Safe and Supportive Observations Policy

Version: 5.3

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Target Audience:

This Policy must be understood by staff working in:

- Bed based units

Preface

P1 - Version Control History:
Below notes the current and previous Version

Version	Date of Issue	Author	Status	Comment
5.1	4th February 2013	Lead Nurse West SBU	Superseded	Appendix 3 – Observation Recording Form – Observation times changed from 20 mins – 15 mins
5.2	1st April 2015	Practice Development and Patient Safety Lead	Superseded	Updated for Mental Health Legislation
5.3	11th April 16		Current	Extended 12 months to allow full review

P2 - Relevant Standards:

a) NHSLA Risk Management Standards-Mental Health & Learning Disability.
6.5 Observation & Engagement of Patients. **See APPENDIX 1.**

b) Equality Standards: Equality Analysis is part of the Policy Development Process following the guidance and be documented on the EA Form. See **APPENDIX 5**

P3 - The 2012 Policy Management System (PMS) and Document Format:
The new PMS introduced in 2012 broadly comprises:

- **Trust Policy Website -** where all Policy Documents are available to everyone
- **New format for Policies -** designed to be accessible for staff to read & follow easily
- **New formal process -** for development and review of Policies

Symbols used in new Policy format:

RULE **= describes what the Trust requires for this part of the process**

STANDARD **= is a national standard which we must comply with**

All Trust Policies will change to the new format as Policies are reviewed every 3 years, or when national policy or legislation or other major change prompts a review. All expired & superseded documents are retained & archived and are accessible through the Policy Coordinator at Policies@hertspartsft.nhs.uk

Managers must bring relevant Policies to the attention of their staff. As current Policies are reviewed and re-published Managers should where possible, facilitate discussion as a group so that all members of the team are aware of what they need to do.

Staff, including students, are responsible for implementing requirements appropriate to their role, by reading relevant Policies and demonstrating to their manager that they understand the key points.

All current Policies can be found on the Trust Policy Website
http://trustspace/InformationCentre/TrustPolicies/default.aspx

PART 1 – Preliminary Issues

Accountable Staff Member
Undertake risk assessment

Nurse in Charge (Consultant or Doctor if available)

1. Agree plan (prescribing observations levels as per plan and review period)
   a. Describe, intensity, frequency and duration and current reasons for observations
   b. Specific interventions: e.g.: Random search, observation schedules and measurable criteria - behaviour, mood, engagement, activity or conversation
2. Allocate to competent practitioner to undertake levels of agreed observation:
   a. Agree formal review, document the process within EPR (Electronic Patient record)

General Observations

1. Explain level of observations to the service user
2. Regularly check and record location of the service user and view environment of any perceived risks and report
3. Maintain principles of Observation
4. Follow agreed plans for handover, formal review and consider changes in level of risk

Intermittent Observations

1. Explain levels of observations to the service user
2. Check and record location of service user (at least every 10 to 15 mins)
3. Maintain the principles of observation
4. Follow agree plans for handover, formal review and consider changes in level of risk

Continuous (Eyesight) / Continuous (Arm's Length)

1. Explain levels of observations to the service user
2. Attend to observations in a proactive and focused manner, acting upon any concerns and reporting risks immediately
3. Maintain the principles of observation
4. Follow agree plans for handover, formal review and consider changes in level of risk
5. Consider additional interventions such as, random search, anti-ligature risks, ongoing risk posed by the environment – REPORT if considered

Staff Handover: This can be hourly or at the point of shift handover - clear documentation written with explicit measure of what has happened describing the current status to new member of staff or the shift co-ordinator via written and verbal reporting.

Change in levels of observations: Identify reason for change in levels – report and recommend increase / decrease in level with clearly documented reason and review formally

Formal Review

1. Introduction

STANDARD

1.1 This document sets out policy and procedure to be followed by the staff of Hertfordshire Partnership University NHS Foundation Trust (the Trust) for the use of safe and supportive observations. The policy is based on the requirements of the Mental Health Act 1983 and Code of Practice 2015.

1.2 The Mental Health Act 2015 Code of Practice sets out a number of guiding principles which should be considered when making decisions about a course of action under the Act. **These guiding principles apply to all actions taken under the Mental Health Act.**

1.3 It is essential that all those undertaking functions under the Act understand the five sets of overarching principles which should always be considered when making decisions in relation to care, support or treatment provided under the Act.

1.4 The MHA Code of Practice stresses that the principles should be considered when making decisions under the Act. Although all are of equal importance the weight given to each principle in reaching a particular decision will depend on context and the nature of the decision being made.

1.5 The five overarching principles are:

1. **Least restrictive option and maximising independence**
2. **Empowerment and involvement**
3. **Respect and dignity**
4. **Purpose and effectiveness**
5. **Efficiency and equity**

Please see Appendix 1 for further information.

All Trust policies referred to in this policy are available on the staff website http://trustspace/InformationCentre/TrustPolicies/default.aspx

1.6 Hertfordshire Partnership NHS Foundation Trust is committed to the safety and well being of service users, staff and visitors. This document defines the standards to be employed relating to the safe and supportive observation of service users at risk to themselves and others. The policy is to be followed by Trust medical staff, nursing, allied health care professionals and support staff who are involved in the supportive observation of service users.

1.7 Most interactions and interventions we engage in are designed to support the service user in achieving their own goals; observation is deliberately designed to frustrate these aims towards specifically risky behaviours.

1.8 The practice of safe and supportive observation is a fundamental part of multi-disciplinary practice in both learning disability and acute psychiatry, which is an important part of the risk management of service users. It addresses the likelihood of service users intentionally or unintentionally harming themselves or others. It also seeks to protect those who are vulnerable, who may abscond or are liable to wander.

1.9 It is important to understand that observation is not a custodial activity but an opportunity to interact therapeutically on a one-to-one basis. When possible and when practicable the nurse should be the same gender as the service user in order to protect privacy and dignity and where possible we should offer choice of gender.

1.10 Safe and supportive observation represents a difficult and demanding element of supporting the service user during the acute phases of mental ill health for service user, nursing staff and relatives. The care provided for the person who may be deeply distressed and potentially at risk requires empathy and engagement combined with a readiness to act.

2.0 Purpose

2.1 Admission to any inpatient facility may mean the service user is a risk for health and safety reasons to themselves or others. As a consequence this will require an ongoing process of risk assessment; will require an agreed and supportive plan, which involves the services user and the carers, when practicable to do so - so all feel involved in decisions about their care. This should be undertaken using the appropriate levels of safe and supportive observation, undertaken in the least restrictive manner, as defined within this policy.

2.2 **RULE** This policy and the outlined procedures will establish a framework that ensures and an effective approach to Safe and Supportive Observations by:

1. By assessing and communicating the level of risk for each service user, based on need
2. Agreeing jointly, where appropriate the correct level of observations
3. Regularly reviewing and explaining to all parties the level of observation

2.3 **RULE** Individuals **will** be involved in decision making where possible with clear explanations given and recorded where this is not achieved. Reductions in levels of observation may also be appropriate where it can be demonstrated that observation is counter-therapeutic.

2.4 Safe and supportive observations should be used as a therapeutic activity - to engage through conversation and/or meaningful activity, whilst facilitating and building a therapeutic relationship. The decision to select supportive observation to enhance safety represents one aspect of a wider collaborative plan, which contributes to the delivery of the agreed outcomes of the individuals care pathway.

2.5 Formal observation systems should be flexible and not rigid, it is important that policy and clinical practice are not restrictive. This should enable the individual to develop coping strategies, encourage self management and reconnect with strengths away from deficits (From Chris Munt MBE 2010).

3. Definitions

3.1 Nursing observation can be defined as “regarding the patient attentively” while minimising the extent to which they feel that they are under surveillance. Encouraging communication, listening, and conveying to the patient that they are valued and cared for are important components of skilled nursing observation

STANDING NURSING
AND MIDWIFERY ADVISORY COMMITTEE
June 1999

Part 2 – What needs to be done and who by

4. Making Observation Supportive and Collaborative:

4.1 The aim of supportive observations is to engage positively, by listening to, learning from and acting upon the communications from the individuals concerned. Where possible the views of the service users and their carer should be sought and given consideration in the care planning process relating to observation.

4.2 Staff attitude towards observations: Staff will need to be aware of their own thoughts, feelings and attitudes about observation to ensure that they can convey the supportive and therapeutic role of intervention to the individual.

4.3 The process of observation must be sensitive to the individual. In particular, whenever possible and upon the request of the service use observations are carried out in a gender-sensitive way or when assessed appropriate because of known vulnerability.

4.4 This is especially pertinent to people subject to continuous observation. Issues of privacy, dignity and consideration of the gender in allocating staff need to be discussed and incorporated into the care plan, where this is compromised immediate action should be taken to correct this situation.

4.5 Where service users are on continuous or intermittent observation staff should endeavour to ensure that they receive both adequate fresh air and exercise on a daily basis, following risk assessment.

4.6 Care must also be taken to ensure that observations are carried out taking into consideration religious and cultural issues. Language issues must be considered as this may be contributing to the reluctance to communicate verbally.

4.7 Maintaining contact with friends and family: Visits to the service user may only be restricted by the Responsible Clinician, Nurse/Person in Charge. Whenever visiting is for any reason restricted the rationale for doing so must be clearly documented in the Service User's notes. If the service user is detained under the Mental Health Act, the guidance on visiting rights given in the Mental Health Act Code of Practice must be followed.

4.8 Including relatives: The aims and level of observation should be communicated, with the service user's approval, to the nearest relative, friend or carer, see service user information leaflet.

4.9 **RULE** Service User Information*:* The service user is entitled to information about why they are under observation and how long it will be maintained. Where appropriate, information should be provided in a written form and translated, if necessary, into the service user's own language. The level of observation must be

reviewed daily with the service user to give them the opportunity to discuss the process and their feelings about it with a staff member **(Appendix 2).**

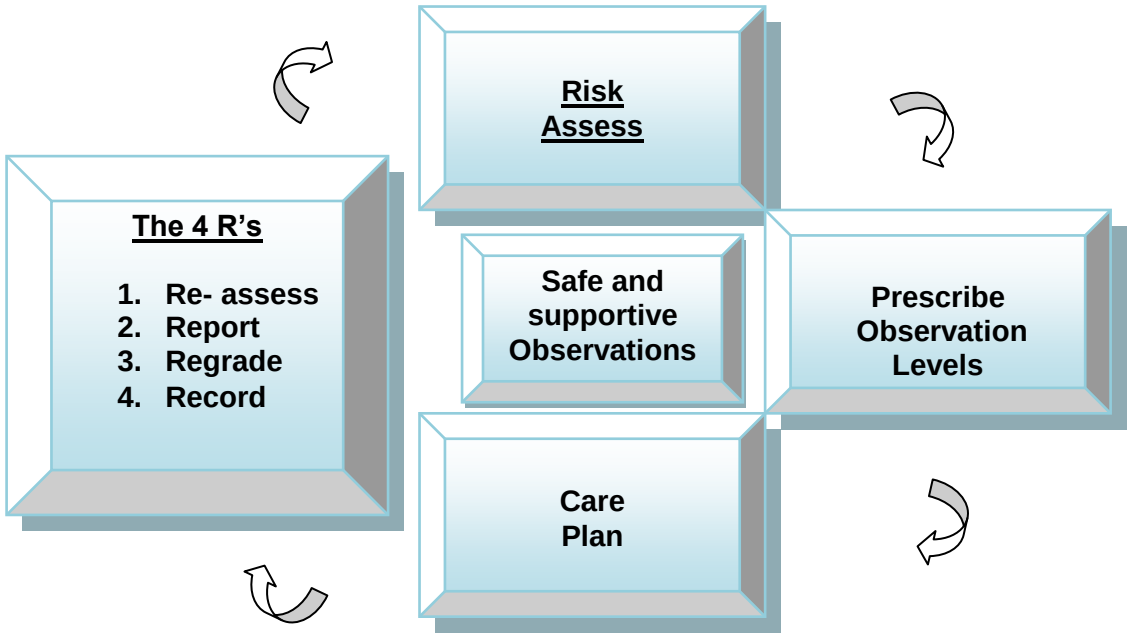
4.10 Visits by children must be assessed in accordance with the Hertfordshire Partnership NHS Trust Child Visiting Policy.

4.11 **STANDARD** Capacity: Where the service user is assessed not to have capacity the plan should reflect this. For further details refer to the HPFT Mental Capacity Policy*:*

1. *We should assume everyone has capacity to make choices, unless this is assessed differently*
2. *Where the person has difficulty in understanding the purpose of observation, every effort should be made to support them help them understand, through any necessary adjustments and least restrictive approach*
3. *A person can make a decision that others may consider unwise.*
4. *If the person is assessed to be unable to make the decision then the persons' best interests have to be followed.*
5. *Least harm, less restrictive.*

5.0 Assessing Risk

5.1 **RULE** All service users admitted to hospital will require some form of observation as prescribed within the supportive observation schedule. The allocation and the frequency of the observation will be determined in the initial and on-going risk assessment and the prescribed observation levels. This will reflect an updated plan with a process to update re-assess as and when presentation changes.



5.2 **RULE** Awareness of service user's history: Staff should be familiar with the service user's history, social context and significant events since admission. This should include awareness of the needs, assessment and overall plan of care drawn up by the multidisciplinary team and link to the principles as defined in the risk assessment policy.

Clinical Risk Assessment and Management Policy

5.3 ***RULE*** *New admissions or significant changes in presentation*: *Any new admissions or sudden changes in presentation will require a review of the current risk assessment and subsequent adjustment of the care plan to aid decision making around practice. Re-assessments during a service user's admission must be undertaken where any change in the individual is noted and documented in the risk assessment and the care plan.*

These include:

- Sudden alteration in usual behaviour
- Re-grading of legal status under the Mental Health Act
- Specific evidence of intentions to harm themselves or others
- Changes in life circumstances (separation, loss, employment)
- RE-ASSESSMENT MUST BE UNDERTAKEN WHERE THE RESPONSIBLE PROFESSIONAL CONSIDERS IT APPROPRIATE with an appropriate rationale recorded in the service user's care notes.

5.4 Periods of Increased Risk: The 'Safety First – five year report of the Confidential Enquiry into Homicide and Suicide by people with Mental Illness' (Department of Health), found that one fifth of in-patients who committed suicide were under non-routine observations (intermittent or constant) at the time they committed suicide. The Report identifies these periods of increased risk as being:

- Evenings and night
- Reduced levels of observation
- Gaps in continuous observation
- Apparent improvement in mood
- Any known triggers for the service user

5.5 **RULE** Higher Observation levels (intermittent and continuous): Service users on intermittent or continuous observations, would not routinely be allowed time off the ward/unit alone or allowed periods on escorted leave - without a review of risk.

If leave is a consideration, the following areas must be considered with regards to the risk assessment, before allowing leave:

- Any leave and the related support is least restrictive and proportional
- The views and wishes of the service user are considered at the time or in advance
- That it is safe to undertake the agreed leave, relative to the presenting concerns, balanced against privacy and safety where interventions are aimed to support therapeutic care
- That appropriate and proportionate staffing resources are in place to support any period of leave, with the necessary contingencies in place to manage risk, where practicable to do so.

Periods of leave are an important part of a service user's care plan and must always be considered in context to a full risk assessment, with consideration given to:

- Leave for ECT at another site or for (physical) medical treatment as well as part of a patient's recovery plan.

- Non-routine observations must not automatically be reduced in the evening or at night or to suit requests without consideration of all risks relative to the situation

- This must only take place following a risk assessment with the service user and or relatives / carers where appropriate

- Care plans must refer to observation level during increased periods of risk and be clearly documented with contingencies and known supportive factors agreed and secured

- The rationale for reducing observations must be clearly documented.

5.6 **RULE** Clinical Outcomes for Supportive Observations: The individual service user's ongoing risk assessment and multidisciplinary plan must reflect each stated aims; which should be easily accessible and clearly written plan for all team members. The plan should be routinely used as reference for practice and consulted by staff undertaking observation activity to enable them to carry out their task effectively, the plan should reflect and consider:

- Specific behaviours - (auditory hallucinations)
- Known responses - (agitation, aggression)
- Identified early warning signs - (hitting the wall)
- Action to be taken - (prevention, de-escalation)
- Contingency plan - (report/call staff)
- Frequency of recording

5.7 **RULE** Care Planning*:* Any prescription of supportive observation must be recorded in a care plan, which guides, reviews and evaluates the supportive observation process, this should include:

- Name

- Level of observation (frequency and intensity)

- Reason for observation

- Review of observation

- Documented changes in the level of observation

5.8 **RULE** Environmental risk assessment: Safety checks are undertaken as part of general observation and any points of concern reported and action taken. Environmental difficulties in observing service users are made explicit and remedial

action taken as far as possible. It is essential to understand that service users in UNOBSERVED or Isolated areas are at higher risk, contingency plans must be in place to assess the challenges of the environment, this should be clearly communicated and documented to support and advise all staff.

5.9 Property and personal search: It may be necessary to search the service user and their belongings whilst having due regard for service users legal and human rights. Follow the HPFT Policy "Searching service users and their Property." Staff carrying out observations should ensure fellow staff know their location if they leave communal areas.

5.10 Eliminating Mixed Sex Accommodation: Any breach of the above standards, where a member of the opposite sex requires care, mixing gender in the accommodation will require continuous observation (eyesight).

5.11 Rapid Tranquilisation: If the Rapid Tranquillisation is used to support the management of disturbed behaviour it is important that the appropriate levels of Supportive Observations are in place, as guided by the Rapid Tranquilisation policy.

Rapid Tranquillisation Policy

6.0 STANDARD Observation Levels:

6.1 The following information outlines the schedule of observations required to support decision making with regards to the prescription of observations in line with ongoing risk assessment and plan.

Supportive Observation Levels – Schedule

Supervision Level	Frequency	Comment
General	30 or 60 minutes	1. Depending on op policy and relating to the overall acuity of the patient population: e.g. - 1hourly in Rehab Units 2. 30 minutes in acute bed based units
Intermittent	At least four times in an hour at intermittent periods between 10 – 15 minutes	Time explicit in care plan, agreed risk assessment and review
Continuous	Eye sight	Proximity must be agreed by MDT and documented in the care plan

	Arm's Length	**Within arm's to enable to immediate intervention**

7.0 STANDARD General observation:

7.1 During a span of duty, the nurse responsible for the service users' care must be able to report at the end of the shift, on the service user's movements, actions, behaviour and mood.

7.2 General observations will be undertaken at 30 to 60 minute intervals unless agree differently in the operational policy of the individual service. This relates to 30 minutes general observations for Acute Units and 60 minutes in rehab units, this will need to be reflected in the Operational Policy, as determined by the (MDT) multidisciplinary disciplinary team.

7.3 General observations will enable the nursing team and the nurse in charge, to have a general awareness of the service users' whereabouts, any signs of deterioration, unusual occurrences or incidents in which the service user is involved and what they have done during the shift.

7.4 **RULE** The nurse responsible for the service users' care during the shift must make sure that their colleagues are made aware of any changes immediately. An entry must be recorded in the service user's notes at the end of each shift.

8.0 STANDARD Intermittent observations:

8.1 The observing nurse must observe the service user whereabouts at agreed intervals as per care plan and risk assessment, discreetly observing the patients movements, actions, behaviour, mood etc. This will enable the nurse to notice any signs of deterioration. Bowers et al (2011) advises a random approach to observations by varying slightly when observation will take place – this may mean approaching earlier than expected, whilst remaining within the agreed plan, this can be completing intermittent observations at least 4 times in an hour as per agreed risk assessment and care plan.

8.2. Intermittent observations at **the 5 minute** interval represent high risk and must not be used.

8.3. Service users on intermittent observation must not be granted leave from the ward/unit without the permission of the MDT. It may be agreed within the MDT and the service user's relatives, carers or friends that they will take responsibility for the service user's safety if all agree that the service user will benefit from a period of leave away from the unit. This must be documented in the notes and downgraded to general observations and reflected in the risk assessment appropriate.

8.4. Service users on intermittent observations should be encouraged to take part in the therapy programme. When a service user engages in therapy the therapist must be made aware of the service user's level of observations and the reasons they applied, additionally the appropriate resource must be allocated to support the facilitator of the group when considering the overall risk and contingencies agreed to manage any potential concerns.

8.5. The National Confidential Inquiry in Suicides and Homicides Report "Avoidable Deaths" (2006) concluded that "intermittent observation regimes provide long gaps in observation and they are unsuitable for the care of high risk patients unless additional measures are taken, such as the observation of ward exits. "In this context "high risk" is defined as "actively suicidal and/or homicidal" and as such should be risk assessed and a higher level of observation used to manage this risk. As a consequence there can be significant risks in relying on intermittent observations as a means of managing actively suicidal risk and so should not be used.

8.5 With regard to Intermittent observations and the risk posed, retrospective analysis of NRLS data of near miss suicides, Len Bowers et al (2010,), undertaken with the National Patient Safety Agency, reported, as part of a review of 600 near miss suicides, that intermittent observation was a useful method to detect and prevent suicide for those assessed as not requiring continuous observations. The key principles of this are as follows:

1. Increase checks (continue intermittent observations, i.e. in high risk areas and times, during the evening and during handover, target bedrooms, bathrooms and toilets).

2. Be awake, be aware, trust your instincts (attend to obvious and subtle cues, check without hesitation) be Caring, Vigilant and Inquisitive.

8.6. **In short, intermittent observations can be appropriate as a method of detecting and preventing suicidal behaviour. But they should never be used as the only means of managing actively suicidal risk.**

9. STANDARD Continuous observation:

9.1 Anybody on Continuous Observations, both eyesight and arm's length, should not be granted leave without a full risk assessment. If a period of leave is to be considered, this should take place in context to the benefits to the patient, potential risks, as well as a possible reduction in the schedule of observations, namely a reduction to intermittent and then general. This must be agreed by the MDT and be part of an on-going risk assessment and care plan.

9.2 Within Arm's Length - The observing nurse must maintain visual contact at approximately an arm's length contact at all times, observing the service user's movements, actions, behaviour, mood etc. This will enable the nurse to notice any

warning signs, possible suicide attempts, aggressive outbursts etc. The service user must be escorted everywhere, including to the toilet and bathroom by the observing nurse.

9.3 The observing nurse should try to occupy the service user with suitable activities if appropriate. However, it is important to bear in mind that the service user may be too ill to participate or may wish to remain silent.

9.4 Upholding the service user's privacy and dignity must be balanced against the safety of the service user, the nurse and others. During times when the service user is of high risk during Arms Length Observation, it may be necessary to employ additional interventions, which should be reflected in the risk assessment and care plan to guide staff undertaken safe and supportive observations these include:

- Random searches for ligatures or items that maybe used for self – harm
- Ensuring that the service user is observed with their arms above the sheets, to prevent undetected self – harm
- Managing the service user with tear free sheets to prevent the use of improvised ligatures
- Undertaking observations with the light on at night, to detect and observe
- Staff observe, without distractions, not reading, eating food or using mobile phones

9.5 The observing nurse must give a verbal and written update / report to the relieving nurse and report any unusual occurrences/observations to the nurse in charge. (This should be documented by the observing nurse, using the relevant recording sheets, with any significant events documented in care notes and communicated to the Nurse in charge of the shift).

9.6 Within Eyesight - The observing nurse must maintain visual contact at all times, observing the service users movements, actions, behaviour, mood.

9.7 This enables the nurse to notice any warning signs, possible suicide attempts, aggressive outbursts etc. The service user can use the toilet, bathroom etc alone but the observing nurse must maintain visual contact.

9.8 The observing nurse must try to occupy the service user with suitable activities if appropriate but it is important to bear in mind that the service user may be too ill to participate or may wish to remain silent.

8.9 Upholding the service user's privacy and dignity must be balanced against the safety of the service user, the nurse and others.

8.10 The service user must be accompanied to the therapy programme if attending. Service users should be encouraged to take part in the therapy programme but the observing nurse must maintain visual contact.

8.11 The observing nurse must record and give a verbal report to the relieving staff member and report any unusual occurrences/observations to the nurse in charge**.**

10.0 Changing safe and supportive observations:

10.1 Decision making: When possible any decisions regarding observations should be made jointly by the MDT. Where a joint decision on the appropriate level of observation cannot be made the nurse in charge/ Modern Matron or relevant manager will be involved.

Any sudden changes in presentation that the Service Users is experiencing suicidal thoughts or difficulty with impulse control MUST be reported to the nurse in charge of the ward.

10.2 Changes to Observations*:* The nurse in charge manages the level of observation in place, based on the agreed risk assessment and current care plan, which must be documented in a timely manner. The psychiatrist will be informed of decisions to decrease or increase as soon as practicably possible based on identified and communicated risk and in accordance with the agreed care plan.

10.3 Review of observation and forward planning: All observation levels at intermittent or continuous should be reviewed at the end of every shift and the risk assessment and plan every 24hours jointly with Doctors or 2x registered nurses, where practicable to do so. The review of observation should be planned in advance, particularly prior to weekends. This will ensure that service users are not left on increased levels of observations inappropriately and clarifying the circumstances that would enable a reduction in observation.

10.4 Supporting plan to downgrade observations*:* There must be a specific plan for each service user, which outlines the agreed changes in behaviour that would facilitate a reduction in observation level and the exact procedure for this decision to guide action. It must detail the role of duty medical staff or nursing staff in this process.

10.5 Reducing observation levels: In circumstances where risk levels are being reduced, the level of observation should be reviewed and changed by the multidisciplinary team following an assessment and risk review of the service user.

10.6 Increasing observation levels: of a service user may be done by a registered nurse or doctor. Any changes to the level of observation must be recorded by the registered nurse/doctor in the service user's notes and the multidisciplinary team notified.

10.7 Silent Hours and reviewing observations: During circumstances where the MDT is unavailable, at least two qualified professionals both of whom are involved in the service user's care and one being the nurse in charge of that shift, may review and

change the level of observation based on the agreed care plan and the most up to date assessment and risk review of the service user.

10.8 Additional resources and review: A medical team member responsible for the care will review the service user, with nursing staff, making any changes in the treatment plan. Where appropriate the co-ordinating Nurse and Team Leader will be informed to facilitate extra staffing if deemed appropriate, if the levels of continuous observations are increased to beyond one per shift.

10.9 **RULE** Daily Review: The level of observation should be reviewed on a daily basis and a risk review completed and recorded, with a review taking place at handover as part of the shift.

10.10 **RULE** Weekly Review of observations*:* The level of observation should be jointly reviewed by members of the MDT if the service user has been on continuous or intermittent observation for more than a week

11. Recording and reporting:

11.1 **RULE** what should staff report and record: All individuals being observed and reported on, will follow the guidance prescribed based on the latest risk assessment and plan, as agreed by the multi-disciplinary team (MDT). This will be on a shift by shift basis or in accordance with clinical need and as allocated by the nurse co-ordinating the respective shift. For all levels of observation, the person undertaking the task of safe and supportive observations should be able to report on the following areas related to the time undertaking the role:

- General behaviour
- Movements
- Posture
- Speech
- Expression of ideas
- Appearance
- Eating / dietary intake
- Mood, attitude and orientation
- Response to medication
- Physical condition**

** A baseline assessment of physical presentation must be recorded as part of the assessment / admission process to allow for later assessment and relevance of this in context to any deterioration of physical condition - (this will be managed with an appropriate ‘track and trigger’ tool when this is fully introduced)

11.2 **RULE** Recording: All decisions regarding observation should be recorded by the doctor or registered nurse in the individual's care notes, records should include, reference to or deviation from:

1. Current mental state
2. Care Plan
3. Current assessment or risk
4. Specific level of observation to be implemented
5. Clear directions regarding therapeutic approach
6. Timing of next review.

11.3 **RULE** Standards for record keeping: When completing written records all staff carrying out observations will keep a current and detailed record to include:

- The full name of the person responsible for the observation, in print (black ink only)
- Time of commencement and conclusion of their observation period (staff)
- Detailed record of the patient's behaviour, mental state and attitude to observation.
- The observation record must be maintained without any omissions
- Alterations or amendments to the observation record must not to be made

DO NOT RECORD OBSERVATIONS RETROSPECTIVELY

11.4 **RULE** Continuity and Communication*:* Observations may involve a number of staff with care being handed over at hourly intervals. Staff involved in observations should be involved in a group service briefing where practicable at the beginning of each shift including; which should form part of the shift allocation process.

- Introducing staff members involved in observation
- A review of service users' status in accordance with the care plan
- Potential dangers identified
- Involvement of carers where appropriate
- Ensuring staff have the competence to undertake the role
- Where practical to do so, a registered staff member should undertake continuous supportive observations at least once during the shift period for each set of observations

11.5 **RULE** Care Plans for Observation*:* - Every service user admitted must have a care plan for observation. Because of its restrictive nature, informed consent must be sought for informal service users.

11.6 **RULE** Observation Forms*:* Observation recording forms are part of the service user care record **(Appendix 3)** and must be completed contemporaneously and archived in line with the Clinical Information Retention and Disposal Schedule in the Trust Care Records Policy.

11.7 **RULE** Named Nurse*:* The named nurse must ensure that records are up to date; a record of the ongoing assessment of need, risk review and any changes must be recorded by staff in the service user's main care record and in any other documentation relating to the process of observation.

12. Communication:

12.1 **RULE** Handover: Communication between shifts should be undertaken via a recognised and structured handover based on the previous shift; this should be supported by multi–disciplinary / nursing care plans. It is recommended that the handover process is consistent and reliably communicates key information.

12.2 **RULE** Shift Evaluation: At the end of any shift the nurse in charge must ensure and clearly document and sign post to the forthcoming shift any significant changes that may impact on the current plan or care of schedule of assigned observations.

12.3 **RULE** Continuity of care: As a result of this, the nurse in charge and the supporting team must, in signing off the schedules of observation, be able to communicate any changes, advise and document any presenting risks so continuity of practise is continued over the shift period.

12.4 Involving the service user: Professionals involved in decisions regarding observation should be alert to current good practice and where possible, decisions agreed following discussion within the MDT and the service users and their carers should be based on risk assessment and risk review, which balances duty of care but does not eliminate the opportunity for empowering the service user to remain responsible for their own lives.

13. Staffing and Safe and Supportive Observations:

13.1 **RULE** No period of continuous observation by a member of staff should be longer than one hour unless deemed appropriate by both the observing nurse and the nurse in charge of the ward. Members of staff should have a change in duty from continuous observation for at least one hour. Team Leaders need to support staff involved in this difficult and demanding task. Exceptional circumstances may mean, a member of staff may need to continuously observe a service user for longer than one hour, e.g. when escorting a service user in an emergency.

13.2 Two to One observation and above: Where it is anticipated that service users' behaviour may become violent, resistive or destructive, and more than one member of staff needs to undertake observation, this should be agreed based on a review of risk and updated in the care plan.

13.3 Staffing and skill mix: The Team Leader (or on call manager during out of hours) and medical staff must have a discussion around capacity on the individual unit prior to admitting service users requiring formal observations if this is though to be of concern. Account should be taken of staff numbers and skill mix, and any related problems should be recorded and feedback to local patient safety/practice governance groups.

13.4 **RULE** Numbers on Supportive obs: Too many service users on continuous observations may increase the level of risk due to nursing staff being over extended and the nurse in charge should highlight this; two service users requiring continuous observation at a given time will require a change in staffing. Staff carrying out continuous observation should not be expected to respond to alarms unless in the event of dire necessity.

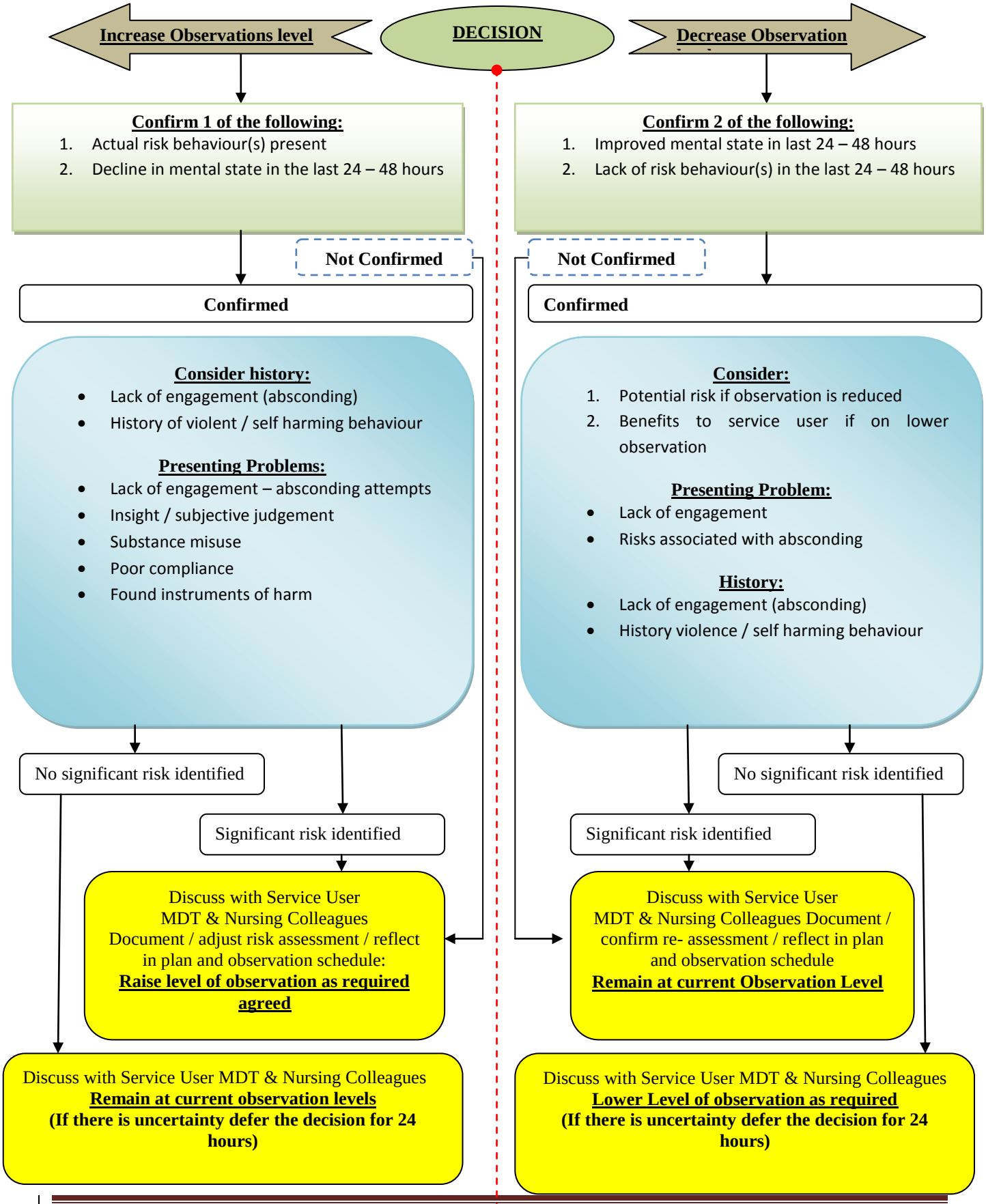
13.5 **RULE** Shift Allocation: of schedules of observation for all service users during any shift is undertaken by the accountable nurse in charge for that period of time. Accountability in this context is ensuring that all staff working on that shift are delegated the appropriate tasks and can competently and responsibly discharge their duties in undertaking safe and supportive observations.

14. Competence

14.1 **RULE** Competence: must be assessed for all staff members who undertake supportive observation, this includes **temporary** staff and **student** nurses, who are in their final year of practice. The Team Leader is responsible for ensuring that all staff have been assessed for this level of competence which should be developed alongside clinical risk and prevention of Violence Management training, please see **below** for schedule of competence.

14.2 Two Year Assessment: All staff deemed able to undertake supportive observations by the Team Leader or nurse in charge will have been assessed using the competency framework every two years or as deemed appropriate according to individual development requirements.

Decisions Flowchart



15. Training and Monitoring:

15.1 The Clinical Observation Competency Checklist should be completed for the relevant staff groups, including relevant new starters, in line with the requirements of the Trust's Mandatory and Risk Management Training Needs Analysis document. For agency nurses, a shift induction list should be completed. Please refer to the Risk Management Training Prospectus with regards to training requirements.

Process for monitoring compliance with this document –

Who	What	Assure
Registered Staff	Every two years supportive obs check (key Questions) Up to date Respect Training Up to date Risk training	Ward Manager/Team Leader Mandatory training Mandatory training
Unregistered Staff	Every two years supportive obs check (key questions) Unreg staff competency framework Up to date Respect Training Up to date Risk training	Ward Manager/Team Leader Mandatory training Mandatory training
Bank and Agency Staff	Every two years supportive obs check or shift checklist Up to date respect training Ward induction / introduction checklist Supportive obs check (key questions)	Ward Manager/Team Leader Mandatory training Mandatory training Bank Bureau
Student Nurses		
1ST Year	Observes and understands Observations: - Has read and reviewed the policy	Registered Nurse / Mentor
2nd Year	Undertakes joint observation with Registered Nurse: - As part of learning objectives - Reviewed and signed off by registered nurse	Registered Nurse / Mentor
3rd Year	Can Undertake Observation – under supervision: - Agreed by mentor - Having completed supportive obs check list	Registered Nurse / Mentor

16. Monitoring

STANDARD

Action:	Lead	Method	Frequency	Report to:
All staff who undertake Safe and Supportive Observation will complete a Competency Assessment	Unit Team Leaders	Complete form (Appendix A of Guidance on Assessment Appendix 4)	2 years	Local Patient Safety Meetings
Bank and temporary staff – unfamiliar with Safe and Supportive Observation – Complete a Competency 10 point check list	Unit Team Leaders	Complete a Competency 10 point check list – (Appendix C of Guidance on Assessment Appendix 4) Evidence stored in ward/unit folder	As needed	Local Patient Safety Meetings
Audit	PACE Team	Gather evidence demonstrating compliance	Annually	SBU Quality & Risk Group and PAIG
Action Plan	Lead Nurse	Review all incidents where recommendations have been identified	Annually	SBU Quality & Risk Group and PAIG
Clinical Care Annual Report of Clinical of Safe and Supportive Observation, Clinical Risk Assessment, and Rapid Tranquilisation	Lead Nurse	Summarising reports	Annually	Clinical Risk & Learning Lesson

PART 3 – Associated Issues

17. Full Version History

STANDARD:

Version	Date	Author	Status	Comment
3	June 2006	P Crosby	Superseded	Archived
4	August 2008	P Crosby	Superseded	Agreed by the Acute Care Forum 13th May 2008 and the Trust Executive on 19.8.08
4.1	August 2008 amended Dec 2009	P Crosby	Superseded	Monitoring requirements updated to NHSLA Level 3.
5.1	4th February 2013	Lead Nurse West SBU	Superseded	Appendix 3 – Observation Recording Form – Observation times changed from 20 mins – 15 mins
5.2	1st April 2015	Practice Development and Patient Safety Lead	Superseded	
5.3	11th April 2016		Current	Extended until 31.08.2016

17. Archiving Arrangements

STANDARD: All policy documents when no longer in use must be retained for a period of 10 years from the date the document is superseded as set out in the Trust Business and Corporate (Non-Health) Records Retention Schedule available on the Trust Intranet

A database of archived policies is kept as an electronic archive administered by the Policy Coordinator. This archive is held on a central server and copies of these archived documents can be obtained from the Policy Coordinator on request.

18. Supporting References

STANDARD:

1. Department of Health (2006) *Mental health observation, including constant observation: Good practice guidelines for staff working in prisons*

2. Patient Safety First 'How to Reduce Harm from Deterioration' *Patient Safety First website*

3. Standard Nursing and Midwifery Advisory Committee (1999) P*ractice Guidance. Safe and Supportive Observation of Patients at Risk*

4. University of Manchester website lists all the National Confidential Inquiries into Suicide and Homicide by People with Mental Illness (NCI/NCISH): http://www.medicine.manchester.ac.uk/

5. Learning from prevented suicide in psychiatric inpatient care: An analysis of data from the National Patient Safety Agency Len Bowers a,*, Charlotte Dack a, Noreen Gul b, Ben Thomas c, Karen James a (2011)

19. Associated Documents

STANDARD:

Clinical Risk Assessment and Management Policy
Rapid Tranquillisation Policy
Non-Physical and Physical Assault Policy

20. Comments and Feedback on this document were requested from:

STANDARD:.

In the case of the **Safe and Supportive Observation Policy**, the following have been consulted so far.

SCIP Trainers	
Head of Nursing and Patient Safety	
Lead Nurses	
Membership of the Senior Nurse Business & Strategy Meeting	All Senior nurses and Matrons – to teams on the Wards and units
Executive Director Quality & Safety / Deputy Chief Executive	
Dr Peter Simmons	PBR and Paris Design Lead
SBU West Clinical Director	Removal on 5 minute observations

APPENDICES & ATTACHMENTS - CONTENTS PAGE

National Health Litigation Authority Risk Management Standards for Trusts providing Mental Health and Learning Disability Services

6.5 Observation & Engagement of Patients

Organisations providing MH&LD services must have an approved documented process for the observation and engagement of patients.

Level 1
Your documented process must include:

a) duties
b) ***observation at differing levels***
c) how the organisation trains staff, in line with the training needs analysis
d) ***how observation is recorded***
e) how the organisation monitors compliance with all of the above.

Level 2
You must evidence implementation of your documented process in relation to:
— recording observation at differing levels.

The assessor will look at between 10 and 30 health records in current use in order to assess compliance. This will typically be equivalent to 10% of all daily admission numbers. To award a score the assessor will need to be assured that 75% of the records presented for this criterion meet the above minimum requirement.

Level 3
You must evidence monitoring of your documented process in relation to:
— recording observation at differing levels.

Where your monitoring has identified shortfalls, you must evidence that changes have been made to address them.
The assessor will look at between 10 and 30 health records in current use in order to spot check the organisation's monitoring results. This will typically be equivalent to 10% of all daily admission numbers.

If the spot check of health records does not demonstrate 75% compliance, these findings will override the evidence provided by the organisation and will result in no score being awarded for this criterion.

The full document can be found http://www.nhsla.com/NR/rdonlyres/6CBDEB8A-9F39-4A44-B04C-2865FD89C683/0/NHSLARiskManagementStandards201213FINALforwebsite.pdf

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Supportive Observation & Your Care

Name:	
Named Nurse:	
Ward:	

It is important to us you are involved in decisions about your care. You will be under a level of observation during your stay. This leaflet explains what you can expect, which will include a copy of your care-plan from your Named Nurse.

LEVELS OF OBSERVATION YOU WILL EXPECT & WHY.

WITHIN EYESIGHT OBSERVATION:
This is a higher level of observation that allows your care team to support you at all times. The nursing staff will not always be close to you, but they will be within "eyesight." The care team will always discuss with you your individual needs around your privacy and dignity.

You may be allocated escorted leave from the ward and your Named Nurse will be able to discuss this with you. You always be informed of status to remain and leave the ward.

WITHIN ARMS LENGTH OBSERVATION:
This is the highest level of observation we use to enable a member of the nursing staff to be close to you at all times to help
you with your current needs. The care team will always discuss
with you your individual needs especially related to privacy and
dignity.

Any leave off the ward is usually only allocated in exceptional circumstances whilst you are being nursed on this level of observation. You care team will explain why this is necessary.

**Each day your care team will review your needs in relation
to your observation level and you will be fully involved in
these discussions to resolve any problems or difficulties
you may face**.

WHY WILL BE DOING OBSERVATIONS?:

Observation is a form of ongoing assessment, used by your care team to help us understand how we can enable you to work towards recovery, whilst maintaining your safety and well being.

The process helps us to become aware of how you may be thinking and feeling so we can work together to assess any risks to yourself or others within the ward environment.

Observation allows your care team to offer you support so we can respond sensitively to your needs. We have different levels of observations, which we put in place subject to how we feel. This will be agreed in a plan and any changes will be shared with you in the form of a plan.

The level observation may mean staff follow you spending more time with you. This has a bearing on your movements on the ward, which may restrict when you exit and enter the ward. Your status and movements on the ward will be explained to you by your Named Nurse or Associate Nurse, who will make themselves known to you. If you have any concerns please ask to speak to the Nurse in Charge – one will be available 24 hours per day.

LEVELS OF OBSERVATION:

Everybody on the ward is nursed on a level of observation; there are 4 levels of observation:

GENERAL OBSERVATION:

This is the minimum level of observation which most patients can expect during their stay in hospital. The nursing staff are however required to know where you are all of the time therefore we ask that if you are allocated leave from the ward you let us know as you leave and return.

INTERMITTENT OBSERVATION:

This is an increased level of observation, used to ensure that nursing staff are regularly available for you to improve your wellbeing and help you to feel safe on the ward. Staff will approach you act at an agreed time interval, to see how they can best support you. You will also be given the opportunity to discuss what you feel is helpful as part of your care-plan You may be able to leave the ward but these needs to be agreed with the staff involved in your care.

Policy Relating To the Supportive Observation of Service Users at Risk

Observation Recording Forms

The following Hertfordshire Partnership NHS Trust recording forms are attached:

- Supportive Observation Record Continuous Observations
- Supportive Observation Record Intermittent Observations
- 30 Minutes Service Users/Ward/Unit Check
- Hourly Service Users/Ward/Unit Check

SUPPORTIVE OBSERVATION RECORD - CONTINUOUS OBSERVATIONS

CONTINUOUS OBSERVATIONS				PAGE NO:
Name:		DOB:		1 of ( )
Reason for Observation:				
Type of Continuous Observation ✓	Eyesight		Arms Length	
Date and time commenced		R/C		

Risk Assessment in place Review by Nurse In charge ✓	Care plan in place	Date	Review	Initials

Hourly Observation Summary: - Comment on behaviour/mood/thought, main location and any other details			
✓	Document any ticked change:		Comments & time:
		Time	
	Asleep		
	Awake		
	Medication		
	Mood change		
	Behaviour change		
	Consultation required		
	Therapeutic activity		
	Obs level changed		
	Other		
Time of handover:			Signature and Name / Title

Hourly Observation Summary: - Comment on behaviour/mood/thought, main location and any other details .			
✓	Document any ticked change:		Comments and time:
		Time	
	Asleep		
	Awake		
	Medication		
	Mood change		
	Behaviour change		
	Consultation required		
	Therapeutic activity		
	Obs level changed		
	Other		
Time of handover:			Signature and Name / Title

CONTINUOUS OBSERVATIONS – continuation				PAGE NO:
Name:		DOB:		1 of ( )

Reason for Observation:				
Type of Continuous Observation ✓	Eyesight		Arms Length	
Date and time commenced		R/C		

Risk Assessment in place Review by Nurse In charge ✓	Care plan in place	Date	Review	Initials

Hourly Observation Summary: - Comment on behaviour/mood/thought, main location and any other details

.

✓	Document any ticked change:		Comments and time:
		Time	
	Asleep		
	Awake		
	Medication		
	Mood change		
	Behaviour change		
	Consultation required		
	Therapeutic activity		
	Obs level changed		
	Other		

Time of handover:	Signature and Name / Title

Hourly Observation Summary: - Comment on behaviour/mood/thought, main location and any other details

.

✓	Document any ticked change:		Comments and time:
		Time	
	Asleep		
	Awake		
	Medication		
	Mood change		
	Behaviour change		
	Consultation required		
	Therapeutic activity		
	Obs level changed		
	Other		

Time Observed:	Signature and Name / Title

SUPPORTIVE OBSERVATION RECORD INTERMITTENT OBSERVATIONS

INTERMITTENT OBSERVATIONS SHEET				PAGE NO: 1 of ( )
Name:		DOB:		
Reason for Observation:				
Date and time commenced		R/C		

Level of Intermittent Observation	✓	Risk Assessment	Care plan in place	Date	Review	Initials
10 mins						
15 mins						

For each observation Time	Initial	Hourly Observation Summary: Comment on behaviour/mood/ thought, location and any other details: ✓	
		☐ Asleep ☐ Awake ☐ Medication ☐ Mood change ☐ Behaviour change ☐ Consultation sought ☐ Therapy ☐ Obs level changed ☐ Other	
Signature Name/Title for hourly summary: ✓			
Time	Initial	☐ Asleep ☐ Awake ☐ Medication ☐ Mood change ☐ Behaviour change ☐ consultation ☐ Therapy ☐ Obs level changed ☐ Other	
Signature Name/Title for hourly summary:			

UNIT _____ **30 MINUTES SERVICE USERS/WARD/UNIT CHECK** **Date** _____

Each member of staff on shift will, in turn, take responsibility to check the ward/unit and the whereabouts of all the service users. Please report and record any points of concern regarding service users or the environment. If you observe anything of an untoward nature please report it to the Nurse-in-Charge for immediate action. If a check has not been carried out the Nurse-in-Charge of the shift must record the reason overleaf.

SERVICE USER		07 00	07 30	08 00	08 30	09 00	09 30	10 00	10 30	11 00	11 30	12 00	12 30	13 00	13 30	14 00	14 30	15 00	15 30	16 00	16 30	17 00	17 30	18 00	18 30
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Staff Initial:																									

UNIT _____ **30 MINUTES SERVICE USERS/WARD/UNIT CHECK** **Date** _____

Each member of staff on shift will, in turn, take responsibility to check the ward/unit and the whereabouts of all the service users.

Ensure that the whole ward/unit environment is checked ie bathrooms, Bedrooms, Bays, Toilets. Please tick when service users are on the ward/unit or put relevant code for their whereabouts. Ie O/L = On leave, WR = Ward round, OP=Outpatient, DH=Day hospital, HV= Home visit, W=walk

Please report and record any points of concern regarding service users or the environment. If you observe anything of an untoward nature please report it to the Nurse-in-Charge for immediate action. If a check has not been carried out the Nurse-in-Charge of the shift must record the reason overleaf.

SERVICE USER		19 00	19 30	20 00	20 30	21 00	21 30	22 00	22 30	23 00	23 30	00 00	00 30	01 00	01 30	02 00	02 00	03 00	03 00	04. 00	04. 30	05. 00	05 30	06 00	06 30
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Staff Initial:																									

Ensure that the whole ward/unit environment is checked ie bathrooms, Bedrooms, Bays, Toilets. Please tick when service users are on the ward/unit or put relevant code for their whereabouts. Ie O/L = On leave, WR = Ward round, OP=Outpatient, DH=Day hospital, HV= Home visit, W=walk

Unit: 30 Minutes Service User/Ward Environment Check Date

Time	Record of concern regarding service user or environment or check not carried out	Signature

Ensure that the whole ward/unit environment is checked ie bathrooms, Bedrooms, Bays, Toilets. Please tick when service users are on the ward/unit or put relevant code for their whereabouts. Ie O/L = On leave, WR = Ward round, OP=Outpatient, DH=Day hospital, HV= Home visit, W=walk

UNIT _____ **HOURLY SERVICE USERS/WARD/UNIT CHECK**

Date _____

Each member of staff on shift will, in turn, take responsibility to check the ward/unit and the whereabouts of all the service users.

Please report and record any points of concern regarding service users or the environment. If you observe anything of an untoward nature please report it to the Nurse-in-Charge for immediate action. If a check has not been carried out the Nurse-in-Charge of the shift must record the reason overleaf.

SERVICE USER	07 00	08 00	09 00	10 00	11 00	12 00	13 00	14 00	15 00	16 00	17 00	18 00	19 00	20 00	21 00	22 00	23 00	00 00	01 00	02 00	03 00	04 00	05 00	06 00
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Ensure that the whole ward/unit environment is checked ie bathrooms, Bedrooms, Bays, Toilets. Please tick when service users are on the ward/unit or put relevant code for their whereabouts. Ie O/L = On leave, WR = Ward round, OP=Outpatient, DH=Day hospital, HV= Home visit, W=walk

Unit: _____ 1 Hourly Service User/Ward Environment Check Date _____

Time	Record of concern regarding service user or environment or check not carried out	Signature

Ensure that the whole ward/unit environment is checked ie bathrooms, Bedrooms, Bays, Toilets. Please tick when service users are on the ward/unit or put relevant code for their whereabouts. Ie O/L = On leave, WR = Ward round, OP=Outpatient, DH=Day hospital, HV= Home visit, W=walk

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APPENDIX 4

Guidance on the Assessment And the Development of Competence Safe and Supportive Observation

Ensure that the whole ward/unit environment is checked ie bathrooms, Bedrooms, Bays, Toilets. Please tick when service users are on the ward/unit or put relevant code for their whereabouts. Ie O/L = On leave, WR = Ward round, OP=Outpatient, DH=Day hospital, HV= Home visit, W=walk

1.0 This document has been produced to support Team Leaders and Charge Nurses in developing a process of assurance and monitoring for competence in Safe and Supportive Observations.

2.0 Assessment Process: For Substantive staff members and assessment of competence should be undertaken every two years (Appendix 2). The process of assessment has 3 possible outcomes:

1. Passing the assessment – completed
2. Re-asses and pass – requiring some additional prompts
3. Fail – Unable despite additional prompts and input – **stopped from doing Observations with plan agreed to support.**

3.0 The attached document (Appendix B) is a completed assessment with model answers that will support the assessment process and as such will support your final judgement.

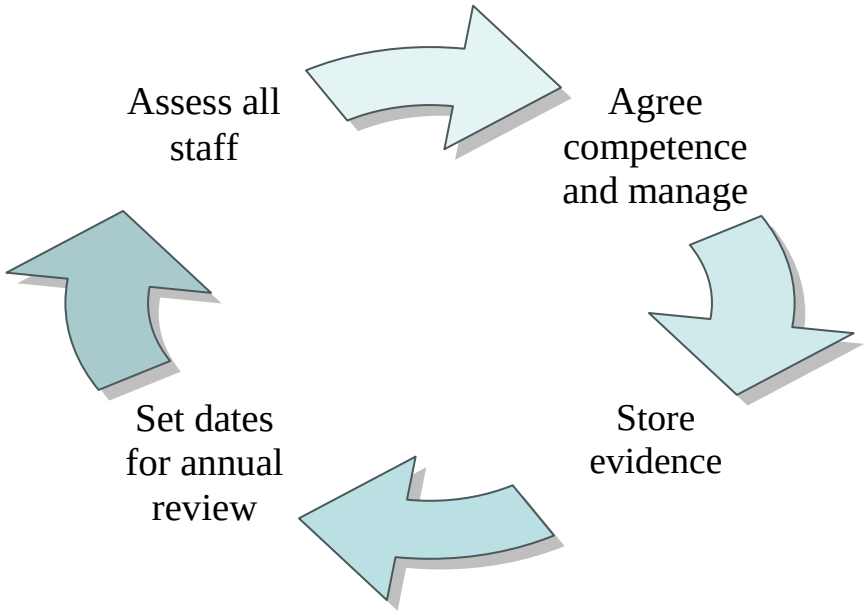

Fig 1

4.0 Team Leaders: It is important that this process is completed every 2 years for all substantive staff training, that Team Leaders have in place a process and evidence that all staff can competently do Safe and Supportive Observations (Fig 1). Registered Nurses running shifts should understand the overall ability of all staff members to undertake Safe and Supportive Observations which should reflected in a locally available register of Staff every 2 years and be available for reference purposes see attached.

Ensure that the whole ward/unit environment is checked ie bathrooms, Bedrooms, Bays, Toilets. Please tick when service users are on the ward/unit or put relevant code for their whereabouts. Ie O/L = On leave, WR = Ward round, OP=Outpatient, DH=Day hospital, HV= Home visit, W=walk

5.0 The Nurse In Charge (NIC) (10 Point Check List) – Bank and Agency Staff:

The Nurse in charge (NIC) of any given shift needs to be satisfied that temporary members are competent and that this is covered in their induction, with evidence to support this process. The following 10 point checklist should be used to competence outside the annual training process (Appendix C).

Ensure that the whole ward/unit environment is checked ie bathrooms, Bedrooms, Bays, Toilets. Please tick when service users are on the ward/unit or put relevant code for their whereabouts. Ie O/L = On leave, WR = Ward round, OP=Outpatient, DH=Day hospital, HV= Home visit, W=walk

Appendix A

Ensure that the whole ward/unit environment is checked ie bathrooms, Bedrooms, Bays, Toilets. Please tick when service users are on the ward/unit or put relevant code for their whereabouts. Ie O/L = On leave, WR = Ward round, OP=Outpatient, DH=Day hospital, HV= Home visit, W=walk

Assessment of competence for carrying out formal levels of engagement/observation

Name: ……. Name of Assessor: ….....

Date of assessment: …….Date.....

Have you reviewed the Hertfordshire Partnership Supportive Observation policy?

Name:

Designation:

Date:

Signature:

1) Describe the different levels of observation and the reasons for doing these?

2) What would you do if you thought that a service user required a different level of observation?

3) What resources or information would you consider when reporting and recording a period of observation?

4) What circumstances can a service user leave the ward and why would a service not be allowed to leave the ward?

5) What factors would you consider if you were observing a patient of the opposite gender?

6) What would you do if the PIT alarms were activated on another part of the ward, or other ward and you were doing engagement/observation?

7) What would you do if a service user refused to engage with continuous observations?

8) How would you explain observations to the patient and their visitors?

9) Describe 2 approaches you would use to engage a Service User in Supportive Observation?

Ensure that the whole ward/unit environment is checked ie bathrooms, Bedrooms, Bays, Toilets. Please tick when service users are on the ward/unit or put relevant code for their whereabouts. Ie O/L = On leave, WR = Ward round, OP=Outpatient, DH=Day hospital, HV= Home visit, W=walk

10) What approach would you take if you believed the person you were observing had a weapon or method that could harm themselves or others?

Passed: ☐ Reassess/ Pass: ☐ Fail: ☐ Stop obs – agree plan to improve

Reassess/ Pass: What prompts required:
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Ensure that the whole ward/unit environment is checked ie bathrooms, Bedrooms, Bays, Toilets. Please tick when service users are on the ward/unit or put relevant code for their whereabouts. Ie O/L = On leave, WR = Ward round, OP=Outpatient, DH=Day hospital, HV= Home visit, W=walk

Appendix B

Staff Register of Supportive Observations (annual assessment) Ward: Year:		
Staff Name	Designation	Date

Appendix C

The Nurse In Charge (NIC) (10 Point Check List) for Competency in Supportive Observations Bank / Agency or staff new to Unit			
No	Area	Yes ✓	No ×
1	Understands the policy		
2	Standards around documentation / timing reporting of observations is clear		
3	Understand the rationale for observations		
4	When to escalate concerns and summon assistance		
5	The specifics and schedules of observations		
6	Understands supporting plans & risk assessment to include AWOL		
7	Understands formal handover - written and verbal		
7a	Introduction to the Service User		
8	Responsibilities in an emergency (Medical / Fire / Psychiatric)		
9	Managing breaks and continuity of care		
10	Providing detailed information between handover period in written and verbal reports		
	Considered competent to undertake Observations		

Name of Inductee: Signature:						
Designation:						
Date:						
Name of unit / ward:						
Shift: ✓	Early		Late		Night	
Complete as appropriate:						
NIC: Signature: Bank: Name of Agency:						

Equality Analysis

Equality Analysis Record Form for Trust Policies

A copy of the Equality Analysis Core Guidance is available on Trust Space

To be completed by the Policy Author	
Name of Policy	**Safe and Supportive Observations**
Description of Policy	**Safe and Supportive Observations for Service Users who are admitted to bed based services, who require a graded review of risk or regular intervention based on presenting risk.**
Authors Name	**Andrew Cashmore**
Job Title	**Lead Nurse – SBU West**
Date	**18 May 2012**
Is this for a New or Reviewed Policy?	**Yes**
Have you completed the Trust's E-Learning on Equality and Diversity	

The Trust, as a Public Sector Organisation has an equalities duty. There are 3 main aims, please show how these are taken into account in this Policy.	
Eliminate unlawful discrimination, harassment and victimisation.	**All Service users admitted to an inpatient facility will require a degree of observations, as assessed by their presenting risk.** **These observations, which are in place to engage service users therapeutically or to manage and support in circumstances when risk is considered to be higher – mean higher levels of observation will seek to purposefully frustrate their desire to harm themselves, by undertaking and observing closely .**

	As part of the process of admission the Service User and their relatives, where appropriate will be given information of Safe & Supportive Observation, so they understand the purpose and function of this level of observation – when a different language is spoken – the policy recommends that the appropriate translations takes place. This impacts on a range of service users: **1. The context of very close observation (continuous observation) – will mean the service user will loose autonomy because they are being observed and being constantly supervised and controlled within an agreed plan** **2. This process maybe in place for a significant period of time as defined and reviewed as part of the on-going risk assessment** **3. This impacts on gender in terms of who undertakes these observations, in this instance the policy advocates a choice of gender** **4. A breech in Eliminating Mixed Sex Accommodation standards, when additional observation is required, because these standards are breeched**
Advance equality of opportunity between different groups.	**As stated above the issues relating to gender have an impact and are managed via EMSA standards and the choice of gender when managing the observation levels**
Foster good relations between different groups.	

More specifically, has the policy addressed the needs of any of the protected groups in a positive or negative way? For those that apply, please complete all the boxes below.

Protected Characteristic (under the Equality Act 2010)	**Positive**	**Negative**	**Any Concerns**	**Reasons** supported by any evidence you have gathered	**Actions** to address areas of concern
Age: E.g. older or younger people Race: people from different ethnic groups					
Disability: physical/sensory/learning/ mental/other health			x	**This may have an impact for services user who are assessed as lacking capacity either via the Mental Health Act or the Mental Capacity**	**Where appropriate reasonable adjustments are considered and least restrictive interventions considered via the appropriate policy framework and developed into the ongoing risk assessment and plan**
Ethnicity/Race: inc issues relating to ethnicity & culture					
Gender (sex): Men/Women			x	**Continuous observations will impact on gender choice**	**Gender is considered when undertaking and where possible a gender choice is given**
Gender reassignment: the process of transitioning from one gender to another (Trans)					
Marriage or civil partnership (inc next of kin, nearest relative etc)					
Pregnancy or maternity			x	**Additional risks exist when managing pregnant service users**	**Gender is considered when undertaking and where possible a gender choice is given**
Religion/belief:					

people who holding religious and non religious beliefs.					
Sexual orientation: lesbian, gay or bisexual, heterosexual etc.					

What Equality information, if any, has influenced this Policy?	Please explain any you have used below.
Service user demographic data	Observations are undertaken for all inpatient
Staff demographic data	
Results of consultation	
Results of Staff Survey	
Results of Service User survey	
National research into inequality in healthcare	
Other (please specify):	

To be completed by the Policy Panel	
The Outcome of analysis and the recommendation is:-	
No major change needed: equality analysis has not identified any potential for discrimination for adverse impact and all opportunities to promote equality have been taken	
Adjust the policy to remove barriers identified by equality analysis or to better promote equality	
Stop and remove the policy/strategy/service or proposal as equality analysis has shown actual or potential unlawful discrimination	
Adverse impact - but continue. If this is selected you should consider whether there are sufficient plans to reduce the negative impact and/or plans to monitor the actual impact and list clear actions of how any mitigating measures will be implemented (including timescales).	
Summary to support the decision and any further advise.	

Name	**Dawn De Coteau**
Department	**Equalities Project Manager**
Date	**15/6/2012**

RECOVERY PRINCIPLES

WHICH UNDERPIN ALL FORMS OF CARE PROVIDED WITHIN THE TRUST

Principles of Recovery Oriented Practice, which underpin all our services are:

1. Individual uniqueness and user centrality to service provision: *in practice:*

- recognises that recovery is a personal journey and unique for each individual.
- understands that Recovery is not necessarily about cure. Recovery outcomes are personal and unique for each person and go beyond an exclusive health focus to include an additional emphasis on social outcomes and quality of life.
- places individuals at the centre of the care they receive. Through a person centred and needs led approach, individual recovery outcomes are achieved.

2. **Real Choices:** *in practice:*

- supports people to make their own choices about how they want to lead their lives and acknowledges choices need to be meaningful and creatively explored.
- supports people to build on their strengths and to take as much responsibility for their lives as they can at any given time.
- is proactive in supporting people to take positive risks and to make the most of new opportunities whilst balancing responsibilities for duty of care.

3. **Attitudes and Rights:** *in practice:*

- involves listening to, learning from and acting upon the communications from individual service users, their relatives and others about what is important to each person.
- promotes and protects people's legal and citizenship rights
- supports people to maintain and develop meaningful social, community, recreational, occupational and vocational activities.

4. Dignity and Respect: *in practice:*

- consists of being courteous, respectful and honest in our interactions.
- involves sensitivity and respect for each individuals values and culture.
- challenges discrimination and stigma wherever it exists both within our own services and the broader community.

5. Respectful Partnerships: *in practice:*

- acknowledges each person is an expert on their own life and that recovery involves working in respectful partnership with individuals, their relatives and carers to provide support in a way that makes sense to them.
- acknowledges the importance of the sharing appropriate information and the need to communicate clearly and to enable effective engagement with services.
- involves working in hopeful, positive and optimistic ways with people who use our services, their families and carers, and the communities within which they live, to support them to realise their own hopes, goals and aspirations.

Guiding Principles – MHA Code of Practice, Chapter 1

It is essential that all those undertaking functions under the Act understand the five sets of overarching principles which should always be considered when making decisions in relation to care, support or treatment provided under the Act.

The MHA Code of Practice stresses that the principles should be considered when making decisions under the Act. Although all are of equal importance the weight given to each principle in reaching a particular decision will depend on context and the nature of the decision being made.

The five overarching principles are:

- ***Least restrictive option and maximising independence***
  Where it is possible to treat a patient safely and lawfully without detaining them under the Act, the patient should not be detained. Wherever possible a patient's independence should be encouraged and supported with a focus on promoting recovery wherever possible.

- ***Empowerment and involvement***
  Patients should be fully involved in decisions about care, support and treatment. The views of families, carers and others, if appropriate, should be fully considered when taking decisions. Where decisions are taken which are contradictory to views expressed, professionals should explain the reasons for this.

- ***Respect and dignity***
  Patients, their families and carers should be treated with respect and dignity and listened to by professionals.

- ***Purpose and effectiveness***
  Decisions about care and treatment should be appropriate to the patient, with clear therapeutic aims, promote recovery and should be performed to current national guidelines and/or current, available best practice guidelines.

- ***Efficiency and equity***
  Providers, commissioners and other relevant organisations should work together to ensure that the quality of commissioning and provision of mental healthcare services are of high quality and are given equal priority to physical health and social care services. All relevant services should work together to facilitate timely, safe and supportive discharge from detention.

Terminology	How it is to be understood	Exceptions
Must	Reflects legal obligations which it is essential to follow	No exceptions
Should	For those to whom this is statutory guidance see paragraphs II – V For those to whom it is not statutory guidance VI – VII	See paragraphs II – VII. Any exceptions should be documented and recorded including the reason for this. Patients, their families and carers, regulators, commissioners and other professionals may ask to see this
May/could/can	Reflects guidance to be followed wherever possible	Good practice but exceptions permissible

Our Values	we are...	you feel...
	Welcoming	Valued as an individual
	Kind	Cared for
	Positive	Supported and included
	Respectful	Listened to and heard
	Professional	Safe and confident

Our Values

Welcoming Kind Positive Respectful Professional