Somerset Partnership NHS
NHS Foundation Trust

OBSERVATION WHILE MAINTAINING SAFETY AND PATIENT ENGAGEMENT

To be read in conjunction with the Search of Patients, Visitors and Property Policy, Clinical Assessment and Management of Risk of Harm to Self and Others Policy, Integrated Care Planning Approach policy, Physiological Observation of Inpatient and MIU Policy, Proactive Care Policy, and Patient Property and Risk Items Policy

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DOCUMENT CONTROL

Reference	**Version**	**Status**	**Author**
DR/Nov12/S&TOP	6	Final	Head of Division for Adult Mental Health Inpatient, Crisis and Community services

Amendments Policy has been amended following recommendations from the clinical audit of the policy. Updated guidance in respect of observations during night shifts and when patients are asleep. Improved guidance for clinical staff to ensure that Level 2 observations are carried out at irregular intervals and identified risks associated with gaps between observations. Feb 2017 – Addition of paragraph to stress that all observations of patients must be visual.

Document objectives: The primary purpose of carrying out observations within in-patient mental health wards is to ensure the safety and wellbeing of patients. Well-conducted observation involves the sensitive monitoring of the patient's physical condition, behaviour and mental state and enables a rapid response to any change. At the same time observation can help the patient and staff member to engage in a positive and trusting way to prevent potentially suicidal, violent or vulnerable patients from harming themselves, others, or being harmed. Observation has an important function in monitoring the physical and mental wellbeing of patients. It is a skilled intervention and when carried out well can be used as an opportunity for the worker to interact in a supportive, therapeutic way with the patient.

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Contact for review	Head of Division for Adult Mental Health Inpatient, Crisis and Community services	
Lead Director	Director of Nursing and Patient Safety	

CONTRIBUTION LIST Key individuals involved in developing the document

Designation or Group
Head of Division Adult Mental Health Inpatient, Crisis and Community
Trust Board
Executive Management Team
Senior Management Team
Claims and Litigation Manager
Equality and Diversity Lead
Acting Head of Mental Health Nursing Head of Patient Safety
Mental Health Act Coordination Lead
Mental Health Ward Managers

CONTENTS

1. INTRODUCTION

1.1 Observation is a mental health nursing intervention which is used to manage risk. It is used to mitigate the risk of self-harm, suicide, aggressive, violent or impulsive behaviour and close monitoring of patients who are diagnosed with a mental disorder which may impact on their physiological welfare such as anorexia nervosa. There have been few reliable studies indicating whether or not observations alone do in fact mitigate these risks. Suicide, for example, is an event that unfortunately happens within mental health settings. Observation can be used as an opportunity for therapeutic engagement with patients and as part of an overall plan of care.

1.2 This policy informs the development of local strategies and procedures for the management of patients who require observation either because of a combination of an assessed mental health problem, or a potential mental health problem awaiting assessment and it being in the interests of the safety of the patient to minimise risk.

1.3 At all times when conducting observations, the Trust fully recognises its responsibilities in respecting the different cultural and diversity needs of its patients and will take these into account when conducting observations upon them. Evidence suggests members of staff may be concerned they are invading the patient's privacy. Equally there is further evidence that observations, along with locked doors, can increase the incidence of aggression and confrontation by patients. Staff concerns and patient behaviour should be managed through effective ward management and supervision for staff and explanation and discussion around planned interventions with patients.

2. PURPOSE & SCOPE

2.1 The primary purpose of carrying out observations within in-patient mental health wards is to ensure the safety and wellbeing of the patients. Well conducted observation involves the sensitive monitoring of the patient’s physical condition, behaviour and mental state and enables a rapid response to any change. At the same time observation can help the patient and staff member to engage in a positive and trusting way to prevent potentially suicidal, violent or vulnerable patients from harming themselves, others, or being harmed. Observation has an important function in monitoring the physical and mental wellbeing of patients. It is a skilled intervention and when carried out well is used as an opportunity for the worker to interact in a supportive, therapeutic way with the patient.

2.2 Although engagement and observation is an activity which may be assigned to any member of staff it remains the responsibility of the nurse in charge of the shift, or, in the case of day hospitals, the person in charge at the time, to ensure the observation level is appropriate to the risk posed.

2.3 Observation is a continuous process and this must be clearly recorded within the patient’s Rio record. The appropriate Observation Forms (appendix B to F) must be used at all times and subsequently uploaded into the Rio record. The decision making process which determines the

observation level set for the patient must be recorded in their Rio progress notes, with the level of observation and any subsequent changes being recorded in the patient's care plan. The nurse in charge needs to have regard for the staffing implications of planned or special observation in terms of the treatment and care of other patients on the ward.

2.4 This policy applies to all staff who are responsible and accountable for the observation and safety of patients on the inpatient mental health wards, whilst in the care of the Somerset Partnership NHS Foundation Trust.

3. DUTIES AND RESPONSIBLITIES

3.1 The **Trust Board** has overall responsibility for procedural documents and delegates responsibility as appropriate.

3.2 The **Executive Lead** is the Director of Nursing and Patient Safety. The Director of Nursing and Patient Safety remains strategically responsible for the development of the policy and monitoring overall levels of compliance to it.

3.3 This policy will be regularly reviewed and maintained by the Improving Quality of Inpatient Services Group. Review of the policy will occur at least once every three years or sooner if required due to local or national guidance**.**

3.4 **Heads of Division/Service** have responsibility for ensuring the implementation of this policy

3.5 **The Ward/Team Managers** have responsibility for ensuring that this policy is embedded into clinical practice and is undertaken with due regard to this policy. The Ward/Team Manager will monitor that staff attend training (complete competencies) to carry out observations and adhere to this policy

3.6 The **Learning and Development Manager** is responsible for updating the Risk Management Mandatory Training Matrix (Training Needs Analysis) on an annual basis and for keeping up to date records of training activity and updating ESR.

3.7 **Specific Observation Duties and Responsibilities** are described within this document.

4. EXPLANATIONS OF TERMS USED

- **SIRIG** – Serious Incidents Requiring Investigation Group.
- **NPSA** – National Patient Safety Agency
- **RiO** – electronic system used by the Trust for recording patients' records
- **DATIX** – electronic database used by the Trust to report Untoward Event Reports, PALS/Complaints, and Local/Corporate Risks.
- **ESR** – Electronic Staff Record used Trust wide
- **MDT** – Multi-disciplinary Team
- **Nurse in charge** – Registered Nurse in charge of the shift**.**

- **What's on @ sompar** – Somerset Partnership newsletter issued to all Trust staff monthly by email
- **MAPPA** – Multi-Agency Public Protection Arrangements

5. GENERAL CONSIDERATIONS

Engagement

5.1 It is essential members of staff use the opportunity presented by observing patients to attempt to engage with them therapeutically. This might range from simply asking a patient how they are while conducting general observations, to having a structured one to one session, or engaging the patient in therapeutic activity during more intense periods of observation (e.g., Level 3 or 4 Observation). Obviously this will depend on the skills of the member of staff carrying out the observation and the mental state and wishes of the patient. For patients who are at risk of physical deterioration in areas such as falls and pressure damage, the regular observations will include the monitoring and recording of these high risk areas. The observation must be regarded as more than merely seeing where the patient is. Consideration must be given to the attitude of the observer in carrying out their role; and for the patient, their mental state, level of engagement with staff and the ward community, level of engagement in groups, physical condition, risk behaviours, etc. This information forms an important part of the patient's treatment and must be considered in handovers and ward reviews and documented on RiO accordingly.

Privacy

5.2 Observing patients 24 hours a day may at times be intrusive and must, as far as possible, be balanced with the maintenance of the patient's privacy and dignity. The patient must, where possible, be involved in the decision making about the level of observation they are subject to and must be informed of the reasons why the observation is occurring. It is important staff feel confident in providing patients with the reasons why it is necessary to carry out observations. It is also essential observations are conducted in a sensitive way which is the least restrictive possible.

5.3 When a patient is subject to observation, irrespective of the level, all observations of patients must be visual; it is not appropriate to rely on hearing a patient talking or moving.

5.4 Observing patients at night can pose particular difficulties, especially while the patients are asleep. It is important to note that it is the responsibility of the person carrying out the observations to ensure that the patient's safety and welfare are monitored. Observation levels at night can be reviewed in line with this policy following a risk assessment that takes into account the patient's privacy and dignity and must be proportionate to the level of risk.

5.5 When a patient appears asleep the member of staff carrying out the period of observation must monitor the patient's physical health, noting changes in body position, breathing etc. Staff must not assume that the patient is sleeping and/or that they should not be woken.

5.6 If the member of staff has not observed the patient move or cannot observe the patient breathing, they must ensure the patient is conscious by:
- Increasing lighting
- Getting close enough to observe breathing
- Checking for a pulse
- Rousing the patient

Anti-discriminatory practice

5.7 Somerset Partnership recognises this policy has the potential to have greater impact on some community groups. For example, staff may misinterpret the verbal and non-verbal communication of a patient from a different culture which may lead to an incorrect assumption about the risk of violence and the patient being unnecessarily placed on enhanced levels of observation.

5.8 When deciding on appropriate levels of observation and on allocating observation duties staff must have regard to issues of faith and spirituality, human rights, gender, disability, sensory loss, ethnicity, sexual orientation, age and culture. The overriding decision in any situation must be safety.

5.9 For further guidance on anti-discriminatory practice please refer to the Trust's Equality and Diversity Policy; details of which are available on the Trust Intranet. Mandatory Training on equality, diversity is also available via the Learning and Development Department. For specific advice the Trust Equality and Diversity Lead may be contacted at Mallard Court, Bridgwater. This policy has been equality impact assessed.

Capacity

5.10 When the patient has capacity to consent to observation, and they are not detained under The Mental Health Act, their consent must be sought about agreeing to engage with the observation. Observation in these circumstances is a form of treatment for mental disorder. Consideration must be given to the use of the Mental Health Act in order to impose observation on a patient with capacity who is refusing it. If a capacity assessment shows that the patient lacks the capacity to consent to observation, then a decision about whether or not to implement observation must be made in the patient's best interests. This decision must be made by the person or team wishing to implement the observation, and that person or team cannot rely on the consent of a family member or carer. Only a Court appointed deputy, or someone with an appropriate Lasting Power of Attorney, can consent to treatment on behalf of an incapacitated person. If implementing the observation places restrictions on the patient which amount to a deprivation of liberty, then consideration must be given urgently to the use of the Mental Health Act in order to sanction this.

6. LEVELS OF OBSERVATION

6.1 There are four levels of observation used within Somerset Partnership NHS

Foundation Trust (see Patient Observation Flowchart Appendix H):

Level One: General Observation

6.2 Level One (General) observation is the minimum level of observation for all inpatients. At this level staff must check on the physical wellbeing and whereabouts of all patients on the ward once an hour as a minimum. The only exception to this is Holford Ward where patients, due to their needs, are checked as a minimum at Level Two: Intermittent Observation (see below). Level One Observations must be clearly recorded in Rio and the level recorded within their care plan. Ward staff must record the whereabouts of the patient using the **General Observation Form Level One (Appendix B)/General Observations (including physical rounding) Form (Appendix C)** and check their wellbeing. This needs to be conducted at night as well as during the day in as minimally an intrusive way as possible.

6.3 At the commencement of every shift, a member of ward staff from the outgoing and incoming shift must, together, physically check the location and wellbeing of all patients on the ward. The nurse from the out-going shift must verbally handover any pertinent information in addition to signing the form to show that this has been carried out.

Level Two: Intermittent Observation

6.4 Patients on Level Two observations must be observed no less frequently than every fifteen minutes and must be seen and assessed at irregular intervals in a pattern that cannot be predicted by the patient.

6.5 For patients being observed at these intervals **Level Two (Intermittent) Observation Record Shift form must be completed (see Appendix D; am, pm and night shift)** and details recorded (after each observation) about the patient's location, mental state and any risk behaviours noted. Patients on intermittent observation must be monitored at night/when asleep and again, this must be done in the least intrusive way possible.

6.6 A nursing review of the patient's level of observation must be conducted at every handover and a multi-disciplinary review must be conducted every 24 hours. These reviews must be fully recorded in the patient's Rio record including the rationale for the decision making. The multi-disciplinary review must involve the patient as far as possible and the ward doctor, consultant (or Responsible Clinician for detained patients). **Appendix E provides an observation review sheet** which may be used to support this process. If patients remain on Level Two observation for longer than three days, a formal multi-disciplinary review of their care and observation level **must** be held. This review must involve medical staff and any decision made regarding the observation level along with the rationale for this decision must be recorded in RiO along with the names of the people involved in the discussion.

6.7 For Level Two observations the nursing team can, after discussion with the senior nurse in charge of the ward, reduce the observation to level one without consulting with the medical team although it would be good practice

to involve the multidisciplinary team as far as is possible. In reaching this decision staff must consider the current risks posed, as well as giving consideration to the reasons why the observation level was originally implemented. The rationale for the decision must be clearly documented in RiO along with the names of the people involved in the discussion.

6.8 At Levels One and Two, attempts must be made to work with patients so that, as far as possible, observation is a collaborative endeavour with patients working alongside staff as far as they are able to engage with observation.

6.9 Clinical Teams practising intermittent observation must be aware of the risk that gaps in observation present to patients at high risk and ensure that they have considered this issue as part of their decision making process.

Level Three: Within eyesight

6.10 This level of observation requires the staff member carrying out the observation to be within sight of the patient at all times and to be constantly aware of their location and wellbeing. The allocated observer must complete **Level Three/Four Observation Record (see Appendix D)** documenting the patient's wellbeing, mental state, the content of any discussion and any noted risk behaviours at the end of each hour as well as making a record on RiO at the end of each shift.

6.11 Consideration must be given by the observer to allow as much privacy as safety permits when the patient is carrying out personal hygiene tasks or is in the bathroom. During these periods the observing staff member must keep up contact to satisfy themselves the patient is safe and well. Consideration must be given when allocating staff for observation regarding the gender of the patient to ensure the privacy and dignity of the patient is respected. However, on occasions, it may be difficult to achieve this, as it is dependent on the gender of the members of the shift.

6.12 A formal review of the patient's level of observation must be conducted every 24 hours and be recorded on RiO along with the names of the people involved in the discussion. This review must involve the most appropriate nurse and the ward doctor or consultant, and for detained patients the Responsible Clinician. The level of observation cannot be decreased without discussion with the multi-disciplinary team as above. However, out of hours, the decision may be made by the most appropriate nurse in discussion with the doctor and consultant on call (and the duty ward manager, if available) by telephone.

Level Four: Within arms-reach

6.13 Level Four observations require the observer(s) to be within arms-reach of the patient at all times and in all circumstances. The allocated observer must complete the **Level Three/Four Observation Record; am, pm and night shift (Appendix F)** documenting the patient's wellbeing, mental state. This must be uploaded to Rio when completed. The content of any discussion and any noted risk behaviours at the end of each hour as well as

making a record on RiO at the end of each shift.

6.14 While the Trust recognises that this is intrusive to the privacy of patients, this is an intervention for patients who are at very high, immediate risk and in such circumstances the patient's safety or the safety of others takes priority over the right to privacy.

6.15 For Level Four observations the observer should be of the same sex as the patient being observed unless there are exceptional circumstances. However the observer MUST be the same sex as the patient being observed during intimate personal activities e.g. washing and dressing.

6.16 A formal review of the patient's level of observation must be conducted every 24 hours and be recorded on RiO. This review must involve the most appropriate nurse and ideally the ward doctor or consultant, and for detained patients the Responsible Clinician.

6.17 The level of observation cannot be decreased without the involvement of the medical team, which must include the ward doctor and the consultant. For detained patients, this must include the Responsible Clinician as part of the multidisciplinary team. It may also include Occupational Therapy and Psychology services. However, out of hours, the decision may be made by the nurse in charge of the ward in discussion with the doctor and consultant on call (and the duty ward manager, if available) by telephone.

Admission

6.18 On admission, including transfers from other wards, patients will be allocated to a minimum level 2 observations for the first 24 hours. If the decision is taken to not apply this level, full reasons must be recorded on RiO and updated within the care plan.

7. ALLOCATION AND HANDING OVER OF OBSERVATION DUTIES

7.1 Observation is a core part of the role of the ward team and must be conducted safely and consistently. The **Nurse in Charge** is responsible for allocating appropriately trained staff to carry out observations throughout the shift and ensuring that they are aware of their allocated duties. Staff must be aware of and take into account that for some individuals (e.g. people with a history of sexual abuse) and for particular faiths or religions there needs to be sensitivity regarding the gender of the allocated member of staff when observation is being organised; this is particularly important when allocating observation duties for enhanced levels of observation.

7.2 At the **end of each allocated period of observation duty the member of staff carrying out the observations** must physically give the observation forms and verbally handover any pertinent information to the member of staff who is taking over. The **member of staff who is continuing observations** must sign the form (for observation Levels Two, Three and Four) to indicate they have received this handover, the patient is safe and well and they are continuing the observations. It is important to note the person carrying out the observation must not stop doing so until this handover has taken place.

7.3 Carers and relatives must not be involved in the activity of observation, even though the carers and relatives may be keen to undertake this responsibility. They are also prohibited from escorting patients from the premises and guaranteeing their return. These activities must only be undertaken by appropriately trained Trust staff and are non-delegable responsibilities.

8. REVIEWING OBSERVATION LEVELS

8.1 The level of observation must be reviewed on an ongoing basis dependent on the patient's individual needs and their care plan. A care plan must be in place for all patients regardless of their current level of observation.

8.2 For patients who also have a diagnosis of Learning Disability, the level of observation will also relate to their specific LD needs. Clinical staff from the LD service will give additional guidance as to the appropriate level of observation in these cases.

8.3 In situations where prompt action, is required the nurse in charge can change levels of observation upwards (i.e. Level One to Two, Two to Three or Three to Four) independently, ideally in discussion with another registered nurse or other professional involved in the patient's care. This change must be documented on RiO and in the patient's care plan, together with the rationale for change. The decision must be discussed with medical staff at the earliest opportunity and this must also be documented. The decision to change observation levels must not be taken independently by an observing nurse.

9. DETERMINING THE APPROPRIATE LEVEL OF OBSERVATION

9.1 Ultimately the clinical team involved with the patient's care must decide on the appropriate level of observation required. The level of observation must be determined following a comprehensive assessment of risk. For guidance on how to assess and manage risk please see the *Clinical Assessment and Management of Risk of Harm to Self and Others Policy* which is accessible to all staff within the 'Policy and Procedures' section of the Trust Intranet.

9.2 The level of observation must be the least intrusive possible and determined by the level of risk identified. No absolute guidance can be given but in general the level of observation should increase with the level of risk presented. Particular attention must be paid to the likelihood of an identified risk event occurring, the severity of the risk if it should occur and how imminent the risk might be.

9.3 In the assessment of risk the following areas must be considered:

- degree of engagement;
- risk factors: mental state examination, substance use, environment, etc;
- history;
- ideation/mental state;
- intent;
- planning;

- actual history of risk incidents with dates, causes, protective factors and consequences;
- patient's awareness of risk;
- benefit and harm of risk;
- protective factors;
- formulation.

9.4 Where the assessment covers more than mental health, e.g. learning disability, other risks will need to be assessed. Examples of other risks may include risks due to physical health, or environmental and social risk.

9.5 Risk to the patient from their physical health must be considered in relation to the level of observation (see the Physical Assessment and Examination of Service Users Policy). For example a person with a high level of risk due to sleep apnoea may be placed on a higher level of observation due to the risk this presents at night. Risk assessment is not an exact science but, where significant potential risks are identified, consideration must be given to increasing the level of observation. When making decisions regarding the level of observation staff must also be aware of and consider cultural differences that could impact on decisions.

9.6 The Trust believes patients must be involved as far as is possible in the planning and delivery of all aspects of their care. When making decisions about the level of risk, and hence the possible level of observation needed, ideally the patient must be involved in the decision making process. Efforts must be made to obtain the patient's consent and understanding about the appropriate level of observation, this should be done routinely when observations are instigated and when observations are reviewed. Where this is not possible, as a minimum the patient must be informed of the level of observation that has been deemed necessary, what this means; i.e. how often they will be observed, what they can expect from the person carrying out observation, the rationale behind the decision and how it will be reviewed. These discussions and explanations must be documented within the care plan, risk screen and progress notes within RiO, the Electronic Patient Record.

9.7 Where patients have English as a second language or have sensory disabilities it is important to ensure professional interpreting services are accessed, including British Sign Language interpreters (please refer to the Interpreting and Translation Policy). Appropriate steps must be taken to ensure people with learning disabilities can read/understand information given to them about observation.

9.8 Any discussion with the patient about the level of observation must be recorded on RiO; similarly staff must document where efforts have been made to engage the patient in such discussions but they have declined to be involved. **Information Sheet – Observation (Appendix A)** provides an information sheet which should be given to patients to help them understand what they can expect from staff carrying out observations. However staff must not use this information sheet as a substitute for discussing observations with the patient.

9.9 Decisions about the appropriate level of observation must be made in discussion with the multi-disciplinary team; where there are disagreements the Responsible Clinician (where the patient is detained under the Mental Health Act 1983) or the senior treating clinician (usually the consultant doctor) retains the final authority for making the decision. All decisions relating to the level of observation of a patient must be documented in RiO. In areas that use seclusion rooms please refer to the Trust's Proactive Care Policy for guidance on reviewing observation levels. Observations/monitoring of a patient following Rapid Tranquillization must be completed as described within the Rapid Tranquilisation Policy/Proactive Care Policy.

9.10 Whilst observation can be carried out by all grades of staff, the nurse in charge of the shift or, in the case of day hospitals, the person in charge, remains accountable for delegation of observation. Relevant information must be communicated to the nurse in charge of the shift and written in the patient record.

9.11 Consideration must be given to times during the ward day when fewer staff are available, such as staff handovers, multi-disciplinary and staff meetings, evenings when fewer activities are available, night shifts where staffing maybe lower than at other times. Mitigating actions should be put in place at these times, including enhancing levels of therapeutic activities and the enhancing of staffing at times of pressure.

9.12 Particular consideration must be given to approaching transitions in the patient's care. It is well recognised that these can be times of stress and vulnerability in a patient's recovery and particular attention must be paid to increased engagement. Examples might be a change in key worker, disruption in the patient's personal or home circumstances, moving towards transfer to another ward or setting or discharge etc.

9.13 Where a patient is being observed at Level Two or above, or has recently been subject to observations, particular care must be taken before considering leave, transfer to and from other facilities and other times when they may leave the premises where the risk of absconding may be greater. Escorting staff are unlikely to be able to prevent absconding or self-harm unless plans are carefully thought through and put in place. When granting leave the ward team must be satisfied the patient is ready to abide by any relevant conditions. Where an informal patient wishes to leave the ward, no formal "granting of leave" process takes place, but clinical staff must assess whether the patient is fit to leave the ward and clearly document the rationale behind their decision making for "granting leave". If not, attempts must be made to dissuade the patient until their mental state and risk assessment supports this clinical judgement. Where the clinical staff consider the patient should not leave (and they are informal) clinical staff must consider assessment under the mental health act and/or the use of doctors' or nurses' holding powers under the Mental Health Act 1983.

9.14 Where a patient has been involved in offending behaviour in the past and they have an identified victim, then particular care must be given to considering the likelihood of absconding. It must be considered, in advance,

how the potential victim might be involved or informed should the patient abscond. Particular attention must be paid to the MAPPA process.

9.15 Where a patient is at risk of absconding then consideration must be given, in advance and within the care plan as to how the patient's relatives, carers and those with close relationships should be informed and involved should this eventuality arise. In making this decision matters such as confidentiality, consent and risk must be considered.

9.16 Where a patient is being observed due to concerns about their physiological condition which is as a direct result of a mental disorder e.g. Anorexia nervosa, staff must be aware of the risk of physiological deterioration and take action in line with the Physiological Observation for Inpatients and MIU Policy and ensure that vital signs are measured where possible and that these are recorded on a NEWS chart. If it is not possible to measure a full set of vital signs, non-contact physical observations must be undertaken, and any concerns escalated appropriately.

10. WHO SHOULD CARRY OUT OBSERVATIONS? ROLES AND RESPONSIBILITIES

10.1 While there is no reason any of the mental health professionals involved in a patient's treatment cannot carry out observation of patients at risk, this duty will normally come under the remit of the nursing team. However, while a patient under observation is engaging in a group activity or therapy the therapist may take on this responsibility provided they have sufficient knowledge of the risks identified, the level of observation required, and of what to do in the event of an emergency.

10.2 The person responsible for carrying out safe and supportive observations will be a **first level Registered Nurse or a health care assistant or student nurse** who is deemed to be competent by the nurse in charge of the shift (**see Observation Competency Checklist Appendix I)**, which must be used in the delegation of observation to unregistered staff, or staff who are unfamiliar with Trust policies). Under no circumstances should student nurses be allocated observation at Levels Three and Four. Where the nurse in charge decides that the use of temporary staff to conduct observations is appropriate they must ensure that the bank or agency staff member is familiar with the client group and the ward and also use the staff competency check list for additional assurance. This should be recorded on the **Observation Competency Checklist (Appendix I).**

10.3 Any person carrying out observations will normally:

- know the patient, be aware of the significant aspects of their history, identified risk factors and the rationale behind the decision taken for enhanced levels of observation;
- be familiar with this policy;
- be familiar with the ward, the ward procedure for responding to emergencies and the potential risks in the environment;
- be familiar with significant events, particularly in relation to risk, since admission;
- other than in exceptional circumstances when carrying out

observations at level two the staff member must not observe for more than two hours at a time. For levels three or four the staff member must not observe for more than one hour at a time. An hours break from observation duties must be provided between each period of observation;

- observation above the general level must be seen as a protected task; in other words the person carrying out observations must not have any other duties allocated to them other than observing and engaging with patients.
- Ward Managers need to support staff involved in this difficult and demanding task. If appropriate, staff should complete an untoward incident form (by clicking on the Incident Reporting link on the homepage of the Trust Intranet) when they are unable to take identified breaks from observation.

11. RECORDING OF OBSERVATIONS

11.1 When an observation check is recorded this must be based on a **visual** sighting of the patient.

11.2 Times must not be written on observation record forms in advance; the time written on the form must record the actual time the patient was visually observed.

11.3 The language used when describing any period of observation must be clear, unambiguous and describe accurately and concisely the current mental state and movements of the patient being observed. Jargon, abbreviations or unsubstantiated information when completing records should not be used.

11.4 Observation forms must not be completed retrospectively. Staff carrying out observation of patients must keep an accurate and contemporaneous record of that observation. All staff are accountable for their entries and these are vital in contributing to high standards of patient care. It is the **responsibility of the member of staff allocated to carry out the observation to keep the record up to date** and this must be completed before handing to the next allocated staff member.

11.5 For Level One observations the staff handing over from morning to afternoon, from afternoon to night and from night to the next morning shift will sign to say that they accept this as a true record. For all other levels (Two, Three and Four) staff taking over on each hour must sign the observation record form to say they accept the handover of the patient and the paperwork is correct.

11.6 It is the responsibility of the Nurse in Charge to allocate staff to carry out observations during each shift. This must be documented on a shift allocation sheet so everyone is aware of their duties. The co-coordinator needs to be assured staff that are allocated are competent to carry out the duty and to record the activity correctly (see roles and responsibilities). At the end of the shift it is the responsibility of the Nurse in Charge to check forms have been completed correctly and that they are then filed in the

correct place.

11.7 Written documentation of observations must only be made on the forms provided in the appendix of this policy. However, the key at the bottom of the form relating to recording a patient's whereabouts and wellbeing may be altered to suit local needs. Once all paperwork for patient observations is completed it must be uploaded into the patient's Rio record as per Trust Policy.

12. TRAINING REQUIREMENTS

12.1 The Trust will work towards all staff being appropriately trained in line with the organisation's Mandatory Training Matrix (training needs analysis). All training documents referred to in this policy are accessible to staff within the Learning and Development Section of the Trust Intranet.

12.2 The Trust is responsible for ensuring staff have the opportunity to attend training relevant to providing safe and therapeutic observations. All staff carrying out observations must attend the following courses and are responsible for accessing them:

- basic risk training
- life support (resuscitation) training;
- prevention and management of violence and aggression;
- equality and diversity.

12.3 In addition staff involved in deciding the level of observation which is suitable for clients must attend clinical risk assessment training. Monitoring of compliance with Clinical Risk Assessment Training will take place at divisional level.

12.4 Please refer to section 10.2 of this document regarding Training Competencies and the Observation Competency Checklist (Appendix I).

13. MONITORING COMPLIANCE AND EFFECTIVENESS

13.1 The Improving the Quality of Inpatient Services Best Practice Group (IQIS), **is responsible for monitoring** overall compliance with this policy, the group will review all incidents, feedback or complaints related to this policy, and feedback and learning points and good practice to the appropriate clinical teams All Best Practice Groups report to the Clinical Governance Group six-monthly using a standard reporting template.

Methodology to be used for monitoring

13.2 Audit of this policy is incorporated into the Trust Clinical Audit plan and appropriately prioritised according to an agreed system for determining the frequency of audit. The responsibility for undertaking audit and signing off key recommendations is held by the IQIS Best Practice Group. The Trust has developed Clinical Audit Standards for Observation (Appendix J).

13.3 The competency of staff engaged in observation duties will be assessed using the Observation Competency Checklist (Appendix I) and monitored at supervision.

Development and Review of Action Plans

13.4 Audit results and recommendations are presented to the Improving Quality of Inpatient Services Group for consideration, identifying both good practice and non-compliance. The audit recommendations are considered and adopted as Trust recommendations and agreed actions identified. This Group is responsible for ensuring these actions are implemented.

13.5 Assurance that actions/recommendations have been implemented is provided to the Clinical Governance Group via the six-monthly Best Practice Group report.

14. REFERENCES, ACKNOWLEDGEMENTS AND ASSOCIATED DOCUMENTS

14.1 References

Department of Health (2002) Mental Health Policy Implementation Guide Adult Acute Inpatient Care Provision. London: Department of Health

Standing Nursing and Midwifery Advisory Committee (1999). Practice guidance: Safe and supportive observation of patients at risk mental health nursing – Addressing acute concerns. London, DOH

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Keeping patients safer on acute psychiatric wards, Bowers, L., NHS Confederation 2009.

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Suicide Inside – a systematic review of in-patient suicides, Bowers, L., Banda, T., and Nijman H., , The Journal of Nervous and Mental Disease, May 2010, 198, 5:315-328

Special Observation in psychiatric hospitals: a literature review, Bowers, L 2010, unpublished research (by kind permission of Professor Len Bowers, Department of Nursing, City University).

Relevant National Requirements

Practice guidance: Safe and supportive observation of patients at risk mental health nursing – Addressing acute concern

NHSLA Risk Management Standards 2012-2013 for NHS Trusts providing Acute, Community, or Mental Health and Learning Disability Services and Non-NHS Providers of NHS Care

14.2 Acknowledgements

Somerset Partnership NHS Foundation Trust would like to make a note of thanks to Oxleas NHS Foundation Trust for agreeing the use of elements of their policy.

14.3 Cross reference to other procedural documents

Clinical Assessment & Management of Risk of Harm to Self and Others Policy

Counter Fraud Policy

Detained Patient Absent without leave (AWOL) Policy including Missing Persons Guidance

Equality and Diversity Policy

Handover Policy for Inpatient wards

Learning Development and Mandatory Training Policy

Mandatory Training Matrix (Training Needs Analysis)

Ministry of Defence Admission Procedure (Rydon Wards)

Inpatient Property Management Policy

Physical Assessment and Examination of Patients/Clients Policy

Physiological Observations Policy for Inpatients and Minor Injury Units Including Wessex House)

Prevention and Management of Violence & Aggression (PMVA) Policy

Privacy, Dignity and Respect Policy

Integrated Care Planning Approach (ICPA) Policy

Interpreting and Translation Policy

Rapid Tranquillisation Policy

Records Keeping and Records Management Policy

Risk Management Policy

Search of Patients, Visitors and Property Policy

Proactive Care Policy

Serious Incidents Requiring Investigation (SIRI) Policy

Untoward Event Reporting Policy

All current policies and procedures are accessible in the policy section of the public website (on the home page, click on ‘Policies and Procedures’). Trust Guidance is accessible to staff on the Trust Intranet.

15. APPENDICES

15.1 For the avoidance of any doubt the appendices in this policy are to constitute part of the body of this policy and shall be treated as such.

Appendix A	Patient information sheet – Observation
Appendix B	**Level One** general observations forms
Appendix C	**Level One** General Observations (physical rounding) Form
Appendix D	**Level Two** intermittent observation forms: am, pm and night shift
Appendix E	**Level Two** Holford Ward ONLY observation review sheet
Appendix F	**Level Three/Four** one to one observation forms: am, pm and night shift
Appendix G	Multi-disciplinary observation review sheet
Appendix H	Patient observation flowchart
Appendix I	Observation competency checklist
Appendix J	Observations Clinical Audit Standards

APPENDIX A

Somerset Partnership NHS Foundation Trust

Observation Information Sheet

Staff working on the ward have a responsibility to ensure the wellbeing of all patients. This includes checking where you are on the ward as well as your safety and welfare on a regular basis throughout the day and night. This is known as "observation".

The frequency of this observation is determined by carrying out an assessment of your mental health needs including an assessment of any risks which you may be exposed to, or pose to yourself or others. You should as far as is possible, be involved in discussions about the level of observation which you are on. Your observation level may be reviewed and changed during your stay. The team use four different levels of observation which are outlined below:

Level One (General Observations): All patients on the ward will have their welfare and whereabouts checked by staff on an hourly basis, this includes checking at night.

Level Two (Intermittent Observations)

Level Two observations means you will be observed at regular intervals throughout the day and night (usually four-five times per hour). Staff will have to observe you and make sure you are safe and well. If you are on Level Two observations, access off the ward may be restricted.

Level Three and Level Four (Close Observations)

There may be occasions where nursing staff are with you at all times, either within eyesight (Level Three) or within arms-reach of you (Level Four). This is called close observations. If you are placed on close observations your team will have a discussion with you and you will be given an explanation of the reasons for this. This level of observation may feel intrusive but it is only carried out when it is considered necessary by the team to keep you or others safe. You will be on close observations for the shortest time possible and your privacy and dignity will, as far as is possible, be respected. If you are on close observations, it is likely you will have to remain on the ward, and may not have access to the garden or elsewhere on the ward.

How staff must behave

Nurses and other staff involved in your observation should have been briefed on your previous medical history, and should know about any particular needs you have or where particular care must be taken. They should try to talk and listen to you and value you as a person. The same person must not observe you for more than two hours at a time if you are being observed on a level higher than general observations. Somerset Partnership recognises that observing patients may seem intrusive at times; however it is important to ensure that the ward is safe and secure and staff will be as discreet as possible.

Deciding which level of observation is needed

Decisions about your level of observation must take into account your current behaviour, the medicines you are taking, your physical health and wellbeing and the current risk you may harm yourself or those around you.

You must be observed using the lowest level of observation considered possible

under the circumstances. A balance must be struck between your privacy and dignity and the safety of yourself or those around you.

When deciding what level of observation is necessary the staff must, as far as is possible, discuss the decision with you, take your views into account and should always tell you what level of observations you are on and give you an explanation of what this means and the reasons for the decision.

Your doctor will be informed of any decision made regarding your observation level as soon as is practicable. Your family, friend or carer should be made aware of the level of observation you are under (as long as you agree to them knowing).

If you have any further questions about observations please approach a member of the team who will be happy to discuss them with you.

APPENDIX B

General Observation Form - Level One- General Observations Form

**NURSE IN CHARGE TO BE INFORMED IMMEDIATELY IF A PATIENT CANNOT BE ACCOUNTED FOR. ** PLEASE ENTER CODE TO INDICATE WHERE PATIENT IS WHEN CHECKS ARE CARRIED OUT

		RECORD THE ACTUAL TIME THE PATIENT WAS VISUALLY OBSERVED																						
ROOM NO.	PATIENT'S NAME																							
1																								
2																								
3																								
4																								
5																								
6																								
7																								
8																								
9																								
10																								
11																								
12																								
13																								
14																								
15																								
16																								
17																								
18																								
19																								

20																								
21																								
22																								
23																								
24																								
	Nurse's Initials																							

L – open lounge	**B** – bathroom	**BA** – bedroom awake	**OT** – groups/ADL	**O** – out	**SP** – smoking pod
D – dining room	**I** – interview room	**BS** - bedroom asleep	**C** – corridor	**AW** - AWOL	**FL**- female only lounge
M – meeting room	**S** – shower room	**LY** - laundry	**A** – activity room	**G** - garden	**OL** - on leave

One incoming and outgoing staff member must do checks together at handover times

07.00hrs handover Incoming staff……. Outgoing staff…….

13.00 hrs handover Incoming staff…….. Outgoing staff…….

20.45hrs handover Incoming staff……. Outgoing staff…….

(Keep on the ward. At the end of each week, scan to ward shared drive and destroy the original)

APPENDIX C

Level One

General Observation (including physical rounding) Form

**** NURSE IN CHARGE TO BE INFORMED IMMEDIATELY IF A PATIENT CANNOT BE ACCOUNTED FOR. ** PLEASE ENTER CODE TO INDICATE WHERE PATIENT IS WHEN CHECKS ARE CARRIED OUT**

				RECORD THE ACTUAL TIME THE PATIENT WAS VISUALLY OBSERVED																						
ROOM NO.	**PATIENT'S NAME**	**FALL RISK**	**PRESSURE DAMAGE RISK**																							
1																										
2																										
3																										
4																										
5																										
6																										
7																										
8																										
9																										
10																										
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16																											
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21																											
22																											
23																											
24																											
	Nurse's initials																										

L **– open lounge**	B **- bathroom**	BA **– bedroom awake**	OT **– groups/ADL**	O **- out**	D **– dining room**
I **– interview room**	BS **– bedroom asleep**	C **– corridor**	AW **- AWOL**	FL **– female only lounge**	M **– meeting room**
S **– shower room**	A **– activity room**	G **- garden**	OL **– on leave**	C **– comfort check**	PAC **– pressure area care (skin bundle)**

One incoming and outgoing member must do checks together at handover times

07.30hrs handover **Incoming staff ……** **Outgoing staff ……..**

13.30hrs handover **Incoming staff ……** **Outgoing staff ……..**

20.45hrs handover **Incoming staff ……** **Outgoing staff ……..**

Comfort check **–** **to be completed where falls risk is 9+**

check pain, thirst, call bell available, need the toilet

Pressure area care **-** **where Waterlow score is 10+**

S **surface (eg mattress, cushion)**
K **keep moving (reposition if necessary)**
I **incontinence**
N **nutrition (offer drink, snack)**

(Keep on the ward. At the end of each week, scan to ward shared drive and destroy th

APPENDIX D

LEVEL TWO (INTERMITTENT) OBSERVATION RECORD – AM SHIFT

Patient Name:	Date:
Primary Nurse:	Consultant:
MHA Status:	RiO number:
Reasons for Observation:	

Staff carrying out observations must be aware of

Location of patient, position if asleep, any suicide attempts, self-harm or attacks on others, thoughts & ideas about self-harm, hallucinations, particularly voices suggesting harm to others, paranoid ideas, specific plans or intentions to harm themselves or others, problems with drugs or alcohol, mobility problems and poor adherence to medication programmes.

When carrying out observations at Level Two each staff member must not observe for more than 2 hours at a time.

Intermittent level 2 observations, no less frequently than 15 minutes

Actual time of visual observation	Assessment of Observations	Staff Name	Grade	Signature of staff taking over Observation

Nursing Review

A nursing review will be completed at the end of each shift period to review the appropriateness of continuing observations. This will be completed by 2 RMNs, one from the outgoing shift and one from the incoming shift. Rationale for any change in observations must be documented clearly in RiO.

Nursing review of observations at the end of each shift (enter summary of observations)	
Continue with current level of observation : Yes No	
Signed: Print:	Signed: Print:
Date:	Time:

(Keep on the ward. At the end of each week, scan and upload to patient record on RiO using document code: OBS and destroy the original when confirmed on RiO)

LEVEL 2 (INTERMITTENT) OBSERVATION RECORD – PM SHIFT

Patient Name:	Date:
Primary Nurse:	Consultant:
MHA Status:	RiO number:
Reasons for Observation:	

Staff carrying out observations must be aware of

Location of patient, position if asleep, any suicide attempts, self-harm or attacks on others, thoughts & ideas about self-harm, hallucinations, particularly voices suggesting harm to others, paranoid ideas, specific plans or intentions to harm themselves or others, problems with drugs or alcohol, mobility problems and poor adherence to medication programmes

When carrying out observations at Level Two each staff member must not observe for more than two hours at a time.

Nursing Review

Intermittent level 2 observations, no less frequently than 15 minutes

Actual time of visual observation	Assessment of Observations	Staff Name	Grade	Signature of staff taking over Observation

Nursing Review

A nursing review will be completed at the end of each shift period to review the appropriateness of continuing observations. This will be completed by 2 RMNs, one from the outgoing shift and one from the incoming shift. Rationale for any change in observations must be documented clearly in RiO.

Nursing review of observations at the end of each shift (enter summary of observations)	
Continue with current level of observation : Yes No	
Signed: Print:	Signed: Print:
Date:	Time:

(Keep on the ward. At the end of each week, scan and upload to patient record on RiO using document code: OBS and destroy the original when confirmed on RiO)

LEVEL 2 (INTERMITTENT) OBSERVATION RECORD – NIGHT SHIFT

Patient Name:	Date:
Primary Nurse:	Consultant:
MHA Status:	RiO number:
Reasons for Observation:	

Staff carrying out observations must be aware of

Location of patient, position if asleep, any suicide attempts, self-harm or attacks on others, thoughts & ideas about self-harm, hallucinations, particularly voices suggesting harm to others, paranoid ideas, specific plans or intentions to harm themselves or others, problems with drugs or alcohol, mobility problems and poor adherence to medication programmes

When carrying out observations at Level Two each staff member must not observe for more than two hours at a time.

Note: Where agreed following risk assessment and patients are observed through observation window this must be noted.

Intermittent level 2 observations, no less frequently than 15 minutes

Actual time of visual observation	Assessment of Observations	Staff Name	Grade	Signature of staff taking over Observation

Intermittent level 2 observations, no less frequently than 15 minutes	Actual time of visual observation	Assessment of Observations	Staff Name	Grade	Signature of staff taking over Observation

Nursing Review

A nursing review will be completed at the end of each shift period to review the appropriateness of continuing observations. This will be completed by two RMNs, one from the outgoing shift and one from the incoming shift. Rationale for any change in observations must be documented clearly in RiO.

Nursing review of observations at the end of each shift (enter summary of observations)	
Continue with current level of observation : Yes No	
Signed: Print:	Signed: Print:
Date:	Time:

(Keep on the ward. At the end of each week, scan and upload to patient record on RiO using document code: OBS and destroy the original when confirmed on RiO)

APPENDIX E

HOLFORD WARD (ONLY) OBSERVATION REVIEW SHEET

Patient Name: Date:

Level 2 Observations

Staff carrying out these observations must be aware of the location of the patient, position if asleep, activities undertaken, any evidence of self-harm or intention to do so, any concerns regarding physical health complaints and/or eating and drinking issues, paranoid ideas and hallucinations, the risk screening as completed on RiO, any tensions building up for the patient, any risk of or plans to abscond and the risk posed to others. Any concerns must be reported to the nurse co-ordinating the shift. Risk concerns are listed below; please indicate those relevant to the patient.

These observations are randomised to prove more effective with regards to risk management. Please indicate on the form with a tick or initials when in the hour you have seen the patient, intervals between observations must not exceed 15 minutes. Staff under taking these observations must not exceed 2 hours in a row.

Risk Concerns: Violence Suicide Deliberate Self Harm Accidental Self Harm Antisocial/Offending Absconding General Obs
(Circle as appropriate)

Minute → / Hour ↓													**Assessment**	**Staff Name, Band and signature**

HOLFORD WARD (ONLY) OBSERVATION REVIEW SHEET

Patient Name: Date:

Risk Concerns: Violence Suicide Deliberate Self Harm Accidental Self Harm Antisocial/Offending Absconding General Obs
(Circle as appropriate)

Minute → / Hour ↓													Assessment	Staff Name, Band and signature

(Keep on the ward. At the end of each week, scan and upload to patient record on RiO using document code: OBS and destroy the original when confirmed on RiO)

APPENDIX F

LEVEL 3/4 OBSERVATION RECORD – AM SHIFT

Patient Name:	Date:
Primary Nurse:	Consultant:
MHA Status:	RiO number:
Reasons for Observation:	

Staff carrying out observations must be aware of

Location of patient, position if asleep, any suicide attempts, self-harm or attacks on others, thoughts & ideas about self-harm, hallucinations, particularly voices suggesting harm to others, paranoid ideas, specific plans or intentions to harm themselves or others, problems with drugs or alcohol, mobility problems and poor adherence to medication programmes.

When carrying out observations at Level Three/Four each staff member must not observe for more than one hour at a time. At the end of each observation period, the nurse should have a break from observation of at least one hour. Under no circumstances must student nurses be allocated observation at Levels Three and Four.

Actual time of visual observation	Assessment of Observations	Staff Name	Grade	Signature of staff taking over Observations

Observation levels 3 & 4 can only be reduced after a multi-disciplinary team discussion or meeting has occurred which includes patients consultant (or designated deputy) and the nurse in charge of the ward. There must be a formal review of level 3 & 4 observations every 24 hours.

(Keep on the ward. At the end of each week, scan and upload to patient record on RiO using document code: OBS and destroy the original when confirmed on RiO)

LEVEL 3/4 OBSERVATION RECORD – PM SHIFT

Patient Name:	Date:
Primary Nurse:	Consultant:
MHA Status:	RiO number:
Reasons for Observation:	

Staff carrying out observations must be aware of

Location of patient, position if asleep, any suicide attempts, self-harm or attacks on others, thoughts & ideas about self-harm, hallucinations, particularly voices suggesting harm to others, paranoid ideas, specific plans or intentions to harm themselves or others, problems with drugs or alcohol, mobility problems and poor adherence to medication programmes

When carrying out observations at level three/four each staff member must not observe for more than one hour at a time. At the end of each observation period, the nurse should have a break from observation of at least one hour. Under no circumstances must student nurses be allocated observation at levels three and four

Actual time of visual observation	**Assessment of Observations**	**Staff Name**	**Grade**	**Signature of staff taking over Observations**

Observation levels 3 & 4 can only be reduced after a multi-disciplinary team discussion or meeting has occurred which includes patients consultant or designated deputy, and the nurse in charge of the ward. There must be a formal review of level 3 & 4 observations every 24 hours.

(Keep on the ward. At the end of each week, scan and upload to patient record on RiO using document code: OBS and destroy the original when confirmed on RiO)

LEVEL 3/4 OBSERVATION RECORD – NIGHT SHIFT

Patient Name:	Date:
Primary Nurse:	Consultant:
MHA Status:	RiO number:
Reasons for Observation:	

Staff carrying out observations must be aware of

Location of patient, position if asleep, any suicide attempts, self-harm or attacks on others, thoughts & ideas about self-harm, hallucinations, particularly voices suggesting harm to others, paranoid ideas, specific plans or intentions to harm themselves or others, problems with drugs or alcohol, mobility problems and poor adherence to medication programmes

When carrying out observations at level three/four each staff member must not observe for more than one hour at a time. At the end of each observation period, the nurse should have a break from observation of at least one hour. Under no circumstances must student nurses be allocated observation at levels three and four

Actual time of visual observation	Assessment of Observations	Staff Name	Grade	Signature of staff taking over Observations

Observation levels 3 & 4 can only be reduced after a multi-disciplinary team discussion or meeting has occurred which includes patients consultant or designated deputy, and the nurse in charge of the ward. There must be a formal review of level 3 & 4 observations every 24 hours.

(Keep on the ward. At the end of each week, scan and upload to patient record on RiO using document code: OBS and destroy the original when confirmed on RiO)

APPENDIX G

Multi-disciplinary Observation Review Sheet

This form is to be used daily by the Nurse in Charge as part of morning MDT handover, to discuss and review all patients on the ward who are on higher level (2, 3 and 4) observations.

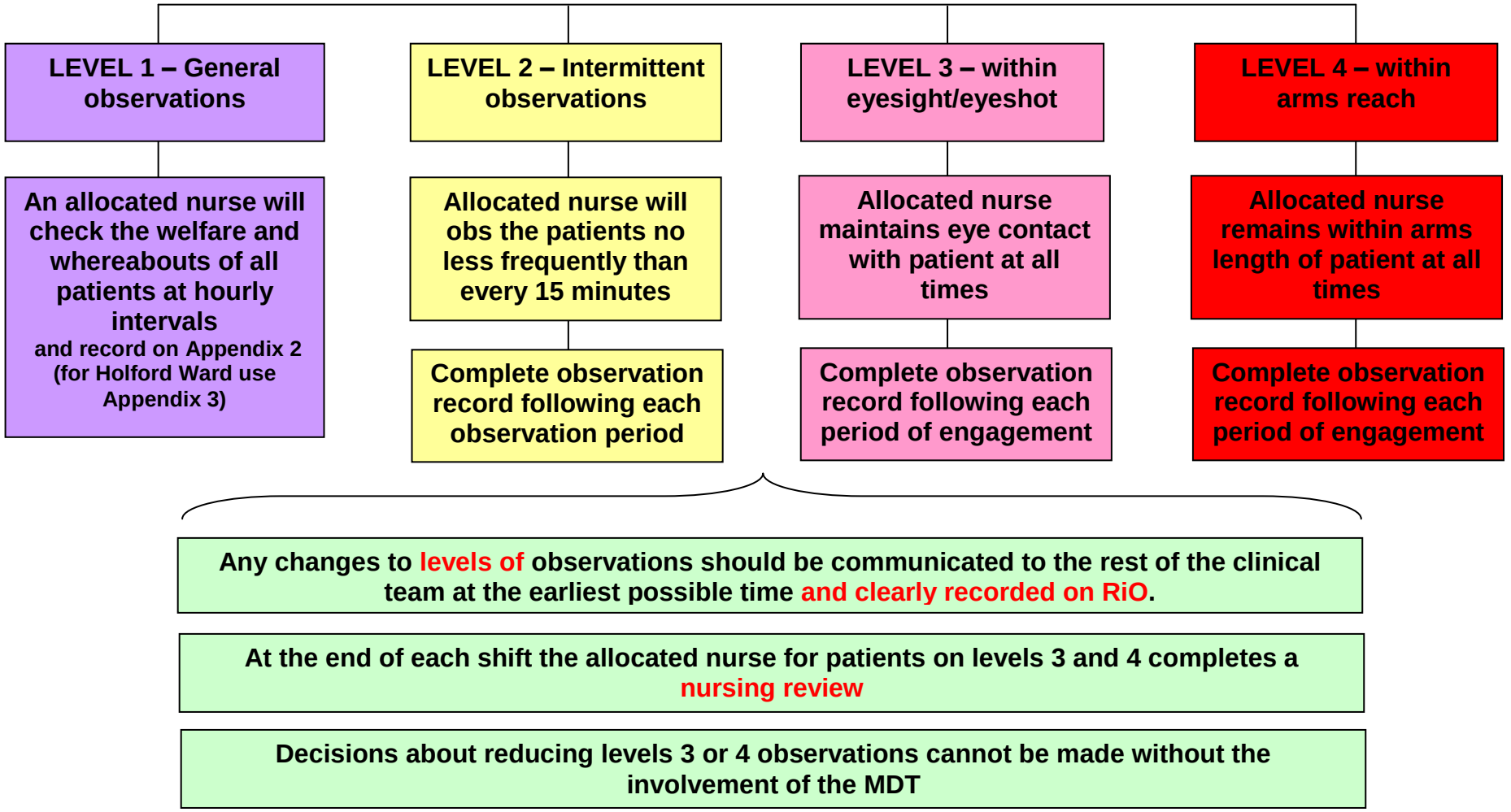
Ward: …… **Date:** ……

	Name
Nurse	
Medic	
OT	
Student	
Other	

	Name of patient	**Level of obs prior to review**	**Nurse in Charge signature**	**Medic signature** *Consultant or nominated deputy*	**Level of obs after review**
1					
2					
3					
4					
5					
6					
7					
8					
9					
10					

(Keep on the ward. At the end of each week, scan to ward shared drive and destroy the original)

Patient Observation Flow Chart



APPENDIX I

Observation Competency Checklist

The nurse in charge of the ward will be satisfied that the staff member allocated observation duties is competent in the following areas:

i) Safe and Therapeutic Observation policy read and understood including need to discuss with patient detail of observation, reasons etc;

ii) Seclusion / De-escalation policy read and understood (if patient to be observed is in seclusion);

iii) Responsibilities regarding documentation and timing of same read and understood;

iv) Understanding the rationale for observation (i.e. self-harming, suicidal etc.);

v) Understanding specifics of the particular observation (i.e. behaviour, physical health etc.);

vi) Understanding when and how to summon assistance if required;

vii) Understanding of the importance of the patients care plan and receipt of formal hand over from the patients named (primary) nurse and being introduced to the patient prior to commencement of period of observation;

viii) Understanding their responsibilities in the event of an emergency on the ward (i.e. fire, serious incident etc).

When this document has been read and understood, please sign below:

Nurse in Charge …… (Print Name)

…… (Signature)

…… Date

Staff Member …… (Print Name)

…… (Signature)

…… Date

Completed Form to be retained on the ward.

Observations – Safe and Therapeutic Clinical Audit Standards

April 2016

Service area(s) to which standards apply:

x	MH Inpatient (CAMHS)		Community CAMHS		CH Specialist Services
x	MH Inpatient (Adult)		C & YP Integrated Therapy		MH Specialist Services
x	MH Inpatient (Older)		School Nursing		MH Community Adult
x	MH Rehab & Recovery		Health Visitors		MH Community Older
	Community Hospital		CH Rehab		Learning Disabilities
	MIU		Musculo-Skeletal		District Nurses

OBSERVATIONS CLINICAL AUDIT STANDARDS					
Standard		**Policy/ document Reference**	**Compliance (%)**	**Exceptions**	**Definitions** *(e.g. any interpretations, directions, or instructions on where/how to find information, **plus** relevant service where applicable)*
1	All staff carrying out safe and supportive observations must be deemed to be competent by the nurse in charge of the shift	10.2	100%	None	"Competent" is defined as having a signed Competency Checklist
2	All levels of observation must be recorded within patients care plan, and it must be clear the patient was involved in this decision	9.6	100%	Where the patient refuses to be involved, or lacks capacity to be involved.	Where this is not possible the rational must be clearly recorded
3	All new admissions to be allocated to level 2 observations for at least the first 24 hours and recorded within the care plan	6.18	100%	Holford Ward, where the minimum observation is level 2	If it is not necessary for the patient to remain on level 2 for 24 hours, there must be a review which must involve medical staff and any decision regarding the observation level along with the rationale for this decision must be recorded in RiO with the names of the people involved in the discussion
4	Staff observing patients at Level 3 or above must attempt to engage with the patient and undertake some form of therapeutic activity	5.1	100%	Patient asleep	Both the attempts to engage and the therapeutic activity undertaken must be documented on RiO (including any refusal). Therapeutic activity might include conversation, and discussion, physical activity, watching television, engaging in conversation regarding observation needs and plan of care.
Level 1: General Observation (all inpatients)					

OBSERVATIONS CLINICAL AUDIT STANDARDS					
	Standard	**Policy/ document Reference**	**Compliance (%)**	**Exceptions**	**Definitions** *(e.g. any interpretations, directions, or instructions on where/how to find information, **plus** relevant service where applicable)*
5	Staff must check on the physical wellbeing and whereabouts of all patients on the ward once an hour as a minimum. Night time observation must be proportionate to level of risk	6.2	100%	Holford Ward, where the minimum observation is level 2	Observations need to be carried out at night as well as during the day. If night time observation is reduced this must be recorded in the care plan. Ward staff must use the General Observation Form Level One (Appendix B/C) form to record the observations.
Level 2: Intermittent Observation					
7	Inpatients on Level 2 Observation must be observed no less frequently than every 15 minutes	6.4	100%	None	It is sensible to observe the patient at slightly varied intervals throughout the hour. Observations need to be carried out at night as well as during the day. Ward staff must use the Level 2 (Intermittent) Observation Record Shift Form (Appendix D/E) form to record the observations.
8	The patient's level of observation must be communicated and recorded at each handover meeting	6.6	100%	None	This must be recorded within the handover record sheet.
9	For patients remaining on Level 2 Observations for longer than three days, a formal multi-disciplinary review of their care and observation level must be held	6.6	100%	Holford Ward, where the minimum observation is level 2	This review must involve medical staff and any decision regarding the observation level along with the rationale for this decision must be recorded in RiO with the names of the people involved in the discussion
10	A reduction in observation level must be made by the multi-disciplinary team and include consideration of current risks posed, consideration to the reasons why the observation level was originally implemented, and the rationale for the decision.	6.7	100%	The nursing team can, after discussion with the nurse in charge, reduce the observation to level one without consulting the medical team.	A record of the decision to reduce (and any decision made to reduce without consulting the medical team), along with the names of the people involved in the discussion must be recorded on RiO.

OBSERVATIONS CLINICAL AUDIT STANDARDS					
	Standard	**Policy/ document Reference**	**Compliance (%)**	**Exceptions**	**Definitions** *(e.g. any interpretations, directions, or instructions on where/how to find information, **plus** relevant service where applicable)*
Level 3: Within eyesight					
11	Inpatients on Level 3 Observations must be kept within sight by the staff member carrying out the observation, who must be constantly aware of their location and wellbeing	6.10	100%	None	The allocated observer must complete Level Three/Four Observation Record (Appendix F) documenting the patients wellbeing, mental state, the content of any discussions noted risk behaviours at the end of each hour as well as making a record on RiO at the end of each shift
12	A formal review of the patient's level of observation must be conducted every 24 hours as a minimum	6.12	100%	None	This review must involve medical staff and any decision regarding the observation level along with the rationale for this decision must be recorded in RiO with the names of the people involved in the discussion
13	A decrease in observation from level 3 must only follow a multi-disciplinary team discussion, which includes a doctor and the nurse in charge of the ward.	6.12	100%	Out of hours, the discussion with the doctor and consultant on call (and the duty ward manager if available) may be by telephone.	A record of the decision to reduce, along with the names of the people involved in the discussion (indicating where this was by telephone if out of hours) must be recorded on RiO. Ward staff must use the Multi-disciplinary Observation Review Sheet (Appendix G) form to record these discussions.
Level 4: Within arm's reach					
14	Inpatients on Level 4 Observations must be within arm's reach of the observer(s) at all times and in all circumstances	6.13	100%	None	The allocated observer must complete the Level Three/Four Observation Record on the am, pm, and night shift (Appendix F) documenting the patients wellbeing and mental state, the content of any discussions and noted risk behaviours at the end of each hour as well as making a record on RiO at the end of each shift. Where gender specific observers are required, this will be demonstrated in the care plan.

OBSERVATIONS CLINICAL AUDIT STANDARDS					
	Standard	**Policy/ document Reference**	**Compliance (%)**	**Exceptions**	**Definitions** *(e.g. any interpretations, directions, or instructions on where/how to find information, **plus** relevant service where applicable)*
15	A formal review of the patient's level of observation must be conducted every 24 hours as a minimum	6.16	100%	None	This review must be recorded on RiO along with the names of the people involved in the discussion. Ward staff must use the Multi-disciplinary Observation Review Sheet (Appendix G) form to record these reviews.
16	A decrease in observation from level 4 must only follow a multi-disciplinary team discussion, which includes a doctor and the nurse in charge of the ward.	6.17	100%	Out of hours, the discussion with the doctor and consultant on call (and the duty ward manager if available) may be by telephone.	A record of the decision to reduce, along with the names of the people involved in the discussion (indicating where this was by telephone if out of hours) must be recorded on RiO. Ward staff must use the Multi-disciplinary Observation Review Sheet (Appendix G) form to record these discussions.
Handing Over of Observation Duties					
17	For inpatients on Level One, the staff handing over will sign Appendix B/C to say that they accept this as a true record	11.3	100%	Holford Ward, where the minimum observation is Level 2	
18	For inpatients on Levels Two, Three and Four Observation, the member of staff who is continuing observations must sign Appendix D/E and F to indicate they have received this handover, the patient is safe, and they are continuing the observations	7.2	100%	None	None