Norfolk and Suffolk
NHS Foundation Trust

Therapeutic Observations

"I didn't know why I was on them, I don't know how I get off them and nobody could tell me the reason, and I was like well how do I know what you're looking for and what I need to work towards" NSFT patient

"Some would interact with you and explain to you, go for a walk with you and I would be ok with somebody by my side" NSFT patient

"During the obs…it was that somebody made that connection with me" NSFT patient

"It was so intrusive, people hanging around while I go to the bathroom and stuff like that" NSFT patient

Therapeutic Observations	
Purpose:	To set out: • Standards and guidance on the management and practice of observations • A legal and best practice framework for the practice of observations • Requirements for staff training/education and assessment prior to carrying out observations
Introduction	A safe and therapeutic culture should be provided for all people receiving treatment for a mental disorder including those who may present with behavioural disturbance and staff should know the location of all patients for whom they are responsible (Code of Practice, 2015). However, there may be times when enhanced levels of observation are required for the short-term management of behavioural disturbance or during periods of distress to prevent suicide or serious self-harm. Enhanced observation should be a therapeutic intervention with the aim of reducing the factors which contribute to increased risk and promoting recovery.
Approved By & Date:	Quality Committee – July 2020
For Use By (Area/Staff):	This is a Trust wide policy for inpatient areas and applies to all staff working in the Trust who have a responsibility for prescribing and/or undertaking therapeutic observations (including temporary, permanent, bank and agency staff). **This excludes Mother & Baby Unit staff.**
Reference No:	**C36**
Version:	12.2
Published Date:	April 2021
Review Date:	July 2022
Equality Assessment:	July 2020

Key messages to underpin and guide good clinical practice

ENGAGE, COMMUNICATE, INVOLVE, RECORD

- Observations are a therapeutic intervention aimed at reducing factors which contribute to increased risk and promoting recovery. The use of enhanced observation levels should never be regarded as routine practice but must be based on assessed and current needs

- Observation practice must focus on engaging the person therapeutically and enabling them to address their difficulties constructively. Our interactions must seek to create rapport which allows those in our care to feel valued and safe to share their experiences with us.

- Therapeutic observations must be recognised as a restrictive practice and may be seen by patients as punitive, intrusive or coercive. It should therefore only be implemented after positive engagement with the patient has been unable to reduce the risk to self or others and for the least amount of time clinically required

- The least intrusive level of observation which is appropriate to the situation should always be adopted so due sensitivity is given to the patient's dignity and privacy whilst maintain the safety of the patient and those around them.

- Patient focussed and clinically accurate documentation of **assessment**, **observation practice** and **review** are essential to provide safe and effective therapeutic observation. It should be a central part of the care plan, to ensure the safe and sensitive monitoring of the patient's behaviour and mental well-being, enabling a rapid response to change, whilst at the same time fostering therapeutic relationships between staff and patient

- Good practice in clinical decision making about enhanced observations will incorporate the views of the multi-disciplinary team, patients and carers. The care plan must detail where it is appropriate and safe for a clinical decision to be made by the PIC and registered practitioners about level of observations where delay would lead to increased risk or disproportionate restrictive practice.

- We must communicate with and involve patients in decision making and care planning and where appropriate their carers throughout their inpatient journey. This starts at admission explaining the level of observations they are being nursed on, the purpose and review procedures. We must regularly revisit this with those in our care to assess understanding and ascertain the views and experiences of patients.

- Any request made by the patient, their carer or relative, about increasing or decreasing the level of observation must be considered in line with current assessment of risk

Therapeutic Observations Process Summary

Therapeutic Observations (T.Obs) should only be implemented after positive engagement with the patient has been unable to reduce the risk to self or others and for the least amount of time clinically required. See policy for management of detained & informal patients

Process	Clinical Practice	Quick ref Policy
Patient's presentation raises concern: clinical decision to start T.Obs	Decision based on MDT discussion/assessment or PIC	See policy sections 4.1
Record continuation note & update risk assessment	Documentation to include: reason for obs, level, decision maker, circumstances for variation and review	See policy sections 4.1
Page 1 of T.Obs form completed in full & Care plan updated to reflect risk management plan	Involve and communicate with patients about their observation plan where appropriate involve carers. PIC is responsible to complete or delegate to registered practitioner.	See policy section: 4.2
PIC delegates T.Obs for shift	PIC responsibility to ensure staff have completed competency & staff have up to date understanding of pt needs and risks. Registered staff should be part of rota where possible	See policy section: 3 & 4.4
Delegated staff carry out T.obs Completing observation record on page 2 and continuation sheets	Clinical staff are responsible for observing and recording pertinent clinical information about the patient in keeping with the observation care plan. Staff must record sleeping position and breathing obs.	See policy section: 4.4
Shift handover: PIC in person check of all patients & review & Sign T.Obs records	The PICs will assess current clinical presentation of patients on T.Obs and review T.obs record giving consider the need for review in response to changes in risk and giving consideration to restrictive practice.	See policy section: 3 & 4.4
New page 1 and page 2 initiated daily at midnight Used forms are uploaded using Mental Health doc. type	The PIC must ensure a new set of T.Obs forms are started at midnight. (The forms can be prepared in advance of night shift)	See policy section: 5
Formal review at least daily with MDT record in clinical notes and update C/Plan, RA & SBAR where appropriate	Where T.Obs are continuing over the weekend, the MDT must make a clear plan detailing circumstances where observations can be reduced and who can make this decision..	See policy section: 4.3 & Appendix 1

See Appendix 1:Reviewing Observations Flow Chart for assistance with decision making

Contents

1. Introduction and aims

At times of distress or pronounced ill-health some patients may become a serious risk of harm to themselves or others. Therapeutic observations may be required for management of behavioural disturbance or during periods of distress to prevent harm to self or others.

Therapeutic observation is one of a range of interventions which may contribute to maintaining safety and recovery journey. However, patient's observation and associated practices are potentially highly restrictive. Therefore, the MDT need to balance the need for positive risk taking using the least restrictive practice verses enhanced observation

The primary aim of therapeutic observations should be to engage positively with the patient to reduce risk and prevent harm. This involves a two-way relationship, established between the patient and the member of staff, which is meaningful, grounded in trust and therapeutic for the patient (NMC 2008).
The purpose of this policy is to ensure that levels of inpatient therapeutic observation are allocated appropriate to the individual's mental and physical health needs. The clinical risk assessment is the basis for determining levels of observations,
This policy will guide:

- When an increased level of observations might be used
- Which staff are best placed to carry out observations
- Responsibilities for ensuring observations are used for the least amount of time clinically required
- Meeting individualised needs of patients
- Engaging with patients where enhanced observations are required
- The process to be followed for assessing the level of risk for each patient, agreeing the appropriate level of observation, review and clinically informative record keeping

This policy has been developed from the Mental Health Nurse Leaders & Directors Forum, National Policy Template for Supportive Observation & Engagement, and NSFT workshops, and supports compliance with MHA Code of Practice (2015) and NICE guidance on Violence & Aggression (2015)

Following this policy, staff will make reasonable adjustments for any communications barriers, disability or other protected characteristic. Assessment and planning should be carried out in partnership with patients and carer where appropriate, be holistic and have regard to the requirement of the Equality Act (2010), including the person's cultural heritage, relationships, disabilities, age, gender and sexual orientation. With regards to transgender patients, unless there is a risk that outweighs their right to choose, the patient should be able to decide which gender the person who escorts them to the toilet is.

2. Definitions

General Observation
This is the minimum level of observation for all patients in inpatient areas. Staff should know the location of all patients in their area, but they need not be kept in sight. Patients subject to general observations will normally have been assessed as being a low risk to themselves or others. Their location and safety will be visibly checked at least once an hour (CCTV is not a substitute for this). • Staff to initial the relevant box on the General (Hourly) Observation Chart • When all patients have been accounted for, they should record the time (i.e. when the last person was seen) in the time completed box (RCA 503) • After completion the forms must be stored securely *(Note: SRRS have agreed variation to the above, these areas must ensure that the required level of observations/checks is formally approved locally and recorded in the areas Operational Policy)*
Intermittent Observation
The patient's location and safety must be visibly checked at specified intervals (CCTV is not a substitute for this). This is for patients who pose a potential, but not immediate risk. Staff should observe patients at irregular and unpredictable intervals, observing staff must take care that the expected number of observations per hour is completed and there is not excessive time between them. The specified frequency of observation must be recorded in the Care Plan and made clear to observing staff.
Continuous observations:
Within Eyesight Observation This observation is for patients assessed to be at the highest level of risk of harming themselves or others but who can be safely supervised within eyesight. As a rule, the patient must be kept within sight at all times, by day and by night, but in some circumstances, this can be negotiable to maximise a patient's dignity provided that safety is not compromised for example when using the toilet, bathing, showering etc. This can only be done following comprehensive clinical risk assessment and care planning with the agreement of the full multi-disciplinary team (MDT), patient and family/carer if appropriate.
Within Arm's Length Observation
This observation is for patients assessed to be at the highest level of risk of harming themselves or others, who need to be supervised at close proximity. Issues of privacy, dignity and consideration of gender in allocating staff need to be discussed and incorporated into the care plan. Observation will be maintained when using lavatory or bathroom facilities. On rare occasions more than one nurse may be necessary in which case the care plan must make clear the number of staff and the distance each is expected to maintain.

3. Duties

Chief Nurse; Is accountable to the Trust Board for the development, consultation, implementation and monitoring of compliance with this Policy, which promotes therapeutic observations, engagement of patients and safeguards against unnecessary use of restrictive practice.

Lead Nurses; have operational responsibility for each services compliance with this policy and will ensure mechanisms in place within each service for:

- Identifying and deploying resources to safely deliver this policy
- Ensuring all clinical staff with responsibility for prescribing and carrying out observation/engagement receive orientation to the content of this policy
- Monitoring compliance and consistent application of the policy

Responsible Clinician; has a legal and professional responsibility for the care and treatment of patients. As part of that responsibility they must have a thorough knowledge of the patients in their care, contribute to patients' care plans including observational level and circumstances where this can be varied. They will provide advice when uncertainty arises regarding level of observation required.

Modern Matrons;

- Are accountable to the Lead Nurse for providing assurance that their respective wards are compliant with the requirements of the policy.

Ward Managers; have overall accountability for the management of their ward and must ensure:

- Registered practitioners understand their role in initiating and reviewing therapeutic observations, and maintaining quality controls (ensuring quality of observations during shift and handover procedures)
- All staff undertaking observations understand the importance of therapeutic engagement and patient/carer involvement in observations.
- Care plans are in place and appropriately identify the required level of observation
- Documented risk review accompanies the decisions made to change the levels of observation.
- With the matron ensuring all ward staff undertake full competency assessment and this is reviewed and recorded in-keeping with policy requirements.
- Identification, responding and where necessary escalating any areas of noncompliance with this policy on their wards

Person in Charge (PIC); is responsible for

- Ensuring the shift staff are always aware of the patient's observation levels on the ward and there are adequate staffing levels to ensure safe and effective care and communicating any deficits to the ward manager, deputy or matron.
- Ensuring those undertaking observational duties have appropriate understanding of the observation care plan for each patient to enable them to carry out observations safely and effectively.
- Delegating staff to carry out therapeutic observational roles who have been assessed to be competent to do so.
- Following clinical decision-making process for PIC and/or Registered Practitioners in regard to initiating and reviewing observation levels.
- Checking observations are undertaken in line with the prescribed observation level, ensuring the appropriate documentation is completed and in accordance with the agreed care plan.
- Observation levels must be discussed during ward handover to ensure continuity of care.

- At shift handover the PIC of both the outgoing and incoming shift are responsible to review and sign the observation record ensure documentation is completed and physically see the patients.

Multidisciplinary Team; will together

- Ensure effective communication which enables responsive and informed clinical decision making about the use of therapeutic observations.
- Ensure levels of observation and risk are regularly reviewed by the multidisciplinary team and a record made of decisions agreed in relation to increasing or decreasing the observation.

Delivering interventions to patients requiring constant observations should not be restricted to members of the unregistered nursing team. All members of the multidisciplinary team, both registered and unregistered staff should engage in targeted interventions intended to aid the patient's recovery.

There is an expectation Registered Practitioners will undertake some observational duties during the course of their shift.

All clinical staff have a responsibility to:

- Understand their role in initiating, carrying out and reviewing therapeutic observations
- Carry out that role in line with the policy
- Inform each patient of the level of observation they are subject to and the reasons for this
- Review the level of observation based on recorded clinical need and risks
- Ensure the care plan is implemented
- Ensure that observations are viewed and used as opportunities to build a therapeutic relationship

4. Complete all the required documentation. Process

4.1 Starting Observations and risk assessment

Risk assessment

The decision to introduce or increase the frequency of observations must be based on the patient's risk assessment informed by the Clinical Policy C82 clinical risk assessment and management.

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

Risk assessment should consider factors such as (this list is not exhaustive):

• Known risk factors (past and present)

• Previous suicide attempts, self-harm or attacks on others

• Recent attempts to harm self or others (including attempted attempting suicide)

• Expression of thoughts about harming self or others (including suicide)

• History/threat of absconding – including risks/concerns

• Command hallucinations to harm self or others

• Paranoid ides (e.g. the service user believes that others pose a threat to them and may react in perceived self-defence)

• Impulsivity/agitation

• Marked changes in behaviour (e.g. someone who has presented as highly agitated quite suddenly becoming calm – or vice versa)

• Poor response to medication, significant medication changes, side-effects experienced effect on concordance

• Recent upsetting news or loss (of any kind)

• Current physical state and any deterioration in physical health and well-being (including falls see also C86 Slips, trips and falls)
• Concern regarding physical state due to alcohol withdrawal (can be life-threatening) and/or
• Illicit/novel psychoactive substance use
• Interactions between service users

Consideration should also be given to searching the service user and their room/property and removing any potentially harmful objects property (C35: Searching Environments and Service Users policy)

The decision to introduce or increase the frequency of observations may in the first instance be appropriately taken by the registered person in charge, when possible in conjunction with medical staff, and in response to an assessed risk. Wherever possible, decisions about the level of therapeutic observation required by an individual patient should be jointly made by the multidisciplinary team and the patient.

The risk assessment and rationale for all changes must be clearly documented in the patients care plan and clinical notes. Any decision to utilise an enhanced level of observation must always be fully documented in the patient's clinical records, the record should indicate that due consideration has been given to the patient's human rights. Such a consideration needs to be explicitly documented at all the subsequent review schedules described.

Therapeutic observations should be recognised as a restrictive practice and may be seen by patients as intrusive or coercive and can cause negative feelings and reactions. It should therefore only be implemented after positive engagement with the patient has failed to reduce the risk to self or others and only used for the least amount of time clinically required.

Status of Patient

Within NSFT, patients are either (a) informal consenting patients with capacity (b) detained under the MHA or (3) fully compliant patients who lack capacity and are subject to DoLS.

Where a patient is an informal patient, all forms of treatment (including observations) may only be delivered with their consent. For detained patients, observations can be delivered under the authority of the MHA. For patients subject to DoLS, observations are completed under the authority of the DoLS and in the patient's best interest. If an informal patient or a patient under DoLS refuses or declines observations that the clinical team feel are necessary, consideration should be given as to whether their continued admission can continue as a consenting informal patient or as a compliant patient under the DoLs regime. Please refer to 'Consent to Treatment C71' and 'Mental Capacity Act C07' policies.

Detained Patients

If a patient is subjected to enhanced observations and is confined to a particular area and is being prevented from having contact with anyone outside the area in which they are confined, then this will amount to either seclusion or long-term segregation and the Trust's Seclusion policy must be followed.

4.2 Care Planning

Care plans that are developed together with the patient, and where appropriate carers, are central to providing compassionate and responsive care at a potentially distressing time.

Decision making in respect of the authority to change levels of observations should be described within the care plan, so that responsibilities for managing risk are well understood. Decision making can therefore be appropriately delegated to the nurse in charge of a ward or area. The risk assessment and rationale for all changes must be clearly documented in the service user's care plan and clinical notes.

The Care plan should be viewed as a high intensity engagement plan, explaining what, when and why, and wherever possible considering patients/carer preferences. It should consider/include: -

- the reason(s) for commencing an enhanced level of supportive observation
- the level of observations and variation prescribed
- the goal(s) of observation
- It should also be specific in detailing what has been agreed by the MDT such as access to fresh air, number and designation of staff allocated, use of toilet/bathroom
- What should happen during times usually associated with privacy (use of toilet, bathing etc.)
- Any delegation of responsibility to change observation levels and under what circumstances
- Activities that have been collaboratively agreed and where necessary escort requirements to accommodate them
- Any items withheld from the patient with rationale

Consideration should be given to the possibility that a patient may require different levels of observation according to time of day, attending therapeutic activities, location on the ward or other factors

For consistency the care plan must be as clear and explicit as possible.

The care plan should be shared at each shift handover and be detailed on the SBAR handover tool.

Privacy and dignity

The privacy and dignity of patients must be considered and maximised and always addressed within the care plan. This must be balanced against the need to maintain safety. For example, person specific care plans for patients under continuous observations should specify whether the patient can use the toilet or bathroom with or without the nurse physically going into the room. The care plan should be clear and explicit to reduce variation in approach from different members of the team.

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

Where a patient is required to be observed whilst involved in intimate personal care, the support must be provided by a practitioner of the same gender unless there is a specific clinical risk.

Therapeutic Observations at night and care of the sleeping patient

Therapeutic observations of patients do not stop at night. There is a duty of care to ensure patients are safe and not in distress either physically or emotionally. It is recognised that patients expect a greater level of privacy after going to bed.

Observations undertaken at night need to include an assessment of an individual's wellbeing with any area of concern or doubt being explored. Consideration must be given to issues/events e.g. recent use of leave, medication changes and/or known risk behaviours.

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. Staff undertaking observation duties of a sleeping patient must record sleeping position using the key provide on observation forms and observation of breathing.

If the member of staff has not observed the patient move for 2 hours or cannot observe the patient breathing, they must ensure the patient is safe by:

Increasing lighting
• Getting close enough to observe breathing (consideration of type and changes of breathing)
• Checking for a pulse
• Rousing the patient

This will require entering bedrooms to ensure that patients are safe and not in emotional distress – and checking that they are not experiencing, or have not experienced, any physical distress, loss of vital signs or collapse.

NG10: Violence and Aggression: short-term management in mental health, health and community settings. National Institute for Health and Care Excellence (2015) does not make any recommendations regarding reduced frequency of additional observations at night. The frequency and extent of monitoring at night must be based on the MDT's assessment of the patients risks and individual needs. If there is deviation from NICE recommendations the MDT are expected to provide a rationale within MDT notes/care plan and ensure governance processes are in place to ensure patients are not at increased risk.

Therapeutic observations in off ward areas

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

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

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

4.3 Reviewing level of observations **(See Appendix 1 for decision tree)**

Observation status must be reviewed a minimum of daily for any patient being nursed above general observation level. MDT meetings/ward rounds should always consider the current plan for any patient on above general level.

The MDT should always plan ahead and ensure that the plan of care for each patient outlines the conditions and observed behaviours that would facilitate a prompt reduction in observation levels.

Therapeutic observations are potentially a restrictive intervention and should be implemented as an exception and at the least intrusive level required to manage the risk. Wherever possible the decision to change levels of observations will be made by the MDT (including staff who know the service user), the service user and their family/carer (as appropriate).

Based on assessment of the **immediate risk**, registered staff may decide to change the level of therapeutic observations prior to consulting with the MDT but there must be consultation with the MDT at the earliest opportunity Staff should offer the service user and their family/carer information about why they are under observation, the aims, how long it is likely to last and what needs to be achieved for it to stop (NICE, 2015).

Consider involving other clinicians from outside the usual MDT when the need for additional observations continues more than 7 days

Changes in levels of Observations (Variation)

Consideration should be given to the possibility that a service user may require different levels of observation according to factors such as:

- Time of day
- Activity engaged in
- Service user request for increased observation (they should be encouraged to report any need for increased observation (e.g. auditory hallucinations/desire to self-harm/abscond etc.)
- Receipt of information
- Proximity to court proceedings/Mental Health Review Tribunals etc.

Where the clinical team have agreed and care-planned a varied level of observation throughout a 24-hour period (e.g. 4 intermittent when in room, within eyesight in communal areas) this **would not** constitute a change in observation level but must be clearly documented in the care plan and on the observation form.

See section 'Therapeutic Observations at night and care of the sleeping patient' for guidance on variation of observation levels at night

Increasing Observations

Registered staff with delegated responsibility for a ward area have the authority to implement an increase in the level of observation in the first instance. Any such decision should be reviewed by the senior nurse or mental health professional on duty in the area at the earliest opportunity.

Decreasing Observations

Patients who are placed on therapeutic observations are people deemed to be at the highest risk. Therefore, reduction in the level of observation levels must follow a formal process to ensure that a team decision is made, which is based on a current mental health and risk assessment whilst considering the views of the patient and carers.

The decision to reduce the level of observations should normally be taken by registered nursing staff or mental health practitioner **in conjunction with the MDT**. However, delegation of authority to decrease level of observations can occur in the absence of the Responsible Clinician RC and MDT. Where the RC and MDT have identified the circumstances in which observation levels may be decreased 2 registered practitioners can implement this change. Delegated responsibility must be recorded in the service user record, including the care plan, it must clearly stipulate the specific circumstances for changes in observation level. (i.e. related to the needs, behavioural presentation and or mental state of the service user).

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

4.4 Conducting observations

Observing staff: Clinical staff are required to observe and record patients functioning, presentation and mental state - It is not considered acceptable to simply note the location of patients. When undertaking any level of observation, the staff tasked with undertaking observation, should, if the patient is awake, not otherwise occupied, or care planned otherwise, engage meaningfully with the patient. **See page 3 key messages to underpin and guide good practice**

Delivering enhanced levels of observation is a complex and at times difficult clinical intervention. The process of engagement and interactions, if appropriately adopted, should enable an accurate picture of a patient's well-being, mental health and potential risk to emerge.

For all patients on continuous observations an hourly summary of the patient's condition, risk behaviours, significant events and any therapeutic interventions must be recorded in the observations record. **See Section 5 for full recording requirements**

For those on intermittent observations, clinically relevant information from each observation must be recorded at the time of the observation in the observations record. Patients should be checked at irregular times but without excessive gaps between observations. For example a patient on x4 observations should not ordinarily be checked at 07:00, 07.15, 07.30, 07.45 but small variations so as there is some unpredictability to reduce risk.

Staff carrying out eyesight or arms-length therapeutic observations **must not**

- Sit in the corridor/area ignoring/not engaging with the service user as this is not therapeutic observation and should only be used in exceptional circumstances, not as a matter of course
- Carry out any activities that are not related to the care/management of the service user and/or that may distract from the observation process. This includes during the night when staff should monitor the service user's breathing

The member of staff ending a period of additional observations should give a verbal handover (being mindful of confidentiality) to the staff member assuming the responsibility. Wherever possible this should involve the service user and their family/carer (as appropriate).

Intermittent Observations	**Within Eyesight and Within Arm's Length Observations**
All staff rotate No more than 2 hours at a time At least 1 hour breaks in between	All staff rotate No more than 1 hour at a time (maximum 2 hours, NICE, 2015) At least 1 hour breaks in between

4.5 Patient and carer involvement

All decisions and reasons should be discussed with the patient and their family/carer (as appropriate). Any request made by the patient, their carer or relative, about increasing or decreasing the level of observation must be considered in line with current assessment of risk.

Patients and their family/carer (as appropriate) should be informed that observations will be reviewed daily and they will be involved wherever possible.

The levels of observation and the reason for their use must be explained to patients, and their carers or relatives where appropriate.

The MDT may consider allowing carers and relatives to undertake observation/engagement at specified times (some patients have identified a preference for having a family member present when bathing, instead of staff, however caution needs to be exercised that undue pressure is not placed on carers or relatives, if carers or relatives are used in this way a record should be made in the care plan and a member of staff must be available to respond immediately to requests for assistance)

Where a patient, and or their relative, have trouble in understanding the rationale and implications of therapeutic observation then this should be appropriately reiterated and clearly documented.

Interpreting services should be used if the patient in unable to speak and understand English. Consider the need for support from experienced colleagues, Easy Read information or other reasonable adjustments where there is a communication difficulty.

After a period of observations ensure the patient receives support and a debrief. Patients and carers should have the opportunity to share their experience and understand what happened, what helped and what didn't help.

5. Recording Requirements

Continuation notes: The patients record must clearly state how decisions about using or changing therapeutic observations were made, and the outcome of daily reviews for the continuing need for observations.

Care plan: There must be care plan, collaboratively agreed wherever possible, for all patients on an enhanced level of observations. The current level of observations must be clear and up to date.

Risk assessment: The risk assessment must underpin the all decisions to initiate, increase, decrease and stop therapeutic observations.

Observations record for enhanced observations:

There is a specific form for each level of observation and the correct form must be selected.

General Observation Form
Intermittent level observation form
Eyesight level observation form
Arms-length observation form
Continuation form (used for all levels of enhanced observation

- A new form must be started at midnight daily and reviewed and updated as is clinically required. Completed forms must be scanned into the patient's electronic patient record.

- **Page 1 and Page 2** must be completed in full with **clinically** relevant information to support the staff undertaking observational duties and to enable effective review.

- **Page 2 and continuation sheets** must be completed with clinically relevant information for each observation. The time must be recorded in 24-hour format, name, designation and signature of staff member must be clearly recorded.

Completed observation forms are a legal clinical record and must be uploaded to Lorenzo in a timely manner using the correct document type = Mental Health to ensure it is displayed in the correct place in the clinical chart.

General (Hourly) Observation Chart: Completed for all patients admitted to the ward

6. Skills and competence of staff

All staff regardless of band/grade **must** have successfully completed an assessment of competence in therapeutic observations (Appendix 2) prior to undertaking additional observations. This includes staff new to the Trust, new to the clinical area and NHS Professionals/agency/temporary staff. This competency assessment must be reviewed with the staff member every 2 years. The competency must be recorded as completed on the Health Roster.

Wherever possible the Clinical Team Leader and/or matron will carry out this assessment but where this is not possible a suitably experienced registered practitioner on duty may complete the competency assessment (e.g. a Band 6 Charge Nurse)

Where the assessment indicates that the staff member is **not** competent to carry out additional observations the Clinical Team Leader (or nominated deputy) and staff member should meet and agree a development plan, including timescale for completion and what duties the staff member may/may not undertake until their competence is reassessed (e.g. routine and intermittent observations only).

In **exceptional circumstances** where there is no-one **immediately** available who has completed the Competency Assessment and a service user requires additional observation the Practitioner-in-Charge should carry out a rapid assessment of competence (Appendix 3) . They should submit an incident report (Datix) recording their actions and the efforts made to obtain staff that have completed the full competency assessment. **The Clinical Team Leader should monitor use of this arrangement and escalate if the circumstances continue beyond 24 hours and/or becomes a frequent occurrence**.

The registered practitioner allocating observations has a responsibility to make sure the member of staff is considered competent and has been provided with adequate information on the patient, the ward environment, and the plan of care for the patient.

Students must not carry out observations at any level without the direct supervision of their mentor/day coach, see ‘Guidance for Mentors / Practice Educators and Healthcare Students’ for detail.

7. Review and Amendment Log

10	Early review	August 2015	RCA 503. Guidance on what to do if a service user cannot be located and time of completion of head count. Guidance on claiming when 3 or more staff are needed for additional observations. Changes to implementation, review and discontinuation decisions as requested by the Executive Team. Clarification from Director of Nursing added November 2015 (Section 9.0)
11	Early review	January 2016	RCA 252 and Regulation 28 December 2015. If the service user requires observation by more than 1 staff, the care plan must specify the number of staff and the level of observations each staff member is required to maintain
11.1	Limited review	February 2019	Limited review only to support Advanced Clinical Practitioners role in reviews of observation levels
12	Planned, extensive review	August 2019	Complete rewrite
12.1	Limited review	December 2020	Limited review to enhance guidance for variation of observations at night
12.2	Limited review	April 2021	Limited review to provide clarity for use of enhanced observations & patient's legal status.

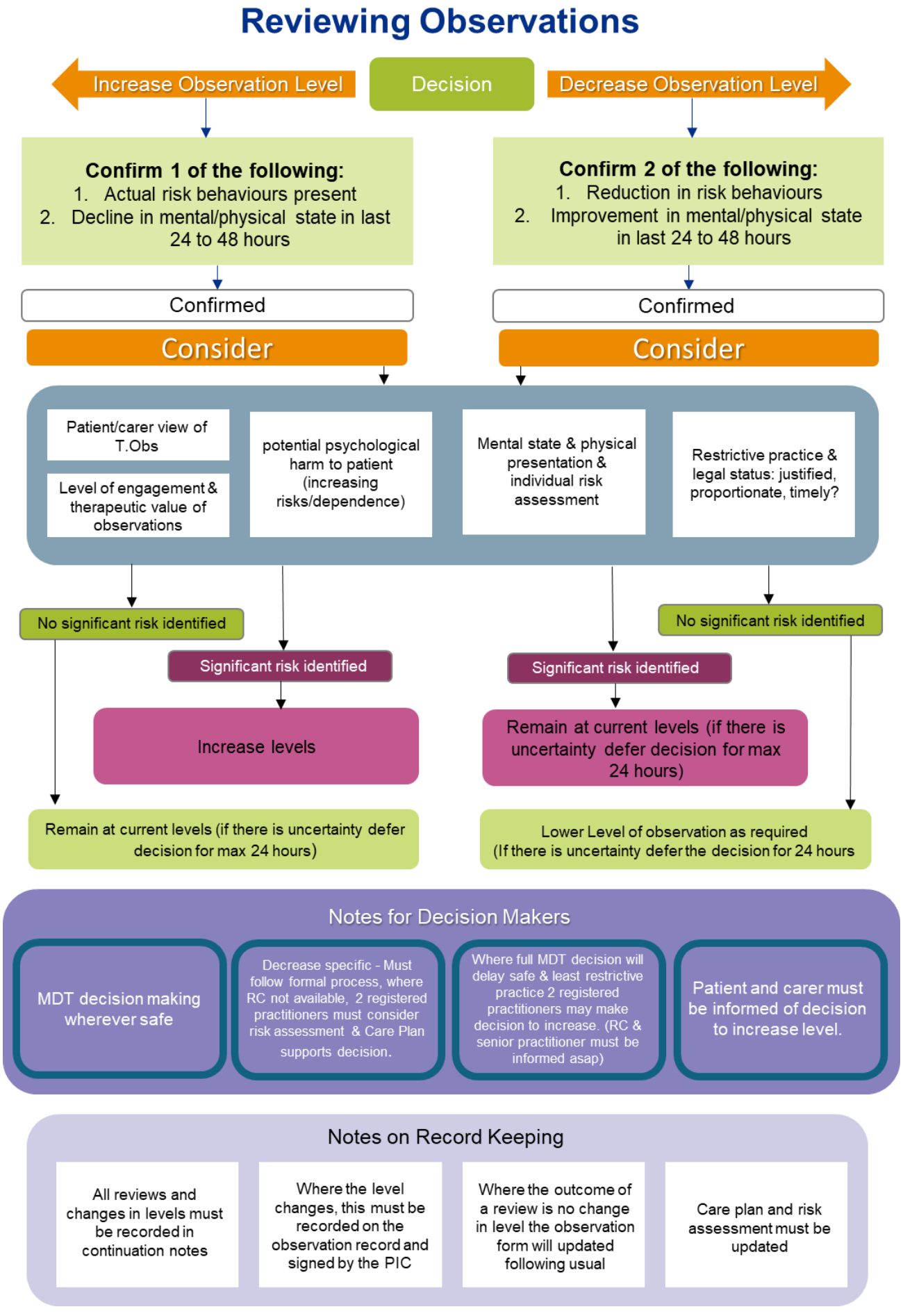
8. Monitoring Statement

Aspects of the policy to be monitored	Monitoring method	Individual/team responsibility for the monitoring	Frequency	Findings: Group/Committee that will receive the findings/monitoring report	Action: Group/Committee responsible for ensuring actions are in place
Recording of observations, care planning and completion of reviews	Check of electronic health record Triangulated Clinical audit	Care Group Lead nurse & matron Quality & Safety Review team	Quality Improvement Post implementation audit March 2021 Thereafter frequency as determined by the Care Group improvement plan/Audit Schedule	Care Group Governance meeting Reducing Restrictive Intervention Committee	Quality Committee
Review of incidents arising from observations	Review of Datix incident reports leading to learning and improvement	Care Group Lead Nurse & Matron	Frequency determined by analysis of incidents	Care Group Governance meeting Reducing Restrictive Intervention Committee	Quality Committee
Patient experience	Survey Local feedback mechanisms	Care Group Lead nurse and Matron in consultation with People Participation Lead	Quality improvement Post implementation survey Thereafter frequency determined by Care Group improvement plan	Care Group Governance meeting Reducing Restrictive Intervention Committee	Quality Committee
Completion of Competency assessments on induction & 2 yearly update	Check of local records	Matron/Lead nurse Quality & Safety review Team	Annually	Care Group Governance meeting	Quality Committee

9. Supporting Information

With reference to:	NG10: Violence and Aggression: short-term management in mental health, health and community settings. National Institute for Health and Care Excellence (2015) In-patient Suicide Under Observation. National Confidential Inquiry into Suicide and Homicide by people with Mental Illness (2015) Mental Health Act 1983: Code of Practice. Presented to Parliament pursuant to section 118 of the Mental Health Act 1983 (2015) Learning from suicide-related claims: A thematic review of NHS Resolution data, NHS Resolution (2018) Engaging people: observation of people with acute mental health problems: a good practice statement. NHS Scotland (2002) From Observation to Intervention: a proactive, responsive and personalised care and treatment framework for acutely unwell people in mental health care. NHS Scotland (2019) Mental Health Nurse Leaders & Directors Forum, National Policy Template for Supportive Observation & Engagement (2018)	
Associated trust policies and documents	C08: Prevention and Management of Violence and Aggression C35: Searching Patients Including Rooms C55: Leave of Absence for Detained Patients and Informal Service Users C86: Slips, Trips and Falls C71 Consent to Treatment	Q12: Missing Persons C107 Seclusion and long-term segregation C07: Mental Capacity Act and Deprivation of Liberty Safeguards Guidance for Mentors / Practice Educators and Healthcare Students (2018)
Written by:	Tracey Holland – Restrictive Interventions Lead/Lead Nurse Helen Smith – Lead Nurse/Quality Improvement Coach Sophie Bagge – People Participation Lead	
In consultation with	Ward Managers, Modern Matrons, Lead Nurses, People Participation Leads, Mike Seaman, Dawn Collins; Restrictive Interventions Committee	

10. Appendix 1



11. Appendix 2

Norfolk and Suffolk
NHS Foundation Trust

Therapeutic Observations Competency Assessment

- **This competency assessment must be completed by all staff (including NHSP/Agency) who carry out therapeutic observations.**
- **The assessment will be completed prior to undertaking unsupervised therapeutic observations (at induction) and thereafter at 2 yearly intervals, unless practice concerns suggest the need to revisit sooner.**
- **The competency assessment will normally be undertaken by Matron/CTMs.**
- ***Once completed the competency must be recorded on the health roster.***
- **Please file copy in personal file and save on secure drive for assurance purposes.**

Staff Name:					
Staff Role (circle one):					
CSW	AP	RN	CN	Other Specify	
Staff regular/agency?:					
Assessor Name:					
Ward:					
All staff who undertake observations must answer the following questions on reading the policy.				Staff Member's Initials	Assessor's Initials
1) Able to identify environmental risk factors (including ligature points)					
2) Able to identify the 4 levels of observations and describe what they are and when they are used.					
3) When undertaking observations of a patient what is the key information you must refer to and consider when planning your observation duty?					
4) Effective MDT communication is crucial to the safe management of patients receiving therapeutic observations and the safety of staff. Describe when, how, who and what you would communicate					

information about patients during a shift				
5) What do you understand by the term 'therapeutic observation' within the context of this policy?				
6) What skills and actions will you demonstrate when allocated to undertake therapeutic observations?				
7) What are the potential benefits of therapeutic observations for a patient and how do you maximise these in your practice?				
8) What are the potential negative impact of therapeutic observations for a patient and how can these minimised?				
9) Which is the correct way to time observation checks therapeutic for a patient who is at risk of self-harm and is nursed on x4 obs per hour? Able to explain answer?				
A: 10:15 10:30 10:45 11:00	B: 10:09 10:23 10:38 10:49	C: 10:05 10:22 10:44 11:00		
10) What do you do if an emergency situation arises whilst on observations?				
11) What is the correct way to sign the observation record as the person allocated to undertake observation duties.				
12) What factors must you consider when undertaking observation duties of patients at night and how would you safely undertake observations of sleeping patients?				
13) What **must** you be recording in relation to therapeutic observations?				
	Awake Patient			
	Sleeping Patient			
14) Scenario based questions – chose a minimum of 2 An informal service user has capacity. A decision has been made to start within eyesight observations however they are requesting to be let out of the ward. What would you do? You are undertaking eyesight observations and an emergency alarm sounds, what do you do? You are undertaking intermittent enhanced observations at intervals of 15 minutes for a service user. When you go to find them, they are in the bathroom with the door shut. What would you do? You are undertaking intermittent observations of a patient at night who is complaining and getting increasingly annoyed about being disturbed. What would you do at the time and how might you address this with the day staff? Whilst completing within eyesight observations you observe that the patient you are observing has taken something off a visitor and tried to hide it from you in her bag. What would you do?				

You have been on days off and there have been several new admissions. You are asked to undertake intermittent observations for a group of patients you don't know. What are your responsibilities and what information do you need from handover to proceed?		
All registered staff must also answer the following questions		
15) What are the responsibilities of the registered staff in initiating, increasing and reducing therapeutic observations?		
16) What factors must you consider in reference to the legal status of patients and least restrictive practice in the use of therapeutic observations?		
17) Why is it important for registered staff to undertake therapeutic observations regularly?		
18) What are the PIC responsibilities during handover of patients on therapeutic observations?		
Competency confirmed: Yes / No (please circle)		
Action plan if competency is not confirmed: Date competency assessment to be repeated:		
Additional comments: Assessor's Name Signature Date: Staff Member's signature Date:		

12. Appendix 3

Norfolk and Suffolk NHS Foundation Trust

Appendix 3

Therapeutic Observations Rapid Competency Assessment

For use in exceptional circumstances only. This cannot be recorded on Health Roster as full competency. See policy C36 section 6

Staff Name:				
Staff Role (circle one):				
CSW	AP	RN	CN	Other Specify
Staff regular/agency?:				
Assessor Name:				
Ward:				

All staff must complete the following:		Staff Member's Initials	Assessor's Initials
Ward orientation / walk-around			
Staff member has been familiarised with ward ligature assessment Able to identify environmental risk factors (including ligature points)			
Describe how they ensure enhanced observations are therapeutic – (benefits/ risks and how these are maximised/minimised)			
Describe the four levels of observation and how they will monitor and engage with patients and the correct recording procedure:			
	General		
	Intermittent		
	Eyesight		
	Arms-Length		
What do you **need** to know/find out about a patient before carrying out therapeutic observations, what are **your** responsibilities?			
	Where can you find this information?		

What should you do if an emergency arises whilst you are allocated to 1:1 observations?			
What **must** you be recording in relation to therapeutic observations?			
	Awake Patient		
	Sleeping Patient		
You are undertaking intermittent observations of a patient at night who is complaining and getting increasingly annoyed about being disturbed. What would you do at the time and how might you address this with the day staff?			
Registered Staff Only			
What are the responsibilities of registered staff in initiating/increasing/reducing therapeutic observations?			
Why is it important for registered staff to undertake therapeutic observations regularly?			
What are yours and the previous PIC responsibilities during handover of patients on therapeutic observations?			
Competency confirmed: Yes / No (please circle)			
Action plan if competency is not confirmed: Date competency assessment to be repeated:			
Additional comments: Assessor's Name Signature Date: Staff Member's signature Date:			
When complete place on staff member's personal file or send to NHSP. ***Update staff member's ESR*** ***Offer staff member a copy for portfolio***			