PRIORY HEALTHCARE

POLICY TITLE:	**Supportive Observation and Engagement**
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Policy Owner:	Kris Irons, Specialist Director, Paul Cowans, Specialist Director
Ratified by:	Kris Irons, Specialist Director
Responsible signatory:	Colin Quick, Chief Quality Officer
Outcome:	The aims of this policy are to: • Provide detail of the supportive nature of the observations • Minimise the risk of potential suicidal, violent or vulnerable patients harming themselves or others and reduce risk behaviours • Ensure that enhanced observations form part of the wider risk management plan for a patient • Provide forms for recording observations
Cross Reference:	H02 Admission, Transfer and Discharge H08 Clinical Governance H11 Consent H34 Care Programme Approach/Care and Treatment Planning H35 Clinical Risk Assessment & Management H38 Missing Informal Patients H62 Healthcare Records H97 Searching Service Users and Their Belongings in a Treatment Environment H129 Location Presence Checks (Forensic Sites Only) HR04.2 Disciplinary Procedure OP04 Incident Management, Reporting and Investigation OP04.4 End of Life Care, Dying and Death OP05 Mental Capacity OP05.2 MCA Deprivation of Liberty Safeguards (England and Wales) OP06 Safeguarding Children OP06.2 Child Protection (Scotland) OP08 Safeguarding Adults OP08.3 Adult Support & Protection (Scotland) OP34 Identification of Service Users

EQUALITY AND DIVERSITY STATEMENT

Priory Group is committed to the fair treatment of all in line with the Equality Act 2010. An equality impact assessment has been completed on this policy to ensure that it can be implemented consistently regardless of any protected characteristics and all will be treated with dignity and respect.

In order to ensure that this policy is relevant and up to date, comments and suggestions for additions or amendments are sought from users of this document. To contribute towards the process of review, email LegalandComplianceHelpdesk@priorygroup.com

SUPPORTIVE OBSERVATION AND ENGAGEMENT

1 SCOPE

1.1 This policy applies to all Healthcare Division sites and services across England, Scotland and Wales where patients are care for and treated on a 24 hour / seven day per week basis. Where there are differences between nations, this will be clearly highlighted.

2 INTRODUCTION

2.1 The observation of patients who are at risk of harm to themselves or others is a key role for colleagues working in Healthcare Division sites.

2.2 Patients may need particular levels of observation in order to maintain their safety and the safety of others. This is additional therapeutic support in response to increased patient risk.

2.3 The aim of this policy is to minimise the risk of patients harming themselves or others. Supportive observations ('observations') are part of the wider risk management plan for a patient.

2.4 The Hospital Director and the Hospital Medical Director will take overall accountability for monitoring the implementation of observations and the general quality of those observations.

2.5 Observation of a patient should be a supportive and therapeutic intervention and part of his/her treatment plan. The use of appropriate observation levels should be aimed at reducing the factors that contribute to the patient's risk to themselves or others as well as promoting recovery.

2.6 The use of enhanced levels of observation can be perceived by the patient as restrictive in nature and a method of containment rather than engagement. For this reason, there is a need for colleagues to act with compassion and to focus on getting the balance right between simply observing the patient and therapeutically supporting and engaging with the patient.

2.7 Assessing levels of observation is an integral part of the admission process and this is completed through the risk assessment process. All patients should be allocated a level of observation upon admission with a colleague identified to undertake those observations. It is a requirement that all patients be observed to the minimum of a Level 1: General Observation (see paragraph 4.5 below).

2.8 All practice must reflect the highest standard of patient care which meets the:

a) Rights of informal and detained patients.
b) Needs in relation to ethnicity, gender, sexual orientation and physical disability.
c) Need for privacy and dignity.
d) Need to engage with patients in a polite and respectful manner e.g. knocking on their bedroom door rather than simply entering the room to undertake observations. There may be times when staff need to go in without knocking and waiting, for example to manage ED behaviours such as over exercising, etc. If this is necessary, it must be discussed with the patient and documented in their care plan.
e) Need to inform and support relatives as required.
f) The patient's requests, as far as possible, in relation to the above; however, the patient's safety is always paramount if particular requirements cannot be met.

2.9 Registered nurses and/or the person in charge of the shift must ensure that there is clear information on each patient's care plans, risk assessments, risk management plans and **H Form: 99A** as to why a patient is being observed and, where necessary, how the observation and engagement is to be undertaken. The risk management plan should form part of the Keeping Safe Care Plan. The Keeping Safe Care Plan should be updated when there are changes in the patient's presentation.

2.10 At handover, the person in charge of the shift must ensure that colleagues are aware of what the key risks are for each patient, any key triggers to be aware of and the type of therapeutic engagement required for the patient.

2.11 Particular patients being cared for using specific therapeutic models such as Dialectical Behaviour Therapy (DBT) may have a care plan in place, discussed with the multi-disciplinary team (MDT), which identifies that there should be limited engagement in response to particular behaviours as part of their treatment plan.

2.12 An outline of observation levels and their purpose should be given at the point of admission and included in the patient handbook where applicable. This will help patients to understand the observation process and encourage and enable them to engage with the process.

2.13 Correct implementation and recording of patient observations is essential in keeping patients, visitors and colleagues safe. A failure to follow the observation policy may result in disciplinary action taken in accordance with HR04.2 Disciplinary Procedure.

2.14 Local arrangements should be considered for implementation using a local procedure in response to specific circumstances, for example, where there is a need to take into account the ward therapy timetable or particular aspects of patient access to the garden and courtyard (as indicated by H Form: 142 Garden and Courtyard Risk Assessment – refer to paragraph 8.6).

- For example in respect of therapy groups the local procedure must include how the nursing and therapy team will communicate with each other regarding the patient, how colleagues will ensure a patient attends the therapy group, what happens should the patient leave the group early or without warning and how patients are safely returned to the ward.
- For example in respect of garden and courtyard access the local procedure must include how the area will be accessed and at what times, how the patients will be observed and the actions to be taken in the event that a patient absconds or attempts to abscond from the area.

2.15 A local procedure may also be required in response to a particular aspect of the physical environment, for example, where a ward is located over two or three floors. Where local arrangements are to be put in place, these should be approved by the Hospital Director. Under no circumstances, should there be local arrangements in relation to observation procedures, which fall outside of this policy.

2.16 If there is a disagreement within the MDT regarding the level of a patient's observations this should be escalated to the Hospital Director or in their absence the manager on-call.

2.17 **Privacy and Dignity**

The patient's views and needs will be taken into account, particularly where there is a history of sexual abuse and vulnerability, when allocating colleagues to undertake observations. However, it must be recognised that it is not always possible to accommodate the patient's preferences (such as same sex staff allocation) and this should be discussed openly with the patient and the outcome of the discussion recorded in the patient's CareNotes clinical record. Similarly, consideration should be given in respect of the views and feelings of patients who identify with another gender, are gender reassigned (including transgender), lesbian, gay and bi-sexual.

2.18 Colleagues undertaking observation duties must not deviate from the care/risk management plan or make their own judgements in delaying / missing an observation, reducing the observation level or permitting a higher degree of privacy for a patient. This is particularly relevant when colleagues are observing a patient of the opposite gender.

2.19 Priory require colleagues who are undertaking observation checks to observe and engage with patients in accordance with the observation level agreed as part of the risk management plan. If the colleague undertaking the observation check has been unable to visually observe the patient in the patient bedroom and receives no response to verbal communication from the patient from the en-suite bathroom having attempted to speak to them (*e.g. [Patient name] are you in there I need to conduct my observation check. Please respond immediately. As you have not responded I now need to enter your bathroom*), the colleague should enter the en-suite bathroom immediately to locate, observe and engage with the patient. Good practice would be for colleagues to shout out or use radio facilities to make another colleague aware prior to entry.

2.20 In addition, Priory require colleagues (not necessarily allocated to conduct observation checks) to enter a patient's bedroom / en-suite facility (regardless of gender or patients preference) if they have a concern about a patient's health and well-being and will support this action in the event that it is questioned.

3 RISK ASSESSMENT AND PRESCRIBING OF SUPPORTIVE OBSERVATIONS

3.1 A detailed risk assessment must be completed for all patients at the time of admission and at the required intervals thereafter. This will inform the decision as to the level of observation prescribed for the patient.

3.2 Risk assessments must be undertaken as a means of understanding the prevailing risk and ensuring the least restrictive practice in accordance with that risk. Further detail on the frequency of risk assessments is given at Paragraph 4 below. The decision to apply observations at a particular level must be based on a risk assessment.

3.3 Risk factors that influence the observation level include the risk of:

a) Suicide.
b) Deliberate self-harm.
c) Self-neglect.
d) Non-adherence with treatment.
e) Violent, aggressive, intimidating behaviour.
f) Absconsion/escape.
g) Inappropriate sexual behaviour.
h) Using or supplying drugs or alcohol.
i) Arson or accidental fire setting.
j) Risk to colleagues.
k) Risk of harmful substance withdrawal.
l) Physical health.
m) Internet and social media.
n) Safeguarding.
o) Other risk factors.

3.4 The completion of the risk assessment and associated risk management plan (in the Keeping Safe Care Plan) for patients is an MDT task. It must, as far as possible, be completed in collaboration with the patient. The plan must reflect the overall view of the MDT and their approach to and management of the patient with regards to the level of observation.

4 INCREASING AND DECREASING OBSERVATION LEVELS

4.1 Observation levels must be reviewed in response to any significant change in the patient's risk profile.

4.2 Any change in the patient's observation levels must be immediately communicated to all staff and clearly identified in the patient's clinical record (entered on the daily progress notes), the care plan, office whiteboard (where applicable) and the observation recording form and must leave no doubt as to the response required.

4.3 **Observation levels can only be reduced by a doctor.** The on-call consultant psychiatrist or a speciality doctor or on-call doctor can reduce observation levels in the event that the patient's Consultant Psychiatrist is unavailable e.g. outside of office hours. Such decisions do not need to be made within the confines of a formal ward round/MDT meeting as this delay may result in the patient remaining on a higher level of observation than necessary. Where a doctor changes the observation levels, this must be done with the agreement of the person in charge. In such cases, the doctor must assure themselves that the patient has been assessed that day by a qualified nurse/the person in charge. An accurate record of the decision must be made in the patient's clinical record as this acts as a formal prescription.

4.4 If a patient's presentation changes and if there is a need to **increase the level of observation**, this can be undertaken immediately by the person in charge of the shift without input from other disciplines. The patient's Consultant Psychiatrist must be informed as soon as practicably possible when this occurs so that the MDT review can be undertaken at the earliest possible opportunity and a new observation prescription formulated if required.

4.5 When observation levels are adjusted, the rationale for the decision must be documented in the patient's clinical record and the names of those individuals involved in the decision recorded.

4.6 A new **H Form: 99A** will be required in response to any adjustments in the frequency of observations.

4.7 Colleagues should ensure others, including the patient, are advised promptly of any adjustments in the frequency of observations so as to ensure clarity and consistency. This will also include updating any ward office whiteboards or similar.

4.8 Adjustments to observation levels can be made in ward rounds. This could include graded reductions with set criteria, which can then be implemented by the nursing team. This needs to be risk assessed, agreed and understood by the MDT and clearly documented in the patient's notes and the Keeping Safe Care Plan.

5 OBSERVATION LEVELS AND THE ASSOCIATED DOCUMENTATION

5.1 Colleagues are always encouraged to use their judgement if they have any concerns and to assertively observe and engage with the patient earlier than the next scheduled observation.

5.2 Colleagues must keep in mind that observation records form part of the legal patient records and assist the clinical team in forming a picture of the patient's mental state and behaviour.

5.3 Communication between colleagues is crucial to the observation and engagement process. The handover of observation duties from one colleague to another should involve a joint observation of/engagement with the patient. The joint observation/engagement at the handover of observation duties is in addition to the prescribed number of observations. The handover between colleagues must be documented on **H Form: 99A** or **H Form: 99F.**

5.4 Forms should not be repeatedly photocopied as this can result in the printed instructions becoming feint and unclear.

5.5 Note that patients should be subject to Level 3 within eyesight observations on arrival to the hospital until the admission assessment commences and a formal level of observation has been agreed.

5.6 **Level 1: General Observation (Level 1):**

a) This is the minimum acceptable level of observation for all patients.
b) This level is appropriate for patients not considered to present a current serious risk of harm to themselves or others and who are considered unlikely to leave their current care setting without prior agreement with the team.

c) The observation levels for patients prescribed Level 1 observations should be reviewed at a minimum of once weekly, with the exception of patients in forensic services who will have at least a monthly review of their observation level, but more often if indicated and patients in rehabilitation and recovery services will have a review of their observation level every three months as a minimum, but more regularly if indicated.
d) The general location of all patients should be known to colleagues.
e) As a minimum, a member of the team must engage with the patient individually to assess his/her mental state at least twice every 24 hours i.e. at least once per shift. This task should be allocated to a specific team member at hand over. This interaction should always include an evaluation of the patient's mood and behaviour associated with risk and should be summarised in the patient's clinical record at least once per shift.

5.7 Patients who are prescribed Level 1 observations do not require the completion of an observation form. Instead, a sufficiently detailed record of the evaluation of the patient's mood and behaviour associated with risk should be documented in the patient's clinical record at least once per shift. Any risk behaviour should be reviewed by the relevant member of the MDT.

5.8 **Level 2: Intermittent Observation: (Not applicable in Scotland)**

a) The patient is checked randomly and at irregular intervals, but on a specific number of occasions in the hour.
b) The observation levels for patients prescribed Level 2 observations should be reviewed at a minimum of once weekly.
c) The number of occasions that observations are to be undertaken in the hour must be recorded in the care plan and on the observation-recording sheet. For example, this could be:
    a) 1 observation an hour
    b) 2 observations an hour or
    c) 4 observations an hour.
d) The colleague undertaking the observations must vary the times at which the patient is observed and the intervals between observations. For example, a patient subject to 4 observations an hour can predict when the next observation will take place if the observations are completed at 15 minutes past, at half past, at quarter to the hour and on the hour. For this reason there is a requirement to make sure the observations are random and unpredictable but relatively evenly spread out i.e. 4 x an hour observations should result in an observation being undertaken within each quarter hour but at unpredictable times for example at 7, 24, 36 and 49 minutes past the hour or similar.

5.9 The frequency of Level 2 observations should be no more than four per hour with the exception of specialist Personality Disorder services, the CAMHS Low Secure Units (LSU) and CAMHS Psychiatric Intensive Care Units (ICU). In exceptional circumstances, to step a patient down from long-term Level 3 or 4 observations, more frequent than 4 per hour observations may be utilised with the approval of the Hospital Medical Director.

5.10 A specific (named) colleague must be allocated to carry out Level 2 observations. A single colleague can undertake no more than 32 observations in the hour. This would be a maximum of eight patients who were subject to four observations per hour (32 observations) but could also be more than eight patients where a combination of different intermittent observations frequencies are in place for example:

- Four patients subject to one observation per hour (4)
- Three patients subject to two observations per hour (6)
- Four patients subject to four observations per hour (20)

This would give a total of 30 observations in the hour with 11 patients.
Colleagues must however take into account the potential impact of increasing the frequency of patient observations during the course of a shift and the impact that this will have on the required staffing numbers.

5.11 **(This section applies to all services except Adult and CAMHS PICU)** It is anticipated that a patient subject to level 2 four observations per hour will generally not be granted unescorted leave within the hospital grounds and/or in the community (off site). Any unescorted ground leave would be by exception and will require clear justification and a discussion involving the patient's consultant psychiatrist, the multi-disciplinary team and the patient. This should be recorded in the informal leave proforma and risk assessment. Arrangements must be put in place in respect of ensuring the patient's intentions and as far as possible, their whereabouts are known. Immediate actions must be taken in the event that the patient does not return to the ward at the agreed time.

5.12 Patients prescribed one or two observations per hour can be granted unescorted ground leave but similarly a clear justification and contingency plan must be documented by the treating consultant psychiatrist in the informal leave proforma and risk assessment.

5.13 **NB: Note that the level of observations known as 'Intermittent' in England and Wales is not recognised in Scotland by the regulatory bodies. Therefore in Scotland, the term General Observations should be used as part of a care plan for example 'A patient on General Observations is to be observed twice per hour to check on their mental health state/whereabouts'.**

5.14 Due to the intensive nature and demands of delivering such high frequency observations the person in charge must be mindful of how many intermittent observations the allocated colleague can safely carry out. This must take into account the patient acuity, the prevailing risk, the ward layout and environment and any incidents occurring during the course of the shift. Where the allocated colleague raises concerns these must be taken seriously and actions taken to resolve those concerns.

5.15 Colleagues should take a proportionate and sensitive approach to the level of engagement with the patient during each observation. It is accepted that engaging briefly with the patient during each observation is likely to become tiring and repetitive. Observing the patient without necessarily engaging with the patient will provide the opportunity for the colleague to assess, to an extent, the patient's mental state. Any concerns must be immediately fed back to the person in charge and documented on the observation form and in the patient's clinical record as required.

5.16 If the colleague has been unable to visually observe the patient, albeit having spoken to them behind a door (for example if the patient is using the bathroom), the colleague must return as soon as practicable and visually observe the patient. If the colleague has concerns about the patient's health and well-being despite obtaining verbal assurance, Priory require colleagues to enter a patient's bathroom (regardless of gender or patients preference) and will support this action in the event that it is questioned. Good practice would be for colleagues to shout out or use radio facilities to make another colleague aware prior to entry.

5.17 For Level 2 observations, **H Form: 99A** Top Sheet should be used to record the observations and then continuation sheets **H Form: 99F** should be used until the observation level is changed and then a new (**H Form: 99A** will be required. In services with longer-term patients where there is stability in the observation levels a new **H Form: 99A** should be introduced on a minimum of a weekly basis after shift handover.

5.18 A sufficiently detailed summary of each intermittent observation should be documented.

5.19 When handing over observation responsibilities both colleagues must confirm the presentation of the patient together and record this on the observation-recording sheet **H Form: 99A** or **H Form: 99F** by jointly signing the sheet.

5.20 **Level 2 High Frequency Intermittent Observation (for specialist personality disorder services and CAMHS LSU/PICU only):**
Due to the increased risk of significant self-harm and the need to avoid dependence on Level 3 and 4 constant observation, specific services (specialist personality disorder services and

CAMHS LSU/PICU) can prescribe intermittent observation up to 12 x hourly for patients assessed as requiring this. These levels of observation should be used for the least time possible.

5.21 The Female Personality Disorder Service may only use 6 x hourly observations as a step down from 12 x hourly moving as soon as possible to 4 x hourly observations.

5.22 Within the Specialist Personality Disorder service there will be a maximum of one patient subject to 12 x hourly observations to one colleague.

5.23 In CAMHS LSU and PICU wards there will be a maximum of three patients on 12 x hourly observations allocated to one colleague.

5.24 The requirement to continue 12 x hourly observations must be reviewed daily by the person in charge in conjunction with the patient's Consultant Psychiatrist/or Speciality Doctor and the rationale for continued use clearly documented in the patient's clinical record.

5.25 **Levels 3 and 4: Constant Observation:**
Level 3 and 4 observations are to be used where there are concerns that the patient could, at any time, seriously harm themselves or others, is at risk of absconding or is at risk of harm from others.

5.26 There are two types of constant observations – Level 3 (Within Eyesight) and Level 4 (Within Arm's Length):

- **Level 3: Within Eyesight**
  This level of observation requires the patient to be kept within sight of the allocated colleague at **ALL** times. This includes when using the bathroom and with visitors.

- **Level 4: Within Arm's Length**
  This level of observation is prescribed for patients at the highest risk. It requires the allocated colleague to be within arms-length of the patient at **ALL** times. This includes when using the bathroom and with visitors. The safety of both the patient and the colleague needs to be carefully considered before implementing this level of observation.

5.27 **Additional staff support** – On occasions it may be necessary for patients who are at a very high risk to require the support of more than one colleague (commonly known as two-to-one (2:1) or three-to-one (3:1)) to ensure the patient's safety. In these instances, **all** colleagues must sign the observation-recording sheet **H Form: 99A** or **H Form: 99F.**

5.28 **Level 3 and 4** observations may be perceived as intrusive by the patient and may cause distress. Colleagues must ensure they approach Level 3 and 4 observations with compassion and that the process is enhanced by positive interaction, which could include encouraging the patient to engage in activities that are appropriate and safe.

5.29 Intimate activities, such as toileting and bathing must be considered by the team when setting the level of observation and **the Keeping Safe Care Plan and the Observation Recording Forms must specifically state very clearly how situations involving private and intimate activities are to be managed (this must also be considered when completing the shift planner).** It is essential that the gender of the colleague and patient should be considered; these should be same sex where possible and it may be necessary for the colleague to be swapped, for example, to enable the patient to use the bathroom. It is important that the patient's right to privacy and dignity are considered and documented in all decisions made by the team and documented as part of the care plan. However, the patient's safety must be paramount in decisions that are made.

5.30 Environmental factors should be considered for the highest risk group of patients. This will include transferring them to a safer room and/or removing items from the environment which may increase their risk to self or others. It may be necessary to search the patient and their belongings and this should be done within the guidance of H97 Searching Patients and Visitors

policy or local procedure. Similarly colleagues must be equipped with the means of raising the alarm and requesting assistance e.g. radios and/or personal alarms.

5.31 The observation levels for patients prescribed Level 3 and 4 observations should be reviewed as follows

a) For all wards where the observation level has not changed, documentation of the review can be entered in the continuous notes.
b) Acute and PICU wards: daily as a minimum with reference made in CareNotes.
c) CAMHS Wards (eating disorders wards, GAU (Tier 4), PICU, HDU and LSU): twice a day with reference made in CareNotes. Note that one review must be undertaken as part of the morning shift handover and the other by a member of the medical team.
d) Rehabilitation and recovery, specialist personality disorder wards, eating disorders wards and forensic services: minimum weekly or at a greater frequency as agreed by the MDT with reference made in CareNotes.

5.32 For Level 3 and 4 observations, **H Form: 99A** should be used and then continuation sheets H Form: 99F should be used until the observation level is changed and then a new Top Sheet (**H Form: 99A**) will be required. In services with longer term patients where there is stability in the observation levels a new **H Form: 99A** should be introduced on a minimum of a weekly basis after shift handover.

5.33 For those patients who are prescribed Level 3 and 4 observations a record must be made of the patient's mood, behaviour and activity no less than hourly on **H Form: 99A or H Form: 99F.**

5.34 There is always a risk of mistaken identity in respect of observing patients and primarily for this reason, when handing over observation responsibilities both colleagues must confirm the presentation of the patient together and record this on the observation recording sheet **H Form: 99A or H Form: 99F** by jointly signing the sheet.

5.35 Note that there is an increased risk of mistaken identity in those instances where patients are wearing facemasks, in these circumstances it is acceptable to ask a patient to remove their facemask to confirm their identity.

5.36 Patients on level 3 and 4 enhanced observations must not be granted leave within the hospital grounds and/or in the community (off site). Only in exceptional circumstances will escorted leave be permitted and will require clear justification and a discussion involving the patient's consultant psychiatrist, the multi-disciplinary team, the patient and where necessary their family. The discussion must be recorded in CareNotes.

5.37 **Combining levels of observation** – If the person in charge and the patient's Consultant Psychiatrist agree, it is possible to combine different levels of observation. Examples would be:

a) Level 3 observation during the day (clearly defined hours) and Level 2 observation at night (clearly defined hours). It is essential that in these circumstances arrangements are in place to ensure that the patient is safe should he/she wake during the night.
b) Differing settings may result in different observation levels e.g. Level 3 observations completed when the patient is in his/her bedroom and Level 2 observations when the patient is in communal areas. In such cases, a member of staff can be positioned within sight of the patient's bedroom and the observation level can change immediately when the patient leaves his/her bedroom, ensuring that at all times it is possible for the prescription to be reliably followed.

5.38 Combined levels of observation must be recorded in the patient's clinical record, care plan and the observation recording form and must leave no doubt as to what is required.

5.39 **A nuanced approach to Level 3 and 4 supportive observations -** In certain instances particular patients e.g. those cared for and treated in bespoke therapeutic placements (referred to as 'pods') are prescribed Level 3/4 supportive observations but a nuanced approach is

required in undertaking such observations. There is a risk for certain patients that if Level 3/4 supportive observations were to be completed at all times this may have an adverse rather than beneficial effect on the patient for example the patient may become over stimulated. In such cases there must be a clear care plan in place for each patient detailing the purpose and the nature of the supportive observations that are to be completed.

5.40 **Recording supportive observations: general principles:** Colleague must complete the observation forms **H Form: 99A** and **H Form: 99F** legibly and must print their name in capitals beside their signature. The recording of observations should be specific and detailed with key information made clear. Colleagues should avoid generic phrases such as 'pleasant', 'settled', 'sleeping' or 'in lounge'. Details should include what the patient is doing and any interactions they have with others.

5.41 A gap should be left on the observation recording form and the reason for the missed observation recorded in the event that an observation is missed. If there is a gap of two or more intervals in the course of a shift, this should be recorded as an incident on the Priory Incident Reporting System.

5.42 Particular wards may put in place patient photographs to aid patient recognition. These photographs may be attached to the relevant form. This should be governed in accordance with Policy OP34 Identification of Service Users.

5.43 The preference is that colleagues complete **H Form: 99A** and **H Form: 99F** at the time that they observe the patient however in certain instances a decision may be made to retain clip boards and pens in the ward office and away from patients due to the serious risks that are present. In such cases this will be governed by the local procedure.

6 IMPLEMENTATION, DELIVERY AND MONITORING OF SUPPORTIVE OBSERVATIONS

6.1 At the beginning of each shift, the person in charge will inform and ensure that all colleagues, who are involved in patient observations, understand who is being observed, at what level and why. During handover, each patient's mental state and their potential risks will be reviewed. The person in charge must ensure that colleagues are aware of what the key risks are for the individual patients, any advance statements that have been made by the patient, key triggers to be aware of and what type of therapeutic engagement and support would be beneficial for that patient. The observation duties should be clearly documented on the shift allocation sheet.

6.2 The key to effective observations is therapeutic engagement, particularly during Level 3 and 4 observations. This will include activities and interventions which are intended to support the patient. The colleague undertaking the observations should introduce themselves and attempt to establish a rapport with the patient. Asking the patient how they would like to spend the time or finding out what helps them can also be important in supporting them to manage their own risk. All interventions should aim to empower and support the patient and not restrict their movement unnecessarily.

6.3 Engagement involves interaction with the patient: listening, encouraging communication and conveying that they are valued and cared for. The colleague undertaking the Level 3 and 4 observations should use empathy, meaningful conversation, use of silence/pauses, listening skills, discuss the patient's feelings and thoughts and respond in a positive way to a patient that may raise issues that may be challenging or uncomfortable to discuss. The colleague must also act in a professional and consistent manner and show respect for mutual boundaries.

6.4 The colleague taking over a period of observations should be aware that the patient may have spent a lot of time talking to the previous colleague and may wish for some quiet time. This is important to discuss at handover with the patient if appropriate.

6.5 Arrangements must be made to ensure that where possible patients are able to attend therapy programmes and one-to-one sessions regardless of their prescribed observation levels. Local

systems must be put in place to ensure that the colleague allocated to undertake the observations is:

a) Aware of and can confirm the patient's whereabouts when group and individual therapy programmes and one-to-one sessions are underway so as to help ensure that sessions are not unnecessarily interrupted; and
b) Immediately made aware of patients who do not attend a therapy or one-to-one session or leave a session unexpectedly.

6.6 It is the responsibility of the person in charge to allocate colleagues that have been deemed competent to carry out patient observations. Where the person in charge considers there are insufficient staffing resources available this should be immediately escalated to his/her manager. An incident form must be completed where staffing issues cannot be resolved.

6.7 It is the responsibility of the person in charge to ensure that patient observations are allocated at the beginning of each shift and these allocations are recorded on the allocation sheet. Colleagues allocated to observations should be rotated regularly. The following overarching principal applies as a guideline however, there will be exceptions as agreed locally: Colleagues undertaking patient observations should be relieved for 60 minutes every two hours (note that the colleague can be 'stepped down' to undertake Level 1 and/or Level 2 supportive observations at this time).

6.8 Patients requiring Level 3 and 4 observations are those who are most vulnerable and have the highest risk and it is important that suitably qualified and experienced colleagues are allocated to carry out these observations.

7 COMPETENCE: INDUCTION AND TRAINING

7.1 All members of the multi-disciplinary team must be aware of the contents and implementation of Policy H47 Supportive Observation and Engagement and sign to state their understanding of this.

7.2 It is safer and better for patients if observations are undertaken by colleagues who are familiar to them and who have undertaken relevant Priory Academy training modules.

7.3 Colleagues allocated to patient observations must have received a satisfactory induction, should be familiar with the ward environment and must ensure they know which patients are to be observed. There is an increased risk of mistaken identity where PPE (in the form of facemasks) is being worn by patients, and staff should be made aware that, in these circumstances, it is acceptable to ask a patient to remove their facemask to confirm their identity.

7.4 As part of their induction and if subsequently deemed necessary, each colleague completing observations and engagement must be assessed as being competent using form **H Form: 99** Observation Competency Checklist.

7.5 A current H Form: 99 Observation Competency Checklist should be in place for permanent or bank colleagues. A copy of the completed competency checklist should be kept in their human resources file and for agency colleagues a copy of the competency checklist should be kept in a file on the ward. The competency checklist must be completed for each ward the bank or agency colleague works on as patient groups and ward environments are different.

7.6 The competency checklist should be completed annually. Additionally, where the bank or agency colleague has a break in service of over three months then the checklist must be completed again. The checklist must also be completed where it is identified that colleagues have fallen short of the requirements of this policy (this may be identified as part of the routine actions of the manager/person in charge or in the event of an incident, near miss or complaint).

7.7 An overarching data sheet should be held detailing the name of the colleague and the dates of the completed observation competency checklists.

7.8 Student nurses may undertake observations with the agreement and oversight of a permanent qualified colleague and as part of an agreed learning outcome for the placement.

7.9 For patients on Level 3 and 4 constant observations, the clip board containing the patient's observation recording sheet, should also contain the latest risk assessment for that patient and the Keeping Safe Care Plan which will outline specifically what the risks are and how they should be managed.

7.10 Colleagues who are undertaking Level 3 and 4 constant observations should ensure that any items are securely attached to their person to prevent them being taken by patients and used to harm themselves and/or others e.g. pens and personal alarms.

7.11 Where concerns are raised about an individual carrying out observations they should not be assigned patient observations until they have been assessed as being competent to do so by their line manager.

7.12 Undertaking Level 3 and 4 observations at night involves the risk of colleagues falling asleep. Any possible action should be taken to help prevent this for example having a supply of fresh air, tea and coffee and a source of sufficient light (which will not disturb the patient). Should a colleague be found to be sleeping during the shift and when undertaking observation duties then proportionate action must be taken first and foremost being a check on the patient's wellbeing and where necessary action taken in accordance with pay and human resource policies and procedures.

8 POINTS TO NOTE

8.1 **Night Time Observations:** Colleagues must be thorough in their approach to undertaking night-time observations.

8.2 The colleague undertaking patient observations at night must be satisfied that the patient is present, breathing and well. This requirement must however be balanced with colleagues recognising the importance of good sleep hygiene for those experiencing mental health problems. Therefore it is essential that as far as possible the patient is not disturbed during the night.

8.3 Where colleagues enter a patient's bedroom to complete the observation they must for example act quietly, avoid the loud opening and closing of the bedroom door and be mindful of unnecessary light (use a torch with a low beam).

8.4 Where observations are being undertaken via the vision screen in the bedroom door the colleague must be satisfied that the patient is present, breathing and well. If there is any doubt or concern the colleague must open the door to enable closer inspection. If concerns remain then the colleague must enter the room quietly and view the patient using a torch with a low beam or, if required, turn a light on to check that the patient is present, breathing and well. Colleagues must be alerted as required to assist where there are concerns.

8.5 At all times a description of the patient's activity during each observation at night is required. This will include for example breathing/snoring being heard or restlessness being observed. Reference should also be made in the event that the patient is awake or happens to wake up.

8.6 **Physical health monitoring for patients with eating disorders** - The focus of the physical health monitoring procedure is to ensure the close monitoring of the patient's physical health. The procedure should be used for patients who are at risk of the following:

a) Re-feeding syndrome.
b) Excessive purging, laxative misuse and water loading.

Excessive exercising.

8.7 Where there are two patients prescribed 'physical health monitoring' for re-feeding syndrome/excessive purging etc., they will be nursed by one colleague and will be prescribed 12 in an hour checks.

8.8 The aim is to have only four patients at any time on this type of observation. Should the need arise for more patients to be cared for on 12 in an hour checks, this must be authorised by the Eating Disorders Clinical Director/Specialist Director.

8.9 Patients who are cared for on the physical health monitoring protocol must be assessed on an individual basis against a number of criteria. These criteria are identified in Appendix 1.

8.10 **CCTV, or similar technology**: Observations should not be undertaken by the medium of CCTV or similar technology other than on an exceptional basis. In all other instances colleagues must attend and physically see the patient.

8.11 **H Form: 142 Garden and Courtyard Risk Assessment** supplements the practice of supportive observation by assessing ward gardens and courtyard spaces to enable colleagues to understand and address absconding and self-harm risk and put in place particular actions to reduce such risk. The actions will include making physical, procedural and relational adjustments to the environment. The risk assessment tool will be completed on an annual basis (as an adjunct to the annual ligature point audit process) and on an as required basis for example in the event of a patient abscond from a garden or courtyard.

8.12 **Emergency situation:** It is essential that patient observations continue in the event of an emergency. Experience shows that patients may take opportunities e.g. when staff are distracted from undertaking supportive observations to harm themselves, harm others or abscond.

8.13 **Observations on leave**: The Keeping Safe Care Plan, Section 17 (Suspension of Detention in Scotland) Leave form (for detained patients) and the informal leave proforma must include, where applicable, how observations are to be carried out when a patient is on leave and escorted by a member of staff, stating all conditions associated to each leave episode. For patients that are authorised unescorted leave, the recording of observations will be suspended until their return.

8.14 **Patients at external sites**: Where patients are cared for at an external site, for example in an acute hospital, there must be a joint plan of care between the Priory site and the external site. This must include clear communication, reporting and handover processes to all observing colleagues. A copy of the Keeping Safe care plan should transfer with the patient.

8.15 The level of observation the patient requires whilst at the external site should be agreed by the MDT (or the nurse in charge when transferred in an emergency) prior to their transfer and observations should continue at the external site as prescribed, with agreed exceptions such as when undergoing surgery. If an approved Secure Transport Provider and their escort staff are used to accompany a patient to hospital, the MDT must agree the specific level of observation required and whether authority is given to use any mechanical restraint and if so, in what specific circumstances. A member of staff familiar to the patient should accompany the Secure Transport staff whenever possible.

8.16 Colleagues undertaking observations at an external site must have a means of communication with colleagues at both the external site and the Priory site. The person in charge at the Priory site must communicate regularly with the Priory colleagues and the person in charge of the external site. Upon arrival at the external site, Priory colleagues must ensure they understand how to request support in an emergency situation, should this be needed, making enquires to understand the local emergency arrangements where required.

8.17 **ZONAL OBSERVATIONS -** In some wards and units there will be a requirement, because of the patient group, the daily programme and the environment (which may be spread over two or more floors) to have a system of zonal observations in place. In such cases:

- Each patient will still have an individual observation level.
- Care and support for the patient will be clearly documented in an individualised care plan.
- The recording of observations will continue to be documented on an individual basis as detailed in Section 4 Observation Levels and the Associated Documentation.

8.18 An application to introduce zonal observations must be discussed and agreed with the Specialist Director from the relevant service network and the Executive Medical Director. There must be a clear implementation plan of the procedure to mitigate risk in place together with a scheduled review.

8.19 Where zonal observations are in place it is essential that the zonal observation procedure is outlined in sufficient detail at staff induction, The procedure must be simple and easy to follow and not allow room for doubt or uncertainty.

8.20 **Observations during patient use of ward computers -** Regardless of the specific level of prescribed observation, when patients are being supervised to use ward computers the observing/supervising member of staff must sit alongside the patient in order to monitor their keyboard activity, in all sessions. At any point, the member of staff has any suspicion/concern about the patient accessing to inappropriate sites, the session must be brought to an immediate end.

9 PHYSICAL HEALTH OBSERVATIONS

9.1 Physical Health Observations differ from mental health observations. Physical Health Observations assist in monitoring a patient's physical needs and enable a prompt response to changes in the patient's physical condition. Note that Physical Health Observations are not a substitute for mental health observations. It must be clear why Physical Health Observations are being undertake and there should be explicit reference to this in the relevant care plan(s) with reviews undertaken as required.

9.2 The Physical Health Observations should be recorded in the patient's clinical record and not on an observation and engagement recording sheet. An example of such observations would be in those cases where a patient with a neurodegenerative disease is at risk of multiple falls and requires one to one care. In these instances a summary of the patient's care and treatment should be recorded in the patient's clinical record at least once per shift.

10 MENTAL HEALTH ACT AND OBSERVATIONS

10.1 Where an informal patient is prescribed Level 2, Level 3 or Level 4 observations and they attempt to leave hospital or they state a desire to leave, colleagues should consider the use of the Mental Health Act using a Section 5(2) or 5(4). If an informal patient is placed on Level 3 or 4 constant observations, they must be assessed under the Mental Capacity Act and Best Interest Process with capacity to consent considered as relevant as this could be deemed as restrictive practice. The patient's clinical record must be updated accordingly.

11 MENTAL CAPACITY ACT (DoLS) AND SUPPORTIVE OBSERVATIONS (Not applicable in Scotland)

11.1 The Mental Capacity Act (2007) places a responsibility on organisations such as Priory Median to protect an individual's right to liberty and to undertake certain procedures when an individual over or under the age of 18 may need to be deprived of their liberty. These procedures are known as Deprivation of Liberty Safeguards (DoLS) (applying to people over the age of 18-years). If it is necessary to place such a patient on Level 2 intermittent or Level 3 or 4 constant observations a DoLS assessment may need to be considered. In this situation, the Mental Capacity Act (applying to people over the age of 16-years) is only relevant for patients not already detained under the Mental Health Act.

12 AUDIT AND MONITORING

12.1 On a shift by shift basis aspects of accordance with this policy will be audited three hourly using Form H47 Nurse in Charge Safety Checks.

12.2 As part of clinical governance, which supports good and evidenced based practice, it is important that there is a regular and comprehensive review process in place. This will be undertaken monthly via the Healthcare Documentation Quality Walk Round. This will give rolling assurance with key issues of note reported to the Clinical Governance Meeting via the Quality Walk Round log. A review of incidents should also be undertaken during the Clinical Governance Meeting and any incidents involving observations be addressed via lessons learnt and action taken.

12.3 Each site is responsible for the ongoing monitoring and reviewing of their practice and must demonstrate that where practice falls down and quality walk rounds or audit reports show poor results, recommendations are made and implemented through action plans with timescales and that this information is communicated to the relevant colleagues.

12.4 An audit of observations will be undertaken at least annually (See policy H34 Care Programme Approach/Care and Treatment Planning, Paragraph 10.2), the results discussed by the Clinical Governance Committee and an action plan in place if necessary.

12.5 In addition to formal audits the ward manager should review on a regular basis the quality of the recording of the observation records and the rotation of colleagues being assigned to carry out observations.

13 REFERENCES

13.1 NCCSDO (2006) The City 128 Study of Observations and Outcomes on Acute Psychiatric Wards
NPSA (2009) Preventing Suicide: A toolkit for mental health services
CQC (2015) Specialist Mental Health Services: Provider handbook
DH (2015) Mental Health Act 1983: Code of Practice
NICE (2015) Violence and Aggression: Short-term management in mental health, health and community settings. NG10
National Confidential Inquiry into Suicide and Homicide by People with Mental Illness (2015): Inpatient suicide under observation
Mackley, A (2018) Suicide Prevention: Policy and Strategy. House of Commons Briefing Paper Number CBP 08221
MHNLD Forum: National Policy Template Supportive Observation & Engagement (July 2018 – Version 2)
Mental Health (Care & Treatment) (Scotland) Act 2003 – Milan Principles
Adult Support and Protection (Scotland) Act 2007
Adults with Incapacity (Scotland) Act 2000
HIS (2019) From Observation to Intervention 'A proactive, responsive and personalised care and treatment framework for acutely unwell people in mental health care'

14 ASSOCIATED FORMS:

14.1
H Form: 35 Welcome to Priory
H Form: 99 Observation Competency Checklist
H Form: 99A Observation and Engagement Record Top Sheet
H Form: 99D Acute Hospitals Ward Daily Planner
H Form: 99E Nurse in Charge Safety Checks
H Form: 99F Observation and Engagement Record Continuation Sheet
H Form: 99G Level 2: 12 and 6 in an Hour Nursing Observation and Engagement Sheet
H Form: 99H Nurse in Charge Safety Checks (Neuro sites only)
H Form: 99J 12 in 60 Observations Form for Physical Health Monitoring in ED Treatment Environments
H Form: 99K Presence Checks (forensic service line only)

H Form: 123 EPC Funding Request Form
H Form: 142 Garden and Courtyard Risk Assessment

15 POLICY ON A PAGE

15.1 PoP-H47

16 EQUALITY IMPACT ASSESSMENT

16.1

How is the policy likely to affect the promotion of equality and the elimination of discrimination in each of the groups?			
Protected Characteristic (Equality Act 20210)	**Impact** Positive/ Negative/ None	**Reason/ Evidence of Impact**	**Actions Taken** (if impact assessed as Negative)
Age	None		
Disability	None		
Gender re-assignment	None		
Marriage or civil partnership	None		
Pregnancy or maternity	None		
Race	None		
Religion or beliefs	None		
Sex	None		
Sexual orientation	None		
Other, please state:	None		
EIA completed by:			
Name: **Role/Job Title:**	David Watts, Director of Risk Management		
Date completed:	Friday 18 November 2022		

17 APPENDICES

17.1 **Appendix 1 -** Physical Health Monitoring for Patients with Eating Disorders

Appendix 1

PHYSICAL HEALTH MONITORING FOR PATIENTS WITH EATING DISORDERS

1 The focus of the physical health monitoring procedure is to ensure patients who meet the criteria as outlined below have their physical health monitored closely and that progress is monitored and observations reflect the patient's current physical need. The procedure should be used for patients who are at risk of the following:
(a) Risk of re-feeding syndrome.
(b) Excessive purging, laxative misuse and water loading, excessive exercising.

2 Patients who are at risk of harm to themselves, to others or absconding should be managed in accordance with the Healthcare Division Observation and Engagement Policy.

3 Where there are two patients prescribed "physical health monitoring" for re-feeding syndrome/excessive purging etc., they will be cared for by one colleague and will be prescribed 12 in an hour observations.

4 The aim will be to have no more than four patients at any one time on this type of observation. Should the need arise for more patients to be cared for on 12 in an hour observations as per this procedure this must be authorised by the Director of Clinical Services.

5 Patients must be assessed on an individual basis and must meet some of the following criteria for "physical health monitoring".

6 **Criteria for "physical health monitoring" for Re-feeding Syndrome:**
(a) Low dietary intake (circa 500 calories per day) over the previous two weeks prior to admission.
(b) Rapid weight loss over two to four weeks.
(c) BMI of 13 and under.
(d) Blood abnormalities.
(e) Low phosphate.
(f) Low glucose.

7 **Management Plan:**
(a) 12 in an hour observations.
(b) Daily SUSS test.
(c) As a minimum QDS BP, glucose monitoring and TPR.
(d) 24 hour fluid input and output monitoring.
(e) Daily bloods, or as required.
(f) Baseline ECG to be completed when this treatment programme commences, with the results acted upon immediately.

Depending on a patient's progress this level of intensive observation is likely to last for one to two weeks. The patient must be reviewed daily. Some patients may need to remain on this management plan for longer than two weeks but the aim is to exit this plan at the earliest opportunity.

8 **Exit from this management programme:**
(a) Evidence of weight gain in conjunction with reduction in markers for refeeding syndrome.
(b) Blood glucose stabilisation.
(c) Cardio-vascular stability.

9 **Criteria for "physical health monitoring" for excessive purging, laxative use and water loading:**
(a) Blood abnormalities.
(b) Low phosphate.
(c) Low glucose.

10 **Treatment plan:**

(a) 12 in an hour observations.
(b) QDS BP and TPR.
(c) SUSS test.
(d) 24 hour fluid input and output monitoring.
(e) Bloods as appropriate.
(f) Baseline ECG to be completed when this treatment programme commences, with the results acted upon immediately.

Depending on a patient's progress this level of intensive observation is likely to last for one to two weeks. The patient must be reviewed after daily. Some patients may need to remain on this management plan for longer than two weeks but the aim is to exit this plan at the earliest opportunity.

11 **Exit from this management programme:**

(a) Stabilisation of physical health.

12 **Criteria for 'physical health monitoring' for excessive exercising -** In some circumstances we may need to use physical health monitoring for excessive exercising where there are other physical health complications. For particular consideration if the patient's BMI is<15.

13 **Management plan:**

(a) 12 in an hour observation.
(b) QDS blood glucose monitoring.
(c) Daily SUSS test.
(d) As a minimum QDS BP and TPR.
(e) 24 hour fluid input and output monitoring.
(f) Daily bloods, or as required.
(g) Baseline ECG to be completed when this treatment programme commences, with the results acted upon immediately.

Depending on a patient's progress this level of intensive observation is likely to last for one to two weeks. The patient must be reviewed daily. Some patients may need to remain on this management plan for longer than two weeks but the aim is to exit this plan at the earliest opportunity.

14 **Exit from this management programme:**

(a) When the exercise is no longer a severe physical threat to the patient.
(b) Physical health complications have stabilised.
(c) Exercising has ceased or significantly reduced.

15 **Transfer to Medical Unit**

15.1 Where possible liaison arrangements should be in place with the relevant local acute hospital given that some patients may require transfer to the local NHS medical services to evaluate and treat potentially serious physical problems.

15.2 Reference: MARSIPAN ***Management of really sick patients with Anorexia Nervosa:*** **October 2013.** Royal College of Psychiatrists and Royal College of Physicians, London.