SAFE AND SUPPORTIVE OBSERVATION AND ENGAGEMENT POLICY

The policy should be read in conjunction with the following:

- Mental Health Act 1983 – Code of Practice England
- Mental Health Act 1983 – Code of Practice Wales
- Local Operational Policy – *Supportive Recovery Risk Management System*
- PiC Operational Policy – *The Safe & Therapeutic Management of Violence & Aggression*
- PiC Operational Policy – *Care of Patients in Seclusion & Longer Term Segregation*
- PiC Operational Policy – *Consent*
- PiC Operational Policy – *Health Record Content & Management*
- PiC Operational Policy – *Search*
- NICE Guidelines NG10: Violence and aggression: short-term management in mental health, health and community settings
- Engaging People – Observation of people with acute mental health problems (The Scottish Government)

This policy should be implemented within the context of the PiC Values:

- Valuing people – respecting our staff, patients, their families and communities
- Caring safely – for ourselves, our patients, our customers and communities
- Working together with everyone
- Uncompromising integrity, respect and honesty
- Taking quality to the highest level

1. INTRODUCTION

Most patients can be treated safely and securely in a ward environment within which they can move freely and are observed and monitored on a frequent, but intermittent, basis by the normal complement of ward staff.

The need for safe and supportive observations is a clinical decision, in addition to the antecedents that indicate disturbed / violent behaviour, observation above a general level should be considered if any of the following are present:

- History of previous suicide attempts, self-harm or attacks on others
- Hallucinations, particularly voices suggesting harm to self or others
- Paranoid ideas where the service user believes that other people pose a threat
- Thoughts or ideas that the service user has about harming themselves or others
- Threat control override symptoms
- Past or current problems with drugs or alcohol
- Recent loss

- Poor adherence to medication programmes or non-compliance with medication programmes
- Marked changes in behaviour or medication
- Known risk indicators

2. SCOPE

This policy applies to all hospital PiC inpatient services. It is relevant to situations in which safe and supportive levels of observation are being considered or applied:

- To prevent or reduce self-harm
- To protect the individual from harm
- To maintain safety and security
- To provide contact, care and support to the patient
- To reduce the likelihood of the individual accessing materials identified as a clinical risk
- To prevent absconding for the safety of self and others

3. PRINCIPLES

Engaging people, even when working with extreme challenging behaviours promotes a culture which supports recovery, hope and person-centred care.

Safe and supportive observations and engagement provide safeguarding for patients during temporary periods of distress, when they are at risk of harm to themselves and / or others; and are a positive component of safe, supportive and therapeutic care.

Observations must be patient focused at all times and the views of the patient should be sought where possible.

The service has a duty of care for safety and security to the patient, staff, visitors and the general public.

Care must be provided in an environment that is conducive to therapeutic interventions and in a manner that reflects the least restriction possible for the safe and supportive management of the patient. [1]

The intended effect is not simply to increase the level of safe and supportive observation and engagement, but to achieve a satisfactory outcome in terms of the well-being, safety and security of the patient and others in the immediate environment.

The patient should be provided with information about why they are under observation, the aims of observation and how long it is likely to be maintained.[2]

[1] Mental Health Act 1983 – Code of Practice England; Mental Health Act 1983 – Code of Practice Wales

[2] NICE clinical guideline (NG10) Violence and aggression: short-term management in mental health, health and community settings

Observation is an opportunity for one-to-one interaction and should be undertaken by competent staff. The observing staff should show the patient positive regard. If a patient is uncommunicative, the observing staff can initiate conversation and convey a willingness to listen.

Observations of patients who are acutely ill, presenting with challenging behaviour or increased risk to self and/or others is undertaken by staff who are skilled in assessing the patient's mental state, developing rapport and therapeutic relationships.

When a patient is in seclusion observing staff at a minimum should be assured that at every prescribed interval that the patient is safe, they are alive and they can be seen to breathe unobstructed and without difficulty.

Some patients will prefer to be active, or may just want to pass the time. It is important that the observing staff elicit the patients' preferences, for example, in music, TV, reading, and attempt to provide these.

The observing staff may need to review his or her own thoughts, feelings and attitudes about observation to ensure that they can convey the supportive and therapeutic role to the patient. In addition the multi-disciplinary team (MDT) must provide an open and supportive environment to enable members of staff to discuss their feelings about participating in observation.

The overall aim is to maintain a therapeutic relationship and reduce risks. Care and support of the patient will be addressed specifically within an individualised MDT care plan. The care plan should anticipate patient's needs, identify short and long-term objectives and indicate how the level of enhanced observation is to be applied.
Patients will have a comprehensive ongoing MDT assessment of risk to others, which will involve the patient to reduce the potential of harming others.

The use of agency staff / temporary staff to undertake the role of observing staff will be kept to a minimum and will only take place when they have completed the competency checklist.

As a minimum observing staff will have completed the enhanced observation competency checklist.

4. CONSIDERATIONS FOR ENHANCED OBSERVATION

Enhanced observation is a therapeutic intervention providing support and engagement (where appropriate and subject to risk assessment) in achieving an agreed goal or objective with the patient. Enhanced observations must be undertaken by staff who have the necessary skills, experience and competence.

When considering enhancing the level of observation, the Nurse in Charge in consultation with the MDT / RC or nominated deputy (duty doctor) should:

- Consider whether enhancing the level of observation will reduce the risks to the patient and others

- Consider the effect of the increase in observation of the patient's behaviour, mental state and dependence on others
- Seek the views of the patient as far as possible
- Consider the least restrictive means possible to ensure the safety and security of those involved
- Any prescribed medications and their effects
- The current assessment of risk
- Review the patient's care plan to ascertain what is already in place for managing the patient
- Seek the views of clinical staff that have an established relationship with and knowledge of the patient

Consideration should be given to environmental factors with special regard to areas where patients can be isolated and / or out of line of sight of staff, e.g. bathroom / toilet areas and bedrooms.

It should be noted that the Department of Health (2001) 'Safety First' [3] report highlights the increased risk of suicide for those newly detained and those in their first 7 days in hospital during evening and night time.

Decisions surrounding increasing and decreasing a patient's level of observation and how these decisions are formed must be recorded as a clinical entry in CAREnotes.

5. REASONS FOR ENHANCING LEVELS OF OBSERVATION & SUPPORT

The frequency, intensity and duration of the behaviour will determine the level of observation necessary to manage the situation. These behaviours and the aims of the level of enhanced observation will be identified in the nursing and/or the multi-disciplinary care plan(s). When planning effective management of the situation, the Nurse in Charge will need to consider the safest environment and staffing levels.

6. DEFINITIONS OF OBSERVATION LEVELS – NICE CLINICAL GUIDELINE NG10

NICE clinical guideline (NG10)[4] Violence and aggression: short-term management in mental health, health and community settings defines 4 Levels of Observation. These definitions have been reviewed and the following levels of observations have been agreed within PiC:

Level 1 – General observation
Level 2 – Intermittent observation
Level 3 – Within eyesight observation
Level 4 – Within arm's length observation

[3] Department of Health (2001) 'Safety First' – 5 – Year Report of the National Confidential Enquiry into Suicide and Homicide by People with Mental Illness

[4] NICE Guidelines NG10: Violence and aggression: short-term management in mental health, health and community settings

Staff who have a clinical input with patients may on occasions participate in the observation of patients throughout the course of their work.

The Nurse in Charge is accountable for the decision to delegate observing staff that are competent to undertake this role.

6.1 Level 1 – General Observation

Aim – to maintain observation of all patients on the ward

This **General** Observation is the **minimum** acceptable level of observation for **ALL** patients. The location of all patients should be known to staff, but not all patients need to be kept within sight. At least once per shift a nurse should sit down and talk with each patient to assess his or her mental state. This interview should always include an evaluation of the patients' mood and behaviours associated with risk along with his/her involvement in meaningful activities and should be recorded in CAREnotes.

6.2 Level 2 – Intermittent Observation

Aim – to enhance support by monitoring the patient's physical whereabouts, current behaviour and risk indicators

Patients on Level 2 observation must be reviewed at least daily by the Nurse in Charge and a record of the review entered in CAREnotes including updating the observation level. Again this should include an evaluation of the patient's mood and behaviours associated with risk along with his/her involvement in meaningful activities.

The MDT / Nurse in Charge must assess the frequency of observation required based on the risks presented. The frequency of Level 2 observation can be set at intervals of 15 to 30 minutes in duration.

6.3 Level 3 – Within Eyesight Observation

Aim – to maintain observation of the patient within sight and ability to manage the risks he/she presents to himself / herself or others

To maintain this level of observation, the observing staff must constantly remain within close proximity (5 metres, 15 feet), and **within sight** of the patient. Nursing the patient on level 3 observations must balance the need for observation and the patient's right to privacy. Clear guidelines must be written in the patient's clinical record and care plan. A copy of the care plan must be attached to the enhanced observation chart.

A **written entry** must be made on the observation chart at no less than **15 minute intervals**. A summary of the patient's behaviour, mental state and risks as well as any intervention must be entered as a clinical note in CAREnotes at the end of each shift.

Patients on Level 3 observation must be reviewed at least daily by the Nurse in

Charge and RC (or nominated deputy) and a record of the review entered in CAREnotes.

Extra nursing resources may be required for Level 3 observation. However each nursing team will be able to absorb one patient on Level 3 observation without requiring extra resources.

6.4 Level 4 – Within Arm's Length Observation

Aim – to ensure immediate safe management of the patient assessed as presenting a severe risk to the safety or security of himself / herself, others or the environment

This intensive level of observation will require the delegated nursing staff to be within reach of the patient at all times**.** On rare occasions more than one member of staff may be needed based on individual patient clinical risk. Clear guidelines must be written in CAREnotes and the care plan. A copy of the care plan must be kept with the enhanced observation chart. Review times and dates should be recorded in the care plan.

A **written entry** on the **appropriate chart**, at no less than **15 minute intervals**, must be completed. A summary of the patient's behaviour, mental state and risks indicated as well as any intervention must be entered into CAREnotes at the end of each shift.

Patients on Level 4 observation must be reviewed at least daily by the Nurse in Charge (or in his/her absence, by the Senior Nurse on Call) **in consultation with** the RC or nominated deputy (Duty Doctor), and a record of the review entered into CAREnotes and the observation documentation.

7. ALTERING THE LEVEL OF OBSERVATION

Any decision to increase or decrease the level of enhanced observation must be based on an assessment of the patient's clinical presentation.

The process should always involve the Nurse in Charge and a member of the MDT, usually the RC, and take into account:

- The patient's recent and past history
- The patient's view
- Staff observations and reports
- Progress against SMART care plan objectives to reduce Enhanced Observations
- Environmental factors

8. INITIATING AND DISCONTINUING ENHANCED OBSERVATION

The formal initiation of enhanced observation will be decided at ward level by the Nurse in Charge, although it is recognised that observations can be increased for

patients who generate concern whilst attending other departments. In this event, the ward must be notified immediately, the RC or nominated deputy will be informed at the earliest opportunity.

The Lead Nurse or equivalent (or in his/her absence the Senior Nurse on Call) is also empowered to reduce the level of observation following discussion with RC / nominated deputy and after consulting the staff and patient. The outcome of the consultation including the rationale must be clearly documented in CAREnotes.

9. OBSERVATIONS DURING THE NIGHT

It is important to aim to create an environment where patients can sleep comfortably throughout the night whilst maintaining patient safety.

On occasions patients may make requests for observations to be reduced during the night time whilst they are asleep. In these circumstances the MDT should complete a full risk assessment.

In making the decision the MDT should apply the Least Restrictive Principle as outlined in the Mental Health Act Code of Practice[5] and consider all risks as outlined in NICE Clinical Guideline NG10.

This should include:

- Suicide – have there been any concerns including recent attempts and verbalising intent?
- Self-Harm – Does the patient have a history of or have they recently attempted to self-harm or verbalised intent?
- Others – Does the patient have a history of targeting other patients on the ward? Is there an ongoing dispute? Is the patient vulnerable to others?
- Escape – Does the patient have a history of absconding / attempted absconding? Have they been behaving in a strange manner in the lead up to the request?
- Active Symptoms of Severe Mental Illness – Is the patient presenting with active symptoms of severe mental illness?
- Significant events – Has a request being made close to a significant event?
- Medication that has the potential to affect cardio respiratory functioning or seizure threshold
- Rapid Tranquilisation within the previous 24 hours
- Chronic health conditions / current physical illnesses including (but not limited to) heart disease; CPD; Epilepsy; Flu; Neuro Malignant Syndrome; Outbreaks of infection; Sleep apnoea and Concussion.

If the MDT agrees to reduce observations at night time these cannot be reduced beyond a minimum of once every 4 hours.

[5] Mental Health Act 1983 – Code of Practice England; Mental Health Act 1983 – Code of Practice Wales

Any care plans reducing routine night-time observations must be signed off by the Director of Nursing or equivalent prior to implementation. The pathway is outlined in Appendix B.

10. ROLES IN ENHANCED OBSERVATIONS Lead Nurse (or equivalent)

The Lead Nurse (or equivalent) will:

- Determine the resources needed to manage the ward;
- Review the patient's needs daily;
- Consider any restrictions placed on the patient to determine whether they are relevant to the safe management of the patient or the ward; and,
- Consider and act appropriately in respect of any complaint the patient may have about his/her care.

The Ward Manager in liaison with the lead nurse (or equivalent)

The Ward Manager or equivalent will:

- In discussion with the Lead Nurse, determine the resources required to manage the ward in light of the enhanced observation.
- Review the patient's needs daily; and,
- Review restrictions placed on the patient to determine whether they are relevant to the safe management of the patient and ward and whether the patient can be nursed within the general environment for the unit/Ward.
- Ensure that there are appropriate care plans for the safe management of the patient.

The Nurse in Charge

The Nurse in Charge will:

- Determine the appropriate level of observation and ensure that it is being maintained;
- Delegate staff to the observation(s). (Staff should not be involved in Level 2, 3 or 4 enhanced observation of the same patient continuously with the care of the patient being handed over at up to a maximum of 2 hourly intervals);
- Ensure that the risks are communicated to the observing staff;
- Discuss the care and management with the patient; and,
- If necessary, remind the Charge Nurse or Lead Nurse and/or RC or nominated deputy (Duty Doctor) of the need for the review.

Observing Staff

The observing staff will:

- Know who they are to observe;
- Be familiar with the patient's care and management plan;
- Facilitate interaction and communication with the patient where appropriate;

- Deliver planned activities with the patient where appropriate
- Record the patient's activity on the observation chart;
- Report any changes in the patients behaviour to the Nurse in Charge; and,
- Brief the observing staff taking over observation of the patient of any relevant changes.

Practice issues:

- All staff are responsible for ensuring ongoing observations of patients. When conducting both general and enhanced observations of patients, staff must make visual contact of the patient ensure and check that the patient is well and is responsive;
- A note of the patient's behaviour and interactions must be made. Any concerns must be reported immediately to the Nurse in Charge;
- Checks are to be conducted within the timeframes required as per observation level;
- Random spot checks must be conducted out of those timeframes;
- Staff must be aware of all patient risk issues.

If patients are in their bedrooms during both day and night time, staff must ensure that they:

- Make visual and physical observations of patients;
- Ensure that the patient is well;
- If the patient is in bed and/or under the covers, they must check for signs of breathing by namely:
  - Listening out for snoring;
  - Observing the chest to see if there is chest movement;
  - Feeling for breath, if they are laying down and face up;
  - Touch if appropriate and if they cannot get any response or establish any breathing
- Discretion must be exercised not to cause disruption and there must be a patient specific care plan regarding any patients with particular sleep problems.

RC / RMO or Nominated Deputy

The RC / RMO or nominated deputy (Duty Doctor) will:

- Provide regular and timely reviews of the patient on Level 3 and 4 enhanced observation;
- Record the review and any changes in management in CAREnotes and the observation documentation; and,
- During weekend periods a review should be made on Friday p.m. and again on Monday a.m. unless there is a duty doctor on-site in which case they must conduct a review.

Allocation of Staff

Every effort should be made to allocate observing staff who know the patient; attention should always be paid to issues of gender and cultural diversity, with a view to respecting the individual and forming the best understanding and rapport possible.

The Nurse in Charge is accountable for decisions to delegate observations to a Healthcare Worker (HCW) and they should ensure they have the necessary competencies.

Handover

Enhanced observations may involve a number of observing staff with the care of the patient being handed over at up to a maximum of 2 hourly intervals. Effective communication between observing staff is key to ensuring patient safety.

Before taking over the patient's care the observing nurse will have familiarised themselves with the patient's mental state, potential risks, patient attitude to the process and their recent clinical notes.

There will be a handover between observing staff and this will be recorded on the observation record. When possible, handovers should involve the patient.

Commissioners

The Lead Nurse or equivalent will inform the Registered Manager or Nominated Deputy that a patient has been placed on enhanced observation Levels 3 and 4, thus allowing a decision to be made on contacting both the commissioners and the clinical team regarding changes to the patient's presentation. A short term use of enhanced observation Level 3 and 4 may not require liaison however, long term (one week +) must include an update to external agencies to facilitate best practice and the opportunity for the external team to review the current treatment plan

11. DOCUMENTATION

Entry on the observation chart should, as necessary, indicate the patient's mood, behaviour, current level of engagement, and dietary intake.

The patient's behaviour and any intervention must be summarised in CAREnotes during every shift.

12. RESOURCE MANAGEMENT

Where extra staffing levels or adjustments in skill mix are indicated, the Nurse in Charge must liaise directly with the Lead Nurse, Charge Nurse, or Senior Nurse on-call, who will be responsible for making an assessment of the situation and where appropriate, reallocating staffing resources. Where possible, efforts should be made to absorb all levels of support within the agreed establishment.

To ensure that continuous observations are safe and supportive for staff, the Charge Nurse will organise a team reflective forum on a weekly basis whilst enhanced observation continues.

When enhanced observation Level 3 and 4 are required on a long term basis the need to pass on this cost will be made by the Registered Manager in line with the PiC review protocol.

13. AUDIT

As part of the PiC clinical governance framework regular clinical audits on the use of supportive observation will be carried out.

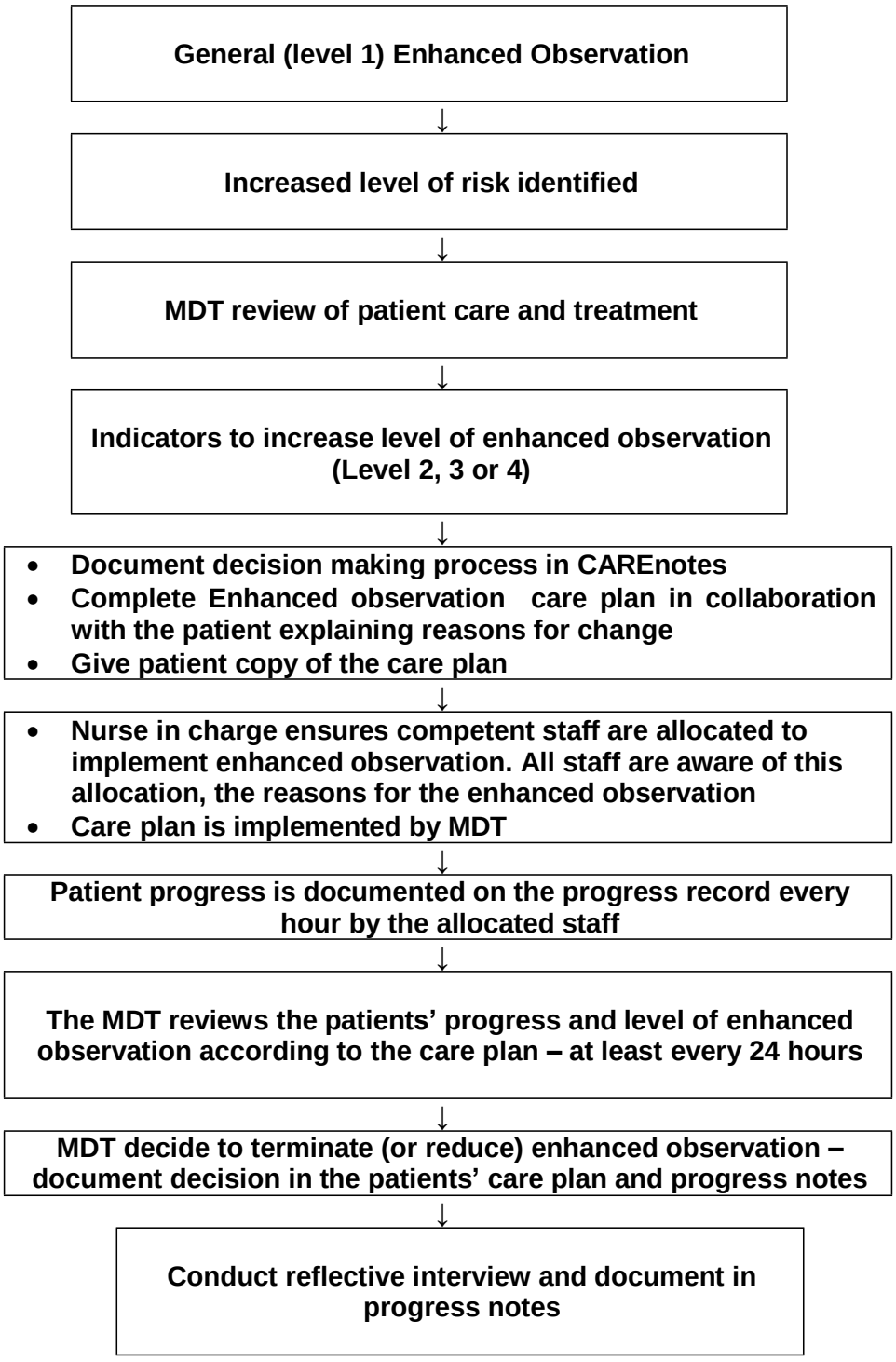
14. TRAINING

The Head of Department is responsible for ensuring that all staff within the department receives an appropriate induction and training specific to carrying out / implementing safe and supportive observation.

Enhanced Observation Competency Checklist

APPENDIX A

ENHANCED OBSERVATION PROCESS FLOWCHART



APPENDIX B

HOW TO MANAGE REQUESTS FROM PATIENTS WHO WANT TO REDUCE OBSERVATION INTERVALS WHILST THEY ARE ASLEEP