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Observation & Enhanced Engagement Procedure

Introduction and Aim

The **key purpose of enhanced engagement and observation** is to provide a period of safety for people during temporary periods of distress when there is a risk of vulnerability, or they are at risk of harm to themselves and/or others. It is essential to ensure this period is therapeutic and supports opportunity to engage with the individual and undertake an assessment of a person's mental state.

The aim of this is to procedure minimise the risk of potentially suicidal, violent, or vulnerable patients from intentionally or unintentionally harming themselves or others as part of a broader risk management plan.

Objectives

This document includes specific guidance on:

- Determining Intensity of Engagement & Observation
- Increasing the intensity of Enhanced Engagement & Observation
- Reducing Increasing the intensity of Enhanced Engagement & Observation
- Responsibility for Engagement & Observation
- Ensuring Appropriate Allocation of Staff

Scope

This procedure applies to all of our staff in all locations 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 27th January 2023 Controlled Document Oversight Group

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1. INTRODUCTION

1.1 It must be recognised that observation is only one aspect of caring for people during periods of high distress.

1.2 The **key purpose of enhanced engagement and observation** is to provide a period of safety for people during temporary periods of distress when there is a risk of vulnerability, or they are at risk of harm to themselves and/or others. It is essential to ensure this period is therapeutic. It can also be used to provide an intensive period of assessment of a person's mental state.

It is clearly not enough to simply observe people. The process must be both safe and supportive. People who need this level of help are going through a temporary period of increased needs. Whatever the cause at that moment, they require safety, compassion, understanding and appropriate treatment. Therefore, **patients must also be engaged in a positive and therapeutic relationship** both during and after an increased period of need. For that reason, this procedure focuses on the practice of **engagement and observation** of people who are patients in mental health inpatient services.

2. POLICY STATEMENT

Intensity of Engagement & Observation

One of the key areas of clinical practice in mental health care is deciding what intensity of care is needed for individuals. To facilitate communication, care planning, intervention and training, Cardiff and Vale University Local Health Board (ULHB) only endorses **the four intensities of engagement and observation that are outlined in this procedure**

3. AIM

3.1 The aim of this is to procedure minimise the risk of potentially suicidal, violent, or vulnerable patients from intentionally or unintentionally harming themselves or others as part of a broader risk management plan.

3.2 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.

3.3 This procedure does not extend to cover observations for purposes other than those stated.

3.4 The procedure at times refers to the role of the Responsible Clinician as defined under the Code of Practice Mental Health Act 1983. The responsible clinician is defined as:

"The approved clinician with the overall responsibility for a patient's case. Certain decisions (such as renewing a patient's detention or placing patient on supervised community treatment) can only be taken by the responsible clinician."

4. OBJECTIVES

4.1 Determining Intensity of Engagement & Observation

The nurse in charge of the ward in conjunction with the nursing team on duty and admitting medical staff must make these decisions in the first instance. Such decisions must always be reviewed at the first available opportunity with members of the multi-disciplinary team and should also consider the views of the admitting Community Mental Health Team (CMHT) / Crisis Resolution Home Treatment Team (CRHTT). If the level of observation determined by the nursing team on duty or admitting medical staff diverges from the view of the CMHT/CRHTT, the reasons for this divergence must be documented.

4.2 Increasing the intensity of Enhanced Engagement & Observation

Enhanced observation must be recognised as a restrictive practice and may be seen by patients as intrusive. The guiding principle should be ensuring the least restrictive option is at the forefront of decision making and deciding the most appropriate level of observation based on the needs and the safety of the patient and others within the clinical setting, whilst balancing the need to respect the patients right to privacy. Enhanced observations should only be implemented when general engagement with the patient has failed to reduce the risks to self-and/or others, or at the point of admission/transfer if there is sufficient evidence to suggest that risks may be present,

and that routine observation levels may not fully mitigate these risks until a fuller understanding is obtained.

A decision to **increase** the enhanced engagement and observation for a person must be made by the nurse in charge of the ward on his or her own initiative or with discussions with the Shift Coordinator, or by a psychiatrist involved in the care or assessment of the person. This decision must be followed up by consultation with the appropriate doctor if not present, as soon as possible and with the MDT (Multi-Disciplinary Team) as soon as is practicable. Staff must feel empowered to escalate the enhanced engagement & observation and be supported in this action. The purpose of and the rationale for the increase must be clearly explained to the patient, documented in the patient record and will be informed by a revised risk assessment/WARRN.

4.3 Reducing Enhanced Engagement & Observation

The decision to **reduce** the intensity of engagement & observation must be a team decision and in discussion with the patient wherever possible. A **minimum** of the nurse in charge of the ward in conjunction with the nursing team on duty and the Shift Co-ordinator or Senior Nurse or psychiatrist involved in the care or assessment of the person can reduce the intensity of engagement and observation when risk assessment indicates the person is able to maintain their own safety with less direct care from staff. When the patient's multi-disciplinary team are on duty, they should be included in the decision-making process to reduce the intensity of engagement and observation. The reduction of intensity of observation must be supported by documented evidence of improvement in the reason for the observation.

4.3.2 When the person is expected to require prolonged periods (more than 24 hours) of enhanced engagement to maintain their safety the nurse in charge or senior nurse must review the status of enhanced engagement once every 24 hours that the patient remains in receipt of enhanced engagement and observation. This review must be clearly documented in the patient record. Where there is any doubt or difference of opinion about 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** of engagement suggested by the involved Clinician. This would also apply if the inpatient team felt a less intensive level of observation was indicated than the CMHT/CRHTT assessment – the higher level of observation should remain in place until the treating psychiatrist has had an opportunity to review.

4.4 Responsibility for Engagement & Observation

It must be acknowledged that it is primarily mental health nurses who provide 24-hour care and who will, therefore, carry most of the responsibility for the engagement and observation of inpatients. However, with the emphasis on multi-disciplinary team working

it seems correct that in appropriate situations other clinicians (aside from nurses) should be involved in the agreement and responsibility for undertaking of the required level of observations and engagement of a patient.

4.4.2 It is important to note that the registered nurse remains accountable for the decision to delegate the implementation of the care plan for engagement and observation to an unqualified member of staff; and for ensuring they have the knowledge and skills to undertake the role. Where this happens, an appropriate handover must take place at the beginning and end of the period, specifying the reasons for the engagement and observation and assessing the suitability of the staff receiving the responsibility to implement the care plan with the patient.

4.5 Ensuring Appropriate Allocation of Staff

4.5.1 The nurse in charge is responsible for ensuring the appropriate allocation of engagement and observation duties. They must always know both which patients are on enhanced engagement and which staff member is responsible for a given time.

4.5.2 When allocating duties for increased engagement and observation, the nurse in charge must satisfy themselves that each member of staff has the knowledge and skills appropriate to the type of enhanced engagement & observation being practised. They should consider the knowledge and skills they have in:

- Risk assessment
- Management and engagement of patients at risk of harming self and others
- Factors associated with self-harm and harm to others
- Establishing and maintaining a therapeutic relationship with the patient and their environment
- Working alongside patients who feel unsafe and vulnerable
- Therapeutic opportunities in engagement & observation
- Making the environment safe
- Recording engagement and observation
- Maintaining safe and therapeutic boundaries.

4.5.3 The person carrying out enhanced engagement & observation (whether permanent, bank or agency staff, student; or staff from other areas) must:

Have received a briefing of the UHB Enhanced Engagement & Observation Policy and have read and understood the policy.

Any member of staff assigned to undertake Enhanced Engagement & Observation should immediately escalate to the nurse in charge if they do not feel confident or able to undertake this role and reallocation of this role will need to be undertaken.

Have been fully briefed about the reasons the patient is on enhanced engagement and observation, including their history, background, and specific risk factors.

Be familiar with the ward; ward emergency procedures such as the location of ligature cutters, and potential risks in the environment, especially where environmental ligature risk assessments have identified risks

All temporary staffing including bank, agency and students working on the ward for the first time must complete the bank/agency/student induction ward checklist at the commencement of their first shift in any **new clinical ward** area.

It is **not appropriate for first year nursing students** to undertake enhanced levels of observations with a patient.

4.6 Ensuring Continuity of Care

4.6.1 Enhanced engagement and observation will involve several nurses or other staff members, with care being handed over at regular intervals. Excellent communication among staff must be maintained; the hand-over process must involve:

- Each member of staff familiarising themselves with the patient's care plan, background, and recent clinical notes before taking over the patient's care.
- A verbal hand-over report to the member of staff taking over whilst maintaining the standard of enhanced engagement and observation set, that includes the patient's risk status and clarity about escorting the patient to the bathroom
- The member of staff taking over must sign the ICP (Integrated Care Pathway) to indicate they have had a hand-over
- The member of staff handing over must then record engagement that has occurred and what they have observed on the ICP.

4.6.2 **There can be no gaps in enhanced engagement and observation within eyesight and within arm's length.** If the staff member assigned to undertake the enhanced observation and engagement is unable to continue due to their shift period ending or rest break period, there must a handover discussion detailing reason for level of observations, known risks and current presentation between the staff member taking over the level of observation and the previous staff member, and there **must be no break in cover.**

4.7 Patients and Carers Needs

4.7.1 Patients must be informed of the enhanced engagement and observation procedure in use within the service. Clear, honest, and open dialogue must take place regarding the reasons for an enhanced engagement & observation and the patient's perspective should be sought and considered as part of the decision-making process. Information regarding their current standard of engagement & observation and how long it may last must be given to the patient. Suicidal – or potentially suicidal – patients will have been offered the opportunity to create a safety plan, which will help the patient understand the reasons for the enhanced observation.

4.7.2 The aims and intensity of engagement and observation must be communicated, with the patient's approval, to the nearest relative, friend, or carer.

4.7.3 Relatives and significant others must not carry out enhanced engagement and observation.

4.8 Night-time

4.8.1 The intensity of engagement & observation **must not be reduced** based on the time of day but on an updated assessment of risk. However, there may be occasions where it is clinically appropriate to reduce observation level by night. If it felt that the patient's observations should be reduced by night, there must be clear documentation as to the reasons for this change any associated risk and mitigation should be clearly documented in the ICP. This decision should also be discussed and agreed with the Shift /Co-Ordinator prior to any change in level of observation taking place.

4.9 Sleeping

4.9.1 When a patient appears asleep the member of staff carrying out the engagement and observation must monitor their physical health noting changes in body position, breathing, etc. **Safety takes priority over privacy.** Staff must not assume that patients are sleeping and/or that they should not be woken.

4.9.2 If the member of staff has not observed the patient moving or cannot observe the patient breathing, they **must ensure the patient is safe by:**

- Increasing lighting
- Getting close enough to observe breathing
- Checking for a pulse
- Rousing them
- Satisfying themselves the patient is safe by other appropriate measures.

4.11 The Reassurance Observation System (ROS)

The Reassurance Observation System (ROS) is an observation tool specifically designed to unobtrusively observe inpatients in their bedroom areas. It comprises of an infrared camera and microphone system connected to an LCD observation panel outside the bedroom. This panel can be accessed by the observing staff member to check on the patient's safety and well-being. However, it should be noted there are occasions the ROS system may not be able to provide this reassurance, for example if the patient is lying under the bed covers, or if the system is unable to pick up signs of breathing. In this instance the patient's bedroom must be entered. The system does not record video/images or sound, only allowing real-time observation.

Patients in bedrooms where ROS is installed will be made aware of the system and explained its use as a tool to check on a patient's safety and well-being and for no

other reason. Any issues with the ROS cameras should be reported to estates immediately.

4.12 Leave

4.12.1 Except in cases of emergency, patients on enhanced engagement and observations must only be allowed time outside of the clinical environment within which they are receiving care if a previously agreed risk assessment and care plan are in place. The risk assessment and care plan must have been agreed by the Responsible Clinician and nurse in charge as sufficient to minimise any potentially increased risk arising from the patient being outside of the clinical environment within which they are receiving care.

4.12.2 The 'clinical environment within which they are receiving care' may extend beyond the inpatient ward; to a local off ward therapy setting for example. Where this is the case the decision to allow this must be part of the risk assessment process and the Responsible Clinician and nurse in charge must judge the necessary arrangements sufficient to minimise any potentially increased risk. The care plan must explicitly state if this time outside of the clinical environment is to be only with an escorting member of staff to avoid confusion. If the nurse in charge delegates this to someone else (e.g., an off-ward therapist or a family member) this must be clearly explained in the patient records.

4.12.3 In exceptional circumstances (e.g., to attend another hospital) a patient receiving enhanced engagement and observation may be allowed time outside of their usual care setting. This decision must be part of the risk assessment process and the Responsible Clinician and nurse in charge must judge the agreed escorting plan sufficient to minimise the inherent risk. If the patient is in the care of a transport provider, the responsibility for the maintenance of safe observations must be explicitly agreed and documented.

4.13 Legal Status

4.13.1 While enhanced engagement and observation may be unavoidably restrictive, they must never become a form of de facto detention for informal patients.

4.14 Escorted leave

Appropriate consideration should be given to the experience of the staff member supporting a patient during escorted leave. Staff assigned to undertake this role must have access to a mobile phone, should be familiar with the Missing Person's procedure and any subsequent actions to take in the event that the person requires additional support or absconds.

If the patient absconds during escorted leave and if there is a known serious risk of harm to self or others, the escorting nurse should immediately undertake actions as highlighted in the Missing Person's procedure: -

1. Contact the Police immediately via 999 whilst attempting to keep the patient in eye sight as much as is possible and if safe.to do so. This is in order to provide the Police with as much detail as possible as to the patient's description and whereabouts.
2. The escorting nurse should contact the Shift Co-Ordinator to report and escalate.
3. The escorting staff should continue to attempt to keep the patient within eye sight for as long as possible until either;
   - They are no longer within eyesight
   - It becomes unsafe to continue
   - The patient has been safely located or has safely returned to hospital

4.15 Record keeping

4.15.1 **The obligation on staff in relation to record keeping for engagement & observation:**

- All patients must have an ICP record completed in their clinical information on Paris to reflect their current level of observation. The nurse in charge would be required to update this record should level of observation be increased/reduced on their shift.

- 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. The staff member allocated to the observation must inform the nurse in charge of any concerns or unplanned absence arise whilst they are completing this observation so appropriate action can be taken.

- **Any enhanced level of observation must always be documented on an ICP chart.** This is to increase staff awareness of any potential risk that may be posed to themselves, or the person being nursed on enhanced observation and may help the person undertaking this observation adjust their approach and communication to meet that person's individual needs. For example, engagement with a patient who is presenting as paranoid and suspicious may differ to engagement with a patient who is experiencing suicidal ideation. The reason for observation may also help the staff member more accurately document the person's presentation during the observation and be more sensitive to signs of deterioration in a person's mental state.

- For any enhanced level of observation, the staff undertaking this observation should document clearly patient activity, presentation, and their engagement with

the patient. For intermittent observations, there must be clear documentation of engagement with the patient at least twice within the hour.

- For intermittent observations, the time each observation was carried out should be documented on the chart. For close observation, a summary of the hour of close observation undertaken should be documented.

- The allocated nurse **makes an entry** in the clinical notes **at least once every shift** that is related to the patient's behaviour and mental state (this should be based on social engagement with the patient as well as observation)

- The relevant care plan and risk assessment including WARRN (Wales Applied Risk Research Network) must be updated accordingly

- The nurse in charge ensures that the general engagement and observation form is filed properly.

5. SCOPE

This document relates to all staff including bank or agency staff, service users and visitors to the mental health areas of the Cardiff and Vale UHB (University Health Board).

6. ROLES AND RESPONSIBILITIES

6.1 The clinician allocated to implementing enhanced engagement and observation duties is responsible for doing so in accordance with this procedure.

6.2 The patient's Primary Nurse and Responsible Clinician are responsible for evaluating the effectiveness of the enhanced engagement and observation care plan.

6.3 The nurse in charge of the ward is responsible for allocating clinicians to enhanced engagement and observation duties. This includes ensuring those allocated have the knowledge and skills required to undertake these duties, are sufficiently alert and are free from other duties which could potentially impede their ability to implement the enhanced engagement and observation care plan.

6.4 The Ward Manager is responsible for ensuring members of ward nursing staff are familiar with the enhanced engagement and observation procedure.

6.5 The nurse in charge of the ward and the MDT are responsible for reviewing the intensity of engagement and observation.

6.6 The senior nurse is responsible for ensuring regular audits of the quality of enhanced engagement and observations. This audit should include;

- Standard and accuracy of documentation on ICP charts

- ICP forms completed on Paris
- WARRN completed and updated accordingly
- Care plans for observation and engagement
- Audit findings must be addressed in managerial supervision where there are discrepancies or learning points identified.
- All findings must be reported in local ward and Directorate quality and safety meetings.

7. LEVELS OF OBSERVATION

1) **General observations** – this is the basic requirement for all mental health inpatients and is to be completed once an hour.

2) **Intermittent observations** - implemented where an inpatient is at risk of any behaviour that constitutes a need for increased engagement but does not represent an immediate risk. The frequency of observation is 5 times within a 60minute period, no more than 15minutes apart.

3) **Close observations within eyesight** - implemented when an inpatient presents an immediate threat of harm to self or others and needs to be **kept within eyesight or at arm's length** of a designated one-to-one nurse, with immediate access to other members of staff if needed.

4) **Special observation within arm's length** - implemented when an inpatient is at the highest risk of harming themselves or others and needs to be **kept within arm's length** of at least one staff member, and often there may be requirement of more **than one staff member due to the risks posed.**

7.1 General Engagement and Observation:

7.1.1 Effective mental health care is about building and sustaining trusting relationships. **Every person who is receiving inpatient care in the UHB must be engaged & observed. This is the general standard of engagement and observation all inpatients can expect**.

7.1.2 General engagement & observation is appropriate for patients who are considered not to pose any serious risk of harm to self or others and are unlikely to leave the usual care setting without prior permission, escort, or at least informing staff of their planned destination. General engagement & observation is intended to meet the needs of most patients for most of the time. It should be compatible with giving patients a sense of responsibility for the use of their time in a carefully planned and monitored way and allow patients to be nursed in the least restrictive manner, whilst also supporting the development of therapeutic relationships and opportunities to assess mental state.

7.1.3 **General Engagement & Observation must include: The clear identification of the Nurse in Charge of the shift, who is responsible for:**

- The Nurse in Charge (NIC) of the outgoing shift and the incoming shift must satisfy themselves by walking around the ward to check the whereabouts and wellbeing of all patients before the handover to the next shift. The handover must include any concerns, any patients currently not present on the ward and their expected time of return, and any unplanned absences (AWOL).
- The allocation of a named nurse to each patient every shift.
- The allocation of nurses to make **visual checks every hour.** The nurse will make a record of the patient's whereabouts on the general observation form (ICP) and inform the nurse in charge of any concerns or unplanned absence, which they will record in the patient's records.
- In many circumstances the nurse in charge of the shift will be the most senior nurse on duty and in the staffing numbers

7.1.4. **The allocation of a Named Nurse for every patient at the start of each shift, who is responsible for:**

- Observing and assessing the patient's health, well-being, and behaviour (unless the patient is off the ward)
- Obtaining a verbal and/or physical response from the patient at each handover (unless the patient is off the ward this must be clearly indicated in the record)
- Working therapeutically with the patient whenever opportunities arise and recording significant factors
- Knowing the general whereabouts of all patients in their care
- Implementing the patients care plan and recording information that relates to the care plan
- Modifying assessments of need (including risk) and the resultant care plan (in conjunction with the team) when appropriate
- Making an entry in the electronic clinical notes at least once every shift that is related to the patient's mental state (this should be based on social interactions with the patient as well as observation)
- Ensuring that the patients care plan and risk management plan reflects their current risk status.

7.15 Role of the Primary Nurse in engagement and observation:

- The primary nurse should engage at least once per week in a therapeutic one to one session with their named patient in line with the AIMS standard, this should be documented under "nursing 1:1" on Paris.
- The primary nurse should make sure there is a care plan for the level of observation to be carried out for their named patient and what may prompt a review.

- The primary nurse should indicate in the patient's intervention plan the patient's current symptoms so the frequency and intensity of such symptoms can be assessed by all ward staff and documented in the patient's case notes.
- Intervention plans must also include 'meaningful' daytime activity to enhance patient experience and their engagement, and should include a balance between therapy, physical exercise and work or leisure pursuits, as appropriate, and access to fresh air where possible.

7.2 Intermittent Engagement & Observation

7.2.1 The patient must be clinically assessed as requiring enhanced engagement and observation because of the risk posed potentially, but not immediately, by their mental and/or physical state.

7.2.3 As part of their risk management plan, patients who are vulnerable or have previously been at high risk of harm to self or others may require planned intermittent engagement & observation. It may also be appropriate as a step down from more intensive engagement & observation, with the rationale that patients who have become used to the one-to-one support of a member of staff to manage their distress can get used to managing with less support in a planned way.

7.2.4 **The patient must <u>be seen</u> and assessed 5 times within the hour, at intervals of no longer than 15 minutes apart.** Staff must be mindful to ensuring that observations are neither predictable nor regular (i.e., engagement <u>must not be</u> at exact intervals. **This is incredibly important for patient safety and to reduce the risk of harm that may arise from predictability.**

7.2.5 Checking the person should not just be about seeing that they are safe. Observations need to be carried out sensitively to cause as little intrusion as possible – and the patient should be invited to discuss any changes to how safe they are feeling. **Safety issues are of greater importance than privacy and dignity and** the procedure by staff of checking on a patient's safety should be seen in terms of positive engagement with the patient.

The documentation on the ICP chart must include the patient's presentation, the engagement taken place with the patient and the location of the patients whereabouts when the observation took place. There must be evidence of engagement with the person documented on the ICP at least twice within the hour period.

7.2.6 Patients on intermittent engagement & observation **must have a care plan that clearly indicates:**

- The level of observation to be carried out and the reason for the intervention.

- The task for the observer e.g., *Encourage patient to spend less time on their own; Check for signs of increased agitation and if displayed…; Note any expressed*

hopelessness and…; Once a shift engages the patient in a discussion around their care plan and assess their current intent to harm themselves

- Consideration of environmental dangers and means to deal with them.

- What activities the patient can safely engage in and where i.e., therapy groups, sports, work programmes etc.

- Access to fresh air when possible.

7.3.1 **To minimise the inherent risks in intermittent engagement & observation it must not be used where risk of suicide is deemed to be imminent,** as the gaps in engagement and observation would allow opportunity for harm. In these cases, within eyesight or within arms' length engagement and observation may be warranted.

7.3.2 Clinical Teams who practise planned intermittent engagement & observation should be aware of the risk that gaps in engagement & observation present to patients and be clear that they have considered this issue as part of their decision-making process.

7.3.3 There may also be occasions where patients who engage in chronic self-harming behaviours may not benefit from intermittent observation and in fact this may increase the risk of harm. In such instances there should be clear MDT discussion in the case notes around the risks posed and rationale for the level of observation to be implemented, this should also be clearly documented in the patient's risk assessment/ WARRN and care plan.

7.3.3 The member of staff undertaking this enhanced engagement & observation must have the knowledge and skills to do so and be familiar with the observation and engagement policy and the needs of person.

7.3.4 Consideration needs to be given to issues of privacy, dignity and the preferences of the patient, including their ethnicity, gender, religion, sexuality, and these considerations must be explained to the patient and recorded.

7.3.5 This review must be clearly documented in the patient's notes, including:
- The information informing the decision
- The contributing members of staff
- The main concerns
- The outcome of the review

How the outcome was shared with the patient and the rest of the Team.

7.4.1 Close Observation and Engagement - Within Eyesight

7.4.2 The patient must be clinically assessed as requiring intensive intervention because of the imminence of the risk posed by their serious mental and/or physical state, or because of their vulnerability as stated in 1.2

7.4.3 **The patient must always be in sight of a member of staff**. Any negotiated exceptions in respect of privacy (e.g., to use toilet) **must** be agreed by the Clinical Team in the context of the assessed risk and the method and purpose of maintaining engagement and observation at this time, clearly stated, and recorded in the patient's care plan.

7.4.4 Every effort must be made by the nurse to actively engage with the patient during the time they are allocated to within eyesight engagement and observation, this engagement must be clearly documented on the ICP chart. For patients at risk of suicide, consideration must be given to using tools to understand and mitigate the risk of suicide, during the 1:1 time afforded by the very nature of close observations.

7.4.5 Consideration needs to be given to issues of privacy, dignity, and the preferences of the patient, including their ethnicity, gender, religion, sexuality, and language. However, **safety issues are of greater importance than privacy**. These considerations must be explained to the patient and recorded.

7.4.6 In some situations, more than one staff member may be required to support the patient and reasons for this must be recorded in the nursing intervention plan.

7.4.7 If the patient is assessed as being at risk of being violent to others or of making malicious accusations then the member of staff must **not** be placed at risk by being left alone and in such instances close observation of more than one staff member may be indicated, e.g., 2:1 observation. This should be recorded in the nursing intervention plan and on the ICP chart.

7.4.8 The environmental dangers need to be discussed and incorporated into the intervention plan. Any tools or instruments that could be used to harm self or others must be removed. It will be necessary to search the patient and their belongings whilst having due regard for patients' legal rights; please refer to the search policy. If the patient wishes to use the toilet, bathroom etc., **the area must be checked** before use for potentially dangerous items. The search and findings should be documented in the patient's progress notes and the Enhanced Engagement and Observation record (ICP).

It should be noted that some patients, for example patients with difficulties regulating their emotions and with chronic self-harm/suicidal ideation may not benefit from the removal of all hazardous items and there should be a clear care plan devised as a result from MDT discussion for managing this potential risk.

7.4.9 When the clinical area is optimally staffed the member of staff undertaking engagement and observation within arm's length should do so for **no longer than two hours in succession.** This is in recognition of the possible difficulty of maintaining concentration for more than this time. During this time the wellbeing of staff members should be considered, and staff should be supported to access hydration or comfort breaks as required and appropriate cover should be provided. Where staffing levels are below agreed numbers, consideration should be given to seeking support from other clinical areas via the Shift Co-ordinator for the rotation of assigned staff, to ensure staff wellbeing and patient safety.

7.4.10 This review should be clearly documented in the patient's notes, including:

- The information informing the decision the contributing members of staff the main concerns
- The outcome of the review
- how the outcome was shared with the patient and the rest of the team

7.5 Close Observation and Engagement – Within Arm's Length

7.5.1 The patient must be clinically assessed as requiring this intensive intervention because of the imminence and danger of the risk posed by their mental and/or physical state or their vulnerability. It is recognised that this level of observation and engagement may feel intrusive and uncomfortable for many people, but its effectiveness as a life-saving intervention must not be under-estimated.

7.5.2 The member of staff undertaking this enhanced engagement & observation must have the knowledge and skills to do so and be familiar with the observation and engagement policy and the needs of person.

7.5.3 The patient must be always in sight and within an arm's reach of a member of staff and in **all circumstances**.

7.5.4 Consideration needs to be given to issues of privacy, dignity, and the preferences of the patient, including their ethnicity, gender, religion, and sexuality. However, **safety issues are of greater importance than privacy**. These considerations must be explained to the patient and recorded.

7.5.5 During within arm's length engagement and observation, a **member of staff of the same sex should always observe a patient using toilet, bathing, or washing facilities, or when undertaking other intimate activity.** However, **safety issues are of greater importance than privacy** and for that reason, unplanned intimate events must be observed no matter the sex of the staff member. It is recognised that this may be distressing for the patient, so it must be carefully and supportively explained on each occasion that it happens.

7.5.6 In some situations more than one staff member may be required and reasons must be recorded in the care plan.

7.5.7 If the patient is at risk of being violent to others or of making malicious accusations then the member of staff must **not** be placed at risk by being left alone and this should be recorded in the care plan.

7.5.8 The environmental dangers need to be discussed and incorporated into the care plan. Any tools or instruments that could be used to harm self or others must be removed. It will be necessary to search the patient and their belongings whilst having due regard for patients' legal rights and refer to the UHB's search policy. If the patient wishes to use the toilet, bathroom etc., **the area must be checked** before use for

potentially dangerous items. The search and findings should be documented in the patient's electronic records.

7.5.9 When the clinical area is optimally staffed, the member of staff undertaking engagement and observation within arm's length should do so for **no longer than two hours in concession**. This is in recognition of the possible difficulty of maintaining concentration for more than this time. During this time the wellbeing of staff members should be considered, and staff should be supported to access hydration or comfort breaks as required and appropriate cover should be provided. Where staffing levels are below agreed numbers, consideration should be given to seeking support from other clinical areas via the Shift Co-ordinator for the rotation of assigned staff, to ensure staff wellbeing and patient safety.

7.5.10 The nurse in charge or senior nurse **must** review the need for this intensity of engagement & observation as appropriate; and as a minimum, once every 24 hours. If a doctor who is familiar with the patient's current mental state is available, they should also be included.

7.5.11. This review should be clearly documented in the patient's notes.

8. IMPLEMENTATION

Before the policy is implemented there needs to be discussion at Clinical Board, Directorate and Ward Quality and Safety meetings to ensure staff are aware of the changes within the policy, including the number of observations increasing from 15 minutes to 5 times per hour for patients who are on an intermittent level of observations. It is the responsibility of the ward management team to ensure that all staff are aware of this change.

9. REFERENCES

Mental Health Nursing: 'Addressing Acute Concerns' *Report by the standing Nursing Committee,* June 1999.

Violence, The short-term management of disturbed/violent behaviour in in-patient psychiatric settings and emergency departments, 2005.

Mental Health Act, Code of Practice, HMSO.

Bowers Len, City 128 study, www.citypsych.com.

Jones R. Mental Health Act Manual 14th Ed.

Sainsbury Centre for Mental Health (2006) the Search for Acute Solutions

Standing Nursing and Midwifery Advisory Committee Recommendations for Observation of Service Users within Mental Health Inpatient Areas(snmac:2000).

The psychiatric ward environment and nursing observations at night: A qualitative study (2019) https://onlinelibrary.wiley.com/doi/full/10.1111/jpm.12583

Methods of observation in mental health inpatient units (2006) https://www.nursingtimes.net/clinical-archive/assessment-skills/methods-of-observation-in-mental-health-inpatient-units-30-05-2006/

10. EQUALITY IMPACT AND ASSESSMENT

Has an equality impact assessment been carried out? If 'yes' append it. If 'no' explain why.

Has any adverse impact been identified? If so, is it justified and lawful?

Explain how the document promotes equality of opportunity and/or good relations between diverse groups.

11. MONITORING COMPLIANCE AND EFFECTIVENESS

Evidence to demonstrate compliance against this policy includes:

- Clinical Observation Records/ICP
- Clinical Risk Assessments
- Care Plans
- Notes from MDT meeting/ward reviews where the decision to re-grade is clearly noted
- Paris records

12. REVIEW

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