

ENGAGEMENT AND SUPPORTIVE OBSERVATION POLICY

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| POLICY REFERENCE NUMBER | CLP8 | |
| VERSION NUMBER | 2.1 | |
| KEY CHANGES FROM PREVIOUS VERSION | Amendments under s2, added s5.9 & 10 | |
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| CONSULTATION GROUPS | <ul style="list-style-type: none"> • Team Leads/Ward Managers/Sisters • Trustwide (MH/LD) Operational Service Leads/Managers • Compliance Team • Risk Team • Mobius Team • Workforce Development and Training Clinical Governance & Quality Sub-committee | |
| IMPLEMENTATION DATE | 30 March 2018 | |
| AMENDMENT DATE(S) | 6 March 2018, November 2019; June 2020 | |
| LAST REVIEW DATE | January 2020 | |
| NEXT REVIEW DATE | January 2023 | |
| APPROVAL BY CLINICAL GOVERNANCE & QUALITY SUB-COMMITTEE | November 2019 | |
| RATIFICATION BY QUALITY COMMITTEE | January 2020 | |
| COPYRIGHT | 2018 | |
| POLICY SUMMARY | | |
| <p>The principles contained within this policy and the associated documents will ensure that engagement and observation are supportive to the patient, carried out professionally and respectfully in order to ensure the safety of the patient, clinical team and visitors.</p> <p>There is emphasis upon engaging and developing a supportive and therapeutic relationship with the patient based upon mutual respect and trust.</p> <p>The therapeutic relationship between the patient and the professional is considered a fundamental element to effective engagement and observation; therefore observation must take place on the basis of proactive engagement and dialogue with the patient consenting, as long as that individual is capable. Staff involved in engaging and observing any patient must be clearly aware of their role and responsibilities in maintaining safety and wellbeing of patients, themselves and others.</p> <p>To ensure recognised national terminology is used throughout this document the “patient” is used to refer a patient, resident, client or service user</p> | | |
| The Trust monitors the implementation of and compliance with this policy in the following ways; | | |
| A Trust wide audit will be undertaken at the minimum of every three years. Service Directors/Leads will nominate clinical leads to undertake the compliance audit who will be supported by the clinical audit department. | | |
| Services | Applicable | Comments |
| Trust wide | ✓ | |

**The Director responsible for monitoring and reviewing this policy is
Executive Director of Nursing**

ESSEX PARTNERSHIP UNIVERSITY NHS FOUNDATION TRUST

Engagement and Supportive Observation Policy

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Assurance Statement

1.0 INTRODUCTION

This policy and associated procedure and appendices takes into account current guidance on Duty of Care, patient engagement and supportive observation issued by the National Institute of Clinical Excellence (NICE 2005; NICE Guidance NG10 2015), the Standing Nursing and Midwifery Advisory Committee (SNMAC 1999) Practice Guidance: Safe and Supportive Observation of Patients at Risk, June 1999 and the Patient Safety Observatory at the National Patient Safety Agency (NPSA) and the Mental Health Act Code of Practice (2015) – Chapter 26

Observation/engagement is important as a supportive mechanism, for the purpose of engaging positively with the patient. It should not be seen as inflexible and rigid but spending time with patients, whether engaged in activity, discussion or simply being with them may allow close assessment and monitoring of behaviour and mental state.

Supportive observation/engagement should be an integral part of the care plan, to ensure the safe and sensitive monitoring of the patient's behaviour and mental well-being. It should enable a rapid response to change, whilst at the same time fostering therapeutic relationships between the member of staff and the patient.

The use of increased observation levels should never be regarded as routine practice, but must be based on assessed and current need. Enhanced observations should be recognised as a restrictive practice and may be perceived by patients as a coercive intervention. It should therefore only be implemented after positive engagement with the patient has failed to reduce the risk to self or others and only used for the least amount of time clinically required.

The least intrusive level of observation that is appropriate to the situation should always be adopted so that due sensitivity is given to the patients' dignity and privacy whilst maintaining the safety of the patient and those around them.

The general principles issued by the NICE guidance (NG10 May 2015) recommend that staff should be aware of the location of all patients for whom they are responsible, but not all patients need to be kept within sight. At least once during each shift a nurse should set aside dedicated time to assess the mental state of, and engage positively with, the patient. As part of the assessment, the nurse should evaluate the impact of the patient's mental state on the risk of violence and aggression, and record any risk in the notes.

Decisions about what level of observation a patient requires will be based and supported by documented evidence of assessed current need.

There may be occasions when it is appropriate to combine observation levels over a 24-hour period, for example, defined observation (level 2) and within eyesight (level 3). This is likely to occur when an increased risk is associated with a particular event or time-frame for the patient, i.e. meal times, during visiting, handover periods.

There will be occasions where a patient is assessed as needing a high level of supportive observation for a protracted period e.g. patients with severe dementia, delirium, mixed presentations at risk of falls etc. where it may be deemed appropriate to review observation weekly as opposed to daily. This review may take the form of a safety huddle (where in use). The aim of safety huddle is to review all patients on high level observations, adopting a positive risk taking approach and taking in to account factors such as patient's medication, level of agitation and acceptance of personal care with input from physio and OT to assess patients' need for special observations.

Any reduction in the level of engagement or observation should ideally be a team decision but to ensure patients are not left on an increased level too long it is recommended that teams plan ahead [particularly at weekends] clarifying the circumstances that would enable a reduction in observation level.

If the risk of falls has been identified, consideration should be given to the use of falls sensor equipment in the event of a reduction in levels of observation.

For seclusion and restricted access please refer to Seclusion and Long Term Segregation Policy and Procedure.

The decision on prescribing, increasing and decreasing levels of engagement and supportive observation must take into account:

- The patient's current mental state.
- Any prescribed and non-prescribed medications and their effects.
- The current assessment or risk and previous risk assessments where appropriate.
- The views of the patient, as far as possible. (NICE: NG10 May 2015).

The outcome of risk assessments and the decision to place a patient on any level of observation must be clearly recorded in the patient's records.

2.0 DUTIES

Trust Board of Directors – are responsible for overseeing the reduction of restrictive practice within its services, recognising enhanced observations should only be used for the least amount of time clinically required. They have a responsibility for ensuring there is an appropriate and adequate infrastructure to support the observation and engagement of patients and that patients are safeguarded and their equality and human rights is not compromised.

Executive Director of Nursing – is accountable to the Trust Board for the development, consultation, implementation and monitoring of compliance with this Policy and procedure, which promotes supportive observations, engagement of patients and safeguards against unnecessary use of restrictive practice.

Service/Associate Directors – have operational responsibility for clinical divisions' compliance with this Procedure and will ensure mechanisms in place within each service for:

- Identifying and deploying resources within the clinical division to safely deliver this Policy and Procedure.
- Ensuring all clinical staff with responsibility for prescribing and carrying out observation/engagement receive orientation to the content of this Procedure
- Monitoring the clinical division's compliance and consistent application of the Procedure.
- Ensuring that all patients subject to prolonged periods of constant observations are reviewed after 14 days and then at least once per calendar month by clinicians independent of the patient's care.

Responsible Clinician – has a legal and professional responsibility for the care and treatment of the service patients. As part of that responsibility they must have a thorough knowledge of the patients in their care, input to patients' current care plans and observational requirements and provide advice when uncertainty arises regarding level of observation required.

Matrons – are accountable to the Service Director for providing assurance that their respective wards' are compliant with the requirements of the Policy and Procedure.

Ward Managers – have overall accountability for the management of their ward and must ensure:

- They understand their role in initiating and reviewing supportive observations
- Care plans are in place and appropriately identify the required level of observation.
- Documented risk review accompanies the decisions made to change the levels of observation
- Deployment of the available resources to safely deliver this Procedure on their wards.
- Identification, responding and where necessary escalating any areas of non-compliance with this Procedure on their wards
- That Peer review occurs when patients are subject to constant observations for longer than 14 days.

Multidisciplinary Care Team – have a responsibility to understand their role in initiating and reviewing supportive observations. They must balance the potentially distressing effect on the individual of increased levels of observation, particularly if these are proposed for many hours or days, against the identified risk of self-injury or behavioural disturbance. Levels of observation and risk should be regularly reviewed by the Multidisciplinary team and a record made of decisions agreed in relation to increasing or decreasing the observation.

The teams must consider how enhanced observation can be undertaken in a way which minimises the likelihood of individuals perceiving the intervention to be coercive and how observation can be carried out in a way that respects the individual's privacy as far as practicable and minimises any distress. In particular care plans should outline how an individual's dignity can be maximised without compromising safety when individuals are in a state of undress, such as when using the toilet, bathing,

showering, dressing etc., as detailed in later a robust care plan based on identified risk should be in place at times usually associated with the need for privacy.

When enhanced observations are used for longer than 14 days, the team should use the skills of the entire team to support patient's recovery.

Nurse in Charge – is responsible for identifying the staff (by their profession and grade) who are best placed to carry out enhanced observation and under what circumstances. This selection should take account of the individual's characteristics and circumstances (including factors such as experience, ethnicity, sexual identity, age and gender). They should ensure staff allocated to undertake increased observations have been assessed as competent to do so.

The Nurse in Charge should ensure that staff allocated to undertake level 2 observation and above do not have additional tasks, such as security duties, which could compromise their ability to carry out increased observations effectively and safely.

The Nurse in Charge should also be checking observations are undertaken in line with the prescribed observation level, and in accordance with the agreed care plan. Competency is checked with staff using **Appendix 1**; records are kept by ward manager/team leader and reviewed yearly. Review could also be done through supervision.

All Registered inpatient clinical staff have a responsibility to:

- Understand their role in initiating, carrying out and reviewing supportive observations/engagement
- Carry out that role in line with the Procedure
- Complete the care plan for their named patient.
- Inform each patient of the level of observation they are subject to and the reasons for this.
- Review the level of observation based on recorded clinical need and risk review.
- Ensure the care plan is implemented.
- Ensure the periods of observation are viewed and used as opportunities to build a therapeutic relationship.
- Complete all the required documentation.
- Fully familiarise themselves with this policy and procedure.
- Ensure that every member of staff undertaking level of observation is aware of their individual responsibility in relation to Infection Prevention & Control standards with regards to clinical practice and patient care within clinical environment.

Non-registered inpatient clinical staff have a responsibility to:

- Understand their role in carrying out supportive observations
- Carry out observations in line with the observation level prescribed
- Ensure the periods of observation are viewed and used as opportunities to build a therapeutic relationship.
- Be familiar with, and implement, the patient's care plan.

- Complete the required documentation accurately and contemporaneously.
- Report any relevant information that would assist the effective review of the patient's needs.

All inpatient clinical staff:

- Observation documentation must be completed by the clinician undertaking the observation and not by proxy
- Staff must ensure that the appropriate observation distance is maintained throughout the period of observation

3.0 DEFINITIONS

This policy and procedure have been developed as follows:

- Clinical observations provide opportunity to build therapeutic relationships
- Engaging with a person whilst carrying out observations can have a positive effect on levels of distress
- Assessment, engagement and intervention should be used to recognise, prevent and therapeutically manage: disturbed or violent behaviour; risk to self; risk of neglect; and abscondment
- The current level and the reason for the observation must be clearly recorded in the patient's clinical notes
- Observations cover the 24 hour period, which means going into patient's bedrooms when the person is sleeping/resting to check on their physical and mental well-being and to ensure there is no loss of vital signs
- At times, it may be necessary to search the patient and their belongings whilst having due regard for the patients legal rights and in accordance with the Trust's Searching Patient's/Visitor's Property Policy/Procedure
- In some circumstances it may be necessary to temporarily remove belongings that could be used to inflict harm to self and other
- All observations will be recorded on the appropriate Observation Recording Form

4.0 PRINCIPLES

The purpose of this policy is to make clear the standards expected of clinical staff for the engagement and supportive observation of patients, and to provide them with direction and guidance for making decisions about observation levels including reviews, carrying out observations, correct completion of documentation and their training requirements.

5.0 MONITORING OF IMPLEMENTATION AND COMPLIANCE

- 5.1 A Trust wide audit will be undertaken at the minimum of every three years. Service Directors/Leads will nominate clinical leads to undertake the compliance audit who will be supported by the clinical audit department.
- 5.2 Ward managers and matrons will monitor the implementation of this policy via supervision.
- 5.3 Enhanced observations will be discussed with Ward Managers at the relevant local team meetings.
- 5.4 To ensure staff are equipped with the skills and confidence to carry out the task of engagement and supportive observation with patients which is an integral part of managing patients as set out within this Policy and Procedure.
- 5.5 The Policy and Procedures will be available via the Trust Intranet site.
- 5.6 Any amendments to this clinical policy will be submitted to the Clinical Governance & Quality Committee for approval
- 5.7 This clinical policy will be reviewed at least once every three years.
- 5.8 The storage retention period for completed observation forms is 3 years.
- 5.9 The engagement and supportive observation record for level 1 (general observation - CLPG8 Appendix 3) can be filed on the ward shared drive or archived with the ward security forms. The retention period is 3 years so it should be deleted from shared drive after this period.
- 5.10 The medical records team will have access to the ward shared drive if required to retrieve information.

6.0 THIS POLICY SHOULD BE READ IN CONJUNCTION WITH THE FOLLOWING TRUST DOCUMENTS

Seclusion and Long Term Segregation Policy and Procedure

Clinical Risk Assessment, Management and Safety Policy and Procedure

Care Programme Approach (CPA) & Non-CPA (Standard Care) Policy

Prevention and Management of Violence and Aggression at Work Policy, Procedure and Guidelines

A Joint Policy Relating to Section 136 Mental Health Act 1983 as amended by the Mental Health Act 2007

Incident Reporting Policy and Procedure

Searching Patient's/Visitor's Property Policy/Procedure

Unified Health and Social Care Written Record Policy

Management of Patients Who Self Harm Policy and Patient Safety Environmental Standards

In-Patient Leave Procedure and Policy

Privacy and Dignity – Safeguarding Good Practice

Guidance and Protocol on the Management of Staffing Levels

Induction, Mandatory & Essential Training Policy

Trust Auditable standards and monitoring arrangements

Infection Prevention and Control Policy and Procedure

7.0 POLICY REFERENCES

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