ENGAGEMENT AND SUPPORTIVE OBSERVATION TRUSTWIDE PROCEDURE (INPATIENTS)

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- Team Leads/Ward Managers
- Trustwide (MH/LD) Operational Service Leads/Managers
- Compliance Team
- Risk Team
- Mobius Team
- Workforce Development and Training
- Clinical Governance & Quality Sub-committee

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PROCEDURE SUMMARY
The principles contained within this procedure 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.

There is emphasis upon engaging and developing a supportive and therapeutic relationship with the patient based upon mutual respect and trust.

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.

To ensure recognised national terminology is used throughout this document the “patient” is used to refer a patient, resident, client or service user.

The Trust monitors the implementation of and compliance with this procedure 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.

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APPENDICES

APPENDIX 1 – CORE COMPETENCIES

APPENDIX 2 – RECORD FOR LEVELS 2, 3 AND 4

APPENDIX 3 – RECORD FOR LEVEL 1 (GENERAL SUPPORTIVE OBSERVATION)
1.0 INTRODUCTION

This procedure 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 into 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 PURPOSE / SCOPE

To provide an agreed Trust-wide structure for engagement and supportive observation to all inpatients.

This is a Trust wide procedure and applies to all staff working in the Trust’s clinical divisions who have a responsibility for prescribing and/or undertaking supportive observations (including temporary, permanent, bank and agency staff).
3.0 ROLES AND RESPONSIBILITIES

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 and 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 Procedure, which promotes supportive observations, engagement and 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.

**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 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 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 the policy and procedure.
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.

4.0 DESCRIPTIONS OF THE LEVELS OF ENGAGEMENT AND SUPPORTIVE OBSERVATION

ENGAGEMENT:
There is a need for nursing interventions to be based on engagement with the patient, not just on observation (Barker and Cutliffe 1997, Jones et al 2000). The engagement process is a way of establishing a clinically based working relationship that should be supportive, explorative and reassuring towards patients who may feel alienated, isolated, threatened, and fearful (Barker 1998, 2000, Barker and Buchanan-Barker 2004).

Engagement is a way of assessing mental state, behaviour, mood and risk. Consideration should be given to the use of activity, discussion and distraction processes, with recognition of sometimes the need for silence and as much privacy as is safely achievable.

Practical Engagement:
- Activities of Daily Living — assisting individuals to maintain self-care, maintaining some responsibility and dignity. Assisting with bed making, tidying room and doing personal laundry. As appropriate; writing letters, making telephone calls.
- Social Interaction — (Respect patient’s right for silence!). If patient wishes to talk, talk and introduce general conversation topics. Explore their previous or current hobbies or interests.
- Coping strategies - Ask the patient what would be helpful to them at that moment in time, what has helped in the past and what could you help them with to try now: distraction, breathing, relaxation, walking.
- Therapy – support access to on-ward occupational therapy activities,
- Walking – walking around the ward, garden or around the grounds.
- Active diversion (The Tidal Model) – is a technique that is used to support the patient to understand their distress/agitation/anxiety etc. Therefore during the engagement with the patient identify what activity may help (and suggest to try ‘as it may work for them!’) e.g. going for a walk, drawing, watch TV, conversation, gym, pool, squeezing objects, listening to music.

Engaging with patients that are very symptomatic and non-responsive is more difficult, however we can often still engage through the senses, connecting them to the world and to our care.
Engage alongside the patient within the ward environment (walking through the garden, walking to the dining room, walking to the bathroom):
- Engage in activities that elicit **sensory-motor feedback** and assist with orientation
- Mechanisms for **Calming** – going to a space that is less noisy and busy.
- Mechanisms for **Soothing** – music, sensory ‘toys’, weighted blanket.
- Mechanisms for **distracting attention** – music, sucking sweets, popping bubble wrap, colouring-in.
- Mechanisms for **grounding** – focusing on the sensory inputs of the here and now through physical body or describing in detail something that can be seen, heard, felt etc.
- Engage the patient in a **physical activity** (5 min) to either reduce arousal or activate.
- Engage the patient in a **personal care activity** (5 min) sensory, nutritional, self-awareness.
- Engage the patient in a **self-care task** (5 min) washing, dressing, make-up, hair.
- Engage the patient in a **food/drink based task** (5 min)
- Engage the patient in a **sensory activity** (5 min) such as self-massage, relaxation, soft music.

**OBSERVATION:**

Supportive observation calls for empathy and engagement combined with readiness to act. It provides an opportunity for staff to interact with the patient in a therapeutic way. Supportive observation can increase understanding of the feelings and motivations of the patient to act in a particular way. It can also offer the patient support and guidance in how to deal with those feelings and thoughts.

There are a number of reasons why a patient may need to be nursed on engagement and supportive observations such as defined or higher, including –
- Intent to harm self/others
- Personal safety
- Social/sexual vulnerability
- Self-neglect
- Risk of falling/wandering
- Risk of absconding
- To support agreed objectives in care plan, e.g. support with identified triggers/dietary intake/supervised visits
- Poor adherence to or non-compliance with treatment programmes/medication regimes
- Physical illness
- Unknown patient recently admitted
- Following a seclusion episode
- To provide an atmosphere where therapeutic risks can be taken
- Marked changes in behaviour/presentation
- Recent loss/bereavement
- Hallucinations- suggesting harm to self or others
- Paranoid ideas- where the patient believes that others pose a threat
• Reaction to medication

NB. This list is not exhaustive.

**Level 1 – Low Level Intermittent**

This is the minimum level of observation for all patients in inpatient areas. Staff should know the location of all patients in their area, but patients need not be kept in sight. This is for patients assessed as being low-risk to themselves or others. The frequency of engagement and supportive observation is once every 30–60 minutes. This is prescribed and recorded in patient’s notes.

During each shift, members of the clinical team must engage with each patient, establishing a rapport which should also include an assessment of mental state, behaviours associated with risk, mood and this should be recorded in patient’s records. The engagement process is a way of establishing a clinical relationship that should be supportive, explorative and reassuring towards patients. In turn this allows for the development of meaningful care plans and risk assessments carried out in collaboration with the patient and taking into account the views of the patient.

The whereabouts of **all** in-patients must be known at all times. All in-patients on level 1 or Zoned supportive observations must be subject to hourly checks **throughout** the 24 hr period; this **must** be recorded on **Appendix 3** of the engagement and supportive observation form. **Appendix 2** of the engagement and supportive observation form must be completed for all patients on level 2, 3 and 4.

Any patients unaccounted for must be reported immediately to the nurse in charge.

Mental health nurses in in-patient settings have 24 hour responsibility therefore after each nursing verbal handover outgoing and incoming nurses must walk around the ward and account for the well-being and whereabouts of each patient including reflection upon mental state and condition. The nurse in charge has ultimate responsibility for ensuring this is undertaken.

Documentation of interactions and level of engagement and supportive observation (including rational for observation level) must be recorded in the patient’s notes and electronic records on a shift by shift basis. Entries should be in line with and refer to assessed care plans. Service requirements may require more entries.

**Level 2 – High Level Intermittent Observation.**

The patient’s location and safety must be visibly checked at intervals that may range from every five minutes to a maximum of every thirty minutes with at least four checks within every one hour period at **irregular** intervals. The patient must not be able to predict the pattern or to anticipate the time of the next checks. This is for patients who pose a potential but not immediate risk of becoming violent or aggressive or absconding or patients who have previously been at risk of harm to self or others, but who are in the process of recovery, require intermittent engagement and supportive observation.
This is prescribed and recorded in patient’s notes.

Whilst a patient is prescribed intermittent engagement and supportive observation they must be periodically checked ensuring throughout that a positive therapeutic engagement takes place. During each shift, the allocated observer(s) must engage with the patient, establishing a rapport which should also include an assessment of mental state, behaviours associated with risk, mood and this should be recorded in patient’s records.

This level of observation must be reviewed daily. Changes should be recorded in case notes.

**Level 3 – Continuous**
This means a nominated staff member will be allocated to each individual being managed on this level of observation and the patient must be kept within continuous eyesight or at arm’s length at all times. This is for patients who could, at any time, make an attempt to harm themselves or others, or where a patient is perceived as being vulnerable. The responsible clinician and relevant members of the multidisciplinary team should be informed at the earliest opportunity when this level of observation is used. This is prescribed and recorded in patient’s notes. Hourly notes should be written and signed on the engagement and supportive observation record sheet (*Appendix 3*) during the designated period of observation. The record sheet must be passed on to the nurse/clinician taking over the observation which should be kept in patient’s notes once completed.

During continuous observation it may well be necessary to search the patient and their belongings, whilst having due regard for the patient’s privacy and dignity, legal rights and cultural and gender sensitivities.

During each shift, the allocated observer(s) must engage with the patient, establishing a rapport which should also include an assessment of mental state, behaviours associated with risk, mood and this should be recorded in patient’s records.

Staff observing a patient on level 3 should never leave the patient before the next nurse/clinician on the rota arrives. A verbal handover should take place; if practicable the patient should be made aware of the changeover.

**Level 4 Within Arm’s Length**
This means a nominated staff member will be allocated to observe the patient in close proximity (i.e. within arm’s length). This is for patients who pose the highest level of risk of harm towards themselves or potentially to others, and it has been determined that this level of risk can only be managed by close proximity of the patient with staff, again more than one nurse may be required to implement this level of observation safely.

**Multi professional continuous observation:**
Usually used when a patient is at the highest risk of harming themselves or others and needs to be kept within eyesight of 2 or 3 staff members and at arm’s length of at least 1 staff member.
This level of engagement and supportive observation is prescribed and recorded in patient’s notes. During each shift, the allocated observer(s) must engage with the patient, establishing a rapport which should also include an assessment of mental state, behaviours associated with risk, mood and this should be recorded in patient’s records.

This must involve maintaining arm’s length contact at all times, including when the patient is asleep or using the toilet. The clinician/s should be in sufficiently-close proximity to ensure immediate intervention (arm’s length).

This type of engagement and supportive observation should only be used in exceptional circumstances for the management of extremely challenging behaviour.

Issues of privacy and dignity, consideration of gender issues, religious requirements and environmental dangers should be discussed and incorporated into the patient’s engagement and supportive observation care plan.

A proactive approach is required which includes agreed optimum observation periods by any one nurse/clinician.

With this intense level of engagement and supportive observation, no one nurse/clinician should be allocated to observe a particular patient for more than 2 hours at a time the Nurse in Charge should allocate a rota at the commencement of shift.

In exceptional circumstances, such as when the patient has to be escorted to attend an appointment elsewhere, this may be increased.

Hourly notes should be written and signed on the engagement and supportive observation record sheet (Appendix 3) during the designated period of observation. The record sheet must be passed on to the nurse/clinician taking over the observation.

At the end of each shift, the allocated nurse/clinician for that shift is responsible and must enter a summary of the content into the patient’s daily records.

The possibility of self-harm by patients under supportive observation must never be underestimated as it is unlikely that closer observation will eliminate the desire for a patient to do so. In fact, patients who habitually self-harm are likely to experience an increase in frustration during periods of reduced opportunity to self-harm.

All completed engagement and supportive observations at this level must be recorded hourly using Appendix 3. These records are to be kept within the patient’s notes and electronic record.

Staff observing a patient on level 4 should never leave the patient before the next nurse/clinician on the rota arrives. A verbal handover should take place; if practicable the patient should be made aware of the changeover.
ZONAL ENGAGEMENT AND SUPPORTIVE OBSERVATIONS FOR LEVEL 3 AND BELOW

This is an approach a ward or clinical area may take to enhance observation of a particular group of patients within a specific ward or environment, e.g. a dementia ward. Zonal observations can be plotted against certain times or functions dependent on the ward layout and key tasks relevant to the patient group. Individual needs assessment will inform individual care plans and individual observation levels as detailed in this procedure. A staff member may be assigned to observe and engage with individuals using specified zones within the ward area.

This is prescribed and recorded in patient’s notes. A risk assessment must be completed followed by an Individual management plan which must be agreed and reviewed on a daily basis by the ward team and in-patient Responsible Consultant.

Staff must maintain a constant presence in communal zones and incorporated this approach with patient’s management plan.

Where higher levels of vigilance and monitoring are standard, daily community meetings can be introduced where patients collaborated with staff in planning meaningful activities and a ‘therapeutic day’ (including recreational, therapeutic and physical activities).

The increase in the level of patient engagement with activities would be marked; whilst activities had been on offer before zonal nursing, this approach will free nursing staff to take part in supporting these activities and the consequent engagement by patients would be significantly higher.

Staff observing patients on level 3 should never leave the patient before the next nurse/clinician on the rota arrives. A verbal handover should take place; if practicable the patient should be made aware of the changeover.

COMBINING ENGAGEMENT AND SUPPORTIVE OBSERVATION LEVELS

There may be occasions when it is appropriate to combine engagement and supportive observation levels over a 24-hour period.

Combining engagement and supportive observation levels should be considered when assessing patient whilst asleep or at night. For example, Level 2 and Level 3 of engagement and supportive observation 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, e.g. two patients who are on level 3 of observation could be overserved by one person in one room i.e. during meal times. Other staff must maintain constant presence in case they are needed.

A combination of engagement and supportive observation levels may also be appropriate when ‘stepping down’ for a patient who has been on a long period of intensive observations.
As with all levels of observation, the decision to combine levels must be based on patient’s **risk assessment** and the rationale behind the decision recorded clearly in the patient’s records.

The patient’s care plan must be clear as to the combination of observations and clearly communicated to all staff involved in the care of the patient and, as appropriate, the patient, family or significant others.

This level of engagement and supportive observation is prescribed and recorded in patient’s notes.

**SAFETY HUDDLE**

This is an additional multi-disciplinary team (MDT) review meeting of patients on level of observations due to safety concerns, predominately for falls risk patients on the older adult wards presenting with advanced dementia, delirium or mixed presentation in a confused state, agitated, have a lack of safety awareness and will often try to mobilise without supervision, walking aid, thus increasing falls risk.

The aim of the safety huddle is to discuss fall prevention strategies i.e. medication review, high/low bed, fall sensors for patients at risk of falls or that are repeat fallers. It is a multi-disciplinary team (MDT) decision to review supportive observations and to ensure that if observation levels are reduced i.e. at night time that falls prevention equipment is used.

The safety huddle is led by a senior clinician and the MDT staff (consultant, ward manager/nurse in charge, occupational therapist, physiotherapist, pharmacist and other relevant staff such as the ward activity coordinator and patient’s named nurse) is invited to attend.

The reduction in the level of engagement and 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.

Safety huddle could also be for patients at risk of choking, any safeguarding issues, violence and aggression or any risk behaviour that raises concerns about a patient’s safety.

**PROTECTED ENGAGEMENT TIME (PET)**

For older adult inpatients, protected engagement time (PET) is established at least once daily, for between 1 - 2 hours in the morning or afternoon, not including night time.

During PET the ward is closed to visitors and professionals from outside the ward (with some exceptions depending on how ward staff choose to implement it).

Ward staff do not make phone calls or carry out administrative duties but actively approach patients who were reluctant to engage with the planned programme previously and offer person-centred alternatives.
ENGAGEMENT AND SUPPORTIVE OBSERVATION AND SMOKING
EPUT is a smoke-free organisation and, as such, smoking is not permitted on any part of the Trust site including buildings, entrance/exits, car parks, pavements/walkways and residences. Staff are not permitted to buy cigarettes for patients, hold lighters/matches for patients or escort patients out to smoke. The Trust has agreed its policy in relation to vaping. All members of staff have a role to play in implementing and complying with the Trust Smoke free policy and procedure and are expected to be familiar with its content.

ENGAGEMENT AND SUPPORTIVE OBSERVATION WITHIN 136 SUITES
Whilst in a 136 suite individuals should be continuously engaged and observed; level 3 minimum. Following assessment should the individual then be admitted to inpatient ward either formally or informally an assessment as to level of supportive observation required should be carried out by the admitting ward, taking in to account the patients presentation and assessed risk/risks.

ENGAGEMENT AND SUPPORTIVE OBSERVATION IN GENERAL HOSPITAL
The need for continuous psychiatric engagement and supportive observation must be agreed between the psychiatric ward and the receiving ward. This will depend on the patient’s risk assessment at the time and can be adjusted accordingly.

SPECIAL CONSIDERATIONS
½ hour engagement and supportive observations should be considered for patients on level 1 (general observation) who are physically unwell.

ESCORT AND ENGAGEMENT AND SUPPORTIVE OBSERVATION
Both the receiving and the sending wards will assess the requirements for engagement and supportive observation and establish and record the requirement for escorting/observation in the respective patient’s ward records. EPUT will provide the appropriate escorting/observing nurse when a high level of observations (level 3 and above) are required and recorded in line with this policy and procedure.

SOME PRACTICAL GUIDANCE:
(a) Staff need to be aware of their own thoughts, feelings and attitudes about observations to ensure that they can convey the supportive and therapeutic role of intervention to the individual.
(b) When making decisions about observation levels, the following should be taken into account – the patient’s current mental state, their view (as far as possible), their gender and religious requirements, as well as the environment itself.
(c) Any identified needs/requirements must be reflected within the patient’s Engagement and Supportive Observation care plan.
(d) Respect a patient’s wishes within safety boundaries, and the level of observation in force.
(e) Informed consent, as with any intervention, should be sought when prescribing supportive observation. If there is doubt as to the patient’s ability to consent, a Mental Capacity Assessment must be undertaken.
(f) If an informal patient is considered to require a period of enhanced engagement and supportive observations, a review of their legal status by
the clinical team should take place immediately and a record made in the notes/records of the review and outcome.

(g) The prescribing of level 3 engagement and supportive observation and above to reduce the risk of absconding should only be considered where there are associate risks of harm to self or others, or the absconding behaviour cannot be managed in a less restrictive way, such as escorted leave.

(h) It is not normal practice, given the associated risks, to grant overnight leave to patients on level 2 and above supportive observation, unless the rationale for supportive observation is unit specific e.g. enhanced supportive observation due to vulnerability whilst on the unit, or it is assessed as therapeutically beneficial; e.g. to facilitate a young person spending time with their family. Prior to granting overnight leave for a patient on enhanced engagement and supportive observation levels (3 and above) should only be granted escorted leave following a risk assessment. The assessment must consider the higher level of environmental and other risks present outside the ward environment and staffing level and observation levels adjusted accordingly. Any discussion regarding leave must be documented; this is to include both the rationale for granting or refusing escorted leave.

(i) Staff should balance the potentially distressing effects on the patient of increased levels of supportive observation, particularly for prolonged periods of time, against the risk of self-injury.

(j) Regular engagement and supportive observation of each patient should be maintained throughout the night shift.

(k) Ensure that electronic falls equipment has been assessed and is used appropriately.

(l) Engaging patients in activities can be very therapeutic and occupational therapists / activity coordinators can assist with this where possible.

(m) Nurse management systems should be aimed at increasing direct patient contact by ensuring staff are available to patients as much as possible.

(n) 1:1 session with named nurse allows the patient to discuss concerns and frustrations.

(o) The engaging and supportive observing nurse/clinician should not observe one particular patient for more than 1 hour at a time without a break from supportive observation duties, unless there are exceptional circumstances, i.e. escorting the patient or other incidents.

(p) Consideration should be given to the environment in which the observation is to take place. Where possible, any tools or instruments that can be used to either self-harm or harm others should be removed. It may be necessary to search a patient’s belongings (refer to Trust policy on
Searching Patients and Their Property). If this is deemed necessary, this should be conducted sensitively and with due regard to legal rights.

(q) Observations through glass is only acceptable when checking a patient’s general whereabouts and the patient can be seen fully and is moving around (refer to Trust policy and procedure on the use of seclusion and long term segregation for additional guidance for seclusion).

(r) It is not acceptable to assume that a patient is sleeping from a visual check through a window; the observer must confirm this by a direct engagement and supportive observation including confirming breathing sounds.

(s) If, in order to hear audible breathing sounds, there is a risk that the patient would be disturbed and that this would be detrimental to the patient, the patient’s breathing may be confirmed by the clear raising and lowering of the chest/abdomen which would be an indicator of breathing.

(t) Consideration must be given to communicating with/providing information in an alternative format where necessary, e.g. via an interpreter, audio tape, large print, accessible language.

(u) Engagement and supportive observation levels should be regularly reviewed and the agreed decisions recorded.

(v) As with all details, a patient’s notes/records of engagement and supportive observation must be kept confidential, unless the patient has given permission for or requests otherwise.

**Particular vigilance should be exercised during ‘high risk’ times. These include:**

(a) Immediately upon admission and during staff handovers
(b) During the early stages of recovery
(c) During the early stages of a course of ECT
(d) Following patient’s use of non-prescribed drugs or alcohol
(e) During periods of physical illness e.g. urinary tract infection
(f) Following return from leave
(g) Following a visit from relatives/significant others
(h) When preparing for discharge
(i) Prior to and following transfer
(j) Major changes in care packages.

### 5.0 PROCESS

#### 5.1 Restriction of Liberty

The least intrusive level of observation that is appropriate to the situation should always be adopted so that due sensitivity is given to the patient’s dignity and privacy whilst maintaining the safety of those around them. It is recognised that clinical services will at times adopt harm minimisation and positive risk taking approaches, for example with patients who self-injure. Where these approaches are used, the clinical strategies employed should be clearly documented in the individual patient’s clinical notes and care plan, so as to communicate the appropriate information to all staff working with those individuals. All decisions about the specific level of observation should take into account:
The patient’s current mental state;
Any prescribed medications and their effects;
The current assessment of risk should include the patient’s ability to perceive potential risk;
The views of the patient.

5.2 Communication and engagement
All clinical team members who have responsibility for the delivery of this policy and procedure must have a proper awareness of its implications and an understanding of any role they have in initiating, carrying out, and reviewing supportive observations. In addition, patients who may be subject to this framework need to be fully informed as to the process by which the policy and procedure is applied and reviewed and be given the opportunity to discuss any concerns or questions they may have with an appropriate member of the multi-disciplinary team.

5.3 Human Rights issues
The European Convention on Human Rights (ECHR) has been enshrined in United Kingdom law since 2000. The provisions indicate that everyone has the right to respect for his/her private life (Article 8). No patient should therefore be subject to unnecessarily intrusive observations in a way that would breach this right. In order for this policy and procedure to comply with the law, observation must be justified: the ECHR permits breaches of Article 8 that are necessary for one or more of the following reasons:

- The interests of national security, public safety or the economic well-being of the country; or
- The protection of disorder or crime; or
- The protection of health or morals; or
- The protection of the rights or freedoms of others;
- Proportionate: even if the use of observations is considered justified, it will only be lawful if it goes no further than is reasonably necessary in each individual case to achieve the relevant objectives. When operating this procedure, clinicians will need to make sure that the use of observations remains ‘proportionate’ and that it is no more intrusive – nor continues longer – than is required by the circumstances.

5.4 Prescription of Supportive Observations
The decision to introduce or increase the frequency of observations may in the first instance be appropriately taken by a registered nursing staff or mental health practitioner, when possible in conjunction with medical staff, and in response to an assessed risk. Wherever possible, decisions about the level of supportive observation required by an individual patient should be jointly made by the multidisciplinary team. The actual practice of delivering supportive observation is largely, though not exclusively, a nursing responsibility. However, the Responsible Clinician has legal and professional responsibility for the care and treatment of individual patients. This authority is exercised through appropriate delegation of responsibilities within the multidisciplinary team. Decision making in respect of the authority to change practice should be described within the care plan, so that responsibilities for managing risk are well understood. Decision making can therefore be appropriately delegated to the nurse in charge of a ward or area.
risk assessment and rationale for all changes must be clearly documented in the patient’s care plan and clinical notes.

On admission the appropriate level of observation will be introduced to reflect the degree of risk or potential risk as identified following a thorough risk assessment by the medical and nursing team. A patient on observation higher than level one/baseline observation should not be automatically excluded from off ward therapy, education or leisure. As part of an initial assessment clinical staff will need to consider the following areas:

- CPA information and contemporary risk assessment;
- Information available from care co-ordinator if known to services;
- Expressed intentions;
- Information shared by relatives and carers;
- Implied intentions;
- Past history including previous suicide attempts, self-harm or assaultive behaviour;
- Hallucinations suggesting harm to self or others;
- Paranoid ideas that pose a threat to self or others;
- Recent loss or bereavement;
- Past or current problems with drugs or alcohol;
- Poor adherence to prescribed medication;
- Marked changes in behaviour or medication;
- Risk of falls;
- Risk of physical vulnerability.
- Safeguarding issues

5.5 Managing care for patients subject to supportive observations.

Supportive observation must be used as an opportunity for supportive and therapeutic interaction to meet the holistic needs of patients. Supportive observation & engagement is an ideal opportunity for a holistic assessment to identify and plan care, taking into account the equality needs of patients including the protected characteristics which are; age, race, disability, gender reassignment, marriage and civil partnership, religion and belief, sex, sexual orientation, maternity and pregnancy. Individualised care plans are central to providing considerate care at a potentially distressing time.

The care plan should be viewed as a high intensity engagement plan, explaining what, when & why it should consider/include:-

- Where possible being written in the first person
- Signposting to any associated advanced statement or directive
- Signposting to any Personal Safety plan
- A working formulation related to the behaviour/presentation creating the requirement for increased observation/engagement
- Use of trauma informed principles
- Frequency of safety checking including at night time
- Frequency of observation/engagement recording
Any items withheld from the patient
What should happen during times usually associated with privacy (use of toilet, bathing etc.)
Any delegation of responsibility to change observation levels and under what circumstances
Any gender specific requirements
The recording requirements
The engagement requirements
Activities that have been collaboratively agreed and where necessary escort requirements to accommodate same.
Relapse signs
Trigger factors
Any agreed private time or unsupervised time with family/carers (however please note comment above)
Frequency of review
My Care, My Recovery
My Care, My Support

The care plan should be shared at each hand over. If for any reason, engaging the patient in dialogue and activities during supportive observation is not possible, then the reasons for this needs to be clearly recorded.

The clinical team should continually review risk in developing an effective care plan for a patient subject to supportive observations. If it is considered necessary to search the patient and their belongings then reference should be made to the Trust’s search policy.

Nursing staff, and in particular the nurse-in-charge/shift co-ordinator, ward manager or their deputy, must be aware of the observation/engagement levels on the ward at all times, ensuring there are adequate numbers and grades of staff available for current and future shifts. Observation status should be discussed during ward handover to ensure continuity of care.

Nurses are expected to interact with the patients whilst undertaking supportive observation/engagement. This interaction should include an evaluation of their mood and behaviours associated with identified risk. A record of these interactions should be recorded at least once a shift, and more frequently if the clinical or ward team deem this appropriate. All interactions therefore need to be documented and used in the overall assessment of the patient. Staff therefore who are tasked with providing supportive observation should be given guidance on the focus of their assessment, as well as the activities and interactions to be engaged in.

Risks associated with all patients within inpatient areas need to be considered when making decisions about supportive observation. Particular emphasis should be placed on vulnerability in terms of gender, age, sexuality, ethnicity and capacity to give informed consent. The information gathered should be used to inform the clinical decision regarding supportive observation.
If appropriate to the patient’s needs a request for support from same gender nursing staff should be facilitated where possible, unless there is a specific clinical risk or other reason why this would be inappropriate.

However, where a patient is required to be observed whilst involved in intimate personal care, the support must be provided by a practitioner of the same gender unless there is a specific clinical risk. An hourly summary of the patient’s condition, risk behaviours, significant events and any therapeutic interventions must be recorded.

Supportive observations of patients do not stop at night. There is a duty of care to ensure patients are safe and not in distress either physically or emotionally. It is recognised that patients expect a greater level of privacy after retiring to bed. Observations undertaken at night need to include an assessment of an individual’s well-being with any area of concern or doubt being explored. A nominated member of the nursing team must therefore ensure that each patient is assessed through regular monitoring to ensure they remain safe and that any individual’s distress or abnormal movement should be explored further. The frequency and extent of the monitoring should be led by the level of supportive observation or based upon individual requirements. The Mental Health Act Code of Practice (2015) states that: “Staff must balance the potentially distressing effects on the patient of increased levels of observation, particularly if these levels of observation are proposed for many hours.”

5.6 Patients supportive observation/engagement in off ward areas

Continuity of therapy, education and leisure will remain a high priority for Patients on increased levels of observation. They should not therefore be automatically excluded from off ward treatments/activities.

Patients may wish to take part in faith/religious activities such as praying or meditation within a multi-faith area of the ward or within hospital grounds. Patients should be supported to attend to their faith needs where possible taking into account the patients’ risk assessment.

Decisions regarding attendance should be based on individual risk assessment and not the level of observation the Patient is receiving.

The individual risk assessment should:

- Consider the environmental risk in the area being proposed for the Patient to attend, e.g. observation line, glazing in windows, furniture;
- Consider the treatment/activities within the area;
- Include the member of staff from the area where it is proposed the patient will attend;
- Consider if a ward based staff needs to escort the patient in order to undertake the observation, or whether this can be safely done by a member of staff from the areas the patient is attending;
- Record the details in the patient’s health care record.
Where the responsibility for undertaking the observation is transferred to a member of staff from the area where it is proposed the patient should attend, the observation record sheet should also be transferred to that staff.

5.7 Care provision for young people aged under 18

Any person under the age of 18 years is legally classed as a child; admission of a child under the age of 18 into adult services should be rare; however, if a young person is admitted consideration should be given to the need for 1:1 support via level 3 observations.

This decision should be made on clinical need and risk management grounds, including the need to safeguard the well-being of the young person, it should not be enforced as a blanket policy. If level 3 observations are not utilised good practice would suggest identification of a member of staff to act as a ‘buddy’ and familiar point of contact for a young person on each shift.

5.8 Skills and responsibilities of staff undertaking supportive observations

The registered nurse or mental health practitioner with overall responsibility for a given environment remains accountable for the decision to delegate supportive observational roles to non-registered nurses or students in training, and for ensuring that they are knowledgeable and competent to undertake this role.

Student nurses would not normally be expected to undertake supportive observation, except where this is an agreed part of their learning objectives and all parties are satisfied with their level of competence. Trusts should liaise with their local HEI re local recommendations.

It is recognised that providing supportive observation for patients is stressful and therefore staff should rotate regularly. It is therefore recognised that generally a member of staff should not undertake a continuous period of observation above the general level for more than 2 hours, unless it is seen as appropriate following consultation with the member of staff in question.

When supportive observation is being handed from one member of staff to another, the nurse-in-charge/shift co-ordinator needs to ensure that the member of staff taking over the responsibility is aware of the focus of their assessment; the plan of care; the information documented during the previous shift and the expected activities and interactions to be engaged in. Where ever possible such handover should involve the patient, so that they are involved in key decisions about their care.

5.9 Patient and carer information and involvement

Levels of observation and the reason for their use must be explained to patients, and their carers or relatives where appropriate. Staff should assess whether the patient and or their relative have understood the rationale and implications of using supportive observation which should be clearly documented.
Where a patient, and or their relative, experience difficulty in understanding the rationale and implications of supportive observation then this should be appropriately reiterated and clearly documented.

Trusts should consider allowing carers and relatives to undertake increased observation/engagement at specified times.

5.10 Privacy, Dignity and Confidentiality of the Patient

A solicitor has a duty of confidentiality towards his/her patient and, therefore, there is a presumption that no third party will be present when the solicitor is discussing matters with a patient. However, a presumption may be overridden if there are compelling reasons in a particular case, dependent upon the level of risk.

The risks should be assessed at the time the solicitor is required to attend and it may be necessary to communicate to the solicitor the reasons why engagement and supportive observations will need to continue during the interview.

Whilst the patient’s privacy and dignity should be maintained at all times, it is recognised that there will be occasions, namely when patients are being observed on levels 3 and 4, when this could be compromised, i.e. use of the toilet, bathroom, dressing, undressing and religious observance. In this instance, staff will continue with the appropriate engagement and supportive observation, however in a sensitive manner, ensuring that the patient is aware as to the reasons for this. Appropriate staff (gender, ethnicity, faith, etc.) should be available to carry out the engagement and supportive observations in these situations or at the patient’s request. Where possible, the same gender (as the patient) clinician should undertake the engagement and supportive observation during these times.

Individual and cultural issues in relation to the engagement and supportive observation (e.g. risk in relation to religious observance, wearing clothing which obscures the face or could allow self-harm to be unobserved, sensitivity to gender issues, etc.) must be considered when prescribing observation and allocating clinicians to carry it out.

6.0 SECLUSION / RESTRICTED ACCESS

For seclusion and long term restricted access please refer to Trust policy and procedure, CLP41.

7.0 PRESCRIBING, INCREASING AND DECREASING LEVELS OF ENGAGEMENT AND SUPPORTIVE OBSERVATION

7.1 Prescribing
It should be noted that the assessment of engagement and supportive observation levels is a continuous process from admission through to discharge.

Levels of enhanced engagement and supportive observation must be reviewed in every 24 hour period, including weekends.
This can be done by the senior nurses. However, for good inter-professional working, this procedure recommends that discussion must take place with the nurse and doctor on duty, about the decisions on the level of engagement and supportive observations to be used.

When deciding on levels of engagement and supportive observation take into account; the patient's current mental state, any prescribed and non-prescribed medications and their effects, the current assessment or risk and the views of the patient as far as possible. (NICE: NG10 May 2015).

Use the least intrusive level of engagement and supportive observation necessary, balancing the patient's safety, dignity and privacy with the need to maintain the safety of those around them (NICE NG10 May 2015).

Give the patient information about why they are on engagement and supportive observation, the aims of supportive observation, how long it is likely to last and what needs to be achieved for it to be stopped. If the patient agrees, inform their carer about the aims and level of engagement and supportive observation (NICE: NG10 May 2015).

Record decisions about engagement and supportive observation levels in the patient's notes and clearly specify the reasons for the observation (NICE: NG10 May 2015).

Record clearly the names and titles of the staff responsible for carrying out a review of engagement and supportive observation levels (see recommendation 1.5 above) and when the review should take place (NICE: NG10 May 2015).

Any level of engagement and Supportive observation must be recorded in patient's notes, including the recording any changes made.

A Medical Officer and the senior nurse/nurse in charge can initiate or change any level of observation, following a documented risk assessment. The Nurse in charge may increase a patient's observations at any time. (See s7.2 on the next page/below).

The reasons for increasing or decreasing a level of engagement and SUPPORTIVE observation and any restrictions must be explained to the patient and his/her carers, unless the patient has given specific instructions not to share any information either with carers, or nearest relative. This must be documented in the patient’s records and the consent to share Information must be signed and dated.

The patient's Responsible Consultant must be informed of any decision to raise the engagement and supportive observation level as soon as possible.

Unplanned leave which has not been agreed by the MDT must not be arranged at the weekend and never with a patient still under level 2, 3 or 4.
7.2 Increasing

In addition to medical team, by a senior nurse, band 6 or above who has knowledge of the patient can INCREASE a patient’s engagement and supportive observation status at any time if a patient appears to present a greater risk than originally identified. This decision by the nurse in charge must be communicated to all staff immediately and recorded in the patient’s notes. The ward doctor and the patient’s Responsible Consultant or the doctor covering, must be informed of any such decision as soon as practically possible.

7.3 Decreasing

A patient’s engagement and supportive observation status can be DECREASED by a senior nurse, band 6 or above who has knowledge of the patient in line with a previously agreed management plan, which is clearly documented and agreed by the patient’s responsible consultant, MDT or resident’s GP. A new risk assessment must be undertaken and documented with clear risk management plans in place. At the time of any decrease the medical team must be notified which would include notifying the Duty Doctor if appropriate medical team not available. In the case of the Nursing home residents the senior nurse must email the residents GP following the decrease.

For any level of engagement and supportive observation if there is significant clinical disagreement, particularly concerning a reduction of the level of observation, this must be left unchanged and reviewed by the MDT or Responsible Consultant. A consensus of agreement must be reached explaining reasons and the outcome of the discussion must be documented in all patient records.

If a 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.

7.4 Review of Engagement and Supportive Observation During Weekends

Ideally the multidisciplinary team (MDT) should always make decisions with regard to the prescription of observation. However, on many occasions (particularly at weekends and evenings), decisions may have to be made by a doctor and the ward nursing team. Such decisions must always be discussed at the first available opportunity with a larger number of the full MDT.

7.5 Discontinuation of High Level Engagement or Supportive Observation

Patients must never be removed from any of the engagement and supportive observation levels without discussion and agreement between medical and nursing staff.

Any reduction in engagement and supportive observation level must be a graduated decreasing process taking into account all aspects of risk.

The decision to discontinue engagement and supportive observation levels 2, 3, & 4 must be discussed with the patient’s Responsible Consultant or designated deputy,
MDT and resident’s GP in advance and process documented in the agreed management plan.

The decision must be communicated to all members of the clinical team including the patient. Once an agreement is reached, the decision must be recorded and signed in the care records, as soon as possible by the ward doctor and the nurse in charge.

7.6 Care Planning Supportive Observation

All levels of Observation must be care planned in the patient’s record. The Plan must:

(a) State clearly any additional-specific instructions to be followed by the designated staff member.
(b) Must clearly show the perceived risks which led to the decision, who was involved in the decision and the patients’ opinion of the need for increased observation.
(c) Must have a summary of risk factors relating to engagement and supportive observation plan
(d) Must state the rational for engagement and supportive observation level.
(e) Must identify known risk triggers/changes in behaviour which would increase risk.
(f) Must state what would be the rationale for reducing observation levels e.g. when with visitors or sleeping.
(g) Must have a rationale for cessation of continuous engagement and supportive observation.
(h) There must also be a specific plan for each patient, which outlines the agreed changes in behaviour that would facilitate a reduction in engagement and supportive observation level and the exact procedure for this decision to be actioned.
(i) Must have details of the role of duty medical staff or senior nurses making the decision.

8.0 RECORDING

The outcome of risk assessments and the decision to place a patient on any level of engagement and supportive observation must be clearly recorded in the patient’s notes.

The recording must state clearly any additional-specific instructions to be followed by the designated staff member.

Arrangements for engagement and supportive observation while the patient is using the toilet or bathroom must be recorded under “Special Instructions” in patient’s notes. For example, the member of staff observing the patient may stand outside a closed toilet/bathroom door and may make visual checks and verbal prompts if concerned that something untoward may be happening or there may be a decision to remain with the patient at all times. Staff must always be able to access the room immediately if it is felt necessary.
9.0 RISK ASSESSMENT

The risk assessment must be updated whenever there are changes in the level of risk requiring changes in the level of engagement and supportive observation.

The care plan must reflect changes in the level of engagement and supportive observations.

Assessing and managing risk is the shared responsibility of all practitioners who are involved in the care of the patient, and should preferably be conducted through a collaborative process that includes the patient’s own view (Barker and Buchanan-Barker 2005).

Issues of privacy, dignity and consideration of the gender arising in allocating staff and the environmental dangers need to be discussed and incorporated into the care plan.

Staff must have awareness and show consideration of potentially intruding into a patient’s own space.

An in-date risk assessment must be used to inform decisions regarding the appropriate level of observation, and the person undertaking the observations must be familiar with the patient’s risk assessment and management plan.

The nurse in charge must ensure an identified member of staff is allocated to engage and supportive observe either an individual patient or a group of patients at the start of each shift.

Any searching of a person and belongings will be conducted where possible with consent as well as sensitively with due regard to legal rights as per Trust Policy Searching Patients Property (CLP75) and Secure Services Searching Policy (SSOP22) and taking into account gender issues.

It may be necessary to remove any tools or instruments that could be used for self-harm or harm to others. It may be necessary to search the patient and their belongings, while having due regard for the patient’s legal rights and conducting the search in a sensitive way. This may include any religious clothing.

In-patient teams caring for those who have been identified with suicidal thoughts and presenting as a significant risk, must thoroughly check AND remove all potential ligatures from the identified patient at risk. This includes belts, ties, shoelaces and bandages (DOH Safety First, 2001).

If consent is not given staff must consult the Responsible Consultant /Senior Nurse Manager/Site Officer/Unit Co-ordinator as per Trust Search Policy CLP75.
At all levels of observation, following each engagement and supportive observation period there must be a handover to staff, this should include, as far as is appropriate the views of the patient.

Risk Assessments must include consideration of High Risk periods including for newly detained inpatients and those within the first seven days of admission evening and at night, Safety First” (DOH, 2001).

Immediately upon admission, every patient must have a risk assessment as per CPA Policy with a management plan developed taking into account possible periods of increased risk for example:
- evenings and night
- reduced staffing
- difficulties in observing patients due to environmental difficulties
- any apparent improvement in a patient’s mood
- actions to be taken in account of these increased risks

The assessment must be completed and appropriate level of observation prescribed on admission and reviewed at least within 72 hours, and as necessary.

Measures must be taken to address blind spots within environments e.g. parabolic mirrors, and any issues identified from environmental audits.

The patient who is considered to be at imminent risk of suicide, or has committed an act of self-harm, is considered at risk of harm to others or deemed vulnerable must be kept on the ward on a specific supportive observation status considered necessary by the team for the first 72 hours or longer.

If the patient is reluctant to remain on the ward, or, insists on leaving the ward, a mental health assessment for possible detention under the Mental Health Act must be made.

Risk assessment includes an interview with the patient and carers, careful study of the patient history, use of ratified risk assessment tools and must take into account the assessments of other professionals as well as the patient, e.g. Social Workers, Psychiatrists, Community Psychiatric Nurses (CPNs), G.P’s, Community Mental Health Team (CMHT) or Family.

Any thoughts, feelings and wishes with regard to suicide, self-harm and harm to others must be approached using direct and respectful questions.

The patient notes, in particular the key events chart are a vital source of information about past behaviour, as are relatives, friends and carers.

Attention to the following factors are considered important: planned intent, severity of planned intent, access to means, preparation, avoidance planning, post-death provisions, recent loss, marked changes in behaviour or medication, paranoid ideas where the patient believes that others pose a threat, withdrawal/disengagement, sudden calmness and denial of recently expressed thoughts/intent and past
incidents/incident on Datix. In some instances advance directives/statement may be available.

A previous history of suicidal attempts or of attacks on others suggests that the patient must be observed until a full assessment can be carried out but this must not automatically mean someone is placed upon increased observation.

Any prescribed medications and their effects must be taken into account together with any recent changes. Please refer also to the following policy/guideline:

CPA and Non-CPA Policy
Secure Services Searching Patients Property MHA 28

10.0 TRAINING

Training of staff in the skill of engagement and observation is provided as part of an e-learning OLM - Online programme.

<table>
<thead>
<tr>
<th>CORE PRACTICE</th>
<th>UPDATE INTERVAL</th>
<th>STAFF CATEGORY</th>
<th>DELIVERY METHOD</th>
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<tbody>
<tr>
<td>Engagement and Observation Training</td>
<td>Annually</td>
<td>Inpatient Mental Health / Learning Disability Nursing Staff</td>
<td>E-Learning</td>
</tr>
</tbody>
</table>

Senior Clinical Staff are responsible for ward based training and ensuring ongoing competency of staff in engagement and observation. Each ward must ensure staff are informed about current requirements, through ward based induction, preceptorship and supervision. Specific training for engagement and supportive observation and engagement will be provided through e learning, and competency will be checked and deficits addressed through the above processes.

The Workforce Development and Training Department will report monthly on compliance levels for mandatory training for the Executive Team, Workforce and Business Support Service Board and Health, Safety and Security Committees.

The training tracker shows staff compliance and aggregated compliance statistics are produced in a monthly report. Managers are responsible for ensuring staff take action to undertake training as soon as possible.

Team Managers/Ward Manager are responsible for checking which training has been undertaken by a member of staff through:

- Training Tracker list which is on intranet.
- Reviewing monthly training report.

Staff who are booked onto mandatory / core practice training and are, for whatever reason, unable to attend, MUST inform their relevant director of their reasons.
Staff who do not attend a mandatory or core practice course will receive notification from the Systems Helpdesk informing them of their non-attendance and managers will receive a copy of this. From this information non-attendees will be automatically re-booked onto another course by the Information Department.

If an individual fails to attend on the second occasion, the Service Director will be notified and the conduct procedures will be initiated if appropriate.

11.0 MONITORING AND AUDIT

Observation is a frequent and significant event in in-patient settings. The nurse in charge will routinely monitor implementation and compliance with this clinical guideline.

It is the responsibility of each ward manager to monitor the implementation of this clinical guideline within each ward and to maintain competency records.

It is the responsibility of each Ward Manager to ensure that employees undertaking the engagement and supportive observations of patients complete the agreed records / documentation as set out within this procedure and its Appendices.

A component of management supervision must include the scrutiny of records / documentation relating to the engagement and supportive observation.

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, with the support of the clinical audit department.

The audit will include as a minimum:

- Roles and responsibilities
- Process for observations of different levels
- Record keeping

Patient’s notes can be used when auditing of the frequency, level and duration of increased levels of observation as well as the clinical reason[s] behind the choice.

The patient’s notes must state clearly any additional/specific instructions to be followed by the designated staff member.

- Must clearly show the perceived risks which led to the decision, who was involved in the decision and the patients’ opinion of the need for increased observation. This audit trail is key information both in monitoring of frequency of the usage of raised levels of observation and in Critical Incident Reviews.
- Summary of risk factors relating to engagement and supportive observation plan
- Rational for engagement and supportive observation level.
- Known risk triggers/changes in behaviour which would increase risk
What would be the rationale for reducing observation levels e.g. when with visitors or sleeping.
- Rationale for cessation of continuous engagement and supportive observation.
- There must also be a specific plan for each patient, which outlines the agreed changes in behaviour that would facilitate a reduction in engagement and supportive observation level and the exact procedure for this decision to be actioned.
- Details of the role of duty medical staff or senior nurses making the decision.

The following will also be audited:

- Clinicians understanding of the policy and procedure and different observation levels
- Have staff been assessed against observation core competencies (Competency is checked with staff using Appendix 2)
- Clinicians’ awareness of their responsibilities and accountability
- Where applicable has the relevant paperwork been completed in line with this policy and procedure.

The findings of such audits will be reported to the relevant Director and discussed at relevant local quality/governance groups and committees.

The outcome of audits will be used to inform any review and / or changes to this policy and procedure and the Trust’s programme of training.

The monitoring of training compliance will be undertaken by Workforce, Development and Training as outlined in this procedure.

### 12.0 A QUICK REFERENCE GUIDE TO THERAPEUTIC OBSERVATION

<table>
<thead>
<tr>
<th>Level 1 (General SUPPORTIVE Observation)</th>
<th>Level 2 (Defined SUPPORTIVE Observation)</th>
<th>Level 3 (Within Eyesight)</th>
<th>Level 4 (Within arms-length)</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>What is it?</strong></td>
<td>Defined random checks of the patient. at least <strong>four</strong> times during each hour at <strong>irregular</strong> intervals.</td>
<td>Continuous engagement and SUPPORTIVE observation of the patient keeping them within eyesight.</td>
<td>Continuous engagement and SUPPORTIVE observation of patients keeping them within arms-length.</td>
</tr>
</tbody>
</table>
**When should it be used?**

<table>
<thead>
<tr>
<th>When</th>
<th>For all inpatients unless a higher level of engagement and SUPPORTIVE observation is indicated.</th>
</tr>
</thead>
<tbody>
<tr>
<td>For patients assessed as being potentially at risk of absconding and/or disturbed or violent behaviour, or requiring regular monitoring due to physical condition and/or effects of medication. Can be used as step down from a level 3.</td>
<td></td>
</tr>
<tr>
<td>NB Must not be used if patient at risk of self-harm/suicide risk</td>
<td></td>
</tr>
<tr>
<td>For patients assessed as being at a high risk of harming themselves or others or where constant monitoring of the patient’s physical condition and/or effects of medication/treatment is required. May be used for managing absconding issues when all other management strategies have proved ineffective.</td>
<td></td>
</tr>
</tbody>
</table>

**Who decides?**

<table>
<thead>
<tr>
<th>Who</th>
<th>Nurse In Charge or Medical Team</th>
</tr>
</thead>
<tbody>
<tr>
<td>Engagement and SUPPORTIVE observation level may be increased or decreased at any time by the nurse in charge, following consultation with the MDT. The Responsible Clinician’s opinion must have been previously sought and recorded indicating potential reasons for changes in observation level.</td>
<td></td>
</tr>
<tr>
<td>Engagement and SUPPORTIVE observation level may be increased or decreased at any time by the nurse in charge following consultation with the MDT. The Responsible Clinician’s opinion must have been previously sought and recorded indicating potential reasons for changes in observation level.</td>
<td></td>
</tr>
<tr>
<td>SUPPORTIVE observation level may be decreased at any time by the nurse in charge following consultation with the MDT. The Responsible Clinician’s opinion must have been previously sought and recorded indicating potential reasons for changes in observation level.</td>
<td></td>
</tr>
</tbody>
</table>

**Who can carry out SUPPORTIVE observation?**

<table>
<thead>
<tr>
<th>Who</th>
<th>Experienced member of staff (registered/</th>
</tr>
</thead>
<tbody>
<tr>
<td>Experienced member of clinical staff or student nurses in final</td>
<td></td>
</tr>
<tr>
<td>Experienced member of clinical staff or student</td>
<td></td>
</tr>
<tr>
<td>Experienced registered clinician.</td>
<td></td>
</tr>
</tbody>
</table>
unregistered). Year of training under supervision. When delegated to an unregistered clinician or student this is under the supervision of a registered member of nursing staff. Nurses in final year of training. When delegated to unregistered clinician or student this is under the supervision of a registered member of nursing staff. When delegated to unregistered clinician this is under the supervision of a registered member of nursing staff.

<table>
<thead>
<tr>
<th>How often should SUPPORTIVE observation levels be reviewed and by whom?</th>
<th>Review at regular intervals – daily.</th>
<th>MDT Mandatory review every 24 hours</th>
<th>MDT Mandatory review every 24 hours</th>
<th>MDT Mandatory review every 24 hours</th>
</tr>
</thead>
</table>

**Special considerations**

1/2 hour SUPPORTIVE observations when patients are physically unwell. Where a unit decides to SUPPORTIVELY record using a checklist etc. this must explicitly state the time the patient was seen / checked and their whereabouts on the unit. Also who carried out the engagement and SUPPORTIVE observation on the patient.

Minimum number of checks, i.e. 4 an hour (maximum of 6). The observation level/ frequency of checks can be increased/decreased dependent on assessed level of risk. Careful consideration of identified and potential risks should be given prior to granting leave.

**Engagement and SUPPORTIVE Observation record sheet must be completed.**

Leave from the unit should only be granted in exceptional circumstances whilst on this level engagement and SUPPORTIVE observations.

**Engagement and SUPPORTIVE Observation record sheet must be completed.**

Leave from the unit should only be granted in exceptional circumstances.
13.0 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

14.0 REFERENCES


Dennis, S. SUPPORTIVE Observation in acute in-patient setting: Mental Health Care vol.21, Sept.1998

Department of Health Safety First ‘February 2001


Seclusion & Long Term Segregation Policy - CLP41.


NICE guidelines [NG10] Published date: May 2015


Standing Nursing and Midwifery Advisory Committee (SNMAC) Practice Guidance: Safe and Supportive Observation of Patients at Risk, June 1999

The Scottish Office Home and Health Department clinical research advisory group (CRAG) CRAG/SCOTMEG. Nursing observation of acutely ill psychiatric patients in hospital. Edinburgh: HMSO, 1995

Observation and Engagement Policy: Anne Leithch, Southern Health NHS, April 2015


Metal Health Act 1983 as amended by the Mental Health Act 2007 and Revised Code of Practice


END