Psychiatric Observations and Engagement

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Purpose of Agreement	This policy sets out the principles and standards of psychiatric observations within relevant inpatient services
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Amendments Summary:

Amend No	Issued	Page	Subject	Action Date
1.4		6	Level 2 added night-time risk assessment. Level 3 observations updated.	November 2017
3.1		8	Changed to daytime observations.	November 2017
3.2		9	Changed to night observations.	November 2017
3.3		9/10	Allocation of appropriate psychiatric observation level upon admission moved from 3.2	November 2017
3.4		11	Reviewing psychiatric observation levels during patients stay moved from 3.3	November 2017
3.5	12		Detained patients on increased psychiatric observations moved from 3.4	November 2017
3.6	12		Informal patients on increased psychiatric observations moved from 3.5	November 2017
3.7	13		Recording process moved from 3.6	November 2017
3.8	13		Bank and agency staff moved from 3.7.	November 2017
5.3	15		Competency tool removed and local induction added.	November 2017
1.3 & 9.1		5, 18	Reference to Standing Nursing and Midwifery Advisory Committee (1999) removed	April 2020
3.3.4		11	Reference to Oakdene ward removed (closed November 2019)	April 2020
1.11 3.5.1 9.1		8, 11, 12, 18	References to CLS11 included	April 2020
2.1		8	References to HR53 updated	April 2020

Review Log:

Version Number	Review Date	Lead Name	Ratification Process	Notes
1	March 2014	Senior staff within AMH/ OPMH/ SMS/ LD/ Neuro Rehab Services Mental Health Act Lead	For approval at service line governance meetings	To update Policy to ensure it remains accurate and comprehensive
2	April 2014	Approval at Service Line Governance Meetings	Once approved to go to Policy Group Sub-Committee and then Assurance Committee	Wording changes
3	September 2014	Policy Group Steering Committee	Once approved to go to Policy Group Sub-Committee and then Assurance Committee	Amendments due to SIRI lessons learnt.
4	October 2015	Robert Pollock, Physical Intervention Lead	Once approved to go to Policy Group Sub-Committee and then Assurance Committee	To update Policy to ensure it remains accurate and comprehensive and is in line with 2015 Code of Practice Guidelines
5	November 2017	Joanna Perry Professional lead	Once approved to go to Policy Group Sub-Committee and then Assurance Committee	Amendments due to SIRI lessons learnt.
6	April 2020	Kevin Borrett, Governance Lead; Kim Thorne, Quality Improvement Matron	*Approved as part of the Covid-19 review of policies*	Amendments due to changes in inpatient services, policy updates and corrections to the text

SUMMARY OF POLICY

This policy is designed to inform clinicians of the differing levels of observation and the practical application of how they should be undertaken. It explains the impact of placing an individual on increased observations, ensuring a clear risk assessment takes place. The policy is designed to incorporate the underpinning principles of the Code of Practice, (2015), whereby the principle of least restrictive practice is maintained.

Required documentation is in the appendices.

Table of Contents

Psychiatric Observations and Engagement

1. INTRODUCTION & PURPOSE

1.1 Psychiatric observations are a routine part of clinical practice, the purpose of which is to ensure the safety of patients during their stay within an inpatient ward as well as promoting therapeutic engagement with patients.

1.2 Increased psychiatric observations will often be necessary to manage risk. However they can also be experienced as being intrusive or on some occasions leading to the patient experiencing distress. Staff must balance the potentially distressing effects on the patient of increased levels of observation, particularly if these observations are proposed for many hours or days, against the identified risk and ensure that they are both proportionate and necessary.

1.3 National guidelines exist to govern the practice of psychiatric observations, published by NICE NG10 Violence and aggression: short-term management in mental health, health and community settings (2015).

Research suggests that most attempted suicides are discovered and prevented by staff checking on patients, particularly in the more private areas of wards. For patients assessed as being at risk of suicide or serious self-harm, a significant preventive mechanism is for nursing staff to be 'caringly vigilant and inquisitive'. For such patients, staff should have a thorough knowledge of the patient as a person, and be constantly and consistently attentive to their state of mind, whereabouts and safety. Unusual circumstances and noises should be noticed and investigated.

1.4 There are the 4 levels of psychiatric observations described in the NICE guidelines which have been adopted by Solent NHS Trust:

Level 1 - General Observation – 60 minutes

- This is the minimum acceptable level for all patients.
- The location of the service user should be known to staff at all times but they are not necessarily within sight.
- Positive engagement with the patient is an integral clinical duty for patients on this observation level.
- Evaluate the patient's moods and behaviours associated with disturbed/violent behaviour, and record these. Any concerns regarding the service user should be escalated to the shift leader.
- Observations should be carried out in a respectful manner, ensuring the patient's dignity is maintained.

Level 2 – Intermittent Observation – 15-30 minutes

- This level is appropriate for patients who are potentially at risk of disturbed/violent behaviour, including those who have previously been at risk but are in the process of recovery.

- The patient's location should be checked every 15-30 minutes. The exact interval of the observation level (e.g. every 15 minutes) should be recorded in the patient's record and on the observation sheet.
- Intrusion should be minimised and positive engagement with the patient should take place.
- Evaluate the patient's moods and behaviours associated with disturbed/violent behaviour, and record these. Any concerns regarding the patient should be escalated to the shift leader.
- Observations should be carried out in a respectful manner, ensuring the patient's dignity is maintained.
- A night-time observation risk assessment must be undertaken, and a care plan put in place where appropriate.

Level 3 – One-to-One Observation - Within eyesight

- Patients, who could, at any time, make an attempt to harm themselves or others should be observed at this level.
- **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 in the patient's electronic record.**
- Any possible tools or instruments that could be used to harm either the patient or anybody else should be removed, if deemed necessary.
- Searching the patient and their belongings may be necessary, which should be conducted sensitively and with due regard to legal rights. Best practice indicates that 2 members of staff should conduct patient searches, with one staff member being the same gender as the patient.
- Positive engagement with the patient is essential.

Level 4 – One-to-One Observation - within arm's length

- 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 level 4 observations will have bathroom privacy.**
- More than one staff member may be necessary on specified occasions.
- Issues of privacy and dignity, consideration of gender issues, and environmental dangers should be discussed and incorporated into the care plan.
- Positive engagement with the patient is essential.

1.5 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:

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.

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

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

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

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.

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

1.7 Staff should always attempt to explain psychiatric observations and their purpose to patients upon their admission to the ward. They should also wherever possible, take into account the patients views when ascertaining the appropriate observation level. The outcome of this should be recorded in the patient's record.

1.8 Psychiatric observations should also promote engagement opportunities between staff and patients to ensure that the therapeutic relationship can be developed in order for patients needs to be met with understanding and empathy.

1.9 This policy relates solely to psychiatric observations within inpatient services. It does not cover the practice of physical health observations of patients.

1.10 A care plan should be put in place, after discussion with the patient where practicable. This should include:

- Which discipline(s) of staff are best placed to carry out enhanced observation and under what circumstances it might be appropriate to delegate this duty to another member of the team. The member of observing staff will be assigned by the nurse in charge who will have assessed their competency in undertaking this task, and draw their attention to this policy.

- The selection of a staff member to undertake enhanced observation will take account of the patient's unique characteristics and circumstances (including factors such as ethnicity, sexual identity, age and gender).For example, it may be inappropriate for a male nurse to undertake enhanced observation of a female patient if there are concerns about dignity and maintaining personal care, or for a female nurse to undertake enhanced observations of a male inpatient if there are specific religious or cultural objections. The nurse in charge must satisfy themselves, through assessment, that the observer is suitable and adequately prepared.

- Enhanced observation must be undertaken in a way which minimises the likelihood of patients perceiving the intervention to be coercive. Staff must be aware of how being under observation can have a negative effect on the individual. This will include how they consider the person's history in thinking about this, if they have any advance statements and the general issues and practicalities of their basic needs like use of the toilet, any physical health requirements, ward-specific issues particularly if on the Psychiatric Intensive Care Unit

(PICU) where there are further restrictions, population mix and how the individual may feel they are being perceived by other patients.

- Observation must be carried out in a way that respects the patient's privacy as far as practicable and minimises any distress. In particular, each unit must have a procedure which outlines steps to maximise dignity without compromising safety when patients are in a state of undress, such as when using the toilet, bathing, showering or dressing.

1.11 If a patient under long-term enhanced observation is also being prevented from having contact with anyone outside the area in which they are confined, then this will amount to seclusion and staff should refer to CLS11 Seclusion and Long Term Segregation policy.

1.12 Observation is likely to engage a person's Article 8 rights to private and family life. The multi-disciplinary team must ensure that they follow this policy, that they consider any negative impact of observation, any distress, intrusion of privacy and dignity and that their decisions are lawful. A key feature to this will be ensuring any deprivation of liberty is authorised. Lead Nurses need to ensure that this Psychiatric Observations and Engagement policy is made known to patients and their carers, that they can have access to it, alongside access to the Codes of Practice for the Mental Health Act (1983, 2007) and Mental Capacity Act (2005), and that they are aware of their rights to access an advocate.

2. SCOPE & DEFINITIONS

2.1 This document applies to all directly and indirectly employed staff within Solent NHS Trust and other persons working within the organisation in line with Solent NHS Trust's Equality, Diversity, Inclusion and Human Rights Policy.

2.2 Solent NHS Trust is committed to the principles of Equality and Diversity and will strive to eliminate unlawful discrimination in all its forms. We will strive towards demonstrating fairness and Equal Opportunities for users of services, carers, the wider community and our staff.

3. PROCESS / REQUIREMENTS

3.1 Daytime observations

3.1.1 During daytime hours (07:00-22:00) Staff undertaking psychiatric observation must, on every observation, ensure that they are able to determine the patient's welfare, including observing for signs of life. This is to occur, even if the service user is asleep within the above hours.

3.1.2 If asleep, signs of life can be determined through:

- Breathing Movements – chest rises/breath exhalation/snoring
- General body movement
- Circulation – usual colour for the person, no cyanosis
- Responsive to sound- calling of name, knocking on a door
- Response to stimuli

3.1.3 In the event of the patient not displaying signs of life, the staff member must raise the alarm immediately and follow the actions as required under the Trust's Resuscitation Policy and as provided during the Trusts resuscitation training programmes.

3.2 Night observations

3.2.1 Mental health services are caring for a patient group with increasingly complex physical and mental health conditions, who may be at risk of coming to serious harm or dying during the night, whilst they are in bed. This is a period during which it may be more difficult to undertake observations, because of lighting conditions, sleeping position (e.g. under bedclothes, or orientation of bed in relation to observation hatch) or the risk of waking somebody who is in need of sleep.

3.2.2 All patients on wards within the Limes and Orchards buildings will have an explicit "night-time bedspace risk assessment", which covers the hours from 22:00hrs to 07:00hrs only to identify three main risk categories that will guide night-time observations:

- Risk of deliberate covert self-harm: is the patient at risk of using less frequent observations, the privacy of their room, or the bed covers to harm themselves?
- Risk of accidental harm through misadventure: is the patient likely to take substances before bedtime or during the night, which may cause them harm?
- Risk of physical health deterioration or death through physical health condition: does the patient have a health condition (acute or chronic), which may mean that they could deteriorate or die suddenly.

3.2.3 If a patient is subject to Do Not Resuscitate (DNA) Cardiopulmonary Resuscitation (CPR) (Older Persons Mental Health (OPMH) only) and the night-time bedspace risks relate to death from known pre-existing conditions, then the patients care plan should explicitly state action to be taken should the patient appear to not be showing signs of life at night-time observation. Wherever possible, this plan should be agreed by the patient, their carer and the Multi-Disciplinary Team (MDT).Where this is not possible, reasons should be documented.

3.2.4 This risk assessment should be recorded as part of the usual risk process within the patient's electronic records, but must be explicit in terms of night-time bedspace risks.

3.2.5 If the patient has low risks or no risks under the three categories in 3.2.2, usual care should be taken when carrying out observations and clinical judgement used about when to enter a room or not.

3.2.6 If the patient has moderate or high risks under the three categories in 3.2.2, then an entry should be made in their care plan describing the risks and the "night-time observation plan" entered as a care plan item.

3.2.6 The night-time observation plan should describe:

- the specific night-time bedspace risks for that patient
- a safety management plan
- The frequency and manner of observations during the night, and how actively the patient should be observed
- The action to take should cause for concern arise

3.3 **Allocation of appropriate psychiatric observation level upon admission**

3.3.1 All patients admitted to inpatient wards will be allocated an appropriate observation level to meet their needs and manage their risks. The level will be one of the predetermined levels as highlighted in Section 1.4 of this policy.

3.3.2 Determining the appropriate psychiatric observation level should follow a discussion between the Nurse in Charge (NIC) of the admitting ward and ordinarily the medical practitioner who has clerked the patient in. To ascertain which psychiatric observation level is most appropriate, the nurse and medical practitioner should consider the following points:

- Is the patient at risk of harming themselves?
- Is the patient at risk of harming other people?
- Does the patient require an increased level of nursing/personal care?
- Is the patient likely to abscond from the unit?
- Will observations increase risk in any way and how can this be mitigated so as not to leave the patient at risk?
- Are they susceptible to physical risk such as falls, and including frailty (OPMH)?

This list is not exhaustive but is merely a guide to help staff ascertain the appropriate psychiatric observation level for the patient. Key factors within the patient's history/presenting complaint will also assist this process and have to be considered by the admitting team.

3.3.3 All patients, as part of the admission process, will be given information on psychiatric observation levels and their purpose. This information is included in Appendix 1. Ward staff should go through this with patients and/or their relatives and carers to ensure that they are aware of psychiatric observations and should encourage patients to contribute to the decision-making process of the appropriate observation level for their needs.

3.3.4 Most inpatient wards will have a minimum standard for psychiatric observation levels which are implemented to reflect the overall level of care required and risks posed by the general patient group that use that particular ward. These should be considered and adhered to by the staff team at the point of the individual's admission.

Minimum standards for each area:

PICU – 15 minutes
Adult Acute – 60 minutes
Kite – 60 minutes
OPMH – 60 minutes

All levels of observation are dependent on the admission risk assessment.

3.3.5 Once the appropriate observation level has been allocated for the patient, it must be communicated to the patient with a rationale for why the level was chosen. The nurse in charge of the ward is responsible for ensuring that this is communicated to all members of staff working that shift and that it is clearly recorded in the patient's notes – explicitly justifying why this level was deemed appropriate to meet the patient's needs and manage their risks, and ensuring allocated staff understand the risk and any likely distress, or invasion of privacy it will cause and how this will be minimised.

3.3.6 In each patient record the following should be clearly documented:

- The reason for the level of observation (e.g. at risk of verbal aggression to other patients, at risk of fire-setting)
- Whether the risk continues when the person is in their bed at night
- How observations should be carried out when the person is in the general ward area and (if different) at night, when they are in bed.

3.3.7 For each ward shift, the Nurse in Charge will allocate appropriate staff members to complete the observation interventions with patients. This involves allocating staff each hour to complete the observations and ensuring that these staff members are aware of any particular needs or risks of each patient that they are observing, and that the observations are clearly and appropriately recorded on the observation form. The nurse in charge should also ensure any specific needs in relation to ethnicity, sexual identity, age, gender or other personal characteristic are considered and communicated to those doing the observation. The Nurse in Charge must be mindful of these factors when allocating staff.

3.4 Reviewing psychiatric observation levels during the patients stay

3.4.1 Throughout the patient's admission to the ward, their presenting needs and risks will fluctuate depending -on the patient's mental state and their wider circumstances at the time. Therefore it is vital that their psychiatric observation level is continually reviewed and amended to ensure that it meets the fluctuating needs of and risks to the patient. Examples that may trigger a review include:

- Improvement or deterioration in the patient's mental state
- Increased incidents of aggression
- The patient receiving bad news
- Attempts to abscond from the ward
- Under the influence of alcohol or illicit substances

3.4.2 Wherever possible, the decision-making process regarding the level of observation a patient requires should be made jointly between the medical and nursing staff and any other relevant members of the MDT. When observation levels are changed, the patient must be informed, and the rationale for the change and the patient's view about the change should be documented in the patient's notes. The risk assessment must include a consideration of any distress, negative impact or invasion of privacy the change to observation is likely to cause, and how this will be minimised.

3.4.3 At times, there will be no other members of the multidisciplinary team available and the decision making process will rest solely with the nursing team. During these times, the following principles will apply:

- When the patients observation level needs to be increased in order to provide appropriate support to manage the change in need or risk, then this is the responsibility of the nurse in charge of the ward.
- When the patient's observation level is to be reduced in order to provide appropriate support to manage the change in need or risk, the nurse in charge of the ward should discuss this with another qualified member of staff. One of these qualified members of staff should be at Band 6 or above. Jointly, they should assess

the needs and risks of the patient and any reduction in observation level must only occur if both clinicians agree it is in the patients' best interest. This only applies to Adult Mental Health (AMH) and Learning Disabilities (LD) Services. In OPMH services, only a medical staff member is authorised to decrease a patient's level of psychiatric observation.

- Any changes to observation levels (both increases and decreases) must be handed over to the medical staff involved in the patients care at the earliest opportunity and all decision making assessments must be clearly documented in the patients' record.
- Whilst the reviews are continual, there should be a maximum review time of 24hrs whereby it is formally reviewed. This is because the observation may be infringing privacy, dignity etc. and it needs to be kept under review to ensure it continues to be proportionate.

3.5 Detained patients on increased Psychiatric Observations

3.5.1 At times, it will be clinically necessary to place detained patients on increased levels of psychiatric observations (Levels 3 or 4) in order to meet their needs and manage their risks. In these instances, patients should have their levels of observation reviewed each shift by the nurse in charge of the ward and in consultation with the medical team wherever possible. When reviewing the observation level, staff must take into account the current level of risk the person is presenting with, any incidents of challenging behaviour since the previous review of observation level, the effectiveness of the current treatment care plan and the patient's wishes. A patient's wishes, feelings and views should always be considered; other factors may outweigh what they wish for, but they should always be considered. Any infringement of privacy, dignity or distress caused by observations must be minimised, ensuring the observations remain proportionate. This review and consequent decision making to either continue to change the observation level must be recorded in the patient's record and risk assessment.

All patients being managed in seclusion will be on Level 3 observations or above. Further information can be found in CLS11 "Seclusion and Long-Term Segregation Policy"

3.6 Informal Patients on increased Psychiatric Observations

3.6.1 At times, it will be clinically necessary to place an informal patient on increased levels of psychiatric observations (Levels 3 or 4) in order to meet their needs and manage their risks. In these instances, staff must consider if this leads to the person being deprived of their liberty. In order to prevent this, the staff team must consider:

- If the patient has capacity and consents to the restrictions they will not be deprived of their liberty.
- If the patient lacks capacity to consent to the observations then the MDT must consider the effect and duration of the observations, alongside the other type of restrictions on the person. If the cumulative effects amount to a deprivation of liberty, then steps must be taken to reduce the restriction so they do not deprive the person of their liberty or seek to authorise these under the Mental Health Act or deprivation of liberty safeguards.
- When considering these issues staff must be clear that compliance is not the same as consent, because a person who lacks capacity to consent cannot consent and that a person whom is objectively 'not free to leave' and under 'continuous supervision and control' and is not consenting to this, is deprived of their liberty.

3.6.2 On occasions where it is clinically necessary to place an informal patient on Level 3 or Level 4 psychiatric observations the MDT must:

- Provide a clear rationale and decision-making process of why alternatives were considered and dismissed to manage the patient's needs and risk and that this is clearly documented in the patient's record.

- Determine if the patient has capacity to consent. If they do not, determine if the person is deprived of their liberty. If the person has capacity to consent discuss the need to increase the level of observation to that of Level 3 or 4 with them to ascertain their views

- Consider the use of the Mental Health Act or applying Deprivation of Liberty Safeguards if the patient lacks capacity and is deprived of their liberty, or has capacity, but does not consent and the care cannot be managed in any other way..

3.7 Recording Process

3.7.1 Throughout the patient's stay on the inpatient unit, their observation levels have the potential to be changed to reflect changes in clinical presentation, needs or risks and any negative impact it may have on them ensuring the level of observation remains proportionate to their needs and risks. Therefore, it is vital to ensure that accurate and consistent documentation and recording procedures are adhered to.

3.7.2 The patient's observation level will be discussed during each MDT meeting, Care Planning Meeting or board review to ensure it remains appropriate and proportionate to meet the needs and manage the risks of the patient. This discussion and outcome will be recorded in the patient's record, with the care plan and risk assessment updated.

3.7.3 Inpatient staff undertaking psychiatric observations must do so using the existing Mental Health Psychiatric Observation Recording Sheets (see Appendices 2, 3 and 4).

3.8 Bank and Agency Staff

3.8.1 During times of increased clinical need and/or staff shortages caused by short-term sickness, all inpatient areas will use Bank or Agency staff to fill the gaps left by regular staff and/or provide extra resource for inpatient wards during times of increased need. It is vitally important that these staff receive a full handover of the needs and risks of the current inpatients prior to beginning their shift and, specifically, their roles and responsibilities for psychiatric observations.

3.8.2 All Bank or Agency staff who have not worked on the ward before must complete a ward induction, which will include an understanding of psychiatric observations. This initial induction should also include orientation to the ward layout, how to raise the alarm in an emergency, security considerations (e.g. doors that need to be locked), and the location of the fire exits.

3.8.3 The nurse in charge of the ward should ensure that the Bank or Agency member of staff is aware of when they are allocated to complete psychiatric observations as per the allocation

sheet, how to raise concerns in an appropriate fashion and the documentation requirements involved in completing observations.

3.8.4 If the Bank or Agency staff are required to undertake Level 2, 3 or 4 observations on an individual patient, then the Nurse in Charge must ensure they are fully aware of the associated risks with the particular patient and be able to satisfy themselves that the Bank or Agency staff is competent to undertake them as in 1.10.

4. ROLES & RESPONSIBILITIES

4.1 Staff

4.1.1 The Chief Executive has ultimate accountability for the strategic and operational management of the organisation, including ensuring all policies are adhered to.

4.1.2 Operational Directors (Adult Services, Substance Misuse Services and Adult Mental Health Services) have the responsibility of ensuring that this policy is cascaded to their Service Managers as appropriate for dissemination and implementation within their inpatient environments.

4.1.3 Operational Managers are responsible for the dissemination and implementation and monitoring of this policy in the areas that they are accountable for.

4.1.4 Modern Matrons/Lead Nurses are accountable for ensuring that this policy is adhered to and implemented by their staff teams. They are responsible for ensuring that staff receive appropriate training support and guidance on how to follow the guidance in this policy and will monitor for breaches of this policy and take action as appropriate to rectify this.

4.1.5 Inpatient staff are responsible for being aware of and following the guidance in this policy at all times. They should also raise potential clinical problems that may arise from this policy with their line manager to enable a review of its contents and suitability. They are also responsible for ensuring new starters to the team and NHS Professional, Bank and Agency staff are aware of this policy.

4.2 Committees / Groups

4.2.1 The Assurance Committee has the responsibility of policy ratification and will seek assurances from clinical services that it represents best practice and is based on current evidence. Ratified policies are then passed to the Trust Board for information only.

4.2.2 The Policy Steering Group Subcommittee will consider this policy following its presentation from the document manager to ensure that it complies with the format and content as stipulated in the Policy for the Development and Implementation of Procedural Documents (Solent NHST/Policy/GO/01) and agree to progress it to approval through the organisation.

5. TRAINING

5.1 Solent NHS Trust recognises the importance of appropriate training for staff. For training requirements and refresher frequencies in relation to this policy subject matter, please refer to the Training Needs Analysis (TNA) on the intranet.

5.2 Staff undertaking psychiatric observations must have their knowledge and competency assessed to ensure that they are safe to do so and that they demonstrate the following key principles:

- The purpose of psychiatric observations as a tool to maintain patient safety and promote engagement
- That they are competent in the assessment of signs of life in people whilst undertaking psychiatric observations
- The recording processes
- How to raise concerns whilst undertaking psychiatric observations, including reviewing timescales, understanding proportionality, human rights issues, how to identify and reduce the negative effects of observation, and protect dignity.

5.3 All Solent NHS Trust, Bank and Agency staff therefore must complete the local induction prior to undertaking psychiatric observations. This induction must cover both theoretical knowledge and an observation of the staff member undertaking a set of psychiatric observations, and must be documented.

5.4 Individual areas may develop local protocols to support staff competency and reflect any specific clinical needs within that area.

5.5 Although it does not directly cover psychiatric observations, the Trust's PMVA course will provide staff with a good understanding of the multiple risks patients may present with which staff can then apply to psychiatric observations.

6. EQUALITY IMPACT ASSESSMENT AND MENTAL CAPACITY

6.1 The Equality Impact Assessment and Mental Capacity Act Assessment identified that this policy is unlikely to lead to discrimination against any particular group and that it takes the situations of service users who lack capacity to make decisions into account. The Impact Assessment can be seen in Appendix 5.

7. SUCCESS CRITERIA / MONITORING EFFECTIVENESS

7.1 The success criteria for this policy would be that psychiatric observations are used -in the appropriate inpatient areas as an effective tool to maximise therapeutic engagement with patients and as a means of managing the risk factors a patient may present with in order to prevent them from harming either themselves or others.

7.2 In order to monitor the effectiveness of this policy in successfully achieving its aims, a number of auditing and benchmarking standards can be used by managers and matrons. This may include the following:

- Inclusion of this policy and guidance on its implications for clinical practice in all local induction packs for new staff/students/temporary staff
- Review of incidents that are raised via the online reporting system or via the SIRI (Serious Incident Requiring Investigation) process to enable trends to be identified and/or lessons learnt to improve practice
- Feedback and complaints from people who use the service

- On-going audit and spot checks relating to psychiatric observation practices on inpatient areas and reviews of documentation pertaining to psychiatric observation within the patients clinical record
- Discussions between individual staff with their line manager through the supervision format, and also reflective practice sessions.
- Consider and review the negative impact of observation and human rights issues on an individual.

7.3 Managers and Matrons have the option of choosing how often they will audit staff practice again this policy. This should be at yearly intervals as a minimum.

7.4 A guide to assist in the standards required within this policy would be as follows:

Standards	Expected Standard	Exceptions	Definitions & Instructions
All patients to be given information, on admission, about Observation	100%	Nil	Ask patients. Entries in patient record
Current risk assessment completed	100%	Nil	Completed risk assessment form
Decisions regarding levels of observation will be recorded in the patient record	100%	Nil	Entries in patient record
Observation Charts and records must contain correct individual client details	100%	Nil	Check all observation documentation
All clinical staff have undertaken appropriate Risk Assessment Training	100%	Nil	Check training records
Local induction packs make reference to Psychiatric Observations and their practice within the inpatient area	100%	Nil	Check Induction packs in all inpatient areas, specifically in regard to how decision-making is recorded, explaining the rationale for levels of observation. This will include consideration of protected characteristics such as age, gender, ethnicity, any distress and any invasion of privacy and dignity that may

			occur and how this is minimised. It should also consider patient consent, capacity and legal status.

7.5 Results from on-going audits and spot checks will be taken to staff team meetings and/or individual staff to raise awareness of good and bad practice that may be occurring. Issues relating to the implementation of this policy should be taken to the relevant Governance and Essential Standards meetings held by services so that these can be addressed accordingly.

7.6 All staff members working for Solent NHS Trust or within inpatient areas run by Solent NHS Trust are expected to comply with the contents of this policy at all times. In rare circumstances, if staff members are **unable** to comply with this policy it must be immediately reported to the Line Manager who must consider what remedial steps will be taken to manage this risk. The Non-Compliance Form (Appendix 6 within the Policy for the Development and Implementation of Procedural Documents (Solent NHST/Policy/GO/01)) must also be completed.

8. REVIEW

8.1 This document may be reviewed at any time at the request of either staff side or management, but will automatically be reviewed 3 years from initial approval and thereafter on a triennial basis unless organisational changes, legislation, guidance or non-compliance prompt an earlier review.

9. REFERENCES AND LINKS TO OTHER DOCUMENTS

9.1 REFERENCES

- Bouic, L. (2005) *Focus on psychiatric observation.* Mental Health Practice. May, Vol.8. No.8
- Bowers, L. & Park, A. (2001) *Special observations [SO] in the care of psychiatric inpatients: A literature review.* Issues in Mental Health Nursing, 22: 769-786
- Department of Constitutional Affairs (2005) Mental Capacity Act. HMSO. London
- Department of Health (2015) Code of Practice. UMSU, London
- Department of Health (1983) Mental Health Act. HMSO. London
- Jones, J., Lowe, T. & Ward, M. (2000) *Inpatients experiences of nursing observation on an acute psychiatric unit: a pilot study.* Mental Health Care. Vol.4. No.4
- NICE Guideline (2005, revised 2006) *Violence: The short term management of disturbed/violent behaviour in psychiatric in-patient settings and emergency departments.* NHS. London
- Pereira, S., O'Shaughnessy, M., Walker, L. & Reynolds, T. (2005) *Safe and supportive observation in practice: a clinical governance project.* Mental Health Practice. May, Vol.8, No.8
- Solent NHS Trust CLS11 Seclusion and Long-term Segregation Policy
- Solent NHS Trust HR53 Equality, Diversity, Inclusion and Human Rights Policy

9.2 **LINKS TO RELATED SOLENT NHS TRUST DOCUMENTS**

- Deprivation of Liberty Safeguards and Mental Capacity Act Policy
- Information Governance Policy
- Admission, Transfer and Discharge Policy
- Safeguarding Vulnerable Adults Policy
- Management of Violence Aggression and Abuse against Staff Policy
- Risk Management Strategy Policy

Appendices

Appendix 1
Explaining what 'Psychiatric Observation' is and why it happens

During your stay in hospital your safety is our priority. It can be difficult, especially in busy environments where there is a lot going on, to keep an eye on everyone. In order to make sure we can do this we have an 'Observation Policy' which gives very clear guidance to staff about how, when and why 'observation' needs to take place. Every mental health hospital has an Observation Policy, and all of these are based on national guidelines produced by government departments. This leaflet aims to explain 'observation' to you in a way that will help you to understand exactly what happens with this and why. If you want to discuss this further then do please ask a member of staff. A staff member of your gender will be made available to do this if you feel more comfortable with this.

There are 4 different levels of 'Observation' set out in the national guidelines;-

1 Level 1 ***General observation 60 minutes***.—this is the minimum requirement that we are expected to work to. This means that staff should always be aware of where you are even if you are not directly within sight at the time. Some contact should take place between a member of staff and each patient/service user at least once a shift. One reason for this is to make sure that staff are aware of how you are feeling and what is happening to you. Sometimes you will see members of staff walking around with clipboards possibly looking like they are ticking things off,--they may well be checking to make sure they know where everyone is.

2. Level 2 ***Intermittent observations.*** - this level is used if there is any cause for anxiety or concern about safety and may well be used with people who are on the way to recovery but may still be finding things difficult. The location of the patient/service user should be checked every 15-30 minutes although staff should try not to intrude but rather make this an opportunity to talk with you and find out how you are feeling.

3. Level 3 ***Within eyesight observation.*** – this is used where there is real concern that someone could harm themselves or others, and means the patient/service user should be within eyesight and accessible at all times, day and night. If staff have real concerns about safety then they may ask to search property or the individual, to make sure they do not have anything they could harm themselves or others with. It is important that staff try to make sure that contact and conversations are positive and supportive.

4. Level 4 ***Within arm's length observation***. – this is necessary when someone is considered to be a high risk in that it is felt that they are highly likely to harm themselves or others. The patient/service user will need to be supervised in close proximity, at all times. More than one staff member may have to be involved with this. Obviously it is important for staff to consider issues of privacy and dignity, but the priority is to keep everyone safe. Staff will attempt to maintain positive and supportive relationships with the patient/service user throughout this.
It is appreciated that being 'observed' can sometimes feel uncomfortable or intrusive but it is important that we fulfil this function properly in order to keep you safe. If you need to be on this level of close observation you may want to talk with the staff about what would help with this, such as would you prefer people to try to engage you in conversation or to leave you in peace? Or would you like people to try and involve you in other activities or not?

Appendix 2

Night Hourly Observations

Date……

Shift leader to confirm all staff are aware of the purpose of observations and how these are to be conducted.

Shift leader…… **Shift leader signature……**

Please document what you observed during this check. This should include any risk behaviours, Location, awake or asleep, and if asleep, what signs of life were determined during this check.											
Room	Patient Name	22:00	23:00	00:00	01:00	02:00	03:00	04:00	05:00	06:00	07:00
1											
2											
3											
4											
5											

6											
7											
8											
9											
10											
11											
12											
13											
14											
15											

16											
17											
18											
19											
20											
21											
22											
Print Name											

Appendix 3 **Daytime Hourly Observations**
Date……

Shift leader to confirm all staff are aware of the purpose of observations and how these are to be conducted.

Shift leader…… **Shift leader signature……**

Please document what you observed during this check. This should include any risk behaviours, Location, awake or asleep, and if asleep, what signs of life were determined during this check.								
Room Number	Patient Name							
1								
2								
3								
4								
5								
6								
7								
8								
9								
10								
11								

12								
13								
14								
15								
16								
17								
18								
19								
20								
21								
22								
Print Name								

Appendix 4

All areas of this form must be fully completed.

ADULT AND OLDER PERSONS MENTAL HEALTH

Psychiatric Observations – Levels 2, 3 and 4 – Within Eyesight and Within Arms Length

Patient Name:	Ward:
Hospital Number:	Date of Birth:
Legal Status:	
Observation Level:	Exact Intervals of Level 2 Observation:

Level 2 Intermittent Observation The observation record should be signed at the exact intervals when observations are carried out

Level 3 & 4 Observations The observation record should be completed and signed following each period of observation.

Does the patient understand what 'observation' is and why it is necessary?

Yes ☐ No ☐

If YES – How has this been explained to the patient?

Verbally: Date informed…….. By Who…… ……..

Given Leaflet: Date given…… By Who…….

Person specific instructions for the patient observations:

Reason for the level observations:

Risks the observer should be looking for:

For level 3 and 4 observations: Does the patient have bathroom privileges, or do they need to be observed at all times including in the bathroom?

Night time observation care plan agreement:

All areas of this form must be fully completed.

Shift: Shift Leader:

Date	Time	Risk Behaviour(s)/factors identified during observations	Signature/designation of member of staff carrying out observations

All areas of this form must be fully completed.

Shift: Shift Leader:

Date	Time	Risk Behaviour(s)/factors identified during observations	Signature/designation of member of staff carrying out observations

Appendix 5

Equality Impact Assessment

Step 1 – Scoping; identify the policies aims	Answer
1. What are the main aims and objectives of the document?	To ensure patient therapeutic engagement and to meet their needs and manage their risks through psychiatric observations.
2. Who will be affected by it?	All inpatients within Adult Mental Health, Older Persons Mental Health, Learning Disability, Neurological Rehabilitation and Substance Misuse Services
3. What are the existing performance indicators/measures for this? What are the outcomes you want to achieve?	The current policy is due for review in April 2014. This policy has proved fit for purpose so the outcomes of this review are to enable any developments within practice to be included in this policy to ensure that the highest and most up to date clinical standards are achieved across all relevant areas of the trust.
4. What information do you already have on the equality impact of this document?	No data is known other than the practice and level of psychiatric observation identified for patients is individual to their needs at any given time
5. Are there demographic changes or trends locally to be considered?	None
6. What other information do you need?	None

Step 2 - Assessing the Impact; consider the data and research	Yes	No	Answer (Evidence)
1. Could the document unlawfully against any group?		x	By having a policy that covers inpatient services and by furthermore ensuring the guidance and practice laid out within this policy is applied to all inpatients at all times, it ensures that no group could be unlawfully treated favourably or unfavourably compared to another
2. Can any group benefit or be excluded?		x	As per the answer above
3. Can any group be denied fair & equal access to or treatment as a result of this document?		x	As per the answer above
4. Can this actively promote good relations with and between different groups?	x		By ensuring that psychiatric observation levels are determined as per individual needs that takes into account individual wishes it can show parity between different groups

			and fairness to all
5. Have you carried out any consultation internally/externally with relevant individual groups?	x		All relevant staff have been consulted
6. Have you used a variety of different methods of consultation/involvement	x		A number of different Groups have been contacted.
Mental Capacity Act implications			
7. Will this document require a decision to be made by or about a service user? (Refer to the Mental Capacity Act document for further information)	x		MCA taken into account in the policy and supports the decision making identified within this policy to ensure patients needs are represented and met

If there is no negative impact – end the Impact Assessment here.

Step 3 - Recommendations and Action Plans	**Answer**
1. Is the impact low, medium or high?	Low
2. What action/modification needs to be taken to minimise or eliminate the negative impact?	Ensuring that this policy is followed at all times by inpatient staff will eliminate the potential for negative impacts being caused by psychiatric observations
3. Are there likely to be different outcomes with any modifications? Explain these?	Not applicable – unless a wider review occurs of psychiatric observations

Step 4- Implementation, Monitoring and Review	**Answer**
1. What are the implementation and monitoring arrangements, including timescales?	Once approved by the services involved the policy will then be passed to the Policy Steering Group Sub Committee for ratification. Once implemented upon the trust intranet, managers and matrons will be responsible in ensuring clinical practice matches this policy. The review period is as set out in the main text
2. Who within the Department/Team will be responsible for monitoring and regular review of the document?	Matrons and managers within inpatient services will be responsible for reviewing this document
Step 5 - Publishing the Results	**Answer**
1. How will the results of this assessment be published and where? (It is essential that there is documented evidence of why decisions were made).	Attached to this policy and published as such on the intranet