University Hospitals of North Midlands NHS
NHS Trust

Trust Policy No. C08
Therapeutic Observation (Specialling) of Adult Patients who are considered at risk of harm to themselves or others

The following personnel have direct roles and responsibilities in the implementation of this policy:

- **All clinical staff**

Version	**3**
Ratified by:	**Quality and Safety Forum**
Date Ratified:	**November 2017**
Date of Issue via Intranet:	**November 2017**
Date of Review:	**November 2020**
Trust Contact:	**Deputy Chief Nurse**
Executive Lead:	**Chief Nurse**

Statement on Trust Policies

Staff Side and Trade Unions
The University Hospitals of North Midlands NHS Trust is committed to ensuring that, as far as is reasonably practicable, the way in which we provide services to the public and the way in which we treat our staff reflects their individual needs and does not discriminate against individuals or groups on any grounds.

Equality and Diversity
The University Hospitals of North Midlands aims to promote equality and diversity and value the benefits this brings. It is our aim to ensure that all staff feel valued and have a fair and equitable quality of working life.

Equality Impact Assessment
The organisation aims to design and implement services, policies and measures that meet the diverse needs of our service, population and workforce, ensuring that none are placed at a disadvantage over others. The Equality Impact Assessment tool is designed to help you consider the needs and assess the impact of your policy'.

Information Governance
Any Trust policy which impacts on or involves the use and disclosure of personal information (patient or employee) must make reference to and ensure that the content of the policy is comparable with the relevant statutory or legal requirement and ethical standards

Data Protection Act 1998 and the NHS Confidentiality Code of Practice
The Data Protection Act (DPA) provides a framework which governs the processing of information that identifies living individuals. Processing includes holding, obtaining, recording, using and disclosing of information and the Act applies to all forms of media, including paper and images. It applies to confidential patient information but is far wider in its scope, e.g. it also covers staff personnel records. The DPA provides a legal gateway and timetable for the disclosure of personal information to the data subject (e.g. health record to a patient, staff file to an employee).

Whilst the DPA applies to both patient and employee information, the Confidentiality Code of Practice (COP) applies only to patient information. The COP incorporates the requirements of the DPA and other relevant legislation together with the recommendations of the Caldicott report and medical ethical considerations, in some cases extending statutory requirements and provides detailed specific guidance.

Freedom of Information Act 2000
The Freedom of Information Act 2000 (FOIA) is an Act which makes legal provision and creates a legal gateway and timetable for the disclosure, to the public, of the **majority** of corporate information held (but not necessarily created) by this Trust. The Trust has a legal responsibility to proactively provide a large amount of information to the public and to pro-actively respond to specific requests for information. Information will not be disclosed when the Trust can claim legal exemption. Any non-disclosure must be conveyed in writing; quoting the relevant exemption together with signposting to internal and external methods of complaint. Locally, guidance on the DPA, FOIA and COP can be obtained from the Information Governance Manager or the Caldicott Guardian.

Mental Capacity Act

Any Trust policy which may affect a person who may lack capacity should comply with the requirements of the Mental Capacity Act 2005 (MCA)

The MCA and its associated Code of Practice provides the framework for making decisions on behalf of individuals who lack the mental capacity to do these acts or make these decisions for themselves. Everyone working with and/or caring for adults who lack capacity, whether they are dealing with everyday matters or life-changing events in the lives of people who lack capacity must comply with the Act.

In a day to day context mental capacity includes making decisions or taking actions affecting daily life – when to get up, what to wear, what to eat etc. In a legal context it refers to a person's ability to do something, including making a decision, which may have legal consequences for the person lacking capacity, or for other people.

The Code provides guidance to all those working with and/or caring for adults who lack capacity, including family members, professionals and carers. It describes their responsibilities when acting or making decisions with, or on behalf of, individuals who lack the capacity to do this for themselves. In particular, it focuses on those who will have a duty of care to a person lacking capacity and explains how the legal rules set out in the Act will work in practice.

The Health Act: Code of Practice for the Prevention and Control of Health Care Associated Infections

The purpose of the Code is to help NHS bodies plan and implement how they can prevent and control HCAI. It sets out criteria by which managers of NHS organisations are to ensure that patients are cared for in a clean, safe environment, where the risk of HCAI is kept as low as possible. Failure to observe the Code may either result in an Improvement Notice being issued by the Care Quality Commission, or in the Trust being reported for significant failings and placed on 'Special Measures'.

The Code relates to healthcare provided by all NHS bodies. Each NHS body is expected to have systems in place sufficient to comply with the relevant provisions of the Code, so as to minimise the risk of HCAI to patients, staff and visitors.

The Trust Board must have an agreement outlining its collective responsibility for minimising the risks of infection and the general means by which it prevents and controls such risks.

Effective prevention and control of HCAI must be embedded into everyday practice and applied consistently by all staff.

Human Rights

The Trust is committed to the principles contained in the Human Rights Act. We aim to ensure that our employment policies protect the rights and interests of our staff and ensure that they are treated in a fair, dignified and equitable way when employed at the Trust.

Sustainable Development

The University Hospitals of North Midlands NHS Trust (UHNM) is committed to demonstrating leadership in sustainability and has a Trust Board approved Sustainable Development Management Plan (SDMP): *Our 2020 Vision: Our Sustainable Future* which sets out the route to developing a world-class healthcare system that is financially, socially and environmentally sustainable.

There are three 'Key Priorities' to aim for by 2020. With the help of employees, key partners and other stakeholders the trust will embed opportunities to:

1. Reduce our environmental impact, associated carbon emissions and benefit from a healthier environment;
2. Improve the resilience of our services and built environment as a result of severe environmental and climatic changes;
3. Embed sustainable models of care and support our local community to be well-connected, healthy, resilient, independent and managing their lives in a positive way.

The SWITCH campaign is designed to achieve these priorities. It is relevant to all departments and all members of staff. The focus is on using resources sustainably in order to provide better patient care, improve health and our working environment.

Version Control Schedule

Final Version	Issue Date	Comments
1	January 2014	Uploaded following ratification
2	December 2015	Policy updated following integration with County Hospital
3	TBC	Amended Behavioural Chart in Appendix G

Contents **Page**

Introduction

1.1 The Trust is committed to improving standards of care and delivery of service that is of the highest quality possible. This includes ensuring there is a system of monitoring in place applicable to patients needs and responsive to alterations in risk, whilst cost effective and efficient.

1.2 Historically in the Trust, when the nursing and/or medical staff have made the decision that a patient requires close supervision in order to maintain his or her safety, it has been common practice to assign a member of staff to supervise (Special) the patient.

1.3 The term 'Therapeutic Observation' is used throughout this policy to refer to the type of supervision commonly known as 'Specialling'.It has been developed, based on National guidance for patient observation issued by the National Institute for Health and Clinical Excellence (2005) in order to provide a structure to support the decision to instigate Therapeutic Observation of a patient, and guide the practical application of this decision.

1.4 Formal observations may impact on the individual's human rights, their privacy and dignity, and for this reason require a skilled and balanced approach to maintaining these rights in a safe environment, using the opportunity for therapeutic interventions in order to facilitate the patient's recovery.

1.5 Nursing staffing ratios / establishments have traditionally reflected bed occupancy not dependency / acuity of patients. Levels of therapeutic observation above level 1 may have an impact on standard staffing / skill mix numbers and requires extra controls and reporting and may require the use of temporary staffing from nurse bank.

1.6 This policy should be read in conjunction with the following documents:

- Nursing & Midwifery Council 2008 The Code: Standards of conduct, performance and ethics for nurses and midwives.
- Trust Policy C17b Duty Rota Administration and Staff Rostering for Nursing, Midwifery and Allied Health Professionals
- Reference Guides
    - Mental Capacity Act (2005) Accessed via Trust Intranet – Clinical Section
    - DOLS. Accessed via Trust Intranet – Clinical Section
    - Code of Practice – Mental Health Act 1983
    - Trust Privacy and Dignity policy C 32
    - Trust Security Policy (EF02)
    - Trust Management of Violence and Aggression Policy (EF15)
    - Trust Policy for Protection of Vulnerable Adults from Abuse (C36)
    - Standard Operational Procedure for the use of Security guards for the management of the violent patient
    - C24 Policy for the Handover, Transfer and Escort Arrangements of Adult Patients between Wards and Departments
    - RM08 Prevention & Management of Patients Slips, trips and Falls

1.7 An Equality Impact Assessment has been completed and shows that this policy has no negative impact on equality.

2. Policy Statement

2.1 The Trust recognises the diversity of the local community and those in its employment. Our aim is, therefore, to provide an environment that is safe, free from discrimination and a place where all individuals are treated fairly, with dignity and appropriately to their need.

2.2 The objective of this policy is to provide a framework for all therapeutic observation, and also heightened levels of therapeutic observation – when patients may be considered "at risk" of harm to themselves and/or others and/or are considered to have an unstable mental condition which may deteriorate. The level of observation will be determined and reviewed following a clinical risk assessment.

2.3 It outlines the responsibilities of staff at all levels to provide a clear pathway of care.

2.4 It outlines the process by which levels of therapeutic observation are determined, recorded and reviewed.

2.5 It promotes the person centred care approach to determining therapeutic observation levels.

2.6 It promotes evidence based practice

2.7 It identifies a review process for the use of extra staffing.

3. Scope

3.1 This policy applies to all employees of the University Hospitals of North Midlands, in all locations including temporary employees, agency staff, bank workers, contractors, locum staff, patients, visitors and any other person who may be affected by its undertaking.

4. Definitions and Guidance

4.1 There are 4 defined levels of therapeutic observation (also see appendix B)

Level of Therapeutic Observation	Descriptor	Action	Evidence
Level 1	General therapeutic observation	Complete comfort rounds/ General assessment of condition at least at beginning and end of each shift.	Recorded in Medical & Nursing Documentation.
Level 2	Intermittent therapeutic observation	Therapeutic Observation at pre-defined intervals, agreed within the care plan. Staff consulted/ made aware of the need for Therapeutic Observation.	Summary of behaviour, physical and mental state recorded in Medical & Nursing Documentation. Consider the use of behavioural charts/ Dementia screening tool where applicable
Level 3	Within Eyesight	One nurse to one patient. Patient within eyesight at all times. Positive engagement with patient. Usually allowed privacy (unless deemed at risk of falling) in the toilet although anticipated time lapses must be reflected in the care plan. Consider whether patient's liberty deprived (contact Senior Nurse Safeguarding if in doubt).	Care plan for therapeutic observations. Regular summary of patient's care, condition and treatment. Rationale for any deprivation of liberty must be clearly documented. Relatives should be made aware of the use of Level 4 observation due to the infringement on the patient's privacy.
Level 4 (this would include, violent, aggressive and high risk patients)	Within arm's length as appropriate Designed for use in exceptional circumstances	Close proximity – be mindful that this may escalate a person's behaviour and you may have to adjust the distance between yourself and the patient. May require more than one staff member. On-going assessment. Positive engagement with patient. Designated nurse present at all times Consider whether patient's liberty deprived (contact Senior Nurse Safeguarding if in doubt).	Care plan for therapeutic observations. Regular summary of patient's care, condition and treatment Relatives should be made aware of the use of Level 4 observation due to the infringement on the patient's privacy.

4.2 The level of Therapeutic Observation required must be decided based on the Risk Assessment (Appendix D), and should be reassessed whenever any change in the patient's condition/circumstances occur or as a minimum in accordance with the review period in appendix D
NB. This can be an increase or decrease in the level required.

4.3 For guidance and advice when assessing older patients, who require Therapeutic Observation, involvement of the liaison nurses for the Elderly Mentally Infirm (EMI) within RAID (Rapid Assessment Interface Discharge team) - bleep [redacted] speed dial for pager; ([redacted]). The final decision on the level of observation required is the responsibility of the ward team.

Advice/involvement of liaison psychiatry services should be considered for some younger adults this might also include advice from the RAID team if due to mental health issues/dementia

5 Roles and Responsibilities

5.1 Chief Executive

- To ensure the provision of adequate resources to enable effective implementation of this policy
- To maintain effective reporting mechanisms into the Board in connection with this policy

5.2 Chief Nurse

- To ensure the provision of adequate training resources to enable the effective implementation of this policy
- To monitor decisions made under the Therapeutic Observation policy
- To create and maintain effective reporting mechanisms into the Board in connection with this policy

5.3 Associate Chief Nurses

- To manage and organise Divisional resources to enable effective implementation of this Policy which may include provision of extra clinical or security staff, on some shifts for some patients
- To monitor and review divisional performance in connection with this policy
- To report issues related to the implementation of this policy via the divisional governance structure

5.4 Medical Staff

- Liaise with nursing staff to identify and review the level of therapeutic observation required for patients using the assessment criteria identified in Appendix D.

5.5 Sister/Charge Nurses, Matrons, Nurse Practitioners and Adult Safeguarding Nurse

- To work together with medical staff and the multidisciplinary team to identify, initiate and review the level of therapeutic observation required for patients using the Violent Patient Risk Assessment (Appendix D) and the Level of Therapeutic Observation descriptors (Appendix B).

- To ensure the level of Therapeutic Observation required is amended appropriately (either increased, maintained or decreased) according to the patient's needs

- To carefully consider requests for additional resources for a "therapeutic observation role"

- It should be noted however that agency or bank staff should not be routinely allocated to provide the supervision unless they have attended specific training to be able to deliver observation and therapeutic intervention

- To ensure that the nurse allocated to the role of 'Therapeutic Observation nurse' receives a break at least every two hours and is not performing this role for their entire shift.

- To ensure DATIX forms are reviewed and action plans implemented immediately

5.6 Clinical Staff

- To supervise the patient according to the level of therapeutic observation indicated, and complete observation chart (see Appendix G).

- Follow the procedure for therapeutic observation of patients.

- To maintain the dignity of the patient and to be fully aware of the Deprivation of Liberty Safeguards that may be evoked.
  assessment holds

- To escalate to Sister/Charge Nurse. Matron, Nurse Practitioner when unable to implement.

- To escalate any concerns to Nurse-in-charge.

- Complete DATIX to highlight untoward incidents or near misses.

6 Education and Training

Clinical staff undertaking therapeutic observation (specialling) should have undertaken preparation for this role which includes the importance of behaviour charts, maintaining individual safety in the event of aggression and the importance of engaging the patient in therapeutic activity. Staff should have received appropriate training and induction, which should include awareness of this policy and it's guidance of observation levels, their purpose and practice.

Clinical staff providing Level 4 Therapeutic Observation should be experienced in managing challenging behaviour.

Training should be held in the staff personal record. Ideally within ESR.

7 Monitoring and Review

Monitoring Arrangements

Regular monitoring will take place to give assurance to the Executive Committee that there is compliance against the policy. This will include:

- Incident reporting via Datix
- Monthly reports to Adult Safeguarding Nurse from Security Manager (Sodexo) when security officers have been requested
- Regular audit of patient notes of challenging patients requiring support from security officers to view compliance of documentation

Review

This policy will be reviewed in three years or sooner if legislation dictates otherwise.

References

National Institute for Health and Clinical Excellence (NICE) 2005

Violence: The short-term management of disturbed/violent behaviour in in-patient psychiatric settings and emergency departments Improving Practice: Improving Care (Guideline Commissioned by NICE 2005)

Clinical Guideline 25. [Online]. Available at:-
http://www.nice.org.uk/nicemedia/live/10964/29715/29715.pdf. (Accessed 19.01.2012)

Appendix A

Procedure for planned therapeutic observation

The primary purpose of any planned level of therapeutic observation will be to either

- Ensure the safety of the observed person
- Ensure the safety of others from the observed person
- Or both of the above

	Action	Rationale
1	The level of therapeutic observation planned must result from a risk assessment (Appendix D). • On admission, each patient will be assessed by medical and registered nursing staff using the Violent Patient Risk Assessment (Appendix D). • The level of Therapeutic Observation will be determined by the medical & nursing staff and specialist psychiatric advice as appropriate. The assessment will be recorded in the Nursing notes	To ensure that the patient safety is maintained by using the correct level of therapeutic observation (Appendix B) .
2	Where the patient has mental capacity, informed consent should be sought; the reasons behind any therapeutic observation level and/or limits set should be explained to the patients in terms and methods compatible with their understanding. Where the patient lacks capacity a Mental Capacity/Best Interests assessment form should be completed to inform all decisions.	To ensure that informed consent is gained
3	For patients with learning disability, mental health needs or those lacking capacity, carers and relatives should be consulted and support staff assessing the person's risk. In an emergency situation, where this is not possible, the carers and relatives should be consulted as soon as is practically possible.	To ensure that the patient's needs are accurately identified.
4	Relatives should be involved with the patients care as much as possible, dependent on their own and the patient's wishes. In particular, explanations should be given sensitively about the level of Therapeutic Observation used.	To maintain normality for the patient. To avoid misunderstandings
5	The reason for the level of therapeutic observation and when the next review is due will be specified in the nursing records. Level 3 and 4 will be reviewed at least every 4 hours by the senior nurse of the ward in conjunction with Matron/Medical staff. Therapeutic observation of the patient should always be carried out in such a way as to	To maintain an accurate record of actions and rationale for such actions. To ensure that any changes are identified and levels of therapeutic observation are appropriate To maintain the Privacy and Dignity of the patient

	Action	Rationale
	enhance the safety of the patient whilst preserving his/her dignity and privacy.	
6	Levels of therapeutic observation to be used should distinguish between those necessary when the patient is awake and those required when they are asleep.	To ensure that patient safety is maintained at all times
7	The clinical records should clearly indicate that the specified level of therapeutic observation is being carried out.	To provide a clinical and legal record of care
8	Along with other important aspect of care, the level of therapeutic observation the person is receiving should be communicated at each handover of staff.	To promote continuity of care.
9	Any nurse allocated to the task of observing the patient should have attended Conflict Resolution training within the previous 3 years and be experienced in managing challenging behaviour for Level 4. The nurse should also be well briefed with regards to the patient's history, background, risks and needs.	To protect patients, staff and others.
10	Nurses should observe for the following features and document any changes. • general behaviour, levels of co-operation, acceptance of help • morbid ideas, violent thoughts/fantasies • self-blame, hopelessness and suicide intent • moods and attitudes • appearance and dress • orientations, awareness and memory • Insight into current situations • Hallucinations / delusions • Substance misuse	To identify changes in the patient and ensure that the correct level of therapeutic observation is being used
11	Nurses allocated to a patient requiring therapeutic observation levels 3 and 4 should not perform this function for longer than 2 hours (or less if staff indicate otherwise) at a time without receiving a break of at least 15 minutes The nurse in charge should ensure adequate staff are available to deliver care appropriately and if a shortfall is identified then they must escalate in accordance with Policy C17b, Appendix 8.	In order to minimise staff stress. To maintain the safety of the patient, other patient's, visitors and staff within the clinical area
12	A mechanistic approach to the therapeutic	It is totally inadequate and unacceptable

	Action	Rationale
	observation process, which may be seen a "watching the doors" or "guarding the patient" **should not** be used.	practice
13	Moving the patient to a side room or alternative bay should be considered where external stimuli appear to be affecting the patient's behaviour, ensure this area is free from items that may cause harm to themselves or others.	To reduce the effects of the external stimuli.
14	Whenever possible the observing nurse should engage the observed person in some constructive and therapeutic activity or intervention, offering support and comfort.	It can be an opportunity to develop a rapport and build up a relationship and strengthen the therapeutic relationship between the observing nurse and the person being observed.
15	It is the responsibility of the nurse in charge to ensure that the level of therapeutic observation as detailed in the care plan is appropriately maintained at all times.	To maintain the safety of the patient, other patients, relatives and staff.
16	The Registered Nurse has the authority and mandate to unilaterally increase the level of therapeutic observation offered to an in-patient if in their clinical judgment, it is necessary to do so. Such action should be recorded in the medical records. The decision will be followed up as soon as practicable by a medical review to identify or exclude any physical reason that has affected the patient – the results of the review will be documented in the medical records. The decision will be jointly reviewed between designated medical and nursing staff at a mutually agreed time.	To ensure that the level of therapeutic observation is appropriate at all times. To maintain accurate records. To ensure that any treatment that may be required to reverse or treat a physical reason is given as soon as possible. To ensure that the level of therapeutic observation is appropriate at all times.
17	If a situation arises where medical and nursing staff cannot agree the appropriate level of therapeutic observation, the patient will remain on a higher level of therapeutic observation.	To maintain the safety of the patient, other patients, relatives and staff.

Appendix B

Level of Therapeutic Observation Descriptors

There are 4 defined levels of therapeutic observation.

Level 1: General Therapeutic Observation

The location of the patient should be known to staff at all times, but they are not necessarily within sight.

- At least twice per shift, the patients allocated registered nurse will endeavour to communicate with the patients and an entry of the outcome of any assessment will be made in the patients nursing notes/medical records.
- The use of comfort rounds is the vehicle by which this can be monitored and recorded.
- At the beginning and end of every shift the whereabouts and general condition of all patients should be part of the handover.

Level 2: Intermittent Therapeutic Observation

This is an increased level of observation for patients, who after assessment, may be deemed to be a potential risk of disturbed and/or violent behaviour and/or fall. This may include those who have a history of previous risk but are in the process of recovery. Patients assessed to be within this category should have a special observation" care plan which should clearly indicate:

- The intervals at which observations should be carried out. Exact times should be specified in the care plan
- The need for an assessment by the registered nurse of the patient on each shift and a summary of the patient's behaviour, physical and mental state should be recorded in the nursing records / patient notes at the end of each shift. All staff on that shift and those who are responsible for the intermittent observation should be consulted prior to taking over and handing over care to the next shift.

Level 3: Within Eyesight Therapeutic Observation

Following a risk assessment, these patients are liable to make an attempt to harm themselves or others at any time. They may be "at-risk" of absconding, falling or are considered to have an unstable physical or mental condition which may deteriorate and requires continuous assessment.

- They should be within eyesight and accessible at all times, day and night. These special observations are carried out on a one nurse to one patient basis. They should have a care plan for special observations contained with their notes.
- For patients who pose a danger to themselves or others, any tools or instruments deemed harmful that could be used should be removed if necessary. This may warrant searching of the patient and their belongings. This should be done with consideration given to the legal rights of the patient and conducted in a sensitive manner. Any items removed must be witnessed and documented by the nurse and the relatives informed.
- The care plan must state if the patient does not require observation whilst using the toilet or taking bath/shower. A regular summary of the patient's condition, care and treatment must be entered on the special observation care plan. This must include changes in mental state, physical, psychological and social behaviour, pertinent development and significant events. Positive engagement with the service user is essential
- It is the responsibility of the nurse in charge to consider if the patient is being deprived of their liberty by the safety measures put in place. If there are concerns that the patient is

being deprived of their liberty then contact the Adult Safeguarding Lead Nurse (or Site Manager out-of-hours)

Level 4: Within Arm's Length Therapeutic Observation

This is the highest level of therapeutic observation for patients liable to suicide attempts, harming themselves or being violent/aggressive towards others. They may be at a "high risk" of falls due to confusion or have an unstable physical condition which may have deteriorated and requires constant assessment.

- They should be supervised with close proximity, with due regard for safety, privacy, dignity, gender and environmental dangers. Issues of privacy and dignity, consideration of gender issues and environmental dangers should be discussed and incorporated into their care plan.
- It may be necessary on rare occasions to use more than one member of staff and or specialist support, for example security. A regular summary of the patient's condition care and treatment must be entered into the Therapeutic Observation care plan. This must include changes in mental state, physical, psychological and social behaviours, pertinent developments and significant events. Positive engagement with the service user is essential. The arrangements for requesting assistance from security is provided in the Standard Operating Procedure – Requesting Security
- It is the responsibility of the nurse in charge to consider if the patient is being deprived of their liberty by the safety measures put in place. If there are concerns that the patient is being deprived of their liberty then contact the Adult Safeguarding Lead Nurse

Appendix C

Standard Operating Procedure

Requesting Security Presence to assist in the Management of High Risk Violent and Aggressive In-patients

Introduction

This Standard Operating Procedure should be read in conjunction with the Trust Policies:-

- Management of Violence and Aggression (EF15)
- Security (EF02)
- Chaperoning (C44)
- Therapeutic Observation (Specialling) of Patients Who are Considered at Risk of Harm to Themselves or Others

Definition of High Risk

Patient presents an extreme risk of physical violence or aggression or threat to the life of themselves or others.

Requesting Security presence

The assistance of Security must be considered on an individual case basis by a multidisciplinary clinical team and should be seen as a last resort once all other factors have been considered.

A 'Violent Patient Risk Assessment' must be undertaken by the Ward Manager / Nurse in Charge to establish the level of risk and the requirement for Security presence **(Appendix D).**

The Ward Manager / Nurse in Charge will seek authorisation for Security presence with the Associate Chief Nurse Nurse. Out of hours, the Ward Manager / Nurse in Charge will seek authorisation from the Nurse Practitioner (out of hours) who will inform either the Duty Manager or the Silver on Call.

Security for Wards is provided as below:-

Main Hospital	Sodexo
Lyme Building	Sodexo
Trent Building	Sodexo
Maternity	Sodexo
Oncology	Sodexo
West Building	Local Security Management Specialist (LSMS) Mon – Fri Police (out of hours)
Renal Building	Local Security Management Specialist (LSMS) Mon – Fri Police (out of hours)

Once authorised, the Ward Manager / Nurse in Charge will contact either Sodexo Security via the Sodexo Helpdesk on extension [redacted] or the Trust LSMS on ext [redacted]- to arrange a face to face meeting with the Sodexo Security Manager / Officer or the Trust LSMS on the Ward and jointly finalise the completion of the Security Presence Request Form (**Appendix E).** Wards in the West Building and the Renal Unit should seek the assistance of the Police out of hours (9)999. The Police will determine the level of assistance required.

Once completed and authorised, the original copy of the completed Security Presence Request Form must be retained on the patient's case notes.

The requirement for on-going security presence should be reviewed by the Ward Manager / Nurse in Charge at least every 4 hours and at the nursing staff shift changeover times. The section for handover information should be completed on Security Presence Request Form (**Appendix E**).

The presence of Security staff does not negate the roles and responsibilities of clinical staff. Security staff **must not** under any circumstances provide supervision in isolation from clinical staff i.e. they should be able to be observed by clinical staff, not behind curtains or closed doors. They should not be involved in the delivery of intimate care, or undertake any care usually in the roles and responsibilities of nursing staff. Their role is to be present to provide support to clinical staff (refer to Trust Policy for Chaperoning C44). The nurse in charge remains accountable for any care provided to the patient, including that provided by the Security Officer.

Violent and aggressive behaviour may be as a result of the patient's illness, reaction to medications and alcohol or drug withdrawal.

If the cause of violence and aggression is of a non-clinical origin and the patient is fully aware of his/her actions and if the patient does not refrain from aggressive and violent behaviour, the Police must be contacted immediately.

Even when a Security Officer is present, the patient must have an identified nurse who is responsible and undertakes the supervision of the patient, providing all required clinical care. Based on a risk assessment, a short comfort break can be taken by the Security Officer in liaison with the Ward Manager / Nurse in Charge, who must ensure that additional cover is provided. For breaks of longer duration the Sodexo Security Manager or Trust LSMS must be contacted by the Ward Manager / Nurse in Charge to arrange replacement cover.

Authorised Signatories

	Job Title	**Person in that Role**
Normal Working Hours 0800hrs – 1700hrs Monday – Friday	Chief Nurse	Liz Rix
	Deputy Chief Nurse	Helen Inwood
	Associate Chief Nurse (Divisional)	
	Associate Chief Nurse (Quality & Safety)	Trish Rowson
	Lead Safeguarding Nurse	Janice Johnson
Outside of Normal Working Hours	Nurse Practitioner (out of hours)	
	Silver on Call to be informed by Nurse Practitioner	
	Duty Manager to be informed by Nurse Practitioner	

An up to date list of authorised signatories must be provided to Sodexo Security and the Trust LSMS.

Incident Reporting

A Datix incident report must be completed by the clinical staff for all requests for Security to assist in the management of all high risk patients which must be updated with the outcome and include details of any delays in response for security assistance.

Use of Radio Handsets

Radio handsets pose a high risk to medical equipment due to their relatively high-transmitted power. They must not normally be used in clinical areas, especially areas such as intensive care or theatres, where there is likely to be a high concentration of equipment with a critical function.

Security Officers should use the normal telephone network to communicate with colleagues. However, in an emergency, any overt risk due to fire, physical violence or serious criminal activity must take priority over the risk of interference with medical equipment.

Where a Security Officer needs to make an urgent call for assistance, he/she should move as far as practicable from any active medical equipment before initiating a call and ensure that clinical staff in the vicinity are aware of the use of the radio. Staff in clinical areas must ensure that Security Officers are aware of these rules for the use of radios.

Sodexo Security Officers - General Guidance and Information

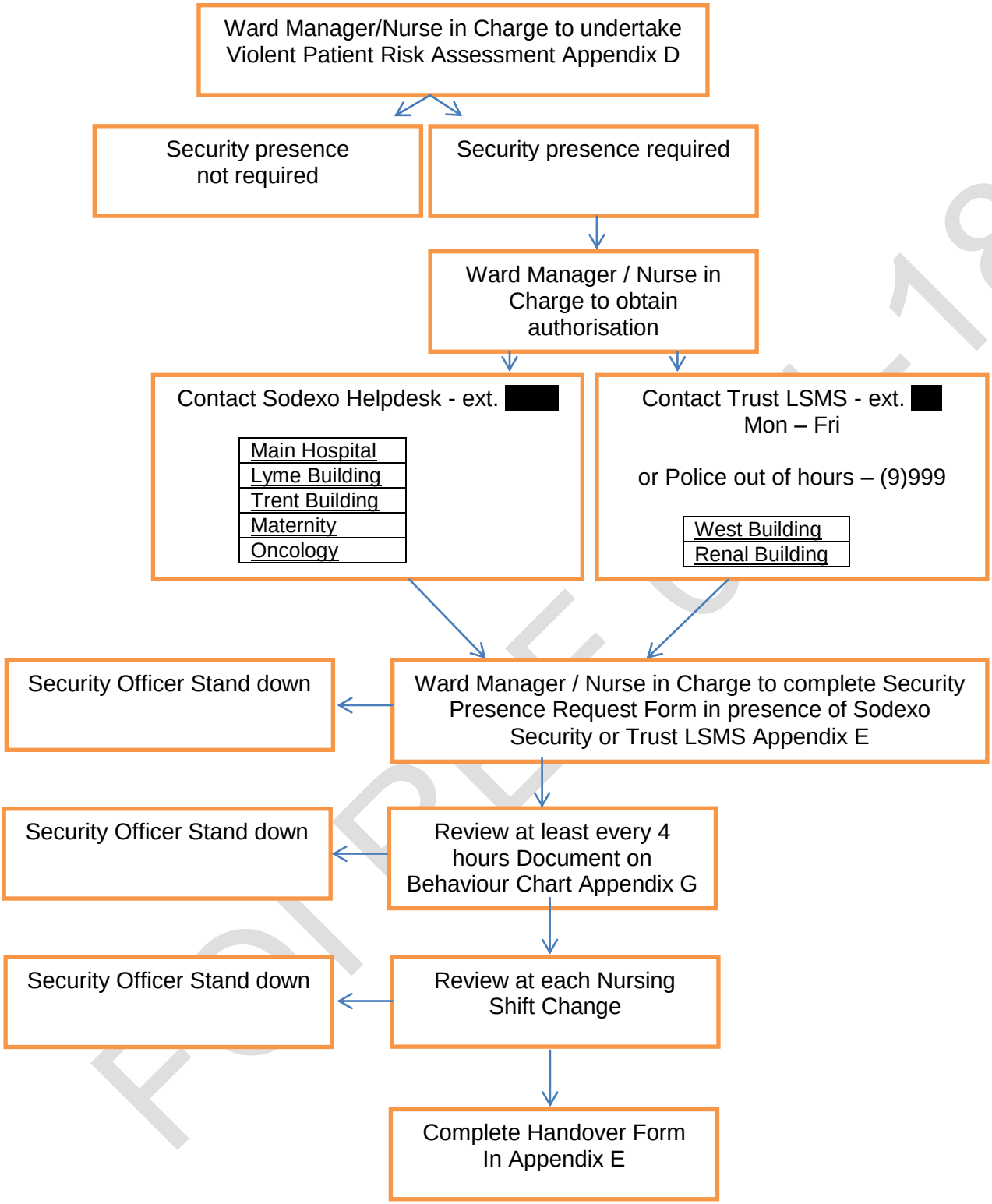
Detailed guidance for Security Officers undertaking this role is available in **Appendix F.** This guidance will be provided by the Sodexo Security Manager or the Trust LSMS at the beginning of their period of supervision.

The Sodexo Security Manager or Trust LSMS will ensure this document is reviewed with the Security Officer at the beginning of any period of observation.

At the beginning of each nurse shift a verbal handover will be given to the Security Officer by the Ward Manager / Nurse in Charge. The handover will provide detail on the patient's current status and will identify if the patient is at risk of physical/non-physical violence to others, along with details relating to confirmation of supervision levels and where the guard is to be located.

At the outset of their period of supervision the Security Officer must be orientated to the clinical environment and informed of fire and emergency procedures and any relevant infection control precaution issues.

Process Flowchart



NB - If Security assistance is not immediately available, escalate via the Management Team to identify if Police assistance is required.

University Hospital of North Staffordshire NHS
NHS Trust

APPENDIX D

Violent Patient Risk assessment to ascertain level of observation

Level of concern	Level of observation	Who should decide	Who should carry out observation	Level of risk	Review period
To maintain general safety for all in patients unless a higher level indicated	Awareness of whereabouts and wellbeing at all times Minimum standard for all inpatients	Dr and qualified Nurse or MDT; qualified Nurse if no Dr available	Allocated member of nursing staff	**1**	weekly
When there is a risk of self-harm, unpredictability or risks are unclear and frequent contact needs to be maintained. As a step down from a higher level of observation	Intermittent checks on mental state and risk Maximum time interval should be specified and checks varied within this. Should be used on admission and post transfer until assessment has been carried out	Dr and qualified Nurse or MDT; qualified Nurse in an emergency	Experienced member of nursing staff	**2**	24hrs
Where there is a serious short-term or other significant risk e.g. violence & aggression	Continuous observation within eyesight – this means in the same room or space (i.e. within easy reach)	Dr and qualified Nurse or MDT; qualified Nurse in an emergency	Experienced member of nursing staff, preferably qualified or in exceptional circumstances security officer	**3**	8hrs
Where there is a serious and imminent risk of suicide or self-harm with impulsivity or a significant risk to others e.g. violence & aggression	Continuous observation within arm's length When more than one person is allocated there must be a lead person doing the observations	Dr and qualified Nurse or MDT; qualified Nurse in an emergency	Experienced member of nursing staff preferably qualified or in exceptional circumstances security officer	**4**	4hrs

APPENDIX E

Security Presence Request Form

To be completed by Ward Manager / Nurse in Charge

Division	**Ward / Department & telephone ext.**
Name of Ward Manager / Nurse in Charge	**Name of qualified staff who the Security Officer will take instruction from on location**
Patient's Name	**Patient's Gender**
Date requested & time requested	**What level of risk does patient pose – see Appendix D. NB patient must be risk level 3/4 to request security.**
Brief reasons for security presence	**Datix Incident Number**
Name of Matron informed **NB - must agree to this request**	**Name of Consultant / Sp Registrar informed** **NB - must agree to this request**
Have RAID / CPN been involved with patient	**Do you feel you may be depriving your patient of their liberty**
Yes / No Comments	Yes – complete DoLS authorisation form No – rationale

Authorised by			
Job Title	**Person in Role**	**Date**	**Time**
Chief Nurse	Liz Rix		
Deputy Chief Nurse	Helen Inwood		
Associate Chief Nurse (Divisional)			
Associate Chief Nurse (Quality & Safety)	Trish Rowson		
Senior Nurse Safeguarding	Janice Johnson		
Nurse Practitioner (out of hours)			
Silver on Call to be informed by Nurse Practitioner			
Duty Manager to be informed by Nurse Practitioner			

Rational for not authorising security presence	
If security presence authorised Where is the Security Officer to be located – e.g. at the bedside or outside the side room or ward door?	**Has it been explained to the patient / relatives the reason why a Security Officer is in attendance?**
Estimated time of arrival of Security Officer	

Handover – to be completed by Ward Manager / Nurse in Charge			
From	**To**		
Ward Manager / Nurse in Charge	**Ward Manager / Nurse in Charge**	**Date**	**Time**
Nurse caring for patient	**Nurse caring for patient**		
Security Officer	**Security Officer**		
Information:-			

- **Note 1**: Every other option and means of preventing / controlling and defusing a situation should be attempted before there is any interaction with a violent person.

  Physical intervention should concentrate on de-escalation and breakaway techniques.

  Staff must only attempt restraint if they have been trained in specific intervention techniques, which minimise the risk of injury to themselves and the aggressor.

- **Note 2**: It is legally acceptable to use “reasonable” force (proportionate & minimum necessary) to defend yourself when under physical attack.

- **Note 3**: Security Officers can escort people from the premises but cannot physically expel them. If the situation requires this the Police must be called.

NB Form to be retained in the patient’s case notes

APPENDIX F

Guidance for Security Officers Providing Assistance in the Management of High Risk Violent and Aggressive In-Patients

Your Role

To ensure patient safety and maintain the appropriate level of supervision and observation, patients may require constant supervision.

These circumstances are when a patient presents an extreme risk of physical violence or aggression or threat to life.

You **must not** under any circumstances provide supervision in isolation from clinical staff. Your role is to be present to provide support to clinical staff.

Supervision

Your physical location is to be agreed with the Ward Manager / Nurse in Charge. This may be within eyesight or at arm's length.

Your role is to observe a patient for the duration as agreed.

A short comfort break can be taken in liaison with the Ward Manager/Nurse in Charge who must ensure that additional cover is provided. For breaks of longer duration the Sodexo Security Manager or the Trust LSMS must be contacted to arrange replacement cover.

You will receive a verbal handover from the nurse caring for the patient, which will include details relevant to the patient's risk of harm or potential harm to others

If you are unsure or feel unable to take on this role, express your concerns at the start of the shift to the Ward Manager/Nurse in Charge and the Sodexo Security Manager or Trust LSMS.

Your role does not include provision of personal care for the patient.

If a patient becomes uncooperative they may be encouraged in a supportive manner i.e. return of a confused patient back to their bed area, this is particularly important for patients with a diagnosis of dementia.

Every other option and means of preventing / controlling and defusing a situation should be attempted before there is any interaction with a violent person. Physical intervention should concentrate on de-escalation and breakaway techniques.

Only if staff have been trained in specific techniques, which minimise the risk of injury to themselves and the aggressor, should they attempt physical restraint. **MECHANICAL RESTRAINTS MUST NOT BE USED**.

It is legally acceptable to use "reasonable" force (proportionate & minimum necessary) to defend yourself when under physical attack. Security Officers can escort people from the premises but cannot physically expel them. If the situation requires this the Police must be called.

The patient must be supervised at all times even if you think they are resting or asleep.

You must only accompany the patient to other clinical areas i.e. to x-ray, outpatients or if they wish leave the Ward for other reasons e.g. to go outside to smoke as requested by the Ward Manager / Nurse in Charge and in the presence of designated clinical staff. You must not be left alone with the patient at any time.

NB You must never leave the ward with the patient without first gaining permission from the Ward Manager / Nurse in Charge, and only then to chaperone designated clinical staff. The Ward Manager / Nurse in Charge must always be informed when you, the patient and the designated clinical staff are leaving the ward and when you will return.

If the patient's condition or behaviour is such that you feel concerned about their safety, or the safety of others in the area you should inform the Ward Manager/Nurse in Charge if immediately available.

If not, and you feel the matter is urgent you should request that staff contact the Police on (9)999 for immediate assistance.

If there is a significant change (deterioration) in the patient's condition or behaviour at any time, inform the Ward Manager / Nurse in Charge as soon as possible.

Use of Radio Handsets

Radio handsets pose a high risk to medical equipment due to their relatively high-transmitted power. They must not normally be used in clinical areas, especially areas such as intensive care or theatres, where there is likely to be a high concentration of equipment with a critical function.

You should maintain contact with the control room at regular intervals throughout the shift. Use the normal telephone network to communicate with colleagues.

However, in an emergency, any overt risk due to fire, physical violence or serious criminal activity must take priority over the risk of interference with medical equipment and you may use your radio handsets. You should move as far as practicable from any active medical equipment before initiating a call and ensure that clinical staff in the vicinity are aware of the use of the radio.

Handover

At the end of each shift, you should await another Security Officer to take over the supervision of the patient. Do not leave the patient unattended. The Ward Manager / Nurse in Charge will hand over to the Security Officer taking over.

Professional issues

The use of personal mobile phones other electronic equipment and reading newspapers/books is not permitted, as this will distract you from providing effective continuous supervision.

Security Officers are not to leave their position for meal breaks/comfort breaks until a replacement Security Officer is in attendance.

Breaks will be designated by the Sodexo Security Manager or the Trust LSMS at the start of the shift.

University Hospitals of North Midlands NHS
NHS Trust

APPENDIX G

ABC Behavioural Record Chart

Name of Patient:
Unit Number:
Ward/Area Location:
Sheet Number:

Date & Time	Ante-Cedent Events: What happened prior to or as the behaviour occurred ?	Detail of behaviour displayed: Refer to definition of behaviour	Consequent Events: What happened immediately after the behaviour?	Signature

'A' stands for **antecedents**, that is, what happens immediately before the behavioural outburst and can include any triggers, signs of distress or environmental information.

'B' refers to the **behaviour** itself and is a description of what actually happened during the outburst or what the behaviour 'looked' like.

'C' refers to the **consequences** of the behaviour, or what happened immediately after the behaviour and can include information about other people's responses to the behaviour and the eventual outcome for the person. Also include what helped.

Please store completed charts in the patient's notes.