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Supportive Engagement and Observation Procedure

Introduction and Aim

Service users may experience periods of distress whilst in hospital, this can lead to increased vulnerability and place the person as a risk of harm to self, harm to others and harm from others. Effective mental health care is about building and sustaining trusting relationships. The care provided during these times plays a crucial role in promoting safety, reducing distress, and supporting recovery through compassionate, person-centred approaches.

Every person receiving inpatient care within mental health services is supported through compassionate engagement and appropriate observation.

This policy has been coproduced with service users, nurses, healthcare support workers, our lived experience team and allied health professionals to reflect their views, wishes and suggestions. Additionally, training has been developed because of this process to compliment the policy. The aim of the policy is to support staff to support patients through engagement and observation safely with the patient at the centre of our work.

Objectives
This document includes specific guidance on:

- determining levels of engagement and observation
- increasing and reducing levels of engagement and observation
- responsibilities for engagement and observation
- ensuring appropriate allocations of staff
- considerations that may impact the wellbeing of both patient and staff during engagement and observation

Scope
This procedure applies to all of our staff in all locations of mental health inpatients including those with honorary contracts and temporary staff

Equality and Health Impact Assessment	As this is a procedural document an Equality Impact assessment has not been undertaken
Documents to read alongside this Procedure	Reassurance Observations System Procedure Missing Person Procedure Clinical Risk Assessment and Management Policy Mental Health Act 1983 Code of Practice for Wales
Approved by	Mental Health Clinical Board 25th February 2026 Controlled Document Oversight Group

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1	April 2014	
2	1/11/2021	
3	07/10/2022	
4	24/02/2026	• Safe patient transfers procedures • Updates in line to Phone use on wards • Managing multiple observations levels

Disclaimer

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Contents Page

a) admission
b) reviewing the level of engagement and observation
c) increasing intensity
d) reducing intensity
e) dignity, respect and preferences
f) engagement and observation at night time
g) enhanced levels of observation and patient leave
h) role of the NIC
i) role of the staff member carrying out levels of engagement and observation
j) handover between levels of observation
k) emergencies
l) ROS

4) Record Keeping

a) ICP
b) general engagement and observation
c) enhanced levels of engagement and observation

5) Care planning and Coproduction

a) intervention plans
b) family/carer involvement
c) role of primary nurse
d) other documentation

6) SUPPORT

a) staff well being and support
b) education and training

INTRODUCTION AND AIMS

The patient is at the heart of all our work as healthcare professionals. For this reason this policy has been coproduced by working alongside our patients, our staff, the lived experience team and allied health professionals to take into account all experiences of observations and recommendations to shape the policy. Focus groups were completed on inpatient wards where both staff and service users were able to attend, and QR codes were also distributed and completed by service users to collect information on service users understanding of observations and level of engagement service users experience whilst an inpatient through their observations and also from their primary nurse. QR codes were also completed by staff to understand from their perspective the barriers around completing effective observations. Allied health professionals have also been involved in meetings and discussions around therapeutic observations and the support they can offer both patients and staff. Best practice from across the UK and national guidelines have also been used to support the policy.

The **key purpose of supportive engagement and observation** is to support service users in hospital on their journey to recovery. Recovery is very individual to the person and it is important that all professionals working alongside patients remain attuned to this and thoughtfully ensure that care is tailored to align with each person's individual needs and their wishes.

It must be recognised that observations are only one aspect of holistic care during a person's inpatient stay. Reliance on observation alone is insufficient and must be complimented by meaningful engagement and support. Most service users will be supported through general engagement and observation practices, however during temporary periods of heightened distress patients may require an enhanced level of engagement and observation, which will be explained further into the policy.

The engagement during observation enhances patient safety. Without active engagement we may miss opportunities for patients to share their experiences, concerns and disclose feelings of distress. Engagement is also integral to the recovery process and helps to foster psychological well being, humanising the person and moves from passive surveillance to therapeutic and supportive interactions. Positive engagement with our patients also supports the development of trusting relationships where the person feels safe to explore their thoughts and feelings, and be actively involved in their care.

Enhanced engagement and observation should be recognised as a form of restrictive practice and may be perceived by patients as intrusive and/or punitive and has the potential to unintentionally retraumatise individuals. Services should be provided with the principle of least restriction, should always be in the person's best interests and should include the person in decision making wherever possible.

To facilitate communication, care planning, intervention and training, Cardiff and Vale University Local Health Board (ULHB) only endorses the intensities of engagement and observation that are outlined in this procedure.

Services may develop best practice procedures in relation to engagement and observation for specific patient groups. All new or amended policies or procedures must be discussed at the Controlled Document Operational Group (CDOG) before they can be formally ratified. Following this they must be shared at Clinical Board, Directorate and

Service area Quality, Safety and Patient Experience meetings to ensure that they are widely implemented and understood.

LEGAL STATUS

When an individual is an informal patient and receiving inpatient care voluntarily in hospital, all forms of treatment including levels of engagement and observation must only be delivered with the person's consent. This includes changes to the level of engagement and observation. In circumstances where there is a concern for the person's safety and they do not agree to engagement and observation including any increase, a review of the person's mental health should take place including consideration to use of the mental health act (MHA). Implementing levels of engagement and observation to ensure the person's safety whilst awaiting assessment may be justified.

In relation to engagement and observation, patients who lack capacity to consent may be subject to Deprivation of Liberty Safeguards (DOLS). However if a patient is actively refusing care or treatment, consideration must be given as to whether MHA is more appropriate. Please refer to MCA and the MHA Code of Practice.

All patients regardless of legal status should be made aware of their right to an independent mental health advocate whilst in hospital, and patients on enhanced levels of observations may want to discuss their situation with an advocate and be supported with their care and treatment.

SCOPE

The information in this policy applies to all patients receiving care within the inpatient environments of Cardiff and Vale University Health Board.

This implementation of this policy applies to all staff working with patients within the inpatient environment including bank or agency staff, students, allied health professionals, and any professionals visiting patients within the inpatient environments of the Cardiff and Vale UHB.

REVIEW

This policy will be reviewed every 2 years or in the light of organisational or legislative changes.

DUTIES AND RESPONSIBLITIES

Responsible clinician – Holds the legal responsibility their patients care and treatment. They are responsible for the overall assessment, treatment and risk management. This includes guiding staff and participating in decisions around levels of engagement and observation to ensure safe, effective care.

Lead nurse – Ensures the correct resources are available to deliver the policy safely in their directorates.

Senior Nurse – Ensures wards operate in line with policy including regular audits, and findings may be reported in directorate quality and safety meetings.

Ward Managers – Holds 24 hour responsibility for their clinical areas, ensuring staff are trained, understand their roles and deliver high quality care. In relation to engagement and observation they ensure staff are aware of the policy, are adequately trained to take participate in delivering levels of engagement and observation and to provide safe individualised patient care. The ward management team also maintain safe staffing levels through effective rostering and appropriate use of temporary staff.

Nurse in Charge – Holds many responsibilities in ensuring the safe running of a shift and safe handover to the next shift. In relation to levels of engagement and observation ensures safe staffing levels and escalates concerns to shift coordinator. The NIC will allocate staff to engagement and observation duties, confirming staff are appropriately skilled, alert and free from other tasks. NIC may need to complete inductions for new staff to the ward including temporary staff. The NIC also reviews levels of engagement and observation as needed during the shift.

Primary Nurse – Coordinates patient's care and treatment during their hospital stay. They build therapeutic relationships through regular 1:1 contact, ensuring the patients views and wishes are considered in intervention plans wherever possible.
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Allocated staff member to levels of engagement and observation – Responsible for the health, safety and well being of patients during engagement and observation. They create a safe environment through positive engagement, report concerns to the NIC and escalate emergencies appropriately.

Allied Health Professionals working alongside the patient – Responsible for sharing assessment outcomes and ongoing work with the rest of the multidisciplinary team including nursing staff. They can participate in decisions around levels of engagement and observation alongside nursing staff and the MDT, and can contribute to creating and implementing intervention plans. They may also be able to participate in enhanced and observation, for example during assessments should this be within their scope of practice and on discussion with the NIC.

LEVELS OF ENGAGEMENT AND OBSERVATIONS

1) **General observation**

2) **Intermittent observation**

3) **Close observation within eyesight**

4) **Close/Special observation within arm's length**

1. General Engagement and Observation:

This level of observation applies to patients assessed as low risk of harm to themselves and/or others within the inpatient ward environment, whilst being supported by 24 hour staff availability and individualised plans of care to support their recovery. General engagement & observation is the least intrusive approach and is intended to meet the needs of most patients for most of the time.

On completion of general engagement and observations the staff member must directly engage with the patient once an hour at specified times. This aims to ensure the patient's safety and well being, allows staff member to monitor for signs of mental and/or physical deterioration and identify any support needs. and. Any concerns should be reported to the NIC. It is important to note that patients have reported instances where their distress was missed due to a lack of engagement during observations, particularly when the Reassurance Observation System (ROS) camera was used. This highlights the need for interaction during hourly checks to ensure emotional well being is not overlooked, which could lead to harm.

The staff member must also directly observe the patient to confirm the person is alive and present on the ward during their interaction. If interaction is not possible (eg during sleep) the patient must still be observed by the staff member completing the check. Second hand reports could result in mistaken identity and/or other human error, which could lead to patient harm.

Between the hourly engagement and observation the staff member should wherever possible remain present in communal areas of the ward to ensure they are accessible for patient interaction, support, to respond to queries, meet the needs of patients where possible or supporting the patient to access further help by another available staff member. On most wards the person completing the general engagement and observation may also be allocated the intermittent observations. When the staff member is unable to meet the patients' immediate needs due to their observation duties, the staff member should signpost the patient to other available staff for support.

It is acknowledged that staff need to observe many patients in a short timeframe. If a concern arises during general engagement and observation the staff member should report to the NIC immediately to ensure a safe and timely response.

The final hour of general engagement and observation of the shift (typically 18:30 and 06:30) should be jointly completed by the person allocated to the general engagement and observations for that time and the NIC. This allows the NIC to identify any concerns and a timely response and ensures accurate handover. On wards where the same staff member is allocated the general and intermittent engagement and observation, the NIC is not expected to complete the intermittent checks during this hour. The role of the NIC is to confirm the well being and location of all patients on the last hour of the shift, address any final concerns in a timely manner and to support the delivery of a comprehensive and informed handover.

2. Intermittent Engagement & Observation

This level of engagement and observation is an enhanced intervention and should be recognised as a form of restrictive practice. It should be used when a patient presents with an increased, but not immediate, risk to themselves, others, and/or from others and the person requires enhanced support. It may also be used as a transitional step from a more intensive engagement & observation, helping the patient to adjust from more enhanced support whilst still maintaining regular access to staff support.

Individuals being nursed on intermittent engagement and observation should be given a clear explanation of the nature of this level of observation and purpose as they have reported this can feel particularly intrusive and affects their sense of privacy. Staff should therefore approach with sensitivity, using relational courtesy wherever possible such as knocking before entering a room. Whilst privacy is an important consideration, patient safety must remain the priority. For example if a patient has not responded to a knock and cannot be seen through the bedroom window or ROS camera, staff must enter to ensure safety.

The allocated staff member must observe the person five times within the hour, at intervals no longer than 15 minutes. To reduce predictability and enhance safety, staff must ensure that the timing is neither regular nor easily anticipated (i.e. must not be at exact intervals). Staff are expected to engage positively during the check to assess mental state, provide timely support, and escalate concerns or signs of deterioration to NIC where appropriate.

Given the restrictive nature of intermittent engagement and observation it may be appropriate, where identified as safe, to collaborate with the patient on how engagement is conducted. For example, a patient resting in their bedroom during the day may prefer engagement twice within the hour to check on their wellbeing, but may be happy for staff to observe on the ROS camera or through a bedroom window on the other checks to minimise disruption and preserve privacy. This should be assessed individually, balancing risk alongside the person's wishes. In some cases, engagement may be required at every observation, and this highlights the importance of individual care planning.

Intervention plans should be co-produced with the patient wherever possible to ensure they understand the purpose and expectations of intermittent engagement and observation. Coproduction supports mutual agreement on how care is delivered, and provides the patient with opportunity to participate in shaping their care.

Intermittent engagement & observation must not be used when there is a risk of imminent danger, as gaps between checks may present a potential for unsafe outcomes and patient harm. In these cases, continuous close engagement and observation would be required.

3. Close Observation and Engagement Within Eyesight

Patients requiring this level of observation have been assessed as experiencing significant safety concerns, such as risk harm to self, others and/or harm from others, and cannot be supported through lower levels of engagement and observation. This is a continuous observation where there is a requirement for the patient to be **within eyesight of the staff member at all times** to maintain safety.

During close engagement and observation within eyesight, staff are encouraged to actively engage with the patient to build rapport, foster trust and promote a sense of safety for the patient. Patients involved in the coproduction process of this policy have shared that they value everyday conversations, not always focused on clinical symptoms, and reported that this can help reduce feelings of restriction and support wellbeing.

Decisions regarding privacy (e.g, using the toilet) should be made through a discussion with the patient and the multidisciplinary team, and be documented in the case notes and intervention plan. This ensures a shared understanding and provides consistency in care. Whilst privacy is important, patient safety must remain the priority. If staff have concerns during close engagement and observation despite an agreed plan for privacy, this should be sensitively discussed with the patient and reported to the NIC. If no privacy arrangements have been documented, it should be assumed that no plan has been made to date to support safe periods of privacy. In cases where privacy cannot be safely supported this should also be explained clearly and compassionately to the patient. Staff should take into consideration that this outcome may cause distress and offer reassurance. This can be further explored by the primary nurse with the patient, and with the wider MDT. Discussions around privacy can be re visited regularly to support shared goal setting and working collaboratively.

All patients on close engagement and observation within eyesight must have a daily one to one conversation with a registered mental health nurse to assess mental state and support ongoing decision making around care and treatment, including levels of engagement and observation. Any exceptions to less than daily nursing 1:1's should be agreed following discussion with the patient and the multidisciplinary team and reasons documented in the nursing intervention plan.

Close engagement and observation is intended to support individuals through temporary periods of distress. The primary nurse should regularly explore with the patient how and when levels of engagement and observation may be safely reduced, support wider decision making. This collaborative working may also include interventions such as the Suicide Awareness and Mitigation Tools (eg SAFETool, safety planning and mitigation framework), and also the Trauma Informed Psychological Skills Training workbooks. When such work has been completed, practising the new skills during close engagement and observation can help patients manage their safety and prepare for reduced levels of engagement and observation.

4. **Close/Special Observation and Engagement <u>Within Arm's Length</u>**

Patients supported at this level of engagement and observation have been assessed as experiencing the highest level of risk, including risk of harm to self, others, and/or from others, and their safety cannot be maintained through a lower level of engagement and observation. **Continuous support is required, including active engagement and continuous direct observation within arm's reach of the patient.** This ensures that staff can respond quickly to signs of distress and minimise risk of harm. **It should be made clear at every handover that a patient requiring this level of observation is to be nursed within arm's reach.**

This level of observation and engagement may feel intrusive or uncomfortable for many individuals, however its role as a potentially life-saving intervention must not be under-estimated. Every effort must be made whilst supporting a patient on through this intensive intervention to engage with the person. This engagement can help feelings of discomfort and is essential to building trust.

When an individual is supported through close engagement and observation within arm's length due to concerns around self harm or suicide, environmental risks must be assessed. Safety related decisions should be clearly communicated to the patient, helping to support understanding ad involvement in care, and regular reviews of restrictive measures should take place. Other interventions such as Suicide Mitigation and Trauma Informed Psychological Skills may also be appropriate to complete, and the skills practiced at this time to support patients manage their safety and prepare for reduced levels of engagement and observation.

Due to it's restrictive nature, this level of engagement and observation should be short term for temporary periods of distress. The NIC or ward management team must review the need for this intensity of engagement & observation on a daily basis. All patients on close engagement and observation within eyesight must have a daily one to one conversation with a registered mental health nurse to assess mental state and support ongoing decision making around care and treatment, including levels of engagement and observation. Any privacy agreements should follow the same principles as outlined within the close observations within eyesight in this policy.

Staff working in dementia settings have reported situations where close observation within arm's length may be appropriate. This has included patients with poor spatial awareness as a result of their cognitive impairment, that may need reassurance and redirecting to prevent distress and/or potential conflict. It has also been reported on occasion this may be used to support patients with the highest risk of falls lower levels of engagement and observation have not been insufficient in maintaining the person's safety. This is to ensure that close support is available, for example to ensure mobility aids are accessible and used appropriately, and not to physically stop patients from falling. Nursing 1:1s in dementia care settings may differ in structure and approach due to the impact of cognitive impairment. However, maintaining positive, person-centred engagement remains essential.

Close/special observation requiring more than one staff member

In some situations, more than one staff member may be needed to support a patient during engagement and observation, including but not limited to when there are concerns about the safety of staff supporting the patient alone, and/or concerns that one staff member is not sufficient maintain the person's safety. The reasons for this must be clear in the patient's intervention plan. The patient should also be informed of the rationale given restrictive nature of this intervention. Staff should wherever possible continue to collaborate with the patient on reducing the level of engagement and observation and create shared goals to work towards recovery.

Feedback from patients around Close Engagement and Observation <u>Within Eyesight and Arm's Length:</u>

During the coproduction process of this policy, patients shared that while they understand the importance of direct observation, the need for this can sometimes feel intimidating. Examples have included when they do not wish to engage in conversation, and during intimate moments such as toileting and/or showering when privacy cannot be agreed. Some individuals reported that being under direct eyesight can feel intrusive and avoiding direct eye contact whilst safely remaining in direct sight of staff member can help reduce feelings of discomfort. Staff are encouraged to be mindful of this feedback and to approach observation in a way that is respectful and supportive of the individual's emotional safety.

Multiple Levels of Engagement and Observation

It is important to recognise that risk can be dynamic and there can be occasions where patients require different levels of observations at different times. Some examples include but are not limited to:

- Mealtimes
- Times of day known to be personal triggers
- Different levels of engagement and observations required in bedrooms in contrast to when in communal areas
- Nighttime

There may be occasions where it is safe to reduce the level of engagement and observation by night, however such decisions should be based on clinical need and assessment of risk rather than time of day. Where possible a conversation around this should take place with the patient. Any such decision must be clearly documentation in a casenote and be reflected in the person's intervention plan.

Expectations around the level of engagement and observation in such situations must be clearly documented in the person's intervention plan and communicated during handover to ensure consistency and safety.

PROCEDURE OF SAFE DELIVERY OF LEVELS OF ENGAGEMENT AND OBSERVATIONS

Admission

Effective communication is essential to delivering safe levels of engagement and observation and this should begin at the point of admission. During admission the Nurse in Charge of the shift will consider information shared by the admitting team, such as the Community Mental Health Team/Crisis Team, and/or the professionals involved in any assessments including Mental Health Act Assessment. The NIC will also discuss levels of engagement and observation with the individual being admitted. The patient should be clearly informed about the purpose and process of engagement and observation; it should also be explained that levels of observations may be increased/reduced over the admission to support safety and maximise independence. Providing such information early into the inpatient stay helps to increase understanding of ward processes and encourages the patient to actively participate in their care and treatment. Consideration should be given to the person's own resources and resilience in being able to stay safe

and access support when needed.Detailed intervention plans coproduced with the patient will support a shared understanding between staff and the patient.

Should family/carers be present at the time of admission, their views may also be taken into consideration to support a better understanding of the patient's needs. Identified family members/carers should receive information in regard to their loved one's level of engagement and observation providing the patient has provided consent to share this information.

Reviewing level of engagement and observation

A review of engagement and observation should take place whenever there are changes to an individual's needs and/or risks to ensure care remains safe and effective. Wherever possible these decisions should include discussions with the patient. Any change to a patient's level of engagement and observation will require the patient's intervention plan to be updated to reflect the change.

A review should also take place when an individual is transferred between wards, a change may not necessarily be required however consideration should be given to the impact of a new environment. This review will take place by the NIC of the new ward, taking into consideration the handover they have received, and wherever possible include a one-to-one conversation with the patient on transfer to the new ward.

Changes to the level of engagement and observation must be clearly documented, including the rationale and details of any other professionals that have been involved in the decision-making process.

Feedback from family/carers may also be helpful when reviewing the level of engagement and observation, this may be especially helpful in dementia settings, where families and carers can help staff to understand the person's history, preferences and behaviours.

Increasing the Intensity of Enhanced Engagement & Observation

Enhanced observations should only be implemented when general engagement has not been sufficient to maintain the safety of a patient and/or those around them. Decisions to increase a person's level of engagement and observation during a shift is made by the Nurse in Charge (NIC) of the ward. This should be informed by an assessment of the patient's mental health and include a discussion with the patient wherever possible, again with consideration to their own strengths and resources in staying safe. They should wherever possible be supported with decisions around how they wish to be engaged at a more enhanced level of observation and how they can be supported to keep themselves safe. The patient should be clearly informed of the change, including the reasons for the new level of engagement and observation and what this will involve.

To support decision making the NIC may discuss the level of engagement and observation with the Responsible Clinician and/or other appropriate members of the MDT. The NIC will also have access to a Shift Coordinator who may be able to provide advice to support staff with their decision making.

If the RC or any other Allied Health Professional believe that an increase in engagement and observation may support the person's safety and wellbeing, they should wherever possible discuss this with the patient. They should then communicate this recommendation to the NIC, document on Paris this discussion and where possible work collaboratively with the NIC to develop an intervention plan that supports their recommendation in practice. Wherever possible the patient should be involved in changes to their care, they should be given time to share their perspective and wishes, balancing this alongside risk.

An increase in levels of observations will also prompt a review of the patient's risk assessment. This may initially be carried out by the NIC, however best practice recommends changes are subsequently reviewed by the MDT and be discussed in ward round.

Reducing Enhanced Engagement & Observation

The decision to reduce the intensity of engagement & observation must be a team decision so that different views and perspectives can be taken into consideration and **always** in discussion with the patient. Best practice would recommend this being an MDT decision where possible, however at a minimum this should be the NIC in conjunction with the nursing team on duty. In this instance the NIC may still consider discussing with the RC and/or other allied health professionals involved in the persons care, they can also access the shift coordinator who may be able to provide advice to support decision making.

When the level of engagement and observation has been implemented to support the safety of the individual and/or others, a one-to-one conversation with the patient **must** take place prior to a reduction, recognising the individual's insight into their own needs and experiences. In dementia settings, this approach may be adapted due to the nature of such illnesses, particularly in advanced stages. However wherever possible, the person should be engaged in this process. Discussions with family and carers may also be beneficial to support decision making.

When reducing the level of engagement and observation, this change should be clearly explained to the patient, including what to expect and how to access support. Providing a clear explanation of the new level may help to prevent confusion or feelings of uncertainty and/or anxiety.

The patient should also have the opportunity to be involved in reviewing their intervention plan after a reduction in the level of engagement and observation to reflect their views and wishes around engagement and support. The reduction of intensity of engagement and observation must be supported by clear casenote documentation including the **nursing 1:1** on Paris, and an update of the WARRN risk assessment.

For patients who have been on close observation within eyesight or arm's length for more than one week, this level of engagement and observation should be reviewed in ward round every week until a reduction is agreed. This review should involve the patient, taking into consideration their views, wishes and experiences and consider needs around safety. The discussions should also include whether nursing staff are able to use clinical judgement to reduce the level of engagement and observation in the time prior to the next ward round and in what circumstances (eg creation of a safety plan)

and/or whether any discussions should take place with specific allied health professionals (eg physio for falls). This information should be supported by clear documentation in the ward round casenote.

Where there is any doubt or difference in opinion and/or uncertainty around the intensity of engagement and observation required, the decision must be discussed with the Responsible Clinician. Until the decision can be mutually agreed the level of engagement should remain at the higher level until a comprehensive MDT review of the engagement and observation can take place.

Dignity, Respect and Preferences

Whilst supporting a patient on enhanced levels of engagement and observation, it is important to consider their dignity, personal preferences, and any protected characteristics under the Equality act 2010. This includes making reasonable adjustments to ensure engagement is effective, respectful and inclusive. Consideration around language barriers that may impact on a person's ability to engage in conversations about their care, and in these circumstances supporting patients to access interpreters for conversations with staff is essential. History of trauma should also be taken into account, recognising that restrictive practices may be distressing and retraumatising for some individuals. Patient safety must remain the primary concern and this should be explored with the patient.

When a patient is being supported through close engagement and observation', efforts should be made to ensure that a staff member of the same gender carries out the observation during private activities such as using the toilet, bathing, or washing—whenever this is practically possible. However, patient safety must always take priority. If an unexpected situation arises where immediate observation is necessary to ensure safety, staff must proceed regardless of gender identity. If these situations happen frequently, the team should consider:
Developing a plan to ensure a same-gender staff member can be made available during such times.
Reviewing the patient's observation level to determine if adjustments are needed to better support both safety and dignity.

Engagement and observation at night-time

Observation must continue throughout the night to ensure those in our care remain safe during this period however changes to engagement may occur to promote sleep. The use of observations at night may still interrupt sleep, and a conversation around observations at night with patients at the beginning of their admission may be helpful for patients to understand the process.

Frequent interruptions to sleep—particularly those related to observation procedures, can contribute to emotional distress and may increase feelings of frustration, anger and/or vulnerability. To minimise this risk of these occurring conversations should take

place with the person to explore strategies and solutions and coproduce an intervention plan to improve sleep. Simple strategies and solutions suggested during the coproduction process of this policy have included the use of sleep masks and/or ear plugs.

When a patient appears asleep the member of staff carrying out the engagement and observation must continue monitor the person's physical well being, noting changes in body position and confirming signs of breathing. In Hafan y Coed, this may be possible on a fully working ROS system, however at times the staff member may need to enter the bedroom.

Safety is a primary concern and staff should not assume a person is sleeping unless there is clear evidence of life. If the staff member cannot confirm that the patient is breathing, they should approach the situation sensitively to minimise disruptions to sleep. The following steps should be taken to ensure the patient's safety:

- Entering the bedroom
- Increasing lighting if necessary
- Move close enough to hear/observe breathing

If breathing cannot be confirmed the staff member must:
- Gently rouse the individual
- Check for a pulse along with breathing if necessary
- Raise emergency alarm if required.

In occasions where staff are concerned about entering the bedroom alone, the should be carried out with the support of another staff member.

Enhanced levels of observations and patient leave

Except in cases of emergency, patients on enhanced levels of engagement and observation must only be permitted time outside of the clinical environment following agreement with the RC. The decision should be documented in the casenotes and nursing intervention plan.

It should be documented in the patient's intervention plan who is authorised to escort the patient outside of the ward environment including to any off ward therapeutic interventions. If the patient is being escorted off ward with an allied health professional (eg OT, physio), a discussion should take place between nursing staff and the professional to decide whether this falls within their scope of practice and they feel able to keep the person safe. This can also be reflected in the person's intervention plan.

When a patient on an enhanced level of engagement and observation is granted escorted leave, the NIC should take into account the experience and skills of the staff member supporting the patient at this time. Before escorting the patient off ward the NIC should confirm the staff member is also familiar with the missing person's procedure and what actions to take if the person were to abscond. Please refer to the missing person's procedure for full details.

Transfer to an Emergency Medical Setting (MEAU/A&E)

There are occasions where patients may require transfer to an emergency medical setting due concerns around physical health including illness and injuries. Due to a duty of care it is highly likely on these occasions the patient will require a staff member to accompany them to that setting to provide care and support.

The patient does not have to be on enhanced observations prior to transfer in order for it to be deemed appropriate for staff to accompany, however it should be made clear by the nurse in charge prior to transfer whether the staff accompanying the patient is present from the perspective of close observations within eyesight/arm's length or whether they are present as an accompanying member of staff providing care and support.

There are other occasions where patients may require extra support within a medical setting in comparison to the ward and require extra staff to maintain that patients safety and alleviate their distress. The nurse in charge is responsible for making this decision, and can access the shift coordinator to discuss any concerns, including arrangement extra staff to support in these instances.

Please see appendix 2 for guidance on transfer of patients to medical settings in relation to their level of engagement and observations.

Role of the Nurse in Charge

Each shift should have a clearly identified NIC, reflected on safecare. The NIC oversees staffing levels on shift, escalates concerns appropriately. The NIC will also record on safecare ward acuity and including patient welsh levels of care, which may fluctuate daily.

In relation to engagement and observation, the NIC ensures patients receive safe timely care with appropriate staff allocated to each level of engagement and observation throughout the day. The NIC should plan daily tasks with adequate rotation of staff on and off enhanced levels of engagement and observation when staffing allows. If changes occur, (eg staff redeployment), the NIC must reallocate duties and ensure new staff allocated are aware.

To support safe and effective care, the NIC must ensure all staff receive a handover that includes the level of engagement and observation a patient is being supported at and the rational for this level. This ensures that the staff member is equipped with the necessary knowledge required to maintain the patient’s safety. This information is typically shared during ward handover periods, however staff that commence the shift outside of these periods, including staff who have been redeployed to the ward must receive a handover from the NIC.

In line with the NMC code of practice the NIC remains accountable for delegating within staff members’ scope of practice, including engagement and observation duties to healthcare support workers. The NIC must be happy that the delegated staff member understands the following:

- The role of carrying out the level of engagement and observation they are allocated to.
- How to escalate concerns
- Have had full handover of the patient and understand the person’s risks

- Are aware of intervention plans including privacy arrangements, person's wishes around engagement and any communication needs
- Are SIMA trained if this is required for the particular level of engagement and observation
- Can maintain a safe environment and therapeutic boundaries
- Know how and where to document the engagement and observation.
- Understand the handover process to avoid gaps in engagement and observation.

For bank/agency staff unfamiliar with the ward the NIC must ensure that an induction to the ward has taken place including a briefing on the supportive engagement and observation policy and a chance to read this.

The NIC is responsible for ensuring accurate record keeping on shift including documentation on the ICP charts for engagement and observation. The NIC will participate in the final check of the shift as outlined earlier in the policy.

Role of the person carrying out enhanced engagement & observation

All staff participating in levels of engagement and observation should:

- Understand the UHB Supportive Engagement & Observation Policy, and revisit this as they feel needed.
- Be confident in their knowledge of the ward environment and emergency procedures, including the location of the resuscitation trolley, ligature cutters and any environmental risks.
- Ensure they have received a handover at the commencement of their shift. Staff commencing later than handover time or being redeployed from another area should report to the NIC for a handover.
- Ensure they understand the reasons for patient levels of engagement and observation and any individual needs.
- Understand how to report concerns around any findings during levels of engagement and observation
- Escalate to the NIC immediately if they feel unable to or unsure about any engagement and observation duties.
- No personal use of mobile phones, headphones, reading or puzzles in communal areas including whilst supporting patients on close engagement and observation. An exception to this is when such devices are being used to support a patient at that time, (one example would be using a mobile phone to play music to a patient, which was reported to be common when supporting patients with dementia).

Familiarise themselves where possible with patient intervention plans.

- Introduce themselves to patients on commencement of any engagement and observation.

New bank/agency staff and students should complete an induction to the ward with the NIC, and ensure they understand ward procedures.

It is <u>not appropriate for first year nursing students</u> to undertake enhanced levels of observations with a patient.

Handover Between Levels of Engagement and Observation.

Therapeutic engagement and observation involve multiple staff members, with care being handed over at regular intervals. Clear communication is essential to maintain continuity and safety.

For general and intermittent engagement and observation:

- A handover should occur hourly with the outgoing staff member sharing key updates, concerns and any actions taken with the incoming staff member.
- If the next staff member is unavailable (eg due to emergency, redeployment or unexpectedly leaving) this must be escalated to NIC immediately.
- In this situation the current staff member must continue with their engagement and observation until a safe handover can be completed to a new assigned staff member.
- Gaps in engagement and observation pose a serious risk to patient safety.

For handover of close engagement and observation within eyesight/within arms length:
The outgoing staff member should:

- Introduce to the new staff member to the patient to share trust and ongoing support from incoming staff member
- Provide incoming staff member with a verbal handover covering the last hour, ideally involving the patient in this conversation.
- Ensure incoming staff member is aware of any concerns.

There can be no gaps in close engagement and observation as this can place patients at risk of harm. At the end of their hour the staff member must remain with the patient until another staff member is free to take over.

Emergencies

All staff participating in engagement and observation should be aware of emergency procedures and know how to call for help if they cannot leave the patient. All staff should have access to a personal alarm to carry on shift to call for help when needed.

Hafan y Coed: Regular staff should wear their lanyard alarms linked to the Pinpoint system. They do not need charging every shift but staff should be aware how to check the battery. Staff have access to a green pinpoint alarm attached to keys, these can be accessed via the TRAKKA cupboard. All wards are issued with x5 temporary badges with lanyard alarms and they can access the TRAKKA cupboard for keys via the ward temporary badges.

Llanfair Unit: Pin alarms and keys should be carried by staff on shift. Alarms can be accessed in the nursing office by NIC. For temporary staff there are x4 spare keys on ward that can also be accessed via NIC.

MHSOP UHL: Personal alarms can be accessed each shift via the NIC. Bank/agency staff will not necessarily have access to keys.

St Barrucs: Staff do not have access to personal alarms but there are affray alarms located on the walls for emergencies. All staff should familiarise themselves with the location of these alarms. Bank/agency staff do not necessarily have access to keys,

should a temporary registered nurse be in charge of the medication keys on a particular shift, they will have access to a ward key attached to the medication keys.

Ligature Cutters:
Staff should not carry items such as ligature cutters in their pockets on ward as they mat be lost, misplaced or taken home, posing a safety risk. Ligature cutters should remain in designated areas of the ward for easy access in such emergency in line with the ward's procedures, all staff should be aware of where to locate these. Only UHB issued ligature cutters should be use to ensure safety and reliability.

The Reassurance Observation System (ROS) in Hafan Y Coed.

ROS is an observation tool present on most wards in Hafan y Coed and consists of an infrared camera and microphone system connected to an LCD observation panel outside the bedroom. It provides real time observation only with no recording of video or sound.

The ROS panel can be accessed by staff to check on the wellbeing of patients with minimal disruption. This can be particularly helpful at nighttime. Patients in bedrooms where ROS is installed must be made aware of this on admission and of its purpose.

During the day staff would be expected to engage with the patient on the hour rather than only observe on the ROS to better assess wellbeing and any concerns. For intermittent engagement and observation use of ROS should align with individualised intervention plans. During nighttime ROS allows staff to check sleeping patients with minimal disruption. If sound and/or visibility is poor (eg under covers, quiet breathing) staff must following observation procedures for sleep.

ROS must not be used for any close engagement and observation. Doing so risks missing warning signs that may result in harm. Such incidents should be reported as a safeguarding concern. In situations where there is concerns for staff safety during close engagement and observation, discussions should be held with the patient wherever possible and discussions with the RC and shift coordinator as to how to keep both the patient and staff safe (eg consideration to more than one staff member).

ROS panels should be closed when not in use to maintain patient privacy and dignity. Faults with ROS including panels that do not close should be reported to estates and considerations how to best protect patient dignity and privacy.

RECORD KEEPING

Integrated Care Pathway (ICP)
All patients must have an ICP record on Paris reflecting their current level of engagement and observation. Once completed this automatically updates the bedstate on Paris. This should be updated whenever a level of engagement and observation changes. The NIC may update or delegate to another registered nurse at this time.

General Engagement and Observation Record
Each ward has a general engagement and observation form that must be completed hourly by the allocated staff member. The General Observations/hourly must state each patient's name, what level of observation the patient is being nursed on, and the person

undertaking this level of observation should sign once completed. Forms may vary between wards and should be overseen by the ward manager and senior nurse to ensure they are fit for purpose.

Most forms are electronic with patient names printed in full for correct identification and are then printed out daily for staff to complete. On wards where names are handwritten, full names must still be used to ensure correct identification, this is especially important for patients who may have communication needs.

It must be clearly documented on this form every hour whether the patient has been observed whether patient is on authorised leave from the ward or if patient cannot be located including unauthorised absence. If a patient cannot be located, the staff member must immediately inform the NIC so appropriate action can be taken without delay.

Enhanced Levels of Engagement and Observation
A specific ICP chart is used for patients supported on intermittent, close engagement and observation within eyesight and at arm's length. This chart is interchangeable between across these levels to maintain continuity when levels change.

The ICP chart must include **addressographs** of patients for accurate identification, as inaccurate identification can lead to patient harm.

Reasons for enhanced engagement and observation must be stated clearly at the top of the ICP as a reminder to support staff awareness of risks and guide therapeutic engagement.

For intermittent engagement and observation, documentation should occur 5 times within the hour. For close engagement and observations, a summary of the hour can be documented. The ICP chart allows space for staff to document their interactions with as well as any changes in mental or physical wellbeing, any other concerns, and actions taken.

Documentation should be clear, compassionate and respectful, using language that a patient can understand should they wish to view their ICP chart. For close engagement and observation staff should encourage the patient to have some involvement in writing the summary of the last hour and if the patient wishes to do so.

CARE PLANNING AND COPRODUCTION

Intervention Plans
Individualised care plans are essential for safe, effective care and recovery. Every patient should have an individualised intervention plan around their level of engagement and observation and wherever possible should be coproduced with the patient. With consent, family and carers can contribute valuable insights that may support development of individualised intervention plans.

Intervention plans should have an outcome of what the intervention plan is trying to achieve and the interventions detailing how this will achieve. Intervention plans should focus on a person’s strengths wishes and recovery goals, detailing who can support the implementation of the plan. The intervention plan may also include how the person

wishes to be engaged during levels of engagement and observation, therapeutic activities available and patient interests, preferences, likes/dislikes. Intervention plans should also be time bound and include review timelines, and any situations that require urgent review. These situations should not be generic and should include specific details.

Patients should also be informed that they can request a review of their intervention plans at any time and add any new information that will support their recovery.

Allied health professionals should be involved where relevant, bringing specialist knowledge and potentially a different perspective. Allied health professionals have been consulted during the review of this policy and are committed to supporting the development of intervention plans with nursing staff when appropriate. Nursing staff are also able to access those professionals involved for support in developing collaborative intervention plans. An example may be to refer to physiotherapy for support with falls risk assessments and safe interventions.

Some patients may choose not to be involved in decisions around their care and treatment including creation of intervention plans. This is ok and should be clearly documented in the patients notes. This however should be reviewed on a regular basis by the primary nurse and MDT as patient's wishes around involvement may change. Staff should always communicate openly and compassionately to patients any decisions that have been made in regard to care, this includes patients who do not wish to have active involvement in planning of care and treatment.

Family/Carer Involvement

Patients have the right to involve their family/carers in their care whilst in hospital and should be supported in this decision. With consent families should be supported to attend ward rounds regularly and receive updates on care and treatment from MDT and also nursing staff. Families and carers value being kept informed when there is consent to share, and they can also offer valuable information especially when communication is limited for any reason that can support decision making.

Role of the Primary Nurse

The primary nurse plays a key role in coordinating the care and influencing the patient's experience during admission. They are responsible for ensuring planned therapeutic engagement with their patients to promote psychological wellbeing and recovery. This is especially important for patients who spend extended time in their bedrooms and may have limited interactions with staff.

In line with the Royal College of Psychiatrists' College Centre of Quality Improvement (CCQI), patients should receive at least one planned engagement per week their key worker or equivalent – this would be the inpatient primary nurse whilst the patient is in hospital. For patients with a cognitive impairment including advanced dementia, the primary nurse should still attempt meaningful engagement with a patient when full conversation may not be possible.

The primary nurse should also consider other barriers to communication when engaging with patients, including the use of interpreters to support one to ones. For other speech

and language difficulties communication cards may be helpful. Communication prompt cards have been developed by a speech and language therapist involved in the review of this policy and development of the engagement and observation training. These tools will support meaningful interaction and allow patients to be included in their care regardless of communication challenges.

The primary nurse may not always be the person to initially develop a patient's intervention plan around engagement and observation as this may be developed in their absence due to clinical need. The primary nurse however should review this with their patients as soon as it is possible within their therapeutic relationship to reflect the patient's needs and preferences.

Other documentation to support the ICP and nursing intervention plans:

To ensure safe, effective care:

- detailed daily case notes with evidence of engagement with the patient by the nurse completing the case note.
- Risk assessments should be up to date and linked to intervention plans
- Additionally clinical documentation tools such as pressure ulcer risk assessment and nutritional assessments can contribute to a holistic understanding of the patient's needs.

SUPPORT AND EDUCATION

Staff Wellbeing and Support

When staffing levels allow, staff should not undertake enhanced levels of engagement and observation for more than two hours consecutively unless they agree to this (eg when accompanying a patient off site). Staff allocated to long periods of time supporting enhanced levels of engagement and observation without adequate break periods may suffer from impaired concentration, particularly at night time. These situations may lead to patient harm and can also have an impact on staff wellbeing.

High acuity and frequent interruptions can lead to excessive multitasking. This can reduce concentration and increase the risk of missed engagement and observation and/or misidentification of patients. It is important for all professionals to be aware of this risk when requesting additional tasks of nursing staff and should not routinely allocate tasks that can be completed within their own scope of practice (eg arranging ward round attendance). Collaborative working and task sharing helps protect nursing time to ensure safe, effective care and delivery to patients.

Staff should be supported to take hydration and comfort breaks even during periods of low staffing. The NIC should plan accordingly and liaise with shift coordinator for support when needed. Consideration should also be given to skill mix, for example gender

specific needs for enhanced engagement and observation, and safecare should be used to highlight staffing issues, acuity and red flags.

Long term exposure to enhanced levels, particularly close engagement and observation where staff may encounter traumatic situations, can impact on staff wellbeing. Ward managers should be alert to changes in the wellbeing of their staff. Support may include stress risk assessments referral to occupational health, signposting to clinical supervision, and services such as Employee Well Being Service and Canopi.

Senior nurses should monitor ward workloads and ensure staff have the correct resources to work safely including staffing levels and review of establishments where appropriate.

The Recovery and Well Being College also provide courses that staff may find helpful to support their wellbeing. Trade unions may also be able to provide advice and support to employees that are members of those unions.

Education and Training

All staff working in inpatient settings, including temporary staff, agency students and other professionals, must read the Supportive Engagement and Observation Policy.

Training has been developed focusing on engagement and observations, and it will be available for all staff to attend. Staff will be expected to have read the policy before attending, and confirmation of this will be requested during registration on the day of the session. The purpose of the training is to complement the policy and promote the sharing of good practice. To get the most out of the session, staff will need an understanding of the policy as this will provide essential context for the training

Staff must also complete all other training relevant to their role to support thorough assessment of mental and physical health and support individual recovery.

REFERENCES

Mental Health Act Code of Practice (2016) **https://www.gov.wales/sites/default/files/publications/2019-03/mental-health-act-1983-code-of-practice-mental-health-act-1983-for-wales-review-revised-2016.pdf**

NHS Scotland (2018) From Observation to Intervention in Mental Health: a proactive, responsive and personalised care and treatment framework for acutely unwell people in mental health care –

NHS Scotland (2022) Observation of People with Mental Health Problems **https://www.gov.scot/publications/observation-people-mental-health-problems/pages/4/**

National Institute for Health and Care Excellence [NICE] (2022) Self-harm: assessment, management and preventing recurrence
https://www.nice.org.uk/guidance/ng225

National Institute for Health and Care Excellence [NICE] (2011) Service user experience in adult mental health: improving the experience of care for people using adult NHS mental health services
https://www.nice.org.uk/guidance/CG136/chapter/Recommendations#hospital-care

Nursing and Midwifery Council [NMC] (2018) The Code
https://www.nmc.org.uk/globalassets/sitedocuments/nmc-publications/nmc-code

National Institute for Health and Care Excellence [NICE] (2015) Violence and aggression: short-term management in mental health, health and community settings
https://www.nice.org.uk/guidance/ng10/chapter/Recommendations#using-restrictive-interventions-in-inpatient-psychiatric-settings-2

National Confidential Inquiry into Suicide and Homicide [NCISH] (2018) - The Assessment of Clinical Risk in Mental Health Services
https://sites.manchester.ac.uk/ncish/reports/the-assessment-of-clinical-risk-in-mental-health-services/

National Confidential Inquiry into Suicide and Homicide [NCISH] (2015) Inpatient Suicide under Observation **https://sites.manchester.ac.uk/ncish/reports/in-patient-suicide-under-observation/**

National Confidential Inquiry into Suicide and Homicide [NCISH] Safer Care for Patients Given a Diagnosis of Personality Disorder: A Learning Resource
https://sites.manchester.ac.uk/ncish/resources/safer-care-for-patients-given-a-diagnosis-of-personality-disorder-a-learning-resource/

Health Services Safety Investigation Body (2024) Patients At Risk of Self-Harm: Continuous Observation. **https://www.hssib.org.uk/patient-safety-investigations/patients-at-risk-of-self-harm-continuous-observation/investigation-report**

Homicide

Royal College of Psychiatrists (2019) Standards for Forensic Mental Health Services: Low and Medium Secure Care – Third Edition Quality Network for Forensic Mental Health Services**https://www.rcpsych.ac.uk/docs/default-source/improving-care/ccqi/quality-networks/secure-forensic/forensic-standards-gnfmhs/standards-for-forensic-mental-health-services-fourth-edition.pdf?sfvrsn=2d2daabf_6**

Royal College of Psychiatrists (2025) Standards for Older Adult Mental Health Services 6 th Edition**https://www.rcpsych.ac.uk/docs/default-source/improving-**

care/ccqi/quality-networks/older-adult-wards-qn/6th-edition-qnoamhs-standards-publishable-document-final.pdf?sfvrsn=34221800_3

Royal College of Psychiatrists (2025) Standards for Acute Inpatient Services Working-Age Adults 9th Edition https://www.rcpsych.ac.uk/docs/default-source/improving-care/ccqi/quality-networks/aims/aims_wa_6th_edition_final_version-updated_september_2017.pdf?sfvrsn=db5e4eb5_0

Royal College of Psychiatrists (2025) Standards for Psychiatric Intensive Care Units Fourth Edition https://www.rcpsych.ac.uk/docs/default-source/improving-care/ccqi/quality-networks/picu/picu-qn-standards-qnpicu/qnpicu-standards-for-psychiatric-intensive-care-units-2025-(fourth-edition).pdf?sfvrsn=6bca9e8b_3

Equality Act 2010 https://www.legislation.gov.uk/ukpga/2010/15/content

APPENDICES

Appendix 1

Bwrdd Iechyd Prifysgol Caerdydd a'r Fro / Cardiff and Vale University Health Board

Record of Enhanced Engagement and Observation

Please ensure the level and reason for observation is clearly stated to maintain patient safety

Level of Observations (please circle correct level):

Intermittent / Close within eyesight

Close within arm's length

(**Intermittent** – requirement of x5 checks within the hour, no more than 15minutes apart)

Reason for observation:

PLEASE ATTACH PATIENT ADDRESSOGRAPH HERE FOR CORRECT IDENTIFICATION OF PATIENT (TO MAINTAIN PATIENT SAFETY)

Staff Name	Date	time	location	**Engagement** - for close observations please ask patient if they would like to contribute their view of the hourly engagement	Staff Initials

○

Appendix 2

Observations – MEAU A&E Guidance

Handover at Transfer

A RN **nurse-to- RN nurse handover** must occur at the point of transfer from mental health to MEAU. MEAU also to be reminded every shift during the stay of the following:

- The current observation level and reason.
- Identified risks (e.g. falls, suicide, infection, aggression).
- Required staff type for observations (RMN or HCSW).
- Legal Framework e.g. Dols MHA
- The reason for the observation level.
- Patients with falls risk should always have standing aid with arms reach.

Infection Prevention and Control (IPC)

- All staff attending patients in MEAU must follow IPC guidance specific to the area.
- This is especially important for patients on observations to prevent transmission to parent ward.
- Where there is an outbreak in MEAU on parent ward consider minimum rotation of staff to reduce spread of infection/exposure to staff

Downgrading Observations

Observation levels may only be reduced following:

- A risk assessment conducted by Mental Health staff.
- An update to IPC documentation reflecting the change.
- MEAU staff must not send MHSOP staff away without discussion with the Mental Health Nurse in charge from the parent ward.

Specific Staffing Requirements 1:1 or Close

- When a patient is transferred to MEAU under close or enhanced observations, appropriate staffing must be arranged.
- The staff provided must match the required skill mix as outlined in the patient's care plan (e.g. RMN or HCSW).
- MEAU staff are also responsible for helping and supporting with providing 2:1 support for personal care when required.
- Mental Health staff must not be left to manage care needs that exceed staffing levels outlined in the care plan.
- Rotation of staff participating in engagement and observation must take place to maintain vigilance and reduce fatigue. Frequency can be decided by nurse in charge in discussion with staff who will be participating in engagement and observation off site and will take into consideration other factors such as location and transportation to location (eg off site in UHW).
- Robust handover provided as nurses rotate, including relevant information form minimum of last 12 hours.
- Observation rotas must be recorded on the shift allocation sheet.
- Correct observation clinical recording keeping must occur as it would if the person was on mental health ward
- The nurse providing enhanced observations must provide a report to MH nurse on parent ward so they can update case note entry each shift- e.g. how the patient has been presenting

Patients on Intermittent Observations prior to transfer

Note: General settings do not typically support intermittent observations.

For patients on intermittent observations:

- The rationale must be clearly communicated during nurse-to-nurse handover.
- Clinical care decisions and interventions should be tailored individually and documented in an intervention plan.
- Documentation must be person-centred.
- For patients at risk of falls, handover must include:
    - Fall risk details.
    - Mobilisation support.
    - Standing aids (must be within reach).

Scope of practice

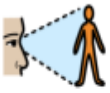
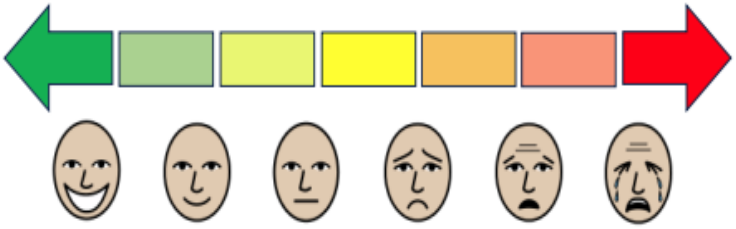
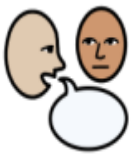
All mental health staff must practice with their scope and not be involved in medical interventions that they are not trained or skilled in performing.
Equally they need to have the correct mental health and skills and knowledge to provide care on enhanced observations

Obs Review during and Following Physical Illness

- Observation needs must be continuously reviewed during MEAU stay and after transfer back to mental health services.
- During the patients stay this would happen in partnership between mental health and MEAU teams
- This would occur if there is a change in risk or clinical presentation
- Changes in clinical presentation (e.g. resolving delirium) may increase fall risk and require:
    - Delirium screening.
    - Close monitoring.

On return to mental health the Nurse in charge reviews clinical presentation and need for observation- completing IPC tool

Appendix 3 – observations communication tool

Close observations	
	Your name:
	Your nurse/carer is:
	You are on **close** observations. A staff member will be with you **at all times**.
	The staff member may need to watch you.
	This is to keep you safe whilst in hospital. 
Mental state	
How are you feeling? 	
Is there anything you want to talk about?	

Needs			
Is there anything you **need**?			
 Drink	 Food	 Toilet	 Shower
 Brush teeth	 Brush hair	 Clothes	 Make a phone call
 Medication	 See the doctor	 Cigarette/vape	 Other
Activities			
Is there anything you **want to do**?			
 Watch TV	 Listen to music	 Use phone	 Play a game
 Go outside	 Reading/writing	 Sleep	 Go to the cafe
 Go to the shop	 Go to the gym	 Go to the Cwtch	 Other