately, at risk in the widest sense. For example, patients with depression but no immediate plans to harm themselves or others and those who are in a process of recovery may require this level of observation and engagement.

The observations must be carried out even when the patient is asleep, unless otherwise indicated by the Multidisciplinary Team, discussed with the patient and family, and documented in the care plan where General Observations (Level 1) overnight should be completed. This level of observation requires the observing clinician to be aware of the patient’s movements, location, and behaviour.

### **Continuous Observations Within Eyesight – Level 3**

This is required when the patient could, at any time, make a serious attempt to harm themselves or others, or when a patient is perceived as being vulnerable to others. The patient should be always kept within sight at day and night. Observations cannot be completed through a window or door.

The patient’s privacy and dignity should be always respected, especially when bathing, using the toilet or dressing. Some flexibility is therefore permissible to ensure privacy at these times, provided this has been previously agreed with the Multidisciplinary Team and documented in the observations care plan.

Issues of privacy, dignity, and consideration of the gender of allocated staff, together with environmental dangers need to be discussed and incorporated into the care plan. However, the effective management of identified risks of harm should remain the priority.

Doors should therefore not be locked, access to the patient should remain unimpeded and the patient’s condition should continue to be monitored by regular verbal and physical checks.

#### **Within Arm's Length Observations – Level 4**

This should be used for patients at the highest levels of risk of harming themselves or others. The patient will need to be nursed in proximity including when the patient goes into the toilet/bathroom.

On rare occasions more than one nurse may be necessary. Issues of privacy, dignity, and consideration of the gender of allocated staff, together with environmental dangers need to be discussed and incorporated into the care plan. However, the effective management of identified risks of harm should remain the priority.

Positive engagement with patients is an essential part of this level of observation.

#### **Zonal observations**

The zonal model aims to ensure appropriate observation and engagement of service users without the need to assign a particular practitioner to be closely observing individual service users for long periods. Instead, a staff member is assigned to observe and engage with individuals within specified zones within the ward area. It can be used for a particular group of service users or area within a specific ward or environment. Zonal observation can also increase assurance of the safety of groups of service users within areas of low traffic with less clear lines of sight. In certain circumstances this can be considered less intrusive and allow greater privacy for service users than increased observation and engagement. The Trust therefore recognises that under certain circumstances a ward or clinical area may wish to operate a zonal observation and engagement model on a time-limited basis. The decision to implement zonal observation and engagement and agreeing procedures and practice for any specific ward or clinical area will lie with the relevant Directorate Senior Leadership Team (SLT).

Appendix 6 contains guidance and a decision-making checklist for the development of the rationale and implementation plan required of any ward area considering introducing zonal observation and engagement. The checklist should be used as evidence as part of the request for support for implementation from the relevant SLT.

### **Therapeutic Observations at Night and Care of the Sleeping Patient**

Therapeutic observations of patients do not stop at night. There is a duty of care to ensure patients are safe and not in distress either physically or emotionally. It is recognised that patients expect a greater level of privacy after going to bed.

Observations undertaken at night need to include an assessment of an individual's wellbeing with any area of concern or doubt being explored. Consideration must be given to issues/events e.g., recent use of leave, medication changes and/or known risk behaviors.

Observations at night should be given special consideration. Mental illness can impact upon sleep patterns, with some individuals experiencing greater fears, anxieties, and levels of arousal during the night. The period immediately after waking can be especially difficult.

Observations at night include confirming that the patient is breathing. At night this will necessitate the observing nurse entering the patient's room to confirm that the patient is safe.



It is not acceptable to observe the patient by torchlight through the bedroom door observation window.

When a patient appears asleep the member of staff carrying out the observations must monitor the patient's physical health noting any changes in body position, breathing etc. Staff must not assume that patients are sleeping and/or that they should not be woken.

If the member of staff has not observed the patient moving or cannot observe the patient breathing, they must ensure the patient is Safe and well by:

- Increased lighting.
- Getting close enough to observe breathing.
- Checking for a pulse.
- Rousing them.
- Satisfying themselves the patient is breathing by other appropriate measures.
- Checking of the neck area where risk history indicates ligatures.

NG10: Violence and Aggression: short-term management in mental health and community settings. National Institute for Health and Care Excellence (2015) does not make any recommendations regarding reduced frequency of additional observations at night. The frequency and extent of monitoring at night must be based on the MDT's assessment of the patients risks and individual needs. If there is deviation from NICE recommendations the MDT are expected to provide a rationale within the notes/care plan and ensure governance processes are in place to ensure patients are not at increased risk.

### **Therapeutic Observations (Off Ward Areas)**

Continuity of therapy, education and leisure will remain a high priority for patients on increased levels of observation. They should not therefore be automatically excluded from off ward treatments/ activities.

Patients may wish to take part in faith/religious activities such as praying or meditation within a multi-faith area of the ward or within hospital grounds. Patients should be supported to attend to their faith needs where possible considering the patients' risk assessment.

Decisions regarding attendance should be based on individual risk assessment and not the level of observation the patient is receiving.

The individual risk assessment should:

- Consider the environmental risk in the area being proposed for the patient to attend e.g., observation line, windows, access to items that may pose a risk.
- Consider the treatment/activities within the area.
- Include the member of staff from the area where it is proposed the patient will attend.
- Consider if a ward-based staff member needs to escort the patient to undertake the observation, or whether this can be safely done by a member of staff from the areas the patient is attending.
- Record the details in the patient's observation care plan.
- Where the responsibility for undertaking the observation is transferred to a member of staff from the area where it is proposed the patient should attend, the observation record sheet should also be transferred to that member of staff.
- Include risk management plans in the event of a crisis

## Legal status of patients on Level 3 observations

Due to the restrictive nature of such close engagement and observation, it is expected that any patients who require to be observed within eyesight or within arm's length will usually be either detained under the 1983 Mental Health Act, or subject to a Deprivation of Liberty Safeguard. If this is not the case the patient's Responsible Clinician needs to review the patient's legal status at the earliest opportunity. However, there may be patients who do not meet the criteria for detention under the Mental Health Act. If this is the case when deciding to implement or continue with the close engagement and observations the level of risk posed needs to be balanced against the patient's human rights. In addition, the patient and family where possible are to be involved in the decision to implement this intervention and consent to the restriction should be obtained.

## Reviewing Level of Observations (See Appendix 1 For Decision Tree)

Observation status must be reviewed a minimum of daily for any patient being nursed above General Observations (Level 1) and documented on SystmOne in the clinical entries. MDT meetings/ward rounds should always consider the current plan for any patient on above Level 1.

The MDT should always plan and ensure that the plan of care for each patient outlines the conditions and observed behaviours that would facilitate a prompt reduction in observation levels. This should also be detailed in the observation care plan.

Therapeutic observations are potentially a restrictive intervention and should be implemented as an exception and at the least intrusive level required to manage risk.

Wherever possible the decision to change levels of observations will be made by the MDT (including staff who know the patient), the patient and their family/carer (as appropriate).

Based on assessment of the **immediate risk**, registered staff may decide to change the level of therapeutic observations prior to consulting with the MDT but there must be consultation with the MDT at the earliest opportunity. Out of hours, the duty doctor can be contacted to discuss the reduction. Staff should offer the patient and their family/carer information about why they are under observation, the aims, how long it is likely to last and what needs to be achieved for it to stop (NICE, 2015).

## Changes In Levels of Observations (Variation)

Consideration should be given to the possibility that a patient may require various levels of observation according to factors such as:

- Time of day.
- Activity engaged in.
- Patient request for increased observation (they should be encouraged to report any need for increased observation (e.g., auditory hallucinations/desire to self-harm/abscond etc.)

Where the clinical team have agreed and care-planned a varied level of observation throughout a 24-hour period (e.g., four intermittent when in room, within eyesight in communal areas) this **would not** constitute a change in observation levels but must be clearly documented in the observation care plan.

See section 'Therapeutic Observations at night and care of the sleeping patient' for guidance on variation of observation levels at night

### **Increasing Observations**

Registered staff with delegated responsibility for a ward area have the authority to implement an increase in the level of observation in the first instance. Any such decision should be reviewed by the senior nurse or mental health professional on duty in the area at the earliest opportunity. The prescription of these observations should then be reviewed by the MDT in a formal review of care.

### **Decreasing Observations**

Patients who are placed on therapeutic observations are people deemed to be at the highest risk. Therefore, reduction in the level of observation levels must follow a formal process to ensure that a team decision is made, which is based on a current mental health and risk assessment whilst considering the views of the patient and carers.

The decision to reduce the level of observations should normally be taken by registered nursing staff or mental health practitioner **in conjunction with the MDT**. However, delegation of authority to decrease level of observations can occur in the absence of the Responsible Clinician RC and MDT. Where the RC and MDT have identified the circumstances in which observation levels may be decreased, two registered practitioners can implement this change. Delegated responsibility must be recorded in the patient record, including the observation care plan, it must clearly stipulate the specific circumstances for changes in observation level. (i.e., related to the needs, presentation and or mental state of the patient).

Where the MDT feels that observations should not be reduced without medical (or other) consultation, this requirement should be clearly recorded in the clinical record and communicated to all members of the multidisciplinary team. If necessary, any out-of-hours concerns can be addressed through the on-call consultant. Decisions should not be reflected to the MDT out of hours.

### **Privacy and Dignity**

The privacy and dignity of patients must be considered and always addressed within the observation care plan. For example, person specific care plans for patients under continuous observations should specify whether the patient can use the toilet or bathroom with or without the nurse physically going into the room. The care plan should be clear and explicit to reduce variation in approach from different members of the team. If appropriate to the patient's needs a request for support from same gender nursing staff should be facilitated where possible unless there is a specific clinical risk or other reason, why this would be inappropriate.

Where a patient is required to be observed whilst involved in intimate personal care, the support must be provided by a practitioner of the same gender unless there is a specific clinical risk.

## 7. Conducting Observations

### Observing Staff:

Clinical staff are required to observe and record patients functioning, presentation and mental state. It is not considered acceptable to simply note the location of patients. When undertaking any level of observation, the staff tasked with undertaking observation, should, if the patient is awake, not otherwise occupied, or care planned otherwise, engage meaningfully with the patient.

Delivering enhanced levels of observation is a complex and at times difficult clinical intervention, staff should therefore undertake observations for no more than 2 hours consecutively. The process of engagement and interactions, if appropriately adopted, should enable an accurate picture of a patient's well-being, mental health, and potential risk to emerge.

For all patients on continuous observations an hourly summary of the patient's condition, risk behaviours, significant events and any therapeutic interventions must be recorded in the observations record.

For those patients on Intermittent Observations (Level 2), clinically relevant information from each observation must be recorded at the time of the observation in the observations record. Patients should be checked at irregular times but without excessive gaps between observations. For example, a patient on x4 observations should not ordinarily be checked at 07:00, 07:15, 07:30, 07:45 but small variations so as there is some unpredictability to reduce risk.

Staff carrying out eyesight (Level 3) or arms-length (Level 4) therapeutic observations **must not**:

- Sit in the corridor/area ignoring/not engaging with the patient as this is not therapeutic observation and should only be used in exceptional circumstances, not as a matter of course.
- Carry out any activities that are not related to the care/management of the patient and/or that may distract from the observation process. This includes during the night when staff should monitor the patient's breathing.

The member of staff ending a period of additional observations should give a verbal handover (being mindful of confidentiality) to the staff member assuming the responsibility. Wherever possible this should involve the patient and their family/carer (as appropriate).

## 8. Recording Requirements

**Nursing Notes:** The patients record must clearly state how decisions about using or changing therapeutic observations were made, and the outcome of daily reviews for the continuing need for observations. This should also include desired outcomes and what steps a patient can take to remove the enhanced observation level.

**Care Plan:** There must be an observation care plan, collaboratively agreed wherever possible, for all patients on an enhanced level of observations. The current level of observations must

be clear and up to date. Where appropriate family and carers should be included in the development of this plan.

**Risk Assessment:** The risk assessment must underpin the decisions to initiate, increase, decrease and stop therapeutic observations. Consideration must be given to whether searching is appropriate to as part of the observation prescription.

### **Observations Record:**

The observation record and care plan must be completed on SystmOne in the enhanced observation record. This observation record should clearly document the observation care plan formulated by staff, the patient and carer on prescription of the enhanced observations. Once completed the observation record is printed off to be completed by delegated staff members completing the observations. SystmOne user guide for enhanced observations can be found via the link in procedures (pg.16).

The Observation Recording Form (Appendix 5) gives specific individualised information concerning the specific level of observation and any restrictions applied to ensure safety, minimise distress and provide intensive care. It provides a rationale for why the patient is deemed to need this intensity of care, their category of risks and interventions to minimise or address them. It is a requirement for all staff involved in observations to give all the details set out on the form and to update it at least hourly unless the patient is on intermittent observations where the details required should be documented at the end of each intermittent observation (4 x hourly).

### **Periods of Increased Risk/Specific Risk Management Plan**

These are identified periods of increased risk that are unique to the individual. The identified interventions to manage this identified risk should be clearly communicated and documented (i.e., during the night or periods of increased emotional distress).

### **Clothing Worn**

The clothing being worn by a patient on Levels 2, 3 or 4 and their physical description should be noted on their Observation Recording Form (Appendix 1). If the patient is not at risk of AWOL and is likely to regularly change their clothes throughout the shift the rationale for not documenting this should be clearly documented on this section of the observation care plan.

The member of staff must record and initial, the time and any comments on the Observation Recording Form. This must be done before handing over clinical responsibility to the next member of staff. For Intermittent Observations (Level 2) comments should be documented at each interval. Under no circumstances should the form be initialled prior to the observation period ending. The full name of the staff member who will be undertaking observations duties should be recorded against the allocated times at the start of each shift to ensure that it is clear to all members of the ward team which staff have been allocated to observe individual patients throughout the shift.

### **Care Planning**

Observation Care Plans that are developed together with the patient, and where appropriate carers, are central to providing compassionate and responsive care at a potentially distressing time.

The Observation Care Plan should be viewed as a high intensity engagement plan, explaining what, when and why, and wherever possible considering patients/carer preferences.

It should consider/include:

- The reason(s) for commencing an enhanced level of supportive observation.
- The level of observations and variation prescribed.
- The goal(s) of observation.
- It should also be specific in detailing what has been agreed by the MDT such as access to fresh air, number and designation of staff allocated use of toilet/bathroom.
- What should happen during times usually associated with privacy (use of toilet, bathing etc.).
- Any delegation of responsibility to change observation levels and under what circumstances.
- Activities that have been collaboratively agreed and where necessary escort requirements to accommodate them.
- Any items withheld from the patient with rationale.
- Steps patients and staff can take to reduce the level of observations/risk behaviours.

Consideration should be given to the possibility that a patient may require different levels of observation according to time of day, attending therapeutic activities, location on the ward or other factors. For consistency, the care plan must be as clear and explicit as possible. The care plan should be shared at each shift handover.

### **Patient and Carer Involvement**

All decisions and reasons should be discussed with the patient and their family/carer (as appropriate) and a leaflet given. Any request made by the patient, their carer or relative, about increasing or decreasing the level of observation must be considered in line with current assessment of risk.

Patients and their family/carer (as appropriate) should be informed that observations will be reviewed daily, and they will be involved wherever possible.

The levels of observation and the reason for their use must be explained to patients, and their carers or relatives wherever possible.

The MDT may consider allowing carers and relatives to undertake observation/engagement at specified times (some patients have identified a preference for having a family member present when bathing, instead of staff, however caution needs to be exercised that undue pressure is not placed on carers or relatives, if carers or relatives are used in this way a record should be made in the care plan and a member of staff must be available to respond immediately to requests for assistance). In addition, there should be a discussion related to any potential risks (recorded in records) with family/friends when going out with patient nursed on observations and agreed management plan

Where a patient, and or their relative, have trouble in understanding the rationale and implications of therapeutic observation then this should be appropriately reiterated and clearly documented.

Interpreting services should be used if the patient is unable to speak and understand English. Consider the need for support from experienced colleagues, easy read information, or other reasonable adjustments where there is a communication difficulty.

After a period of observations ensure the patient receives support and a debrief. Patients and carers should have the opportunity to share their experience and understand what happened, what helped and what did not help.

## **9. Observation in general hospital settings**

Local agreements should be reached to ensure safe care when a service user is transferred from inpatient services to another NHS facility. Where observations have been prescribed by the MDT or Liaison Psychiatry Service (LPS) advise observations are required, the relevant mental health ward should provide staffing resource for observations. If not assessed by LPS and the request for observations is made by the general hospital staff alone, then the assessing hospital would be expected to provide the staffing resource.

## **10. Skills and Competence of Staff**

**All** staff regardless of band/grade **must** have successfully completed an assessment of competence in therapeutic observations (Appendix 2) prior to undertaking additional observations. This includes staff new to the Trust, new to the clinical area and NHS Professionals/agency/temporary staff. This competency assessment must be reviewed with the staff member every 2 years. The competency must be recorded as completed on the HealthRoster.

All permanent staff working on an in-patient unit who may be required to undertake nursing observations will receive training as part of their local induction plan, this includes successful completion of an assessment of their competence using the Trust approved Competency Assessment tool on a 2-year basis (Appendix 3) and the completion of an e-learning package.

Wherever possible the ward manager or CNS will carry out this assessment but where this is not possible a suitably experienced registered practitioner on duty may complete the competency assessment (e.g., a Band 6 Charge Nurse)

Where the assessment indicates that the staff member is **not** competent to carry out additional observations the Clinical Team Leader (or nominated deputy) and staff member should meet and agree a development plan, including timescale for completion and what duties the staff member may/may not undertake until their competence is reassessed (e.g., routine, and intermittent observations only).

The Competency Assessment will be included in the requirements for relevant staff and successful completion recorded on the individual's training record via Health Roster. Undertaking safe observations is included within the Trust's Competency Framework for in-patient nursing staff.

All bank and agency staff are expected to complete the Competency Assessment successfully prior to taking part in enhanced levels of observations. This could be through either attending a training session (bank staff) or locally (agency staff).

## 11. Monitoring Effectiveness of Implementation

Compliance with this policy will be monitored as part of the Trust's overarching Governance Assurance framework. Specific arrangements are detailed in the table below:

Aspects Of Policy to Be Monitored	Monitoring Method	Individual/ Team Responsibility for the Monitoring	Frequency	Findings: Group/Committee That Will Receive the Findings/ Monitoring Report	Action: Group / Committee Responsible for Ensuring Actions Are in Place
Recording of observations, care planning and completion of reviews.	Clinical audit of system one and observation care plans.	Ward Manager and CNS.	Monthly for the next 6 months until improvement.  Quarterly with a 6-month peer review.	Empowering environments QSG DMT	DMT
Review of incidents arising from observations.	Review of Datix reports leading to learning and improvement.	Ward manager and Matron.	Frequency determined by analysis of incidents.	Empowering environments QSG DMT	DMT
Patient experience.	Survey local feedback mechanisms.	Ward manager, CNS, and Matron in consultation with People Participation Lead.	Monthly.	Empowering environments QSG DMT	DMT
Completion of Competency assessments on induction & 2 yearly update.	Check of local records held by ward managers.	Matron/ward manager and CNS	Annually.	Empowering environments QSG DMT	DMT

## 12. Equality considerations and statement

The Trust has a duty under the Equality Act and the Public Sector Equality Duty to assess the impact of Policy changes for different groups within the community. In particular, the Trust is required to assess the impact (both positive and negative) for a number of 'protected characteristics' including:

- Age
- Disability
- Gender reassignment
- Marriage and civil partnership
- Race
- Religion or belief
- Sexual orientation



- Pregnancy and maternity; and
- Other excluded groups and/or those with multiple and social deprivation (for example carers, transient communities, ex-offenders, asylum seekers, sex-workers, and homeless people).

The author has considered the impact on these groups of the adoption of this policy/guideline. There are no specific adverse impacts for people with 'protected characteristics' or otherwise.

If you require this policy in a different format e.g., larger print, Braille, different languages, or audio tape, please contact the policy development lead.

### **13. Links to Other Procedural Documents**

This policy should be read in conjunction with the following Trust procedural documents:

- AWOL (Absent Without Leave) Policy
- Clinical Risk Assessment Policy
- Controlled Access Policy
- Deprivation of Liberty Guidelines
- Incident Reporting Policy
- Mental Capacity Guidelines
- Positive & Proactive Care: The Recognition, Prevention and Therapeutic Management of Violence and Aggression
- Search Policy
- Search Policy
- Seclusion Policy
- Section 17 Leave Policy

### **14. ATTACHMENTS**

#### **Procedures**

[SystemOne QRG – Recording Enhanced Observations \(cpft.nhs.uk\)](https://cpft.nhs.uk/systemone-qrg)

## References and Acknowledgements

Bowers, L. Whittington, R. Nolan, P. Parkin, D. Curtis S. Kamaldeep B. Hackney D. Allen T, Simpson A (2008) "Relationship between service ecology, special observation, and self-harm during acute inpatient care: City- 128 Study. The British Journal of Psychiatry 193, pp395-401

Bowers, L.; Dack, C.; Gul, N.; Thomas, B.; James, K. (2011) Learning from prevented Suicide in psychiatric in-service user care: An analysis of data from the National Service user Safety Agency.

Department of Health (2015), Code of Practice Mental Health Act 1983. London: TSO

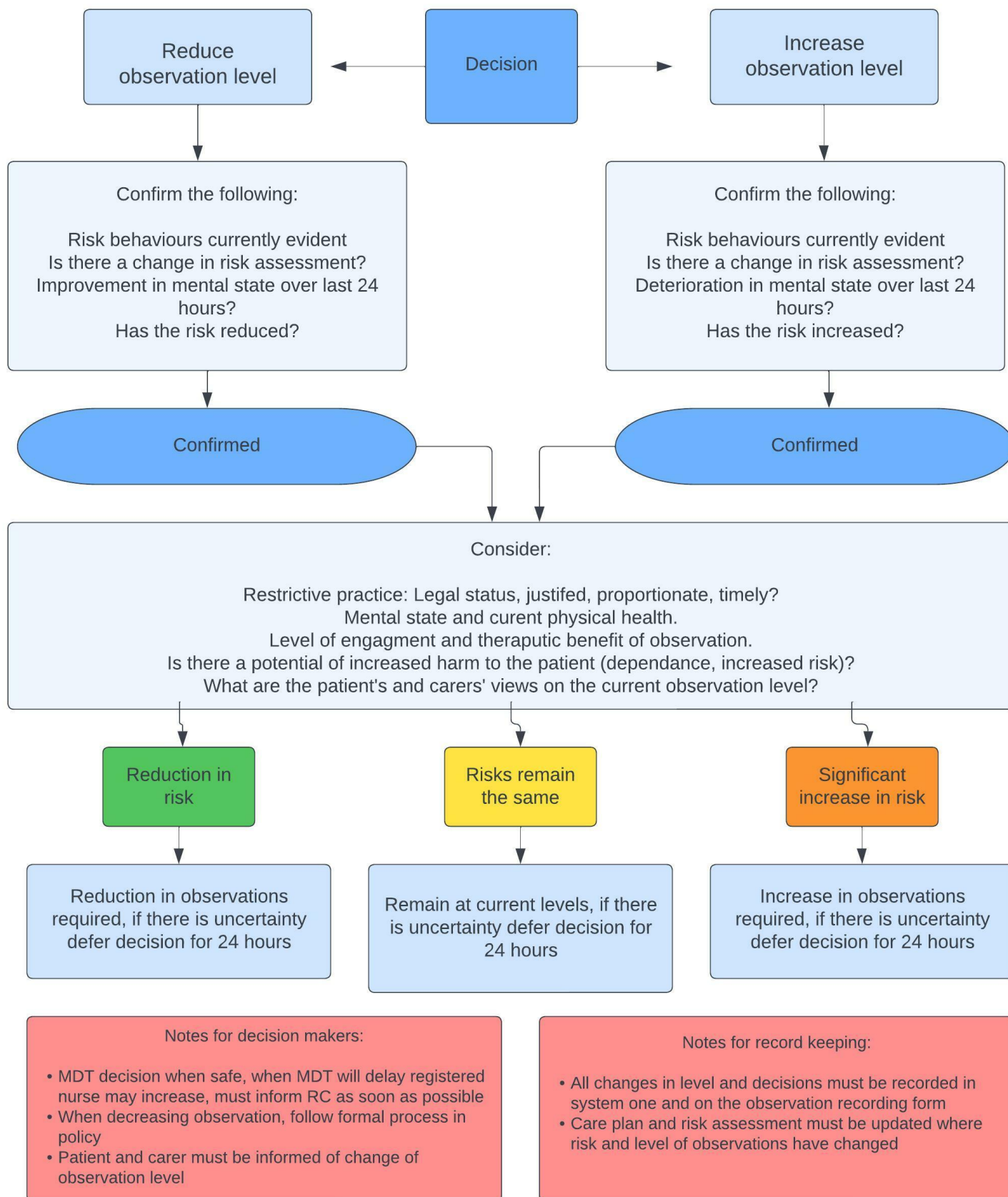
National Confidential Inquiry into Suicide and Homicide by People with Mental Illness. In-service user Suicide Under Observation. Manchester: University of Manchester 2015

NICE guideline May 2015

"Violence and aggression: short-term management in mental health, health and community settings" <https://www.nice.org.uk/guidance/ng10>

## 15. Appendices

### Appendix 1 - Decision Tree



## Appendix 2 - Assessment of Competence

Undertaking Safe and Supportive Observations - All HCAs and Registered Nurses are required to satisfactorily complete an assessment of competence to provide nursing observations on the ward.

### KNOWLEDGE

*Assessment of these competencies should be completed during the first week as part of the staff member's induction and BEFORE the staff member is required to undertake observations without direct supervision.*

*Please also plan and record the date on which the new staff member will have their observations skills supervised and the remainder of the assessment completed.*

COMPETENCY	Assessor Signature	Staff Signature	Date Achieved
<p><b>The staff member demonstrates the following:</b></p> <p>Understands the Trust's Enhanced Observation and Engagement Policy.</p> <p>Understands the Trusts guidance within the policy regarding the practice and recording of observations.</p> <p>Understands the range of observation levels and the implications for practice.</p>			
<p><b>The staff member demonstrates the following:</b></p> <p>Understands (appropriate to role) the assessment of risk and formulation of risk management plans relating to:</p> <ul style="list-style-type: none"> <li>• Violence and aggression and conflict resolution</li> <li>• Self-harm</li> <li>• Self-neglect</li> <li>• Risks unknown / still to be assessed</li> </ul> <p>Understands the importance of enhanced measures taken to observe patient at night / when resting:</p> <p>Use of dimmer switches</p> <ul style="list-style-type: none"> <li>• Use of torches</li> <li>• Importance of assurance of patient wellbeing</li> </ul> <p>Understands the importance of recording observations on the observation sheet and in the patient's contemporaneous notes.</p>			
Date of planned supervised practice of observations:			
Staff Name:	Designation:		
Assessor name:	Designation:		

## SKILLS

*These competencies should be assessed by a combination of discussion and direct observation by a registered nurse*

COMPETENCY	Assessor Signature	Staff Signature	Date Achieved
<p><b>The staff member demonstrates the following:</b></p> <p>Effective engagement and observation of patients under supervision</p> <p>Ability to identify and communicate indicators of increasing / decreasing risk</p> <p>Effective documentation of the observations made on the recording sheet and in the contemporaneous notes</p> <p>Ability to contribute towards / devise effective care plans in collaboration with the patient incorporating the level of observations required</p> <p>Works collaboratively with team members to assess risk and maintain the safety of individual patients and their behaviour</p>			

Staff Name:

Designation:

Assessor Name:

Designation:

## ATTITUDES

*These competencies should be assessed by a combination of discussion and direct observation by a registered nurse of the new staff member's practice.*

COMPETENCY	Assessor Signature	Staff Signature	Date Achieved
<p>The staff member demonstrates the following:</p> <p>A positive, professional, and engaged approach to nursing observations</p> <p>An acceptance of nursing observations as integral to the patient's safety and the integrity of the environment for all patients and staff</p> <p>A collaborative working alliance with the patient including discussion regarding the rationale for observations, the review of observations and activities during observation</p> <p>Consistent vigilance in the undertaking of observation of patients at risk</p> <p>A team orientated approach to risk assessment and observation, evidenced through collaborative discussion</p> <p>A willingness to seek immediate assistance should any concerns be raised</p>			

Staff Name:

Designation:

Assessor Name:

Designation:

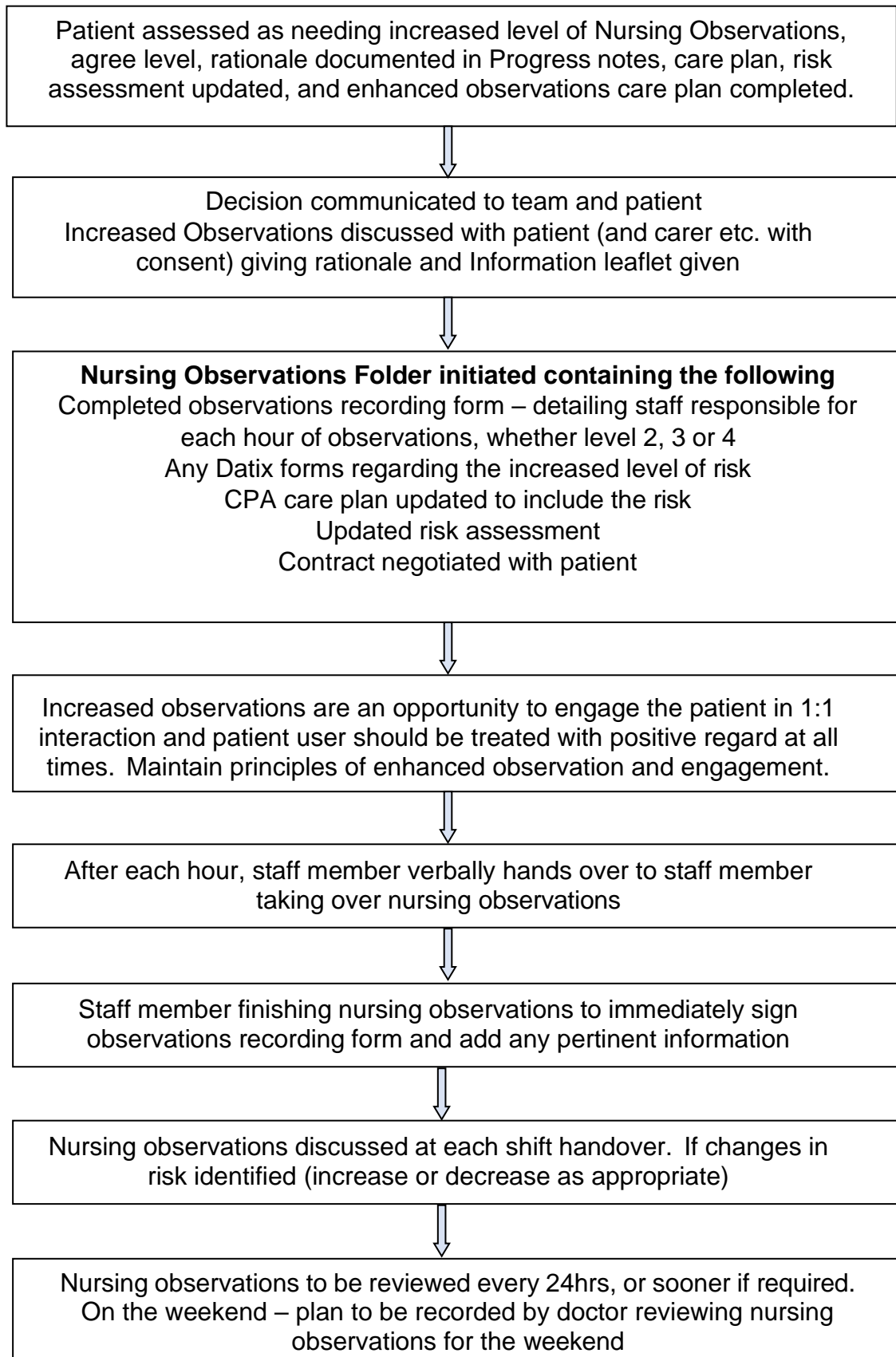
### Appendix 3 – Knowledge and Skills Assessment Record/Log

This will be a record of staff on each ward who have completed the assessment of competence

Ward Name						
Staff Name	Designation	Policy Competence completed	Date of Learning completion	Signed by staff member	Signed by assessing staff member	Comments/Action

## Appendix 4 – Flow Chart illustrating the procedure for Managing Clinical risk through Enhanced Observations

The following is an example of the procedure for CPFT. It is intended to provide a framework for services to meet the policy statements.





## Appendix 5 – Observation Recording Form

# Observation Recording Form

Ward:

Rationale:

--

Patient Risk Category	Level of Observation

Periods of Increased Risk / Specific Risk Management Plan:

--

Environmental Boundaries	Social Contact	Supervision During Visiting  Physical Health Observation

Clothing Worn (in case of absconding)

--

Form Completed By:

Date:

Last Team Review:

Ref:

Review At Shift Handover:

Name	Comments

**Ward:**

**Patient's Name: Peter Parker the rd-TestPatient DOB: 09 Jun 1994**

**NHS Number:**

Date:

**Observation Rota:**[illegible]

**Ward:**

**Patient's Name:** Peter Parker the rd-TestPatient **DOB:** 09 Jun 1994

**NHS Number:**

**Date:**

**Important Note:**

**For Level 2 (Intermittent Observations) an entry should be recorded within the pertinent comments for each observation carried out, it is insufficient to document one entry covering the hour period.**

Time	Pertinent Information	Signature

## **Appendix 6 – Zonal observations**

### **Principles guiding the implementation of Zonal Engagement & Observation**

- Zonal Engagement & Observations must be service user focused at all times.
- The Service has a duty for safety and security to the service users, staff and visitors.
- Care must be provided in an environment and manner that reflects the least level of restriction possible for the safe and supportive management of the service user.
- Zonal Observation and Engagement should therefore be seen as one method of reducing risk and enhancing the service user experience. It is integral part of a wider risk assessment and contextual management process.
- Care and support of the service user will be addressed specifically within an individualized care plan. Service users will be assigned a level of observation and engagement as outlined in the wider procedure and the assigned nurse should carry out the observations and engagement and make the associated records at the assigned times.

### **Zones**

Not all ward lay outs are appropriate for Zonal Observation and Engagement. Any introduction of zonal observation and engagement in a ward area should be agreed with the wider clinical team, including discussion with service users and carers where appropriate. The decision should be informed by data and reported incidents and monitoring of its effectiveness should include incidents within the ward zone area, and precise location as well as service user feedback.

Zones should have explicitly defined rooms, corridors, and spaces within them. The zone should be described clearly with defined boundaries as to where the zone starts and ends. Example of a zone may be: Zone 1 – communal lounge/corridor. Staff assigned to these areas must explicitly understand that they are not observing simply the physical space but rather are on hand to engage and intervene where necessary to maintain safety within that zone. However, staff should ensure they are able to continue to monitor the area allocated without distraction and should seek assistance from team members to ensure continuity of zonal observation can be safely balanced with service user engagement.

### **Professional Roles in Zonal Observations and Engagement**

#### **The Matron/Ward Manager will:**

- Determine the resources needed to manage the ward.
- Review the service users' needs daily
- Consider and act appropriately in respect of any complaint service users may have about the observation and engagement management.
- Be responsible for ensuring that risk recognition and management of service users is discussed at each handover.
- Ensure that a risk assessment process is used by the clinical team to agree that a zonal approach is used.
- Instruct on how and when zonal observation and engagement is implemented and reviewed.
- Ensure that there are appropriate Safety/ Care Plans in place for individual patients

**The Nurse in Charge will:**

- Delegate staff to the zone(s). (Staff should remain in a zone for a maximum of two hours at any one time);
- Ensure that known and relevant risks are communicated to the observing nurse(s);
- Discuss the care and management with the nurse;
- With the MDT, continue to review the level of observation of individual patients as per policy.
- Ensure they are familiar with Safety/Care Plans in place for individual patients.

**Observations and Engagement Staff (Zone staff) will:**

- Know their zone.
- Know who they are to observe and engage.
- Be familiar with the observation and engagement status of all service users in their observation zone.
- Facilitate interaction and communication with service users, whilst remaining vigilant in zonal observation.
- Provide a handover for the nurse taking over from them.
- Report any changes in service user behaviour considered significant to the nurse in charge.
- Report any concerns to the nurse in charge

## Zonal Observations Decision Making Checklist

*The ward considering the use of zonal observations should have a clear rationale and implementation plan. The following checklist can be used to develop the plan as well as assisting the relevant Directorate SLT to support the decision.*

Questions	Yes	No	N/A	
Is there evidence of MDT discussion regarding implementation of zonal observation?				
Is there a clear rationale for the use of zonal observations				
Is the use of zonal observation for: One individual A group of individuals				
Are there clear zones identified within the ward area?				
Is there an identified process for allocating staff to zones?				
Is there clear guidance as to times in which the zones will be operated?				
Is there clear guidance as to how observation levels may need to change as service users move between areas and at different times?				
Is there evidence that staff assigned have had clear guidance and instruction as to the use of zonal observations (including harm minimisation and safety planning)				
Is there evidence that the roles of all staff members have been clearly defined and that staff are clear on their roles and responsibilities? This includes bank and agency				
Is there evidence of a process to escalate concerns regarding the use of zonal observations and a clear process for discontinuing in cases of concern?				
Is there evidence of individualised care/safety plans which identify how zonal observations will be used?				
Is there evidence that use of zonal observations is an open and transparent process for service users				
Is there a clear plan to ensure continuity of zonal observations can be balanced with engagement?				
Is there a clear plan for the assessment and management of individual risks through alternate levels of observations alongside use of zonal observations				

## Appendix 7

### INFORMATION LEAFLET

#### Introduction

This leaflet aims to describe how we will help you to maintain your own safety whilst on the ward. We will work with you to decide the level of risk you are able to safely take with your health and wellbeing. This means making a decision that is based on promoting safety and taking positive risks.

Such decisions take into account assessing and dealing with possible risks for service users, family members, and the wider public.

#### What levels of Engagement and Observations are there?

- Level 1 - General
- Level 2 - Intermittent
- Level 3 - Within eyesight
- Level 4 - Within arms length

#### Why have I been given this leaflet?

- Because we are worried about your safety and the safety of others around you
- We care about you and how your thoughts, feelings and actions are making you feel more vulnerable at the moment
- We will do all we can to help you feel more in control of your thoughts, feelings and actions, and support you to keep yourself safe and to feel less vulnerable and at risk.

#### How will we support your though this period?

- Your care and treatment plan may involve you being placed on **Level 3 or 4**.
- This means that a nurse will be especially assigned to care for you who will provide more dedicated time for discussing your thoughts and feelings.
- They will also be closely observing you to make sure you and other service users are safe.
- When you were admitted to the ward, a clinical risk assessment was carried out with you by the doctor/nurse, and it was agreed what level of engagement and observation will be provided. Your assessment and level of observation is ongoing and may change depending on your vulnerability, and how you and staff are feeling in relation to your own safety and that of others.
- Such enhanced engagement and observation may be seen as intrusive, but it is hoped that this will be minimised by staff being open and honest with you about the risks they feel are present. The aim is to help you to remain safe, and to enable you to take back responsibility and personal control for your own behaviours and actions as soon as you can.

**Will my level of engagement and observation change?**

Levels of engagement and observation will be reviewed every day, and it is expected as your mental health and personal wellbeing improves, the type of engagement and level of observation required will reduce until you are on a general engagement and observations.

**What if I don't agree with the level of engagement and observation I am receiving?**

It is important that you are in agreement with your treatment plan. Your views will be considered, and it is essential that you try to understand that any decision about the type of engagement and observation you receive is in your best interests to maintain your safety. There may be times when you do not agree with this at the time but come to respect the decision taken later.

**If I am receiving Level 3 or 4 engagement and observation – can I come and go from the ward?**

If you are a service user on Level 3 or 4, you may not leave the ward without a member of staff being with you.

**Will I notice any changes?**

It is hoped that you will notice the improvements to your health over time and in the reduction of engagement and the level of observations you require.



## Back Page

### Policy Circulation Information

Recipients:	All staff / Clinical staff only
Key words to be in search.	To be dispensed of when functionality of VerseOne enables word search within the document.

### Quality Standards

CQC Standards	
Other Quality Standards	NICE, Professional Codes of Conduct
Relevant legislation if any	

### Version Control

Version	Date	Author	Comments
1.0			
2.0			