Livewell Southwest

Supportive Observation within Mental Health Units

Version No 3.1

Review: May 2019

Notice to staff using a paper copy of this guidance.

The policies and procedures page of LSW intranet holds the most recent version of this document and staff must ensure that they are using the most recent guidance.

Author: **Modern Matron – Glenbourne Unit**

Asset Number: **663**

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	Advanced Nursing; Volume 32.1 2002 Wyder M (2004) Understanding deliberate self harm: an enquiry into attempted suicide. The City 128 Study of Observation and Outcomes on Acute Psychiatric Wards bowers et al December 2006. Research Report. Produced for the National Co-ordinating Centre for the National Institute for Health Research Service Delivery and Organisation Programme (NCCSDO)
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Document review history

Version No.	Type of change	Date	Originator of change	Description of change
For previous review history please contact the PRG secretary.				
2	Ratified	June 2011	Policy Ratification Group.	Minor typo's
2.1	Updated	July 2013	Modern Matron, Glenbourne Unit	Updated
2.2	Extended	September 2014	Modern Matron, Glenbourne Unit	Extended no changes
2.3	Extended	April 2015	Modern Matron, Glenbourne Unit	Extended no changes
3.0	Rewritten	February 2016	Modern Matron Glenbourne	To reflect changes in evidence base and practice.
3.1	Minor amendment	November 2016	Modern Matron Glenbourne	Minor amendment

Supportive Observation within Mental Health Units

1 Introduction

1.1 Engagement by way of structured observation, is an integral part of preventing or minimising the risk of harm to a person or people within an inpatient unit.

1.2 The purpose of observation is to ensure the sensitive monitoring of the patient's behaviour and mental state, enabling a rapid response to any change, whilst at the same time fostering positive therapeutic relationships through engagement. This may be achieved by establishing good rapport with patients, promoting their coping skills and being aware of their individual needs.

1.3 The intensity of observation should be tailored to meet a person's needs in a variety of ways, and while safety of all must be of ultimate concern, it is necessary to balance this with the potential harm of observation which might feel restrictive or prevent a person's recovery.

1.4 The aim of this policy is to secure therapeutic engagement between clinical staff and patients in order to reduce harm. The policy provides a framework for standard and enhanced levels of observation when patients are considered to be at risk or require additional support. This policy offers guidance on carrying out observations in a way which involves minimal restriction on a person, minimises conflict, and promotes dignity by involving people in how these observations are carried out. These principles are guided by the updated Mental Health Act Code of Practice (2015), and NICE Guidance for Violence and aggression: short term management in mental health, health and community settings (2015).

2 Purpose

2.1 The policy is to guide staff in the implementation of observation within an in-patient setting.

3 Definitions

3.1 MDT – Multi Disciplinary Team - a group of multi professional staff who are involved in the treatment of the service user.

3.2 People / persons - the terms are used throughout the policy and refer to the service user being observed in every service. This is in order to prevent confusion in terminology which may be different in each setting.

4 Duties and Responsibilities

4.1 The policy was devised by Matrons of in-patient units within Livewell Southwest. The Chief Executive is ultimately responsible for the content of policies and their implementation.

4.2 Directors are responsible for identifying, producing and implementing Livewell Southwest policies relevant to their area.

4.3 Locality managers will support and enable operational Clinical Leads and Managers to fulfil their responsibilities and ensure the effective implementation of this policy. The Team Manager is responsible for ensuring the policy is adhered to by clinical staff.

4.4 All clinical staff who undertake observations are responsible for ensuring they adhere to this policy and supporting those they line manage to ensure their understanding and competence. Where elements of the policy are not, or cannot be adhered to, an incident report should be raised in order that this can be reviewed. Consistent failure or inability to follow elements of the policy should be escalated to Senior managers for review.

5 Who should carry out Observation

5.1 Competent staff

a. The National Confidential Inquiry into Suicide and Homicide by those with Mental Illness (2015) found that over half of inpatient deaths occurred when staff assigned to observations were less experienced or worked on an agency basis and were therefore less familiar with the person being observed. It is therefore necessary to ensure that observations are carried out by those that have been assessed as competent to carry out observations as per this policy, and have a full understanding of the person's risk management plan.

b. As well as completing an assessment of competence, the staff member should be familiar with the unit, its emergency procedures and the potential risks within the environment.

5.2 Assessment of competence

a. Each staff member should receive a one off assessment of their understanding of observations by a registered healthcare practitioner prior to undertaking observations. See Appendix G.

b. The staff member being assessed must be given time to thoroughly read and familiarise themselves with the policy prior to assessment. Ideally this should form part of the induction process.

c. The assessment must be carried out collaboratively in order that the assessing professional is able to actively question the staff member on their understanding and comprehension of the key principles involved. There should be opportunities to explore scenarios.

d. Where a person is considered competent, the document should be signed by both parties and a record sent to the staff member's line manager (if from a

different department) and a copy held on the unit for future reference.

e. Where the person is not considered competent, this should be raised with their line manager. They should not commence observation.

5.3 Preparation and Handover

The staff member is responsible for ensuring they are fully aware of the person's risk management plan. Specifically, this includes knowledge of:

- The reason why the person is being observed and what the observation is hoping to prevent or identify.
- The specific behaviours and triggers which may become present if a person is at increased risk.
- When to alert concerns to a registered member of staff.
- How best the person likes to be interacted with or what level of engagement to avoid.
- Other risk management strategies for the individual and their likes and dislikes.

The staff member should feel supported to raise concerns where they do not feel they can effectively carry out observations for a given individual.

It is the responsibility of the nurse in charge to ensure that staff carrying out observations have received this information although the handover itself can be delegated.

5.4 Individualised Observation

Bowers et al (2006) found that the views of people being observed varied. Many found that observation could be intrusive and others that it was a positive experience. While it is an expected standard that the risk management plan for an individual be collaborative in order to promote less restrictive options and self-management, it may also be the case that a person requires a specific group of staff to be assigned to carrying out observations.

5.5 Skill Mix

a. The person being observed should be supported by a staff member with the necessary skills to meet the person's identified needs. This may require consideration of the different skills, experiences and approaches available within the clinical team.

b. The team manager is responsible for ensuring that shift allocation is done so by paying attention to skill mix and safer staffing numbers. Where this cannot be achieved, this should be escalated to service leads.

c. The nurse in charge is responsible in the manager's absence for ensuring they

have an adequate skill mix on their shift to meet the needs of the people in the unit. Where this cannot be achieved they should submit an incident report which will be reviewed by team managers and service leads.

5.6 Additional staffing

a. Where a person is being observed by a dedicated member of staff, it should be at the discretion of the nurse in charge whether this requires additional staffing numbers. The decision to increase numbers should be made by reviewing the safer staffing numbers for the unit and clinical activity within the unit.

b. Where additional staff members are required, this should be authorised by the relevant locality manager and their deputy within working hours, or the on call director outside of these times.

c. Where an allocated one to one member of staff is required as part of an eating plan, or to avoid Psychiatric Intensive care Unit (PICU) transfer (in the case of someone at imminent risk of self-harm, violence or AWOL), this may be financially supported by the local commissioning group. a 'One to One' form should be completed and sent to relevant senior managers and commissioners as per Appendix I. It should specify how the increased observations aim to prevent transfer of the person and why this is considered clinically recommended.

5.7 Dignity and cultural diversity

Gender

a. It is recommended practice that male staff should not be assigned to carry out observation with females if the person is alone in their bed space and / or asleep. This guidance is made in relation to local learning from complaints and incidents, and to ensure that key elements of a risk management plan, for example, checking a person's neck when in bed, can be carried out without risking distress to either staff or the person being observed.

b. The guidance is made broadly, however should not affect decisions related to individualised care planning eg. where allocation of the same gender may create conflict or be counter-therapeutic.

c. Similarly, males may require male only staff allocation and this should be based on the principle of providing individualised, safe and dignified care.

d. Where decisions around gender cannot be achieved due to skill mix, this should be reported as an incident for review.

5.8 Students and trainees

a. Engagement and observation is a necessary part of a risk management strategy in inpatient areas within Livewell southwest. It is therefore the case that those

training in these areas should be familiar with this policy in a way that is appropriate to their role and learning contracts.

b. It is expected that pre-registration nursing students working in an inpatient setting have a working knowledge of how best to assess risk, implement a collaborative risk management plan and carry out supportive observation and engagement safely. Carrying out observations are therefore an important part of learning however, the allocation of a student to observations requires a structured approach.

c. The student must first be considered competent to carry out observations as in Appendix G.

d. The nature and frequency of allocation must be agreed between the student and their mentor within their learning contract.

e. The student may require direct supervision however the dignity and view of the person being observed should be paramount. The university recommends that students are always directly observed when completing levels of observation higher than intermittent.

f. A student / trainee has supernumerary status and therefore should not be relied upon as part of safer staffing numbers. It is the responsibility of the student and their mentor to explore where frequency of allocation exceeds that specified in their learning contract.

6 Levels of Supportive Observation

6.1 Level One: 'General' Observation

a. Description

'General observation' is the standard level of observation for all in-patients. The nurse in charge, is responsible for ensuring these observations are carried out by a competent and appropriate member of staff (see dignity section).

It is good practice to be aware of the location of patients at all times however, this policy sets out minimum intervals of observation, in order to engage with a person and monitor their level of risk.

b. Frequency

The minimum levels of observation over a 24 hour period have been agreed as follows:

- For acute inpatient wards, (Bridford, Harford, Cotehele, Edgcumbe and Cotehele), the minimum frequency of observations should be carried out Hourly. This is due to the potential for rapid escalation of risk of onset of distress. (see Appendix C)

- For the low secure unit (Lee Mill), people should be observed hourly when awake, however this can be reduced to two hourly when asleep due to the risks associated with the people admitted to the service. (see Appendix D)

- For recovery units (Syrena and Greenfields) where risks have less potential to escalate quickly, and more frequent observation may impede recovery, general observations are set a minimum of four hourly. (see Appendix E)

c. Principles of general observation

Outside of these observations, the approximate location of all patients should be known to staff, but this should be balanced with the need to promote recovery and maintain dignity.

The staff member carrying out supportive observations must do so in a way that does not solely rely on a brief visual evaluation of their location and safety at that moment. The purpose of general observations is to review a person's potential for increase in risk which may require further engagement or more frequent observation. It is recommended that as a minimum standard when awake, the staff member should greet the person and ask how they are. Any concerns should be discussed with the nurse in charge for review. Where a person is asleep, the staff member should ensure that the person is breathing at a normal rate.

It is also necessary that staff are accessible to people in crisis and that the person is aware of how to access their support. Therefore, when not immediately engaged in an alternative activity, it is good practice for staff to base themselves in communal areas of the ward or tell a person how they can request assistance if required.

d. Recording

As a standard, the observations should be recorded using the appropriate forms (see appendices A – E) and stored according to record retention standards for the purpose of audit and review. Where the staff member has concerns about the safety or welfare of a person, they should inform the nurse in charge at the earliest available opportunity to ensure review. These concerns must also be recorded in SystmOne.

6.2 **Level Two: 'Intermittent' Observation**

a. Description

Intermittent observation is the least restrictive way of observing someone who has a potential increased risk of harm to themselves or others, rather than immediate risk. The National Confidential Enquiry into Suicide and Homicide by People with mental Illness 2015, found that 91% of deaths of inpatients under observation occurred when being observed intermittently. It is therefore necessary to ensure that the supporting assessment and decisions made are done so in a safe and considered way.

Risks may include, self-harm, violence, vulnerability, unauthorised absence (AWOL), deterioration in physical health, Falling, or any other need for a mechanism which

prompts timely additional support and engagement.

b. Risk Assessment

The decision to introduce intermittent observation into a person's risk management plan must first be based on a reasoned and thorough assessment of risk and documented on SystmOne.

The risk assessment should be carried out by a competent practitioner, and include:

- The nature of the risk and any precipitating triggers or incidents.
- Historical risk and incidents.
- The person's view of their risks and ability to self-manage this risk.
- The view of others, for example, team members, family or friends.

c. Risk Management

The risk assessment should inform a clear risk management plan which must be shared with all staff involved in caring for the person and must include :

- The nature of the risk.
- The frequency of intermittent observation.
- How staff should best engage with the person being observed.
- What triggers and behaviours might indicate an increase or decrease in risk and therefore prompt review.
- Clear guidance for staff on when to escalate their concerns and what actions to take.
- Alternatives and additional risk management strategies to minimise risk, for example, planned occupational therapy, sensory aids, self-management strategies etc.
- Any specific recommendations around the person carrying out the observation and engagement based on minimising conflict and maintaining dignity. For example, where a person may prefer a member of the opposite sex or where a group of staff may trigger conflict.
- The person's view of the plan and their own self-management strategies.

d. Risk assessment and management for a person who is at risk of self-harm and suicide

Wyder (2004) notes that individuals who have survived a suicide attempt, reported thinking about their actions for 10 minutes or less. It is the case that suicidal or para-suicidal acts can be carried out impulsively and without apparent trigger. It is recommended that patients at risk of suicide should be considered for frequent observations for example at intervals up to 5mins and 10mins, 10 minute, 5 minute or

continuous observations. It is therefore of paramount importance that the assessment involves the person and their own choices in self-managing risk.

Similarly, while it may be the case that a person engages in risky acts without an expressed desire to end their life, assessment should consider the potential for doing so unintentionally. For instance, a person may cut themselves as a maladaptive form of anxiety management and not to end their life, however may chose areas which increase the risk of severing an artery. Observation may therefore be a necessary intervention.

e. Review and reduction of Intermittent Observation

Routine review of Intermittent observations, as with all enhanced observations, should be carried out daily by a competent practitioner, and a record made of the reasoned decision to reduce, increase, or maintain level of observations. More frequent review may be prompted as per the criteria in the person's risk management plan or in event of a change in presentation.

A registered health professional can and should initiate intermittent, continuous and close observation or increase the level of observation as appropriate, and will communicate with the Consultant Psychiatrist and wider MDT at the earliest opportunity.

Intermittent observations can be reduced by any registered healthcare professional, provided they have carried out a risk assessment which is documented on SystmOne, and must include a clear description of why reduction is clinically indicated.

While good practice indicates involving the wider MDT in risk management decisions, in the absence of this, a registered healthcare professional may reduce intermittent observation, and involve the nurse in charge and / or ward Doctor if available.

f. Principles of Intermittent observation

As with general observation, the approximate location of the person should be known to staff within reason, but this should be balanced with the need to promote recovery and maintain dignity.

Similarly, as with general observations, the staff member carrying out supportive observations must do so in a way that does not solely rely on a brief visual evaluation of their location and safety at that moment. Effective engagement to build a therapeutic relationship is ultimately required to ensure robust assessment and management of risk.

The purpose of intermittent observations is to assist in the overall plan for managing their risk and prevent or reduce harm. The observation should therefore be carried out as described by the person's individual risk management plan. Again, where the person is asleep, the staff member should ensure that they are breathing at a normal rate.

In line with the search policy, a method of managing risk without the need for constant observation, or in conjunction with this may be to remove items the person has access to and may use to cause harm. This may include shoelaces, dressing gown cords etc. The decision to do so must be proportionate to the risks posed to the person.

g. Recording of Intermittent Observation

In addition to the guidance above and a general record in the tabbed journal, the staff member carrying out the observation must also make a record that they have completed the observation at each interval, and also record a summary of the person's presentation over an hourly period. (see Appendices A – E).

Where the person's risk appears stable, it is acceptable to complete the summary at the end of the hour, or before the detail is passed on the next staff member assigned to carry out the observations. It is never acceptable for documentation to be left incomplete or delayed, until the end of a shift for example. It may however, be the case that recording is delayed on an exceptional, short term basis, e.g. responding immediately to an incident. Where this is the case the staff member should ensure they return to document the record as soon as possible.

The document should be scanned onto SystmOne to be included as part of the person's clinical record.

Any changes made to the circumstances of the observation such as a change in time intervals of engagement, a new observation chart must be started and the details of the change must be recorded in the risk assessment and management plan.

6.3 Level Three Continuous observation within eyesight

a. Description

Continuous observation is the dedicated observation of one or more staff members to a person at imminent risk of harm to self or others. The person must be within sight of the person at all times and be able to intervene or raise an alarm if the person requires immediate intervention to maintain their safety.

b. Risk Assessment

As with all enhanced levels of observation, the decision to introduce constant observation into a person's risk management plan must first be based on a reasoned and thorough assessment of risk and documented on SystmOne.

The risk assessment should be carried out by a competent practitioner, and include:

- The nature of the risk and any precipitating triggers or incidents.
- Historical risk and incidents.

- The person's view of their risks and ability to self-manage this risk.
- The view of others, for example, team members, family or friends.

c. Risk Management

The risk assessment should inform a clear risk management plan which must be shared with all staff involved in caring for the person and must include :

- The nature of the risk.
- The specific duration of constant observation if not indicated over an entire 24hr period or in certain situations.
- How staff should best engage with the person being observed.
- What triggers and behaviours might indicate an increase or decrease in risk and therefore prompt review.
- Clear guidance for staff on when to escalate their concerns and what actions to take.
- Alternatives and additional risk management strategies to minimise risk, for example, planned occupational therapy, sensory aids, self-management strategies etc.
- Any specific recommendations around the person carrying out the observation and engagement based on minimising conflict and maintaining dignity. For example, where a person may prefer a member of the opposite sex or where a group of staff may trigger conflict.
- The person's view of the plan and their own self-management strategies.

d. Review and reduction of continuous observation

Routine review of constant observations, as with all enhanced observations, should be carried out daily by a competent practitioner, and a record made of the reasoned decision to reduce, increase, or maintain level of observations. More frequent review may be prompted as per the criteria in the person's risk management plan or in event of a change in presentation.

A registered health professional can and should initiate intermittent, continuous and close observation or increase the level of observation as appropriate, and will communicate with the Consultant Psychiatrist and wider MDT at the earliest opportunity.

Continuous observations can only be reduced in isolation by a senior registered healthcare professional working at band 6 or above, provided they have carried out a risk assessment which is documented on SystmOne, and must include a clear description of why reduction is clinically indicated.

While good practice indicates involving the wider MDT in risk management decisions, in order to prevent unnecessary restriction, or obstructive observation of a person this

may be reduced prior to an MDT review. Where available the senior healthcare professional should include other team members including ward Drs where possible.

6.4 Principles of Continuous Observation

a. Engagement

The staff member/s carrying out supportive constant observations must do so in a way that does not solely rely on a visual evaluation of their location and safety at that moment. Effective engagement to build a therapeutic relationship is ultimately required to ensure robust assessment and management of risk. Diversional activities and the use of therapeutic dialogue must form a fundamental part of constant observation.

Consideration must also be given to ensure that staff are able to fully observe the service user in proportion to their risk assessment e.g. requesting that they do not cover their neck when in bed.

b. Restrictive Practice

The person being observed may find constant observations obtrusive and restrictive, therefore while safety remains paramount, there may be specific guidance made available in the risk management plan to promote the person's dignity. For example, a person at risk of leaving the unit may not require constant observation when in their bed space, and require the dedicated member of staff to be available outside the room, waiting to resume constant observation in communal areas. This approach ensures the person has some privacy.

In line with the search policy, a method of managing risk without the need for constant observation, or in conjunction with this may be to remove items the person has access to and may use to cause harm. This may include shoelaces, dressing gown cords etc. The decision to do so must be proportionate to the risks posed to the person.

c. Recording of continuous observation

The staff member responsible for carrying out observations must be identified on an hourly basis at the commencement of each shift. It is customary for this staff member to observe an individual for one hour at a time however it may be necessary to extend the allocation for up to two hours. Due to the potential for concentration levels to be affected by engaging with someone who is at imminent risk, it is not recommended for staff to be allocated for more than two hours at a time.

While a risk assessment and management plan should always be recorded on commencement of observation, instigation of observations should not be delayed whilst awaiting completion of this record.

The staff member will be required to write a summary of the service user's presentation on the observation chart (Appendix A – E) at the end of the period of

observation and feedback their observations to the nurse in charge.

Any concerns or changes should also be documented within the tabbed journal on SystmOne.

This observation chart will form part of the entry to be made in the daily records tabbed journal of SystmOne before the end of each shift. The entry must include details of changes in mental state, physical, psychological and social behaviours, pertinent developments and significant events. All staff involved in continuous observation and the nurse in charge on the shift should be consulted prior to the completion of this summary to ensure accurate and complete information is documented.

6.5 Level Four Constant (special) observation within arm's length

a. Description

The constant observation of a person within arm's length should be used where a person is at active risk of harm and requires quicker intervention than can be provided by constant observation in line of sight. This observation is indicated for those in highest need of intervention to manage risk and may need to be carried out by more than one staff member.

b. Risk assessment

As with all enhanced levels of observation, the decision to introduce constant observations within arm's length, into a person's risk management plan must first be based on a reasoned and thorough assessment of risk and documented on SystmOne.

The risk assessment should be carried out by a competent practitioner, and include:

- The nature of the risk and any precipitating triggers or incidents.
- Historical risk and incidents.
- The person's view of their risks and ability to self-manage this risk.
- The view of others, for example, team members, family or friends.

c. Risk management

The risk assessment should inform a clear risk management plan which must be shared with all staff involved in caring for the person and must include:

- The nature of the risk.
- The specific duration of constant observation if not indicated over an entire 24hr period or in certain situations.
- How staff should best engage with the person being observed.

- What triggers and behaviours might indicate an increase or decrease in risk and therefore prompt review.
- Clear guidance for staff on when to escalate their concerns and what actions to take.
- Alternatives and additional risk management strategies to minimise risk, for example, planned occupational therapy, sensory aids, self-management strategies etc.
- Any specific recommendations around the person carrying out the observation and engagement based on minimising conflict and maintaining dignity. For example, where a person may prefer a member of the opposite sex or where a group of staff may trigger conflict.
- The person's view of the plan and their own self-management strategies.

d. Review and reduction of constant observation within arm's length

Routine review of constant observations within arm's length, as with all enhanced observations, should be carried out daily by a competent practitioner, and a record made to aid reasoned decisions to reduce, increase, or maintain level of observations. More frequent review may be prompted as per the criteria in the person's risk management plan or in event of a change in presentation.

A registered health professional can and should initiate intermittent, continuous and special observation and will communicate with the Consultant Psychiatrist and wider MDT at the earliest opportunity.

Continuous observations can only be reduced in conjunction with the MDT and overall agreement by the person's Responsible Clinician. It cannot be reduced in isolation.

The MDT risk assessment should be documented on SystmOne, and must include a clear description of why reduction is clinically indicated.

e. Principles of constant (special) observation within arm's length

The decision to use this level of observation must be used only where less restrictive options are not considered sufficient to reduce the risk of harm to a person due to the restrictive nature of the observation.

The nurse in charge must ensure that a safety check is conducted on the person's room and associated day areas and potential hazardous objects removed. It may be considered necessary to search the service user and their room for concealed items Staff will be expected to adhere to the Searching of Property or Person policy.

Removal of belts, tights, shoe laces and sharp objects is often indicated with this level of observation however where a considered decision is made not to remove such items, this must be recorded in the patient record and risk management plan.

f. Recording of constant observations within arm's length

The staff member/s responsible for carrying out observations must be identified on an hourly basis at the commencement of each shift. It is customary for this staff member to observe an individual for up to one hour only at this level, due to the potential for concentration levels to be affected by engaging with someone who is at imminent risk.

While a risk assessment and management plan should always be recorded on commencement of observation, instigation of observations should not be delayed whilst awaiting completion of this record.

The staff member will be required to write a summary of the service user's presentation on the observation chart (Appendix A – E) at the end of the period of observation and feedback their observations to the nurse in charge.

Any concerns or changes should also be documented within the tabbed journal on SystmOne.

This observation chart will form part of the entry to be made in the daily records tabbed journal of SystmOne before the end of each shift. The entry must include details of changes in mental state, physical, psychological and social behaviours, pertinent developments and significant events. All staff involved in continuous observation and the nurse in charge on the shift should be consulted prior to the completion of this summary to ensure accurate and complete information is documented.

g. Leaving the unit if under enhanced observation

a. If a person is at risk and requires enhanced observation, it is not commonly expected or recommended that they should routinely leave the ward environment.

b. However, this may be indicated as part of a therapeutic plan or if they are required to attend an appointment that cannot be postponed. Where this is the case, the benefits of leaving the ward should outweigh the risks of potential increase in risk and a management plan should be agreed to support the period of leave.

h. Principles

a. If the person leaves the ward they must be accompanied at all times by one or more competent members of staff. The members of staff must ensure they comply with this policy and are responsible for the documentation and the safe return of the person to the ward.

b. The staff member should take with them a means of contacting the ward and summoning assistance if required, eg. a mobile phone and lone worker device.

c. In the case of a person attending a group, or therapy activity off the ward, there must be consideration to the staff required to facilitate the group and to comply with the requirements of the observation. People on intermittent observations on the ward may also require a dedicated staff member to carry out this observation when in a group in an occupational therapy department or any area that is off the ward. The safety of the person and the need for therapeutic sessions should be discussed and agreed jointly with therapy and nursing staff during daily planning meetings and care/treatment planning.

d. There must always be a robust verbal handover from therapy department to ward and ward to therapy department, which will support the exchange of required paperwork on which to record observations.

7 Environmental Observation

a. As well as the observation of individuals, it is recommended practice to ensure that daily unit practices support staff observation of areas of high risk within a unit. Bowers et al (2006) supports the practice of checking high risk areas eg. the bathroom during high risk periods e.g. handover times.

b. It is also necessary to ensure that staff are based in communal areas in order that they are accessible to people who may request support.

7.1 Night time practice

When a person is unable to sleep, staff should take the opportunity to engage in dialogue with the person and ensure they are not at increased risk of harm. Staff should base themselves in areas of the ward where they can be accessible for support and be able to listen for sounds that indicate a person is not asleep.

8 Escalation of Professional Differences

8.1 There may be occasions where disagreement exists between professionals regarding the level of observation required.

8.2 Where this is the case the higher level of observation should always remain until the disagreement is resolved.

8.3 Unit staff should make the Team manager and responsible clinician aware of any differences of opinion initially. The risk management plan should be formally reviewed at a risk management meeting held with multi-disciplinary representatives. If this does not successfully resolve the dispute, the service manager or professional leads may be consulted in order to review the case.

9 Policy Audit

9.1 On a six monthly basis unit Matrons should audit a sample of observation records using the audit tool Appendix H.

The observation records should be reviewed by the ward manager or senior nurse on a regular basis as agreed by the ward manager and Matron.

10 Training Implications

10.1 All staff involved in undertaking observations must receive appropriate and relevant training. This includes a working knowledge of the operational policy and associated paperwork.

11 Monitoring compliance

11.1 The observation forms should be routinely monitored by Senior unit staff and findings escalated to unit Matrons as above.

All policies are required to be electronically signed by the Lead Director. Proof of the electronic signature is stored in the policies database.

The Lead Director approves this document and any attached appendices. For operational policies this will be the Locality Manager.

The Executive signature is subject to the understanding that the policy owner has followed the organisation process for policy Ratification.

Signed: Director of Operations

Date: 16th May 2016

Appendix A

Intermittent Observation Chart

Patient's Name		**NHS Number:**			
Date:		**Ward:**		**Room No:**	
Reason for Observations:				**Interval time:**	
				……minutes	

Person allocated	**Time checks**	**Initials**	**Location**	**Summary of presentation to be completed hourly by nurse undertaking observations.** (*e.g. tearful but able to engage, appears agitated toward staff)*	**Signatures**
Name:					Signature 1: Signature 2:
Name:					Signature 1: Signature 2:
Name:					Signature 1: Signature 2:
Name:					Signature 1: Signature 2:
Name:					Signature 1: Signature 2:
Name:					Signature 1: Signature 2:
Name:					Signature 1: Signature 2:
Name:					Signature 1: Signature 2:
Name:					Signature 1: Signature 2:
Name:					Signature 1: Signature 2:

Signature 1: I confirm that I have read the policy and accept responsibility for these checks.

Signature 2: I confirm that I am the Nurse in charge of the Ward and have deemed this person competent and have delegated the checks to them

Appendix B

1:1 Within eyesight / arms length close observation (delete as appropriate)

Patient's Name		**NHS Number:**	
Date:		**Ward:**	
Reason for Observations:			

Person Allocated	Time checks	initials	Location	Observations by nurse doing hourly checks (*e.g.. tearful but able to engage, appears agitated toward staff)*	Signatures:
Name:					Signature1: Signature 2:
Name:					Signature 1: Signature 2:
Name:					Signature 1: Signature 2:
Name:					Signature 1: Signature 2:
Name:					Signature 1: Signature 2:
Name:					Signature 1: Signature 2:
Name:					Signature 1: Signature 2:
Name:					Signature 1: Signature 2:
Name:					Signature 1: Signature 2:
Name:					Signature 1: Signature 2:

Signature 1: I confirm that I have read the policy and accept responsibility for these checks.

Signature 2: I confirm that I am the Nurse in charge of the Ward and have deemed this person competent and have delegated the checks to them

Appendix C

Hourly Observation Sheets for Acute In-patient Wards: Bridford, Harford, Edgcumbe, Cotehele, Plym Bridge (delete as appropriate)

Nurse in Charge - Print Name and Sign:		am					pm			Date:				
Room	**Name**	**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**
Member of staff allocated														
Signature 1: I confirm that I have read the policy and accept responsibility for these checks.														
Signature 2 I confirm that I am the Nurse in charge of the Ward and have deemed this person competent and have delegated the checks to them														

Key	**A** – Absent without leave	**G** - Garden	**L** – On Leave	**OW** – Off Ward	**W** – On Ward
Notes	All levels of supportive observation set out in this policy require that the prescribed level of observation is carried out whether or not the patient is asleep and the nurse must assure themselves at every observation interval that the patient appears to be breathing.				

Nurse in Charge - Print Name and Sign:								Date:				
Room	**Name**	**20:00**	**21:00**	**22:00**	**23:00**	**24:00**	**01:00**	**02:00**	**03:00**	**04:00**	**05:00**	**06:00**
Member of staff allocated												
Signature 1 I confirm that I have read the policy and accept responsibility for these checks.												
Signature 2 I confirm that I am the Nurse in charge of the Ward and have deemed this person competent and have delegated the checks to them												

Key	**A** – Absent without leave	**G** - Garden	**L** – On Leave	**OW** – Off Ward	**W** – On Ward

Notes	All levels of supportive observation set out in this policy require that the prescribed level of observation is carried out whether or not the patient is asleep and the nurse must assure themselves at every observation interval that the patient appears to be breathing.

Appendix D

Observation for Lee Mill: (Hourly from 7 am to Midnight and two hourly at night)

Nurse in Charge	Print Name and Sign:	am	pm	Date:	

Room	Name	07:00	08:00	09:00	10:00	11:00	12:00	13:00	14:00	15:00	16:00	17:00
Member of staff allocated												
Signature 1 I confirm that I have read the policy and accept responsibility for these checks.												
Signature 2 I confirm that I am the Nurse in charge of the Ward and have deemed this person competent and have delegated the checks to them												

Key	**A** – Absent without leave	**G** - Garden	**L** – On Leave	**OW** – Off Ward	**W** – On Ward
Notes	All levels of supportive observation set out in this policy require that the prescribed level of observation is carried out whether or not the patient is asleep and the nurse must assure themselves at every observation interval that the patient is appears to be breathing.				

Nurse in Charge - Print Name and Sign:								Date:			
Room	**Name**	**18:00**	**19:00**	**20:00**	**21:00**	**22:00**	**23:00**	**24:00**	**02:00**	**04:00**	**06:00**
Member of staff allocated											
Signature 1 I confirm that I have read the policy and accept responsibility for these checks.											
Signature 2 I confirm that I am the Nurse in charge of the Ward and have deemed this person competent and have delegated the checks to them											

Key	**A** – Absent without leave	**G** - Garden	**L** – On Leave	**OW** – Off Ward	**W** – On Ward
Notes	All levels of supportive observation set out in this policy require that the prescribed level of observation is carried out whether or not the is patient is asleep and the nurse must assure themselves at every observation interval that the patient is alive and can be seen to breath unobstructed and without difficulty.				

Appendix E

Four Hourly Observation for Recovery In-patient Wards: Greenfields + Syrena

Nurse in Charge	**Print Name and Sign:**		am		pm		night	**Date:**		
Room	**Name**	**Surname**	**07:00**	**11:00**	**15:00**	**19:00**		**23:00**	**03:00**	
Member of staff allocated										
Signature 1 I confirm that I have read the policy and accept responsibility for these checks.										
Signature 2 I confirm that I am the Nurse in charge of the Ward and have deemed this person competent and have delegated the checks to them										

Key	**A** – Absent without leave	**G** - Garden	**L** – On Leave	**OW** – Off Ward	**W** – On Ward
Notes	All levels of supportive observation set out in this policy require that the prescribed level of observation is carried out whether or not the is patient is asleep and the nurse must assure themselves at every observation interval that the patient appears to be breathing.				

Practice Guidance

Who Can carry out observation:

All staff working in an inpatient setting must be familiar with the supportive observation policy. They must also know the person being observed, their risk assessment and the risk management plan.

Staff can only commence observation of a person if assessed as competent.

Staff allocation should be based on promoting the dignity of the person being observed.

Students are not able to carry out observation unless agreed in a learning contract.

A One to One form must be completed on commencement of all one to one observations.

No period of observation will be longer than one hour, except in exceptional circumstances. There should be a break of ½ hour from each observation.

Risk Assessment and Management:

Risk management plans should be collaborative and include the person's self-management strategies and strengths.

Decision making should be clear and timely in the person's SystmOne record.

Frequency of Observation and documentation:

Observation should be carried out using the principle of engagement and used as opportunities to develop therapeutic rapport and explore risk.

• General supportive observations will be undertaken:

− Hourly at Glenbourne, Plymbridge, Edgcumbe and Cotehele
− Hourly (daytime) and two hourly (night times) at Lee Mill
− Four hourly at Greenfields and Syrena

The Observation record must identify the staff member allocated. Signatures of the staff who undertake the observation and the nurse in charge responsible must be completed on the form.

All observations must have a specific risk management plan. The observation record must identify:

- The interval at which observations must be carried out
- The location of the person

- An hourly summary of the person's presentation. This will be completed by the staff member responsible for the observations

The staff member responsible for the observation and the nurse in charge responsible for the unregistered staff must both sign the observation record.

An entry must be made in the tabbed journal at the end of every shift. The summary on the observation chart will form part of the entry to the tabbed journal.

Leaving the unit:

Any people being observed on one to one or intermittent observations must not be allowed to leave the unit unescorted. The staff member responsible for the observation must complete the documentation and handover to the staff member identified to continue the observations.

If the person who is on intermittent or one to one observations is allowed to leave the unit, this must be following an MDT discussion which is incorporated within the care plan.

Reduction of enhanced observations:

One to one observations and intermittent observations will be reviewed every 24 hours by the nurse in charge or their nominated deputy, and reviewed by the Responsible Clinician/MDT at least weekly. The review must be recorded in the electronic record.

Good practice supports MDT review and reduction of enhanced observations. However, in the absence of this, a senior registered practitioner at band 6 and above can reduce the observation following a reasoned risk assessment and documented risk management plan. This is in order to prevent unnecessary restrictions being imposed on a person.

Any breach of the observation policy must be reported via the incident reporting system.

Competency Assessment: Understanding the Supportive Observation in Mental Health Units Policy 2016

This assessment must be carried out by a registered healthcare professional who has been assessed as competent to carry out observations.

Name of Staff member:
Name of Assessor:
Date:

Carrying out Supportive Observation: General Questions

Can you provide examples of where people may require observation? What risks might be present?

Answer:

What are the various levels of intermittent observations?

Answer:

What things might you consider when ensuring you carry out observation in a dignified way?

Answer:

If you needed to swap with a member of staff your assigned observations, what should you do?

Answer:

What would you consider if you are asked to accompany a person on enhanced observation to leave the unit?
Answer:

What should you be observing and documenting when the person appears to be asleep?

Answer:

How would you know that you have been allocated observations and any changes?

Answer:

What would you do if you noticed another member of staff was not completing their observations?

Answer:

Level One: General Observation and engagement

You are assigned to observing all people on the unit at hourly intervals.
How would you go about ensuring people know you are available to offer support?

Answer:

What areas of the unit would you base yourself in?

Answer:

A person appears reluctant to make eye-contact when you introduce yourself and appear troubled, what action would you take?

Answer:

Level Two: Intermittent observation and engagement

You are asked to observe and engage with a person every 10 minutes. What do you need to be aware of to carry out this observation safely?

Answer:

What items do you consider should not be available to a person being observed if they are at risk of harming themselves?

Answer:

If you were unable to take over your observations on time what should you do?

Answer:

Level Three and four: Constant (One to One) Observation and Engagement within Line of sight and Arm's Length

You notice the person being observed has shoelaces on their shoes. What action would you take and how would you go about this in a sensitive way?

Answer:

What are the differences between arm's length and within line of sight observations?

Answer:

Under what circumstances are you able to leave a constant observation?

Answer

A person asks you to turn away when they are using the toilet, how would you deal with this?

Answer:

Assessing, Managing and Reviewing Observations: (Registered staff only)

How often should observations be reviewed, and by whom?

Answer:

How would you manage a ward where there were 5 people being observed at 5 minute intermittent observations, to ensure they are carried out safely?

Answer:

What should be documented in a risk assessment?

Answer:

What should be documented in a risk management plan?

Answer:

What should you think about if a person has been put onto 1:1 observations with regards to staffing levels, skill mix and documentation?

Answer:

What self-management strategies might you encourage a person to use in conjunction to observation?

Answer:

Assessor

Do you feel confident that the member of staff has an accurate understanding of how to complete safe observation from their answers above?

Comments:

Signature
Grade
Date

No

Actions

Audit tool for Observation Chart Sample

Unit:

Date:
Please state Yes or No:

Standard	Chart One	Chart Two	Chart Three	Chart Four	Chart Five	Chart Six	Actions
Was the patient's name completed?							
Was the NHS Number recorded?							
Was there a care plan identifying the observation level?							
Was the date of observation completed?							
Was the ward identified?							
Were the reasons for observation completed?							
Was the interval time recorded?							
Was the person allocated box completed?							
Were the time checks recorded?							
Was the activity recorded?							
Was the summary of presentation recorded?							
Did the summary demonstrate a clear representation of the patient?							
Were there two signatures for each hourly allocation of observation?							
Does the entry into the daily record correspond with the observation chart?							

Comments / Action Plan

Signed Print Name

The results of this audit must be fed back to Locality Managers

Inpatient Unit One to One request

This form must be completed for all patients on a 1:1, 2:1 or for supported eating

The form must be filled out at the beginning and again at the end of each occurrence

Patient Name	
Date of Birth	
NHS Number	
Address	

Reason for 1:1 • Safeguarding • Risk to others/self • Personal Care – give details of complexity • Preventing out of area admission	
Ward	
Start date	
Start time	
Finish date	
Finish time	
Review date(s)	

Budget number	
Type of Staff	Agency / NHSP / Overtime / CST
Staff Grade	

Please e-mail this form at the beginning of the 1:1 and at the end of every 1:1 to:

1	IPP Requests	Devon Clinical Commissioning Group	D-CCG.IPP-Requests@nhs.net
2	Dave McAuley	Deputy Director of Operations	david.mcauley@nhs.net
3	Tracy Clasby	Locality Manager – City Wide Services	tracy.clasby@nhs.net
4	Mike Howe	Management Accountant - Finance	michael.howe@nhs.net
5	Lisa Gimingham	Deputy Locality Manager	lisa.gimingham@nhs.net
6	Helen O'Toole	Deputy Locality Manager	hotoole@nhs.net
7	Vicky Clarke	Modern Matron – Glenbourne Unit	vclarke4@nhs.net
8	Karen Full	Administrator – Glenbourne Unit	karen.full@nhs.net
9	Sophie Rowntree	Finance	sophierowntree@nhs.net
10	Lauren Griffiths	Referral Co-ordinator	laurengriffiths@nhs.net
11	Jess Austen	Referral Co-ordinator	jausten@nhs.net