South London and Maudsley NHS
NHS Foundation Trust

ENGAGEMENT AND OBSERVATION POLICY

Version:	5.3
Ratified By:	Governance Executive
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Date Policy Comes Into Effect:	28th September 2011
Author:	Sarah Burleigh, Assistant Director of Nursing
Responsible Director:	Director of Nursing and Education
Responsible Committee:	Clinical Risk Committee
Target Audience:	Clinical Staff – In-patient Services
Review Date:	August 2014

Equality Impact Assessment	Assessor: Sarah Burleigh, Assistant Director of Nursing	Date: 05.09.11
HRA Impact Assessment	Assessor: Sarah Burleigh, Assistant Director of Nursing	Date:05.09.11

Document History

Version Control

Version No.	Date	Summary of Changes	Major (must go to an exec meeting) or minor changes	Author
1.0	May 2002			S. Burleigh, Assistant Director of Nursing
2.0	July 2005	Shift of emphasis to therapeutic engagement.	Major	S. Burleigh Assistant Director of Nursing
3.0	July 2005		Major	S. Burleigh Assistant Director of Nursing
4.0	April 2011	Changes made to meet NHSLA Requirements	Major	S. Burleigh Assistant Director of Nursing
5.0	September 2011	Further changes made to meet NHSLA Requirements	Major	S. Burleigh Assistant Director of Nursing
5.1	January 2012	More explicit guidance on observation standards	Minor	S. Burleigh Assistant Director of Nursing
5.2	August 2012	Minor updates to the monitoring table to reflect NHSLA requirements.	Minor	S. Burleigh Assistant Director of Nursing
5.3	December 2012	Minor update to the Enhanced Observation/Engagement Record.	Minor	S. Burleigh Assistant Director of Nursing

Consultation

Stakeholder/Committee/ Group Consulted	Date	Changes Made as a Result of Consultation
Clinical Risk Committee	13/06/2011	Minor amendments.

Plan for Dissemination of Policy

Audience(s)	Dissemination Method	Paper or Electronic	Person Responsible

Clinical Staff – In-patient Services. Heads of Nursing, CAG Executives	email	Electronic	S. Burleigh Assistant Director of Nursing

Contents

1. Introduction

All of the patients who are admitted to the in-patient units require a level of engagement and observation. They will be experiencing varying degrees of vulnerability and distress due to a serious mental illness, and other factors such as social exclusion, dependency and physical health problems.

Due to the varying degrees of illness experienced by patients within in-patient wards it is essential that therapeutic relationships be built up as soon as the person is admitted to hospital. The aim of this approach is to be able to support the patient through their distress and to help develop a trusting relationship, which will have positive benefits for the patient and for the nurse.

From the perspective of the patient, the minimum expectation whilst on the ward is that members of the team engage with them, and interaction should take place at least once per shift from allocated members of staff, including student nurses and health care support workers. Emphasis within this policy is placed upon communication. It is also concerned with providing patients with something meaningful to do throughout their day, and using activities during the period of observation and engagement. Terms such as supervision, close obs, constant obs, are not acceptable. Using the terms below allows the staff, the patient and the relatives and carers to have a shared understanding about what is happening.

Observation and engagement should be safe and therapeutic. Consideration should be given to the use of activity, discussion and distraction processes, but recognition should also be made of the need for silence and as much privacy as is safely achievable.

2. Definitions

2.1 Risk assessment

A gathering of information and analysis of the potential outcomes of identified behaviours. Identifying specific risk factors of relevance to an individual and the context in which they may occur. This process requires linking historical information to current circumstances to anticipate possible future change.

2.2 Engagement

To `engage` with patients rather than `observe` them, can offer a significant improvement to the patients experience, it can also enhance the work experience for staff involved in the process. The purpose of engagement is to interact with the patient, encouraging communication, listening and conveying to the patient that they are valued and cared for. These are important components of skilled nursing observation.

An environment which offers a full programme of activities and specific time with individual staff members is more likely to have a beneficial emotional and psychological impact on the patients and the staff. (STAR Wards.www.starwards.org.uk)

2.3 Observation

One definition of nursing observation is; “regarding the patient attentively”, this, however, suggests just watching/looking at the patient, even if with great skill. Patients have commented that it feels uncomfortable at best, and dehumanising at worst to be just `watched over`.

Observation provides an opportunity for health and social care staff to interact with the patient in a therapeutic way. It can increase understanding by the staff of the feelings and motivations of the patient to act in a particular way. It can also offer the patient support and guidance in how to deal with those feelings and thoughts.

The practice of undertaking systematic `observation`, is aimed at preventing potentially suicidal, violent or vulnerable patients from harming themselves or others. It also provides a valuable source of information which is useful in the multidisciplinary assessment of the patient. Observation is not simply an activity to support a custodial approach, observation provides an opportunity for health and social care staff to interact with the patient in a therapeutic way. It can increase understanding by the staff of the feelings and motivations of the patient to act in a particular way. It can also offer the patient support and guidance in how to deal with those feelings and thoughts.

3. Purpose and Scope of the Policy

Engagement and formal observation is a multi-disciplinary approach to care.

The patient, relatives and carers are fully informed of the process and are provided with written and verbal information as often as necessary.(See Appendix 6). The patient wherever possible should be part of the evaluation and reviewing process, both during the application of the observation levels and after the observation has ceased.

4. Roles and Responsibilities

Team leaders are responsible for ensuring that their staff have completed the competency assessment for enhanced engagement and observation, and that they have read and understood this policy.

Modern Matrons should maintain an overview of the patients on enhanced observations, and ensure that their care plans are updated alongside their changing needs

The nurse in charge of the shift is responsible for ensuring that all of the patients are engaged with, and patients who are on enhanced levels of observation have a completed care plan stating the aims of the enhanced engagement. Records of the enhanced engagement process will be maintained using the Trust forms.

Student nurses can observe the process and accompany the qualified nurse when completing enhanced engagement and observation., but can not be allocated patients requiring enhanced levels of engagement or observation

5. Process for Observation at Differing Levels

The named levels of patient observation and engagement are as follows:

- Within Arms Length (Enhanced)
- Within Eyesight (Enhanced)
- Intermittent Observation
- General Observations

5.1 Within Arms Length (Enhanced)

This is the most intense level of observation. It is applied if the risk assessment suggests this level of enhanced observation is required. Service users at the highest levels of risk of harming themselves or others may need to be nursed in close proximity at all times including when the service user goes into the toilet / bathroom. On rare occasions more than one nurse may be necessary. Attempts at positive engagement with the service user are an essential aspect of this level of observation.

5.2. Within Eyesight (Enhanced)

Within eyesight is required when the service user could, at any time, make an attempt to harm themselves or others. The service user should be kept within sight at all times, by day and by night. A team decision should determine level of proximity and observation whilst attending to personal needs (i.e. using the toilet or taking a bath).

5.3 Intermittent Observation

This must only be used when reducing the levels of observation from an enhanced status.

A joint decision must be taken with the doctor, nurse and the patient when using the risk assessment process. This decision must be recorded in the notes and care planned. During this level of observation it is very important to discuss this with the patient, and to ensure that there is an agreed understanding about the purpose of the observation, encouraging the patient to take a level of responsibility about their role in the engagement process.

The time between observations must vary and length of time with the patient should also vary depending on the level of assessment which is taking place This level of observation is required when service users are potentially, but not immediately at risk in the widest sense. For example, service users with depression but no immediate plans to harm themselves or others and, those who are in a process of recovery may require this level of observation and engagement. The observation must be carried out even when the service user is asleep, unless otherwise indicated by the Multi-disciplinary Team.

This level of observation requires the observing clinician to be aware of the service user's movements, location and behaviour. The duration of intervals at which the observations should be carried out is to be agreed by the Multi-disciplinary Team and/or the Shift Coordinator. Observations need to be carried out sensitively in order to cause as little intrusion as possible. However, this observation should also be seen in terms of positive engagement with the service user.

5.4 General Observation

General observation is the **minimum acceptable** level of observation for all inpatients. The location of all the patients must be known to allocated staff, but not all patients need to be kept within sight.

5.5 Trust Observation Policy Standards

Standard 1.

As a **minimum requirement** for all in-patients they will be engaged with/checked every hour throughout the night as well as during the day shifts. This will be done as unobtrusively as possible at night to avoid waking the patients, but on occasions it may be necessary to actually wake a patient.

Standard 2.

At the beginning of every shift, it will be the responsibility of the nurse in charge to carry out a visual handover to the nurse in charge of the next shift, identifying all of the patients present on the ward, and to account for all other patients who are absent from the ward, and be aware of their whereabouts

Standard 3.

Intermittent Observation

This must only be used when reducing the levels of observation from an enhanced status.

6. Responsibility for Placing a Patient on Enhanced Levels of Observation

This is a joint responsibility between the **nurse and doctor**. The nurse involved in this process needs to have enough clinical experience to clearly state the reasons for placing someone on these levels of observation, and what staff should be doing whilst they are with the patient. The nurse in charge of the shift should be best placed to make these decisions, but as a minimum requirement a Band 5 nurse or above will be able to make these decisions with the doctor. The Consultant must be informed of all patients on enhanced levels of observation.

7. Reviewing Levels of Observation

For enhanced levels of observation, observation levels must be reviewed on every shift, including weekends. This can be done by the senior nurses and ETL/Night site managers. However, for good inter-professional working, this procedure recommends that discussion must take place with the nurse **and doctor on duty**, about the decisions on the level of observations to be used.

7.1 Increasing Observation

Increasing levels of observation can be initiated by qualified nursing staff. Ideally this would be in conjunction with other members of the multi disciplinary team, but if necessary this can be initiated as part of an overall care plan, in response to an increased level of risk to the patient and / or others within the environment. All appropriate documentation must be completed when observation levels are increased, and a clear record made within the electronic patient journey system (epjs)

7.2 Decreasing Observation

The reduction in the level of observation should ideally be a team decision to ensure service users are not left on an increased level of observation inappropriately. Nurses and doctors directly involved with caring for the patient can reduce the level of observation for a patient, if certain behaviours are met and specific criteria are observed. There should be a specific documented plan for each service user outlining the agreed changes in behaviour that would facilitate a reduction in observation level and the exact procedure for this decision to be actioned. Individual practitioners can not reduce the level of enhanced observation without wider discussion with the clinical team.

8. Length of Time Observing

It is recommended that observation by nursing staff should not exceed one hour at a time, and that there should be an opportunity for reflection and discussion following the observation period. This is based on the need to be concentrating attentively, and also that a therapeutic intervention can sometimes be emotionally draining. However, it is also recognised that a period of observation with a patient may be highly positive for the patient and the nurse, and they may both wish to continue for a period of time, there must be room made available for this negotiation to take place. This may occur if there is engagement in activities of daily living such as cooking or washing, also if the patient and nurse go out of the hospital together for a walk, or if both parties are engaged in a meaningful discussion.

9. Record-Keeping

The Engagement and Observation Record proforma should always be used whenever enhance observation are initiated. The record should include the date and time of initiation, level of observation, the time frequency of the observations where appropriate, and should be signed by those taking the decision to initiate and/or make changes to observation(s). It could also include the name and designation of the person undertaking the observation.

The Engagement and Observation Record proforma (Appendix 4) must be scanned and filed on the patients care record [ePJS] which also records care plans.

Any changes to the level of observation and engagement should be clearly documented in the patient's care record, stating the client-staff ratio, proximity, frequency, the person initiating or reviewing and the date and time for this clearly stated. For observation within eyesight and arms length specify and document the proximity in terms of the use of toilet and bathroom as agreed by the team and or the shift coordinator.

The ***risk assessment*** must be updated whenever there are changes in the level of risk requiring changes in the level of observation. When documenting the risk level on the care record, this must be recorded under a new risk assessment. The ***care plan*** must reflect changes in the level of observations. This means discontinuing care plan entries for existing care plans and completing a new one for the new level of observation. Issues of privacy, dignity and consideration of the gender arising in allocating staff and the environmental dangers need to be discussed and incorporated into the care plan.

10. Monitoring Compliance

What will be monitored i.e. measurable policy objective	Method of Monitoring	Monitoring frequency	Position responsible for performing the monitoring/ performing co-ordinating	Group(s)/committee (s) monitoring is reported to, inc responsibility for action plans and changes in practice as a result
Duties	Audit of the Audit Proforma	Annual	Assistant Director of Nursing, CAET	Quality Governance Committee

What will be monitored i.e. measurable policy objective	Method of Monitoring	Monitoring frequency	Position responsible for performing the monitoring/ performing co-ordinating	Group(s)/committee (s) monitoring is reported to, inc responsibility for action plans and changes in practice as a result
Observation at differing levels	Audit of the Observation Proforma	Annual	Assistant Director of Nursing, CAET	Quality Governance Committee
How the organisation trains staff, in line with the training needs analysis	Audit of register of attendees of appropriate courses	Annual	Deputy Director of Education & Training	Education & Training Committee
How observation is recorded	Audit of the Observation Proforma	Annual	Assistant Director of Nursing, CAET	Quality Governance Committee

11. Associated Documentation

- The Risk Framework
- Patients' Search Policy

12. References

1. Standing Nursing & Midwifery Advisory Committee(1999) Practice Guidance. Safe and Supportive observation of patients at risk.
2. Bowles.N et al (2002). Formal Observation and engagement. A discussion paper. Journal of Psychiatric and Mental Health Nursing. 9. p.255-260
3. Thurgood.M (2004) Engaging clients in their care and treatment. Cited in The Art and Science of Mental Health Nursing. Ian Norman and Iain Ryrie. Open University Press.
4. South London and Maudsley NHS Trust. Patient Observation Policy May 2002.
5. Jones et al (2000) Psychiatric Inpatients` Experience of Nursing Observation. A United Kingdom Perspective. Journal of Psychosocial Nursing. Vol 38, No.12.

13. Freedom of Information Act 2000

All Trust policies are public documents. They will be listed on the Trusts FOI document schedule and may be requested by any member of the public under the Freedom of Information Act (2000).

APPENDIX 1: EQUALITY IMPACT ASSESSMENT

EQUALITY IMPACT ASSESSMENT

PART 1 – INITIAL SCREENING

1. Name of the policy / function / service development being assessed? Enhanced Engagement and Observation Policy

2. Name of person responsible for carrying out the assessment? Sarah Burleigh

3. Describe the main aim, objective and intended outcomes of the policy / function / service development? Aim: To ensure that staff delivering enhanced engagement and observation are clear about ther procedures and documentation required, also that they have been assessed as competent. Objective: Intended Outcomes: Patients will be observed safely by appropriate staff during their in patient stay

4. Is there reason to believe that the policy / function / service development could have a negative impact on a group or groups? NO

5. What evidence do you have and how has this been collected? N/A

6. Have you explained your policy / function / service development to people who might be affected by it?

Yes

If 'yes' please give details of those involved

Yes, circulated to, Heads of Nursing, Ward Managers. The policy was previously the topic of focus groups of service users.

7. If the policy / function / service development positively promotes equality please explain how?

N/A

8. From the screening process do you consider the policy / function / service development will have a positive or negative impact on equality groups? Please rate the level of impact and summarise the reason for your decision.

Positive: Low
Negative: Low

Neutral: High (highly likely)

Date completed: …….September 2011……..

Signed …….Sarah Burleigh…….

If the screening process has shown potential for a high negative impact you will need to carry out a full equality impact assessment

Appendix 2 – Human Rights Act Assessment

To be completed and attached to any procedural document when submitted to an appropriate committee for consideration and approval. If any potential infringements of Human Rights are identified, i.e. by answering Yes to any of the sections below, note them in the Comments box and then refer the documents to SLaM Legal Services for further review.

For advice in completing the Assessment please contact Paul Bellerby, Legal Services [paul.bellerby@slam.nhs.co.uk]

HRA Act 1998 Impact Assessment	Yes/No	If Yes, add relevant comments
The Human Rights Act allows for the following relevant rights listed below. Does the policy/guidance NEGATIVELY affect any of these rights?		
Article 2 - Right to Life [Resuscitation /experimental treatments, care of at risk patients]	No	
• Article 3 - Freedom from torture, inhumane or degrading treatment or punishment [physical & mental wellbeing - potentially this could apply to some forms of treatment or patient management]	No	
• Article 5 – Right to Liberty and security of persons i.e. freedom from detention unless justified in law e.g. detained under the Mental Health Act [Safeguarding issues]	No	
• Article 6 – Right to a Fair Trial, public hearing before an independent and impartial tribunal within a reasonable time [complaints/grievances]	No	
• Article 8 – Respect for Private and Family Life, home and correspondence / all other communications [right to choose, right to bodily integrity i.e. consent to treatment, Restrictions on visitors, Disclosure issues]	No	
• Article 9 - Freedom of thought, conscience and religion [Drugging patients, Religious and language issues]	No	
• Article 10 - Freedom of expression and to receive and impart information and ideas without interference. [withholding information]	No	
• Article 11 - Freedom of assembly and association	No	
• Article 14 - Freedom from all discrimination	No	

Name of person completing the Initial HRA Assessment:	Sarah Burleigh, Assistant Director of Nursing
Date:	05.09.11
Person in Legal Services completing the further HRA Assessment (if required):	N/A
Date:	N/A

Appendix 3 – Checklist for the Review and Approval of a Policy

This checklist must be used for self-assessment at the policy writing stage by policy leads and be completed prior to submission to an appropriate Executive Committee/Group for ratification.

	Title of document being reviewed:	Yes/No/ Unsure	Comments
1.	**Style and Format**		
	Does the document follow The South London and Maudsley NHS Foundation Trust Style Guidelines? i.e.:		
	• The Trust logo is in the top right corner of the front page only and in a standard size and position as described on the Intranet	Yes	
	• Front page footer contains the statement about Trust copyright in Arial 10pt	Yes	
	• Document is written in Arial font, size 11pt (or 12pt)	Yes	
	• Headings are all numbered	Yes	
	• Headings for policy sections are in bold and not underlined	Yes	
	• Pages are numbered in the format Page X of Y	Yes	
2.	**Title**		
	Is the title clear and unambiguous?	Yes	
3.	**Document History**		
	Is the document history completed?	Yes	
4.	**Definitions**		
	Are all terms which could be unclear defined?	Yes	
5.	**Policy specific content**		
	Does the policy address, as a minimum, the NHSLA Risk management Standards at Level 1 where appropriate	Yes	
6.	**Consultation and Approval**		
	Has the document been consulted upon?	Yes	
	Where required has the joint Human Resources/staff side committee (or equivalent) approved the document?	N/A	
7.	**Dissemination**		

	Title of document being reviewed:	Yes/No/ Unsure	Comments
	Does the document include a plan for dissemination of the policy?	Yes	
8.	**Process for Monitoring Compliance**		
	Is it explicit how compliance with the policy will be monitored?	Yes	
9.	**Review Date**		
	Is the review date identified on the cover of the document?	Yes	
10.	**References**		
	Are supporting references cited?	Yes	
11.	**Associated documents**		
	Are associated SLaM documents cited?	Yes	
12.	**Impact Assessments**		
	Is an Equality Impact Assessment included as the appendix of the document?	Yes	

Appendix 4

Enhanced Observation/Engagement Record

ALL NURSES MUST PRINT AND SIGN NAME AT END OF ALLOCATED OBSERVATION PERIOD

Nurse supervisors are designated throughout the shift (on rotation).

WITHIN ARMS LENGTH – The patient is never out of sight of the supervisor who is also within arms length and with no barrier between the patient and the supervisor. Record every hour
WITHIN EYESIGHT – The patient is never out of sight of the supervisor. Record every hour.
INTERMITTENT OBSERVATION – Random checks between 10 to 30 minute intervals and record. Only to be used when reducing levels of enhanced observation.

Patient Name: _____ Ward: _____
Is Patient on : **INTERMITTENT / WITHIN EYESIGHT / WITHIN ARMS LENGTH** **(Please circle agreed observation level)**
Initiation Date:_____ Initiation Time:_____ Today's Date:_____

Time	Nurse's Name	Nurse's Grade	Nurse's Signature	Rationale for enhanced observation	Comments on Patient's Behaviour and mental state.

Rationale for enhanced observation can be shown as:-
SH: Self Harm AB: Absconding F: Falling AG: Aggression PC: Physical Care MW: Mental Well-being ** Examples of this include: dis-inhibited behaviours, wandering, floridly psychotic, severely depressed, severely anxious/agitated, elated, sleep disturbance, poor motivation, medical condition.

Appendix 5

Information for patients and their visitors

Engagement and Enhanced Observations

Patients are admitted to our in-patient wards for assessment and treatment. As part of this, staff will continually assure that they know where patients are and what they are doing at all times. They will also continually monitor their patients mental state and, in particular, assess whether they are potentially a risk to themselves or others. This is known as “risk assessment” and patients will be involved in making these judgements.

If unit staff believe that a patient has the potential to harm themselves or others, that patient may be provided with additional support with specific staff allocated to engage with them on an individual basis. This is often referred to as “enhanced observation”. The member of staff concerned will not simply watch the patient but rather will seek to engage with them and work to help them understand what is going on for them and to maximise their safety.

This process of enhanced engagement will usually only last a short period of time and the reasons for introducing it will be discussed, wherever possible, with the patient prior to its commencement. It will also be regularly reviewed and these reviews will also involve the patient in discussions. In some cases it may be necessary to search the patient or his or her belongings to remove potentially dangerous items from them.

There are two forms of enhanced engagement

- **within eyesight** means that a nurse or experienced health care assistant will ensure that they are able to see the patient at all times. This will be because we are concerned that the patient may be a risk to themselves or others but do not believe that the risk is immediate. The member of staff involved will actively seek to work with the patient to provide reassurance and to address the causes of concern.
- **within arms length** engagements will be applied where staff believe that the patient is at immediate risk and will involve a member of staff being physically close to the patient at all times. This will include times when the subject is using the toilet or bathroom and when they are in bed. (A member of staff of the same sex will do this)

We appreciate that being subject to this sort of attention can be very uncomfortable and it is something that is only undertaken when there is serious concern for someone’s safety. We will always try to work with patients to help them to understand the reasons for taking these measures and to discuss with them alternatives.

Where staff feel that a patient is no longer at quite such a high level of risk, they may, for a short period of time, be placed on “**intermittent observation**” which will involve staff assuring themselves that you are OK at least four or five times an hour.

All these procedures are based on the Trust’s “Engagement and Formal Observation Policy”, which goes into much more detail. Staff will provide you with a copy of the full policy on request.

If you are unhappy about the way that these arrangements are being applied you should try to talk to a member of staff about your concerns. If you do not wish to do this or do not get a satisfactory response, you may also wish to contact the Trust’s Patients Advice and Liaison Service (PALS) PALS can help you to answer any questions you may have and to support you in negotiating with ward staff. There may also be independent advocacy services available and ward staff will advise you how to contact these.