Clinical Observation and Engagement Policy
& Guidelines for Best Practice

Mental Health & Learning Disability Service

Author:

Responsible Lead Executive: Medical Director, Associate Director of Nursing, (Mental Health & Learning Disability), Chief Operating Officer, North

Director:

Endorsing Body: Lanarkshire Health and Social Care Partnership Mental Health Programme Board

Governance or Assurance: NHSL Joint CHP Clinical Governance & Committee

Implementation Date: Risk Management Committee January 2013

Version Number: 5

Review Date: July 2019

Responsible Person: Associate Director of Nursing (Mental Health & Learning Disability)
CONTENTS

i) Consultation and Distribution Record
ii) Change Record

1. INTRODUCTION

2. AIM, PURPOSE AND OUTCOMES

3. SCOPE
   3.1 Who is the Policy Intended to Benefit or Affect
   3.2 Who are the Stakeholders

4. PRINCIPAL CONTENT

5. ROLES AND RESPONSIBILITIES

6. RESOURCE IMPLICATIONS

7. COMMUNICATION PLAN

8. QUALITY IMPROVEMENT – MONITORING AND REVIEW

9. EQUALITY AND DIVERSITY IMPACT ASSESSMENT

10. SUMMARY OF POLICY / FAQS

11. REFERENCES
CONSULTATION AND DISTRIBUTION RECORD

Contributing Author / Authors
• Stewart Marshall, Senior Nurse MH&LD
• Lis Lawson, Project Manager MH Modernisation

Consultation Process / Stakeholders:
• Tricia Rhodie, Service Manager, MH & LD
• Dr Alastair Cook, Associate Medical Director
• Jim Wright, General Manager
• The Mental Health Programme Board
• The Mental Health and Learning Disability Management Team
• The Mental Health and Learning Disability Clinical Governance Committee
• The Mental Health Service Improvement Board
• The Joint CHP Risk Management and Clinical Governance Board
• Staff side consultation through David Boyd and wide staff consultation across the mental health and learning disability professional groups including nursing, medical, AHP and psychology.

Distribution:
First Port

CHANGE RECORD

<table>
<thead>
<tr>
<th>Date</th>
<th>Author</th>
<th>Change</th>
<th>Version No.</th>
</tr>
</thead>
<tbody>
<tr>
<td>October 2003</td>
<td>Primary Care</td>
<td>Introduction of “Observation and Guidelines for Good Practice”</td>
<td>1</td>
</tr>
<tr>
<td>January 2015</td>
<td>Dr A. Cook, Maria Docherty</td>
<td>Revision and enhancement of policy with additional guidance provided</td>
<td>3</td>
</tr>
<tr>
<td>January 2017</td>
<td>Dr A. Cook, K. McCaffrey</td>
<td>Revision and enhancement of policy with additional guidance provided to levels of observation</td>
<td>4</td>
</tr>
<tr>
<td>March 2018</td>
<td>Risk Dept.</td>
<td>GDPR statement added into section 3 and updated name of Data Protection Act</td>
<td>4</td>
</tr>
<tr>
<td>Nov 2018</td>
<td>K McCaffrey</td>
<td>Reviewed</td>
<td>5</td>
</tr>
<tr>
<td>Month</td>
<td>Name</td>
<td>Notes</td>
<td>Page</td>
</tr>
<tr>
<td>-----------</td>
<td>---------------</td>
<td>---------------------------------------------------------</td>
<td>------</td>
</tr>
<tr>
<td>March 2020</td>
<td>R McGuffie</td>
<td>Extended until July 2021 (COVID-19)</td>
<td>5</td>
</tr>
<tr>
<td>March 2020</td>
<td>K. Torrance</td>
<td>Extended by Corporate Policies team until August 2021 – COVID 19</td>
<td>5</td>
</tr>
</tbody>
</table>
Clinical Observation Policy MH&LD

1. INTRODUCTION

In 2003 NHS Lanarkshire developed a policy and guidelines for good practice in the clinical observation of patients within Mental Health and Learning Disability services. This policy has been updated to reflect current national policy, legislation, guidance, principles and best practice.

This policy and guidelines has taken into consideration the potential for staff to develop a values based, recovery focused approach to mental health delivery. In keeping with similar NHS Lanarkshire Policies the underpinning principles of patient safety, accurate information and consistency will apply.

2. AIM, PURPOSE AND OUTCOMES

- This policy aims to set out the principles for NHSL Mental Health and Learning Disability staff to adhere to in the delivery of care and treatment to patients. In the majority of cases, these will be patients undergoing treatment within mental health and learning disability inpatient facilities.

- To provide clinical staff with guidance and direction on reducing risk of harm to patients and others by means of individual therapeutic observation and engagement.

- The key purpose of observation is to provide a period of safety for people during temporary periods of distress when they are at risk of harm to themselves and/or others. It is essential to ensure this period is therapeutic and, although it may be perceived as not needed at the time, that it will generally be seen as a positive experience by the patient in time. It can also be used to provide an intensive period of assessment of a person’s mental state.

- The outcome will be a consistent approach across all NHSL Mental Health & Learning Disability services to ensure safe and supportive practice by reducing the risk of individual harm by employing therapeutic observation and engagement as an intervention appropriate to assessed individual need.

- Observation should be prescribed proportionately with a care and management plan recorded on an individual basis.
3. **SCOPE**

3.1 **Who is the Policy intended to Benefit or Affect?**

This policy will be of benefit to:

- **Patients**
  By receiving a therapeutic intervention aimed at protecting them from harm as a consequence of the nature of their mental ill health, learning disability, mental or physical impairment to aid their recovery

- **Carers and Relatives**
  By having a level of reassurance that a therapeutic intervention will be employed as appropriate to reduce the risk of harm to patients in receipt of hospital care and treatment

- **Staff**
  By having clear guidance and direction on incorporating observation levels aimed at reducing risk of harm to or from individual patients as part of any therapeutic intervention

- **Organisation**
  By having clear guidance and direction through standardised policy

3.2 **Who are the Stakeholders**

Clinical staff from NHSL Mental Health and Learning Disabilities Service, Patients, Carers and Relatives.

NHS Lanarkshire take care to ensure your personal information is only accessible to authorised people. Our staff have a legal and contractual duty to keep personal health information secure and confidential. In order to find out more about current data protection legislation and how we process your information, please visit the Data Protection Notice on our website at [www.nhslanarkshire.scot.nhs.uk](http://www.nhslanarkshire.scot.nhs.uk) or ask a member of staff for a copy of our Data Protection Notice."
4. PRINCIPAL CONTENT

4.1 Assessment of risk

Assessment of risk is a necessary preliminary to and component of, safe and satisfactory observation. High level of judgment based on training and experience is required to define risk in an individual and factors such as knowledge of the patient, presenting symptoms, reason for admission and past history will all be taken into account in determining the risk level of the patient and the appropriate level of observation.

All patients will have a risk assessment completed which will be regularly reviewed by the Multi-Disciplinary Team (MDT).

Following completion of risk assessment the MDT will determine the level of observation required which should be in keeping least restrictive option and recorded in notes, care place updated accordingly.

N.B. There are also specific observation guidelines for patients following ECT which are in line with SEAN Standards. See ECT – Local Roles & Protocols.

4.2 Levels of Observation

There are 3 distinct levels of observation:
Clinical Observation Policy MH&LD

Special Observation

The patient will be clinically assessed as requiring intensive and skilled interventions as a consequence of risk to self or due to their degree of vulnerability. THE PATIENT WOULD BE IN SIGHT AND WITHIN TOUCHING DISTANCE OF STAFF MEMBER AT ALL TIMES

Constant Observation

The patient will be clinically assessed as requiring monitoring at all times to reduce the assessed risk. An allocated member of staff should be constantly aware at all times of the precise whereabouts of the patient by means of SIGHT AT ALL TIMES AND IN ALL CIRCUMSTANCES

General Observation

This is the level of observation that will meet the needs of most of the patients most of the time. The staff will have a knowledge of the patients general whereabouts at all times and whether the patient is in or out of the ward.

All areas across NHS Lanarkshire Mental Health & Learning Disability Services will use these three terms alone to ensure a consistent approach across the service. See (Appendix 1) for full definition of each level of observation.
4.3 Care Plan, Recording and Reporting

- The patient’s care plan should be informed using the Risk Assessment and outline the agreed changes in behaviour as discussed at MDT Review that would facilitate a change in observation levels and the exact procedure for this to be actioned, thereby avoiding unnecessary restrictions. Decisions regarding enhanced observations should be dependent on the persons needs throughout the 24 hour period, eg person may require enhanced observation throughout the day, however the care plan may allow for reduced observations when asleep.

- The Patient Observation Recording Sheet should be utilised for all patients on enhanced observations. See (Appendix 4)

- There is a system of communication between staff members to ensure all changes in the level of observation are known, recorded and auctioned

- A care plan will incorporate the level and therapeutic engagement / observation of the individual

- All staff involved in decision making and carrying out observations must adhere to the guidelines contained within this policy

- The staff on duty should have knowledge of the patient’s general whereabouts at all times, whether in or out of the ward, regardless of observation level

- Staff will endeavor to ensure the respect for privacy in all matters, including bathing and attending to personal toilet needs, without compromising safety through the use of unobtrusive visual observations

- With enhanced observations all members of staff designated to carry out this level of observation will understand fully the nature of the current risks to the patient and others

- Patients on all levels of observation will have the opportunity to engage in therapeutic interventions that meet individual needs. All interventions must be accurately documented in the nursing notes

- The Risk Assessment informs the review of patients subject to enhanced observations and must be undertaken when clinically indicated or as a minimum, on a daily basis and the outcome recorded in the patient’s notes
5. **ROLES AND RESPONSIBILITIES**

5.1 **Decisions Regarding Levels of Observation**

The decision regarding level of observation must be based on a Risk Assessment, including careful assessment of the available evidence with regard to the patient’s mental health at that time.

Decisions regarding the level of observation for each patient should be made by the multi-disciplinary team and where possible must include the patient, carers and relatives.

In keeping with the general principle that observation levels should be set at the least restrictive level, for the least amount of time within the least restrictive setting; this policy allows nursing or medical staff to alter the observation level according to the patient’s immediate clinical need.

Any decision made regarding observation status should be clearly communicated with the patients and carers. It should be highlighted that this is part of their therapeutic intervention within the ward and should not be seen or indicated as a punitive measure. Information will be provided to patients and carers on admission with regard to the use of the observation.

**Increasing Observations**

The majority of decisions regarding increasing the level of observations will continue to be made as part of MDT discussions and reviews in consultation with the responsible consultant.

This policy however, allows medical or nursing staff to increase a person’s observation level in response to a change in their clinical presentation in a situation(s) where medical and nursing discussion is impractical.

The decision to increase levels of observation should be made having due regard to the principles of “least restriction”.

Any registered nurse can increase the observation level, and inform the nurse in charge and appropriate medical staff as soon as possible.

Where this may impact on staffing requirements the decision should also be communicated to the service manager or if out of hours or weekends senior on-call staff.

In all such cases the staff will complete a robust clinical risk assessment clearly documented in the Generic Integrated Care Pathway (ICP) Risk Assessment and will act in the best interest of the patient at all times.
Clinical Observation Policy MH&LD

The decision making will be clearly documented in the nursing notes to evidence the decision making process and that the reason for increase is meeting that persons clinical need.

Any decision to alter observation status should still include consultation with patient and where appropriate their carer.

Reducing Observation

The majority of decisions regarding the reduction of enhanced observations will continue to be made as part of MDT discussions and reviews in consultation with the responsible consultant.

In circumstances where the consultant has made the decision that the reduction in observations levels should be made by medical staff only, the patient would be “Blue Flagged” (Appendix 3) and this would be recorded in the Patient’s notes.

This policy also allows for medical or nursing staff to reduce a person’s observation level in response to a change in clinical presentation, with due regard to the principles of “least restriction”.

This decision should be made by a Band 6 Nurse or above with another registered nurse or junior doctor on the ward but followed up by discussion with the patient’s clinical team, as soon as possible.

In all such cases the staff will complete a robust clinical risk assessment clearly documented in the Risk Assessment and will act in the best interest of the patient at all times.

The decision making will be clearly documented in the nursing notes to evidence the decision making process and that the reason for reduction is meeting that persons clinical need.

The Nurse in Charge has defined responsibilities which are:

• Ensuring staff have relevant competencies to undertake enhanced observations in keeping with their responsibility within Delegation of Duties under Delegating Effectively parts 29, 30 & 31 from The Code: Standards of Conduct, Performance and Ethics for Nurses and Midwives (NMC, 2008).

• Profile of Core Skills for Observation (Mental Health) provided to support staff during clinical supervision and PDP process (Appendix 2).

• Retains responsibility for co-ordination of decisions regarding observation levels.
Clinical Observation Policy MH&LD

- Should always know who is being observed (at an enhanced level) and which staff member (from the multi-disciplinary team) is responsible for a given time period.

- Gives consideration to the length of time individual staff have been engaging with enhanced levels of observation and co-ordinates appropriate relief for staff.

- Ensure staff are aware of the Escalation Process and utilise this when appropriate. (Appendix 5)

5.2 Role of Unregistered Staff in Observation

Unregistered staff such as clinical support workers and health care assistants deemed by the nurse in charge to have the necessary skills and experience will be expected to carry out patient observation.

Prior to delegating patient observation to unregistered staff the registered nurse will ensure they are fully informed regarding patient’s condition, background history, reason for utilizing enhanced observation and the associated risks.

This will continue to be overseen by the registered nurse who has assigned these duties as they retain accountability and responsibility for the patient, any concerns or issues should be reported to the registered nurse immediately.

5.3 Role of Student Nurses in Observation

Only 3rd year student nurses should be delegated clinical observation responsibilities during an inpatient placement and only in situations where there is capacity to effectively supervise them.

Students should not be asked to carry out clinical observation duties for more than one hour at a time and not more than once on any given shift.

5.4 Role of “Responsible Others” in Observation

Caring for someone in distress is not a process to which only professionals can contribute. The importance of relatives and carers being actively involved in the recovery process is widely acknowledged. These individuals may be highlighted in the patient’s care plan as “responsible others” whose interaction would continue to benefit the patient even during periods when requiring enhanced levels of observation. This will be discussed and agreed by the MDT and clearly documented in the Patient’s care plan.

The multidisciplinary team shall be responsible for reviewing the care plan in relation to individuals participating in therapeutic engagement out with the ward. The plan will detail all “responsible others” by name and identify associated risks as well as the reason for the level of observation selected.
6. **RESOURCE IMPLICATIONS**

   A. Staff:
   There may be manpower implications depending on level of observations and how many people are on observations.

   B. Financial
   C. Education/Training/Awareness
   D. Environmental Impact

7. **COMMUNICATION PLAN**

   - This policy will be launched using the weekly staff briefing and it will be available on First Port
   - This policy will be discussed at the appropriate management team meetings and local partnership forum
   - Staff within HR will be briefed on the content of the policy

8. **QUALITY IMPROVEMENT – Monitoring and Review**

   This policy will be reviewed in two years time or sooner if needed. An article will appear in the staff brief in advance of the review date advising that the policy is coming up for review in order to give staff the opportunity to comment.

9. **EQUALITY AND DIVERSITY IMPACT ASSESSMENT**

   This policy meets NHS Lanarkshire’s EDIA

   (tick box)

10. **Summary or Frequently Asked Questions (FAQs)**

    To help staff understand long or complex policies, please ensure you send a summary or a frequently asked questions list with your completed policy
Clinical Observation Policy MH&LD

11. REFERENCES

Mental Health (Care & Treatment) (Scotland) Act 2003 – Milan Principles

Adult Support and Protection (Scotland) Act 2007 – Section 1, Section 2

Adults with Incapacity (Scotland) Act 2000

The 10 Essential Shared Capabilities for Mental Health Practice


Appendix 1

There are 3 distinct levels of observation and these are described as follows:

(The staff on Duty should have knowledge of the patient’s general whereabouts at all times, whether in or out of the ward)

**General Observation** - This is the level of observation that is intended to meet the needs of most patients for most of the time.

Patients will be requested to advise a member of the nursing staff when they leave the ward, their intended whereabouts and their expected time of return.

Any limits should be agreed with the patient and documented and updated within the patient’s care plan.

**Constant Observation** - The constant level of observation should be used for patients assessed as posing a significant risk to self or others including risk of self-harm, risk of violence or due to their degree of vulnerability.

The patient will be clinically assessed as requiring monitoring at all times to reduce the assessed risk.

An allocated member of staff should be constantly aware at all times of the precise whereabouts of the patient by means of Sight at All Times and In All Circumstances.

Considerations of privacy will be subordinated to those of safety where proportionate in managing level of risk. This will be clearly documented in the care plan. As this form of observation is potentially very intrusive it should only be used when judged strictly necessary by the clinical team.

**Special Observation**

This special level of observation will in general be prescribed rarely.

The patient will be clinically assessed as requiring intensive and skilled intervention as a consequence of risk to self or due to their degree of vulnerability.

The patient should be in sight and within touching distance. The designated member of staff supporting the patient should remain in very close proximity to the patient at all times and in all circumstances. In some situations more than one member of staff may be required. Special observation can be carried out in a safe area within the ward which is least restrictive and ensures where possible the patient can engage in therapeutic activities promoting personal centered care.

Considerations of privacy would be subordinated to those of safety where proportionate in managing level of risk. These will be clearly documented in the care plan. As this form of observation is potentially very intrusive it should only be used when judged strictly necessary by the clinical team.
Appendix 2

A PROFILE OF CORE SKILLS FOR OBSERVATIONS (MENTAL HEALTH)

This checklist is to support staff and their line managers when completing their PDP in relation to determine the level of competence of staff to carry out patient observations. It also provides staff with a focus regarding the knowledge & skills required for this type of intervention and enable them to further develop the necessary skills.

It remains the nurse in charge’s responsibility in allocating tasks to staff and they should consider each individual situation and the particular care requirements of the individual when doing so.

COMMUNICATION

When communicating with patients - be able to:

- Build a therapeutic relationship
- Demonstrate good listening skills
- Be confidential
- Give clear feedback
- Support equality and value diversity
- Recognise potential barriers to effective communication and address same
- Explain any restriction placed on the patient
- Give Observation Information Leaflet to patient and carer
- Explain observation care plan
- Be open, honest and direct
- Be aware of non-verbal messages
- Know when people don’t want to talk
- Know when talking would provoke a crisis
- Be warm and genuine without disclosing personal details
- Advise patients of rights to individual Advocacy
- Advise on Trust Complaints and Suggestions policy

When communicating with staff – be able to:

- Record patients’ progress on recording sheet
- Pass on relevant information to appropriate people
- Write concise notes
- Be clear and precise
- Document accurately for audit purposes
- Feel confident to contribute to decisions/plans about nursing care

Interventions and treatments

Monitoring - be able to:
Clinical Observation Policy MH&LD

- Monitor possible indicators of mental state e.g. food and fluids, sleep pattern, motor activity
- Record and monitor both verbally and in writing
- Use observation skills effectively
- Use ward observation policy
- Ensure that daily or weekly observations are adhered to e.g. BP, temperature, weight, fluid balance charts
- Make full use of ward environment e.g. facilitating patient privacy
- Identify environmental hazards

Approaches to Care – be able to:

- Gain patients’ trust
- Know how to cope with physical and verbally abusive behaviour
- Diffuse difficult situations
- Cope with critical patients who are unhappy with their care
- Encourage development and use of anxiety /relaxation/anger management skills (where appropriate)
- Use distraction techniques to deal with voices

Medicine administration – be able to:

- Identify when medication is needed
- Identify side effects of medications
- Give advice on obtaining information on medication in use

Attending to patients hygiene / personal care needs – be able to:

- Assist patients with personal hygiene needs when necessary
- Motivate patients to fulfil their own hygiene needs
- Assist and encourage cleanliness of bed area

Attending to patients dietary needs – be able to:

- Monitor food and fluid intake
- Encourage balanced diet and fluid intake

Health, Safety and Security

Training and development - be able to:

- Provide evidence of attendance to mandatory PAMOVA training (Level 1 available on Learnpro), level 3 advised if required to carry out enhanced observations
- Provide evidence of suicide prevention training e.g. ASIST, SAFE TALK, STORM
- Evidence awareness of relevant NHSL policies and procedures e.g. Observation and Engagement and Violence and Aggression

Developed with reference to:

- NBS Core Skills and Competencies - Mental Health Nursing Observation Group 2003
- NHS Knowledge and Skills framework
Clinical Observation Policy MH&LD

Protocol for Nursing Observation Review
Reduction of Elevated Observation Level

DETERMINE IF PATIENT IS “BLUE - FLAGGED” BY MDT/CONSULTANT

BLUE - FLAGGED

NO ACTION
NO CHANGE IN OBSERVATION UNLESS FULL MEDICAL REVIEW

NOT BLUE-FLAGGED

CONSTANT

SPECIAL

DOUBLEDIMPROVEMENT IN MENTAL/CLINICAL STATE OVER LAST 24 HRS (e.g. settled mental state, reduction of suicidality, agitation, absconding risk, psychotic symptoms)

INFORMED BY REVIEW OF ICP RISK ASSESSMENT THE BAND 6 NURSE AND ANOTHER RMN OR JUNIOR DOCTOR REDUCE OBSERVATION LEVEL CLEARLY DOCUMENT REASON FOR REDUCTION AND BOTH SIGN NURSING RECORDS IN ICP AND THE COMPLETE UPDATED RISK ASSESSMENT

NURSE IN CHARGE ENSURES CLINICAL TEAM IS INFORMED OF THIS DECISION AS SOON AS PRACTICAL

DECISIONS BASED ON CLINICAL JUDGEMENT & DYNAMIC, ON-GOING PROCESS OF ASSESSMENT & MANAGEMENT OF POSITIVE RISK TAKING WHILST ENSURING PATIENT SAFETY
Appendix 4

Patient Observation Recording Sheet

<table>
<thead>
<tr>
<th>Patient's Name</th>
<th>CHI No</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Consultant  

Named Nurse

Observation Status:  

<table>
<thead>
<tr>
<th>Constant</th>
<th>Special</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Blue Flagged*

*IF BLUE-FLAGGED DECISION TO CHANGE OBSERVATION STATUS IS TO BE MADE BY RMO ONLY.

<table>
<thead>
<tr>
<th>DATE</th>
<th>TIME</th>
<th>STAFF NAME /SIGNATURE</th>
<th>PATIENT ACTIVITY</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Staff should hand over after maximum 1 hour constant / special OBS period and sign sheet at that time.

Extended by Corporate Policies team until August 2021 – COVID 19
Appendix 5

Observation & Engagement Policy Escalation Route

NURSE IN CHARGE

Reviews all patients on EOs
- Review presenting risks
- Ensure management plan is appropriate to identified risk
- Communicate information to staff on duty / at handover

Mon-Fri 9am-5pm contact
MENTAL HEALTH SERVICE MANAGER

Evenings & weekends contact should be made with ON-CALL MANAGER

- Review Daily Bed State to determine staffing levels & levels of clinical activity across all inpatient areas
- Transfer staff where possible between areas to accommodate increased clinical activity
- Secure additional staff through bank, excess hours or overtime
- Review clinical appropriateness of transferring patients to another clinical area to rationalise levels of clinical activity
- Review capacity of receiving ward(s) to admit patients who require EOs
- Ensure appropriate risk assessment completed for safe provision of inpatient staffing levels
- Service manager to forward to GM, ADNS & AMD