Rotherham Doncaster and South Humber NHS Foundation Trust

Enhanced Therapeutic Observations and Care Policy

DOCUMENT CONTROL:

- **Version:** 9
- **Unique Reference number:** 29
- **Approved by:** Quality Safety and Standards Group
- **Date approved:** 25 September 2026
- **Document Author:** RRI Lead and Safer Staffing Lead
- **Title of Accountable Director:** Chief nursing officer
- **Date issued:** 26 November 2026
- **Review by date:** 31 October 2029

Contents

1 Policy summary 3
2 Introduction and Aim 3
3 Procedure 5
3.1 Quick guide 5
3.2 Levels of observations 7
3.3 Process for prescribing enhanced observation 16
3.4 When should enhanced observations be set? 17
3.5 LIO 18
3.6 Legal status of patients subject to enhanced observations 19
3.7 Capacity issues, patients aged 16 and over 19
3.8 Under 18s 20
3.9 Patients under the influence of alcohol or other substances 20
3.10 Language barriers 20
3.11 Management Plan 21
3.12 Reviewing levels of observation 22
3.13 Discontinuation of observation 24
3.14 Record keeping 24
3.15 Handover 25
3.16 Support for colleagues 26
3.17 Competency 26
3.18 Maintaining safe staffing levels 26
4 Responsibilities 27
5 Training 30
6 Monitoring arrangements 30
7 Related documents and references 31
8 Appendices 31
8.1 Appendix A Definitions and principles 31
8.2 Appendix B Competency assessment 32
8.3 Appendix C Supportive therapeutic observation record 33
8.4 Appendix D Health of nation outcome scales for acquired brain injury (HoNOS-ABI) health of the nation outcome scales for acquired brain injury 33
8.5 Appendix E Example allocation template 33
8.6 Appendix F Within arm's length observation and engagement, area specific arrangements for Magnolia Lodge 33
8.7 Appendix G Enhanced Therapeutic Observations and care easy to understand guide 33
8.8 Appendix H Visual observations for patients at new beginnings protocol 37

1 Policy summary

This policy sets out the Trust's approach and expected standards for the implementation of Enhanced Therapeutic Observations and Care (ETOC) across all relevant inpatient services. It describes the different levels of observation used within the Trust, when they should be implemented, and how they should be delivered to provide safe, person-centred and therapeutic care.

Enhanced observations may be required for a range of clinical presentations across mental health, older people's, neurorehabilitation and physical health services. This includes patients presenting with increased risks associated with suicide or self-harm, behavioural disturbance, delirium, dementia, cognitive impairment, neurological conditions, physical frailty, falls risk or physical deterioration. The policy therefore supports a consistent approach to assessing, implementing and reviewing enhanced observations, ensuring that interventions are proportionate to the individual's assessed needs and delivered using the least restrictive approach possible.

The policy also sets out the competency standards expected of colleagues undertaking enhanced observations and emphasises that observations should not be limited to surveillance, but should maximise opportunities for therapeutic engagement, reassurance, recovery, prevention of deterioration and the promotion of independence wherever appropriate. Patients receiving enhanced observations should be supported through clear and compassionate communication, regular multidisciplinary team (MDT) review, collaborative plans of care and ongoing evaluation of whether the level of observation remains clinically appropriate.

For patients requiring enhanced observations because of falls risk, physical frailty, delirium, dementia or other physical health needs, this policy should be read alongside the Trust's Falls Manual and any other relevant clinical policies to ensure care is coordinated and reflects current evidence-based practice.

2 Introduction and Aim

Observations are a minimally restrictive intervention of varying intensity in which a colleague observes and maintains contact with a patient to promote their safety, wellbeing and the safety of others. They are an essential component of care across both mental health and physical health services and should always be tailored to the individual’s assessed needs. Patients may require increased observation for a wide range of reasons.

Within the Trust there are four levels of observation, grouped under the overarching categories of general and enhanced observations.

General observations represent the baseline level of observation applied within the Trust. These observations are undertaken intermittently to establish a patient's whereabouts, assess their presentation and wellbeing, and identify any changes that may require escalation or intervention.

Enhanced Therapeutic Observations and Care (ETOC) is a person-centred therapeutic intervention used when a patient requires a higher level of supervision

than can be provided through general observations alone. The purpose of enhanced observations is to reduce identified risks to the individual or others while promoting recovery, maintaining dignity, preserving independence wherever possible, and delivering safe, compassionate and effective care. The level of observation should always be proportionate to the patient's current presentation, assessed risks and clinical needs, and reviewed regularly to ensure it remains appropriate.

Across mental health, older people's and physical health services, enhanced observations should focus on meaningful therapeutic engagement rather than passive surveillance. The intervention should support patients to understand and manage their care needs, promote recovery where appropriate, prevent deterioration, maximise independence, and provide reassurance during periods of increased vulnerability.

The Enhanced Therapeutic Observations and Care approach described within this policy is informed by emerging evidence and best practice, including trauma-informed care, person-centred care, least restrictive practice and psychologically informed approaches that support patient engagement, safety and experience across all clinical settings. Colleagues should also refer to **Appendix G: Enhanced Therapeutic Observations and Care – Easy to Understand Guide**, which provides a concise overview of the processes described within this policy.

The purpose of this policy is to provide a clear and consistent approach for colleagues initiating, undertaking and reviewing Enhanced Therapeutic Observations and Care (ETOC), ensuring that patients requiring this intervention receive safe, effective, person-centred and therapeutic care throughout their admission. The policy provides a framework to ensure that observation practice is therapeutic in nature, promotes recovery where appropriate, prevents deterioration, and that each patient's level of observation and engagement is proportionate to their individual needs, strengths and identified risks.

Enhanced observations may be required for patients presenting with a range of mental, cognitive and physical health needs, The policy supports colleagues to make evidence-based decisions that create a safe, therapeutic and least restrictive environment, and provides the rationale for assessing, implementing and reviewing the appropriate level of observation.

Where enhanced observations are implemented because of physical frailty, delirium, dementia, neurological impairment or an increased risk of falls, they should actively support falls prevention through appropriate supervision, timely assistance with mobility, regular assessment of the patient's changing needs, environmental risk reduction and prompt escalation of concerns where deterioration is identified. This policy should therefore be read in conjunction with the Trust Falls Manual and other relevant clinical policies to ensure that observation practice complements wider falls prevention and patient safety strategies.

The policy promotes personalised care, treatment and safety planning informed by the patient's individual needs, clinical presentation, strengths, indicators of deterioration or harm, advance statements where available, the views of carers and those important to the patient, and the purpose of their admission. Observation plans

should be reviewed regularly by the multidisciplinary team to ensure they remain clinically appropriate and continue to deliver the least restrictive intervention necessary to maintain patient safety.

It is imperative that this policy is read in conjunction with the current Trust safety policies and procedures detailed in Section 8.

This policy applies to all colleagues involved in the assessment, planning, implementation and review of Enhanced Therapeutic Observations and Care (ETOC) across the following inpatient services:

- adult mental health
- older people's mental health
- forensic learning disabilities
- neurorehabilitation
- intermediate care (IC) wards and other inpatient physical health services where enhanced observations are required.

The principles within this policy apply to all patients who require an increased level of observation, regardless of the underlying clinical reason. Enhanced observations may be implemented to manage risks associated with suicide, self-harm, behavioural disturbance or aggression, or to support patients experiencing delirium, dementia, cognitive impairment, neurological conditions, physical frailty, impaired mobility, physical deterioration or an increased risk of falls. The purpose and delivery of enhanced observations should therefore reflect the individual's assessed needs, with interventions tailored to the clinical setting and focused on promoting safety, therapeutic engagement, recovery where appropriate, prevention of deterioration, maintenance of independence and the least restrictive approach to care.

3 Procedure

3.1 Quick guide

3.1.1 Competency and training to undertake enhanced therapeutic observations and care

All colleagues including bank as part of their induction to the ward, are to complete the competency checklist and a knowledge and skills assessment annually and this is to be recorded as part of supervision.

3.1.2 Least restrictive principle

Enhanced therapeutic observations and care should be set on an individual basis, at the least restrictive level for least amount of time, in the least restrictive environment, taking into consideration the patients risks and risk management plans. The rationale for enhanced levels of observations must be clearly documented in the electronic patient record (EPR) and plan of care. The patient is to be involved in the planning of this with the multi-disciplinary team and their involvement and review as part of the supportive process.

3.1.3 Allocation of observations

- This is to be completed by the nurse in charge of the ward, and a colleague will be allocated observations fairly, on a rota taking into consideration other ward activity.
- Wherever possible a colleague should not be expected to undertake observations for longer than 1 hour at a time.

3.1.4 Recording of observations

All observations are to be recorded contemporaneously in the EPR. In the event that an observation has been missed or not carried out at the agreed time, colleagues must first check that the patient is safe, inform the nurse in charge, then complete an incident report form explaining why the observation was not carried out.

3.1.5 General

General observations are the minimum level of observation for all inpatients and apply to every patient unless an enhanced level of observation has been prescribed. They are intended to ensure the patient's safety and wellbeing through regular therapeutic contact and visual checks, while supporting the early identification of any deterioration in the patient's mental or physical health. As a minimum, a visual check must be undertaken hourly and recorded within the EPR.

3.1.6 Intermittent

Intermittent observations are used when a patient requires an increased level of supervision because they are potentially, but not immediately, at risk of harming themselves or others, or where there are concerns regarding their physical health, cognition, mobility or safety. This may include patients at increased risk of falls, delirium, neurological impairment, physical deterioration or unsafe mobilisation. Visual checks must be undertaken at the frequency specified within the care plan (for example every 10, 15 or 30 minutes) and recorded in the EPR.

3.1.7 Within Eyesight

Within eyesight observations are prescribed when a patient is assessed as presenting a significant and immediate risk that requires continuous visual supervision. This may relate to risks of suicide, self-harm, violence, severe behavioural disturbance, wandering, delirium, repeated unsafe mobilisation, significant falls risk or rapid physical deterioration. The patient must remain within the allocated colleague's eyesight at all times, with therapeutic engagement and ongoing assessment forming part of the observation.

3.1.8 Within Arm's Length

Within arm's length observations are prescribed for patients presenting the highest level of immediate risk, where colleagues need to remain in close proximity to enable immediate intervention. This may include patients at high risk of suicide, serious self-harm, violence, extreme behavioural disturbance, recurrent unsafe attempts to mobilise, severe delirium, neurological impairment, or significant physical deterioration where continuous close supervision is required to maintain safety. The rationale for this level of observation must be clearly documented within the care plan and risk assessment. Where there is a risk of harm to others, this level of observation must not be undertaken by a single colleague.

3.2 Levels of observations

There are four levels of observations within this policy:

- general
- intermittent
- within eyesight
- within arm's length

General observations are the baseline observation for all patients. Intermittent, within eyesight and within arm's length are all classed as enhanced observations. Zonal monitoring can be used to observe patients subject to general or intermittent observations where clinically appropriate. Colleagues should refer to section 5.2.5 for further guidance.

Consideration should be given to the location of the patient's bedroom, where possible it should be close to the nursing station. Where there are concerns about risks to others, the location of any vulnerable patients should be taken into consideration. Equally, consideration should be given to patients requiring enhanced observations because of physical frailty, recurrent falls, post-fall monitoring, delirium, fluctuating cognition, neurological impairment, wandering behaviours or unsafe mobility, ensuring the ward environment supports safe observation, prompt assistance and minimises environmental risks.

At least once during each 24-hour period, a registered professional should set time aside to engage positively with each patient and review their psychological, emotional and physical wellbeing. This provides an opportunity to review the patient's observation level, Dialog+, mobility, cognitive presentation, falls risk, physical health status and any indicators of deterioration that may require a change to the observation plan or wider care interventions.

In addition, any unusual occurrences or incidents involving the patient, together with a general summary of what they have done during each shift, should be recorded. If a patient declines this opportunity, colleagues should make reasonable efforts to engage the patient and document these attempts.

For patients subject to enhanced observations, colleagues should take every opportunity to spend time with and engage the patient therapeutically, while balancing the individual's need for privacy, rest and independence where clinically appropriate. For patients receiving enhanced observations because of delirium, dementia, neurological impairment, fluctuating cognition, falls risk or impaired mobility, observations should include appropriate supervision, timely assistance with mobility, monitoring for changes in physical or cognitive presentation, reassurance and environmental risk reduction in line with the patient's assessed needs. If the clinical risk escalates, use of a higher level of enhanced observation should be considered.

A registered professional should aim to undertake (as a minimum) one third of the observations during each shift where practicable.
Observation levels should never be prescribed as a blanket approach (for example, for all new admissions or all patients at risk of absconding) but must always be

based on an individualised assessment of the patient's mental and physical health needs, identified risks and clinical presentation.

Colleagues should also be mindful of increased vulnerability during the early stages of admission, where risks may not yet be fully understood. This includes patients with acute mental illness, delirium, fluctuating cognition, neurological conditions, recent falls, impaired mobility or physical deterioration, who may require closer assessment until their presentation is fully established.

If a patient is internally transferred whilst subject to enhanced observations, the observation level should normally be maintained until the receiving clinical team has undertaken an assessment and, where appropriate, for a minimum of 48 hours or until reviewed by the MDT. If the patient's clinical presentation or level of risk changes, the level of observation should be reviewed and amended without delay. A post-supportive reflective interview with the patient should take place at the end of an episode of supportive observations (other than general), where clinically appropriate and in line with the patient's cognitive ability and clinical presentation. The prescribed observation level should be recorded directly within the EPR using the supportive observations template under the restrictive interventions node within the clinical tree. Observations should subsequently be documented through the ward view 'to-do list' as they are completed.

For further guidance on recording observations within the Electronic Patient Record (EPR), colleagues should also refer to the relevant user guide. Where enhanced observations are implemented primarily because of falls risk, recurrent falls, mobility impairment or physical deterioration, colleagues should also follow the Trust Falls Manual and other relevant clinical policies to ensure observation practice forms part of a coordinated falls prevention and patient safety plan.

3.2.1 General observation and therapeutic engagement

General observations are the baseline level of observation for all patients and will be applicable to most patients who are considered a low risk of vulnerability, suicide, self-harm, or harm to others. General observations should be performed as a minimum hourly.

The trust recognises the importance of completing general observations in a timely way, and that consequently; general observations don’t always provide a practical opportunity to engage therapeutically with patients. Therefore, the trust views the functions of observing a patient subject to general observations and engaging with them therapeutically as two distinct tasks.

When performing a general observation, colleagues must as a minimum:

- locate and visibly check that the patient is safe and breathing if not visibly active or awake
- be mindful of and respond accordingly to any signs of deterioration
- follow up on or delegate appropriately any concerns noted or reported including any patient requests that do not need to be immediately dealt with during the observation round

The colleague undertaking the observation must be able to see the patients head and that nothing is impeding their breathing. If colleagues are trained and competent to use LIO, this can be utilised to compliment the visual check by observing the patient's vital signs on the tablet device.

Colleagues can also visibly check the patient is breathing through a physical check. If there are concerns around the patient's presentation, then a physical check of breathing must be undertaken.

Throughout a shift there will be several other opportunities in addition to set hourly observations for colleagues to be aware of the wellbeing and location of all patients (especially those subject to general observations), such as shift handovers, mealtimes, and medication times. Although there is requirement to formally record a patient observation at these times, they provide an opportunity for colleagues to note and act on absences and record where appropriate their observations of a patient's engagement in a particular activity.

The general whereabouts of patients should be known by the respective ward team throughout the shift, but not all patients need to be kept within eyesight, however at the commencement of each shift the nurse in charge should be aware of the location of each patient and (where practicable) briefly engage with them. This will also inform a robust handover process.

It is anticipated that psychiatric intensive care units and intensive nursing areas may engage with and observe all their patients more frequently, as determined by their local services and environment.

When agreeing the times for undertaking routine observation of patients', consideration needs to be given to the need to vary these so that patients do not become over familiar with the timeframe and consequently modify their behaviour to fit around this.

Therapeutic engagement with patients subject to general observations will be delivered in line with the admission, transfer and discharge manual, including patient flow and out of hours (OOH) procedures, specifically via named nurse or nominated deputy engagement, daily 1:1's and other therapeutic activities.

3.2.2 Intermittent observations and therapeutic engagement

Intermittent observation is intended to be used for patients who are potentially but not immediately at risk of seriously harming themselves or others, or there are concerns about their physical health which requires them to be monitored and supported at specific times.

Minimum standards for intermittent observation and engagement include:

- the specified frequency of engagement and observation must be recorded in the observation care plan
- the patient's location and safety must be visibly checked at the specified intervals
- where implemented for a risk of harm to self, the intervals should be varied within a specified timeframe and reflected in the observation care plan

- observing colleague must ensure that the expected number of observations and engagement per hour is completed
- the observations must be completed at night unless specified otherwise by the MDT and is clearly rationalised in the observation care plan

This level of observation is determined by the MDT in conjunction with the patient and their family or carer as appropriate and addressed through personalised care planning for each patient. The intervals between the observation and engagement must be clearly identified by the person who has prescribed the observations. This may vary according to the MDT's assessment of need but will usually be between 5 and 30 minutes. Observations and engagement should be carried out at least at the time intervals stated.

However, for some patients to increase safety, intermittent observation and engagement should be carried out at varied intervals within a time frame. The varied intervals should be agreed by the MDT and outlined in the observation care plan and must be communicated to colleagues completing the periods of observation.

For example, a patient who was previously a high suicide risk and on a within eyesight observation, however, is showing signs of recovery, and the MDT have reduced the engagement and observation level to intermittent, may not have a check completed at exactly every 15 minutes as they may know the exact time they are being checked.

Intermittent observations are still to be used to foster engagement and not solely a checking process, therefore, there needs to be consideration around how many intermittent observations are being carried out at any given time. If a ward has more than four patients on intermittent observations, the nurse in charge should follow locally agreed processes to maintain safe staffing levels. Where this is not possible, the nurse in charge must escalate the situation to the ward manager or matron, or if out of hours the bronze on call.

An appropriate colleague who has been assessed as competent by a registered professional can be responsible for carrying out intermittent observation and engagement over the prescribed period. They will have an awareness of the patient's whereabouts and safety at specified intervals. This level of observation should be part of a collaborative care approach with the patient around positive risk and will often support reducing the need for within eyesight and arm's length observations.

Leave outside the ward should be considered in relation to the trust's leave policy. This level of observation and engagement can also be used when implementing zonal monitoring. Please refer to section 5.2.5 for further information.

3.2.3 Within eyesight observations and therapeutic engagement

Within eyesight observations will usually be prescribed when the patient is assessed as being a significant risk to themselves and or others. Within eyesight observations provide an ideal opportunity to engage therapeutically with the patient being observed.

Minimum standards for within eyesight include:

- the patient must always be within eyesight, by day and night (unless stipulated by the MDT, see below for considerations)
- an hourly summary of the patient's presentation completed by the colleague undertaking the observation (including physical health where relevant), risk behaviours, significant events, physical condition (especially where the observation relates to a deterioration or specific physical health concern) and any therapeutic interventions

An observation care plan must be in place. Any restrictions on a patient's movement must be documented in the observation care plan and reviewed at the same time as the ongoing risk management plan.

Consideration should be given to whether the patient may only require 'within eyesight observation' at specific times or within specific environments for example, using the bathroom and toilet, within specific areas of the ward, at mealtimes, post visiting time or at night when in bed. This should be determined by the MDT.

The MDT must determine the plan for the patient when they have visitors, and this should be outlined in the observation care plan. The responsibility of 'within eyesight observation' should not be transferred to a visitor, unless in exceptional circumstances which have been agreed, risk assessed, and care planned by the MDT.

If it is agreed by the MDT that the patient is to be afforded a degree of private time with a visitor, it is the responsibility of the colleague (allocated to be with the patient during that time) to:

- remove any items that the patient could use to harm themselves, where there is known or suspected risk of self-harm
- ensure that the patient does not leave the ward (unless this has been assessed and a risk management plan is in place)
- always remain in visual contact. This could be achieved by sitting away from the patient's room door or the other side of the visiting space, enabling a degree of audio privacy but maintain sight of the patient

In certain situations, more than one colleague may be required to carry out this observation. The observation care plan will stipulate the number of colleagues required.

On Magnolia Lodge colleagues are to refer to the patients risk management plan for guidance on what approach to take when visitors are present.

3.2.4 Within arm's length observations and therapeutic engagement

Within arm's length observations will be prescribed to patients at the highest levels of risk (for example, a high risk of suicide or there are other concerns around physical health), who need to be nursed in close proximity.

Where the observation care plan identifies a risk in relation to potential violence and aggression, consideration must be given to maintaining a safe distance in line with organisational training. Also, if there is a risk of harm to others, this level of

observation must not be prescribed using one colleague. Within arm's length observation are the highest level of observations.

These observations can only be undertaken by a colleague who is familiar with the ward environment and the patient they have been allocated to.

Minimum standards for within arm's length observations include:

- issues of privacy, dignity, and gender must be considered when allocating colleagues, and must be discussed by the MDT and incorporated into the care plan. Best practice is based on how the patient presents and their wishes. Where clinically appropriate patient's wishes should be met
- observation will be maintained when using toilet or bathroom facilities. Colleagues of the same gender should accompany the patient
- engagement and observation will usually continue at night when the patient is asleep, any reduction in observation level to within eyesight observations must be agreed by the MDT and reflected in the care plan

It may be necessary to search the patient and their belongings. Colleagues should refer to searching of a person or their property policy for further guidance.

A patient who is prescribed within arm's length observation is likely to be mostly ward based given the inherent level of risk. Fresh air should be facilitated on hospital grounds, ideally ward garden areas and courtyards. It should be clearly documented in the observation care plan about the length of time, the designation of the colleagues, and the number of colleagues needed to facilitate time outside.

In cases of ward emergency, the observing colleagues are to stay with the patient as they evacuate the ward.

Patients on within arm's length observation can be escorted to a general hospital for medical appointments. Routine medical appointments should be planned in advance. For patients who are subject to detention under the Mental Health Act 1983, all leave will comply with the requirements of section 17, colleagues are to refer to the policy and guidance on the management of leave for in-patients (including section 17 guidance)

For emergency appointments, the nurse in charge should ensure that a colleague who is adequately trained attends with the patient, the ward managers or matron, registered clinician and if out of hours the bronze on call and duty doctor are notified. Emergency section 17 Leave should be sought if the patient is detained under the Mental Health Act.

There will be no change to the observation and engagement level when the patient is in the company of visitors. The only exception to this may be when observation is due to risks associated with behaviours that challenge in dementia and a responsible adult (usually a relative) can safeguard the patient during their visit. Any such arrangement must be agreed with the relative and documented within the EPR.

Some services may deem it appropriate for patients subject to an enhanced observation to leave the ward unaccompanied by a colleague (for example, a young

person being allowed to leave the ward with their parents), this should only be where the risk is considered to be reduced when the patient is not in the ward environment. This must be agreed in advance by the MDT with a clear plan documented in the observation care plan and risk assessment.

Consideration should be given to whether observations can be reduced to within eyesight once the patient has retired to bed and is asleep. This should be discussed and agreed within the MDT and reflected in the observation care plan. The observation care plan should define the steps or processes in place to reduce the observation in collaboration with the patient.

For area specific arrangements for Magnolia Lodge (neurorehabilitation ward) within arm's length observation and leave arrangements please refer to appendix F.

3.2.5 Zonal monitoring

The Zonal monitoring approach aims to provide appropriate observation of individual patients without the need to assign a colleague to a specific patient. Zonal monitoring should be prescribed by the MDT based on clinical need and a dynamic risk assessment and not used to manage colleague shortages or be financially driven.

An example of when to implement zonal monitoring would be corridor observation when there is an eliminating mixed sex accommodation (EMSA) breach or an outbreak of an infectious disease such as COVID-19 where more than one patient is expected to isolate in their room. Identified colleagues will be responsible for observing, assisting and engaging with all patients within a designated zone.

Zonal nursing allows an alternative method of observation involving boundaries and time restrictions for certain ward areas and are supported by colleagues who observe and engage with patients individually and as groups, for set periods. This means patients have equal access to colleague resources and are subject to less restrictions in a "managed" environment (Clarke 2007) as cited in Carr, P. 2012 and should not be confused with the 'zoning focused support' or 'traffic light' approaches (Gamble et al. 2009, Gamble 2006) as cited in Carr, P. 2012, which rely on the targeted allocation of colleague resources to patients categorised by risk.

In certain circumstances zonal monitoring can be less intrusive and allow greater privacy for the patient in comparison to other enhanced observation approaches. The trust therefore recognises that under certain circumstances a ward or clinical area may wish to operate a zonal monitoring approach.

The decision to implement zonal monitoring and engagement and agreeing procedures and practice for any ward or clinical area will lie with the relevant MDT.

Principles guiding the implementation of zonal monitoring:

- zonal monitoring must be patient focused at all times
- the service has a duty for safety and security to the patients, colleagues, and visitors
- care must be provided in the least restrictive way and in the most suitable environment

- zonal monitoring is a method of reducing risk and enhancing patient experience. It is an integral part of a wider risk assessment and contextual management process

Not all ward layouts are appropriate for zonal monitoring.

The zone should be described clearly with defined boundaries as to where the zone starts and ends. Zones should have explicitly defined rooms, corridors, and spaces. Example of a zone may be: Zone 1, day area, courtyard, group room, small interview room.

Colleagues assigned to these areas must explicitly understand that they are not only observing the physical space but also on hand to engage and intervene with patients where necessary.

3.2.5.1 Roles and responsibilities specific to zonal monitoring

Colleagues should be mindful of their roles and responsibilities relating to zonal monitoring in addition to those set out in the policy.

The ward manager or their deputy will:

- consider if a blanket restriction needs putting in place with a regular time frame of review please refer to blanket restrictions policy
- ensure that a risk assessment process is used by the clinical team to agree that a zonal approach is used for patients
- instruct on how and when zonal monitoring is implemented and reviewed

The nurse in charge will:

- delegate colleagues to the zone(s). When delegating zones, the nurse in charge should be mindful of the intensive nature of observations and the impact this may have on colleague concentration. This may be 15 particularly relevant at night where colleagues may require more variety in tasks to support them in staying focussed
- observing colleague will:
    - know their zone
    - be familiar with the engagement and observation status of all patients in their observation zone

3.2.6 Observations and engagement at nighttime

General observations must continue during the night and will primarily be undertaken to:

- ensure the patient is present on the ward and safe
- offer support to patients experiencing difficulty sleeping
- recognise and respond promptly to any deterioration in the patient's physical or mental wellbeing
- monitor for signs of life
- support the ongoing assessment and management of patients at increased risk of falls, delirium, cognitive impairment, neurological deterioration or unsafe mobility.

Any changes to enhanced observations during the night must be agreed by the MDT and reflected within the patient's care plan, observation plan and risk assessment.

For patients identified as being at increased risk of falls, enhanced observations should form part of the patient's overall falls prevention plan and be implemented alongside the interventions identified within the Trust Falls Manual. This may include regular supervision, responding promptly to call bells, assisting with mobility and toileting, ensuring walking aids and essential items are within reach, maintaining a safe environment, using bed or chair sensor alarms where clinically indicated, and monitoring for changes in cognition, mobility or physical condition that may increase falls risk. Enhanced observations should complement, rather than replace, individualised falls prevention measures.

It is important that, at the point of admission, colleagues establish and record the patient's usual sleep pattern so that significant changes can be recognised. For example, if a patient who is normally restless throughout the night has not moved since the previous observation, colleagues should enter the room to undertake a welfare check and confirm the patient's wellbeing.

Whilst this list is not exhaustive, colleagues should consider the following when checking patients for signs of life during the night:

- is there evidence that the patient is breathing, with visible chest movement?
- can breathing be heard, including snoring where this is known and documented to be normal for that individual?
- has the patient changed position since the previous observation?
- has breathing become laboured or changed, suggesting possible physical deterioration?
- if lighting allows, has there been any change in skin colour or pallor?
- for patients with delirium, dementia, neurological impairment or fluctuating cognition, has there been any change in responsiveness, confusion or behaviour?
- for patients at increased risk of falls, is the patient attempting to mobilise independently, climbing out of bed or displaying behaviours that increase the risk of falling?
- where there is an identified risk of ligature or self-harm, has the agreed night-time risk management plan been followed, including ensuring the patient's hands, neck and head remain visible where clinically indicated?

If, at any point during a night-time observation, colleagues have concerns regarding a patient's physical or mental wellbeing, they must enter the room, assess the patient's level of consciousness and undertake any appropriate clinical assessment, including response to verbal or auditory stimulus where required. Any concerns should be escalated promptly in accordance with the patient's clinical condition. Extended periods of sleep should be accompanied by regular welfare checks that are proportionate to the patient's individual needs. During daytime hours, colleagues should consider gently waking patients who have remained asleep for an unusually prolonged period to offer food, fluids, medication where appropriate, assistance with mobilisation and toileting, and to assess their physical and mental wellbeing, unless there is a documented clinical reason not to disturb them.

Please also refer to Section 5.5 regarding the appropriate use of Low Intensity Observations (LIO) at night and to the Trust Falls Manual for the assessment and management of patients at risk of falls.

3.2.7 Leave arrangements for patients subject to enhanced observation

Patients who leave the ward when subject to enhanced observation must agree to intermittent check-ins (most likely by phone) and a time of return. These details must be formulated as part of the care and risk management plan.

The nurse in charge or delegated others must always be aware of the stated whereabouts of each patient subject to enhanced observations whether on or off the ward. Where a patient subject to enhanced observations does not return from leave as agreed, immediate action must be taken to locate the patient.

3.3 Process for prescribing enhanced observation

The decision to introduce enhanced observations will vary for individual patients and will be based on an appropriate risk assessment at a particular point in time.

All patient, carers, and relatives where possible should be involved in the planning of enhanced observation and the development of personalised action planning from the point of admission. In addition, where other professionals are involved in the patient care, they should be consulted.

This includes discussing meaningful interventions and interactions, tailored to the patient's needs and strengths that aids recovery. This should ensure the patient is supported to carry out activities either with a colleague on a regular basis or time on their own as appropriate.

This should also include proactively planning contact with carers, relatives, and friends. There must also be a collaborative approach where possible in recognising early warning signs which may be triggers for distress and increased risk of self-harm or suicidal thoughts. This in turn will help to ensure the level of observation is patient centred and needs to be led rather than a blanket approach.

Carers are often first to notice signs of deterioration and understand what actions can have positive and negative impacts on the patient. If the patient has given consent for their carer to be involved, then it is important that they are informed of the observation level (unless the individual is deemed to lack capacity and due process should be followed in relation to the Mental Capacity Act). However, it is accepted, particularly in the early hours of an admission, observations may be prescribed by the nurse in charge in collaborative discussion with a medic.

Following a thorough risk assessment, the level of observation should be agreed, the rationale documented, and observation care plan formulated and recorded. The patient should be informed of the observation level and be provided with a copy of their observation care plan in an accessible format, and where necessary translated into their own language. Advanced directives should be used when completing care plans.

3.4 When should enhanced observations be set?

The prescribing of enhanced observations should, wherever possible, be the result of multidisciplinary team (MDT) discussion and collective clinical decision-making and should, where appropriate, involve the patient and their family or carers.
In certain circumstances, the nurse in charge or registered clinician assessing the patient may need to initiate enhanced observations following a rapid change in the patient's presentation before discussion with the wider MDT or medical colleagues can take place. If a decision is made by a single clinician to initiate enhanced observations, a member of the medical team or on-call doctor should be contacted at the earliest opportunity to review the clinical decision and agree the ongoing management plan. This may include reviewing the patient's legal status where appropriate. The patient should then be reviewed by the MDT as soon as practicable and a comprehensive assessment completed.

All decisions regarding the level of observation must be based on an individualised assessment of the patient's clinical presentation, identified risks and care needs, and should be consistent with relevant national guidance, including NICE Guideline NG10 *Violence and Aggression: Short-term Management in Mental Health, Health and Community Settings* (2015), alongside other relevant physical health and patient safety guidance where appropriate.

Enhanced observations should be considered where there is evidence of increased risk or deterioration, including but not limited to:

Mental health and behavioural risks

- history of suicide attempts, self-harm or violence towards others
- command hallucinations or other psychotic symptoms associated with increased risk
- paranoid beliefs resulting in perceived threat from others
- thoughts, plans or expressed intent to harm self or others
- vulnerability to exploitation or harm from others
- reduced self-control or behavioural disturbance
- substance misuse or intoxication
- recent significant loss or trauma
- marked changes in behaviour, mood or emotional state
- significant changes in medication
- absconding, escape or missing person risk
- sexually disinhibited or sexually risky behaviour.

Physical health, cognitive and falls-related risks

- delirium or acute confusion
- dementia or fluctuating cognitive impairment
- behavioural and psychological symptoms associated with cognitive impairment
- physical frailty or deconditioning
- recurrent falls or a significantly increased risk of falls
- post-fall monitoring where enhanced supervision is clinically indicated
- unsafe or impulsive mobilisation
- Parkinson's disease or other neurological conditions affecting mobility, balance or judgement

- neurological impairment, including acquired brain injury or stroke
- deterioration or exacerbation of physical health conditions
- behaviours associated with wandering or reduced awareness of personal safety.

Where enhanced observations are implemented primarily because of falls risk, physical frailty, delirium, neurological impairment or unsafe mobility, the observation plan should form part of the patient's overall falls prevention and physical health management plan and should be implemented alongside the interventions described within the Trust Falls Manual.

A psychological formulation or care plan, together with interventions such as a Wellness Recovery Action Plan (WRAP), Dialectical Behaviour Therapy (DBT) skills or Positive Behaviour Support Plans (PBSP), may assist patients in understanding and managing their difficulties where appropriate.

When supporting patients who self-harm, colleagues should also refer to the Self-harm in Primary and Specialist Care Services Policy and incorporate the relevant documentation into assessment, risk management and care planning.

Further guidance can be found in:
- Appendix E – Assessing Needs
- Appendix F – Assessing Risks
- Appendix G – Assessing Care Plans

Consideration should always be given to observation strategies that have previously been effective for the individual patient.

When a registered professional or the nurse in charge initiates an enhanced level of observation, the overall treatment plan must be reviewed, including the patient's legal status, leave arrangements, prescribed medication and any physical health or falls prevention interventions.

The prescribed level of observation must never be determined by staffing availability and should always be based on the patient's individual needs, assessed level of risk and current clinical presentation.

3.5 LIO

The LIO system (non-contact technology) can be used to complement observations and undertake vital sign checks within single use bedrooms. Whilst LIO does not replace in person observation, it can be utilised to support these observations through additional vital sign checks or by enabling colleagues to perform additional checks in between those scheduled.

The decision to use LIO must be made by the MDT including the responsible clinician (RC), detailed in the patient’s observation care plan and communicated at each handover, so all colleagues are aware. The patients clinical risk assessment must also be considered and reviewed daily.

Colleagues will record the observation and engagement directly in the EPR in the restrictive interventions node under the clinical tree. Colleagues who use Oxehealth should be adequately trained and understand how to utilise the technology.

The Oxehealth technology can be used to assist with falls prevention and response by, alerting colleagues in advance or to a fall. Please refer to the vision based patient monitoring system policy for further information.

3.6 Legal status of patients subject to enhanced observations

Due to the restrictive nature of such close observation, it is expected that any patients who require to be observed within eyesight or within arm's length will be either detained under the Mental Health Act 1983, or subject to a deprivation of liberty safeguards authorisation. If this is not the case the patient's RC must review the patient's legal status at the earliest opportunity.

Any patient within the neuro rehabilitation service who is assessed as requiring detention under the Mental Health Act 1983 should be considered for transfer to a specialist provider. Consideration must be given to the patient's own wishes and any instructions detailed within their advance statement if one is in place. Where a patient's expressed wishes or instructions cannot be accommodated a full explanation is to be provided to the patient.

There may be patients who do not meet the criteria for detention under the Mental Health Act. If this is the case, when deciding to implement or continue with an enhanced observation, the level of risk posed must be considered in balance with the patient's human rights. In addition, where possible the patient should be consulted on the proposed intervention and where possible consent to the observation should be obtained.

Any patient who is placed on enhanced observations must be given a full explanation, both verbal and written as to why the decision has been made, and what restrictions it places on them.

3.7 Capacity issues, patients aged 16 and over

Where there is concern about the patient's ability to consent to the restrictions, colleagues should apply the principles of the Mental Capacity Act 2005 (MCA) and its associated Code of Practice (2007), in line with the trust Mental Capacity Act 2005 Policy and Accessible Information Standards and take all reasonable steps to provide information about the need for the level of observation in a suitable format.

If the person is still struggling to understand the information a formal assessment of capacity should be undertaken and evidenced on a MCA1. Where the patient lacks capacity to be able to consent, a decision should be made in their best interests which is the least restrictive of their rights and freedoms. This should be evidenced on a MCA2 and documented on the observation care plan.

Any restriction placed on the patient must be necessary to prevent the patient from coming to harm and must be a proportionate response to the likelihood and seriousness of harm.

Colleagues need to continue to facilitate opportunities for patients to gain capacity to understand their care plan at appropriate intervals, particularly if there is an identified improvement in the patient's mental state. Colleagues should refer to the trust Mental Capacity Act 2005 policy for further guidance.

Where the patient lacks capacity and is subject to continued observation under this policy but does not meet the criteria for detention under the Mental Health Act 1983 (for example on Magnolia Lodge) the MDT must consider the use of the Deprivation of Liberty Safeguarding (DoLS). Colleagues should issue an urgent authorisation and request a standard authorisation under the DoLS. Colleagues should refer to the trust's MCA Deprivation of liberty policy. Details of the restrictions should be included on the request for authorisation, DoLS form 1.

Where the outcome of a mental capacity assessment confirms the patient has capacity to consent and they cannot be persuaded to remain on the ward where they will be subject to the restrictions, and it has been determined the patient does not meet the criteria for detention under the Mental Health Act (1983), colleagues are to facilitate the safest possible discharge of the patient.

3.8 Under 18s

Colleagues should refer to the trust policy for the care and treatment of children under the age of 18 on adult mental health inpatient areas, but in summary the child or young person under the age of 18 is to be cared for on a minimum of within eyesight observation level.

3.9 Patients under the influence of alcohol or other substances

Any patient who has or is suspected to have consumed alcohol or other substances such as illicit drugs or is appearing intoxicated must be assessed physically in the first instance by a suitable clinician based on the presentation, and appropriate medical intervention offered. If a medic does not undertake the assessment in person, the patient must be discussed with a medic and a plan agreed.

Following assessment an MDT discussion should inform whether the patient needs to be placed on enhanced observations in line with the medical recommendations. Once intoxication has subsided the ongoing need and rational for observations should be reviewed.

3.10 Language barriers

Where English is not the patients first language interpreting services should be obtained as soon as practicable to facilitate assessment and explain decisions about the level of observations.

An interpreter should also be employed during any MDT review of the ongoing observation level to ensure that the patient remains involved in the decision-making and to facilitate the most accurate and comprehensive assessment possible. Please see the interpreters policy (provision, access and use of, for patients, service users and carers) for further information.

3.11 Management Plan

An observation care plan should be therapeutically focused, completed in collaboration with the patient who should sign and retain a copy in an accessible format where practicable. This should be translated into the patient's preferred language if required. Where a patient is unable to accept or declines a copy of a care plan, the reasons must be recorded in the EPR.

The observation care plan should be agreed by the MDT and include:

- rationale for commencing supportive therapeutic observation
- the level of observation prescribed
- what the goal of observation is
- the expected period of the supportive therapeutic observation and when it will next be reviewed
- number, gender, and designation of colleagues required.

The care plan should be specific in detailing what has been agreed with the MDT, and offer clear guidance to the observing colleague regarding how these should be facilitated, such as:

- What the observing colleague should do to support the patient during times of privacy:
    - using the toilet or bathroom
    - getting changed
- access to fresh air
- visitors (both social and legal)

The care plan will support with specific instructions for the observing colleague to follow. These could include some of the following examples:

- whether the supervising colleague can allow the patient to use the bathroom or toilet with or without the colleague going into the room?
- when the patient is in the bedroom should the supervising colleague sit inside the room or observe from the outside the room?
- should the supervising colleague enter the bedroom at night to check on the patient or can this be safely employed from outside the room?

The care plan must be as explicit as possible to ensure everyone involved is clear around roles and expectations. Advanced directives should be used when formulating care plans.

The observation care plan must be completed in the EPR. It is accessible from the restrictive interventions node under the clinical tree.

In some circumstances where the observation is prescribed to support a specific risk, and management of that risk is subject to its own trust policy, it is acceptable for colleagues to create a single care plan to encompass both risk and enhanced observation. In these circumstances, colleagues are responsible for ensuring all relevant care plan actions and scheduling are applied An example of this is where there will be a falls management plan in place; however, where a patient requires enhanced observations because of an increased risk of falls, an enhanced observation care plan must also be completed. The two care plans should complement one another and, where appropriate, may be integrated to ensure a

coordinated approach to falls prevention, therapeutic observation and ongoing risk management, recognising that these interventions are intrinsically linked.

There may be instances where a patient may benefit from being prescribed two or more observations levels at the same time. For example, a patient might be on within eyesight observations in communal areas and 15-minute intermittent observations in their bedroom.

To mitigate any potential difficulty in documenting from separate care plans, the recommended solution is that a single care plan is used, with actions added so that each specific observation is detailed individually. The care plan could be optimally scheduled to accommodate performing the care plan for both observations, overriding the schedule where required. A potential solution in the scenario above would be to schedule the care plan to hourly to align with the within eyesight observations but perform it early where the 15-minute intermittent observation is required.

Colleagues should be mindful of periods of increased risk including mealtimes, handovers, evenings, and night times, post visiting times and following any reduction in observations. These risks should be considered as part of the observation care plan collaboratively with the patient.

3.12 Reviewing levels of observation

Observation levels must be reviewed daily, however any member of the MDT can request a review at any time, should they deem it appropriate.

The minimum standards of reviewing enhanced observation are:

- review by MDT at least once every 24 hours. Where possible this should include the RC. In exceptional circumstances this can be delegated to another doctor or approved clinician who knows the patient
- evenings and weekends, reviews can be undertaken by ward-based nursing colleagues in consultation with the on-call doctor
- Consultant in charge or RC review occurring a minimum of once per week

However, where a patient is subject to long term observations and their presentation is static, the MDT may choose to reduce the review frequency.

This decision must be agreed by the MDT and detailed in the patients care plan. In such instances the nursing team should be mindful of the patient's presentation on each shift to ensure that the prescribed level remains appropriate.

Changes to a patient's observation level should, where possible, be informed by colleagues who have knowledge of the patient and agreed by the patient's RC.

Delegated authority to decrease observations can occur in the absence of the consultant in charge or RC. Where the RC and MDT have identified in advance the circumstances in which observation levels may be decreased a registered professional can implement this change.

Delegated responsibility must be recorded in the EPR and must clearly stipulate the specific circumstances for change in observation levels.

There should be a graded reduction of within arm's length and within eyesight observations. All observation should initially be graded to the next level down for at least 24 hours. There should be a separate review prior to any further reduction.

Any decision to vary observation levels should be made by the MDT and wherever possible involve the patient. However, it may be necessary for a registered professional to increase observations in response to urgent changes in presentation and to maintain safety for the patient and ward environment. This decision may be unilateral; however, every effort should be made to collaborate with other professionals on duty or on call. The decision should also be considered by the MDT at the earliest opportunity.

Decreasing observations level for patients who may have been subject to an extended period of enhanced observations may be anxiety provoking for the patient and may result in additional challenges. It is therefore recommended that observations should be decreased at a planned time, and this decision should be made in collaboration with the MDT.

Decreasing observations are most likely to be successful and less distressing for the patient when managed in collaboration with clear communication and expectations set.

It may be useful to agree with the patient that if they are struggling, they can request to have their observation levels increased temporarily. Alternatively, a patient may be offered one-to-one engagement time.
Any challenges to reduced observations should be explored with the patient and a collaborative approach taken to resolve the issues. Where the level of observation is reviewed the outcome should be shared with the patient and the care plan updated. The nurse in charge must make every effort to update the wider MDT and reflect the changes in the 24-hour report.

Where there is a dispute regarding the appropriate level of observation, particularly in relation to reducing a level; the current observation level should be left unchanged until it can be reviewed by the wider MDT. A consensus must be reached before changes are made with the decision-making clearly documented in the EPR.

Wherever there is a change to observation levels, this must be comprehensively detailed in the EPR with the rationale underpinning the change.

Any extended use of within eyesight or arm's length observations (14 days and over) must be supported by a peer review. Once a peer review has been activated monthly reviews must be undertaken thereafter until the level of observation is reduced to intermittent or below. If an individual subject to long term observations above general is being prevented from having contact with anyone outside the area in which they are confined, then this will likely amount to long-term segregation and the MDT must initiate and adhere to the trust's management of a secluded or segregated patient policy.

A comprehensive risk assessment and management plan must be updated to reflect the observation care plan.

3.13 Discontinuation of observation

The decision to discontinue observations must be agreed by the MDT.

Observations should normally be discontinued within working hours, to ensure that clinicians who know the patient can be involved in the decision. However, there may be circumstances where a review or termination is clinically indicated outside normal working hours, especially where a delay could be detrimental to the patient. Out of hours, the nurse in charge in collaboration with the team on duty and the on-call medic.

3.14 Record keeping

All interactions with patients relating to observations including assessments and decisions must be captured in the EPR.

There are several distinct recording requirements related to therapeutic observations, these are:

- following an initial assessment or review of an observation the observations' status must be recorded on the observation template and reflected on the ward view
- the observation care plans must be updated to reflect the observation frequency and any personalised care requirements. The patient should be offered the opportunity to sign and retain a paper copy of their care plan
- the face risk assessment must reflect the prescribed level of observation and should be updated when a level is changed and any new risks and mitigations are identified
- each observation must be recorded by performing the appropriate observation care plan and linking to the appropriate data entry document. General observations must be performed and recorded hourly and Intermittent observations (including zonal) should be performed and recorded in line with the intervals stated in the care plan
- a handover must be provided to the colleague taking over a period of enhanced observation and the observation record must be updated to reflect the patient presentation and detail the therapeutic engagement offered
- review and MDTs must be recorded using the appropriate templates. In most instances this will be using the subjective, objective, medication, risk assessment, plan template (SOMRAP) and the MDT template, however colleagues should use the most appropriate clinical template based on speciality and assessment type

Where more than one colleague is undertaking observations for the same patient, both colleagues' names and signatures must be recorded in the EPR. Student nurse entries must be countersigned by a registered colleague.

Observations should be recorded live in the EPR at the time the observation is performed or for enhanced observations at the end of each observation period.

However, where there is a delay in recording, a retrospective entry should be made including a full explanation for the delay.

If there is a missed observation, the patient or patients involved must be located and checked immediately followed by an update on the digital reporting system and line manager notified.

A comprehensive observation and engagement ward guide can be accessed here.

If the EPR is unavailable, paper record keeping should be undertaken using the appendices below and uploaded to the document centre in the EPR under the observation category when the system is restored.

3.14.1 Colleague allocation

The nurse in charge or delegated shift coordinator will agree and document an observation rota on the shift planner at the commencement of every shift, this is to ensure that observations are distributed evenly and according to competence. See appendix E for an example template.

Every effort must be made to allocate observations to colleagues who know the patient.

Enhanced observation should not be allocated to the same colleague for more than one hour at a time, with a minimum of one-hour break between each observation period. In exceptional circumstances however, colleagues may need to remain on an observation until they can be safely relieved. Regular intervals between observations will support colleague wellbeing and lessen the risk of reduced concentration.

Any changes to the rota must be documented and countersigned by the nurse in charge. Observation may require the involvement of several colleagues throughout the shift, with care being handed over at hourly intervals. The nurse in charge may allocate observation levels to non-registered clinicians who are familiar with the ward environment and have achieved their competency to carry out observations.

3.15 Handover

A group briefing will take place at the beginning of each shift, for all colleagues involved in observing a patient, during which the patient's mental state is discussed, potential risks highlighted and attitudes to the process discussed. Before taking over the patient's care, each colleague should familiarise themselves with the patient's background, recent entries in clinical records and care plans.

It is the responsibility of the nurse in charge to ensure they hand over the specifics of the observation (for example fresh air, visitors, bathroom facilities and actions in case of an emergency). Prior to undertaking an observation, a hand-over should relay the patient's presentation from the previous observation period in addition to the group briefing and review of the clinical record mentioned above. Colleagues should share any strategies that have found to be effective during the previous period.

3.16 Support for colleagues

The MDT must provide an open and supportive environment, to enable colleagues to discuss their feelings about participating in enhanced therapeutic observations and care. This could be in clinical supervision, team safety huddles, colleague meetings and MDTs or ward rounds.

3.17 Competency

All trust colleagues (including bank and agency) who work across mental health in-patient wards and are involved in the delivery of supportive observations must complete the following task before undertaking supportive observations for the first time and annually thereafter or where there are concerns regarding practice:

- competency assessment at appendix B which is to be stored in the colleague's personal file

The nurse in charge must ensure all colleagues (including bank) have completed the relevant training and competency assessment prior to assigning them observation duties. For bank colleagues a training and competency record should be held at ward level and a copy to be sent to the bank provider. For colleagues who do not regularly work on the ward the nurse in charge should complete a competency assessment as part of the colleague's local induction and orientation.

If a colleague fails an assessment, the assessment should be stored in the colleague's file and there must be a plan to reschedule with sufficient time afforded for the colleague to prepare and should be supported through supervision. The colleague should not undertake any observations until they are deemed competent to do so.

Where the colleague is a member of the trust bank, the bank office must be informed as soon as practicable that a colleague has failed to reach competency. Bank colleagues who have not met the trust standard to perform observations must not undertake observations anywhere in the trust even if they are deemed competent elsewhere until they have been reassessed and demonstrated competency once again.

Where colleagues fail the competency assessment twice, or there are concerns regarding a colleague's motivation to pass, managers should consult the trust performance (capability) management policy and procedure or seek advice from human resources.

3.18 Maintaining safe staffing levels

The nurse in charge of the ward is responsible for maintaining safe staffing levels and acting upon and escalating concerns appropriately via local management structure and on call systems. Unsafe staffing levels must also be reported via the trust incident management system. Colleagues should refer to the trust safer staffing policy for further information.

Consideration should also be given to the safe transfer of patients to other wards who may be better placed to manage additional observations due to a lower acuity or fewer patients subject to enhanced observations.

4 Responsibilities

The trust has a duty of care and a duty of confidentiality to ensure that all aspects of healthcare record keeping are properly managed. The trust must adhere to the legislative, statutory, and good practice guidance requirements relating to healthcare records management.

The chief executive is responsible for ensuring that an appropriate infrastructure is in place to ensure that observations take place safely and efficiently.

The board of directors is accountable for ensuring that the supportive therapeutic observation policy is relevant and reviewed regularly including incidents and near misses. To ensure guidance and training which is in place for colleagues, patients and agency colleagues meets the needs for the policy and statutory legislative requirements.

Executive director of nursing and allied health professionals and chief operating officer are responsible for the strategic and operational management of the supportive therapeutic observation of patients within the trust. This includes ensuring that a robust policy is in place to ensure appropriate levels of engagement and that robust governance and control mechanisms are in place to facilitate safe practice.

Care group directors, care group nurse directors, care group medical directors or deputy care group director are responsible for overseeing that:

- the implementation of all policies and procedures which are in place to meet the needs of patients
- the monitoring of adherences to this and other related policies
- adequate resources and training are available to the clinical team
- colleagues employed within the inpatient areas receive induction and training to equip them with the knowledge and skills to effectively implement this policy.

Matrons are responsible for:

- monitoring compliance with the policy ensuring that all colleagues receive adequate training in accordance with this policy
- ensuring all colleagues within their service areas are competent to undertake all levels of patient engagement and observation
- having oversight on any incidences and near misses within their service areas which may affect implementation of the policy and to bring this to the attention of the care group director.

Ward managers and deputy ward managers are responsible for:

- ensuring all colleagues receive appropriate training in relation to the implementation of this policy
- that all colleagues are competent in delivering all levels of observation and engagement and additional support is provided to those where there are concerns
- ensuring there are sufficient resources available to meet service demand and clinical needs of patients in relation to observation and engagement
- ensuring the policy is implemented and evaluated appropriately by checking understanding through supervision

- ensuring any near misses or incidences whereby the policy is compromised are investigated and shared with the matron

They will ensure that the matron and care group nurse directors are informed of any incidences during working hours in line with this policy and the trusts' incident management policy.

Nurse in charge is responsible for ensuring within their delegated line of responsibility that:

- colleagues are identified that are best placed to carry out observations
- where delegation of the allocation of observations to the shift coordinator has taken place, they must agree and sign off the delegation duties
- all colleagues have completed a competency assessment (appendix B) and are competent to carry out observations
- all colleagues on duty including bank colleagues are competent to deliver observations
- the policy is implemented, and all relevant documentation related to this policy is completed
- where the policy is not adhered to especially when observations are not completed in line with the definition, that action is taken with the individual colleague
- the ward has appropriate resources to carry out observations and when this is compromised this is escalated to the ward manager or deputy ward manager
- the nurse in charge (including if bank) agrees and approves that the enhanced therapeutic observations and care have been completed appropriately in the EPR

Registered professionals, named nurse, registered professionals (psychologists, nurses, allied health professionals and medical professionals) have the responsibility to ensure that:

- any observation and engagement is an opportunity for relationship building and therapeutic engagement
- that every care plan is completed with observation and engagement, this is to be updated for all named patients, and to include the patient whenever possible and including visitors or other patients in their care as the need arises
- they discuss with patients the rationale for the level of observation and engagement and the reason they have been allocated, ensuring individual needs are recognised when communicating observation and engagement levels. A collaborative plan should be considered around daily reviews of the observation and engagement with the MDT
- a review the observation care plan is frequently undertaken, as specified in the review time frames of the plan
- identification, management and deployment of resources (within guidance from nurse in charge) this could include a review of the skill mix of colleagues required or additional colleagues
- they are accountable for the decision to delegate engagement and observation to a non-registered professional as well as ensuring that they are sufficiently knowledgeable and competent to take responsibility for this role

- the patient is made aware that they are being cared for using a particular level of engagement and observation, the reasons why and reason for the completion of all relevant documentation. This may be under the deprivation of liberty safeguards (DOLS) or Mental Capacity Act (MCA) best interest process if the patient lacks the capacity to engage and consent to the intervention

Students from any professional group, no students can be rostered to engage and observe a patient on enhanced levels of observation and engagement. However, to enhance their learning experience, they can participate in observation and engagement with another colleague under the guidance of a registered professional who is competent in this role. Non-registered professionals are to ensure that:

- periods of observation and engagement are opportunities for relationship building, therapeutic engagement and to support recovery and well-being
- they are familiar with the risk assessment and observation care plan which they will be fundamental in implementing and implement the observation care plan for each person in their care
- they complete documentation for the prescribed observation they are delivering, overseen by the registered professional or nurse in charge
- they inform the nurse in charge of any concerns or improvements regarding supportive therapeutic observation during their period of intervention. This can then be updated by the nurse in charge or named nurse in the patients care plan

Bank and agency colleagues as these colleagues do not work on the ward on a regular basis, they will not have an in-depth knowledge of the patients. If they are to engage and observe patients on any level of engagement and observation, they are to be given a full handover by the nurse in charge of the ward, which will outline:

- why the patient is on a specific level of observation
- any risk factors, for example, suicide, violence, verbal abuse
- risk management and observation care plan which will be accompanying the therapeutic observation record sheet
- action to take if the patient attempts to leave or becomes suicidal, violent or verbally abusive

The nurse in charge must be satisfied that any non-permanent colleagues have completed the ward induction, are familiar with this policy and meet the required competency framework (see appendix B).

Multidisciplinary team (MDT), the members of the MDT have a responsibility to understand their role in initiating and reviewing enhanced therapeutic observations and care. They must consider:

- comprehensive review of the patients' observation and engagement, especially those that are proposed for an extended period, against the identified risk of self-harm or behavioural disturbance
- the level of risk and observation should be reviewed daily by the MDT and a record of decisions and conversations made to evidence the increase or decrease of the observation

If enhanced therapeutic observations and care other than general are used for longer than 14 days, the MDT should make use of the MDTs' skills to support the patient's recovery and well-being.

5 Training

Employee groups requiring training: All inpatient and bank colleagues working on inpatient wards as defined in the scope of the policy

- How often should this be undertaken: Annually.
- Length of training: 1 hour.
- Delivery method: Self-assessment competency assessment.
- Training delivered by whom: Online training or competency assessment in this policy
- Where are the records of attendance held: ESR/colleague file or bank provider

Employee groups requiring training: Students.

- How often should this be undertaken: Ward induction.
- Length of training: 1 hour.
- Delivery method: Competency assessment completed by student.
- Training delivered by whom: Nurse in charge.
- Where are the records of attendance held: Part of student competency documentation.

As a trust policy, all colleagues need to be aware of the key points that the policy covers. Colleagues can be made aware through:

- all user emails for urgent messages
- local induction
- daily email (Monday to Friday)
- group supervision
- intranet
- continuous professional development sessions
- one to one meetings or supervision
- posters
- practice development days
- special meetings
- team meetings

6 Monitoring arrangements

6.1 The effective implementation of this policy

Frequency of use of observation

- How: Audit, the focus of the audit will be key decision and action points from the policy and care plan, including:
    - frequency of use of observation
    - compliance with the policy and care plan
    - length of individual observations
    - review process of levels of observation
    - review of the digital reporting system for those on enhanced levels of observations

- Who by: matrons or service managers.
- Reported to: The care group quality meetings, clinical quality group, safety, quality, operational and assurance group and quality committee.
- Frequency: Annually.

7 Related documents and references

- Carr, P. (2012) Using zonal nursing to engage women in a medium secure setting: Peter Carr describes how a new way of observing at-risk patients in one ward led to an increase in the quantity and quality of therapeutic activities and a reduction in incidents, Mental Health Practice (Vol. 15, Issue 7), Royal College of Nursing Publishing Company (RCN).
- NICE (2015) Violence and aggression: short-term management in mental health, health and community settings. NG10. Overview, Violence and aggression: short-term management in mental health, health and community settings, guidance, NICE.
- Patient Safety Incident Response Framework (August 2022)

- Admission, transfer and discharge manual, including patient flow and out of hours (OOH) procedures
- Care and treatment of children under the age of 18 on adult acute mental health inpatient areas policy
- Incident management policy
- Interpreters policy (provision, access and use of, for patients, service users and carers)
- Leave for inpatients policy and guidance (including section 17)
- MCA, deprivation of liberty (DoL) policy
- MCA, Mental Capacity Act 2005
- Mental health engagement and observation
- Patient falls manual
- Performance (capability) management policy and procedure
- Safer staffing policy
- Searching of a person or their property policy
- Secluded or segregated patient management policy
- Self harm in primary and specialist care services policy
- Vision based patient monitoring system policy

8 Appendices

8.1 Appendix A Definitions and principles

This policy is based upon recommendations from the national institute for health and clinical excellence (NICE) guideline 10 violence and aggression: Short term management in mental health, health and community settings (2015), NICE guideline 25 ‘the short-term management of disturbed or violent behaviour in psychiatric inpatient settings and emergency departments and the mental health code of practice (2015). As well as learning from deaths including national intelligence around Regulation 28s.

Supportive therapeutic observation practice is a process involving paying close attention and providing one to one support to someone presenting as more vulnerable or with increased risks in a way that recognises that person’s individual

needs. It will involve a balance of compassionate vigilance and concern whilst working to ensure that observations are not intrusive or obstructive, so the extent to which the person feels monitored or under surveillance is minimised. When referring to supportive observation this includes therapeutic engagement with patients.

Observations and therapeutic engagement with patients should include rapport building via simple demonstrations of compassion and conversations about everyday things, which are an essential prerequisite to encouraging patients to open up about their experiences of emotional distress.

High quality observation and therapeutic engagement will incorporate listening and fostering interaction, rapport, building and collaboration with the patient and conveying to the patient that they are valued and cared for.

Supportive therapeutic observation is a partnership between the multidisciplinary team, and the patient, and their carers or family. It should not be delivered in a way that is, or perceived as, custodial, or punitive.

As a general principle the level of supportive therapeutic observation should be set at the least restrictive level, for the least amount of time in the least restrictive setting possible. The rationale for enhanced levels of observations must be clearly documented in the patient record and management plan.

As observation and engagement levels are determined to meet the needs of each individual patient, colleagues should not routinely place a group of patients on a specific level of observation and engagement purely on the basis that they are being nursed in a high intensity environment such as a psychiatric intensive care unit.

Where possible the patient's consent should be sought regarding the reasons behind the need for enhanced supportive therapeutic observation and the limits this will impose on them.

That as far as possible and taking into consideration the patient's own wishes, their family or carers will be kept informed or involved in decisions around their care and treatment, including the need for enhanced levels of observation and engagement.

8.1.1 Therapeutic observation and engagement

Therapeutic observation and engagement approaches must be considered by the MDT daily to ensure the right level of supportive observation is prescribed.

8.1.2 Multi-professional involvement

This refers to the widest possible involvement across all professionals involved in the patient care, this is not limited to trust colleagues and should be extended to external agencies and voluntary groups where appropriate.

8.2 Appendix B Competency assessment

- Appendix B Competency assessment (staff access only) (opens in new window)

8.3 Appendix C Supportive therapeutic observation record

- Appendix C Supportive therapeutic observation record (staff access only) (opens in new window)

8.4 Appendix D Health of nation outcome scales for acquired brain injury (HoNOS-ABI) health of the nation outcome scales for acquired brain injury

- Appendix D Health of nation outcome scales for acquired brain injury (HoNOS-ABI) health of the nation outcome scales for acquired brain injury (staff access only) (opens in new window)

8.5 Appendix E Example allocation template

- Appendix E Example allocation template (staff access only) (opens in new window)

8.6 Appendix F Within arm's length observation and engagement, area specific arrangements for Magnolia Lodge

Patients who are assessed as requiring within arm's length engagement and observation are not appropriate for admission to the neuro rehabilitation unit and would require a more secure setting or a setting that is able to provide specialist mental health input.

Support would be offered by specialist nurses and therapists from the Neuro Rehabilitation team in providing timely assessment and advice regarding the appropriate placement of any neuro rehabilitation patients who require within arm's length observation and engagement. If the level or risk posed by a patient admitted to the ward escalates to the point, they are deemed to require within arm's length observation and engagement during their admission, urgent steps will be taken to find an alternative placement that will meet their needs more appropriately.

In the event of this occurring, Magnolia Lodge colleagues should:

- urgently update the matron in charge of the ward (or bronze on call), consultant in rehabilitation medicine (or on call doctor) and the clinical neuropsychologist (during office hours)
- make an immediate referral to liaison psychiatry to arrange an urgent assessment of the patient's mental state
- call an urgent meeting for all clinical colleagues, social work colleagues involved in the patients care and invite relevant family members to attend, so that transfer to a more appropriate service can be discussed and agreed
- If required, contact the specialist placement team

8.7 Appendix G Enhanced Therapeutic Observations and care easy to understand guide

8.7.1 Definition

Supportive therapeutic observation involves paying close attention and providing individualised support to patients presenting as vulnerable or with increased risks in a way that recognises their personal needs.

8.7.2 Principles

Observations and engagement must be performed in a meaningful way and always be centred around compassionate care.

Colleagues should feel confident to discuss openly their thoughts and feelings and be supported in the delivery of enhanced therapeutic observations and care via multidisciplinary meetings (MDT), supervision and safety huddles.

8.7.3 The patient first

The patient including their families and carers should be involved in decisions around supportive therapeutic observation where possible. Where there is a language barrier, interpreting services should be accessed as soon as possible.

8.7.4 Least restrictive

Supporting therapeutic observation should be least restrictive in terms of the observation level prescribed, duration applied and environment.

8.7.5 Multi disciplinary team (MDT) roles and responsibilities

Therapeutic observation should be informed by the MDT. All colleagues have a role to play in the prescribing, reviewing, and undertaking of enhanced therapeutic observations and care and engagement. Colleagues must consider patients mental capacity, Mental Health Act status, age categories and whether a patient is under the influence of drugs or alcohol.

8.7.6 Role of Oxehealth (non-contact technology)

The LIO system can be used to support therapeutic observation and vital sign checks within single use bedrooms. It can also help with good sleep hygiene.

Please refer to the Vision based monitoring system (non-contact technology) policy for further information.

8.7.7 The four types of therapeutic observation and engagement described in the policy

8.7.7.1 General observation and engagement

This is the minimum level for all patients. It will therefore apply to most patients who are considered to be a low risk of vulnerability, suicide, self-harm or harm of others. The trust recognises the importance of completing general observations in a timely way, and that consequently; general observations don't always provide a practical opportunity to engage therapeutically with patients.

The minimum standards that compromise general observation and engagement includes:

- locate and visibly check that the patient is safe and breathing if not visibly active or awake (the use of Oxevision is not a substitute for this)
- be mindful of and respond accordingly to any signs of deterioration
- follow up on or delegate appropriately any concerns noted or reported including any patient requests that do not need to be immediately dealt with during the observation round

Throughout the span of duty there will be several opportunities for colleagues to be aware of the wellbeing and location of all patients on general observation and engagement, in particular, during shift handovers, meal and medication times.

8.7.7.2 Intermittent observation and engagement

This level of observation and engagement is for when patients are potentially but not immediately at risk of seriously harming themselves or others or there are concerns about their physical health which requires them to be monitored and supported at specific times. This level of observation and engagement can also be used when implementing zonal monitoring.

Minimum standards for intermittent engagement and observations include:

- the specified frequency of observation and engagement must be recorded in the ward view and supportive observations template and made clear to observing colleagues
- the patient's location and safety must be visibly checked at the specified intervals
- where implemented for a risk of harm to self, the intervals should be irregular and unpredictable
- Observing colleagues must take care that the expected number of engagement and observations per hour is completed

The observations and engagement must be completed at night unless specified otherwise by the MDT.

8.7.7.3 Within eyesight observation and engagement

This level would usually be prescribed when the patient is assessed as being a significant risk to themselves and or others and this is reflected in the care plan and risk assessment. Within eyesight observations provide an ideal opportunity to engage therapeutically. Colleagues observing should take every opportunity to spend time with and engage the patient therapeutically, striking a balance for the patient who may also benefit from time to themselves to relax and reflect.

Minimum standards for within eyesight observations and engagement include:

- the patient must be kept within eyesight at all times, by day and by night
- an hourly summary of the patient's condition (including physical health where relevant), risk behaviours, significant events and any therapeutic interventions

Consideration should be given to whether the patient may only require 'within eyesight observation' at specific times or within specific environments, for example, using the bathroom and toilet, within specific areas of the ward, at mealtimes, post visiting time or at night when in bed. This should be determined by the MDT.

8.7.7.4 Within arm's length observation and engagement

This level will be prescribed to patients at the highest levels of risk (for example, a high risk of suicide or there are other concerns around the physical health), and they will need to be nursed in close proximity. Where the observation care plan identifies a risk in relation to potential violence and aggression, consideration must be given to maintaining a safe distance in line with training. Also, if there is a risk of harm to

others, this level of observation and engagement must not be prescribed using one colleague.

Minimum standards for within arm's length observation and engagements include:

- observation and engagement will be maintained when using toilet or bathroom facilities
- issues of privacy, dignity and consideration of gender in allocating colleagues need to be discussed by the MDT and incorporated into the care plan
- observation and engagement will usually continue at night when the patient is asleep; any reduction in observation level to within eyesight must be discussed by the MDT and reflected in the care plan

It may be necessary to search the patient and their belongings, whilst having due regard for their legal rights (searching of a person or their property policy must be adhered to). It is likely they will need to be accompanied to the bathroom or toilet. In such circumstances female colleagues should accompany female patients and male colleagues should accompany male patients.

For further detail on the definitions and minimum requirements please refer to the supportive therapeutic observation policy.

8.7.8 Management Plan and risk assessment

An observation care plan is to be developed with the patient and recorded in the electronic patient record (EPR). The detail from the observation and engagement plan should also be reflected in the patient's risk assessment. Both must be reviewed as and when the observation level changes. The care plan will support specific instructions, such as whether the practitioner should enter the patient's bedroom at night.

Observations should normally be discontinued within working hours, to ensure that clinicians who know the patient can be involved in the decision. However, there may be circumstances where a review or termination is clinically indicated outside normal working hours, especially where a delay could be detrimental to the patient. Out of hours, the nurse in charge in collaboration with the team on duty and the on call medic can make the decision.

Remember, there is no urgency to decrease engagement and observation levels out of hours and it is advisable for this to be an MDT approach during working hours.

8.7.9 Recording observation

The undertaking of general observation and engagement should be recorded hourly, directly in the EPR using the supportive observations template under the restrictive interventions node within the clinical tree. Any changes to the level of observation and engagement should be amended on the ward view, supportive observations' template, care plan or risk assessment and the patient advised accordingly.

A comprehensive observations and engagement ward guide can be accessed on the intranet page (staff access only) (opens in new window).

In the event that the EPR is unavailable, paper record keeping should be undertaken using the appendices in the supportive therapeutic observation policy and uploaded to the EPR when next available.

For further detail on the definitions and minimum requirements please refer to the supportive therapeutic observation policy.

8.7.10 Allocation of observation and engagement

The nurse in charge or delegated shift coordinator will agree and document an observation rota on the shift planner at the commencement of every shift, this is to ensure that observations are distributed evenly and according to competence.

8.7.11 Competency and training

All colleagues including bank and agency colleagues as part of their local induction should be orientated to the policy and complete the competency checklist and knowledge and skills assessment. For regular colleagues this should be completed annually, and compliance and learning recorded in supervision.

8.7.12 Missed observation and engagement time slots

If there is a missed observation an incident report should be completed, and the line manager should be informed.

8.8 Appendix H Visual observations for patients at new beginnings protocol

Colleagues at New Beginnings should adhere to the overall principles detailed in the enhanced therapeutic observations and care policy, specifically how to perform a therapeutic observation and engage therapeutically with patients, in addition to section 5.2.1 general observation and therapeutic engagement. Colleagues should follow the specific guidance detailed in this protocol when performing observations. These variations have been agreed following consultation with patients and colleagues and are intended to ensure patients safety without being overly intrusive.

8.8.1 Purpose

To regularly check the physical and mental wellbeing of patients completing an inpatient medically assisted drug or alcohol detoxification.

8.8.2 Aim

Determine how a patient is presenting at a moment in time and determine if a nursing intervention is required.

8.8.3 Performing checks

Colleagues must:

- perform checks every 2 hours until night time observations are stepped down
- ensure they have a clear view of the patient and their presentation
- document on the observation chart patient location and presentation before signing it
- report any concerns to the nurse in charge

8.8.4 Process

All patients must be checked every 2 hours for the first four days of admission. This can be increased if it's deemed necessary by the clinical team.

On or after the fourth day, overnight observations can stop unless any of the following risks are identified:

- physically unwell
- deterioration of mental wellbeing
- appearing over or under sedated
- still scoring above 8 on CIWA or showing any other signs of severe withdrawals
- it has been discussed in daily MDT that there are other risk factors present which results in the need for checks to continue
- the nurse on duty overnight deems it necessary to continue overnight checks due to a new risk being identified

If a patient does not require further nightly observations, then their last check will be 10pm and begin again at 6am.