The Newcastle upon Tyne Hospitals NHS Foundation Trust

Enhanced Observation Policy: for patients with Mental Health Problems and Acute Behavioural Disturbances

<table>
<thead>
<tr>
<th>Version No.:</th>
<th>1.0</th>
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<tbody>
<tr>
<td>Effective From:</td>
<td>8 May 2014</td>
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<td>Ratified By:</td>
<td>Clinical Policies Group</td>
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1 Introduction

1.1 The Newcastle upon Tyne Hospitals NHS Foundation Trust (the Trust) has a duty of care to ensure the safety of patients in its care and takes all possible steps to do so. The purpose of this policy is to ensure that all in-patients level of observation within the Trust be allocated appropriate to their needs. There may be times during their admission when patients may pose a risk to themselves or others. A clinical risk assessment is the basis for determining levels of observation and applies to any patient including patients who may be detained under the Mental Health Act.

1.2 This policy provides a framework for all patients, either on admission or during admission, in accordance with their assessed level of risk and identified needs. All categories of observation set out in the policy must be adhered to fully. The staff member responsible for carrying out the observations must assure themselves at every observation interval that the patient (and other patients and staff) is safe and that all identified risks are minimised. Underlying physical causes should be sought and treated as in any other patient.

1.3 This policy is based upon recommendations from the National Institute for Health and Clinical Excellence (NICE) Guideline 25 (2005) and is intended to address the mental health needs of patients who are considered to be vulnerable or at risk of suicide, self harm or harm to others. The Trust is committed to providing a safe, sound and supportive environment to all patients, visitors and staff. It is recognised that patients may have changing clinical, behavioural and social needs and may require varying degrees of support (including observation) to be offered during these phases.

2 Scope

2.1 This policy sets out the process and procedures for guiding practitioners in making decisions to ensure a safe and therapeutic environment, to facilitate the assessment and management of in-patients level of observation and the rationale for supporting those decisions.
2.2 If an observational care plan is instigated because of concerns about possible psychiatric illness and/or risk of violence, self-harm or harm to others secondary to this, then the Mental Health team can be contacted for advice and/or intervention and the Patient Services Co-ordinator must be informed. Contact details are as follows;

- Liaison Psychiatry Team Tel 24842 (9am-5 pm Mon to Friday)
- On call Psychiatrist out of hours via St Nicholas Hospital switch board
- Patient Services Co-ordinator via Dect 24300 or 26623.

3 Categories of observations

3.1 NICE Guideline 25 (2005): ‘the short term management of disturbed/violent behaviour in psychiatric in-patient settings and emergency departments’ makes recommendations regarding terminology which includes the following to be adopted by the Trust;

3.1.1 **General Observation** (this is the routine level of observation afforded to every patient in the Trust).

3.1.2 **Within eyesight** means the patient should be kept within eyesight and accessible at all times, by day and by night and, if deemed necessary, any tools or instruments that could be used to harm themselves or others should be removed. It is required when the patient could, at any time, make an attempt to harm themselves or others. It may be necessary to search the patient and their belongings, while having due regard for the patient’s legal rights and conducting the search in a sensitive way. Positive engagement with the patient is an essential aspect of this level of observation.

3.1.3 **Within arms length** is needed for patients at the highest levels of risk of harming themselves or others, who should be supervised in close proximity. On specified occasions more than one member of staff may be necessary. Issues of privacy, dignity and the consideration of gender in allocating staff, and the environmental dangers need to be discussed and incorporated into the care plan. Positive engagement with the patient is an essential aspect of this level of observation.

3.1.4 Both of the levels of observation described in 3.1.1 and 3.1.2 should be considered to mean that patients are within sight of staff at all times, ‘arms length’ observation means that the patient must be within reach at all times. Where curtains are required for privacy, this must not prevent staff from being able to see the patient.

In line with NICE Guidance 25 (2005), observation above a general level should be considered if any of the following are present:
- History of previous suicide attempts, self-harm or attacks on others (if known)
- Hallucinations, particularly voices suggesting harm to self or others
- Paranoid ideas where the patient believes that other people pose a threat
- Thoughts or ideas that the patient has about harming themselves or others
- Self-control is reduced.
- Past or current problems with drugs or alcohol (if known)
- Recent bereavement.

The attached care plan (appendix 1) incorporates a checklist which will aid the decision making process.

3.2 Within eyesight observation

This level will be prescribed for patients who could, at any time, make an attempt to harm themselves or others and thus need to be kept within eyesight and accessible by a staff member. Staff must ensure they do not place themselves at risk of violence and aggression and a safe distance should be maintained at all times.

- A specific observation care plan is required (appendix 1). Issues of privacy, dignity and the consideration of gender in allocating staff, and environmental risks need to be discussed and incorporated into the care plan on an individual case by case basis including toileting and personal care. The staff member responsible for carrying out the prescribed observations over the period must document a brief summary of the patient behaviour.

- Careful consideration should be given to patients with Learning Disability. Previous research has shown that when suffering physical pain and distress some patients with LD present with difficult behaviour which can be misinterpreted as mental illness. Always listen to the patient and family or carers. Contact the Learning Disability Liaison Nurse if you are working with a patient who is under a higher level of observation.

- Providing communication support for those who need it will be critical in assessing and understanding the behaviour of patients who need communication support. This may involve professional Spoken Language
Interpreters, British Sign Language Interpreters, Deaf Blind Guides, Learning Disability Advocates or a relative/partner who is familiar with the patient’s communication – such as stroke and ‘neck breathing’ patients.

3.3 Within arms length observation

This level will be prescribed for patients at the highest levels of risk of harming themselves or others, who should be supervised in close proximity. On specified occasions more than one member of staff may be necessary.

In addition to the considerations outlined in 3.2 above, the following must be implemented.

- A member of staff will provide a minimum of one to one intervention throughout the whole period of prescribed ‘within arm’s length observation’. On some occasions more than one member of staff may be necessary to carry out this level of observation. The care plan (appendix 1) will stipulate the number of staff required.

4 Aims

The primary aim of observation is to engage positively with the patient; observation should be seen as an integral part of a therapeutic care plan. The purpose of observation is to ensure the safe and sensitive monitoring of the patients behaviour and mental well-being, enabling a rapid response to change, whilst at the same time fostering therapeutic relationships between staff and patient. Patients who are on higher levels of observation may feel restricted and may need highly sensitive specific and sophisticated forms of care.

5 Duties, Roles and responsibilities:

5.1 The Chief Executive is responsible for:

Ensuring that appropriate and adequate infrastructure exists to support the observation and engagement of patients.

5.2 The Directors, Clinical Directors and Directorate Managers are responsible for:

The strategic and operational management of the observation and engagement of patients within the Trust.

5.3 Head of Department/Managers, Matrons, Sisters and Charge Nurses have a responsibility to:

- Ensure that all staff are made aware of policies and receive appropriate training in their application
• Ensure that policies are implemented and evaluated appropriately
• Ensure that periods of observation are viewed as opportunities for therapeutic engagement and relationship building
• Identify/manage and deploy resources to meet service requirement.

5.4 Registered staff have a responsibility to:

• Ensure that if an observational care plan is instigated because of concerns about a patient’s possible psychiatric illness and/or risk of violence, self-harm or harm to others secondary to this condition then the Mental Health team can be contacted for advice and/or intervention and the Patient Services Co-ordinator must be informed
• Provide communication support if this is required
• Complete observation care plan for their named patient
• Inform each patient of the level of observation they have been assessed to require and the reasons for this
• Provide support and where appropriate information to relatives/carers present
• Ensure that the observation care plan is implemented
• Ensure that periods of observation are viewed as opportunities for therapeutic engagement and relationship building
• Review the care plan on a regular basis, usually in discussion with the Mental Health Team
• Complete documentation as specified.

5.5 Non-professionally registered staff have a responsibility to:

• Ensure that periods of observation are viewed as opportunities for therapeutic engagement and relationship building
• Be familiar with and implement the observation care plan for each individual in their care
• Complete documentation contemporaneously as specified
• Report any relevant information to assist the effective review of patients level of observation.

6 General Principles

6.1 Observation is an intervention that is used both for the short-term management of disturbed/violent behaviour and to prevent self-harm (NICE Guideline 25 2005). The key to all levels of observation is safety and protection from harm and maintenance of well-being. Within the Trust, this policy should be utilised across all clinical settings to support the delivery of effective patient care.

6.2 Levels of observation should be discussed and/or negotiated with the patient and (whilst taking into consideration patient confidentiality and capacity issues) their family/partner/carer wherever possible. Staff must clearly explain the reasons for
the level of observation. This will be based on a sound ongoing risk assessment, which is reactive to dynamic risk factors.

6.3 Levels of observation should be based on patient need not driven by financial constraints.

6.4 Consideration should be given to ensuring a safe environment for patients and staff.

6.5 Intensive engagement and observation of patient may be seen as intrusive, particularly where it is prolonged for many hours. It is important therefore that staff balance the potentially distressing effect against the risk of harm and justify its use by continually assessing the effectiveness of observation in minimising the risk of harm.

6.6 The least intrusive level of observation that is appropriate to the situation should always be adopted so that due sensitivity is given to a patient's dignity and privacy whilst maintaining the safety of the patient and/or those around them.

6.7 It may be necessary to search the patient and their belongings, while having due regard for patient legal rights and conducting the search in a sensitive way in order to remove tools or instruments that could be used to harm themselves. A chaperone should be present during any search.

7 Who should set the levels of observation?

The prescribing of observation levels should, wherever possible, be the result of a joint medical/nursing assessment, though nursing staff may need to initiate a level of observation above general level on admission or following a rapid change in the patient circumstances before discussion with medical staff can take place.

8 When should observation levels be set?

8.1 If at any time during or following admission a patient is considered to be at risk either to themselves or others an assessment should be made regarding enhanced levels of observations.

8.2 Consideration should be given to periods of identified increased risk such as evenings and night; nursing handover periods; following a reduction in the levels of observation; improvement in mood etc. and document how specified actions can be taken.

9 Informing the patient

Every effort should be made to inform and explain the level and procedure of observations and any restrictions.
10 Record Keeping

10.1 The observation levels prescribed must be recorded into the patient record. An individualised observation record and plan of care should also be drawn up with the involvement of the patient where appropriate.

10.2 The plan of care should include:

- Level of observation and exact intervals at which the observation should be carried out
- The reason for observation and any specific times or environments as outlined in this policy
- Identification of risks
- Stipulations of what the observing nurses are required to do and frequency thereof, in order to support the patient.
- Any changes to the level of observation should be amended on the plan of care.

10.3 The level of observation, including the risk behaviours and factors identified should also be recorded and signed. Records of observation should always accurately reflect prescribed levels of observation.

10.4 Participating staff will make a brief summary of the patient's behaviour and mental state in accordance with the plan of care.

11 Who should carry out observation?

It is the responsibility of the nurse-in-charge to ensure that observations are carried out according to the agreed level. The staff member responsible for carrying out within arm’s length or eyesight observation will usually:

- Be a registered nurse, nursing healthcare assistant with appropriate training or on rare occasions a member of the hospital security staff
- The patient’s views and needs should be taken into account when allocating staff to undertake observations
- The multidisciplinary team (MDT) will review levels of observations and plan for occasions when non-registered staff are expected to be responsible to carry out observations.
12 Carrying out observation

12.1 Observation usually involves a number of nurses, with care being handed over at intervals. Excellent communication amongst staff must be maintained.

- At the beginning of each shift, the nurse-in-charge shall inform and ensure that all members of the ward team, who are involved in observations with a patient, understand the procedure, in terms of who is being observed at what level, and why.

- Before taking over the patient’s observation, each nurse will have familiarised themselves with the patient plan of care, current risks and individual needs.

The member of staff undertaking observation:

- Should take an active role in engaging positively with the patient.

- Should be appropriately briefed about the patient’s history, background, specific risk factors and particular needs.

- Should be familiar with the ward, the ward policy for emergency procedures and potential risk in the environment.

- Should be approachable, listen to the patient, know when self-disclosure and the therapeutic use of silence are appropriate and be able to convey to the patient that they are valued.

12.2 If the nominated staff member cannot continue the observation for any reason, he/she will be responsible for notifying the nurse-in-charge, whilst ensuring that observations are maintained by another member of staff (e.g. staff toilet and/or meal breaks).

12.3 When observing patients staff should be assessing changes in the patient hourly or at any significant change in behaviour or incident:

- General behaviour
- Movement
- Posture
- Speech
- Expression of unusual ideas
- Appearance
- Orientation
- Mood and attitude
- Interaction with others
- Reaction to medication
12.4 The purpose is not just visual observation but also about listening and assessing behaviours and reactions and passing this information to other members of the multi-disciplinary team to ensure a dynamic process.

12.5 Staff should also be aware of the other team members’ current duties/locations and how to gain rapid access for assistance if required.

12.6 All staff should be aware that the person carrying out the observations should offer therapeutic engagement and interventions. Staff should also aim to empower the patient and not restrict their movement unnecessarily.

13 Reviewing levels of enhanced observation

13.1 Throughout a patients stay, the level of risk will be reviewed, usually in discussion with the Mental Health Team.

13.2 Where a patient is subject to an enhanced level of observation above general, the continued need for this should be reviewed at a minimum of every 24 hours by the MDT.

13.4 Any decision to increase levels of observation should be made by the MDT wherever possible, however, where necessary qualified nursing staff have the authority (and professional duty) to increase the level of observations in response to urgent changes in need, state, or condition. The increase in the level of observation should be communicated to the patient and will usually be discussed with the Mental Health Team and Patient Services Co-Ordinators as soon as practicable or necessary by the nurse in charge.

13.6 Whenever the level of observation has been reviewed a rationale should be recorded in the patient’s notes.

14 Training

Initial training will be provided by colleagues from Northumberland Tyne and Wear Mental Health Trust. This will be delivered to large volumes of staff including Registered Nurses, Nursing Healthcare Assistants and Portering and Security staff. Thereafter, education will be supported by Clinical Educators within the Trust and provided for new staff where appropriate during local induction.

15 Equality and diversity

The Trust is committed to ensuring that, as far as is reasonably practicable, the way we provide services to the public and the way we treat our staff reflects their individual
needs and does not discriminate against individuals or groups on any grounds. This document has been appropriately assessed with the Equality and Diversity lead.

16 Monitoring compliance with the policy

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<tr>
<th>Standard/process /issue</th>
<th>Monitoring and audit</th>
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<tr>
<td></td>
<td>Method</td>
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<tr>
<td>1 Documentation of patients who have been under enhanced observation will be completed per policy.</td>
<td>Audit of the medical record</td>
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<tr>
<td>2 Staff will receive appropriate education.</td>
<td>Training records will be maintained of attendance at education sessions</td>
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<tr>
<td>3 Patients and their Carers will be involved in decisions about the level of observation implemented</td>
<td>Audit of the medical record</td>
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17 Consultation and review

This policy was developed in consultation with colleagues from Northumberland, Tyne and Wear NHS Foundation Trust, senior medical and nursing colleagues within the Trust and the Safeguarding Team.

18 Implementation

This policy will be placed on the intranet and listed as ‘NEW’. It will be circulated to Directorate Managers and Matrons to be disseminated to all staff.

When the policy is published, briefing and education sessions will be provided for clinical staff to raise awareness of the policy and staff responsibilities. Ongoing education will be provided if assessed as necessary.

19 References

20  Associated Trust Policies

- **Clinical Handover Policy** (2013)
- **Clinical Record Keeping Policy** (2012)
- **Clinical Records Management Policy** (2013)
- **Induction Policy** (2013)
- **Missing Adult Patients Procedure** (2011)
- **Policy on Restraint (Adults)** (2012)
Factors to be considered when undertaking an initial assessment of a person with a suspected mental health problem, please ensure that where required, appropriate communication support e.g. interpreter, is provided:

1. If you answer yes to any of these questions please consider whether Enhanced Observation is required
   - A physical cause for the problem(s) has been ruled out? (May still require Enhanced Observation)
   - Drug and/or alcohol intoxication has been ruled out as a cause? (May still require Enhanced Observation)
   - Is the patient known to have a history of previous suicide attempts, self-harm or violence/aggression?
   - Does the patient have hallucinations, particularly voices suggesting harm to self or others?
   - Does the patient have paranoid ideas where they believe that other people pose a threat
   - Thoughts or ideas that the patient has about harming themselves or others.
   - Does the patient have an altered state of consciousness that may cause them to be a risk to self or others
   - Past or current problems with drugs or alcohol (if known).
   - Any significant recent life event (such as bereavement) that may cause them to be a risk to self

If yes to any of the above, record summary below:

2. Issues explored through brief questioning
   What recent event(s) precipitated or triggered this behaviour? Give details below:

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<tr>
<th>Care plan developed with</th>
<th>Patient</th>
<th>Family/Partner/Carer where appropriate</th>
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<td>Insert name</td>
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<tr>
<td>Staff Name &amp; Designation</td>
<td>Staff Signature</td>
<td>Date</td>
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Care needs factors to consider  | Intervention required |
Risk assessment above indicates there is a current risk to self or others.  | 1:1 enhanced observations with a nurse within arm’s length at all time |
Consider:  |  |
and carers where possible

• Allocation of a member of staff to undertake observations and ensure that they are familiar with specific risk factors and particular needs
• Psychiatrically trained staff required Y/N
• The need to maintain privacy and dignity (consider gender of nurse and patient)
• Remove items from the vicinity which could be used to cause harm to self or others, this may require a search of belongings in which case this should be conducted sensitively, with the patients knowledge and with regard to their legal rights.

Engagement in therapeutic positive relationship
• Adopt an active role and positive listening

Observe the following continuously whilst enhanced observation is in place this must be recorded at least hourly or if there is a change in presentation
• General behaviour.
• Movement.
• Posture.
• Speech.
• Expression of unusual ideas.
• Appearance.
• Orientation.
• Mood and attitude.
• Interaction with others.
• Reaction to medication.
• Level of consciousness.
• Cognitions/thoughts

This level of observation must be reviewed every 24 hours by the Multidisciplinary Team who should also agreed what needs to change for the observation level to be reduced e.g.
• Reduction in agitation/confusion.
• Reduction in verbal aggression to other staff/patients /visitors.

Actions to minimise identified risk factors and behaviours e.g.
• Ensure frequent orientation to environment.
• Ensure all interventions are clearly explained
• Consider use of other relevant care pathways e.g. Delirium Care Pathway
• Involve family/partner/carer
• Ask the patient if they would like to talk to a chaplaincy or minister of their religion
• Liaise with the LD Nurse if required

Advice and support available from:
1. Use of Mental Capacity Act.

2. Use of Mental Health Act

3. Further advice.
   Liaison Psychiatry Team Tel 24842 (9am-5 pm Mon to Friday.)
   On call Psychiatrist out of hours via St Nicholas Hospital switch board.
   Patient Services Co-ordinator via Dect 24300 or 26623