Sheffield Health and Social Care NHS Foundation Trust

Policy:

NPCS001 - Observation of In Patients - Routine and Enhanced Observations of Patients

Executive or Associate Director lead	Director of Nursing, Professions and Care Standards
Policy author/ lead	Head of Mental Health Legislation
Feedback on implementation to	Head of Mental Health Legislation

Document type	Policy
Document status	V3.1
Date of initial draft	5 September 2017
Date of consultation	18 April 2017
Date of verification	4 October 2017
Date of ratification	5 October 2017
Ratified by	Executive Directors' Group
Date of issue	5 October 2017 (Amended July 2018)
Date for review	31/10/ 2022*(Fifth Extension from 30/04/2022 by PGG on 25/04/2022)*

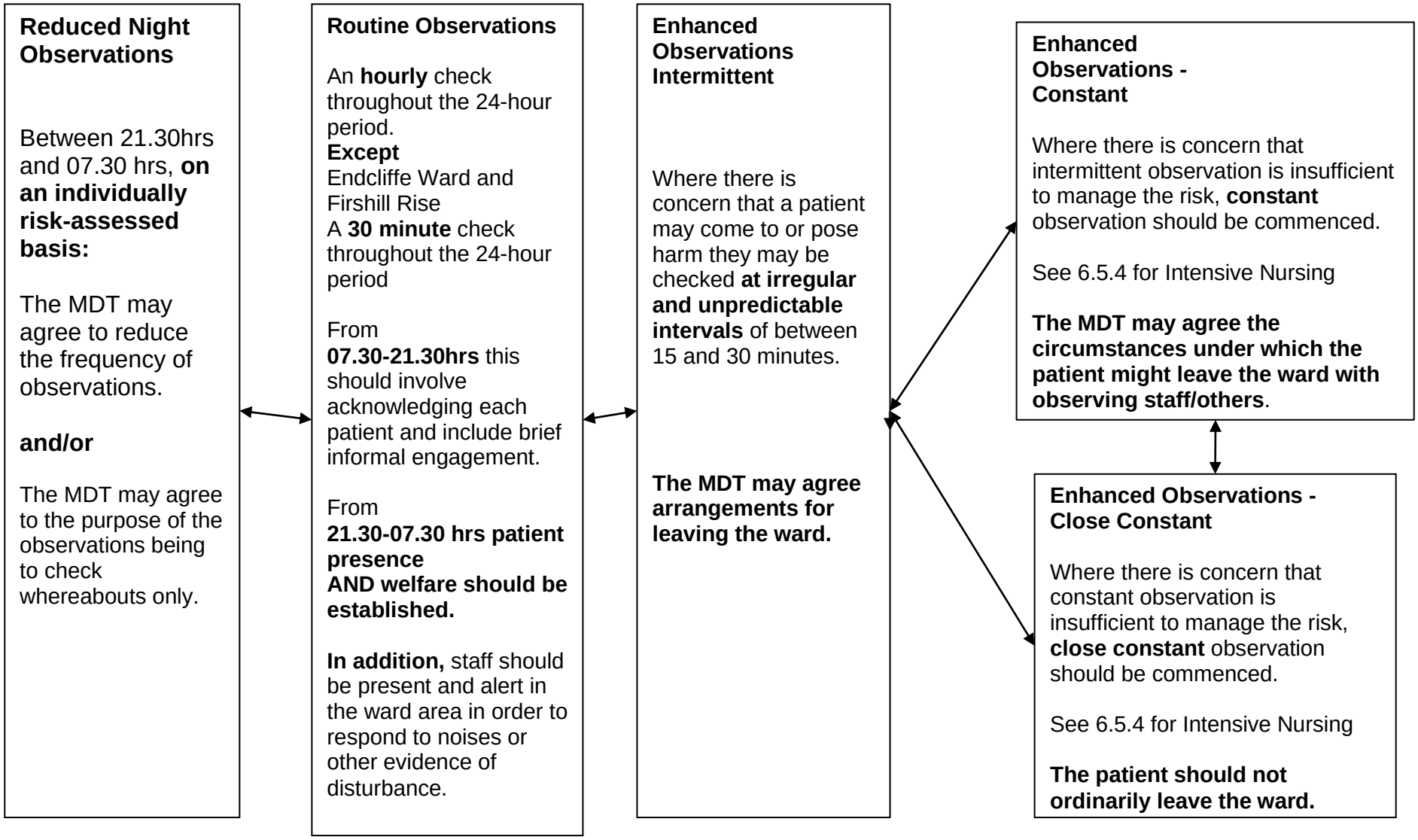
Target audience	Operational managers of clinical teams Service Directors and Clinical Leads Registered Nurses in inpatient areas Staff undertaking observation duties

Keywords	

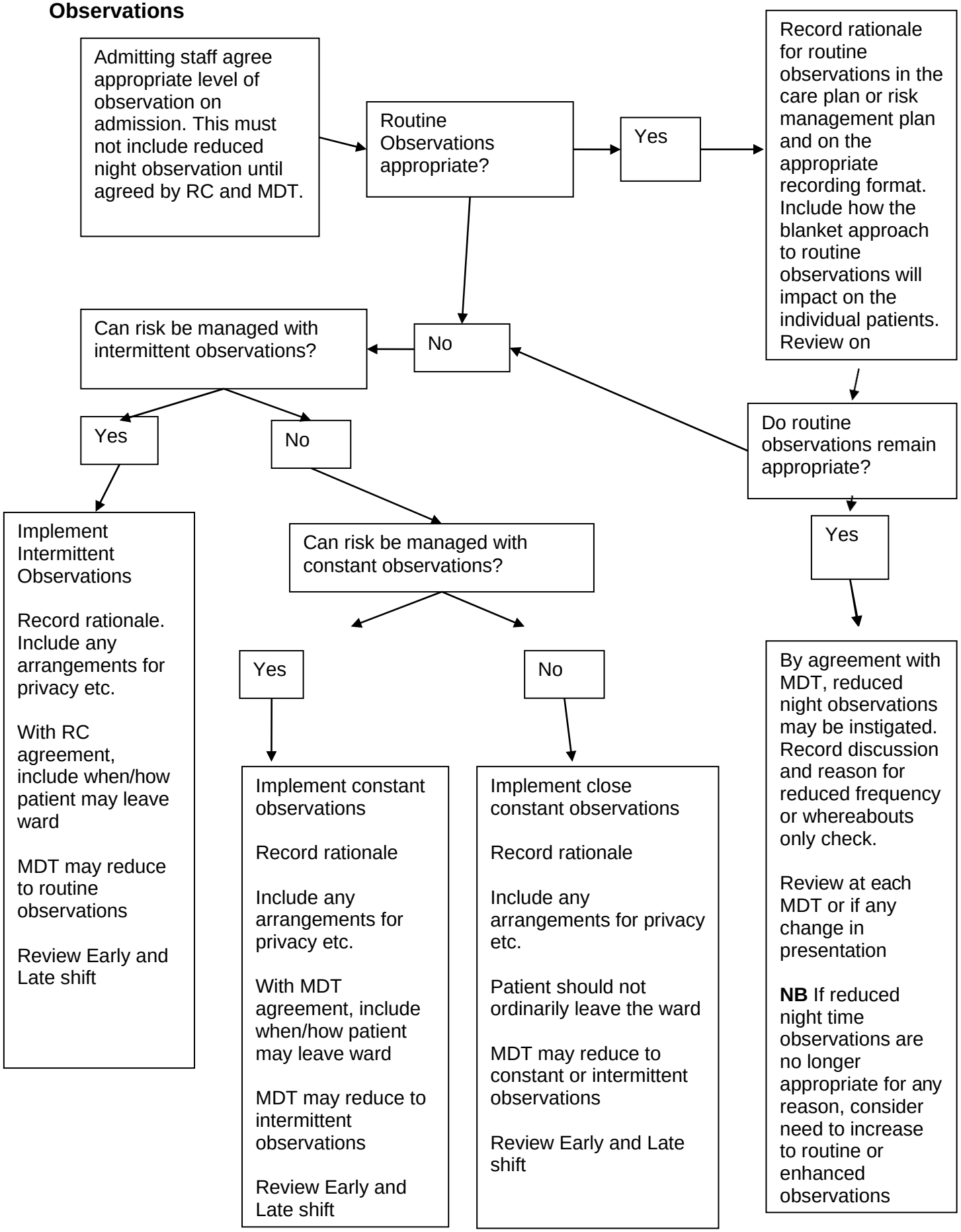
Policy Version and advice on document history, availability and storage
V3.1 Fifth Extension to Review Date ratified at QAC 11 May 2022
V3.1 Fourth Extension to review date ratified by QAC October 2021.
V3.1 Third Extension to review date ratified by QAC August 2021.
V3.1 Second Extension to review date ratified by QAC February 2021.
V3.1 Extension to review date ratified by QAC in October 2020.
V3.1 Amended July 2018 to clarity intermittent observations.
V3 Previous policy dated March 2013.
Updated policy will be available on the Trust Intranet and circulated to all Inpatient team leads.

Contents

Flowchart – any reduction from routine observations to reduced night observations; from close constant to constant; from constant to intermittent; or from intermittent to routine must be agreed by the MDT (see definition of MDT below). Intervals and rationale must be recorded in the care plan or risk management plan.



Flowchart -
Implementing and Discontinuing Observations



1. Introduction

Patient safety is of paramount concern to service users, carers, relatives and staff. The needs and demands of patients in different phases of mental illness and in different care settings are varied. Observation serves two purposes: 'routine observations' ensure that staff have knowledge of a patient's general whereabouts; 'enhanced observations' are employed in order to manage individually identified risk.

The Mental Health Act Code of Practice 2015 (CoP) stipulates:

Staff should know the location of all patients for whom they are responsible in a hospital ward or service. It is not necessary to routinely keep patients who are not considered to present a serious risk of harm to themselves or others within sight. (CoP para 26.28). For the purpose of this policy this level of observation is referred to as 'routine'.

However:

There may be times when enhanced levels of observation are required for the short-term management of behavioural disturbance or during periods of distress to prevent suicide or serious self-harm. (CoP para 26.30).

Research suggests that most attempted suicides are discovered and prevented by staff checking on patients, particularly in the more private areas of wards. For individuals assessed as being at risk of suicide or serious self-harm, a significant preventive mechanism is for nursing staff to be caringly vigilant and inquisitive. (CoP para 26.29)

However:

Staff should balance the potentially distressing effect on the individual of increased levels of observation, particularly if these are proposed for many hours or days, against the identified risk of self-injury or behavioural disturbance. (CoP para 26.34)

It is clear from the above that the CoP supports a 'blanket' approach (see below) to patient whereabouts and an individually assessed risk-based approach where serious harm might ensue. Such interventions, necessarily involving intrusion into patients' privacy, are therefore warranted - if they are necessary and proportionate - to maintain safety, despite the requirements of Article 8 of the European Convention on Human Rights and Fundamental Freedoms 1950 (ECHR).

This policy aims to provide a framework for the observation of SHSC inpatients which balances the impact of intrusion against the need for vigilance.

A blanket approach to routine observations is approved by this Policy; the implementation of enhanced observations must be based on individual risk assessment.

The CoP is <u>statutory guidance</u> for SHSC; departures from the CoP must be able to withstand judicial scrutiny. (CoP page 12). Its guidance for the observation of patients describes what 'should' occur. 'Should' requires that any exceptions to this policy are documented and recorded, including the reasons. (CoP page 14)

2. Scope

This policy applies in all in-patient settings throughout Sheffield Health and Social Care NHS Foundation NHS Trust where routine and enhanced observation takes place. It is expected that the policy will be employed in conjunction with any necessary local guidelines.

If a patient who is not detained pursuant to the Mental Health Act 1983 (MHA) or who is not lawfully deprived of their liberty pursuant to the Mental Capacity Act 2005 (MCA), requires enhanced observations, immediate consideration should be given to their legal status – enhanced observation is likely to amount to Deprivation of Liberty (*Cheshire West v P* [2014] UKSC 19).

NB Where there is a 'real and immediate' risk of suicide, ECHR Article 2 requires the Trust to take positive steps (the 'operational duty') to preserve the life of both detained and informal patients. (*Savage v South Essex Partnership NHS FT* [2008] UKHL 74; *Rabone v Pennine care NHSFT* [2012] UKSC 2).

This policy does not apply in settings, including social care environments where observation does not take place.

3. Definitions

Patient: The term 'patient' is used in the CoP. In this document it is used to describe a person using SHSC services, also known as a service user, client etc.

Responsible Clinician/Consultant Psychiatrist: An Approved Clinician with overall responsibility for the patient's care. All patients detained pursuant to the MHA have a responsible clinician (RC).

Shift Co-ordinator: This role is also known as nurse-in-charge. Usually a band 5/6 nurse. Their main responsibility is to co-ordinate the shift and to perform clinical and managerial roles.

Multi-disciplinary Team (MDT): A team of health and social care professionals working together to provide direct care for the same group of Service Users. The MDT may consist of nursing, medical staff, psychology, social worker, pharmacy and Occupational Therapy staff.

As a minimum, for the purposes of this policy, the MDT will consist of the shift co-ordinator or senior nurse on the ward and the RC or their formally nominated deputy.

Blanket Restrictions: The term 'blanket restrictions' refers to rules or policies that restrict a patient's liberty and other rights, which are routinely applied to all patients, or to classes of patients, or within a service, without individual risk assessments to justify their application. Blanket restrictions should be avoided unless they can be justified as necessary and proportionate responses to risks identified for particular individuals. The impact of a blanket restriction on each patient should be considered and documented in the patient's records. (CoP para 8.5).

ECHR Article 2: The right to life.

ECHR Article 8: The right to respect for private and family life.

Observations: 'Regarding the service user attentively, while minimising the extent to which they feel they are under surveillance'. (Standing Nursing and Midwifery Advisory Committee (SNMAC) 1999).

Observations Flowchart: The basis for individual decision-making with regard to the necessary level of observations, balanced against the intrusiveness of the intervention. Deviation from the core elements must be agreed by the MDT. Decisions must be fully documented, including a clear rationale and the agreed intervals for observation.

Routine Observations: An hourly check of the patient's whereabouts if present on the ward, EXCEPT ENDCLIFFE WARD and FIRSHILL RISE, where 30 minutes checks take place. These must be carried out across the 24-hour period unless the patient is subject to any of the provisions detailed below. (see Section 17 Mental Health Act Authorisation of Leave Policy and Missing Person's Policy for unauthorised/unplanned absence).

Reduced Night Observations: On an individually risk-assessed basis, between 21.30hrs and 07.30 hrs the MDT may agree to reduce the frequency of observations **and/or** to the purpose of the observations being to check whereabouts only.

Enhanced Observations

- **Intermittent Observations -** Staff engaging with patients and observing their condition at irregular and unpredictable intervals of between 15 and 30 minutes. High use of intermittent observation on wards has been shown to be associated with low levels of self-harm and has been shown to be tolerated by most patients. (MHA CoP Para 26.31).
- **Constant Observations –** The patient remains within eyesight of nominated observing staff at all times, (CoP para 26.32) unless it is agreed by the MDT that privacy is to be allowed in specified circumstances. (CoP para 26.33) The MDT may agree the circumstances under which the patient may leave the ward during periods of constant observation.
- **Close Constant Observations –** The patient remains within arms' length of nominated observing staff at all times, (CoP para 26.32) unless it is agreed by the MDT that privacy is to be allowed in specified circumstances. (CoP para 26.33). The patient should not ordinarily leave the ward during periods of close constant observations.

4. Purpose

The purpose of this policy is to facilitate the safe observation of SHSC patients in a manner which can be utilised in the Trust's diverse care areas and which can meet individual patient needs. It is an integral element of overall clinical risk management.

Consultation resulted in consensus that the standard level of observation should be the same throughout the 24-hour period, and that to balance vigilance against intrusiveness and disturbance of sleep the optimal interval is 1 hour.

The primary purpose of routine observation is to establish the location of all patients for whom the ward is responsible. Routine observation should be purposeful. It should provide a presence on the ward in order to reassure patients that staff are available if needed, to afford patients the opportunity to engage in informal conversation with staff, and to facilitate staff intervention should anything untoward occur, e.g. bullying or exploitation between patients.

The primary purpose of enhanced observation is to maximise service user safety and to minimise risk. In addition, 'Enhanced observation is a therapeutic intervention with the aim of reducing the factors which contribute to increased risk and promoting recovery. It should focus on engaging the person therapeutically and enabling them to address their difficulties constructively (e.g. through sitting, chatting, encouraging/supporting people to participate in activities, to relax, to talk about any concerns etc).' CoP Para 26.30

This policy does not attempt to describe the nature or extent of risks that might be managed through the use of observations, as these will vary from care area to care area and patient group to patient group.

5. Duties

5.1 **The Chief Executive** is responsible for ensuring that the systems on which the Board relies to govern the organisation are effective. The Statement of Internal Control is signed annually indicating that systems of governance, including risk management are properly controlled. The Trust's Chief Executive through the Executive Director of Operations is responsible for keeping the policy updated and available for staff.

5.2 **The Deputy Chief Executive** has lead responsibility for risk management in the Trust.

5.3 **The Service Directors** are responsible for ensuring that all Managers in their areas are aware of the policy, understand the requirements and support its implementation. Each **Service, Clinical Director and Corporate Department Director** is operationally responsible for all risk management issues within their service area.

5.4 **The Executive Medical Director**, through the Clinical Directors, is responsible for ensuring that medical staff adhere to the policy.

5.5 **Service Manager/Head of Department/ Team Leader** will ensure all staff (including new starters, agency and contractors) are aware of the overall Clinical Risk Management Process, the Observation policy and the risks associated, and ensure that the control measures are in place to manage those risks.

5.6 **Ward Manager** is responsible for ensuring that the policy is fully implemented within the ward environment. They must ensure that the policy is readily available to all staff at all times and that relevant staff attend appropriate training in **CLINCAL RISK MANAGEMENT**.

Appropriate systems for recording, monitoring and auditing of patient observations must be in place.

The Ward Manager is responsible for ensuring that staff receive any training relevant to their grade and duties with regard to the observation of patients, and, through feedback from staff supervision, monitor competency levels for staff in assessing risk, and in observing and engaging patients.

The Ward Manager must ensure that any staff member who lacks the necessary competence is **not** permitted to engage in observations of patients until appropriate remedial action is taken.

5.7 **Shift co-ordinator/ Nurse in Charge** is responsible for the safe and appropriate delegation of observation duties to other appropriately prepared staff, for ensuring that observations are carried out and recorded, and for the maintenance of appropriate records of decisions to implement or alter observations.

The shift co-ordinator/ nurse in charge will be involved in decisions to reduce levels of observation as part of the MDT, unless a more senior nurse is available to act in place of or in conjunction with the shift co-ordinator/nurse in charge.

The shift co-ordinator/nurse in charge, in the absence of the Ward Manager or other more senior nurse, must ensure that any staff member who lacks the necessary competence is **not** permitted to engage in observations of patients until appropriate remedial action is taken.

The shift co-ordinator/nurse in charge will make a rota each shift, detailing the observations to be carried out and naming staff responsible for each allocated period.

In addition to routine hourly observations, staff should be allocated to be present on the ward at all times in order to respond to noises, untoward occurrences or a patient's need for help.

5.8 **Responsible Clinician or Nominated Deputy** in conjunction with the ward manager will ensure that the Risk Management Process is properly implemented and monitored within the MDT. For the purposes of close constant and constant observations the RC/Nominated Deputy will liaise with the nurse in charge/shift coordinator/senior nurse with respect to decisions regarding the reduction of levels of observation.

5.9 **All Registered Health Care Professionals** are responsible for ensuring that their practice is safe, using systematic clinical risk assessment and management processes in the delivery of patient care and treatment. Those Healthcare professionals undertaking risk assessments are required to ensure they have received training to do this and are competent at using the Risk Assessment Tools and processes within the Trust. This training is provided as part of the Risk Management Training.

Registered nurses are authorised to implement enhanced observations in response to identified risk at any time during their shift.

5.10 **Unregistered staff** are responsible for informing the shift co-ordinator/nurse in charge if they do not feel adequately prepared to undertake the observations of patients in general, of any concerns about the safe observation of a particular individual.

Unregistered staff must make the shift co-ordinator/nurse in charge or other registered nurse aware of any concerns about patient safety which may warrant enhanced observations.

5.11 **Student Nurses** all students will have access to a mentor and ongoing support within the clinical setting. The supervisor/ mentor of a student will take responsibility for ensuring that a student nurse is assessed as being competent in carrying out any level of observation as follows:

- Placement A students may undertake routine observations and reduced night observations only
- Placement B students may carry out routine, reduced night and intermittent observations
- Placement C and Return to Practice students may undertake routine, reduced night, intermittent and constant observations

Student nurses must not undertake close constant observations, see 6.7.2.

5.12 **Observing Staff** are responsible for completing full and accurate records of their observation duties in the correct format and contemporaneously.

Observing staff are responsible for the observation of the patient or patients to whom they are allocated until they are formally relived of this duty. The handing over responsibility from one staff member to another must be properly recorded.

6. Process

6.1 Guiding Principles

Staff should apply the CoP Guiding Principles (CoP para 1.1) in the in use of observations:

- **Least restrictive option and maximising independence**
  The least restrictive level of observation should be utilised.

- **Empowerment and involvement**
  Patients, their carers and others with knowledge of the patient should (if the patient consents) be involved in decisions regarding the necessary and appropriate level of observation, whether reduced or enhanced.

  Relatives or relevant others may be informed of the instigation of enhanced observations, with the patient's consent. If the patient lacks capacity to consent to such disclosure, consideration of the need to disclose should follow the

Patients should be closely involved in discussions about how staff might work with them to minimise the negative aspects and potential for distress resulting from enhanced observations, such as agreeing when and how the patient might prefer to engage in activity, and when they might prefer to spend time quietly and not to be actively engaged.

- **Respect and dignity**
  The selection of a staff member to undertake enhanced observation should take account of the individual's characteristics and circumstances (including factors such as ethnicity, sexual identity, age and gender). (CoP para 26.33)

  Decisions regarding the use of enhanced observations should always include consideration of how privacy and dignity can be maintained without compromising patient safety. This should include a plan for managing the patient when they are in a state of undress, e.g. toilet, bathing, showering, dressing. (CoP para 26.33)

- **Purpose and effectiveness**
  The purpose of observation should be understood by those instigating the procedure and those carrying out observation duties. There is a need to balance the potentially distressing effect on the individual of increased levels of observation, particularly if these are proposed for many hours or days, against the identified risk of self-injury or behavioural disturbance. (CoP para 26.33)

- **Efficiency and equity**
  Access to sufficient staff resources, adequately trained and prepared is essential to the safety of patients subject to enhanced observations. Those patients subject to routine or reduced levels of observations should receive equitable care and not be unduly disadvantaged by the allocation of staff to enhanced observations, especially when staff are engaged in 2:1 observation, or other increased staff to patient ratio.
  The shift co-ordinator/nurse in charge will prepare a shift rota allocating staff to routine and enhanced observations and to provide a presence on the ward.

6.2 Implementing observations.

6.2.1 On Admission, admitting nursing and medical staff should review any available documentation and following the admission interviews, agree the necessary level of observation; reduced night time observations are NOT permissible on admission, but may be instigated with MDT agreement.

6.2.2 If routine observations are appropriate, this decision and the reasons for routine observations must be included in the care plan or risk management plan.

6.2.3 In the event that an enhanced level of observations is required to manage presenting risk, the admitting nurse, in consultation with any

senior nursing staff as necessary, will select an appropriate member of staff who will undertake the first period of observations. Please refer to the guiding principles, above.

6.2.4 The patient should be given clear information about the level of observations that will be carried out as part of their care, why they have been implemented, how and why these might change, and (if intermittent observations are implemented) that they will be checked randomly at intervals of 15 to 30 minutes.

6.2.5 The admitting nurse, in consultation as above, will ensure that the care plan or risk management plan includes the following information:

- The reason for enhanced observations
- The level of observations implemented
- The agreed arrangements for privacy
- The agreed arrangements for leaving the ward
- Particular behaviours or other signs to observe for and report/record
- The factors which would prompt any reduction/increase in observations
- If the enhanced observation includes preventing the patient from having contact with others (not including observing staff) **on a long-term** basis (long-term is not defined) the arrangements will amount to either **seclusion or long-term segregation.** If this is the case, the patient's confinement must be managed in accordance with the policy for seclusion (which includes an addendum for long-term segregation if facilities exist to provide the latter). (CoP para 26.35)

NB there may be occasions when a patient is prevented from having contact with other patients in order to minimise their own distress or the disruption/distress of vulnerable others. Such enhanced nursing, unless it occurs long-term (undefined) will not amount to long-term segregation as it described in the Code of Practice.[1] However, the care plan or risk management plan should give clear reasons for nursing the patient separately and the circumstances under which it is envisaged that the separation might end.

6.2.6 The admitting nurse and shift co-ordinator/nurse in charge must ensure that staff members allocated to observation duties have received the information detailed above, and have had adequate preparation in order to carry out these duties safely.

6.2.7 If constant or close constant observations are implemented, the staff undertaking these duties should have received the information detailed at 6.7.3 (below), and adequate preparation to be able to

[1] Preventing a patient from mixing freely with others for the purpose of managing 'a sustained risk of harm posed by the patient to others, which is a constant feature of their presentation'. (CoP para 26.150).

undertake the observations sensitively and in keeping with the patient's wishes with regard to engagement, activity and quiet time.

6.2.8 Registered and unregistered substantive staff, or those working on the ward through bank or agency arrangements, of any discipline, may undertake observations subject to adequate preparation. **It is preferable to allocate regular staff members with appropriate experience in circumstances of increased risk or increased patient need/dependency.**

6.2.9 The need for enhanced observations should be reviewed on the Early and Late shifts. Please see 6.4 and 6.5 below for reducing observations.

6.2.10 Enhanced observations should not be reviewed for reduction during the night shift

6.3 Increasing observations

The need to increase observations from reduced night observations to routine observations; from routine to intermittent; from intermittent to constant or close constant; or from constant to close constant can be taken by any registered nurse in consultation as necessary with the shift co-ordinator/nurse in charge/senior nurse. Staff increasing levels of observations should be mindful that that service users sometimes find observation provocative, and that it can lead to feelings of isolation and dehumanisation (NICE Guidance NG 10 1.4.13), but **any urgent action to ensure patient safety should not be delayed by discussions about the decision to implement enhanced observations.**

6.4 Reducing routine observations to reduced night time observations

6.4.1 The MDT may agree to reduce hourly routine observations by:

- Maintaining hourly checks, but NOT checking welfare
- Maintaining welfare checks, but at intervals greater than one hour
- Maintaining presence only checks at intervals greater than one hour

6.4.2 The risk assessment for reduced nigh time observations must be clearly detailed in the care plan or risk management plan.

6.4.3 If there is a reason to return to routine observations after a period of reduced night time observations, enhanced observations should be considered and the rationale for not implementing enhanced observations clearly documented.

6.5 Reducing enhanced observations

6.5.1 Any decision to reduce enhanced observations should be made by the MDT.

6.5.2 The RC (but NOT his/her deputy) may give permission for close constant observations to be reduced to constant observations at the discretion of the shift co-ordinator/nurse in charge or senior nurse on duty in the event that the Early or Late shift review indicates that is safe to do so.

6.5.3 The RC (but NOT his/her deputy) may give permission for 2:1 observations to be reduced to 1:1 observations at the discretion of the shift co-ordinator/nurse in charge or senior nurse on duty in the event that the Early or Late shift review indicates that is safe to do so.

6.5.4 In circumstances where it is known that it is a regular feature of a patient's presentation for them to require **periods of intensive nursing, involving constant or close constant observation in order to provide support and to ensure the safety of the patient or others,** the RC (but NOT his/her deputy) may give permission for such intensive nursing to be terminated at the discretion of the shift co-ordinator/nurse in charge or senior nurse on duty when it is safe to do so. **This permission must be recorded in the care plan or risk management plan, and time spent under intensive nursing conditions must be recorded as constant or close constant observations as appropriate, see below.**

6.6 Record keeping

6.6.1 Routine observations should be reviewed at each evaluation of the care plan or risk management plan, and a record made detailing why routine observations remain appropriate.

6.6.2 Reduced night time observations should be reviewed at each regular MDT review/ward round, and a record made detailing why reduced night time observations have become or remain appropriate, or are to return to routine or increase to enhanced levels of observation.

6.6.3 Enhanced observations should be reviewed each Early and Late shift, and a record made detailing why enhanced observations remain appropriate.

6.6.4 The care plan or risk management plan should include detailed information regarding decisions agreed in relation to increasing or decreasing levels of observation (CoP para 26.34).

6.6.5 A detailed record of each patient's required level of observations and an accurate log of the observations actually carried out must be maintained in the appropriate format. This must include a signature or electronic means of identifying who recorded the patient's presence, absence and welfare, as appropriate.

6.7 Undertaking observation duties

6.7.1 **Substantive staff and agency/bank staff** of any grade or discipline may undertake observation duties at the discretion of the shift co-

ordinator/nurse in charge, subject to adequate preparation. See 6.2.2 – 6.2.7 above.

6.7.2 **Student Nurses** all students will have access to a mentor and ongoing support within the clinical setting. The supervisor/ mentor of a student will take responsibility for ensuring that a student nurse is assessed as being competent in carrying out any level of observation as follows:

- Placement A students may undertake routine observations and reduced night observations only
- Placement B students may carry out routine, reduced night and intermittent observations
- Placement C and Return to Practice students may undertake routine, reduced night, intermittent and constant observations

Students in training must not undertake close constant observations. With this enhanced level of observation there is an increased likelihood that the observer may need to physically intervene to prevent a person harming themselves or others. Student nurses are not taught the use of physical restrictive interventions as part of their basic training. These specialist skills will be developed during their preceptorship programme.

6.7.3 The shift co-ordinator/nurse in charge is **accountable** for the practice of unregistered staff to whom observation duties are delegated. Therefore the shift co-ordinator/nurse in charge should satisfy themselves that the staff members allocated to the observation of patients are aware of:

- The purpose of the checks they are responsible for
- What is included in purposeful, hourly routine observations
- Which patients need welfare checks at night, and frequency
- Which patients need presence checks only at night, and frequency
- What the frequency of intermittent observations means
- What signs/symptoms/behaviours etc they are observing for
- What to report immediately to qualified staff
- What, how and where to record the observations
- How and when they are to take responsibility for observations
- How and when they hand over responsibility to another staff member
- If constant or close constant observations are in place, how to utilise the time effectively and therapeutically, such as engaging in activities

6.7.4 Unregistered staff members are **responsible** for:

- Carrying out their allocated observation duties on time
- Reporting anything untoward immediately to registered staff
- Maintaining the observation duties until formally relieved
- Signing to take over and to hand over responsibility for observations
- Maintaining all necessary records
- Informing the shift co-ordinator/nurse in charge of any concerns about their ability to undertake patient observations in general, or of concerns about their ability to undertake the observation of individual patients

6.8 Routine observations and presence on the ward

6.8.1 Routine observations will take place on a **HOURLY** basis throughout the 24-hour period, **EXCEPT ON ENDCLIFFE WARD and FIRSHILL RISE, WHERE CHECKS TAKE PLACE EVERY 30 MINUTES** throughout the 24-hour period:

- From **07.30-21.30hrs** this should involve acknowledging each patient and include brief informal engagement.
- From **21.30-07.30 hrs patient presence AND welfare should be established hourly**

In addition, staff should be present and alert in the ward area across the 24-hour period in order to respond to noises or other evidence of disturbance.

6.8.2 In the event that the patient expresses any needs or concerns during routine observations or to staff otherwise present on the ward, these should be acted upon immediately if possible, or reported immediately to the shift co-ordinator/nurse in charge. A record should be made of such instances.

6.8.3 **NIGHT TIME - 21.30-07.30 hrs.** Unless reduced night time observations have been agreed by the MDT, patient welfare should be checked. This will entail establishing that they are breathing and that there are no other visible signs of distress. The intrusive nature of this check is acknowledged and is the reason for considering reduced night time observations.

6.9 Reduced night time observations

6.9.1 Staff undertaking reduced night time observations should be aware of the specific arrangements for observing each patient at night. Patients should not be disturbed unnecessarily at night.

6.10 Intermittent observations

6.10.1 Where there is concern that a patient may come to or pose harm they may be checked at **irregular and unpredictable** intervals of between 15 and 30 minutes.

6.11 Constant observations

6.11.1 Unless the MDT has specified the circumstances under which a patient may be allowed privacy, constant observation requires that observing staff keep the patient WITHIN SIGHT AT ALL TIMES.

6.11.2 If privacy is allowed, times when the patient is not within sight must be clearly recorded

6.11.3 The MDT may agree arrangements for a patient subject to constant observation to leave the ward. This may include a relative or carer taking

responsibility for the patient's safety during a period of authorised leave. Please refer to the Section 17 Mental Health Act Authorisation of Leave Policy; non-staff taking this responsibility need to be aware of their legal responsibilities for detained patients.

6.11.4 Observing staff, under the guidance of the shift co-ordinator/nurse in charge, should ensure that patients are offered appropriate psychological therapies, physical activities, leisure pursuits such as film clubs and reading or writing groups, and support for communication difficulties when being nursed on constant observations. (NICE Guidance NG 10 1.2.7)

6.12 Close constant observations

6.12.01 Unless the MDT has specified the circumstances under which a patient may be allowed privacy, close constant observation requires that observing staff keep the patient WITHIN ARM'S LENGTH AT ALL TIMES.

6.12.2 If privacy is allowed, times when the patient is not within sight must be clearly recorded

6.12.3 Patients on close constant observations should not ordinarily leave the ward.

6.12.4 Observing staff, under the guidance of the shift co-ordinator/nurse in charge, should ensure that patients are offered appropriate psychological therapies, physical activities, leisure pursuits such as film clubs and reading or writing groups, and support for communication difficulties when being nursed on close constant observations. (NICE Guidance NG 10 1.2.7)

7. Dissemination, storage and archiving (Control)

The policy will be available to all staff via the Trust's Intranet Page.

The changes from the previous version will be discussed at team level, ensuring that all staff are aware and able to implement the policy.

8. Training and other resource implications

There is an implementation plan in place which covers all Directorates and no specific training needs have been identified regarding the policy itself. Roll out of electronic recording via Tablets is currently underway.

9. Audit, monitoring and review

This section should describe how the implementation and impact of the policy will be monitored and audited. It should include timescales and frequency of audits.

If the policy is required to meet a particular standard, it must say how and when compliance with the standard will be audited.

Monitoring Compliance Template						
Minimum Requirement	Process for Monitoring	Responsible Individual/ group/committee	Frequency of Monitoring	Review of Results process (e.g. who does this?)	Responsible Individual/group/ committee for action plan development	Responsible Individual/group/ committee for action plan monitoring and implementation
A) Describe which aspect this is monitoring?	e.g. Review, audit	e.g. Education & Training Steering Group	e.g. Annual	e.g. Quality Assurance Committee	e.g. Education & Training Steering Group	e.g. Quality Assurance Committee

Policy documents should be reviewed every three years or earlier where legislation dictates or practices change. The policy review date should be written here.

10. Implementation plan

All policies should include an outline implementation plan (this will summarise sections 7, 8 and 9 above). It should include consideration of:

- *Dissemination, storage and archiving*
- *Training and development requirements and who will provide the training*
- *Any new job roles and responsibilities and how these will be implemented*
- *Resources needed*
- *Timescales*
- *Lead role and responsibilities for implementation*
- *Audit or monitoring of implementation planned*

Action	Progress to date	Lead	Timescale	Comments
Contribute to development of policy to involve all inpatient services and ward managers	Final amendments made 18th April 2017. Completed.	Anne Cook	April 2017	Complete
Identify lead to implement per directorate		Shirley Lawson – Acute/Inpatients Anthony Bainbridge - Specialist Directorate Maxine Statham - Learning Disabilities		
Develop implementation group	First meeting taken place 18th April 2017.	Shirley Lawson	April 2017	Complete
Sign off at Directorate SMT and recommend to Policy group for ratification.	Completed	Richard Bulmer acute inpatients Anita Winter Learning Disability Michelle Fearon Specialist	27th June 2017	
Ratification at Policy Group	Discussed at Policy Group and returned for final amendments. Final discussion due 4th October 2017	Anne Cook/ Margaret Saunders	4th October 2017	
Disseminate and communicate final policy at team level	In progress to commence once final policy has been received.	Shirley Lawson – Acute/Inpatients Anthony Bainbridge - Specialist Directorate Maxine Statham - Learning Disabilities		
Amend electronic observation tablets	In progress	Simon Robinson		To be agreed
Agree go live date (4-6 weeks from ratification)	To be agreed once final policy received.	Shirley Lawson – Acute/Inpatients Anthony Bainbridge - Specialist Directorate Maxine Statham - Learning Disabilities		

11. Links to other policies, standards and legislation (associated documents)

SHSC Missing Persons' policy
SHSC Seclusion Policy (and Long Term Segregation Addendum)
SHSC Section 17 Mental Health Act Authorisation of Leave Policy

12. Contact details

Title	***Name***	***Phone***	***Email***
Clinical Nurse Manager – Inpatient	Shirley Lawson	01142718173	Shirley.lawson@shsc.nhs.uk
Assistant Clinical Director – Specialist	Anthony Bainbridge	01142264267	Anthony.bainbridge@shsc.nhs.uk
Assistant Clinical Director – Learning Disabilities	Maxine Statham	01142263986	Maxine.statham@shsc.nhs.uk

13. References

Human Rights Act 1998
Mental Capacity Act 2005
Mental Health Act 1983

Cheshire West v P [2014] UKSC 19
Rabone v Pennine care NHSFT [2012] UKSC 2)
Savage v South Essex Partnership NHS FT [2008] UKHL 74

Mental Health Act Code of Practice 2015
NICE – Violence and aggression: short-term management in mental health, health and community settings (NG10) May 2015
Standing Nursing and Midwifery Advisory Committee (SNMAC) 1999

The European Convention on Human Rights and Fundamental Freedoms 1950

Appendix A – Version Control and Amendment Log (Example)

(Use Arial bold point 14 for titles)

Version No.	Type of Change	Date	Description of change(s)
0.1	New draft policy created	July 2015	New policy commissioned by EDG on approval of a Case for Need.
1.0	Ratification and issue	Sept 2015	Amendments made during consultation, prior to ratification.
2.0	Review / ratification / issue	Sept 2016	Early review undertaken to update the policy to in order to comply with new regulatory requirements.
2.1	Review on expiry of policy	June 2019	Committee structure updated
3.0	Review / ratification / issue	August 2019	Full review completed as per schedule.
3.1	Extension to review date	Oct 2020	Extension to review date was ratified by QAC on 26/10/2020. New review date = 28 February 2021.

Appendix B – Dissemination Record (Example)

Version	Date on website (intranet and internet)	Date of "all SHSC staff" email	Any other promotion/ dissemination (include dates)
1.0	July 2007	July 2007	
2.0	January 2009	January 2009	
2.1	April 2013	April 2013	Launch through Policy Governance Group - May 2013
3.0	Aug 2016	Aug 2016	Re-launch of Policy Governance Group

Appendix C – Stage One Equality Impact Assessment Form

Equality Impact Assessment Process for Policies Developed Under the Policy on Policies

Stage 1 – Complete draft policy

Stage 2 – **Relevance** - Is the policy potentially relevant to equality i.e. will this policy potentially impact on staff, patients or the public? If **NO** – No further action required – please sign and date the following statement. If **YES –** proceed to stage 3

This policy does not impact on staff, patients or the public (insert name and date)

Stage 3 – **Policy Screening** - Public authorities are legally required to have 'due regard' to eliminating discrimination , advancing equal opportunity and fostering good relations , in relation to people who share certain 'protected characteristics' and those that do not. The following table should be used to consider this and inform changes to the policy (indicate yes/no/ don't know and note reasons). Please see the SHSC Guidance on equality impact assessment for examples and detailed advice this can be found at http://www.shsc.nhs.uk/about-us/equality--human-rights

	Does any aspect of this policy actually or potentially discriminate against this group?	**Can equality of opportunity for this group be improved through this policy or changes to this policy?**	**Can this policy be amended so that it works to enhance relations between people in this group and people not in this group?**
AGE	**No**		
DISABILITY	**No**		
GENDER REASSIGNMENT	**No**		
PREGNANCY AND MATERNITY	**No**		
RACE	**No**		
RELIGION OR BELIEF	**No**		
SEX	**No**		
SEXUAL ORIENTATION	**No**		

Stage 4 – **Policy Revision** - Make amendments to the policy or identify any remedial action required (action should be noted in the policy implementation plan section)
Please delete as appropriate: Policy Amended / Action Identified / no changes made.

Impact Assessment Completed by (insert name and date) Anne Cook September 2016

Appendix D - Human Rights Act Assessment Form and Flowchart

You need to be confident that no aspect of this policy breaches a person's Human Rights. You can assume that if a policy is directly based on a law or national policy it will not therefore breach Human Rights.

If the policy or any procedures in the policy, are based on a local decision which impact on individuals, then you will need to make sure their human rights are not breached. To do this, you will need to refer to the more detailed guidance that is available on the SHSC web site
http://www.justice.gov.uk/downloads/human-rights/act-studyguide.pdf
(relevant sections numbers are referenced in grey boxes on diagram) and work through the flow chart on the next page.

1. **Is your policy based on and in line with the current law (including case law) or policy?**

✓ **Yes. No further action needed. Policy based on Mental Health Act 1983 Code of Practice (2015)**

☐ **No. Work through the flow diagram over the page and then answer questions 2 and 3 below.**

2. **On completion of flow diagram – is further action needed?**

☐ **No, no further action needed.**

☐ **Yes, go to question 3**

3. **Complete the table below to provide details of the actions required**

Action required	By what date	Responsible Person

Appendix E – Development, Consultation and Verification

This section should include details of:

- *Who was involved in developing the policy and any guidance followed?*
  Anne Cook, Clinical Nurse Manager Forest Lodge, following the Mental health Act Code of Practice 2015

- *Groups and individuals consulted (including staff side groups and service user / carer involvement).*

Ward staff and Managers of each area where this policy applies were invited to participate in discussions and to comment on drafts

- *Any changes made as a result of the consultation process.*

The practice of 2-hourly routine daytime checks and 30 minutes night-time checks was reviewed.

One hourly routine checks across the 24 hour period, with the facility to adapt these to different care area and in light of different patient needs, were adopted.

Endcliffe Ward maintains 30 minutes observations as 'routine'.

Close Constant Observations amended to match the MHA Code of Practice – ie within arm's length (previously two arms' length)

Patient information document updated to match revised policy

Recording document altered to reflect hourly routine observations and possibility of reduced observations at night.

'Intensive Nursing' which in effect permitted enhanced observations to be discontinued without RC input in previous policy removed in order to achieve consistency.

Student Nurses' roles in undertaking observations clarified.

- *Which governance group verified the document*

Inpatient SMT

- *Dates for consultation and verification.*

27TH June 2017

Appendix F

Common indicators that suggest the need for observation include, for example:

Psychological	Physical
• A history of previous suicide attempts, self harm, or attacks on others. • Hallucinations, particularly voices suggesting harm to self and others. • Paranoid ideas where the patient believes that other people pose a threat. • Thoughts and ideas that the patient has about harming themselves or others. • Specific plans or intentions to harm themselves or others. • Past problems with drugs or alcohol. • Recent loss. • Poor adherence to medication programmes. • Anniversaries or other significant dates	• Recent commencement on neuroleptic medications • Over-Sedation • History of cardiac and/or respiratory problems • History of epileptic conditions • Exhaustion through over activity
Note - The above is provided as an illustration and is not a definitive list or framework	

Risk Issues relating to management through Observation

Teams and nursing staff should be aware and mindful of the fact that managing patient risk through observation can cause risk factors of its own. This does not prevent the need for patient observations, but relevant issues should be incorporated as teams and staff approach their ongoing reviews, re-assessments and patient engagement**.** Common and known risk factors considered to be influenced by management through increased levels of observations are as follows:

- **Increased periods of risk** for patient self harm and suicide may be during the evening and night. This policy provide for flexible and informed approaches to observation through the night for patients managed through routine and intermittent observations, informed by individual patient risk assessments. In undertaking such risk assessments nursing staff should be informed by this increased risk period of the day.

- Levels of risk can be increased, **following decisions to decrease or discontinue previous levels of increased observation**. Teams and staff should be mindful of this, and while formal approaches to observation may have been reduced or discontinued, appropriate levels of active patient engagement and monitoring should continue for a period of time.

- **Changes in nursing staff allocated** to undertake increased levels of observation, if not effectively managed, **can create periods of risk**. Teams should manage this through clear local arrangements, in line with these guidelines, for the allocation of staff to such duties and clarity of arrangements for staff handovers. Nursing staff undertaking constant or close constant observations should not discontinue their responsibilities until actively relieved by a colleague.

- Differing levels of observations, as a means to manage, monitor and assess a patients presentation is an ongoing process. Evaluating the ongoing need for this, in response to **apparent improvements in a patient's mood and presentation**, should be carefully considered. Changes to levels of observation should be based upon accurate and meaningful information.

Sheffield City Council

NHS Sheffield Health and Social Care NHS Foundation Trust

Routine Observations Record Sheet **Ward:** **Date:**

Appendix G

S = Sleep A = Awake L = Leave

I = In O = Out

The whereabouts of all patients should be known throughout the 24hour period and therefore routine checks of all patients must be carried out hourly across the 24-hour period

Patient Name	07 30	08 30	09 30	10 30	11 30	12 30	13 30	14 30	15 30	16 30	17 30	18 30	19 30	20 30	21 30	22 30	23 30	00 30	01 30	02 30	03 30	04 30	05 30	06 30	**Notes – identify the interval and purpose of any reduced night time obs -** W = safe and well
Staff Initials																									
Staff Name																									

Filing - To be filed in Ward Central filin