Kent and Medway
NHS and Social Care Partnership Trust

Therapeutic Observation and Engagement of Patients Policy

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DOCUMENT TRACKING SHEET

THERAPEUTIC OBSERVATION & ENGAGEMENT OF PATIENTS POLICY

Version	Status	Date	Issued to/approved by	Comments
0.1	Draft	Jan 2007	Patient Focus Group	
1.0	Approved	18/04/08	Patient Focus Group	
1.1	Redraft	Aug 2009		
2.0	Approved	25/08/09	Clinical Governance	
2.1	Draft	March 10	Legal Services	Amendments made to ensure legally compliant
3.0	Approved	08/04/10	Chief Executive	Authorised
3.1	Reviewed	22/10/2012		Reviewed and updated to include intentional rounding, guidance concerning communication to patients about observations and staff awareness of policy.
4.0	Approved	28/11/2012	Trustwide Patient Safety Group	Authorised
4.1	Reviewed	15/04/2012		Reviewed and updated to ensure a more robust policy was in place concerning the duties of the nurse in charge and the frequency.
4.2	Reviewed	Oct 2013		Reviewed and updated to ensure a more robust and less repetitive policy was in place. Revised forms included in the appendices.
4.3	Reviewed	Feb 2014		Reviewed and updated to include feedback from consultation, eating disorder observations, revised intermittent observations and caringly vigilant and inquisitive staff.
5.0	Approved	Feb 2014	Trustwide Patient Safety Group	Authorised
5.1	Reviewed	August 2016		Reviewed and updated to include feedback from consultation and to reflect the intermittent observation changes in the NICE guidelines.

5.2	Reviewed	July 2017		Reviewed to include the Therapeutic Staffing model. The Policy was reviewed to issue guidance on practicewhen patients are observed and escorted off Trust Premises. Change of the General Observations recording format. Policy now includes staff competence assessment
6.0	Approved	July 2017	Trustwide Patient Safety Group	Authorised
6.1	DRAFT	November 2018	Trustwide Patient Safety and Mortality	DRAFT
7.0	Final	December 2018	Trustwide Patient Safety and Mortality	Ratified.
7.1	Final	March 2019	Interim Deputy Director of Nursing	Correction of wording in section 14.4
8.0	Final	March 2022	Deputy Director of Nursing	2.3 Within eyesight definition 15: Observations in Community Inpatient Rehab settings Appendix H Review and update of competencies Approved

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RELATED POLICIES/PROCEDURES/PROTOCOLS/FORMS/LEAFLETS

	REFERENCE
Search Policy	KMPT.CliG.138
Care Programme Approach (CPA)	KMPT.CliG.001
Chaperone Policy	KMPT.CliG.062
Intimate Care Policy	KMPT.CliG.015
Mental Capacity Act Policy and Guidelines	KMPT.CliG.052
Long Term Segregation and Seclusion Policy	KMPT.CliG.065
Training Policy	KMPT.HR.003
Falls Prevention and Management Policy	KMPT.CliG.166
Nutrition Policy for Inpatient Services	KMPT.CliG.040
Delivering Same Sex Accommodation Policy	KMPT.CliG.139
Community Recovery Care Group Inpatient Rehabilitation Service Operational Policy	KMPT.

SUMMARY OF CHANGES

Date	Author	Page	Changes (brief summary)
December 2018	Deputy Director of Nursing and Practice		Policy to include the reviewing of enhanced therapeutic observations by a range of clinical staff, rather than solely medical colleagues To include safety huddles as standard practice on in patient wards Included a section on enhanced observations for patients at risk of falls and for patients that have risks associated with nutrition and hydration.
March 2019	Interim Deputy Director of Nursing and Practice	Section 14.4	Correction of wording regarding reducing the level of observations.
March 2022	Deputy Director of Nursing and Practice	Section 15 Section 5.5-5.10 Competency checklist Section 2	Therapeutic Observations in Community Rehab Units Reduction of restrictive practices Updating the checklist to include guidance on gender sensitive care Updating definition of eyesight observation

CONTENTS

1 INTRODUCTION AND PURPOSE

1.1 All inpatients benefit from therapeutic observations and engagement and all patients are observed for their safety and wellbeing hourly. This is referred to as 'general observations'. Some patients at times during their inpatient stay require short term enhanced levels of therapeutic observations to maximise safety and wellbeing, and support their recovery. Enhanced therapeutic observations are initiated following a review of the patient's risk assessment. It is one intervention as part of a broad range of interventions in the patient's care plan. Enhanced therapeutic observations aim to support the patient's best interest; giving an opportunity for focused assessment and intervention (DoH, 1999).

1.2 This policy applies to both informal and detained patients. However in relation to informal patients, consideration needs to be given to their status and the lawfulness of any restriction/deprivation of liberty that enhanced observations may result in. In this case, it may be necessary to utilise provision of the Mental Health Act or Mental Capacity Act.

2 LEVELS OF OBSERVATIONS AND ENGAGEMENT

NICE (2015) defines four levels of observation:-

2.1 **General** - low level intermittent
General observations are completed hourly for every patient

2.2 **Intermittent** – high level intermittent
This level of observation is referred to as an enhanced observation and is completed 4 times each hour

2.3 **Continuous eyesight observations**
The patient should be within eyesight and accessible at all times, day and night unless an MDT decision has been made that the patient can have bathroom privacy. This must be documented within the patients' electronic record.

2.4 **Continuous arms-length observations**
Continuous observations (both eyesight and arms length) in most cases involve one member of staff with the patient. On rare occasions where the risks require so, two or three members of staff will work together to provide continuous observations. Patients at the highest levels of risk of harming themselves or others may need to be observed at this level. The patient should be supervised in close proximity at all times. No patient who is on arms' length observations will have bathroom privacy must be able to see the patient at all times.

3 METHOD FOR RECORDING - DISTRESS, OBSERVATION, NEED, ENVIRONMENT (DONE)

3.1 When performing intermittent and continuous level of observation staff are required to use the acronym '**DONE**' as a prompt and guide to positively engage with and assess each patient. Staff may vary the questioning according to the reason the patient is receiving enhanced observations (Please see appendices D, E, F&G for Observation Recording Forms). Recording Forms are uploaded to the electronic clinical documentation record and the level of enhanced observation is noted within the progress note, with a summary of how the patient has presented during the shift and any recommendations for enhanced observation review and/or future interventions.

'DONE' stands for:

Distress	Has anything caused the patient distress? What action was taken?
Observations	What did the patient spend time doing? What did the patient tell us?
Need	What did the patient need during this time of observation? What intervention was offered?
Environment	Were any new potential risks noted in the environment? What was done about this?

Adapted from Aneurin Bevan Health Board (2012)

4 GENERAL OBSERVATIONS

4.1 General Observation is the minimum acceptable level of observation and engagement for all inpatients who are present on the ward. The location of all patients must be known to staff. For patients that are present on the ward, general observations require an hourly check, as well as at the change of shift. This is an opportunity for staff to observe and talk to patients, checking their welfare and making any amendments to the care plan.

4.2 Staff who have completed an induction to the ward environment and have received handover can carry out this level of observation.

4.3 Patient's whereabouts will be recorded on the General observation record form (see Appendix D) and recorded on the progress note. The level of observation is noted within the progress note, and any recommendations for observation review and/or future interventions. Any member of the Multi-Disciplinary Team (MDT) may at any time, request a review of the patient's observation level. This requested review must be communicated immediately to the Nurse in Charge of the shift.

4.4 The General Observation Record Form is archived.

5 DECIDING WHEN TO START ENHANCED THERAPEUTIC OBSERVATIONS

5.1 All inpatients will be observed at least hourly during their hospital stay, whilst on the ward.

5.2 When there is a change in the patient's presentation or a concern in relation to the patient's presentation deteriorating, the clinical team will discuss and agree whether enhanced observations need to be commenced. This element of the care plan will be based on current risks as identified in the risk assessment.

5.3 Where possible, the patient and/or their carer will be involved in deciding this element of the care plan. The decision to start enhanced observations might be following an MDT review. Equally, the decision might be taken outside of the MDT and at any time of day or night; and will always be based on the patient's presenting needs at that time.

5.4 When making decisions as to the appropriate observation level for patients, practitioners should give due regard and consideration to the Code of Practice, particularly the five guiding principles:

5.4.1 **Least restrictive option and maximising independence:** Where it is possible to treat a patient safely and lawfully without detaining them under the Act, the patient should not be detained. Wherever possible a patient's independence should be maintained with a focus on recovery.

5.4.2 **Empowerment and participation**: Patients, their families and carers should be fully involved in decisions about care, support and treatment.

5.4.3 **Respect and dignity**: Patients, their families and carers should be treated with respect and dignity and listened to by professionals.

5.4.4 **Purpose and effectiveness**: Decisions about care and treatment must be appropriate to the patient, and must be performed to current national guidelines and/or current, available evidence-based practice.

5.4.5 **Efficiency and equity**: Providers, commissioners and other relevant organisations should work together to ensure that the quality of commissioning and provision of mental health care services is equivalent to physical health and social care services.

5.5 Whilst these principles relate to patients detained under the Mental Health Act (1983, amended 2007), they can equally be applied for informal patients.

6 DECIDING WHEN TO REDUCE OR STOP ENHANCED THERAPEUTIC OBSERVATIONS

6.1 The justification to continue with enhanced therapeutic observations should be discussed at every shift. This may include handover, ward review, safety huddles and other appropriate forums specific to the care group and care setting.

6.2 The decision to reduce or stop enhanced therapeutic observations must include a clinical case discussion between at least two registered nurses or doctors; one of which must be a Band 7 clinician or above. Clear documentation must be written within the patients RiO record to evidence this clinical discussion, including the names of all professionals involved.

7 CLINICAL LEADERSHIP RESPONSIBILITIES

7.1 Nurse in Charge, Shift Co-ordinators, Ward Managers, Ward Consultants, Matrons and Service Managers have a responsibility to monitor the practice associated with therapeutic observations, the appropriateness of their use, the quality of this as an intervention and be sensitive to the resources required.

7.2 They must also be aware of the training needs of their staff in regard to implementing this policy, and have robust systems in place to ensure competencies in delivering therapeutic observations are met by permanent and temporary staff. This includes the use of the Therapeutic Observation and Engagement of Patients Competence Checklist (See Appendix H).

7.3 Only staff deemed competent can conduct observations of patients.

8 NURSE IN CHARGE RESPONSIBILITIES

8.1 The nurse in charge of the shift is to ensure that therapeutic observations and engagement are implemented according to best practice for the duration of the shift.

8.2 The observational duties are allocated to staff members at the beginning of each shift and take account of patient need and complexity, and staff expertise and needs.

8.3 Staff are to be informed of the patient's observation level, the clinical risks identified and the interventions that are indicated during the period of time they have been allocated.

9 STAFF RESPONSIBILITIES WHEN ALLOCATED ENHANCED OBSERVATIONS

When allocated enhanced observations, the staff member is to

9.1 Be prepared to commence their observation with the patient in advance of taking over from the last clinician. This will include having resources for any appropriate interventions identified for this time.

9.2 Introduce themselves to the patient and the staff member that is currently with the patient and hear about how the last hour has gone.

9.3 Obtain the up to date enhanced observation sheet (see Appendix F and G) from the previous staff member.

9.4 Discuss with the patient how they would best like to spend their time and agree how patient will be supported to maintain dignity if needing to use the toilet or shower during the time of this enhanced observation (see Appendix C).

9.5 Support the patient to get the most therapeutic experience from the enhanced observation.

9.6 Support the patient with the transition to the next staff member allocated enhanced observation.

10 CLINICAL SITUATIONS IN WHICH THE USE OF ENHANCED THERAPEUTIC OBSERVATIONS MAY FORM PART OF THE PATIENT'S CARE PLAN

10.1 When a patient's disturbed behaviour poses risk to themselves or others

10.1.1 Observation and engagement is an intervention that is used both for the short-term management of disturbed/violent behaviour and to prevent self-harm (NICE 2005). Where possible, this involves a two-way relationship, established between the patient and the member of staff, which is meaningful, grounded in trust, and therapeutic for the patient (NMC 2008). Observation and engagement also provides an opportunity to collaborate with the patient in managing their risks, protect others and to explore the key interventions required to manage those risks. Commonly this may include patients who have a history of self-harm, vulnerability/being exploited or of violence. The aim of the intervention in these instances would be to minimise the imminent risk of harm occurring.

10.1.2 Clinical decision making in this regard has to balance imminent risk against longer term efficacy of this intervention.

10.2 When a patient is at risk of falls

10.2.1 It is important to consider the benefits of an increased level of therapeutic observation for patients that are at a high risk of falls, and use this time in positive engagement with the patient. This is an effective intervention in the management of falls for patients that remain at high risk of falls, despite other interventions being included in their care plan and implemented (See Falls Policy). Examples of activities that are beneficial for patients in reducing the risks of falls can include playing board games, playing cards, reading and discussing the news with the patient discussing items that interest them etc.

10.3 **When a patient is at risk of not maintaining food and or fluid intake**

10.3.1 Observation and engagement is an effective intervention in supporting patients to maintain required nutrition and fluids, either for physical or mental health reasons. It is important that diet and fluid is encouraged and recorded on the food and fluid balance chart for patients where this risk has been identified, totalling the amount after each shift. Older adults may have a weaker sense of thirst and, if necessary, should be helped and encouraged to drink regularly during observations.

10.3.2 It is also important to ensure that patients are not drinking excessive quantities of fluid and it may be necessary to increase therapeutic observation levels in these instances. The usual amount of fluid would be 6-8 glasses, but could be more dependent on physical activity or hot weather. It is possible, although very rare, to drink so much water the body cannot get rid of the excess quickly enough and sodium levels in the blood become dangerously low. This can have serious health consequences.

10.4 **When unable to offer a single sex environment**

10.4.1 Observation and engagement is required on rare occasions that patients need to be unavoidably admitted to a bed within a corridor of the opposite gender. (See Delivering Same Sex Accommodation Policy).

11 INTERMITTENT OBSERVATIONS

(See Appendix E. For students see appendix B)

11.1 Intermittent observation is usually used if a service user has clinical needs that require close regular monitoring, but does not represent an immediate risk. Intermittent Observation means that the patient's location and wellbeing must be checked **randomly four times within the hour** and intermittent observations specified in the care plan. The times should be spaced out throughout the hour and not completed in a short time frame. This level is appropriate when patients are potentially, but not immediately, at risk. Patients who are assessed as not presenting with immediate plans to harm themselves or others, or patients who have previously been at risk of harm to self or others, but who are in a process of recovery, require intermittent observation.

11.2 Any patient admitted to an inpatient unit who has been assessed and has been deemed to be at serious and imminent risk of harm to self or others must not be placed on intermittent observations.

11.3 Intermittent observation of patients is initiated when there are doubts as to the safety of the patient but no clear indicators of risk. This can be implemented by any member of the MDT and discussed with the MDT.

11.4 The staff carrying out intermittent observations must be able to observe the patient's whereabouts randomly 4 times over a one-hour period. Staff in some instances due to the risk may need to observe discreetly observing the patient's movements/actions, behaviour, mood etc. This will enable the nurse/staff to notice and report any signs of deterioration, and ensure that observation is not just routine and predictable. Where the patient is informal the observing staff must leave proper regard for the patient's rights and freedom.

11.5 The patient must be told why they are being intermittently observed, how long it will be maintained or reviewed, and what may happen, but staff do not need to discuss the

exact frequency to prevent predictive time scales. The patient information leaflet must be provided and translated, if necessary, into the patient's own language/Braille. For some patients, a written contract stating the roles and expectations of staff and patient might have therapeutic potential.

11.6 Checks must be sensitive causing the minimum intrusion but with an emphasis on positive engagement.

11.7 Intermittent observation will be implemented after an in-depth assessment by the nurse in charge and medical members of the MDT. Any recommendations must be recorded in the patient's notes.

11.8 In allocating a particular nurse or staff to complete intermittent observations, the nurse in charge must consider:

11.8.1 The reason for intermittent observation

11.8.2 The nurse/staff's skills, experience, competence and training (See appendix H. For Students, see appendix B.)

11.8.3 The relationship the staff has with the patient

11.8.4 The gender and sexual orientation of the patient - particularly when intimate acts of daily care are to be observed i.e. going to the toilet and showering

11.8.5 Any history of reported or suspected sexual or other abuse.

11.9 When observation begins the observing nurse/staff must explain the procedure and reasons to the patient.

11.10 Any period of intermittent observation must be clearly identified in the care plan and must report on any unusual occurrences noted by the nurse in charge and a record made in the patient's notes. The patient will be asked to confirm in writing on the care plan that they have read and understood it, if appropriate.

11.11 The nurse in charge is responsible for the delegation of intermittent observation to individual staff.

11.12 If the MDT take the view that a patient on intermittent observations should not leave the ward/unit they must immediately instigate an assessment to determine whether detention under MHA or MCA is warranted. Should the assessment show that detention is not warranted the patient may not be prevented from leaving.

11.13 Patients on intermittent observations should be encouraged to take part in a Therapeutic Programme. When a patient engages in therapy the therapist must be made aware of the patient's level of observations.

11.14 This observation is to be evidenced by the use of the form identified within Appendix F.

11.15 An MDT decision should be made concerning a patient leaving the ward or hospital grounds whilst on intermittent, within eye sight and within arm's reach levels of observation. If the MDT takes the view that informal patients on this level of observation should not leave the ward/unit but should remain (escorted) within the hospitals/ unit's grounds, they must immediately instigate an assessment to determine whether detention under MHA or MCA is warranted. Should the assessment show that detention is not warranted the patient may not be prevented from leaving.

12 CONTINUOUS OBSERVATION

Within eyesight and arms length

12.1 Within eyesight and within arms-length continuous observations are required when the patient's risks indicate the need for continuous care, by day and by night. Depending on the clinical reason for continuous observations, it may be necessary to search the patient and their belongings whilst having due regard for patients' legal rights (See Search Policy).

12.2 This level applies where the safety of the patient, other patients, carers /relatives, visitors or staff members are at significant risk and harm could occur at any time.

12.3 Continuous observations can be requested by any member of the MDT but the decision to carry out this level of observation must be taken by the Nurse in Charge in partnership with the MDT, communicated to the rest of the MDT as soon as practically possible, recorded on RiO.

12.4 It is the responsibility of the nurse in charge of the respective unit to delegate the continuous observation as a specific task to appropriately trained staff (see Appendix H. For students see appendix B).

12.5 The staff carrying out the continuous observations **must observe the patient according to the DONE methodology (see page 1)** and to act in a timely way if deterioration is observed

12.6 In allocating continuous observations, the nurse in charge must consider:

12.6.1 The reason for this level of observation.

12.6.2 The staff skills, experience, competence, knowledge and rapport with the patient and training (See appendix H. For students see appendix B).

12.6.3 The gender of the patient - particularly when intimate acts of daily living are to be observed i.e. going to the toilet and using the shower.

12.6.4 The wishes and needs of the patient according to their identified sexuality and gender.

12.6.5 Any history of reported or suspected sexual and/or abuse.

12.6.6 The nurse in charge must give clear and concise instructions to the observing nurse and must ensure that these instructions are clearly understood and are documented in the patient's care plan.

12.6.7 Patients on continuous observations will be encouraged and accompanied to participate in a therapeutic programme if appropriate. Continuous observations of the patient must be maintained by the observing staff whilst the patient is in the therapy programme. This will be done by the observing nurse remaining engaged with and in active support of the patient taking part in the therapeutic activity.

12.6.8 No staff shall be expected to be consecutively involved in this level of observation for a period exceeding 1 hour although in exceptional circumstances, 2 hours will be an acceptable limit.

12.6.9 When a patient is cared for using arms-length continuous observations, one or more than one staff member may need to be present.

12.6.10 The observing nurse must maintain continuous arm's length contact at all times, the patient must be escorted everywhere, including the toilet and bathroom (see appendix for best practice guidance, addressing privacy and dignity).

13 REVIEWING TO INCREASE THE LEVEL OF OBSERVATION

13.1 MDT reviews of the patient's level of observation must occur on a daily basis. With the patient's agreement, the involvement of family and carers is essential and as such they must be involved in the risk assessment and they must also be kept informed of the patient's progress within the levels of observation. Patients must be cared for in the least restrictive manner possible to maintain safety in line with deprivation of liberty guidance.

13.2 If a patient is on general or intermittent observations and a member of staff considers that the patient's presentation may require an increased level of observation, they must inform the nurse in charge immediately.

13.3 The nurse in charge will usually place the patient on the next level of observation whilst an MDT discussion takes place to reach a decision on the appropriate level of observation at the earliest opportunity.

13.4 The purpose of this discussion will be to:

- Confirm the current level of observation
- Increase the level of observation further or
- Return the patient to the original level of observation
- Consider whether the MHA or MCA status requires review

13.5 These decisions will be fully documented on RiO and therapeutic time given to the patient to discuss and agree the reviewed decision and recommendation with the patient and their family.

14 REVIEWING TO DECREASE THE LEVEL OF OBSERVATION

14.1 If a patient is receiving intermittent, arm's length or within eyesight observations and the patient no longer clinically requires this, the nurse in charge must arrange a MDT discussion to decide on the level of observation necessary. The decision to reduce level of observation must include at least a Band 7 level nurse; in collaboration with at least one other qualified member of the MDT (examples would be Registered Mental Health Nurses, Occupational Therapists, Psychologists, Ward Doctors and Psychiatrists.

The MDT discussion will involve:

- A review of the patient's current mental state
- A review of the patient's past and current risks
- A review of their presentation on the ward
- The patient's views on their observation level

14.2 The result of this meeting will be to:

- Confirm the current level of observation
- Reduce the level of observation further

14.3 The decision will be fully documented in the patient's RiO record and discussed with the patient and their family. The risk assessment and care plan will be updated.

14.4 If a Psychiatrist is not involved in the review, the clinical reviews may only reduce the level of observations by one level, e.g. from arms length to eye sight, eyesight to intermittent, intermittent to general observations. Any further reviews must include the ward's Consultant.

15 INPATIENT COMMUNITY REHABILITATION THERAPEUTIC OBSERVATIONS

15.1 The following guidance is specifically for Inpatient Community Rehabilitation as an addition to this policy. It describes the rationale and purpose of therapeutic observation and engagement within an Inpatient Community Rehabilitation setting. Psychiatric observations are a routine part of clinical practice, the purpose of which is to ensure the safety of service users during their admission within an inpatient rehabilitation unit, as well as promoting therapeutic engagement with service users.

15.2 Fostering self-management, autonomy and choice is central to the care offered within the service, however staff should still be mindful of and regularly review risk status and risk management plans. The primary objective within Rehabilitation Services is to promote self-care, optimise independence and to maximize the opportunities for service users to feel in more control of their lives. Therefore, care and safety plans should enable these objectives.

15.2 The rehabilitation units are open units and therefore service users accepted into the service will have needs that can be met within this setting. The decisions to adopt a lower level of observation than that described within the Trust's Observation Policy can only be made where a robust and individualized risk assessment has been made and can be evidenced. Positive risk taking is central to risk management for service users on an Inpatient Rehabilitation unit, nonetheless, the adoption of lower levels of observation must be the subject of an ongoing and dynamic process of continually assessing and monitoring risk, both in terms of risk to self and risk to others

15.3 A Risk Assessment is completed within 24 hours of admission to inpatient rehabilitation. The observation levels must be agreed at point of admission and i) documented and recorded on Rio and ii) reviewed at the MDT / service user review meeting or as and when required in association to a change in risk profile.

15.4 Implementation of the observation protocols within all KMPT Inpatient Rehabilitation units will be to provide assurance that a service user has been observed every 2 hours during the hours 0700 to 2200. The Staff Nurse in charge of the shift is responsible for ensuring that observations take place prior to each handover; morning, afternoon and night. Staff undertaking observations are expected to engage with the service user and note their presentation to determine their welfare.

15.6 Between 2200- and 0700-hours, service users will experience observations at a minimum of twice per shift and therefore a lower level of observation. It is the responsibility of the night Staff Nurse in charge to review the service user and decide if this is an appropriate level of observation. If there are any concerns regarding emerging risks, then the observation level MUST be increased and reviewed the following day by the MDT.

15.7 In the event of service users showing signs of relapse, becoming acutely unwell, risks increase or where there are other explanations, such as hearing bad news, the Rehabilitation observation protocol can cease. Subsequently the Trust Therapeutic Observation Policy will be implemented in the interest of service user and staff safety. Service users will be notified of the change in observation levels where practicable and appropriate. The MDT may need to assess whether the service user is safe and suitable to remain within the inpatient unit.

15.8 It is the Unit Manager's responsibility to ensure that all staff have completed the Therapeutic Competency Checklist. Agency and NHSP staff will be expected to complete the Competency Checklist as part of their Induction.

16 RECORD KEEPING AND REPORTING

16.1 The Nurse in Charge of the shift will prepare the observing nurse/staff as to what form of record or report will be required at the end of the period of observation. All decisions relating to observations categories must be recorded in the patient's notes together with the reason for such a decision.

16.2 The observation recording forms within the appendices of this policy must be used for general, intermittent, within eyesight and arm's length observations. Any other information regarding the patient's mental state, behaviour, risks etc. must be noted and recorded in the patient's progress notes with reference to the appropriate section of the care plan.

17 GENDER & ETHNICITY

17.1 Patients being observed within eyesight or arm's length will need to have a staff member with them when bathing, dressing, at night and when using the toilet. Staff will ensure that a female patient will have a female staff member and male patients will have a male staff member with them at these times. Individual patient's preferences will be considered, and should be discussed and agreed with the patient. Staff will also ensure that ethnicity and cultural issues are considered as part of the patients' care. Every effort must be made to ensure that privacy and dignity is maintained.

17.2 The Ward Manager is responsible for ensuring that all new staff are aware of patient's observation levels and the policy, which must be carried out as part of their Induction to the ward and have had their competence assessed.

17.3 A yearly clinical audit will be facilitated, registered with the Clinical Audit Department and led by the Deputy Director of Nursing and their team

17.4 The Ward Manager is to have a system in place on the ward to ensure that every member of staff has read the policy and is aware of their responsibility to follow it and address any concerns they may have. Competence must be assessed annually as a minimum and when the policy has been updated.

17.5 Temporary staff will be educated about the use of enhanced therapeutic observations and the practice associated with this. Temporary and permanent staff will be given an aide memoire as part of this training (See Appendix I)

18 TRAINING NEEDS ANALYSIS

18.1 Therapeutic Observation of Patients

Set out below is the training needs analysis for all staff groups identifying which members of staff require training and the level they require.

The aim of the training is to ensure all staff are aware of their duties/roles and responsibilities to enable them to implement the policy.

Staff group	Awareness of Policy	Awareness of own and team specific roles	Competency in clinical practice
Medical Staff	✓	✓	✓
Registered Nurses	✓	✓	✓

Registered Occupational Therapists	✓	✓	✓
Technical Instructors	✓	✓	✓
Non Registered Staff Health	✓	✓	✓
Non Registered Staff Social Services	✓	✓	✓
Psychologists	✓	✓	✓
Art/Drama Therapists	✓	✓	✓
Speech & Language Therapists/Physiotherapists	✓	✓	✓
Other Therapists	✓	✓	✓
Social Workers	✓		
Porters			
Domestics			
Catering/Kitchen Staff			
Admin (non clinical)			
Non Clinical Not Admin			
Managers	✓	✓	✓

19 OBSERVATIONS OF PATIENTS WHILST OFF TRUST PREMISES

19.1 When a need arises that require a patient to be escorted off the ward and Trust premises, the nurse in charge must allocate this task to a member of staff competent to undertake the task, one who is aware of the policy, capable of assessing ongoing risk, report and escalate the risk during the escort.

19.2 The nurse in charge must give a detailed handover to the escorting member of staff, of the destination, risk, patient's presentation and ensure that the staff is aware of how to seek support if required. The escorting staff must be given a ward phone when going off site and the patient must be observed at the same level as when on the ward.

19.3 The MDT will determine and agree whether a patient receiving enhanced observations can be escorted off Trust premises for clinical reasons. A risk assessment must be conducted and the number of escorting staff best to support and maintain patient safety must be determined beforehand.

19.4 The escorting staff on return to the ward must ensure that the time away from the ward is accounted for and documentation made on the observation sheet and on Rio detailing the patient's presentation, mental state, mood and interaction during the period they were escorted.

19.5 Where the patient is escorted to the Acute Trust or General Hospital for medical short appointments and/or treatment of 24hrs or less, the KMPT ward/service responsible for the patient will escort the patient and observe the patient on eyesight observation with the agreed number of escorting staff.

19.6 When a patient is taken to A&E for assessment/treatment, staff from KMPT will inform the Psychiatric Liaison Team and observe the patient during assessment and treatment in A&E until the Medics agree whether or not the patient is to be admitted for further assessment or treatment.

19.7 The KMPT ward/service must inform the Psychiatric Liaison Team that the patient is going to be transferred to the Acute Trust/General Hospital for the purposes of further assessment and or treatment. The Psychiatric Liaison Team will support with assessment and advice to the escorting staff if required.

19.8 For patients that are on enhanced observations and a section of the mental health act at the point of transfer, see the Mental Health Act Policy and Discharge and Transfer Policy.

19.9 Upon return to the KMPT service/ward the admitting nurse or therapeutic staff must conduct a risk assessment to determine appropriate level of observation, inform the MDT of the level of observation, update care plan and risk assessment.

20 EQUALITY IMPACT ASSESSMENT

20.1 The Equality Act 2010 places a statutory duty on public bodies to have due regard in the exercise of their functions. The duty also requires public bodies to consider how the decisions they make, and the services they deliver, affect people who share equality protected characteristics and those who do not. In KMPT the culture of Equality Impact Assessment will be pursued in order to provide assurance that the Trust has carefully considered any potential negative outcomes that can occur before implementation. The Trust will monitor the implementation of the various functions/policies and refresh them in a timely manner in order to incorporate any positive changes.

21 HUMAN RIGHTS

21.1 The Humans Rights Act 1998 sets out fundamental provisions with respect to the protection of individual human rights. These include maintaining dignity ensuring confidentiality and protecting individuals from abuse of various kinds. Employees and volunteers of the Trust must ensure that the Trust does not breach the human rights of any individual the trust comes into contact with.

APPENDIX A QUICK REFERENCE GUIDE TO OBSERVATION POLICY

	GENERAL – (intentional rounding)	INTERMITTENT	WITHIN EYESIGHT	WITHIN ARMS LENGTH
Definition	Be aware of the patient's mental state and whereabouts	Observed randomly 4 times within an hour as specified in the care Plan	Observed by being within eyesight at all times as specified in the care plan	Observed at all times at arm's length as specified within the care plan
Nursing requirements	Each staff member delegated responsibility for a defined group of patients per shift	Delegated staff member to carry out the intermittent observations	1 to 1	1 to 1 As a minimum
Frequency of rotating staff	30/60 minute observations are to be carried out with all patients by a designated healthcare professional	As agreed locally and as ward situation dictates	Preferably 1 hourly up to a maximum of 2 hourly in exceptional circumstances. This may be extended within the Forensic service line when escorting.	Preferably 1 hourly up to a maximum of 2 hourly in exceptional Circumstances. This may be extended within the Forensic service line when escorting.
Who can carry out observations*	All trained ward staff; other professional staff inducted to the ward environment and relatives/close friends with agreement of MDT.	All trained ward staff, other professional staff inducted to the ward environment and relatives/close friends with agreement of MDT	All trained ward staff	All trained ward staff .
Who can review observations	Ongoing	Band 7 or above nurse in collaboration with clinical colleagues	Band 7 or above nurse in collaboration with clinical colleagues	Band 7 or above nurse in collaboration with clinical colleagues
Freq. of review	Ongoing	Per shift or when risks change earlier than this	Per shift or when risks change earlier than this	Per shift or when risks change earlier than this
Mean recording observations	In normal patient notes for the shift	In normal patient notes for the shift. Also Patient Observation recording form	Hourly entries of relevant details in patient notes, as per DONE methodology.	Hourly entries of relevant details in patient notes, as per DONE
Leaving the ward	No restriction	Within the grounds of the facility or local area with agreement of the MDT but must be escorted	Not normally allowed off ward but agreed leave can be implemented within the grounds and must be escorted	Not allowed off the hospital environment except in exceptional circumstances with agreement of the MDT (e.g. X-ray at a general hospital, must be escorted)

*The nurse in charge to use their discretion as to who is suitable to carry out observations. See appendix B for students' involvement with observations.

APPENDIX B NURSING STUDENTS ROLE IN OBSERVATION

As part of the development and training of students nurses their involvement in the practice of observation of patients is important. Students must be encouraged to shadow staff who undertake observation but must not be in a position to take a lead responsibility unless they are deemed capable by their mentor / supervisor. The capability of the student can only be agreed once the student has fulfilled the criteria within their placement objectives, have a clear understanding of the policy and have reached a level of experience within the training.

The following guidelines are to help the nurse in charge of the ward make an informed decision on the suitability of a student nurse to undertake the level of observation of a patient. Only Mental Health students can undertake observations on their own. Other Nursing students do not have the training, experience or need to participate at this level.

1. **First year students** cannot undertake observations on their own. They can accompany (shadow) an experienced trained nurse to gain insight into the reasons for observations, how they are undertaken, what they are observing for and how to document in the care plan and notes and report observations.

2. **Second year students** following a full placement induction and assessment from their mentor in the following areas may then take part in general and intermittent observations on their own. They must:

    - Have a clear understanding of the different levels of Enhanced Observation and have shadowed staff in this practice.

    - Have read and have a clear understanding of the Policy on Patient Observation.

3. **Supported Practice Students** can be considered to undertake observations within eyesight if they have achieved points one and two above and are considered competent to do so by the nurse in charge and the student has achieved their placement objectives successfully which relate to their assessment documentation. The student must also feel comfortable to undertake this level of observations. If they do not feel comfortable they must discuss their concerns with the nurse in charge before undertaking Observations.

Students cannot undertake observations within arm's length at all.

This appendix will be reviewed periodically.

APPENDIX C SUPPORTING PATIENTS TO MAINTAIN THEIR DIGNITY WHEN USING THE TOILET OR SHOWER FACILITIES WHILST BEING CARED FOR ON ENHANCED OBSERVATIONS

Staff are advised to discuss with patients in care planning how privacy and dignity will be maintained during enhanced observation and give the patient choices to help avoid embarrassment. Consider that there might be another member of staff on duty that the patient may be more comfortable with and ask the patient. Don't take it personally if the patient would prefer someone else, but ask the patient for suggestions on how you can make them as comfortable as the other staff member does. Then try to put those into effect in future and should also be included in the care plan.

Remember that irrespective of the activity, if a patient is on within eyesight observations, or arms-length observations, this still needs to achieved.

Things that may help could be:

- Discuss with the patient in advance possible ways of making them relax.
- Playing music on the radio or phone with a speaker on, run a tap or encourage the use of headphones
- Use your peripheral vision, try avoiding staring head on.
- Demonstrate non- e m b a r r a s s m e n t , try putting the patient at ease, use the patient's toilet terminology/comfortable words.
- Distraction – talk about something completely different from what is going on (holidays, news, and weather, etc.) with complete nonchalance.
- Afterwards attention to hand hygiene; washing hands together utilising the opportunity for health education.
- Speak about toiletry products and the importance of good hygiene (including dental hygiene)

(Advice on toilet management extracted from the inpatient suicide preventions e-learning course available from the institute of psychiatry by Professor Len Bowers).

APPENDIX D GENERAL OBSERVATION RECORD FORM

NHS
Kent and Medway
NHS and Social Care Partnership Trust

Instructions for the use of the form

One form to be completed for all patients on General Observations per ward for a 24hr period.
Staff must complete name of the ward, name of patients and dates in full.
When the patient has been located and accounted for staff to input the relevant location code to the corresponding time slot.
Patients must be accounted for at each handover.

Date: **Ward:**

Room	Patient Name	MHA Status	07:00	H/over	08:00	09:00	10:00	11:00	12:00	13:00	14:00	H/over	15:00	16:00	17:00	18:00	19:00	20:00	H/over	21:00	22:00	23:00	00:00	01:00	02:00	03:00	04:00	05:00	06:00
1																													
2																													
3																													
4																													

Room	Patient Name	MHA status	07:00	H/over	08:00	09:00	10:00	11:00	12:00	13:00	14:00	H/over	15:00	16:00	17:00	18:00	19:00	20:00	H/over	21:00	22:00	23:00	00:00	01:00	02:00	03:00	04:00	05:00	06:00
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Room	Patient Name	MHA status	07:00	H/over	08:00	09:00	10:00	11:00	12:00	13:00	14:00	H/over	15:00	16:00	17:00	18:00	19:00	20:00	H/over	21:00	22:00	23:00	00:00	01:00	02:00	03:00	04:00	05:00	06:00
13																													
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19																													
20																													
Observing staff initials																													
Staff designation																													

Staff must follow the DONE Guiding Principles when conducting observations: KEY

DA: Dining Area; **C**: Corridor **QR**: Quiet Room **A**: Activity Room **T**: Transferred	**L**: Lounge **TR**: Treatment Room **BSB**: Bed Sleeping & Breathing **BA**: In Bedroom Awake **D**: Discharged **SR**: Side Room	**OL**: On Leave **WC**: Toilet, Shower, Bathroom **AWOL**: Absent Without Leave **ON**: Overnight Leave **AW**: Activity off the ward **O**: Other

APPENDIX E INTERMITTENT OBSERVATION RECORDING FORM

Within the intermittent time period **(randomly four times within the hour)**, staff should introduce themselves and are advised to use the acronym '**DONE**' as a prompt to positively engage with and assess each patient, which stands for:

- **D**istress – How is the patient feeling? How is their mental state? Are there changes to risk?
- **O**bservations – How responsive are they? Are they socially isolating themselves?
- **N**eed – Are they hungry or thirsty? Are they comfortable? If relevant - Do they need assistance with toileting or repositioning if impaired mobility? Do they need a little reassurance?
- **E**nvironment - Do they feel safe? Are there environmental risks? Do they want to leave the ward?

Instructions for the use of this form

- A separate recording form must be used for each patient subject to observation.
- Enter patients full name, NHS number and the date
- Allocated nurse to enter their name, abbreviated job title and signature at the end of the period of observation
- The time covered by the observing nurse must be entered in the time column.
- Report any changes to risk to the nurse in charge of the shift.
- Completed forms to be filed in the patient's clinical notes.

The reason for the observation level must be documented in the care plan and related directly to risk assessments undertaken.

Patients name:- **NHS Number:-**	**Level of observation:- Intermittent (randomly 4 times per hour)**
Named Nurse:-	**Date:-**
Reasons for enhanced observation:	
Care plan reflects need for intermittent obs (tick for yes) ☐	**Risk assessment reflects need for obs (tick for yes)** ☐

Maintaining the level of observation when the patient is in bed is crucial and the care plan must indicate how this will be achieved.

Exact time observed and location	**Name of Allocated Nurse & job title (i.e. RMN, HCA)**	**Signature**	**Feedback on patient engagement during your observational period** **e.g. use 'DONE' as guidance**

Exact time observed and location	Name of Allocated Nurse & job title (i.e. RMN, HCA)	Signature	**Feedback on patient engagement during your observational period** **e.g. use 'DONE' as guidance**

APPENDIX F WITHIN EYESIGHT OBSERVATION RECORDING FORM

Within the eyesight observation period, staff should introduce themselves and are advised to use the acronym '**DONE**' as a prompt to positively engage with and assess each patient, which stands for:

- **D**istress – How is the patient feeling? How is their mental state? Are there changes to risk?
- **O**bservations – How responsive are they? Are they socially isolating themselves?
- **N**eed – Are they hungry or thirsty? Are they comfortable? If relevant - Do they need assistance with toileting or repositioning if impaired mobility? Do they need a little reassurance?
- **E**nvironment - Do they feel safe? Are there environmental risks? Do they want to leave the ward?

Instructions for the use of this form

- A separate recording form must be used for each patient subject to observation.
- Enter patients full name, NHS number and the date
- Allocated nurse to enter their name, abbreviated job title and signature at the end of the period
- Completed forms to be filed in the patient's clinical notes.
- Report any changes to risk to the nurse in charge of the shift.

Patients name:- **NHS Number:-**			**Level of observation:- Within eyesight**
Named Nurse:-			**Date:-**
Reasons for enhanced observation:			
Care plan reflects need for within eyesight obs (tick for yes) ☐			**Risk assessment reflects need for obs (tick for yes)** ☐
Exact time observed and location	**Name of Allocated Nurse & job title (i.e. RMN, HCA)**	**Signature**	**Feedback on patient engagement** **e.g. use 'DONE' as guidance**

Exact time observed and location	Name of Allocated Nurse & job title (i.e. RMN, HCA)	Signature	**Feedback on patient engagement** **e.g. use 'DONE' as guidance**

Exact time observed and location	Name of Allocated Nurse & job title (i.e. RMN, HCA)	Signature	**Feedback on patient engagement** **e.g. use 'DONE' as guidance**

APPENDIX G WITHIN ARMS LENGTH OBSERVATION RECORD FORM

Within arm's length observation, staff should introduce themselves and are advised to use the acronym '**DONE**' as a prompt to positively engage with and assess each patient, which stands for:

- **D**istress – How is the patient feeling? How is their mental state? Are there changes to risk?
- **O**bservations – How responsive are they? Are they socially isolating themselves?
- **N**eed – Are they hungry or thirsty? Are they comfortable? If relevant - Do they need assistance with toileting or repositioning if impaired mobility? Do they need a little reassurance?
- **E**nvironment - Do they feel safe? Are there environmental risks? Do they want to leave the ward?

Instructions for the use of this form

- A separate recording form must be used for each patient subject to observation.
- Enter patients full name, NHS number and the date
- Allocated nurse to enter their name, abbreviated job title and signature at the end of the period.
- Completed forms to be filed in the patient's clinical notes.
- Report any changes to risk to the nurse in charge of the shift.

Patients name:- **NHS Number:-**			**Level of observation:- Within arm's length observation**
Named Nurse:-			**Date:-**
Reasons for enhanced observation:			
Care plan reflects need for within arm's length obs (tick for yes) ☐			**Risk assessment reflects need for obs (tick for yes)** ☐
Exact time observed and location	**Name of Allocated Nurse & job title (i.e. RMN, HCA)**	**Signature**	**Feedback on patient engagement** **e.g. use 'DONE' as guidance**

Exact time observed and location	Name of Allocated Nurse & job title (i.e. RMN, HCA)	Signature	**Feedback on patient engagement** **e.g. use 'DONE' as guidance**

Exact time observed and location	Name of Allocated Nurse & job title (i.e. RMN, HCA)	Signature	**Feedback on patient engagement** **e.g. use 'DONE' as guidance**

APPENDIX H THERAPEUTIC OBSERVATION AND ENGAGEMENT OF PATIENTS COMPETENCE CHECKLIST

Ward: ……

Staff Name: ……

Job Title: ……

Name of Assessor: ……..

Policy Question	Not Competent	Areas of Development	Competent
Who can initiate increased levels of observations? All members of the MDT, concerned with the safety of the patient or others. The level of observation must be discussed with the nurse in charge and a medical member.			
In addition to risk to others, what other antecedents may be present that would indicate a possible need for increase observations. - Physical health – nutrition/hydration - Risk of falls - History of previous suicide attempts, self-harm or attacks on others hallucinations. - Paranoid ideas where the service user believes that other people pose a threat thoughts or ideas that the service user has about harming themselves or others. - Past or current problems with drugs or alcohol - Recent loss, bereavement, job, significant financial loss. - Poor adherence to medication programmes or non-compliance with medication programmes marked changes in behaviour or medication known risk indicators. - Vulnerability from others, e.g exploitation, wondering, confusion, sexual disinhibition. - Incidents of being absent without leave – pending a review by the MDT. - Social events, social stresses, arguments family, friends and carers. - Delivering gender safe care: ensuring patient safety where risk may arise from gender identification			
What information should be given to patients on increased levels of observations? The service user must be provided with information about why they are supported or cared for using enhanced observation, the aims of observation and how, they will be reviewed and how the patient can contribute towards the care plan. The patient should be informed how dignity and privacy will be maintained e.g. when using toilet or other instances privacy is required.			

What information should be on the Observation Form? (Intermittent, Eyesight and Arms-Length) - Patient Name in full. - NHS Number - Named Nurse - Date - Level of observation - Reasons for observation: a brief summary why observations are in place, what risk to the patient from self or others and what need to do to minimise this identified risk. - Care plan and Risk Assessments reflect the need for observation.			
Where will you find information and instruction on how to administer the increased observations i.e. any specific instructions. - Care plans - Observation form - Risk Assessment - Rio Notes			
How often are increased observations reviewed? Daily: By the nurse in charge and a member of the medical team. Following an incident of significant event that may affect the patient's care or safety.			
What do you do if you are unable to locate a patient during any checks. Report immediately to the Nurse in Charge and continue to search until given additional instruction.			
What do you need to do or know before commencing your observation time? Complete a work based competency observation checklist: substantive staff complete yearly with ward manager/matron. Agency: Complete the work based competency checklist on ward induction once every 6 months with the nurse in charge, ward manager or matron. NHS Professionals: complete the work based competency check list at least once yearly, with the nurse in charge, ward manager or matron. • Understand the rationale for the observation level as indicated in the care plan. • Have Knowledge of the policy • Understand the risk indicators to observe for • Know what to do in an emergency or how to get cover if you are the opposite gender and the patient needs privacy to attend to intimate needs • Have access to a personal alarm. • Know not to leave until relieved.			
What do you need to do before ending allocated observation time? Ensure another member of staff has taken over			

Advise the patient of the handover Ensure that you have documented the vents of the time you were observing the patient Ensure a handover to the incoming staff of key events or ongoing plans Unusual occurrences must be handover to the nurse in charge and a record made in the case notes.			
How often is a patient on intermittent observations expected to be seen Randomly four times within the hour.			
What is continuous observation? Within Eyesight: The staff must have the patient within their sight and be close enough to intervene if required as well as engage with that patient Within Arm's length: not more than arm's length away from the patient			
How to observe a patient whilst they are in the toilet, bathroom or need privacy for intimate needs such as personal care In such instances the patient should be observed a staff of the same gender If of opposite sex the patient should be informed that when they need to use the toilet or need privacy or intimate personal care needs they should request a staff of the same gender or alert the staff If no notice is given by the patient, staff must alert the nurse in charge to get a nurse the of the same gender, staff must not leave the patient but use their alarm to call for support. The door must not be closed and left ajar Staff should maintain verbal contact with the patient. Staff should observe that patients do not take things they will not need when they are in the toilet or may use to self-harm.			
What may need to be considered when the patient on continuous observation is in bed? When patients are in bed, it may be necessary to ask them to keep their head and neck uncovered. This should be assessed on an individual basis. It will be necessary to ensure that the patients" bedroom door is open sufficiently to allow observation. The observing staff member will be required to reduce the disturbance this may cause in terms of noise and attempt to reduce it as much as possible Issues of privacy and dignity will also be considered.			
D.O.N.E, is a framework of assessment that staff can use to observe patients, it must be used in a patient centred manner and flexibly to allow staff to assess the patient and their environment, staff can vary the questions as they observe the patient at different times.			

Distress – How is the patient feeling? How is their mental state? Are there changes to risk? **Observations** – How responsive are they? Are they socially isolating themselves? **Need** – Are they hungry or thirsty? Are they comfortable? If relevant - Do they need assistance with toileting or repositioning if impaired mobility? Do they need a little reassurance? **Environmen**t - Do they feel safe? Are there environmental risks? Do they want to leave?			
What are the expectations in terms of engagement with the patient on within eyesight or arms length The observation record should include evidence that staff have attempted to engage positively with the patient by enquiring after their wellbeing, offering and/or engaging in activities, conversation etc. A registered Nurse is expected to have spent at least one hour with the patent on close observation per shift.			
What is Caring Vigilantly? This requires staff to be observant, and inquire changes in patient behaviour and mood. Staff will inquire if patients spend more time in, toilet, bath or isolated, patients missing their meals, or activity. Staff will care vigilantly for all patients on the various levels of observations.			
What do you need to check when a patient is sleeping? Respirations (clear raising of chest/abdomen) Breathing sounds			
When is it appropriate to observe a patient through a window? Observation through glass is only acceptable when checking a patient's general whereabouts and the patient can be seen fully and is moving around. • Seclusion • When it's unsafe to enter the room.			
Legal Considerations Staff to be aware how patients detained under MHA (1983), MCA or Informal patients' rights are observed and ensure that restrictive practice is minimised.			
Where will you find a copy of the Policy? On the Trust Intranet.			
What is the length of time that a member of staff can undertake observations?			

No staff shall be expected to be consecutively involved in this level of observation for a period exceeding 1 hour although this can be for a maximum of 2 hours in exceptional circumstances.			

COMMENTS

WARD MANAGER/ MATRON/ASSESSOR: ……..

SIGNATURE: ……

STAFF NAME …….

SIGNATURE ……

DATE OF COMPLETION……..