NHS
Mersey Care
NHS Foundation Trust
Community and Mental Health Services

TRUST-WIDE CLINICAL POLICY DOCUMENT

SUPPORTIVE OBSERVATION

Policy Number:	**SD04**
Scope of this Document:	**All clinical staff**
Recommending Committee:	**Patient Safety Committee**
Ratifying Committee:	**Executive Committee**
Date Ratified:	**April 2019**
Next Review Date (by):	**April 2022**
Version Number:	**4.7**
Lead Executive Director:	**Medical Director**
Lead Author(s):	**Head of Nursing Secure Division**

TRUST-WIDE CLINICAL POLICY DOCUMENT

Version 4.7
2019

Striving for perfect care

and a just culture

NHS
Mersey Care
NHS Foundation Trust
Community and Mental Health Services

TRUST-WIDE CLINICAL POLICY DOCUMENT

SUPPORTIVE OBSERVATION

Further information about this document:

Document name	**Supportive Observation Policy (SD04)**
Document summary	**This document details (i) when general and enhanced observations should be used, (ii) which staff are best placed to carry out these observations, (iii) responsibilities for ensuring enhanced observations is used for the least amount of time clinically required, (iv) the process to be followed for assessing the level of risk for each service user, agreeing the appropriate level of observation, carrying out and recording observations and regularly reviewing the level of observation**
Author(s) Contact(s) for further information about this document	**Alison Baker** **Senior Nurse** **Telephone: 0151 473 0303, ext. 2739** **Email: alison.baker@merseycare.nhs.uk**
Published by Copies of this document are available from the Author(s) and via the trust's website	**Mersey Care NHS Foundation Trust** **V7 Building** **Kings Business Park** **Prescot** **Merseyside** **L34 1PJ** **Trust's Website www.merseycare.nhs.uk**
To be read in conjunction with	**SA 02 Risk Management Strategy** **SA 10 Use of Clinical Risk Assessment** **HR 10 Equality & Human Rights** **SD 18 Support of Service Users who present with Challenging behaviour** **SD 19 Advance Statements & Advance Decisions** **SD 28 Seclusion** **SD 38 Zero Suicide** **SD 48 Reducing Restrictive Practice** **SD 49 Clinical Handover at Nurse Shift Changes** **NICE Guideline NG10, Violence & aggression:short term management in mental health, health & community settings**
This document can be made available in a range of alternative formats including various languages, large print and braille etc	

Copyright © Mersey Care NHS Trust, 2015. All Rights Reserved

Version Control:

		Version History:
Version 4.1		November 2003
Version 4.2		January 2005
Version 4.3		February 2007
Version 4.4	Draft Number 1 for consultation	October 2015
Version 4.5	Submitted to Executive Team for ratification	February 2017
Version 4.6	Ammendment for Executive Team Ratification	April 2017
Version 4.7	Slight amendment to wording only	April 2019

SUPPORTING STATEMENTS

this document should be read in conjunction with the following statements:

SAFEGUARDING IS EVERYBODY'S BUSINESS

All Mersey Care NHS Foundation Trust employees have a statutory duty to safeguard and promote the welfare of children and adults, including:

- being alert to the possibility of child/ adult abuse and neglect through their observation of abuse, or by professional judgement made as a result of information gathered about the child / adult;
- knowing how to deal with a disclosure or allegation of child / adult abuse;
- undertaking training as appropriate for their role and keeping themselves updated;
- being aware of and following the local policies and procedures they need to follow if they have a child / adult concern;
- ensuring appropriate advice and support is accessed either from managers, *Safeguarding Ambassadors* or the trust's safeguarding team;
- participating in multi-agency working to safeguard the child or adult (if appropriate to your role);
- ensuring contemporaneous records are kept at all times and record keeping is in strict adherence to Mersey Care NHS Foundation Trust policy and procedures and professional guidelines. Roles, responsibilities and accountabilities, will differ depending on the post you hold within the organisation;
- ensuring that all staff and their managers discuss and record any safeguarding issues that arise at each supervision session.

EQUALITY AND HUMAN RIGHTS

Mersey Care NHS Foundation Trust recognises that some sections of society experience prejudice and discrimination. The Equality Act 2010 specifically recognises the *protected characteristics* of age, disability, gender, race, religion or belief, sexual orientation and transgender. The Equality Act also requires regard to socio-economic factors including pregnancy /maternity and marriage/civil partnership.

The trust is committed to equality of opportunity and anti-discriminatory practice both in the provision of services and in our role as a major employer. The trust believes that all people have the right to be treated with dignity and respect and is committed to the elimination of unfair and unlawful discriminatory practices.

Mersey Care NHS Foundation Trust also is aware of its legal duties under the Human Rights Act 1998. Section 6 of the Human Rights Act requires all public authorities to uphold and promote Human Rights in everything they do. It is unlawful for a public authority to perform any act which contravenes the Human Rights Act.

Mersey Care NHS Foundation Trust is committed to carrying out its functions and service delivery in line the with a Human Rights based approach and the FREDA principles of **F**airness, **R**espect, **E**quality **D**ignity, and **A**utonomy.

Contents

Section	Page No
1. Purpose and Rationale	5
2. Outcome Focused Aims and Objectives	6
3. Scope	7
4. Definitions	7
5. Duties	9
6. Process	11
7. Consultation	20
8. Controls and Archiving	21
9. Implementation and Monitoring	21
10. Equality and Human Rights Analysis	22
11. Appendix A – Guidance on Risk Assessment	28
12. Appendix B – Zonal Observation and Engagement	29
13. Appendix C – Template Documenation	31
14. Appendix D – Competency Assessment	35

1. PURPOSE AND RATIONALE

Purpose

1.1 This Policy explains:

(a) why this Policy is necessary;

(b) when general and enhanced observations should be used;

(c) which staff are best placed to carry out these observations;

(d) responsibilities for ensuring enhanced observations is used for the least amount of time clinically required;

(e) the process to be followed for assessing the level of risk for each service user, agreeing the appropriate level of observation, carrying out and recording observations and regularly reviewing the level of observation.

Rationale

1.2 The Trust has a duty of care to ensure the safety of service users in its care which is also compliant with chapter 26 of the Mental Health Act Code of Practice (2015). As part of that duty there must be a Policy and Procedure for the observation of patients that is fully compliant with NICE Guideline (NG10, Violence & aggression:short term management in mental health, health & community settings).

1.3 Observation is a supportive mechanism, for the purpose of engaging positively with the service user. It is an integral part of the care plan, to ensure the safe and sensitive monitoring of the service user's behaviour and mental well-being, enabling a rapid response to change, whilst at the same time fostering therapeutic relationships between staff and service user.

1.4 Staff should know the location of all service users for whom they are responsible during their inpatient stay. But it is not necessary to routinely keep service users, who are not considered to present a serious risk of harm to themselves or others, within constant sight.

1.5 The use of observation levels should never be regarded as routine practice, but must be based on assessed and current need.

1.6 On occasions during periods of distress or pronounced ill-health some service users may become a serious risk of harm to themselves or others. Enhanced observations may be required for management of behavioural disturbance or during periods of distress to prevent suicide or serious self harm.

1.7 Enhanced observation, over and above general observations, is a therapeutic intervention with the aim of reducing factors which contribute to increased risk and promote recovery. It should focus on engaging the person therapeutically and enabling them to address their difficulties constructively.

1.8 Enhanced observations is also a restrictive practice and may be perceived by service users as a coercive intervention. It should therefore only be implemented after positive engagement with the service user has failed to reduce the risk to self or others and only used for the least amount of time clinically required.

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

1.10 This policy and procedure ensures a consistent and auditable approach to:

(a) meeting individualised needs of service users;

(b) agreeing an appropriate level of observation based on the individual's needs;

(c) reviewing the level of supportive observation;

(d) engaging with service users where enhanced observation is required;

(e) effective record keeping of the decision making process leading to the level of observation and delivery of that observation level in line with service user need.

2. OUTCOME FOCUSED AIMS AND OBJECTIVES

2.1 A member of the nursing team will set aside dedicated time, at least once per shift, to assess the service user's mental state and engage positively with the service user. A record of this assessment will be recorded in the service user's health record.

2.2 At shift hand over staff from the on-going and incoming shifts will establish a verbal and or physical response from each service user present on the ward (As per SD 49 Clinical Handover at Nurse Shift Changes)

2.3 Dependent on assessed need and risk, service users will be observed at minimum prescribed intervals. A record of this assessment will be recorded in the service user's health record and where there is CCTV installed, compliance with delivery of the prescribed observation level will be subject to a spot check using CCTV footage.

2.4 No Service user will be observed at predictable intervals. Predictable observation can provide opportunity to plan or engage in harmful activities. Compliance with this requirement will be evidenced by the observation record and where there is CCTV installed this will be subject to a spot check of CCTV footage.

2.5 The rationale for any change to a service user's level of observation will be recorded in the service user's health record.

2.6 Every service user on enhanced observations (i.e. levels 2, 3 and 4) will have a collaborative care plan in place, this will detail a summary of the service user's condition, risk behaviours and significant events, suggested therapeutic interventions must be included in the care plan. For those on level 3 Observation, the maximum observing distance should be included in the care plan.

2.7 Decisions about changing a service user's level of supportive observation will be timely and subject to an auditable decision making process. Any delegation of decision making by multi disciplinary teams should be encouraged and documented, clearly identifying who is making the decision in the absence of the Responsible Clinician and under what circumstances changes should be made (i.e. related to the needs, behavioural presentation and or mental state of the service user).

2.8 For all service users requiring level 2 supportive observation a written record will be made at minimum prescribed intervals. For those service users requiring level 3 or level 4 observations a written evaluation of behavioural presentation and/or mental state will be made every one hour. All records will be made contemporaneously by the staff member allocated to the duty of providing supportive observation and held in the service user's health record.

2.9 The patient record will contain evidence of prescribed review, interventions used and meaningful engagement with service users.

2.10 A documented MDT Peer review will occur for all service users subject to constant observations for prolonged periods of time (anything exceeding 14 days) and if continued at a minimum of every 1 month thereafter.

2.11 All service users subject to constant observations for longer than 3 months will have a formulation of the behaviour /presentation leading to the requirement for constant observations for an extended period, the formulation will be reflected in a Multi Disciplinary care plan developed to meet those needs, Support Plans, Personal safety plans, or Advanced statements should be developed based on this formulation. The formulation will be reviewed at a minimum of every three months or until constant observation is discontinued.

2.12 For those service users requiring constant observation for longer than 14 days, a collaborative daily planner will be developed with the service user and multi disciplinary team, this will identify which members of the Multi disciplinary Team will deliver targeted interventions over the 24 hour period.

2.13 All staff will be aware of the impact on the wider service user population when required to provide constant observation, staff will report if any antagonism is directed at the person being observed and support the service user accordingly, this will be documented in the service user's health record. As far as possible the multi disciplinary team will attempt to meet the needs of the whole service user group in a timely manner.

2.14 If a service user subject to enhanced observation is confined to a particular area and being prevented from having contact with anyone outside the area in which they are confined, then this will amount to either seclusion or long-term segregation and the Trust's Seclusion Policy will be applied.

3. SCOPE

3.1 This is a Trust wide policy and applies to all staff working in the Trust's clinical divisions who have a responsibility for prescribing and/or undertaking supportive observations (including temporary, permanent, bank and agency staff).

3.2 It should be applied to all service users cared for in in patient settings.

4. DEFINITIONS

4.1 **The practice of supportive observation** – this can be defined as regarding the service user attentively whilst minimising the extent to which they feel that they are under surveillance. It requires staff to be caringly vigilant and inquisitive, and have a thorough knowledge of the service users in their care, the service users' current care plans and their observational requirements. Unusual circumstances and noises should always be investigated.

4.2 **Levels of supportive observation** – are defined as general observations (level 1), intermittent observations (level 2); within eyesight (level 3); and within arm's length (level 4). Decisions about what level of supportive observation a service user requires will be based and supported by documented evidence of assessed current need.

4.3 **General Observation (Level 1)** – this is the minimum level of observation for all service users in inpatient areas. Staff should know the location of all patients in their area, but patients need not be kept in sight. Service users subject to general observations will normally have been assessed as being a low-risk to themselves or others. Their location and safety will be visibly checked at a minimum of hourly intervals and a record made.

In some specialist and forensic areas there may be a need to increase frequency of these general observation intervals. Patients in the Secure Division must be observed for clinical and security purposes at least every 30 minutes and their location recorded.

The intended whereabouts of service users who are on leave from the ward should also be known at all times.

4.4 **Intermittent Observation (Level 2)** – this means that the service user's location and safety must be visibly checked at specified intervals. These intervals may range from every five minutes to a maximum of every thirty minutes. This is for service users who pose a potential, but not immediate risk. The specified frequency of observation will be recorded in the Care Plan. Observing service users at predictable times can provide service users with the opportunity to plan or engage in harmful activities. This should be taken into account when determining the frequency of observation required. In the Secure division the maximum interval is every 15 minutes.

4.5 **Zonal** Observations – this is an approach a ward or clinical area may take to enhance observation of a particular group of service users within a specific ward or environment, e.g. a dementia ward. A staff member may be assigned to observe and engage with individuals using specified zones within the ward area. Any ward intending to introduce this type of observation should first refer to Appendix B.

NB Zonal Observations should not be confused with the Care Zoning initiative being implemented in some areas of Mersey Care NHS Foundation Trust. Care Zoning is an approach to prioritise care and interventions, and not a substitute for Supportive Observation.

4.6 **Within Eyesight (Level 3)** – this means a nominated staff member will be allocated to each individual being managed on this level of observation and the service user must be kept within continuous eyesight at all times. This is for service users who could, at any time, make an attempt to harm themselves or others, or where a service user is perceived as being vulnerable. On rare occasions, it may be necessary that more than one nurse is required to implement this level of observation safely. In High Secure Services where observation levels have been initiated or increased by the nurse in charge, an appropriate Doctor should be asked to review the patient. The responsible clinician and relevant members of the multidisciplinary team should be informed at the earliest opportunity.

4.7 **Within Arms Length (Level 4)** – this means a nominated staff member will be allocated to observe the service user in close proximity (i.e. within arms length). This is for service users 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 service user with staff.

5. DUTIES

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

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

5.3 **Chief Operating Officers** – have operational responsibility for clinical divisions' compliance with this Policy and will ensure mechanisms are in place within each service for:

(a) identifying and deploying resources within the clinical division to safely deliver this Policy;

(b) all clinical staff with responsibility for prescribing and carrying out observations receiving orientation to the content of this Policy;

(c) monitoring the clinical division's compliance and consistent application of the Policy;

(d) ensuring that all service users subject to prolonged periods of constant observations are reviewed after 14 days and then at least once per calendar month by clinicians independent of the patient's care;

(e) ensuring prolonged periods of observation or any that extend beyond two weeks are recorded in the service user's health care record.

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

5.5 **Matrons** – are accountable to the Chief Operating Officer for providing assurance that their respective wards' are compliant with the requirements of the Policy.

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

(a) they understand their role in initiating and reviewing supportive observations;

(b) care plans are in place and appropriately identify the required level of observation;

(c) documented risk review accompanies the decisions made to change the levels of observation;

(d) deployment of the available resources to safely deliver this Policy on their wards;

(e) identification, responding and where necessary escalating any areas of non compliance with this Policy on their wards;

(f) that Peer review occurs when patients are subject to constant observations for longer than 14 days.

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

The teams must consider how enhanced observation can be undertaken in a way which minimises the likelihood of individuals perceiving the intervention to be coercive and how observation can be carried out in a way that respects the individual's privacy as far as practicable and minimises any distress. In particular care plans should outline how an individual's dignity can be maximised without compromising safety when individuals are in a state of undress, such as when using the toilet, bathing, showering, dressing etc, as detailed in 6.17 a robust care plan based on identified risk should be in place at times usually associated with the need for privacy.

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

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

The Nurse in Charge should also be checking observations are undertaken in line with the prescribed observation level, and in accordance with the agreed care plan.

5.9 **All Registered inpatient clinical staff have a responsibility to:**

(a) understand their role in initiating, carrying out and reviewing supportive observations;

(b) carry out that role in line with the Policy;

(c) complete the care plan for their named patient;

(d) inform each patient of the level of observation they are subject to and the reasons for this;

(e) review the level of observation based on recorded clinical need and risk review;

(f) ensure the care plan is implemented;

(g) ensure the periods of observation are viewed and used as opportunities to build a therapeutic relationship;

(h) complete all the required documentation;

(i) fully familiarise themselves with the policy.

5.10 Non-registered inpatient clinical staff have a responsibility to:

(a) understand their role in carrying out supportive observations;

(b) carry out observations in line with the observation level prescribed;

(c) ensure the periods of observation are viewed and used as opportunities to build a therapeutic relationship;

(d) be familiar with, and implement, the service user's care plan;

(e) complete the required documentation accurately and contemporaneously;

(f) report any relevant information that would assist the effective review of the service user's needs;

(g) fully familiarise themselves with this Policy.

6. PROCESS

Restriction of Liberty

6.1 The least intrusive level of observation that is appropriate to the situation should always be adopted so that due sensitivity is given to the service user's dignity and privacy whilst maintaining the safety of those around them. It is recognised that clinical services will at times adopt harm minimisation and positive risk taking approaches, for example with patients who self-injure. Where these approaches are used, the clinical strategies employed should be clearly documented in the individual service user's clinical notes and care plan, so as to communicate the appropriate information to all staff working with those individuals. All decisions about the specific level of observation should take into account:

(a) the service user's current mental state;

(b) any prescribed medications and their effects;

(c) the current assessment of risk should include the service users ability to perceive potential risk;

(d) the views of the service user.

Communication and engagement

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

Human Rights issues

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

(a) the interests of national security, public safety or the economic well-being of the country; or

(b) the protection of disorder or crime; or

(c) the protection of health or morals; or

(d) the protection of the rights or freedoms of others;

(e) proportionate: even if the use of observations is considered justified, it will only be lawful if it goes no further than is reasonably necessary in each individual case to achieve the relevant objectives. When operating this policy clinicians will need to make sure that the use of observations remains 'proportionate' and that it is no more intrusive – nor continues longer – than is required by the circumstances.

Prescription of Supportive Observations

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

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

(a) CPA information and contemporary risk assessment;

(b) information available from care co-ordinator if known to services;

(c) expressed intentions;

(d) information shared by relatives and carers;

(e) implied intentions;

(f) past history including previous suicide attempts, self-harm or assaultive behaviour;

(g) hallucinations suggesting harm to self or others;

(h) paranoid ideas that pose a threat to self or others;

(i) recent loss or bereavement;

(j) past or current problems with drugs or alcohol;

(k) poor adherence to prescribed medication;

(l) marked changes in behaviour or medication;

(m) risk of falls;

(n) risk of physical vulnerability.

6.6 In relation to on-going care needs and appraisal of risk, clinical staff will be required to observe and record service users functioning at ward level including their:

(a) interaction with others;

(b) emotional state;

(c) attitudes;

(d) external triggers;

(e) adherence to boundaries;

(f) level of insight;

(g) potential risk of absconding.

The MDT should be aware of the risk of dependency developing in those subject to constant observations for prolonged periods.

Managing care for service users subject to supportive observations.

6.7 Supportive observation must be used as an opportunity for supportive and therapeutic interaction to meet the holistic needs of service users. It is therefore imperative that during supportive observations the service user should be engaged in dialogue and useful activities appropriate to their needs. Such activities need to be collaboratively identified with the service user and documented a care plan, which should be reiterated at each hand over. If for any reason, engaging the service user in dialogue and activities during supportive observation is not possible, then the reasons for this needs to be clearly recorded.

6.8 The holistic assessment is an opportunity to identify and plan care taking into account the equality needs of patients from the protected characteristics which are:

(a) age;

(b) race;

(c) disability;

(d) gender reassignment;

(e) marriage and civil partnership;

(f) religion and belief;

(g) sex;

(h) sexual orientation;

(i) maternity and pregnancy.

6.9 Staff undertaking supportive observation should be familiar with the ward, the ward policy for emergency procedures and potential risks in the environment or with individual service users and their planned care.

6.10 The clinical team should continually review risk in developing an effective care plan for a service user subject to supportive observations. A consideration of any tools or instruments that could be used to harm themselves or others should be made and where appropriate such items removed for safekeeping. It may be necessary to search the service user and their belongings in line with the Trust's search policy (SD 20), to ensure no potential means to inflict injury are hidden on the service user's person.

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

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

6.13 An appropriate CPA assessment and care plan should be established - considering clinical risk and a review of relevant history / case notes - with every service user on admission to an inpatient area. This review should include direct dialogue with the service user and significant other as well as a consideration of any Advanced Statements and Decisions that have been established. The risks associated with all service users within inpatient areas need to be considered when making decisions about supportive observation. Particular emphasis should be placed on vulnerability in terms of gender, age, sexuality, ethnicity and capacity to give informed consent. The information gathered should be used to inform the clinical decision regarding supportive observation.

6.14 If appropriate to the service user's needs a request for support from same gender nursing staff should be facilitated where possible, unless there is a specific clinical risk or other reason why this would be inappropriate.

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

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

6.17 Where supportive observation at level 2 or above has been decided upon, consideration needs to be given as how this can be maintained during times when personal/ intimate activities need to be undertaken. The way that supportive observations undertaken should be based on the assessed needs of the service user. Any decision to reduce supportive observation from levels 2 and above during visiting times or intimate times such as bathing should be based on a robust documented risk review to include MDT discussion.

Patients on observation in off ward areas

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

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

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

6.21 The individual risk assessment should:

(a) consider the environmental risk in the area being proposed for the patient to attend, e.g. observation line, glazing in windows, furniture;

(b) consider the treatment/activities within the area;

(c) include a/the member of staff from the area where it is proposed the patient will attend;

(d) consider if a ward based staff needs to escort the patient in order to undertake the observation, or whether this can be safely done by a member of staff from the areas the patient is attending;

(e) record the details in the patient's health care record.

6.22 Where the responsibility for undertaking the observation is transferred to a member of staff from the area where it is proposed the patient should attend, the observation record sheet should also be transferred to that staff

Care provision for young people aged under 18

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

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

Increasing Supportive Observations

6.25 Decisions about supportive observations should be made as far as possible via multi-disciplinary discussion, based on the on-going assessment of the service user's needs as described above. This process should include the service user wherever possible. Registered nursing staff with delegated responsibility for a ward area have the authority to implement an increase in the level of observation in the first instance. Any such decision should be reviewed by the senior nurse on duty in the area or medical staff at the earliest opportunity.

Decreasing Supportive Observations

6.26 The decision to reduce the level of observations should normally be taken by registered nursing staff or mental health practitioner in conjunction with the MDT. However delegation of authority to decrease level of observation can occur in the absence of the Responsible Clinician, if the Responsible Clinician, has identified who and under what circumstances changes can be made (i.e. related to the needs, behavioural presentation and or mental state of the service user). This must be clearly documented in the patients record.

6.27 Wards teams should look to plan ahead and ensure that the plan of care for each service user outlines the conditions and observed behaviours that would facilitate a prompt reduction in observation levels.

6.28 Where the Responsible Clinician feels that observations should not be reduced without medical consultation this requirement should be clearly recorded in the clinical record and communicated verbally to all members of the multi-disciplinary team. If necessary, any out-of-hours concerns can be addressed through the on-call consultant.

6.29 It is also recognised that in certain specialist areas such as forensic and high secure services long-term care needs and dynamic risk assessment enables clinical teams in conjunction with service users to develop care plans which adjust the level of observations during the course of the day, based on service user need and the known risks associated with a given activity and the environment of care. With the full agreement of the clinical teams care plans can be routinely adjusted to reflect the required level of observation afforded a service user during the course of the day provided this is underpinned by a robust assessment and care plan and that the care team regularly reviews the plan and allows practitioners to modify the plan in the event of changes to a service user's presentation.

Skills and responsibilities of staff undertaking supportive observations

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

6.31 Student nurses would not normally be expected to undertake supportive observation, except where this is an agreed part of their learning objectives and all parties are satisfied with their level of competence. **First year students are not to undertake any level of observations.** Second year students should only undertake level two observations. Level three observations as a maximum should only be undertaken by third year students and **only under the direct supervision of a qualified (RMN) member of staff.** Students should not be engaged in supportive observations for more than 60 minute periods All students will have immediate support available to them and be in receipt of supervision that would enable them to withdraw from this role with immediate effect should the need arise.

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

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

Service user and carer information and involvement

6.34 Levels of observation and the reason for their use must be explained to service users, and their carers or relatives in an appropriate format where applicable. Staff should assess whether the service user and or their relative have understood the rationale and implications of using supportive observation which should be clearly documented.

6.35 Where a service user, and or their relative, experience difficulty in understanding the rationale and implications of supportive observation then this should be appropriately reiterated and clearly documented.

Reviewing observation levels

6.36 Observation status must be formally reviewed at regular intervals. This will be a minimum of daily for Level 2 and 3. Within arms length (level 4) should be reviewed at least three times a day, twice in the day and once at night (every 8 hours). Service users who remain on Level 2, 3 and 4 observation continuously for more than 1 week should have observation levels reviewed at a Multi Disciplinary Team review.

6.37 In the case of the High Secure Services which provides long-stay care for individuals who pose specific risks to themselves and others a variation to these review schedules has been applied. Within High Secure Services whenever supportive observations has been introduced a multi-professional review of any Level 4 observations will be undertaken on a daily basis. Where Clinical Teams develop substantive care plans to manage longer-term risk, the schedule for review of the care plan and associated level of observation can be undertaken on a weekly basis within the care team setting.

6.38 Where changes to levels of observation outside of the regular reviews are needed, discussion should take place at ward level with the medical team and where appropriate the consultant &/or responsible clinician informed of any changes. The decision must be recorded contemporaneously giving a rationale for the change.

Recording of supportive observations

6.39 Any decision to utilise an enhanced level of observation must always be fully documented in the service user's clinical records, the record should indicate that due consideration has been given to the service user's human rights. Such a consideration needs to be explicitly documented at all the subsequent review schedules described.

6.40 Delivering enhanced levels of observation is a complex and at times difficult clinical intervention. The process of engagement and interactions, if appropriately adopted, should enable an accurate picture of a service user's well-being, mental health and potential risk to emerge. The assigned staff should sit down and talk to the service user to formally evaluate and assess their mental state, mood, behaviour and risk.

6.41 Delivering interventions to service users requiring constant observations should not be restricted to members of the nursing team. All members of the Multidisciplinary should engage in targeted interventions intended to aid the service user's recovery.

6.42 It is important to accurately record the individual's mental health and identify any clinical indicators of risk in the service user's clinical notes. All records specifically utilised in services in support of this policy must be fully completed with any individual timed observations being captured accurately and contemporaneously, see Appendix C for example templates. In addition the following information needs to be detailed within the service user's clinical record:

(a) a current risk assessment and care plan;

(b) date and time that the observation level was instigated, altered or reviewed;

(c) explicit record made of the current observation level in force and any specified timescales to be applied, or environments which are restricted;

(d) any specific instructions and rationale related to individual service user needs;

(e) reasons for current observation levels;

(f) indicators of risk or relapse;

(g) approach adopted in providing appropriate level of support and identification of number and gender requirements of staff assigned to provide care;

(h) clear information regarding expected engagement and therapeutic interventions;

(i) the possible or anticipated reaction of the service user being cared for.

Observation in general hospital settings

6.43 **When a service user is transferred from inpatient services to another NHS facility**, such as an Acute General Hospital, there is a requirement to review the risk assessment prior to transfer and an appropriate level of observation will be allocated based on identified risk, during their presence at another NHS facility. **It is the responsibility of Mersey Care NHS Foundation Trust to provide the required supportive observation during the stay at the alternative NHS facility**. However, if a client known to mental health services is being cared for routinely in an NHS facility and requires supportive observation to meet their mental health needs, but has not been transferred from a mental health inpatient service, then it is the responsibility of the NHS facility to provide this intervention.

Skills and training of staff

6.44 The Trust will ensure that all staff operating this policy (whether registered, un-registered, bank, agency) are appropriately orientated in line with the organisation's induction and mandatory training policy (HR28).

6.45 Induction and training will incorporate: clinical risk assessment; risk management; clinical engagement; attitudes and demeanour of staff and the potential affects of supportive observations; environmental safety, roles and responsibilities of multi-disciplinary teams; and recording of supportive observations.

6.46 Inexperienced or newly appointed staff should have the policy explained to them as part of their local induction. Nursing staff and other mental health practitioners providing this level of input should have two periods of supervised practice before they are considered competent. This should consist of at least one supervised practice of intermittent observation (level 2) and one supervised session at an enhanced level (3 or 4). Those reviewing competency must be a minimum of band 5 with at least one year's post qualification experience. Any concerns over individual competence in this area will be dealt with in a supportive way, but the competence of the practitioner must be verified before being allowed to operate independently.

6.47 Proof of competency should be held by the Ward Manager and individual member of staff (can be attached to PACE).

6.48 Any Mersey Care practitioner operating this policy should understand fully what is expected of them and be able to describe the required practice standards they would provide when charged with delivering the level of care and support to service users subject to this policy.

6.49 All Mersey Care staff operating this policy will have received an introduction to the policy during their induction that will equip them with the knowledge required to implement the policy effectively. In-house learning, capturing the elements described above, which incorporate the Trust's practice guidelines will be available to all clinical staff and will provided on a regular, rolling basis.

6.50 In addition all Mersey Care staff who have responsibility for carrying out supportive observations will normally:

(a) have knowledge of or be made aware of the service user, their history, background and risk factors;

(b) be familiar with the ward and the potential risks in the environment;

(c) must be fully conversant with the respective service user's individual care plan and demonstrate a willingness to listen and initiate conversation as appropriate.

Resource Management

6.51 Each Division and clinical area will be expected to develop local protocols for wherever circumstances require that clinicians and managers need to consider and upgrade staffing levels. Such protocols would incorporate systematic evaluation and review of any additional resources allocated for this purpose.

6.52 Where additional resources are required to provide an appropriate level of support to service users, clinicians involved in the care of the service user must utilise these agreed protocols to ensure managers and other senior professionals can provide support to facilitate this. Furthermore protocols must include the governance arrangements that need to be in place to arbitrate and obtain consensus around risks posed should variances of professional opinion occur within service.

Reporting Incidents

6.53 When a service user subject to supportive observation is involved in a serious untoward incident it is important that a post incident review occurs. The Responsible Clinician and local service manager will ensure that all such reviews are undertaken in a safe supportive environment to ensure improvements – if appropriate – are identified to limit the prospects of any similar incident occurring in the future.

6.54 The action to be taken in reporting incidents should be in line with the process outlined in the Trusts Policy for Reporting, Management and Review of Adverse Incidents (SA03) which is available on the Trust website.

7. CONSULTATION

7.1 Review of this Policy has been led by the Senior Clinical Nurse with specialist role for advising on supportive observation practice. The revisions to the Policy take account of the No Force First Initiative and implementation of Care zoning and engagement initiatives within the Trust.

7.2 Consultation on proposed changes to this policy document will be led by the clinical divisions' Head of Nursing (or equivalent) and will include but not be limited to:

(a) Executive Nurse Team;

(b) Service Directors;

(c) Heads of Discipline;

(d) Senior Nurses;

(e) Matrons.

7.3 This Policy will be reviewed again in two years time or sooner if there are any changes to legislation or updates to best practice.

8. IMPLEMENTATION AND MONITORING

8.1 Each clinical division should have in place procedures for monitoring practice, trends, compliance and standard of record keeping for delivery of this Policy. The Chief Operating officer will identify any barriers to the process and/or substantive changes requiring an implementation plan and/or escalation.

9. Equality and Human Rights Analysis

Title: Supportive Observation Policy SD04
Area covered: Trust Wide Policy

What are the intended outcomes of this work? 1.11 The Trust has a duty of care to ensure the safety of service users in its care which is also compliant with chapter 26 of the Mental Health Act Code of Practice (2015). As part of that duty there must be a Policy and Procedure for the observation of patients that is fully compliant with NICE Clinical Guideline 25 (CG25 Violence). 1.12 Observation is a supportive mechanism, for the purpose of engaging positively with the service user. It is an integral part of the care plan, to ensure the safe and sensitive monitoring of the service user's behaviour and mental well-being, enabling a rapid response to change, whilst at the same time fostering therapeutic relationships between staff and service user. 1.13 Staff should know the location of all service users for whom they are responsible during their inpatient stay. But it is not necessary to routinely keep service users, who are not considered to present a serious risk of harm to themselves or others, within constant sight.
Who will be affected? Patients

Evidence
What evidence have you considered? The policy
Disability inc. learning disability See cross cutting
Sex See cross cutting
Race See cross cutting
Age See cross cutting
Gender reassignment (including transgender) See cross cutting
Sexual orientation See cross cutting
Religion or belief See cross cutting
Pregnancy and maternity

See cross cutting
Carers See cross cutting
Other identified groups See cross cutting
Cross cutting The holistic assessment is an opportunity to identify and plan care taking into account the equality needs of patients from the protected characteristics which are: • Age • Race • Disability • Gender reassignment • Marriage and civil partnership • Religion and belief • Sex • Sexual Orientation • Maternity and pregnancy A documented MDT Peer review will occur for all service users subject to constant observations for prolonged periods of time (exceeding 14 days) and a minimum of every 1 month thereafter. All Service users subject to constant observations for longer than 3 months will have a formulation of the behaviour leading to the requirement for constant observations for such an extended period, the formulation should be reflected in a Multi-Disciplinary care plan developed to meet those needs, Behavioural Support Plans or Personal safety plans should be developed based on this formulation. The formulation will be reviewed at a minimum of every three months or until constant observation is discontinued.

Human Rights	**Is there an impact?** **How this right could be protected?**
This section must not be left blank. If the Article is not engaged then this must be stated.	
Right to life (Article 2)	Human rights based approach supported. Human Rights issues The European Convention on Human Rights (ECHR) has been enshrined in United Kingdom law since 2000. The provisions indicate that everyone has the right to respect for his/her private life (Article 8). No service user should therefore be subject to unnecessarily intrusive observations in a way that would breach this right. In order for this policy to comply with the law observation must be Justified: the ECHR permits breaches of Article 8 that are necessary for one or more of the following reasons: The interests of national security, public safety or

	the economic well-being of the country; or The protection of disorder or crime; or The protection of health or morals; or The protection of the rights or freedoms of others. Proportionate: even if the use of observations is considered justified, it will only be lawful if it goes no further than is reasonably necessary in each individual case to achieve the relevant objectives. When operating this policy clinicians will need to make sure that the use of observations remains 'proportionate' and that it is no more intrusive – nor continues longer – than is required by the circumstances.
Right of freedom from inhuman and degrading treatment (Article 3)	Human rights based approach supported. 1.4 On occasions during periods of distress or pronounced ill-health some service users may become a serious risk of harm to themselves or others. Enhanced observations may be required for management of behavioural disturbance or during periods of distress to prevent suicide or serious self harm. 1.5 Although already included in the current Supportive Observation policy, observation during times usually associated with privacy is still poorly documented and not routinely incorporated into patient care plans, emphasis need to be raised re this issue.
Right to Liberty (Article 5)	Human rights based approach supported. Restriction of Liberty 1.4 The least intrusive level of observation that is appropriate to the situation should always be adopted so that due sensitivity is given to the service user's dignity and privacy whilst maintaining the safety of those around them. It is recognised that clinical services will at times adopt harm minimisation and positive risk taking approaches, for example with patients who self-injure. Where these approaches are used, the clinical strategies employed should be clearly documented in the individual service user's clinical notes and care plan, so as to communicate the appropriate information to all staff working with those individuals. All decisions about the specific level of observation should take into account: • the service user's current mental state

	• any prescribed medications and their effects • the current assessment of risk should include the service users ability to perceive potential risk • the views of the service user. A documented MDT Peer review will occur for all service users subject to constant observations for prolonged periods of time (exceeding 14 days) and a minimum of every 1 month thereafter.
Right to a fair trial (Article 6)	Human rights based approach supported.
Right to private and family life (Article 8)	Human Rights Based approach supported
Right of freedom of religion or belief (Article 9)	Human rights based approach supported.
Right to freedom of expression Note: this does not include insulting language such as racism (Article 10)	This article is not engaged
Right freedom from discrimination (Article 14)	Human rights based approach supported

Engagement and involvement
9.1 Review of this Policy has been led by the Senior Clinical Nurse with specialist role for advising on supportive observation practice. The revisions to the Policy take account of the No Force First Initiative and implementation of Care zoning and engagement initiatives within the Trust.
9.2 Consultation on proposed changes to this policy document will be led by the clinical divisions' Head of Nursing (or equivalent) and will include but not be limited to: • Executive Nurse Team • Service Directors • Heads of Discipline • Senior Nurses • Matrons

Summary of Analysis
Eliminate discrimination, harassment and victimisation
1.14 The use of observation levels should never be regarded as routine practice, but must be

based on assessed and current need.

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

Advance equality of opportunity

No issues identified

Promote good relations between groups

No issues identified

What is the overall impact?

The impact is intended to be positive and is about maintain the safety and wellbeing of both the patient directly affected by the policy and also other patients.
It is noted 'Enhanced observations is also a restrictive practice and may be perceived by service users as a coercive intervention. It should therefor only be implemented after positive engagement with the service user has failed to reduce the risk to self or others and only used for the least amount of time clinically required'.

Addressing the impact on equalities

Action planning for improvement

A documented MDT Peer review will occur for all service users subject to constant observations for prolonged periods of time (exceeding 14 days) and a minimum of every 1 month thereafter.

Recording of supportive observations

9.3 Any decision to utilise an enhanced level of observation must always be fully documented in the service user's clinical records, the record should indicate that due consideration has been given to the service user's human rights. Such a consideration needs to be explicitly documented at all the subsequent review schedules described.

For the record

Name of persons who carried out this assessment:

George Sullivan Secure Services Equality and Human Rights Advisor
Alison Baker Senior Nurse

Date assessment completed: February 9th 2017

Name of responsible Director: Executive Director of Nursing

Date assessment was signed: January 2016

Action plan template

This part of the template is to help you develop your action plan. You might want to change the categories in the first column to reflect the actions needed for your policy.

Category	Actions	Target date	Person responsible and their Directorate
Involvement and consultation			
Data collection and evidencing			
Analysis of evidence and assessment			
Transparency	Ensure policy goes on Trust website along with this assessment.		

10. Appendix A - Guidance on Risk Assessment

10.1 Risk assessment should include an interview with the service user and carers, careful study of the service user's history, use of risk assessment tools and must take into account assessments of other professionals, e.g. psychiatrists, CPNs or CMHT. The service user's thoughts, feelings and wishes with regard to suicide, self harm and harm to others should be approached using direct and respectful questions. Consideration also needs to be given to Advanced Statements/Directives. This can be a relief to service users who may not have been able to share such information with anyone else. The service user's notes are a vital source of information about past behaviour, as are relatives, friends and carers. A previous history of suicidal attempts or of attacks on others suggests that the service user should be observed until a full assessment can be carried out. When reading the history or gathering information from relatives or carers, it is important that nurses get as much detail as possible. There are also a number of simple and reliable tools that have been developed to appraise risk and these can form a useful adjunct to other methods of gathering information. Please refer to Mersey Care policy (SA10) 'The Use of Clinical Risk Assessment Tools.'

10.2 Factors which might indicate a need for increased levels of observation (level 2 and above) include:

(a) history of previous suicide attempts, self-harm or attacks on others;

(b) hallucinations, particularly voices suggesting harm to self or others;

(c) paranoid ideas where the service user believes that other people pose a threat;

(d) thoughts and ideas that the service user has about harming themselves or others;

(e) specific plans or intentions to harm themselves or others;

(f) past or current problems with drugs or alcohol;

(g) recent loss or bereavement;

(h) Poor adherence to medication programmes;

(i) poor adherence to medication programmes or non-compliance with medication programmes;

(j) marked changes in behaviour or medication;

(k) known risk or relapse indications;

(l) risk of falls;

(m) risk of physical vulnerability.

10.3 It is recognised that a restrictive, risk adverse application of supportive observations can become counter therapeutic. Therefore, it is appropriate that

clinical teams ensure that the application of this policy generates a safe and therapeutic environment of care. For example, following an appropriate assessment, a clinical team may identify a risk of self harm that is known and understood, but in their professional view this risk is most appropriately managed within a general observation approach. This policy is not designed to impose practices on clinical teams. Effective management of risk does not mean total eradication of risk. This policy requires clinical teams to demonstrate objectivity and rigour in their risk assessment process.

11. Appendix B ZONAL ENGAGEMENT & OBSERVATIONS

Introduction

11.1 Zonal observations and engagement is an approach a ward or clinical area may take to enhance the observation of a particular group of service users within a specified ward or clinical area. Zonal observations can be plotted against certain times or functions dependent on the ward layout and key tasks relevant to the service user group. Individual needs assessment will inform individual care plans and individual observation levels as detailed in this wider policy.

11.2 Traditionally, service users who intermittently present an increased level of risk have been placed on continuous observations by one or more member of the nursing team. However, this model of observation does not always result in a positive clinical outcome for the service user.

11.3 The alternative system of Zonal Engagement & Observations is considered to be less intrusive and allows greater privacy for the service user than traditional methods.

11.4 The Zonal Engagement & Observation approach aims to ensure appropriate observation of individual service users without the need to assign a particular nurse to be in close proximity to the service user for long periods this decision will always be based on clinical need and not be financially driven.

11.5 Identified staff will be responsible for observing and engaging with all service users within a particular zone (area) of the Ward. This will entail checking on people in rooms within the zone, assisting a person to find their way about within the zone intervening when necessary to maintain safety of those in the zone. Calling for help from other staff as needed.

Principles guiding the implementation of Zonal Engagement & Observation

11.6 Zonal Engagement & Observations must be service user focused at all times.

11.7 The Service has a duty for safety and security to the service users, staff and visitors.

11.8 Care must be provided in an environment and manner that reflects the least level of restriction possible for the safe and supportive management of the service user.

11.9 Zonal Observation and Engagement should therefore be seen as one method of reducing risk and enhancing the service user experience. It is integral part of a wider risk assessment and contextual management process.

11.10 Care and support of the service user will be addressed specifically within an individualized care plan service users will be assigned a level of observation as outlined in the wider policy this may be level 1, 2, 3 or 4 the assigned nurse should carry out the observation and make the associated records at the assigned times.

Zones

11.11 Not all ward lay outs are appropriate for Zonal Engagement and Observation. Any introduction of zonal observation in a ward area should be agreed with the wider clinical team service manager and following discussion with service users and carers where appropriate. Advice should be sought from health and safety representatives. The decision should be informed by data and reported incidents and monitoring of its effectiveness should include incidents being plotted against the ward zone chart with the date, time and precise location as well as service user feedback.

11.12 Zones should have explicitly defined rooms, corridors and spaces within them. The zone should be described clearly with defined boundaries as to where the zone starts and ends. Example of a zone may be:

(a) Zone 1 – day area/Courtyard/Group Room/small interview room.

11.13 Staff assigned to these areas must explicitly understand that they are not observing simply the physical space but rather are on hand to engage and intervene where necessary to maintain safety within that zone.

Professional Roles in Zonal Engagement & Observations.

11.14 The Ward Manager or their Deputy will:

(a) determine the resources needed to manage the ward;

(b) review the service users needs daily;

(c) consider and act appropriately in respect of any complaint the service user;

(d) may have about their observation status and management;

(e) be responsible for ensuring that risk recognition and management;

(f) of service users is discussed at each handover;

(g) ensure that a risk assessment process is used by the clinical team to agree that a zonal approach is used by patients;

(h) instruction on how and when zonal observation is implemented and reviewed;

(i) ensure that there are appropriate Care management Plans.

11.15 The Nurse in Charge will:

(a) delegate staff to the zone(s). (Staff should remain in a zone for a maximum of two hours at any one time);

(b) ensure that known and relevant risks are communicated to the observing nurse(s);

(c) discuss the care and management with the service user;

(d) review the level of observation as per policy;

(e) ensure that there are appropriate Care management Plans.

11.16 Observing and Engagement staff (Zone staff) will:

(a) know their zone;

(b) know who they are to observe;

(c) be familiar with the observation status of all service users in their observation zone;

(d) facilitate interaction and communication with the service user;

(e) provide a handover for the nurse taking over from them;

(f) report any changes in the service users behavior considered significant to the nurse in charge;

(g) report any concerns to the nurse in charge.

12. Appendix C – Template Documentation

12.1 **(The following templates are only provided as exemplars for the recording of supportive observations. Each Division will develop reporting templates in line with the needs or their respective service users. However, all forms must contain the fields laid out as a minimum.)**

Ward Checklist for General Observations (Level 1)

	Date:							
Service User	Time							
Signature of member of nursing team responsible for observations								

OBSERVATION PLAN AND RECORD OF INTERVENTIONS

Date & Time Commenced		Intermittent		Within Eyesight		Within Arm's length		Number of Staff Required	

Patient Name		Patient No.		Responsible Clinician		Ward	

SUMMARY OF KEY RISKS/REQUIREMENTS (The full Care Plan must be read in addition to this summary)

DATE	TIME	ALLOCATED MEMBER OF STAFF (Print full name and sign)	NOTE OF ENGAGEMENT UNDERTAKEN AND OBSERVATIONS MADE To include times when intermittent checks were made - including the patients perspective
		Name: Sig:	
		Name: Sig:	
		Name: Sig:	
		Name: Sig:	
		Name: Sig:	
DATE	**TIME**	**ALLOCATED MEMBER OF STAFF**	**NOTE OF ENGAGEMENT UNDERTAKEN AND OBSERVATIONS MADE**

		(Print full name and sign)	To include times when intermittent checks were made - including the patients perspective
		Name: Sig:	
		Name: Sig:	
		Name: Sig:	
		Name: Sig:	
		Name: Sig:	
		Name: Sig:	
		Name: Sig:	
		Name: Sig:	
		Name: Sig:	
		Name: Sig:	
		Name: Sig:	

Appendix D Supportive Observation Competency Checklist

As part of local ward induction all inpatient nursing staff and practitioners need to be assessed as competent to undertake supportive therapeutic observations, this assessment should be completed by a band 5 staff with at least one years experience, a minimum of two assessments should be completed and repeated if concerns over competence are raised.

Name of staff to be assessed **Name of assessor**

Grade of staff to be assessed **Grade of assessor**

Date

Competency	Achieved		Comment	Assessor signature
	Yes	No		
Before assessing the member of staff undertaking supportive observation are they able to explain:- 1. The frequency of observations required of a patient being supported by level two observations 2. The differences between level three and level four supportive observations				
Competency	**Achieved**		**Comment/Action Required**	**Assessor signature**
	Yes	**No**		
3. The ward policy for emergency procedures and potential risks in the environment				

Whilst the member of staff is undertaking supportive observation :- 1. Before the member of staff takes over the observation do they familiarise themselves with the focus of the assessment, the plan of care, the information documented during the previous shift and the expected activities and interactions to be engaged in with the patient.				
2. Does the member of staff Engage with the patient during the time they are undertaking the supportive Observation.				

Competency	Achieved		Comment/Action Required	Assessor signature
	Yes	No		
3. Does the member of staff adhere to the care plan, in terms of frequency of observations and distance				

required to provide the necessary support prescribed.				
4. Does the member of staff make the contemporaneous record required of the prescribed observation				
5. Does the member of staff engage in activities supported by the care plan				
6. If there is a change in the patients presentation does the member of staff seek support/inform the nurse in charge				
7. When handing over the task of supportive observations to another member of staff is the focus of assessment, plan of care, activities and interactions explained to the member of staff taking over the observation				
A copy of this completed form should be retained by line manager and included with the individual staff members PDP, a copy can be made for the individuals portfolio if requested				