Essex Partnership University
NHS Foundation Trust

THERAPEUTIC ENGAGEMENT AND SUPPORTIVE OBSERVATION POLICY (INPATIENTS)

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See Procedure	
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See Procedure	

Services	**Applicable**	**Comments**
Essex MH&LD services	✓	

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

Therapeutic Engagement and Supportive Observation Policy (Inpatients)

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ESSEX PARTNERSHIP UNIVERSITY NHS FOUNDATION TRUST

THERAPEUTIC ENGAGEMENT AND SUPPORTIVE OBSERVATION POLICY (INPATIENTS)

Assurance Statement

1.0 INTRODUCTION

Therapeutic Engagement and Supportive Observation is an intervention by which staff engage with a patient to develop a therapeutic relationship, offer therapeutic intervention and to reduce risk to the patient and others on the ward.

It is imperative that this policy has patients and their loved one's experiences at the heart of it. In partnership with reading this policy therefore, please pay particular attention to Appendix 1 "A Case Study – Frankie's story" and Appendix 2 "A Patients View", whereby you can read about experiences of patients and a carer in relation to observations. Please also see and use Appendix 3, which is an information leaflet for patients, relatives and carers.

Therapeutic Engagement and Supportive Observation should be used to support care and treatment and not purely to avoid risk. It is an opportunity to build therapeutic relationships and maximise the opportunity for therapeutic support. It should be goal directed and seen as an integral part of the inpatient care plan, one that will also contribute to the management and reduction of risk. It should take 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 mindful of patient and carer preferences are central to providing considerate care at a time of increased need and vulnerability; and in order to promote dignity.

Enhanced Therapeutic Engagement and Supportive Observation should be used to provide intensive support in response to the patient having increased mental and/or physical health needs. Enhanced observations are defined as anything above hourly checks and can be restrictive in practice. They need to be weighed up with the potential benefits therefore.

This policy, 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.

The purpose of this policy is to make clear the standards expected of clinical staff for the Therapeutic Engagement and Supportive Observation of (and with) patients, and when appropriate their carers. This policy will provide staff with direction and guidance for making decisions about observation levels including reviews, correct completion of documentation and training requirements.

This policy and its associated procedures have been developed with the following principles:

Observations of this kind provide opportunity to build therapeutic relationships. Engaging with a person whilst carrying out observations can have a positive effect on levels of distress, promote feelings of safety and are seen as being supportive rather than punitive. Ongoing assessment, engagement and intervention being used to recognise risk to self and/or others and/or from others i.e. in cases of vulnerability or disinhibition; and proactively and therapeutically manage such risk.

This means that:

The level and the reason for any enhanced Therapeutic Engagement and Supportive Observation must be clearly recorded in the patient's clinical notes. This is particularly important for any changes to the level of observations also.

Therapeutic Engagement and Supportive Observations cover the whole 24-hour period. This means when the person is sleeping there is still a requirement for the staff member to check their physical well-being (non-contact observations unless as assessed as needing more). It should be carried out with minimal disturbance to the patients sleep; however, safety must be prioritised. When the patient is resting, staff should still take the opportunity to check on their physical and mental well-being and ensure there is no loss of vital signs. All observations will be recorded on the appropriate observation recording form.

2.0 ROLES AND RESPONSIBILITIES

2.1 As per *CLP28 Clinical Risk Assessment and Safety Management*; accountability and responsibility for managing clinical risk is one that is shared between the organisation, individual practitioners, patients and carers.

2.2 **The Trust Board** is responsible for:

- Ensuring that the principles of this policy and procedure and other associated policies are implemented across the organisation;
- Ensuring necessary financial resources
- Ensuring there is an appropriate and adequate infrastructure to support the engagement and supportive observations of patients and that patient are safeguarded, and their equality and human rights is not compromised.

2.3 **The Executive Director of Nursing** will ensure:

- That this policy and procedure is embedded into clinical practice and monitored;
- The regular review and updating of this policy and procedure and in accordance with national guidance and promotes engagement and supportive observations, of patients and safeguards against unnecessary use of restrictive practice;
- The identification and implementation of training to meet educational needs arising from any relevant audits, reviews, reports and lessons learnt.

2.4 **Directors / Associate Directors** will:

- Co-ordinate the management of clinical risk within the Trust and identify risks in a clinical context. This includes designing and implementing steps to investigate those risks.
- Report to the appropriate Committee/Quality *group* for decision-making.
- Have a structured, robust approach to incident investigation which looks beyond immediate actions and assumed causes and identifies the contributory factors, latent conditions and root causes which lead to an incident occurring.
- Address with relevant line managers clinical risk issues such as ligature risks in line with the associated trust policies.
- Support services in being aware of and implementing best clinical practice, evidence based interventions and engagement skills.

2.5 **Clinical Directors** will be responsible for ensuring all medical staff are conversant with this policy and procedure.

2.6 **Service Managers** will:

- have operational responsibility for clinical services compliance with this policy and procedure, and will ensure mechanisms in place within each service for:
  - Identifying and deploying resources within the clinical service to safely deliver this policy and procedure.
  - Monitoring the clinical services' compliance and consistent application of the policy and procedure through Matron's Assurance and clinical audit.

2.7 **Multidisciplinary Care Team** will:

- Have a responsibility to understand their role in initiating, carrying out 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, in line with *Trauma Informed Principles* (Appendix 4). Where possible, the reasons for initiating and maintaining observations should be discussed and explained to the patient in keeping with collaborative and therapeutic working.
- Regular review of levels of observation and risk are required, at least once per shift, as well the period the patient has been on the level of observations. This should consist of reviewing the individual risk and whether observations are effective in reducing this. This review should be done with the patients input where this is supportive. If for a prolonged period, the review should be balanced with effectiveness of the intervention and the risk.
- Reviews must consider how observation can be undertaken in a way which minimises the likelihood of individuals perceiving the intervention to be intrusive and must consider their trauma history. In addition, how observation can be carried out in a way that respects the individual's privacy as far as practicable and minimises any distress.
- Ensure a record is made of decisions agreed in relation to increasing or decreasing the observation following review. This record must include the patient's views and participation in the review and reasons as to why they were unable to participate and whether they have been advised of their right to have an advocate.
- Ensure the care plans 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.

2.8 **Responsible Clinicians** will:

- Have a legal and professional responsibility for the care and treatment of patient.
- Ensure they are kept up to date on the patient's care.
- Ensure they provide input to patient's current care plan and observational requirements.
- Provide advice when uncertainty arises regarding level of observation required.

2.9 **Matrons / Integrated Clinical Leads** will:

- Provide assurance to the service managers that their wards are compliant with the requirements of this policy and procedure through Matrons Assurance.
- Have oversight of all engagement and supportive observations on their units.
- Be responsible for monitoring staff competencies for carrying out engagement and

supportive observations.

2.10 **Ward Managers** will:

- Have overall accountability for the management of their ward and must ensure that:
    a) All clinical staff (permanent, bank and agency) with responsibility for prescribing and carrying out therapeutic engagement and supportive observation have read and understood the content of this policy and procedure. They must keep records that staff have done this as part of induction to the ward.
    b) Ward staff understand their role in initiating and reviewing such observations.
    c) Ward 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.
    d) Care plans are in place and appropriately identify the required level of observation.
    e) Documented risk review accompanies the decisions made to change the levels of observation.
    f) Deployment of the available resources to safely deliver this policy and procedure on their ward.
- Identify and respond to any areas of non-compliance with this policy and procedure on their ward, escalating as necessary and ensuring that staff competency records are up to date and maintained. Use opportunities for reflective practice and identify staff that may require further support.

2.11 **Nurse in Charge** will:

- Be responsible for identifying staff who are best placed to carry out level 2, 3 or 4 observation. This selection should take account of the individual's characteristics, circumstances (including factors such as experience, ethnicity, sexual identity, age and gender) and preferences where possible. They should also take into account the individual's care plan and the rationale for their being on observations as well as any patterns of heightened risk that have previously been identified for that individual. Use professional judgement to allocate numbers of staff to the levels of observations to be carried out on the ward, along with other duties.
- Ensure staff allocated to undertake observations have been assessed as competent to do.
- Ensure all documentation is completed by assigned staff by the end of shift.
- Support the Nurse in Charge on other wards within their unit in decisions with changes of observation levels.

2.12 **Site Coordinator** will:

- Support wards and nurse in charge to review observation levels out of hours when needed.

2.13 **All Registered Inpatient Clinical staff** will be responsible for:

- Understanding their role in initiating, carrying out and reviewing therapeutic engagement and supportive observations.
- Carrying out that role in line with this policy and procedure.
- Completing the care plan with their named patient; and when appropriate/ with consent of the patient including their family or carer's in constructing this.
- Including each patient in the decision of what level of observation they are support on

and the reasons for this with a focus on collaborative goal setting.

- Reviewing the level of observation based on recorded clinical need and risk review.
- Ensuring the care plan is implemented.
- Ensuring the periods of observation are viewed and used as opportunities to build a therapeutic relationship.
- Completing all the required documentation.
- Fully familiarising themselves with this policy and procedure.
- Ensuring 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.

2.14 **All Non-Registered Inpatient Clinical staff** will be responsible for:

- Understanding their role in carrying out therapeutic engagement and supportive observations, this includes ensuring that they have an understanding of the reason for the patient being on such observations and have received a handover before commencing any period of engagement from the person who was previously assigned and from suitably qualified clinical staff.
- Carrying out such observations in line with the observation level prescribed.
- Ensuring the periods of observation are viewed and used as opportunities to build a therapeutic relationship; in line with the ambition of moving from a culture of observation to engagement.
- Becoming familiar with, and implementing, the patient's care plan.
- Completing the required documentation accurately and contemporaneously.
- Reporting any relevant information that would assist the effective review of the patient's needs.
- Escalating any concerns they may have e.g. with regards to ensuring a patient's dignity and maintaining a safe level of care with the Nurse in Charge or suitably qualified substitute.

2.15 In order to achieve the aim of minimising and managing risk, the following mental health practice standards will be implemented. These include standards set by the Royal College of Psychiatrists, the Nursing and Midwifery Council and the Health and Care Professions Council (HCPC).

All staff will:

- Receive a local induction and be briefed on appropriate procedures. Individuals will be required to sign to confirm that the following areas have been covered within their induction: clinical policies; record keeping policies; agreed clinical protocol for ECT; security training for secure services.
- Have clear lines of responsibility for the administrative maintenance of clinical records, including the filing of reports and records of treatment CP9 Record Management Policy.
- Have access to Trust's electronic systems. That will be fully documented within Essex; systems will be in place to ensure ease of access and 24-hour availability of information for all clinical staff (CPA and Non CPA Policy); and within Bedfordshire, systems will be in place to ensure that out of hours' contact is documented as soon as is practicable.

- Have a clear understanding of the interface between health and social care. It is essential that care plans, support plans and risk management safety plans record the responsible agency and individual.

3.0 DEFINITIONS

3.1 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, physical 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 is not limited to but can include:

- 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 or facilitating visitors.
- Social Interaction — (Respect patient's right for silence). If patient wishes to talk, introduce general conversation topics. Explore their previous or current hobbies or interests. Do not assume that the patient prefers silence and take responsibility for initiating conversation; or facilitating conversations with their peers.
- Promoting or developing 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. Coping strategies may include identifying emotions, thoughts or urges, distraction through activities such as colouring in, reading, imagining a safe place or a future experience, breathing exercises – this can be as simple as breathing in and out at a count of four, engaging with the senses – smell; sight; taste; touch; sound to self soothe.
- Therapeutic intervention – support access to on-ward therapeutic interventions and promote participation in groups including when necessary with adaptations.
- Physical activity – walking around the ward, garden or around the grounds (if care plan allows). This is an opportunity to implement a '5,4,3,2,1' activity; where you each name 5 things you can see, 4 things you can hear, 3 things you can smell, 2 things you can touch, 1 thing you can taste.
- 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/fidget toys, listening to music.
- *Safewards interventions* that may be available on the ward, e.g. Mutual Help Meetings, Coping Box, reading messages on the discharge tree – see (www.safewards.net for more information).

Engagement with patients can include any of the following:

- 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** – e.g. going to a space that is less noisy and busy, or with reduced lighting.
- Mechanisms for **Soothing** – e.g. music, sensory 'toys', weighted blanket.
- Mechanisms for **distracting attention** – e.g. music, sucking sweets, popping bubble wrap, colouring-in, playing a game/sport, something that brings mental stimulation.
- 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.

  (see also Appendix 5: Engagement Prompt Card, Appendix 6: Stepping into my shoes and Appendix 7: Coping with hearing voices for resources created by Lived Experience Ambassadors and Patients, and the Hearing Voices Network for resources to use for engagement

3.2 Observation:

Engagement and 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 cared for on defined or higher engagement and supportive observations levels, it is key that staff know the reasons why an individual is on this level of observations and can respond accordingly.

Some of these risks may be:

- 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

3.3 Levels of Observations:

3.3.1 Level 1 – General Observations

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, or able to manager the risks through a different intervention/way. The frequency of engagement and supportive observation is once every 60 minutes. This is prescribed and recorded in patient's notes. Any patients unaccounted for must be reported immediately to the nurse in charge. No member of the clinical team (Registered Nurse, Health Care Assistant, Doctor, Psychologist, Occupational Therapist, Activities Co-ordinator etc.) will be assigned to conduct therapeutic and supportive observation at any level for more than two hours at a time.

3.3.2 Level 2 – Intermittent Observation

With this level of enhanced observation, the patient's safety must be visibly checked a minimum of four times at irregular intervals within every one-hour period. The patient must not be able to predict the pattern or to anticipate the time of the next checks. This enhanced level of observation 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, or are at risk of vulnerability but in the process of recovery. This is prescribed and recorded in the patient's notes.

This level of Therapeutic Engagement and Supportive Observation, as with all levels of enhanced observations, must be reviewed on a shift-by-shift basis.

The Nurse in Charge should allocate an observations rota at the commencement of a shift. During each shift, the allocated observers 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.

In order to provide adequate opportunity to engage, no member of the clinical team will be assigned to observe more than three patients on Level 2 at one time.

Changes must be recorded in case notes and any concerns reported to the Nurse in charge.

It is worth noting that during research completed by Len Bowers there was no statistically

significant association between constant special observation and self-harm outcomes. The lack of association with self-harm suggests that the use of constant observation could be reduced without compromising patient safety.

3.3.3 Level 3 – Continuous Within Eye Sight

This means a nominated staff member will be allocated to each patient being managed on this level of observation and the patient must be kept within continuous eyesight and the observer is able to engage with the patient as per care plan. 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 and at immediate risk

This is prescribed and recorded in patient's notes. Hourly notes must be written and signed on the Therapeutic Engagement and Supportive Observations Record Sheet 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.

3.3.4 Level 4 – Continuous 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; more than one nurse may be required to implement this level of observation safely.

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 is prescribed and recorded in patient's notes. Hourly notes must be written and signed on the *Therapeutic Engagement and Supportive Observations Record Sheet* 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.

3.3.5 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 more than one member of staff and/or at arm's length of more than 1 staff member.

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

3.4 Zonal Engagement and Supportive Observations

This is an approach a ward or clinical area may take for level 1, 2 and 3 observations 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 policy and procedure. A staff member may be assigned to observe and engage with individuals using specified zones within the ward area.

Staff must maintain a constant presence in communal zones and incorporate this approach with each patient's management plan within those established zones.
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 at least once a week.

3.5 Applicable to all levels of Observations

Issues of privacy and dignity, consideration of whether a patient might benefit from a member of staff being a particular gender carrying out observations, religious requirements and environmental dangers should be discussed and incorporated into the patient's therapeutic engagement and supportive observation care plan.

In exceptional circumstances, such as when the patient has to be escorted to attend an appointment elsewhere, the level of observation may be reviewed to ensure the time away from the ward happens safely and in a supported way.

The possibility of self-harm by patients under supportive observation must never be under estimated 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.

A proactive approach is required which includes agreed optimum observation periods by any one nurse/clinician. Staff observing a patient on level 3, 4, or multi professional observations should never leave the patient before the next nurse/clinician on the rota arrives and the appropriate handover has been conducted.

All checks must be recorded on the *Therapeutic Engagement and Supportive Observations Record Sheet*, stating exact time, location, activity and/or presentation of patient and any interventions or actions taken. Entries are signed off by the observer

3.6 Combining Therapeutic Engagement and Supportive Observation Levels

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

A combination of 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 followed by an individual management plan which must be agreed and reviewed at least once a week. 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.

3.7 Leave from the ward

Due to the level of risk someone is being support to manager under enhanced engagement and supportive observations, it is assumed that the patient should not have time away from the ward, until these are reduced. However, it is important that care is individualised and so if there are individual whereby the team feel it is in the patient's best interest to access leave, and then a multi-disciplinary decision will take place, and should involve the views of the patient and their carer/s. This decision should be clearly documented within the patient notes. The plan for leave should be clearly set out in the care plan, with a plan as to how the person's safety will be maintained while off the ward

The team may reduce the level of engagement and supportive observation that the person is on for this to happen, and a decision will be made as to whether the leave is escorted by staff or not.

3.8 Safety Huddle

This is an additional multi-disciplinary team (MDT) review meeting of patients on level of observations due to safety concerns or the deterioration in mental or physical state of the patient being observed. See *CG20 Handover Guidance* for definition and details regarding Safety Huddles.

The safety huddle is requested by anyone within the team 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.

They are an opportunity for a quick and proactive review of care, raising concerns and obtaining support in implementing any necessary interventions. Outcomes should be recorded in the patient's notes to support ward review, MDT review etc.

3.9 Carers

Carers are an integral part of someone's care and risk assessment. Carers will often be able to support professionals in telling them about what the individual is usually like, when well, and how they best engage with others. This brings a key opportunity for staff to better individualise care.

Where the patient has given consent, the carer should be updated in a timely manner about the level of observations the patient is on, and the rationale as to why. The carer should be given the opportunity to give their view on this. The carer should also be welcomed to review this level of observations with the MDT and patient themselves. This includes being able to discuss concerns when decisions are being made to 'downgrade' a patient's observation levels, and to have their voices heard and listened to when practically possible.

In the absence of carer involvement, all patients should be aware of their right to have an Independent Mental Health Advocate or an Independent Mental Capacity Advocate.

Appendix 3 gives an information leaflet that carers can also be given, about Therapeutic Engagement and Supportive Observations.

4.0 PRINCIPLES

This policy and associated procedure follows the general principles issued by the NICE guidance (NG10 Violence and aggression: short-term management in mental health, health and community settings 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 member of the clinical team should set aside dedicated time to assess the mental state of, and engage positively with, each patient. As part of the assessment, the engager should evaluate the impact of the patient's mental state on the risk of violence and aggression, record any risk in the notes; report any concerns to the Nurse in Charge.

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. It is also important that observations are collaborative with the patient; and are seen as opportunities for enhanced support when particularly vulnerable to proactively reduce risk and promote safety. On these occasions, the patient should feel able to advocate for a short term therapeutic intervention that at another time may be viewed as a restrictive practice in order to promote their long term recovery and coping strategies.

Decisions about what level of observation a patient requires will be based and supported by documented evidence of assessed current need. Where discussions for prescribing observations take place, the clinical teams will ensure they factor any information with regards to the patient's trauma history. To then consider how restrictive interventions, such as high levels of observation, may impact on them in harmful ways such as re-traumatisation. For example, a patient with a history of interpersonal trauma, such as domestic violence or sexual abuse, may experience re-traumatisation as a result of being constantly watched on observations, or when otherwise restricted or even secluded; this is because feelings associated with past traumatic experiences, such as being unable to escape, being violated, or lacking control over their lives, may be recreated and re-experienced in the present as a result of the restrictive intervention. A service-user's preferences in terms of the gender of the staff who undertake restrictive interventions, such as observations, must also be considered.

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.

5.0 MONITORING OF IMPLEMENTATION AND COMPLIANCE

5.1 A Trust wide audit will be undertaken at the minimum of every three years. The policy author will usually lead the audit, with the relevant clinical leads responsible for collecting data in their area. The clinical audit will be supported by the clinical audit department.

The following will be audited:

- Clinicians understanding of the policy and procedure and the different observation levels.
- Staff have been assessed against observation core competencies.
- The relevant paperwork has been completed in line with this policy and procedure. This includes the patients' notes for decision making, levels and duration of increased levels of observation as well as the rationale for decision.
- Have we gained feedback from patients about their experience of Therapeutic Engagement and Supportive Observations.
- A Lived Experience Ambassador to complete a peer review of the quality of such observations.

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 the clinical audit will be used to inform any review and/or changes to this policy and procedure and the Trust's programme of training.

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

5.3 Service Managers will monitor compliance and consistent application of the policy and procedure through matron's assurance and clinical audit.

5.4 Ward managers and matrons will monitor the implementation of this policy via supervision with staff. A component of management supervision must include the scrutiny of records/documentation relating to the Therapeutic Engagement and Supportive Observation. Please refer to the *1:1 Support and Appraisal Policy and Procedure HR48*.

5.5 The policy and procedure will be available via the Trust Intranet site.

5.6 Any amendments to this clinical policy will be submitted to the Clinical Governance & Quality Sub-Committee for approval.

5.7 This clinical policy and associated procedure will be reviewed at least once every three years, or sooner should there be a need to revisit the contents following any updates in national guidance, outcomes of any untoward incidents, changes roles and responsibilities or changes in practice.

5.8 The Therapeutic Engagement and Supportive Observation recording takes place on Oxehealth which pulls information through to Mobias/Paris and Oxehealth. Documentation is required for each time a level of Therapeutic Engagement and Supportive Observations are comleted (hourly for Level 3 observations and level 4 observations, intermittently through the hour for level 2 observations and hourly for level 1 (general observation). Please refer to the Oxehealth SOP

6.0 POLICY REFERENCES / ASSOCIATED DOCUMENTATION (EXTERNAL)

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7.0 THIS POLICY SHOULD BE READ IN CONJUCTION WITH THE FOLLOWING TRUST DOCUMENTS

- CLP41 Seclusion and Long Term Segregation Policy and Procedure
- CLP28 Clinical Risk Assessment and Safety Management Policy and Procedure
- CLP30 Care Programme Approach (CPA) & Non-CPA (Standard Care) Policy and Procedure
- RM05 Therapeutic and Safe Interventions and De-escalation Policy and Procedure CPG3 Adverse Incident Procedure, including Serious Incidents
- CLP75 Searching Patient's/Visitor's Property Policy and Procedure
- CP9 Records Management Policy CG71 Self Harm Clinical Guidelines
- CPG75 Ligature Risk Assessment & Management Procedure
- CG58 Slips, Trips and Falls Clinical Guidelines
- CG45 Managing Leave for Informal Patients Guidelines
- CG60 Sexual Health and Behaviour in Inpatient Units Clinical Guidelines HR21 Induction, Mandatory & Essential Training Policy and Procedure CLP1 Clinical Audit Policy and Procedure

APPENDIX 1: A CASE STUDY – FRANKIE'S STORY

(This experience of observations was written by her loving and intelligent father Martin who has given permission to share widely).

Frankie was taken by ambulance to hospital from her care facility early on a Tuesday morning. She was having difficulty breathing with a 'gurgling chest'. The paramedics checked out Frankie's vital signs on arriving at the facility and she was showing all the symptoms of having pneumonia. Having been admitted to hospital. Frankie was given a blood test and the results were consistent with a pneumonia/chest infection diagnosis; so she was treated with antibiotics and steroids. Due to her long-term mental health condition of schizophrenia being combined with her physical illness Frankie was put on an enhanced level of observations. The level of observations thought to be appropriate at the time meant that a staff member was to be permanently with her. Nevertheless, staff were finding it difficult to maintain this level of observation.

Frankie had gone absent from her care home on the Sunday evening, a couple of days before. She had checked herself into a local hotel; went swimming, ordered some food and settled down to watch some television. On a tip-off from her parents, Frankie was visited by the police in the early hours of the morning who confirmed that she was safe and well in the hotel for the time-being. It did mean Frankie missed her regular medication on the Sunday evening and Monday morning however. There was also some doubt about whether she had refused medication on the Monday evening having been returned to the care home in the afternoon; and a similar doubt about whether she was able to take medication next morning too, as no administration of any meds featured in the paramedics' handover to the hospital. Frankie was a Clozapine patient and she was assessed by a nurse from the Mental Health Liaison Team on the Wednesday morning at the hospital. After contacting the care home by telephone, the nurse documented that Frankie had "Clozapine dose in the morning on 26/1/20 [Sunday] and in the evening on 25/1/20 (sic) [Saturday] therefore has had dose within 48 hours". Being 10.30 am on 29/1/20 (Wednesday morning) the 48 hours conclusion at that point was not quite accurate however. Frankie was given her morning dose of Clozapine (one quarter of daily) on Wednesday by a hospital doctor before being 'medically cleared' ready for discharge to a mental health facility. The Accident & Emergency clerking notes taken at the hospital were then sent over to the relevant mental health ward as a bed had been found there.

Due to a delay in available transport, Frankie arrived on the mental health ward at 11 pm on Wednesday evening with her steroids and antibiotics as TTOs (take away medication). The transfer was not ideal in terms of timing, particularly as she still had no day clothes and was tired. Frankie went straight off to bed but was woken by the Duty Doctor at 3.15 am for admission clerking and a National Early Warning Score (NEWS) assessment. Frankie's vital signs had improved somewhat since her admission to the previous hospital, although she refused a blood pressure test at this time. Unfortunately, there was no discharge letter from the hospital but the comprehensive A&E clerking notes were available. The Duty Doctor placed Frankie on a less strict level of observations (intermittent enhanced observations) with a view to checking on her every 15 minutes or so. The ward meeting on Thursday morning was a short one in terms of Frankie's participation, being just six hours or so later. Anyone who knew Frankie would know that she could 'sleep for England'. A 9.30 am start after an 11.15 pm bedtime and interrupted sleep was not going to happen! There were further attempts to try and clarify her medication regime at the ward round, but these efforts were not conclusive.

Other limitations were that the ward meeting staff were unable to see the hospital's blood results as they were on a different system and Frankie, due to the medical emergency had missed her monthly blood test appointment at the Clozapine clinic the day before. At the previous visit to the clinic, the staff had also alerted a sudden, significant escalation in Frankie's BMI. Unfortunately,

this had remained unacknowledged by the community team. After some further sleep during Thursday morning, Frankie was feeling much brighter. However, she refused another NEWS assessment, probably because it was coming up to lunchtime. Historically, lunch was an important feature on the wards for Frankie, particularly as breakfast was not! She had often been known to refuse things like blood pressure tests at mealtimes in the past, but agree to them later. NEWS was documented in her notes to be carried out twice daily, but unfortunately, the second attempt was overlooked that day. One of the doctors at the ward round telephoned the care home in the early afternoon. They told him Frankie had taken her meds on the evening of 27th (Monday] and morning of 28th [Tuesday] so it was decided to recommence Clozapine along with Frankie's other meds apart from any Clonazapam. On the face of it, Frankie was carrying a significant amount of risk therefore:-

- Frankie had been discharged with a medical condition from hospital that she was still being treated for;
- There had been a limited participation of Frankie as the patient in the ward round;
- There was real confusion about Frankie's medication and what she had taken when. No definitive MAR sheets from the care home had been made available;
- Bloods data was not accessible on the ward;
- Latest NEWS data (particularly blood pressure) was not available;
- A seriously elevated BMI in a short space of time had recently been flagged up by the Clozapine clinic but not investigated.

Frankie went off to bed on the Thursday evening having taken her meds, which included her recommenced (300mg) evening dose of Clozapine. She was observed on the 'intermittent enhanced observation' throughout the night and at 5.30 am was seen to have moved from her bed to the floor. After several more 15 minute checks Frankie was discovered to be dead at 7.30 am in the morning and the pathologist concluded at the inquest that she had "been dead for at least an hour, maybe two". Indeed, it seems likely that Frankie died soon after she moved to the floor, at which point, she would have also ceased to snore loudly.

I felt sorry for Frankie. I felt sorry for the staff on the ward in the morning, vainly trying to do CPR, de-fib etc. (according to the reports that I later read). I felt sorry for the Health Care Assistant involved in the obs. I felt sorry for the ward matron who rang to tell me that Frankie had passed away just as the three police officers arrived at my door. I felt sorry for Vicki who answered the door to the police. I felt sorry for Frankie's Mum when I had to inform her of Frankie's death by telephone (as she was in Australia at the time). The appropriate level of observations, with the right level of expertise and the right timing; thereby truly 'knowing' the patient; must surely help to accurately assess and mitigate risk; and feed the development of the appropriate level of therapeutic engagement and supportive observations for a particular patient on an ongoing basis. I am grateful to have been able to contribute to this project and hope any sad and traumatic cases such as Frankie's can be avoided in future as a result of this reissued policy, appropriate staff training and its implementation.

Martin Jeremiah (Frankie's Dad)

The Deputy Director of Quality and Safety for Inpatient and Urgent Care Services, Katy Stafford, adds: Frankie was (and will continue to be in our memories) an incredibly intelligent, explorative, creative, humorous, kind and sociable, individual. Sadly, Frankie suffered with her mental health for years, and had a lot of experience of hospital admission. With this experience, Frankie often used her insight and designer mind-set to think of ways in which services could be better for everyone. It is with great sadness that Frankie is not able to help us re write this policy in person. It is with great honour that her story and her father are. While Frankie is not here to physically help us write the policy, her death very much informs how we approach observation and engagement, and changes in practice. I know that those reading this policy want to give the best care they can to patients. Frankie's story is an example whereby things could have been different if staff had been able to actively engage with her, and personalise her care through therapeutic observations and supportive engagement. It feels important to note, how it must have felt for Martin to hear Frankie had been dead upon numerous 'observations' from staff. It is humbling to see Martin contribute and lead improvement work in response to this. Please let Frankie's story help give this policy and the importance of engagement and observations real meaning.

APPENDIX 2: A PATIENT'S VIEW

Engagement and Observations done well

I was in my room at night, feeling incredibly vulnerable and scared, I had never been in such a bad place in my mental health. I had no access to my family and usual home comforts except the few things I had brought into hospital with me. A nurse was on my 1:1 observations, she spoke to me in a warm and calm manner, asking how I was feeling. She asked in a genuine way, I knew she cared about the answer. She went on to teach me some coping strategies for the distress I was experiencing. Her engagement at this time will stay with me for ever, I now use the skills she taught me regularly and in that moment had a huge sense of comfort. If a nurse had come and merely starred at me at this time, I would have felt unbearable, lonely and undignified.

Engagement and Observations done well (2)

I was under section and on 1:1 observations. The staff member had to always accompany me in the bathroom because I sometimes presented as a risk to myself. My arms were badly bruised as I had spent a few days in general hospital and had been attached to drips and cannulas. I needed to wash my hair but it was difficult as my arms were sore. She offered not only to wash my hair for me, she dried and gently combed it out. She added oil as it was very dry and offered to plait it. I felt she really wanted me to feel comfortable and invested in my holistic well-being.
I felt valued and cared for as she didn't have to make such effort but offered to lift my own well-being. It was a very kind gesture. I have never forgot her thoughtfulness.

Engagement and Observations done poorly

I have unfortunately been regularly hospitalised due to my mental health problems. Sometimes on a Section and occasionally Level 3 or 4 observation too. I understand why they do this. During the night shifts, almost all ward nurses were non-regular staff, who I didn't know. Frequently I would spend the whole night with someone I didn't know seated by my head with my light full on - I accept the need of observations but how they are done could be different. The staff would never interact with a patient, instead they usually spent the night reading a magazine and were constantly on their mobile phone. This meant my sleep would be disturbed by the noise of paper or phone for much of the night. This was a regular and usual behaviour from people who only seemed concerned in racking up paid hours, then rushing off the ward. Very little 'care', support, connection or nursing was offered or received.

Engagement and Observations – mixed view

I was in hospital and staff checked in on me once an hour, every hour. Some staff would come and say 'hello' and ask how I was or If need something, this felt caring and supportive, I knew I could raise any difficulties I was having and support them to support me to stay safe. Other staff would come and stare through a window at me, without a word. This felt incredibly threatening and cold. Two different approaches to the same check makes a huge difference.

Engagement and Observations – mixed view (2)

I have mixed experiences of being on observations. There were staff who actively avoided me; I was too 'risky'; had made a formal complaint about my care already; actively sought opportunities where I knew the person was unfamiliar with me or my needs. There were times when no one had even introduced themselves and so I could detach myself from any emotional impact my actions would have – this was when I was at my most suicidal. There were staff that didn't book shifts on the ward during that period following incidents they were involved in; it was communicated to me that it was because I was a liability, and they would rather work elsewhere. In contrast, though during the same episode of care, there were people who were confident, would alternate, described me as being someone that they enjoyed 'working with'.

I think that was a big difference; being on observations felt collaborative. I was made to feel safe. The staff member got to know me, and vice versa, it was a relationship based on trust, communication. They learnt what mattered to me; my puppy, my ‘day job’ we focused on goals, distractions. It wasn’t about whether the staff member was permanent or agency; or whether it was day or night; although I do recognise there could be variations in care, it was because they held the hope, when I had none. They made me believe in my own ability to recover; saw that their role was to engage with me, not just watch me. Even when I was no longer on Level 4, or Level 3, these staff noticed when I was struggling. That relationship meant I felt able to reach out when I needed extra support; even when it meant going back onto enhanced observations; it empowered me to be in a place where I could take control of my own safety.

APPENDIX 3:	INFORMATION FOR PATIENTS, RELATIVES AND CARERS LEAFLET

Therapeutic Engagement and Supportive Observation

Information for patients, relatives and carers

What is Engagement and Observation?

Sometimes during a hospital stay, patients may require extra care from staff through an increased level of engagement and observation. This might be to keep vulnerable patients safe; to prevent any harm to themselves or others; or because they are physically unwell. Any increased level of engagement and observation is also seen as a more regular opportunity to talk to a patient and hear what care and activities they think might help them the most at any given time on the ward. Staff will keep the person informed about anything useful to be noted down.

What is the Most Common Level of Observation?

General Observation is the minimum level of observation for all inpatients. It means staff will record the location of each patient every hour in a 24 hour period. During each shift, nurses will also generally assess the welfare of every patient on the ward and address any concerns. This is the only level of observation where the patient is able to leave the hospital environment.

What are the Enhanced Levels of Observation?

There are three types of enhanced observation: **Intermittent**, **Within Eyesight** and **Within Arms Length**. If a person is being cared for on any of the following observation levels they will generally not be allowed to leave the hospital environment, unless it is to seek urgent medical assistance and appropriate plans are in place to keep them safe. Indeed, physical health conditions (and associated risks with these conditions) might also play a major part in determining an appropriate level of enhanced observation for a patient.

1) **Intermittent Enhanced Observation:** This level of observation is mostly used when staff are *concerned* about a patient's level of risk, either to themselves or to others. Staff will check to see where the patient is and how they are, at specified intervals between 15 and 30 minutes over each 24 hour period.

2) **Within Eyesight Enhanced Observation:** This level of observation is mostly used if there is a risk the patient *could* try to hurt themselves or another person at any time. Staff must keep them within eyesight at all times. This includes when they are using the lavatory and bathroom facilities. If necessary, anything they could use to harm themselves or others will be removed and staff may need to search them and their belongings. However, staff must do this in a sensitive way and must keep the patients' legal and human rights in mind.

3) **Within Arms Length Enhanced Observation:** This observation means that one or more members of staff will stay within arms length of a patient at all times. This also includes when they are using the lavatory and bathroom facilities. This form of observation will be used if the person *is likely* to hurt themselves or others and if necessary, anything that might have the potential to cause such harm will be removed. As far as possible, the privacy and dignity of the patient must be respected and they must be asked their opinions on different aspects of being under this type of observation; (for example, would they prefer to be observed by staff of the same gender as themself).

How are Levels of Engagement and Observation Decided?

It is important that support is tailored to each patient as an individual, so staff will assess their mental and physical health care needs on a regular basis. Staff will also bear in mind any other factors, for example: medication changes and patient history. If an enhanced level of engagement and observation, or any change in this, is thought to be beneficial at any stage, staff will discuss this with the person (and any nominated relative, friend or carer), explain the thinking, take their views into account, respect the patients dignity and privacy as far as they are able and always use the minimum level of observation necessary. They will, if possible, also let the person know how long a change is likely to last. In particular, staff will carefully and formally review any reduction in levels of observation.

Are There Any Other Considerations?

When planning and conducting the appropriate levels of engagement and observation with a patient, staff will also abide by the Trust's local policy, relevant national guidance and best practice. For example, they will consider any relevant equality and diversity factors of Age, Disability, Gender & Gender Identity, Race, Religion & Belief and Sexual Orientation.

For further information, please see ……..

APPENDIX 4: TRAUMA INFORMED PRINCIPLES

A trauma-informed approach to care involves practices that adhere to a particular set of values. It translates the knowledge that most mental health service users have experienced trauma in their lifetime into the development of effective relationships and service delivery, so that these service users can be active participants in their recovery rather than passive recipients of care.

Traumatic events can happen at any age and as many as 1 in 3 people in the UK have experienced at least one traumatic event in their life time. Many people will recover from that event, whereas for others this can cause long-lasting harm. Trauma can include but are not limited to:

- one-off or ongoing events
- being directly harmed or witnessing harm to someone else
- living in a traumatic atmosphere or being affected by trauma in a family or community

When we experience trauma, our responses are loosely grouped into the following categories it is important to note not everyone will respond in this way. It is also vital to know that a person does not have control over which response will happen to the event:

- Freeze – feeling unable to move.
- Flop – Being unable to protest.
- Fight – fighting, struggling or perhaps shouting for help.
- Flight – hiding or moving away from the danger.
- Fawn/friend – trying to please someone who harms you

Individuals who have experienced trauma can present with:

- Emotional dysregulation – difficulty recognising, communicating, managing and expressing emotions
- Difficulty forming relationships; trusting others
- Hypervigilance and hyperarousal
- Difficulty in thinking, concentrating, interpreting the world and other people's intentions
- Physical health comorbidity
- Increased risk of self-harm or suicide

To be trauma-informed involves reframing behaviours that may have previously been considered dangerous or destructive as responses to distress; a person's method of managing and communicating their difficulties; coping strategies that prevent them from becoming overwhelmed. They are seen as a response to the person's thoughts, feelings, memories or urges, but has negatively affected the individual's quality of life or prevented them from achieving their goals to the extent that they are now in in need of being supported in the mental health inpatient environment.

Through engagement we can encourage the person to explore other means of expressing themselves and their feelings, such as to:

- Talk or write about their experiences, to express themselves through music or art
- Practice mindfulness activities – to keep them in the present
- To build their self-esteem, such as promoting routine, activities of daily living
- Learn coping skills when in crisis through distress tolerance techniques

- Supporting them identify thoughts, feelings, emotions, urges and practice regulation skills
- Promote access to peer support and increase social networks.

A key way of being able to do this is by becoming familiar with the patient's strengths, their care plan and what matters to them.

The core principles of trauma-informed care are:

- Choice
- Collaboration
- Trust
- Empowerment
- Safety

Adhering to these principles can enable those that work in healthcare to provide effective care for all service users, staff and visitors while practising in a way that promotes inclusion and recovery of those who have experienced trauma.

It is also vital that we acknowledge that we can inadvertently re-traumatise someone who has experienced previous trauma. Re-traumatisation refers to the re-emergence of symptoms previously experienced because of trauma, although the trigger may not be traumatic it reminds the person of the event. This could be the use of restrictive practices – such as prone or supine restraint, seclusion or enhanced observations, which could be particularly difficult for anyone that has experienced sexual harm – or triggers in the environment such as the banging of office doors or violence and aggression for a person that has experience of being in conflict.

When restrictive practices cannot be avoided, or the ward environment cannot be changed; service users should be given as much of a voice and choice as possible; including helping the person to identify their own triggers and having as much involvement as possible in their care.

Some further resources, included those that can be printed off in PDF format can be found on the Mind (2023) website at:

https://www.mind.org.uk/information-support/types-of-mental-health-problems/trauma/about-trauma/#:~:text=Going%20through%20very%20stressful%2C%20frightening,re%20affected%20by%20our%20experiences.

A video explanation 'What is trauma?' By the author of "The Body Keeps the Score", Bessel van der Kolk, which offers further understanding in less than 8 minutes can be found at https://www.youtube.com/watch?v=BJfmfkDQb14

APPENDIX 5: ENGAGEMENT PROMPT CARD

Co-Produced with patients across inpatient wards

Broader ward engagement tools - https://www.safewards.net/

Support in managing voices - https://www.hearing-voices.org/resources/

Learn and engage in positive coping skills together (DBT informed) - https://dbtselfhelp.com/dbt-skills-list/

Quick and easy engagement to do in the moment:

- Ask the patient what they are interested in
- Do a mindfulness activity
- Read a newspaper together
- Play a word game
- Pick and plan a quality improvement project for the ward
- Create a personalised board of engagement (board/poster where the patient write what they'd like staff to engage in with them)
- Find something soothing for each of the senses
- Print off a crossword
- Listen to and discuss music
- Find some ward art materials

Conversation starters:

- As a child, what did you want to be when you grew up?
- Who inspires you?
- What is the one thing you are most proud of?
- For what do you feel most grateful?
- What are your happy memories?
- Where is your happy place?
- What is your favourite comedy film?
- Complete this sentence – 'it might surprise you to learn this but I once….'

APPENDIX 6: STEP INTO MY SHOES

STEP INTO *My Shoes*

Ideas For Getting To Know New People

The ward or service that this pack belongs to is:

_____

Introduction

Being on a mental health ward can at times mean being surrounded by others and yet still feeling lonely.

You can have lots of contact and support with others and still feel alone. Especially if you don't feel understood by the people around you or that you don't have a sense of connection with them.

Getting to others better can pass time, improve the relationship with staff, create opportunities for informal peer support or long lasting friendships.

However, we recognise that this is not easy, especially when you and those around you may already be struggling.

These cards were designed to offer ideas, suggestions and activities that all aim to help people to get to know each other better.

The cards can be used in pairs, in groups, with staff, even with visitors who may be coming for the first time to this environment.

They can be helpful as a distraction or to ground you - to bring you back to the present moment.

There is no order to do them in.
There is no right way or wrong way.
You can spend as little or as long with each activity as you wish to.

You will notice, each card involves six items. This means that you can adapt them to include rolling a dice and then answering the question that matches the number that you roll!

If someone is finding the task difficult please imagine 'stepping into their shoes' and look at ways that they can still participate.

Before long, as people get to know each other better, they often realise that they have far more in common than they have differences. We hope that these cards help you to do that.

Would You Rather? 1/4

Take it in turns to ask each other some or all of the following questions.
'Would you rather':

1. **Be able to fly or breathe underwater?**
2. **Be able to see into the future or relive a special moment from your past?**
3. **Go through your whole life being the most hilarious person or being the most intelligent person?**
4. **Spend a year with the same song stuck in your head or with an itch you can’t scratch?**
5. **Be able to sleep standing up or walk lying down?**
6. **Have blue hair or green hair?**

Would You Rather? 2/4

Take it in turns to ask each other some or all of the following questions.
'Would you rather':

1. **Have people admire you for your good deeds or respect you for your power?**
2. **Live in a world where there is no crime or no privacy?**
3. **Have an exciting but dangerous life or a boring but meaningful life?**
4. **Be liked by everyone or have everything you've ever wanted?**
5. **Be the center of attention or go unnoticed?**
6. **Watch TV or listen to music?**

Would You Rather? 3/4

Take it in turns to ask each other some or all of the following questions.
'Would you rather':

1. **Find true love or win the lottery?**
2. **Have to sing to every song you hear, or dance to it?**
3. **Be the best at something that no one takes seriously or be average at something well respected?**
4. **Run at 100 miles per hour or fly at 20 miles per hour?**
5. **Have to give up social media or watching movies for a year?**
6. **Live a peaceful life in a cabin in the woods or an exciting life in a busy city?**

Would You Rather? 4/4

Take it in turns to ask each other some or all of the following questions. 'Would you rather':

1. **Fly a kite or sail a boat?**
2. **Live in a tree house or an igloo?**
3. **Go back in time or forward?**
4. **Be a bird or a fish?**
5. **Have melted ice cream or cold chips?**
6. **Go on a luxury holiday or an adventure?**

Quick Questions. 1/2

Take it in turns to answer these questions. At the end, see if anyone wants to more questions about some of the answers.

1. **What is your proudest achievement?**
2. **If you could write a book, what would it be about?**
3. **What is the happiest moment in your life? What made it so special?**
4. **What is the scariest thing you've ever done for fun?**
5. **What is the best gift you've ever given/received?**
6. **If you could be doing anything right now, what would you choose?**

Quick Questions. 2/2

Take it in turns to answer these questions.

1. **What's the best piece of advice you've ever been given?**
2. **Where is one place you'd love to travel to?**
3. **What one piece of advice would you give to someone in a situation similar to yours right now?**
4. **What would your dream day look like?**
5. **If you could travel back in time, where/when would you choose?**
6. **Name one fear you have managed to overcome in your lifetime.**

Quick Questions. 3/3

Take it in turns to answer these questions.

1. **If you were a colour, what would it be?**
2. **What superpower would you choos to have? Why?**
3. **What was your favorite television show when growing up?**
4. **If you could only eat one thing for the rest of your life, what would it be?**
5. **If you had one wish, what would you wish for? Why?**
6. **If you were stranded on an island, what 3 things would you bring with you?**

Favourites. 1/2

Take it in turns to answer with your favourite:

1. **Type of takeaway food to eat.**
2. **Colour.**
3. **Musician or band you listen to. or television or movie.**
4. **Quote or script.**
5. **Activity to do in your free time.**
6. **Subject from when you were at school or job that you have had.**

Favourites. 2/2

Take it in turns to answer.

1. **Favourite thing you have heard today?**
2. **Thing a member of staff or patient has ever said to you?**
3. **Way to distract yourself?**
4. **Thing that you have done, for yourself?**
5. **Thing you have done that was nice, for someone else?**
6. **Way to make you feel better about a situation you can not change?**

Unusual facts

Take it in turns to answer. The most unusual:

1. **Thing you have ever eaten**
2. **Place you have ever been to**
3. **Thing you have ever done for fun.**
4. **Fact about yourself (or your 'party trick'**
5. **Thing you have ever owned**
6. **Film you have ever watched or book you have ever read**

More about me

Take it in turns to answer.

1. **1 difficult situation you have overcome in the past**
2. **One quote or spiritual passage that helps you to get through a difficult time**
3. **A person in the media or in your personal life that inspires you**
4. **The most helpful thing you have ever done when you felt ovewhelmed**
5. **3 things you have or would put in a self soothe or coping box**
6. **1 problem you have managed to problem solve in the last day or few days.**

Naming Questions

Take it in turns to name the following:

1. **1 thing you did today that has made you proud.**
2. **2 things that others can do if you are experiencing a difficult moment.**
3. **1 thing that has helped you get through a tough time.**
4. **2 things you can do to or have seen others do to keep busy whilst on the ward.**
5. **1 thing that someone has done with you that has been helpful since you have been on the ward.**
6. **1 way that you can soothe yourself/ make you feel calmer.**

The five senses

Take it in turns to answer the following:

1. **Your favourite smell that makes you feel more awake**
2. **The type of music you listen to when you feel sad and want to improve your mood**
3. **A place that you find calming**
4. **Something you like to touch or hold when you need to feel comforted**
5. **A food you turn to when you need a treat**
6. **The smell that you find more relaxing**

Being mindful

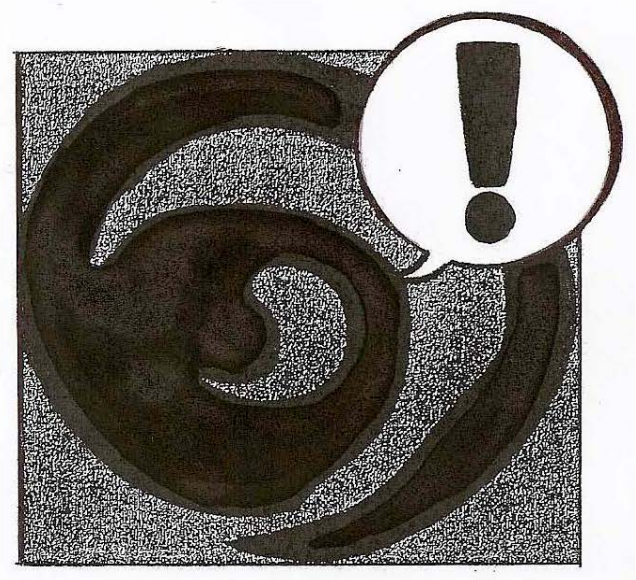
Answer these questions in your pair or groups:

1. **A type of music or meditation that you can practice when you want to feel in the present moment**
2. **A breathing exercise that has helped you when you are feeling overwhelmed**
3. **A place that you find calming and imagine being at when distressed**
4. **An activity that helps you to forget what else is happening around you**
5. **A way that you can ground yourself**
6. **Five things you can see, four things you can hear, three things you can smell, two things you can touch, one thing you can taste right now.**

STEP INTO

My Shoes

HEARING VOICES
COPING



STRATEGIES

The following are suggestions for coping with the experiences of hearing voices, and seeing visions and having tactile sensations. It is hoped some of these ideas can help you, or someone you care about, towards living positively with these experiences and to maintain a sense of ownership over them.

Remember that you are not alone:
Research shows that 4% of people hear voices, this is the same number as have asthma. Voice hearers throughout history have included a great many influential people: religious prophets, doctors and psychologists, philosophers, artists, poets, explorers and politicians.

The following list was compiled by the Manchester Hearing Voices Group.

Be Prepared: Some people get a warning sign that the voices are about to start. For example, they know what can trigger the voices or they hear another noise like whistling or an extra heart beat. This can be used as a positive thing because you are forewarned. You can then learn to use relaxation and breathing techniques to calm right down. Decide if you want to listen to them, if you don't and you hear the whistles, distract yourself.

Don't Believe What The Voices Tell You: This can be difficult and takes a lot of determination, but you don't have to believe or do what the voices tell you. Be aware that sometimes the voices become nastier and more persistent when you stand up to them. This can be a sign they know their days are numbered.

Use Selective Listening: Some voice hearers find they hear positive as well as negative voices or that the same voices say both helpful and unhelpful things, so they develop their skills of selective listening, learning to take what is useful from the voices and ignoring the rest. For example "I need to get to the shops before they close". There is a difference between this speech pattern and "We want you to go to the shops before they close". It is often the subtle switches between reminding yourself of something and interacting with the voices. Change statements like "We want you out of the house now" to "I'm going out".

Take Care of Yourself: Taking a regular bath or shower can be very therapeutic. This can be a challenge for some people when they are feeling low but it can be a great way to pamper yourself. Try playing relaxing music when you are taking a bath.

Use Stepping Stones: Set small goals to start with, such as getting out for a certain amount of time each day. Remember to reward yourself for your progress.

Being Busy: Keeping busy to distract yourself from the voices has proved useful for some people. For other people it has just been tiring and restrictive. Experiment with different activities and find what works for you.

Hearing Voices Group: Going to your nearest hearing voices support group can mean that you have time in the company of others who truly understand what it means to live with the experience of hearing voices. This can create a sense of fellowship and shared solidarity between group members which can minimize the sense of isolation that many voice hearers feel. Many people have found that the onset of voices was preceded by a traumatic incident in their lives. Groups can offer a safe place to explore these experiences.

Structure and Routine: Many voice hearers have discovered that planning, combined with good self-awareness, can be very helpful. For example, a person who tends to hear the voices in the afternoon can plan to get their cooking and cleaning done in the morning, and then rest in the afternoon.

Social Support Network: It is useful to build up a network of people in your life who can give you support at different levels of intensity at different times and in different ways. Your partner, siblings, Helplines, friends, relations and your doctor may be included.

Educating Others On How Best To Help You: It is useful to develop your communication skills so you can describe to concerned people how best it is they can help you. These should be people in your life who will want to support you in coping with your experiences, both in a professional and personal capacity. Give clear descriptions of what you find helpful and why, and how others can help you.

Develop Your Rules of Engagement:
Many people have increased their abilities to be assertive with their voices. This can involve making a contract with the voices. Saying something to them like "I am too busy to talk just now. "I will listen to you if you come back at 7 pm when I have finished my dinner". Sometimes the voices stick with these contracts. Some people find ignoring the voices more helpful. Others have found just shouting and swearing at the voices makes them feel better.
Use A Mobile: Some people find that if the voices get nasty in public places they want to scream and shout at them, but this can be embarrassing. Try carrying a mobile phone or a realistic toy that is cheaper for these occasions – this way you can shout at the voices without attracting the attention of other people. This will also work if you find a public phone you can use if you need to.

Get Creative: Writing about, drawing or sculpting what you see and hear can be helpful to get a handle on your experiences. It can also help distract you away from the voices. You can develop your creative potential and gain a sense of achievement. It can also be very relaxing.

Hobbies: If you feel up to going, common interest groups can be a great way to meet people and to learn. If that feels too much, drop-in centres can be a good way to jump-start getting back out again and meeting people.

Music: This is a popular coping strategy. Different styles of music can be helpful or unhelpful to different individuals. Learn what you find the most therapeutic. Some people have found that listening to music whilst wearing headphones can be a useful distraction from voices.

Journals: Keeping a diary of what the voices say to you and keeping a journal of your feelings can be a very helpful way to develop your self awareness and find patterns of what makes you feel bad and what triggers your voices. Some people find that when they are with a helpful professional like a psychologist or a counsellor they may want to talk about their experiences, but find it hard to find the words. Some people have found that giving their diary to the professional can be a helpful way of explaining what life is like for them. Other people just like to write their problems out and not read what they have written, or just thrown it away. Be aware that what you write is your private property and keep it in a safe place. Do not give it to anyone unless you choose to of your own free will.

Religious Activity: Some people have found spiritual activities useful for helping them to live with their voices. Be cautious though of cult groups or people that may try to pressure you in to becoming more involved than you want to. The first time you go to a new place of worship take a friend with you.

Praying And Prayers Of Others: Some voice hearers have specifically described the benefits of praying and also having others pray for them in their struggles.

Change The Picture: If you see frightening images forming on carpets or curtains for example it can be possible to try and change the shapes of them to something neutral like a tree or flower.

TV And Radio: Some people find TV or a radio a useful distraction. Others find these interact with their voices and cause distress. But turning them off because of the voices can be allowing the voices to control you and your time. If you find that certain words or events on TV or radio trigger your voices or very difficult emotions try changing the channel as an alternative to turning them off. If it gets too bad then you can turn off. For people whose voices make it hard to concentrate on reading, TV or radio, try children's books or programs to help build concentration.

Medication: Finding the right kind of medication for you can be helpful, but it can take time and be a process of trial and error to get it right. Finding the right dosage of medication can be a very important factor in determining how successful it will be for you.

Read And Learn About Hearing Voices: Learn all you can about others who have had the experience. Useful books include "Accepting Voices" by Marius Romme and Sandra Escher. Also very helpful is "Working with Voices: Victim to Victor" by Ron Coleman and Mike Smith. Ron is a voice hearer who has been through the psychiatric system and survived to write this useful book with nurse Mike Smith.

Adrenalin Rushes: Some people like horror or action movies because of the climax of the film and the adrenalin rush. It gives them a distraction from the voices. If this works for you then be aware that such an adrenalin rush can make it harder to relax when you want to go to bed so you could use this strategy in the day and try to avoid it during the night.

Alternative Complementary Therapies: These are used to support or replace conventional medicines. There are a great range available including massage and acupuncture and many people find them helpful.

Self-injury Or Self-Harm: These have sometimes been described as coping strategies for the distress of hearing voices. If you use self-injury to cope with your voices, consider alternative forms of expression, or more controlled self-injury like wearing a rubber band on your wrist and pinging it when you feel the impulse to harm yourself. Drawing on yourself with a red felt tip pen can be an alternative to self-harm, as can squeezing ice on your hands.

Being Aware of Substance Use: Some people have found that using street drugs or alcohol has such a negative impact on their voices that they choose to abstain. Beware of the risks associated with alcohol and drugs and how these could, or do, influence your voices.

Use Visualisation: Using creative or positive visualisation, i.e. imagining how you would like to be in various scenarios, can be a powerful helping tool. If you read and see the story in your head as you read you can use your imagination to create and manipulate these mental pictures. Construct a room in your head that only you hold the key to and use it to lock up your voices.

Celebrate: Reward yourself with some helpful treat each time you take control. When voices become less frequent people can find they are left with a void to fill. When this happens you can become anxious. The anxiety can invite the voices back. Be aware of these times, think positively, stay in control and use your social supports.

Hearing Voices Network Helpline:
Web: www.hearing-voices.org

Restricted and Prohibited Items List – Inpatient Units

Prohibited items include:

- Alcohol and drugs or substances not prescribed (including illicit and legal highs)
- Fire hazard items (flammable liquids, matches, incense
- Material that incites violence or racial/cultural/religious/gender hatred
- Material that incites self-harm
- Metal clothes hangers
- Laser pens
- Medicines (unless agreed that the patient can hold such medication)
- Super Glue or similar epoxy / thiocyanate based adhesives
- Bladed articles, firearms and other weapons including replicas and homemade or manufactured items (items with intent, and designed to inflict harm)
- Cash exceeding the amount specified in Trust Policy
- No illegal Pornographic material
- Tobacco and tobacco products (this can be stored as per policy but not ingested)
- Explosives, inflammable liquids or substances or other ignition sources

Restricted items include:

- Alcohol based aftershaves, perfumes, polishes, toiletries etc.
- Energy drinks
- Polythene and plastic bags
- Chewing gum, plasticine, clay *(prohibited with secure and CAMHS services)
- Electronic or chargeable vapes
- DVD's, games or CD's with an over 18 certificate
- Adhesives and adhesive tape
- Higher risk craft tools inc scissors, strong glue, tools
- Wire, cord, rope, string or plastic ties (with the exception of electrical flexes which may be shortened if felt to pose a risk)
- Clingfilm, foil
- Pressurised aerosol containers
- Heating devices e.g. hair dryers, tongs or crimpers
- Glass, Tins or metal canisters
- Covert listening devices, recording equipment or transmitting devices, e.g. dictaphones or small stereo

Risk assessments and personalised care related to restricted items

Access to items will depend on many factors, some of which may be fixed and others subject to change. The risk assessment and ensuing management of access to security items should take a procedural and individualised approach, where possible in collaboration with the patient, which avoids the implementation of unreasoned blanket bans. For items that may be considered suitable only for restricted use, staff should complete a thorough risk assessment and provide the patient with a transparent rationale that explains the management outcome. A dynamic and personalised risk assessment considers:

1. **Personal risk:** individual's historical risk and current mental state
2. **Interpersonal risk:** direct risk to others- patients and staff
3. **Environmental risk:** ward dynamics; general service safety (level of security, rehabilitative/acute)
4. **A common sense consideration** of the item in question

Access to mobile phones and the internet.

Wards should provide personal access to the internet and mobile phones, particularly to communicate with friends and family. Restrictions on access should be individually justified and not be a blanket measure. Wards may provide non-camera phone handsets and arrange for safe charging of patients' electronic items (electrical leads can be a ligature risk), e.g. with short-lead chargers or charging in the nursing office).

Essex Partnership University
NHS Foundation Trust

STANDARDS FOR WEIGHING OF INFANTS, CHILDREN AND YOUNG PEOPLE

POLICY REFERENCE NUMBER:	
VERSION NUMBER:	2
AUTHOR:	Hannah Van Der Puije
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RATIFICATION BY FINANCE AND PERFORMANCE COMMITTEE:	August 2022
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POLICY SUMMARY
These procedural guidelines provide detailed operational guidance for staff about standard for weighing of infants, children and young people in Southend and Essex. It will enable staff to provide the opportunity for all nurses to observe the child's general health and be alert to any safeguarding concerns.
The Trust monitors the implementation of and compliance with this policy in the following ways;
Essex Children's Safeguarding Group Meeting Internal and External Audit Children's Quality and Safety Meetings

Services	Applicable	Comments
Trustwide	✓	
Essex MH&LD		
CHS		

The Director responsible for monitoring and reviewing this policy is Executive Director of Mental Health

ESSEX PARTNERSHIP UNIVERSITY NHS FOUNDATION TRUST

STANDARDS FOR WEIGHING OF INFANTS, CHILDREN AND YOUNG PEOPLE

CONTENTS

Assurance Statement

Equality and Diversity Statement

The Trust is committed to ensuring that equality, diversity, and inclusion is considered in our decisions, actions and processes. The Trust and all trust staff have a responsibility to ensure that they adhere to the Trust principles of equality, diversity, and inclusion in all activities. In drawing up this policy all aspects of equality, diversity, and inclusion have been considered to ensure that it does not disproportionately impact any individuals who have a protected characteristic as defined by the Equality Act 2010

ESSEX PARTNERSHIP UNIVERSITY NHS FOUNDATION TRUST

1.0 INTRODUCTION

1.1 This document outlines the position of Children's Health Services (CHS) in relation to assessment of weight and length/height in infants and children on admission and at intervals thereafter. Weighing and measuring infants and children is an essential skill required of nursing staff.

1.2 The RCN's position in relation to the weighing of infants, children and young people in the acute setting. For the purposes of this document, the term 'child' is used to refer to an infant, child or young person under the age of 19 years (National Service Framework (NSF) for children, young people and maternity services: standard 7, Department of Health (DH) 2003; National Service Framework (NSF) for children, young people and maternity services in Wales, Welsh Assembly Government (WAG) 2005).

1.3 Measurement of weight and length/height is essential in the management of children in hospital to ensure accurate medication doses, as well as fluid and dietary requirements. Infants require their weight checked regularly to ensure optimum nutrition and growth are being achieved (National Institute for Health and Care Excellence, 2017).

1.4 The Standards for Medicines Management (Nursing and Midwifery Council, 2013) states "as part of administering medication the registered nurse must record the weight of the patient on the prescription sheet for all children." Growth is a significant index of health in children. A child's weight and length/height is required during their appointment in clinics or at home visit. It is important that a regular accurate assessment is made of a child's weight and length/height by nursing/health care assistant staff. The National Formulary for Children (British Medical Journal Group and Pharmaceutical Press, 2022) highlights the need to make an accurate assessment of the child's weight to ensure the correct dose of medication is prescribed.

1.5 For infants and children below the age of 2 years the weight, length, and head circumference should be measured routinely. For children ≥2 to 18 years weight and standing height are the appropriate measures.

1.6 These measurements aid in monitoring the effects of dietary intervention and help when calculating appropriate nutritional requirements for individuals.

1.7 It is important that these measurements are done accurately and routinely if they are to be of value.

1.8 For the monitoring of growth of all paediatric patients in homes and paediatric outpatients Clinic

2.0 PRINCIPLES

2.1 Detail The purpose of this guideline is to support the accurate assessment of weight and length/height in infants and children in order to facilitate accurate:

- Growth monitoring and observation assessment
- Calculation of medication doses in line with BNFc Formulary
- Monitoring of weight and height to guide interventional procedures

2.2 **Senior Managers**

All registered nurses, nursing students and health care assistants who observe and monitor children are trained and competent in weight measurement and documentation according to their level of responsibility.

The registered nurse maintains accountability to ensure non-registered staff are trained and competent in any nursing skill, including obtaining accurate weight measurements.

The practitioner is trained in the accurate use of weighing equipment and maintains this competence by receiving regular updates.

All practitioners require comprehensive induction training when joining a new health care organisation. Obtaining accurate weight measurements is a vital component of induction.

Registered nurses must keep their knowledge and skills up to date (NMC, 2015).

2.3 **Supervisors and Practice Assessors**

Team leaders, practice development nurses and nurse specialists are in an ideal position to teach staff how to weigh children correctly. Only a competent registered nurse is able to assess the competence of registered or non-registered members of the nursing team.

3.0 SCOPE

3.1 This guideline applies to:

- All qualified nursing staff who measure and weigh children in CHI
- All undergraduate and post-registered nursing students who measure and weigh children in CHI
- All seconded nursing staff who measure and weigh children in CHI
- Healthcare Assistants (HCAs) whose competence to measure and weigh children in children's services has been approved and signed-off. etc.

4.0 PROCEDURE FOR WEIGHING INFANTS AND CHILDREN IN CHILDREN'S SERVICES

4.1 A child must be weighed on presentation/admission to CHI, unless otherwise indicated. Medication should not be administered prior to obtaining a child's weight. Weight is required for the calculation of fluids and medication.

Children will be weighed in Kilograms (Kgs) only using one of the following scales:

- A baby scale (for children under 2 years old)
- Stand on scales for children over 2 years' old
- Seat type scale for children who are unable to stand

4.2 Current Advanced Paediatric Life Support (APLS) guidelines have been shown to be reasonably accurate in a study by Lineen et al (2019). However, accuracy can decrease with increasing age, estimation should not replace an accurate measurement as soon as possible.

4.3 If the child's clinical condition does not allow for weight to be measured using one of the scales above, an estimate of the child's weight can be made using Table 1 below as a guide. The 50th centile weights for age and gender are used. If a child presents as small or big for age, use clinical judgement.

Table 1

Approximate weight (Kg) for age and gender (Advanced Paediatric Life Support, 2016).

Approximate weight for age and gender		
Age	**Boys**	**Girls**
Birth	3.5 Kgs	3.5 Kgs
1 month	4.5 Kgs	4.5 Kgs
3 months	6.5 Kgs	6 Kgs
6 months	8 Kgs	7 Kgs
12 months	9.5 Kgs	9 Kgs
18 months	11 Kgs	10 Kgs
2 years	12 Kgs	12 Kgs
3 years	14 Kgs	14 Kgs
4 years	16 Kgs	16 Kgs
5 years	18 Kgs	18 Kgs
6 years	21 Kgs	20 Kgs
7 years	23 Kgs	22 Kgs
8 years	25 Kgs	25 Kgs
9 years	28 Kgs	28 Kgs
10 years	31 Kgs	32 Kgs
11 years	35 Kgs	35 Kgs
12 years	43 Kgs	43 Kgs
14 years	50 Kgs	50 Kgs
Adult	70 Kgs	70 Kgs

When the actual weight is obtained, the medication dose should be recalculated and changed if necessary. In some cases, if the dose is within 10% of the dose prescribed according to the child's estimated weight, it may not be necessary to re-prescribe. This depends on the drug, and is also influenced by a number of patient factors e.g. renal/liver function, adverse effects of the drug, severity of disease. Contact the Clinical Pharmacist and/or the Medical team for advice.

5.0 INFANT / CHILD WEIGHING PROCESS

Weight is carried out on presentation to each clinical area i.e. Child Development Centre (CDC), GP surgery Weighing room, Children Centre HUBs, Out Patients Departments or the Clinical Ward setting (Royal College of Nursing, 2017). The Child Growth Foundation (https://childgrowthfoundation.org/) suggests best practice as:

- An explanation of the process is given to the child and parent/guardian.
- Verbal assent/consent is sought from the child and parent/guardian.
- Infants from birth to 2 years of age should be weighed without clothes or nappy.
- For children over 2 years of age, nappies should be changed immediately prior to the procedure.
- Children over 2 years of age should be weighed with minimal clothing and without shoes.
- Shoes, slippers and jackets / heavy outer clothing should be removed and pocket contents should be emptied.
- If a child refuses to remove some clothing this must be noted in the Child's/young person's SystmOne healthcare record.
- If a cast or heavy medical dressing is present, this must be detailed in the child's assessment record, Medication Prescription and Administration Record, weight chart and Operating Theatre checklist, where applicable.
- Scales should be set at zero prior to weight assessment.
- A paper towel should be used for baby scales as the scale temperature can be cool.
- All weights are taken and recorded in Kgs.
- Inform the parent/guardian and where appropriate, the child, of the child's weight. This will act as a reference point thereafter and advise the parent/guardian of any weight loss or gain.
- For accuracy, in-patients should ideally be weighed at the same time

(early morning) and using the same scales.

- The scales used must be noted in the child's/young person's care plan on SystmOne, so that the same scales is used thereafter, ensuring reliability and accuracy.

- All subsequent weight recordings can be single checked/signed by a RN until competent.

- All nursing students must continue to have weights checked and co-signed by a Registered Nurse.

- Weighing scales are cleaned between each patient use.

- Subsequent weights for in-patients must be plotted and compared to the previous weight.

- Significant fluctuations in weight should be double-checked to ensure accuracy.

- Where a weight discrepancy is identified requiring immediate action, for example a medication dose adjustment, the evidence must be documented and the child's primary medical team informed.

- Where a weight highlights a concern, for example if a child is considered to be underweight or overweight, the evidence must be documented and appropriate action taken - inform the child's primary medical team, consider dietitian referral, consider seeking advice from pharmacist re medication doses. Refer to manager, Faltering Growth – Guideline for assessment and management of infants and children under 2 years (2019).

6.0 CLEANING SCALES AND LENGTH MEASURES

6.1 Scales

- Disconnect from the mains before cleaning
- Put paper towel on the scales before the child
- Use alcohol based wipes to clean the scales after use
- (Do not use large amounts of water as this may damage the electronics)

Equipment and Maintenance

Only grade 3 clinical electronic scales in metric setting should be used – a green sticker with background letter M (which means approved for medical use). Scales should be calibrated and maintained annually. The clinical engineering department are responsible for the following:

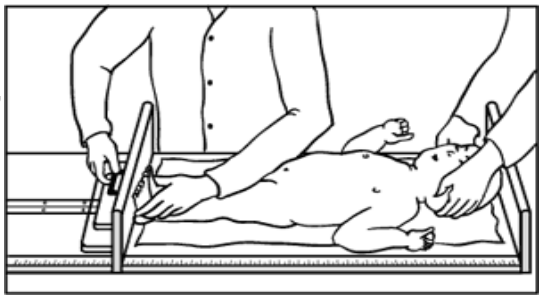
- Equipment calibration
- Equipment maintenance/servicing

- Any equipment found to be inaccurate/malfunctioning must be removed from service and sent to the clinical engineering department

7.0 MEASURING LENGTH / HEIGHT

7.1 Just Measuring length is essential for accurate growth assessment as it is indicative of organ and muscular-skeletal growth. Length is also a very stable measure of growth as it is not influenced by changes in hydration status or by cerebral changes. This measurement also helps to determine the nutritional status of an infants and children by comparing the percentile reached for weight against that reached for length.

Measuring Technique – Length

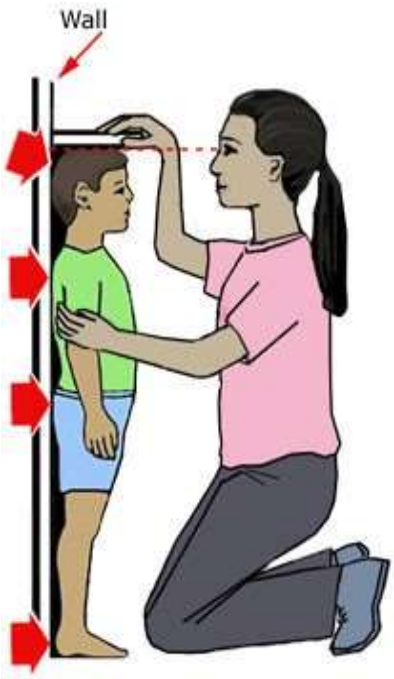


- Measure length for infants and children <2 years or <90cm, removing all clothing, shoes, and nappy.
- Use a length-board or mat.
- Remove hats and or hair accessories.

7.2 Ensure the back is straight, legs are together and straight, and head is straight, the heels are against the footboard, the shoulders are touching the baseboard and the crown of the head is touching the headboard.

7.3 Two people are required for measuring length – one holding the infants head straight and against the headboard and the other one holding the knees together, legs straight and feet against the footboard. The one holding the legs should record the measurement.

Note: children <2 years who are too long for the length board should be measured standing if possible. If not possible discuss with a dietitian for alternative methods of measurement. This should be recorded in their medical notes and personal child health record.



Measuring Technique - Height

- Measure height for children ≥ 2 years or ≥90cm, removing shoes.
- Use a correctly installed Stadiometer or approved portable measuring device only.
- Remove hats and or hair accessories.

- Measure height recorded to the last millimetre.

- Position feet together with backs of heels touching the board.

- Ensure head touching the board and child is looking straight ahead with the bottom of their ear and nose in a horizontal plane.

7.4 Child must stand as straight as possible (back and legs must be straight, the heels must be straight, the heels, the buttocks, the shoulder blades and back of head are touching the measurement board).

Note: children <2 years who are too long for the length board should be measured standing. This should be recorded in their medical notes and personal child health record.
If a child is unable to stand, measure lying down, using an approved length measuring device and plot as for height. Alternative measurements may be considered e.g. Arm span. This should be recorded in their medical notes and personal child health record.

Length Measuring Equipment

- Put paper towel on the length measure before the child
- Use alcohol based wipes to clean the length measure after use.

Video resources on both height and length measurement are available via the following link: https://www.rcpch.ac.uk/resources/uk-who-growth-charts-guidance-health-professionals

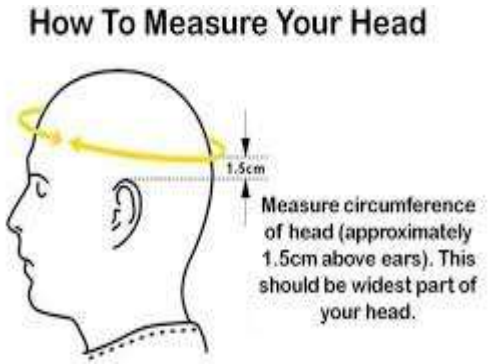
8 HEAD CIRCUMFERENCE MEASUREMENT

8.1 The head circumference measure is an indicator of somatic growth and is a useful measure of nutritional adequacy and age appropriate neurodevelopment in infants and children below the age of 2 years. In the first 2 weeks of life there is a moulding effect of child birth and this should be considered when measuring.

Measuring Technique - Head Circumference

- Remove hats and or hair accessories.
- Patient must be in a supported upright position + looking straight ahead.

- Measure using a disposable paper tape.
- Measurement should be made just above the eyes and should include the maximum circumference of the head.



8.2 All measurements should be recorded in the patient's nursing and medical notes. If available, record in the child's personal child health record.

8.3 Plot all anthropometry for children under 2 years of age on the UK-WHO 0-4 years growth charts (2009). For children over 2 years of age the UK-WHO 2-18 years must be used (2012). Preterm infants should be plotted on the UK-WHO Low Birthweight Growth Charts (2009).

8.4 There are specific growth charts available for certain diagnosis (e.g. Down's syndrome, Williams syndrome).

9.0 MONITORING OF IMPLEMENTATION AND COMPLIANCE

- This policy will be distributed by the Service Managers to be disseminated to their staff.
- Training must be provided to all new staff required to undertake measurement of height, weight and head circumference as part of their induction.
- In addition the procedure will be monitored by the relevant Service Managers utilising complaints, compliments, and untoward incident reports.
- Monitoring of staff awareness of this policy will be reviewed by Team Leaders / Managers.

10.0 POLICY REFERENCES / ASSOCIATED DOCUMENTATION

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END

Appendix 1


Measuring and Plotting Advice.pdf


Girls 2-18 Years Growth Chart.pdf


Boys 2-18 Years Growth Chart.pdf

Appendix 2: Template for Competency Packs

ASSESSING GROWTH IN PRE-SCHOOL CHILDREN ASSESSMENT CRITERIA

Procedure Title:	Assessment of growth in pre-school children
Trainee	
Trainer	
Service:	
Date:	

All the criteria within this Training Pack must be achieved to gain competency and then evidence below

Evidence of training and competence	
Date	
Trainer's signature	**Print Name**
Trainee's signature	**Print Name**

REVIEW: Annual assessment /training or when new evidence or information requires update.

Appendix 3: Leicester Height Measure

Leicester Height Measure

Diagram 1

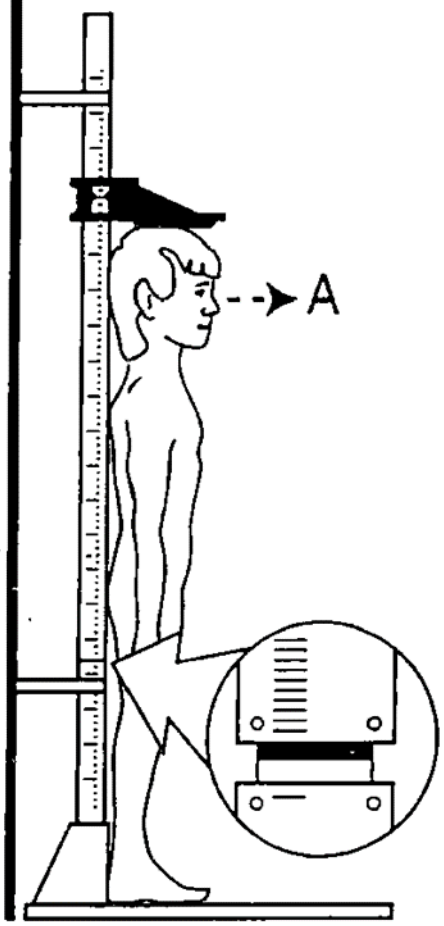
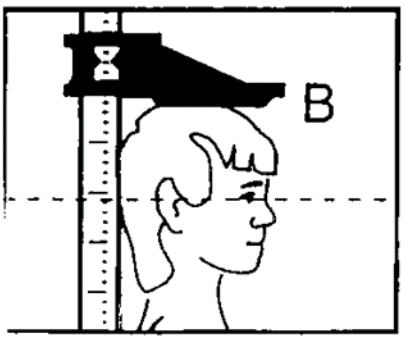


Diagram 2



A precision instrument for measuring children and adults from 75cm [approx 2ft 6 in] - 205cm [approx 6ft 9in]. Recommended by Child Growth Foundation.

Installing the Leicester Height Measure

Slot the white upright sections firmly together* and ensure that the bottom section locks into the blue base. Slide on the measuring arm and position the 2 white stabilisers as required [see diagram 1]. Ensure the stabilisers stay clear of the joins. The base should be placed on a firm uncarpeted surface with the stabilisers resting against a wall/door to give the Leicester rigidity.
NB: The Metric and Imperial scales are calibrated to take account of the 3cm difference between the black measurement arrow and the flat surface of the measuring arm.

5 easy steps to Accurate Measurement

1 Stand subject on the "feet" preferably barefoot with his/her heels together and touching the backstop. The spine at pelvis and shoulder level should touch the upright. Shoulders should be relaxed, arms to the side. Remove headgear [bows, ribbons etc.] where possible.

2 Lower the measuring arm onto the head and position the head so that an imaginary horizontal line runs between the earhole and the lower border of the eye socket [see diagram 2].

3 Ask the subject to stand up straight.*

4 Read off the Metric height to the last completed millimetre. Do not round up! Measure with care.

5 Record the height in the boxes provided on the subject's PCHR, record card or centile chart. Date and initial your entry and then plot your measurement - again with care.

[* tip: you need assemble only 2 or 3 upright sections if you are measuring young children. NB: Children under 18 months or who are not able to stand straight should be measured supinely].

This Leicester Height Measure has been distributed by the:
Child Growth Foundation.
2 Mayfield Avenue, Chiswick, London W4 1PW
Telephone: +44 (0)20 8995 0257 Fax: +44 (0)20 8995 9075

Appendix 4: Equality Impact Assessment Form

Department		Service or Policy		Date Completed:	

GROUPS TO BE CONSIDERED

Deprived communities, homeless, substance misusers, people who have a disability, learning disability, older people, children and families, young people, Lesbian Gay Bi-sexual or Transgender, minority ethnic communities, Gypsy/Roma/Travellers, women/men, parents, carers, staff, wider community, offenders.

EQUALITY PROTECTED CHARACTERISTICS TO BE CONSIDERED

Age, gender, disability, race, sexual orientation, gender identity (or reassignment), religion and belief, carers, Human Rights and social economic / deprivation.

QUESTION	RESPONSE		IMPACT	
	Issue	Action	Positive	Negative
What is the service, leaflet or policy development? What are its aims, who are the target audience?	Procedure guidance Staff		Yes Yes	
Does the service, leaflet or policy/ development impact on community safety • Crime • Community cohesion			n/a	
Is there any evidence that groups who should benefit do not? i.e. equal opportunity monitoring of service users and/or staff. If none/insufficient local or national data available consider what information you need.	Offered to all		Yes	
Does the service, leaflet or development/ policy have a negative impact on any geographical or sub group of the population?			No	
How does the service, leaflet or policy/ development promote equality and diversity?	Offered to all clients		Yes	
Does the service, leaflet or policy/ development explicitly include a commitment to equality and diversity and meeting needs? How does it demonstrate its impact?	Offered to all clients		Yes	
Does the Organisation or service workforce reflect the local population? Do we employ people from disadvantaged groups			Yes where possible	
Will the service, leaflet or policy/ development i. Improve economic social conditions in deprived areas ii. Use brown field sites iii. Improve public spaces including creation of green spaces?			n/a	
Does the service, leaflet or policy/ development promote equity of lifelong learning?			Yes	
Does the service, leaflet or policy/development encourage healthy lifestyles and reduce risks to health?			Yes	
Does the service, leaflet or policy/ development impact on transport? What are the implications of this?			Yes	
Does the service, leaflet or policy/development impact on housing, housing needs, homelessness, or a person's ability to remain at home?			n/a	
Are there any groups for whom this policy/ service/leaflet would have an impact? Is it an adverse/negative impact? Does it or could it (or is the perception that it could exclude disadvantaged or marginalised groups?	Children and young people		Yes No	
Does the policy/development promote access to services and facilities for any group in particular?	Children and young people		Yes	