Policy:

NPCS 001 Safe, Supportive Engagement of Inpatients (General and Enhanced)

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Policy Owner	Head of Nursing
Policy Author	Head of Nursing

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Summary of policy
Operational Managers of Clinical Teams.
Service Directors and Clinical Leads.
Registered Nurses working in In-patient Areas
Staff undertaking Observation Duties.

Target audience	All Clinical Staff

Keywords	Safe, Support, Engagement, Observations, Therapeutic Activities, Risk,

Storage & Version Control

Version 4 of this policy is stored and available through the SHSC intranet/internet. This version of the policy supersedes the previous Version 3 (July 2018). Any copies of the previous policy held separately should be destroyed and replaced with this version.

Version Control and Amendment Log (Example)

Version No.	Type of Change	Date	Description of change(s)
0.1	New draft policy created	07/2021	New policy commissioned by EDG on approval of a Case for Need.
1.0	Approval and issue	08/2021	Amendments made during consultation, prior to ratification.
2.0	Review / approve / issue	09/2021	Early review undertaken to update the policy to in order to comply with new regulatory requirements.
2.1	Review on expiry of policy	09/2021	Committee structure updated
3.0	Review / approval / issue	10/2022	Full review completed as per schedule

Foreword

Following a review of the literature and discussions with Dr Russell Ashmore of Sheffield Hallam University, significant changes to this Policy have been made; it is no longer referred to as ‘observation’, but as ‘**engagement**’ of our service users. The use of language is more than simply semantics; it is about being present in the ‘now’ with our service users and truly supporting them with their distress, in a trauma-informed manner.

This Policy will outline the meaning of engagement and how we might actively and supportively engage our service users, using structured and ad-hoc activities to help alleviate their distress.

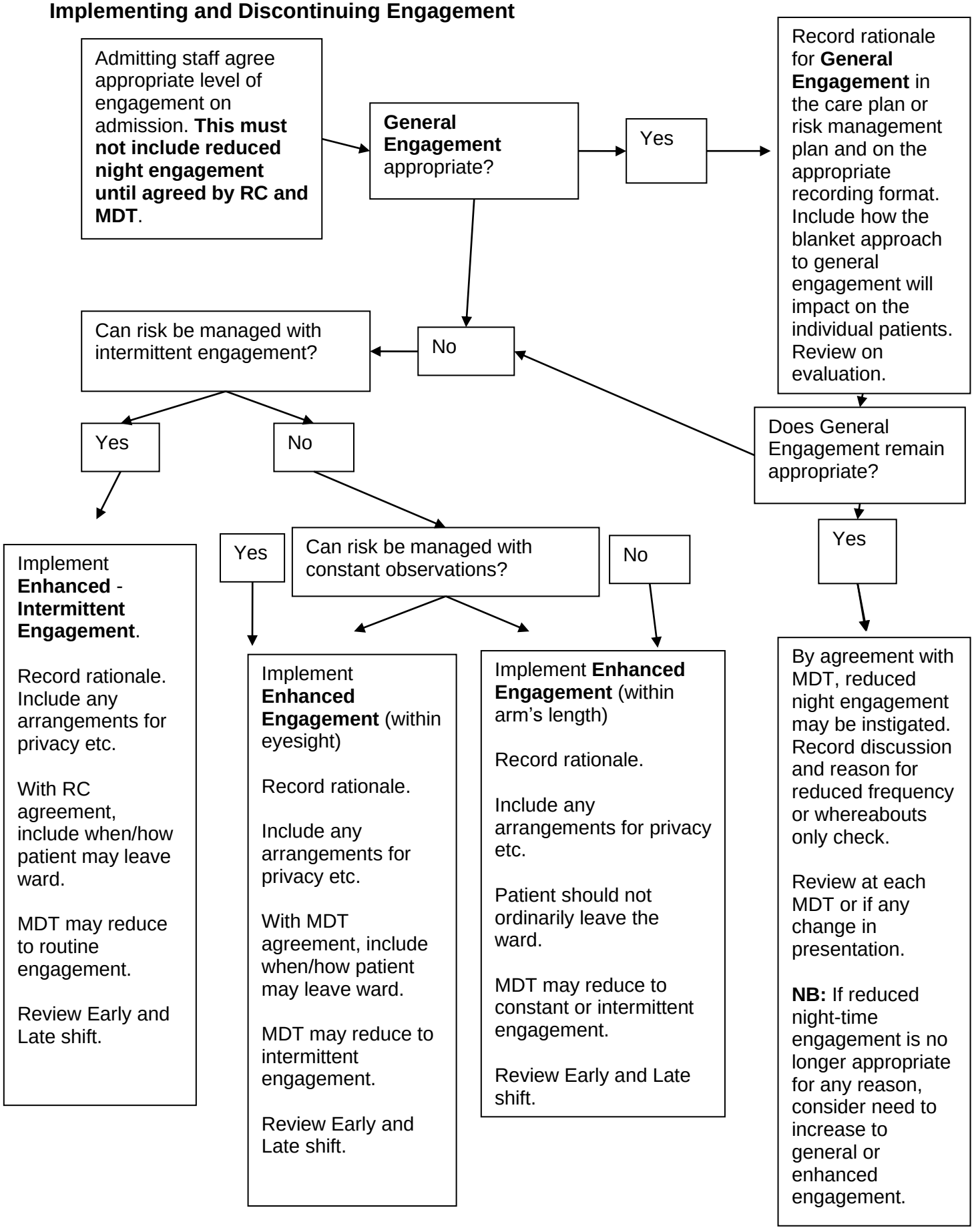
Recent recommendations suggest that constant observations should be conducted by experienced and skilled staff with expertise in engaging patients (Schroeder, 2016) and thus advance the role from one of maintaining surveillance and safety, to one of **active therapeutic engagement** (Chu et al., 2020).

Contents

Flowchart for Implementation of Safe, Supportive Engagement.

Routine	Reduced Nights	Enhanced - Intermittent	Enhanced -Constant	Enhanced -Close Constant
• An hourly check throughout a 24-hour period	• On an individually risk assessed basis, between 21.30hrs and 07.30hrs, the MDT may agree to reduce the frequency of engagements **and or** to the purpose of the engagements being to check whereabouts only.	• 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 -30 minutes	• The patient to always remain within eyesight of nominated observing staff at all times unless it is agreed by the MDT that privacy is to be allowed in specified circumstances. • The MDT may agree the circumstance under which a patient may leave the ward during the period of constant engagement	• The patient to always remain at an arm's length of the observing staff unless it is agreed by the MDT that privacy is to be allowed in specified circumstances. • The patient should not ordinarily leave the ward during the periods of constant engagement. • The level of each individual engagement will be documented in the Service User's Care Plan

Flowchart
Implementing and Discontinuing Engagement



1 Introduction

1.1 All service users admitted to the in-patient wards require a level of engagement and observation. They will be experiencing varying degrees of vulnerability and distress due to a serious mental illness and may have other factors affecting their health, such as physical health or safeguarding issues.

1.2 Due to the varying degrees of illness experienced by service users within in-patient wards, it is essential that a therapeutic relationship is built in a least restrictive but timely manner on admission to the hospital. The aim of this approach is to be able to support the service user and to help develop a trusting relationship, using meaningful activity which will have positive benefits for the service user and the staff team.

1.3 The needs of service users who are in different phases of their recovery and in different care settings are varied. Engagement serves two purposes; 'General Engagement' ensures that staff are aware of the service user's general whereabouts and 'Enhanced Engagement' is employed to manage individually identified risk.

The Mental Health Code of Practice [CoP] (Department of Health [DH], 2017) states: "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" (para 26.28).

However:

There may be times when enhanced levels of engagement are required for the short-term management of behavioural disturbance or during periods of distress to prevent suicide or serious self-harm (CoP, DH 2015, para 26.30).

1.4 The perspective of our service users is of paramount importance. Staff should provide **supportive engagement,** and this should be offered at least once per shift, from allocated members of nursing staff, including student nurses, healthcare support workers and Nursing associates.

1.5 The use of language and the word 'engagement' within this Policy is of paramount importance; the shift from simply 'observing' service users, to actively providing therapeutic support through engagement is key.

1.6 This Policy emphasises the importance of communication and building the therapeutic relationship with our service users. It also relies on the staff team providing opportunities for meaningful activity and engagement throughout the day to our service users, during the period of support. Terms such as: 'supervision', 'close obs', 'constant obs' are not acceptable. Using the terms outlined in this policy will allow service users and their relatives / carers and the staff team to have a shared understanding about what is happening.

1.7 Engagement should be safe and therapeutic. Consideration should be given to the use of activity, discussion, and distraction techniques, but recognition should also be made for the need for silence and as much privacy as is possible.

1.13 It should be noted that the environments in which we care for our service users present risks, such as **Ligature Anchor Points (LAP).** It is therefore paramount that these risks are considered when considering levels of engagement. Staff should remain vigilant to the risks presented by the environment and refer to the relevant risk assessments and LAP risk assessments for further details.

1.14 LAP, Blind spots and engagement should be outlined in the Inpatient Environmental Induction (Appendix C) which will be given to all staff working in inpatient services,

2 Scope

2.1 This is a Trust-wide Policy and applies in all in-patient settings throughout Sheffield Health and Social Care NHS Foundation NHS Trust where General and Enhanced Observations take place. It is expected that the Policy will be employed in conjunction with any necessary local guidelines.

2.2 If a service user 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).

2.3 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).

3 Purpose

3.1 This policy explains:

(a) Why this policy is necessary.
(b) When General and Enhanced Engagement should be used.
(c) Which staff are best placed to carry out the engagement activities.
(d) Responsibilities for ensuring Enhanced Engagement is used for the least amount of time clinically required.
(e) The process for assessing the level of risk for each service user, agreeing the appropriate level of engagement, carrying out and recording activities.

3.2 Engagement is a multi-disciplinary approach to care.

3.3 The service user, relatives and carers are fully informed of the process and are provided with written and verbal information as often as necessary. The service user wherever possible should be part of the evaluation and reviewing process, both during the application of engagement levels and after the activity and support have ceased.

3.4 To ensure that all staff are clear about the privacy and dignity issues for their service user, whilst being provided with support through observation windows or curtains.

4 Rationale

4.1 The Trust has a duty of care to ensure the safety of service users in its care which is also compliant with Chapter 26 of the Mental health Act Code of Practice (DH, 2015). As part of that duty, there must be a policy and procedure for the observation of patients that is fully compliant with NICE Guideline 10: Violence and Aggression: Short-term Management in Mental Health, Health and Community Settings (2015) https://www.nice.org.uk/guidance/ng10

4.2 Engagement is a supportive mechanism, for the purpose of engaging positively with the service user. It is an integral part of the care plan; ensuring the safe and sensitive monitoring of the service user's behaviour and mental well-being, enabling a rapid response to change, whilst at the same time fostering therapeutic relationships between staff and service user.

4.3 Staff should know the location of all service users for whom they are responsible during their inpatient stay. It is not necessary to routinely keep service users who are not considered to present a serious risk of harm to themselves or others, within constant sight.

4.4 The use of engagement levels should never be regarded as routine practice and must be based on assessed and current need.

4.5 On occasions during periods of distress or pronounced ill-health, some service users may become a serious risk of harm to themselves or others. Enhanced Engagement may be required for management of behavioural disturbance or during periods of distress to prevent suicide or serious self-harm.

4.6 Enhanced Engagement, over and above General Engagement, is a therapeutic intervention with the aim of reducing factors that contribute to increased risk and promote recovery. Enhanced Engagement should focus on engaging the person therapeutically and enabling them to address their difficulties constructively.

Enhanced Engagement is also a restrictive practice and may be perceived by service users as a coercive intervention. They should only be implemented after positive engagement with the service user has failed to reduce the risk to self or others and only used for the least amount of time clinically required.

4.7 The least intrusive level of engagement that is appropriate to the situation should always be adopted so due sensitivity is given to the service user's dignity and privacy whilst maintaining the safety of the service user and those around them.

4.8 This policy and procedure ensure a consistent and auditable approach to:

(a) Meeting individualised needs of the service user.
(b) Agreeing an appropriate level of engagement based on the individual's needs.
(c) Reviewing the level of support and engagement.
(d) Engaging with the service user where Enhanced Engagement is required.
(e) Effective recording of the decision-making process leading to the level of engagement and delivery of that observation level in line with the service user need.

5 Outcome focused Aims and Objectives

5.1 A member of the nursing team will provide dedicated time, at least once per shift, to assess the service user's mental state and engage positively with the service user. A record of this assessment will be recorded in the service user electronic patient record (EPR). Service users will be offered a programme of structured and individualised activities, in order to provide them with meaningful support.

5.4 The rationale of any change to a service user's level of engagement will be recorded in the EPR including care plans.

5.5 Every service user receiving Enhanced Engagement will have a collaborative care plan in place. This will detail a summary of the service user's condition, risk behaviours and significant events. Suggested therapeutic interventions must be included in the care plan. For those on Enhanced Within Eyesight Engagement, the maximum observing distance should be included in the care plan.

5.6 Decisions about changing a service user's level of support and engagement will be timely and subject to an auditable decision-making process. Any delegation of decision-making by multi-disciplinary teams should be encouraged and documented; clearly identifying who is making the decision in the absence of the Responsible Clinician and under what circumstances changes should be made (i.e., related to the needs, behavioural presentation and or mental state of the service user).

5.7 For all service users requiring Intermittent Enhanced Engagement, a written record will be made at minimum prescribed intervals. The MDT will agree the frequency of the offers of engagement, and these will be unpredictable in nature.

5.8 For those service users requiring Enhanced Engagement (either within eyesight or arm's length), a written evaluation of behavioural presentation and/or mental state will be made each shift. All records will be made contemporaneously by the staff member allocated to the duty of providing support and engagement and held in the EPR. Those shift patterns that are 'long days' then a twice daily summary will be entered.

5.9 The EPR will contain evidence of prescribed review, interventions used and meaningful engagement with the service user.

5.10 A documented MDT Review will occur for all service users subject to Enhanced Engagement (within eyesight or arm's length) for prolonged periods of time (anything exceeding 14 days). Should the Enhanced Engagement continue more than 1 month, an independent review should be considered via the Directorate Leadership Team and safeguarding collegues.

5.11 All service users subject to Enhanced Engagement for longer than 3 months will have a formulation of the behaviour/presentation leading to the requirement for this level of support. The formulation will be reflected in a multi-disciplinary care plan developed to meet those needs. Support plan and personal safety plans should be developed based on this formulation. The formulation will be reviewed at a minimum of every weekly MDT or until Enhanced Engagement is discontinued.

5.12 For those requiring Enhanced Engagement for longer than 14 days, a collaborative daily planner will be developed with the service user and multi-disciplinary team. This will identify which members of the multidisciplinary team will deliver targeted interventions over the 24-hour period.

5.13 All staff will be aware of the impact on the wider service user population when required to provide Enhanced Engagement. Staff will report if any antagonism is directed at the person being supported and support the service user accordingly. This will be documented in the EPR and incident reporting.

5.14 If a service user subject to Enhanced Engagement is confined to a particular area and being prevented from having contact with anyone outside the area in which they are confined, this will amount to either seclusion or long-term segregation and the Trust's Seclusion Policy will be applied.

6 Categories of Engagement and Observation

The formal observation and engagement levels of service users are as follows:

- Within Arm's Length (Enhanced)
- Within Eyesight (Enhanced)
- Intermittent Engagement (Unpredictable time intervals)
- General Engagement

6.1 Within Arm's Length Engagement (Enhanced Engagement)

This is the most intense level of support.

6.1.1 This level of support is applied if the risk assessment suggests this level of enhanced engagement is required. Service users at the **highest levels of risk** of harming themselves or others may need to be nursed in close proximity at all times, including when the service user enters the toilet / bathroom. On occasions, more than one member of staff may be required to safely undertake this level of support. Attempts at positive engagement with the service user are an essential aspect of this level of support.

6.1.2 Where the 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.

6.1.3 The allocated nurse / staff member will provide **one to one support** throughout the whole period of prescribed 'within arm's length engagement'. On specified occasions, more than one member of staff may be required to safely provide this level of support. The engagement care plan will stipulate the number of nurses/staff required. The support plan will also document the individualised and group activities that may be utilised, in order to provide therapeutic engagement and support to the person.

6.1.4 Issues of privacy, dignity and the consideration of gender in allocating staff, and the environmental risks need to be discussed and incorporated into the care plan. The staff member responsible for carrying out the prescribed level of engagement must document hourly. This documentation should make reference to: a brief summary of the service user's behaviour, mental state and activities / engagement strategies utilised.

6.1.5 Consideration should be given to how the service user's dignity could be maximised, without compromising safety, when an individual is in a state of undress; such as when using the toilet, bathing, showering or dressing, and so on.

6.1.6 Consideration should be given as to whether engagement could be reduced to 'within eyesight' once the service user has retired to bed and is asleep. This should be fully discussed with the multi-disciplinary team and reflected in the engagement care plan.

6.1.7 Should the service user decline offers of support and engagement activities, staff may wish to consider changing the allocated person, as this may improve levels of engagement. The risk of lack of engagement and any plans to mitigate this should be contained within the engagement and support care plan.

6.1.8 Leave outside of the ward area should be considered, only in exceptional circumstances and in accordance with the appropriate risk assessment in place. Should leave be undertaken, the service user will be accompanied and escorted by the number of staff required, as documented in the engagement and observation care plan.

6.2 Within Eyesight Engagement (Enhanced Engagement)

Within eyesight engagement is required when the service user could, at any time, make an attempt to harm themselves or others.

6.2.1 The service user should be always kept within sight, both by day and by night. A team decision should determine the level of proximity and strategies for engagement whilst attending to personal needs (using the toilet or taking a bath).

6.2.2 A specific engagement care plan is required. The staff member responsible for carrying out the prescribed support over the period must document a summary of the service user's behaviour, mental state, and general well-being, including activities or engagement opportunities offered and accepted in the EPR.

6.2.3 The care plan must stipulate what the observing nurses / staff are required to do to support the service user during these periods.

6.2.4 Consideration should be given to whether the service user may only require 'within eyesight' engagement at specific times or within specific environments; for example, when using the bathroom or toilet, within specific areas of the ward, at meal times, post-visiting time, or whilst in activity / education.

This should be based upon clinical risk assessment and incorporated into the service user's individual care plan.

6.2.5 The allocated nurse / support staff will provide one-to-one support throughout the whole period of prescribed 'within eyesight' engagement. On specified occasions, more than one member of staff may be necessary to carry out this level of observation. The care plan will stipulate how many nurses / support staff are required.

6.2.6 Should the service user decline offers of support and engagement activities, staff may wish to consider changing the allocated person, as this may improve levels of engagement. The risk of lack of engagement and any plans to mitigate this should be contained within the engagement and support care plan.

6.2.7 The responsibility for 'within eyesight' engagement should not be transferred to family members, carers and friends; unless in exceptional circumstances which have been agreed, risk-assessed and care planned by the MDT.

6.2.8 Leave outside of the ward area should be considered in relation to the Trust's Leave Policy. However, the service user will be escorted at all times by a member of Trust staff

6.3 Intermittent Engagement

This level is appropriate for service users **potentially, but not immediately** at risk of increased vulnerability or suicide, self-harm. It may include those who have previously been at higher risk and have had their engagement level reviewed and reduced by the multi-disciplinary team.

6.3.1 Those Service users where their history isn't established should not be placed on intermittent engagement on admission. New service users must be placed on an enhanced level of engagement (either 'within eyesight' or 'within arm's length), until a full risk assessment can be completed.

6.3.2 The service user should be offered supportive engagement during the time they are with the staff member. The times of these observations should vary and the length of engagement be dependent on the service user's needs. This may of course include structured activities, both ward-based and individualised.

6.3.3 This level of engagement requires the nurse / support worker to be aware of the service user's movements, location and presentation. The duration of intervals at which the engagement and activities should be offered is to be agreed by the multi-disciplinary team and / or Shift Co-ordinator. Offers of support and engagement need to be carried out sensitively, to cause as little intrusion as possible. This should also be seen in terms of positive engagement with the service user.

6.3.4 A specific engagement care plan is required that details either the intervals at which the engagement activities should be carried out, or the specific number of times within a specified timeframe that the service user should be offered support. This care plan should include individual protective factors which may influence the frequency, level or duration of offers of engagement.

6.3.5 To ensure that positive engagement can take place, consideration needs to be given to the number of service users that are allocated to a staff member at any one time. Consideration needs to be given by the Nurse in Charge / Shift Co-ordinator to the number of staff required for the physical environment and how positively this lends itself to patient engagement and observation.

6.3.6 Consideration should be given as to how the service user's dignity could be maximised without compromising safety when they are in a state of undress; such as when using the toilet or bathroom.

6.3.7 Should the service user decline offers of support and engagement activities, staff may wish to consider changing the allocated person, as this may improve levels of engagement. The risk of lack of engagement and any plans to mitigate this should be contained within the engagement and support care plan.

6.3.8 Leave outside of the ward should be considered in relation to the Trust's Leave Policy. However, responsibility for engagement and observation of service users remains with a member of Trust staff at all times.

6.4 General Engagement

General engagement is the **minimum acceptable** level of support for all service users on the ward. The location of all service users must be known to staff, but do not need to be kept in line of sight.

This level of engagement applies to service users who are deemed to be **low risk** in terms of their vulnerability, suicide, self-harm or harm to others.

6.4.1 Some areas of the ward are high risk for suicide attempts and self-harm namely bathrooms, bedrooms, and toilets. This may include any other accessible rooms that are not routinely under direct supervision. Therefore, these areas should be randomly and intermittently checked by staff. This is particularly important at times of reduced staff supervision, which are high risk times for suicide attempts. **Staff must be actively vigilant during nursing handovers and during the evening.**

6.4.2 The member of staff allocated to general engagement and support should be able to see clearly that the service user is breathing. Should the member of staff not be assured, they should enter the service user's bedroom to check they are able to observe signs of breathing; the chest rising and falling, for example.

6.4.3 Consideration should be given to how the service user's dignity could be maximised without compromising safety, when they are in a state of undress: using the bathroom, toilet, showering or dressing, for example.

6.4.4 The Nurse in Charge should ensure that time has been set aside to review the mental and physical wellbeing of the service user and positively engage with them. This should happen at least once per shift (both day and night duty). This should be clearly documented in the daily notes. Night duty may take this by exception in order to promote sleep hygiene.

6.4.5 The positive engagement could take place in many ways and formats; for example, group work, therapeutic one-to-one sessions and engaging in hobbies and interests. A discussion with AHP would be beneficial.

6.4.6 The level of engagement should be appropriate to meet the service user's needs. If the clinical risk escalates, use of increased observation should be considered.

Zonal Engagement and Observations

6.5.1 The Zonal Engagement approach aims to ensure appropriate observation of individual service users without the need to assign a particular staff member to be near the service user for long periods.

6.5.2 This decision will always be based on clinical need and a dynamic risk assessment, based on individual needs. There should be a discussion and agreed decision with the ward MDT when implementing Zonal Engagement.

6.5.3 Zonal observation should not be used to manage staff shortages and should not be financially driven.

6.5.4 An example of when to allocate zonal observation 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.

6.5.5 Identified staff will be responsible for observing and engaging with all patients within a particular zone (area) of the ward. This will entail checking on people in rooms within the zone, assisting a person to find their way about within the zone intervening when necessary to maintain safety of those in the zone. Calling for help from other staff as needed.

6.5.6 In certain circumstances this can be considered less intrusive and allow greater privacy for the patient than enhanced engagement.

6.5.7 Principles guiding the implementation of Zonal Engagement:
• Zonal Engagement must be service user focused at all times.
• The Service has a duty for safety and security to the patients, staff and visitors.
• Care must be provided in an environment and manner that reflects the least level of restriction possible for the safe and supportive management of the patient.
• Zonal Engagement should therefore be seen as one method of reducing risk and enhancing the patient experience. It is integral part of a wider risk assessment and contextual management process.
• Care and support of the patient will be addressed specifically within an individualized care plan.

6.5.8 Patients will be assigned a level of engagement and observation as outlined in the wider procedure and the assigned nurse should carry out the engagement and associated records at the assigned times.

6.5.9 Staff assigned to these areas must explicitly understand that they are not simply observing the physical space but rather are on hand to engage and intervene where necessary to maintain safety within that zone.

7 Roles and Responsibilities

7.1 All staff are responsible for ensuring the privacy and dignity of service users is maintained at all times. This means that staff should ensure that any viewing windows or window coverings are closed after use at all times.

7.2 Ward staff have a responsibility to induct all new service users to the ward environment and explain the ward routine such as how to get a refreshment or snack. It is at this time that the observation windows or doors are explained, so that the service user understands the function of the window.

7.3 Staff must knock on the service user's door prior to opening the window, curtain, or door. This is to try to maximise the person's dignity and privacy wherever possible.

7.4 Ward Managers are responsible for ensuring that all observation windows, doors and curtains are in good working order and are clean.

7.5 The Nurse in Charge / Shift Co-ordinator should ensure (as far as is possible) that the gender of the staff is observed when allocating and compiling the observation rota.

7.6 The service user's characteristics and circumstances (such as ethnicity, sexual identity, gender and age) should be taken into account when the Nurse in Charge is allocating observations to staff (particularly for Enhanced Engagement and Observations).

7.7 All wards must report to Estates if a window is broken or requires repair. It must be repaired as quickly as possible to preserve dignity and privacy for the service user.

7.8 Ward Managers are responsible for ensuring that all in-patient nursing and support staff are aware of the Engagement Policy and are competent in delivering this aspect of care.

7.9 All in-patient staff should ensure that their competency is up to date and should use supervision to discuss and escalate any issues regarding their competency.

7.10 Every effort should be made to discuss, inform, and explain to the service user about the level of engagement and any requirements to assist in implementation. With some service users, it may be necessary to use a range of mechanisms to explain this. Service users should be offered the opportunity to speak with a member of the Multi-Disciplinary Team regarding any concerns or questions they may have, relating to the level of engagement. The team should support and encourage the service user to co-produce the engagement care plan (this may also involve carers or family members). The service user should be offered a copy of their care plan, detailing engagement strategies and this should also be communicated with their nearest relative / carer / friend, with their consent.

7.10 Responsibility for placing a service user on an Enhanced Level of Engagement

7.10.1 This is a joint responsibility and good practice between the nurse and doctor (or MDT). *The absence of a doctor should not be a barrier to placing a service user on Enhanced Engagement.* The nurse involved in this process should have enough clinical knowledge and experience to clearly state the rationale for the Enhanced Engagement and what staff should be doing during this time to support the service user. The Consultant must be informed of all service users receiving Enhanced Engagement.

7.10.2 Assessing levels of engagement and support is an integral part of the admissions process and therefore all service users should be allocated a level of engagement as soon as they arrive on the ward. Following a thorough risk assessment by the nursing and medical staff, the level of engagement should be agreed, the rationale documented and the care plan formulated. The care plan and risk assessment should contain the full details of the rationale, the risks and why the level of support and engagement are necessary.

7.10.3 Where appropriate, the service user and their carers and / or family should be included in discussions regarding engagement levels.

7.11 Reviewing Levels of Engagement

For Enhanced Levels of Engagement, this must be reviewed on every shift, including weekends. This can be done by nurses in charge of that shift, however for good practice this Policy recommends that a discussion should take place with the **nurse and doctor on duty and documented in the EPR.**

7.12 Increasing Levels of Engagement

Increasing levels of engagement can be initiated by qualified nursing staff. Ideally, this would be in conjunction with other members of the Multi-Disciplinary Team but if necessary, this can be initiated as part of an overall risk assessment and risk

management care plan, in response to an increased level of risk to the service user and / or others within the environment. All appropriate documentation must be completed when engagement levels are increased, and a clear record made within the service user's electronic care records.

7.13 Decreasing Levels of Engagement

The reduction in the level of engagement should ideally be a MDT decision, to ensure that service users are not left on an increased level of engagement inappropriately.

Nurses and doctors directly involved in caring for the service user can reduce the level of engagement if a risk assessment and patient discussion agree.

A care plan will be present for each service user on engagement. This will outline the agreed changes in presentation that would facilitate a reduction in engagement level and the precise procedure for this decision to be actioned.

Individual practitioners cannot independently reduce the level of Enhanced Engagement without wider discussion with the clinical team and completion of the care plan. All appropriate documentation must be completed when observation levels are reduced, and a clear record made in the service user's electronic care records.

7.14 Length of Time - Engagement

7.14.1 It is recommended that engagement by nursing / support staff should not exceed one hour at a time, and that there should be an opportunity for reflection and discussion following the engagement and support session. This is based on the need to be concentrating attentively and actively engaging the service user; the result of this intensive therapeutic intervention may be emotionally draining.

7.14.2 However, it is also recognised that the period of engagement may be highly positive for both the service user and the member of staff, hence they may both wish to continue for an additional period. There must be room for this discussion and negotiation to take place. This may occur if there is engagement in activities of daily living such as cooking, washing, leaving the ward for a walk with staff, or both parties are engaged in a meaningful discussion or activity, for example. Consideration should be given to specific characteristics (see 7.6), when allocating a member of staff to Enhanced Engagement.

7.15 Record Keeping

7.15.1 The Engagement Record proforma should always be used when Enhanced Engagement are initiated. The record should include: date and time of initiation and termination, level of engagement, the time frequency of the engagement where appropriate, and should include the name and designation of the person undertaking the engagement and support. There should also be a record of positive and therapeutic activities and engagement opportunities offered to the service user and how these have impacted on the mental wellbeing of the person.

7.15.2 Any paper documents should be scanned onto the electronic care record system.

7.15.3 Any changes to the level of engagement should be clearly documented in the service user's care record; stating the service user to staff ratio, proximity, frequency, the

person initiating or reviewing and the date and time. For engagement within eyesight or arm's length, specify and document the proximity in terms of use of the toilet and bathroom, whilst considering dignity of the service user.

7.15.4 The **risk assessment** must be updated whenever there are changes to the level of risk, requiring changes in the level of engagement. The **care plan** must reflect changes in the level of engagement. The care plan must also state the suggested engagement strategies for the service user, during periods of support. It must also detail the issues of privacy, dignity and consideration of the gender arising in allocated staff, along with any environmental dangers or risks and how these are to be mitigated.

8 Definitions

8.1 **Patient:** The term 'patient' is used in the CoP (DH, 2015). In this document, it is used to describe a person using SHSC services, also known as a service user.

8.2 **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).

8.3 **Shift Co-ordinator / Nurse in Charge:** 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.

8.4 **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 / Nurse in Charge or senior nurse on the ward and the RC (or their formally nominated deputy).

8.5 **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, DH, 2015 para 8.5).

8.6 **European convention on Human Rights (ECHR)**. The provisions indicate that everyone has the right to respect for his/her/they private life (Article 8). No service user should therefore be subject to unnecessarily intrusive observations in a way that could breach this right. In order for this policy to comply with the Law, observation must be justified: the ECHR permits breaches of Article 8 that are necessary for one or more of the following reasons.

(a) the interests of national security, public safety or the economic well-being of the country; or
(b) the protection of disorder or crime; or
(c) the protection of health or morals, or

(d) the protection of the rights or freedoms of others.
(e) proportionate even if the use of observations is considered justified, it will only be lawful if it goes no further than reasonably necessary in each individual case to achieve the relevant objectives. When operating this policy clinicians will need to make sure that the use of observations remains proportionate and that it is no more intrusive, nor continues longer than is required by the circumstance.

8.7 **Supportive Engagement –** to 'engage' with the service user, rather than 'observe' them, can offer a significant improvement to the service user experience. It can also enhance the work experience for the staff team involved in the process. The purpose of therapeutic engagement is to interact with the service user; encouraging communication, listening and conveying to the service that they are valued and cared for. Unusual circumstances and noises should always be investigated.

8.7.1 An environment which offers a full programme of activities and specific time with individual staff members is more likely to have a beneficial emotional and psychological impact on service users and staff (Dodds and Bowles, 2001). It will also ensure service users have regular access to groups, therapeutic activities, meals and drinks, and that staff are entering bedrooms, toilets and bathrooms frequently to observe these areas, in order to maintain safety.

8.7.2 Evidence informs us that when clinicians engage in behaviours which have been called 'caringly vigilant and inquisitive', then prevention of suicide on in-patient wards is much more likely (Bowers et al., 2011). The phrase captures the nursing staffs' thorough knowledge of the service user as a person, together with a constant and consistent attentiveness to their state of mind, whereabouts and safety.

Some examples of 'caringly vigilant and inquisitive' behaviour include: following a service user who is in distress and providing support / distraction, listening carefully to safety calls (scrutinising the service user response, when in the bathroom or toilet), noticing a service user absence, noticing suspicious / out of character actions, noticing that a service user appears physically ill, noticing that a service user is taking a long time in the toilet, responding to an unusual noise.

8.7.3 Proactive engagement is a term used to describe the frequent checks by staff to ensure service user needs and safety are maintained. The principle of proactive engagement is that staff should ask the service user how they are feeling and try to utilise observations in a supportive manner, to engage the person, rather than simply 'watching' them. Staff could consider asking the service user the following questions:

- How are you today?
- What plans do you have for today?
- Can I help with anything?

Staff should also refer to the Engagement Care Plan for details about their hobbies or interests and what distraction techniques might be useful for the person.

8.8 **Engagement Flowchart:** The basis for individual decision-making about the necessary level of engagement, 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.

8.9 **General Engagement: An <u>hourly check</u> of the patient's whereabouts if present on the ward, EXCEPT <u>ENDCLIFFE WARD and FIRSHILL RISE, where 30 minutes checks take place.</u>** 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). Efforts should be made to engage with the service user at every opportunity.

8.10 **Reduced Night Engagement:** On an individually risk-assessed basis, between 21.30hrs and 07.30 hrs the MDT may agree to reduce the frequency of engagement and support **and/or** to the purpose being to check whereabouts only. This is help promote sleep, which is necessary to effective mental and physical wellbeing.

8.11 **General Engagement -** this is the minimum level of support for all service users in inpatient areas. Staff should know the location of all patients in their area, and patients need not be kept in sight. Service users subject to General Engagement will have been assessed as being low risk to themselves or others. Their location and safety will be visibly checked at a **minimum of hourly intervals** and a record made. Opportunities to engage such as group work, 1:1 sessions and so on, may be offered to the person.

8.11.1 In some specialist and forensic areas there may be a need to increase frequency of these General Engagement intervals. Service users in secure areas must be observed for clinical and security purposes at least **every 30 minutes** and their location recorded. Efforts should still be made to engage the service user in meaningful activity, however.

8.11.2 The intended whereabouts of service users who are on leave from the ward should also be known at all times.

8.12 **Enhanced Engagement -** Enhanced Engagement may be provided on an intermittent basis with staff engaging with patients and providing support at **irregular and unpredictable intervals**.

Alternatively, Enhanced Engagement may be provided on a **continuous basis** with the individual remaining either within eyesight of staff or, for the most serious degrees of risk, within arm's length.

- **Intermittent Engagement –** the service user's location and safety must be visibly checked at specified intervals. These intervals may range in length and should be agreed by the MDT. This is for service users who pose a potential but not immediate risk. The specified frequency of engagement will be recorded in the Care Plan. Engaging with service users at predictable times can provide the opportunity to plan or engage in harmful activities. This should be taken into account when determining the frequency of engagement required. In secure areas the maximum interval is 15 minutes.

- **Within Eyesight Engagement** – a nominated member of staff will be allocated to each service user being managed on this level of enhanced engagement. The service user must be **kept within continuous eyesight at all times**. This enhanced support should be considered for use with service users who could make an attempt to harm themselves or others, or where they are perceived as being vulnerable.

On rare occasions, it may be necessary that more than one Nurse/Healthcare worker/AHP/medic is required to implement this level of support safely**.** In secure areas where engagement levels have been initiated or increased by the Nurse in Charge, an appropriate Doctor should be asked to review the service user. The responsible Clinician and relevant members of the Multi-Disciplinary Team should always be informed at the earliest opportunity.

"The patient remains within eyesight of nominated observing staff at all times (CoP, DH, 2015, para 26.32), unless it is agreed by the MDT that privacy is to be allowed in specified circumstances" (CoP, DH, 2015, para 26.33). The MDT may agree the circumstances under which the patient may leave the ward during periods of constant observation.

- **Within Arm's Length Engagement** – a nominated staff member will be allocated to support the service user in close proximity (i.e., within arm's length). This is for service users who pose the highest level of risk of harm towards themselves or potentially to others and where it has been determined that this level of risk can be only managed by close proximity of the service user with staff.

  "The patient remains within arm's length of nominated observing staff at all times, (CoP, DH, 2015 para 26.32) unless it is agreed by the MDT that privacy is to be allowed in specified circumstances" (CoP, DH, 2015, para 26.33). The patient should not ordinarily leave the ward during periods of close constant observations.

9 Duties

9.1 **Board of Directors** – are responsible for overseeing the reduction of restrictive practice within the Trust, whilst recognising enhanced engagement should only be used for the least amount of time clinically required.

They have the responsibility for ensuring there is an appropriate and adequate infrastructure to support the therapeutic engagement of service users are safeguarded and their equality and Human Rights are not compromised. 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 Nursing and Professions is responsible for keeping the policy updated and available for staff.

9.2 **Executive Director of Nursing and Professions**- is accountable to the Trust Board for the development, consultation, implementation and monitoring of compliance within this Policy, which promotes supportive engagement of service users and safeguards against unnecessary use of restrictive practice.

9.3 **Director of Operations and Transformation** - has operational responsibility for the Clinical Directorates' compliance with this Policy and will ensure mechanisms are in place within each Directorate for:

(a) identifying and deploying resources within the clinical directorate to safely deliver this Policy.

(b) all clinical staff with responsibility for prescribing and carrying out engagement and support, receiving orientation to the content of this Policy.

(c) monitoring the Clinical Directorates' compliance and consistent application of this Policy.

(d) ensuring that all service users subject to prolonged periods of enhanced engagement are reviewed after 14 days and at least once per calendar month by clinicians independent of the service users' care.

(e) ensuring prolonged periods of engagement and support or any extended beyond 14 days are recorded in the care records.

9.4 **Heads of Service** - are responsible for ensuring that all Managers are aware of the Policy, understand the requirements and support its implementation.

9.5 **Clinical Director-** is operationally responsible for all risk management issues within their service area.

9.6 **Heads of Nursing** are responsible and accountable for providing assurance that their respective wards are compliant with the requirements of this Policy.

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

9.8 **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 Engagement Policy and the risks associated, and ensure that the control measures are in place to manage those risks.

9.9 **Ward Managers** - have overall accountability for the management of their ward and must ensure:

(a) they understand their role in initiating and reviewing supportive and therapeutic engagement of service users.

(b) care plans are in place and appropriately identify the required level of engagement.

(c) documented risk review accompanies the decisions made to change the levels of engagement.

(d) deployment of the available resources to safely deliver the Policy on their wards.

(e) identification, responding and where necessary escalating any areas of non-compliance with this Policy on their wards.

(f) that Peer review occurs when patients are subject to Enhanced Engagement for longer than 14 days.

9.9.1 Ward Managers must ensure that the policy is readily available to all staff at all times and that relevant staff attend appropriate training in **Clinical Risk Management.**

9.9.2 Appropriate systems for recording, monitoring and auditing in-patient engagement strategies must be in place.

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

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

9.10 Shift Co-ordinator / Nurse in Charge - is responsible for the safe and appropriate delegation of supportive and engagement duties to other appropriately prepared staff. They are responsible for ensuring that supportive interventions are carried out and recorded, and for the maintenance of appropriate records of decisions to implement or alter engagement strategies or levels. The selection should take into account of the individual's characteristics and circumstances (including factors such as experience, ethnicity, sexual identity, age and gender). They should ensure that staff allocated to undertake supportive engagement are assessed as competent to do so.

9.10.1 The Shift Co-ordinator/ Nurse in Charge will be involved in decisions to reduce levels of engagement 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.

9.10.2 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 therapeutic support of patients until appropriate remedial action is taken.

9.10.3 The Shift Co-ordinator / Nurse in Charge will make a rota each shift, detailing the activities / engagement to be carried out and naming staff responsible for each allocated period. In addition to general hourly engagement, 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.

9.11 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 Enhanced Engagement (within eyesight or arm's length) supportive engagement, the RC/Nominated Deputy will liaise with the Nurse in Charge / Shift Co-ordinator / Senior Nurse with respect to decisions regarding the reduction of levels of engagement. The Responsible Clinician has a legal and professional responsibility for the care and treatment of service users and must have a thorough knowledge of those in their care, current care plans and engagement requirements and provide advice when uncertainty arises regarding level of support.

9.12 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 so 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.

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

9.13 Unregistered staff - are responsible for informing the Shift Co-ordinator / Nurse in Charge if they do not feel adequately prepared to undertake engagement of service users, of any concerns about the safe support of a particular individual.

9.13.1 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 engagement.

9.14 **Student Nurses** -all students will have a named practice assessor and daily support within the clinical setting from practice supervisors. The supervisor/ assessor 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.

Student nurses must not undertake within arm's length Enhanced Engagement.

9.15 All Staff - are responsible for completing full and accurate records of their engagement duties in the correct format and contemporaneously.

9.15.1 Staff are responsible for the supportive engagement of the service user(s) 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.

9.15.2 On admission, the appropriate level of engagement will be introduced to reflect the degree of risk or potential risk as identified, following a thorough risk assessment by the medical and nursing team. A service user receiving support and engagement higher than General Engagement should not be automatically excluded from off ward therapy, education or leisure. **In fact, this should form an active part of their care plan.** As part of this initial assessment clinical staff will need to consider the following areas:

(a) Contemporary risk assessment.
(b) Information available from the Care Co-ordinator if known to services.
(c) Expressed intentions and discussion with service user.
(d) Information shared by relatives and cares.
(e) Implied intentions.
(f) Past history including previous suicide attempts, self-harm or assaultive behaviour.
(g) Hallucinations suggesting harm to self or others.
(h) Paranoid ideas that pose a threat to self and others.
(i) Recent loss or bereavement.
(j) Past or current problems with drugs and alcohol.
(k) Poor adherence to prescribed medication.
(l) Marked changes in behaviour or medication.

(m)Risk of falls.
(n) Risk of physical vulnerability.

9.15.3 In relation to on-going care needs and appraisal of risk, clinical staff will be required to observe and record service users' functioning at ward level including:

(a) interaction with others
(b) emotional state.
(c) subjective thoughts/mood/reflections
(d) external triggers
(e) adherence to boundaries
(f) level of insight
(g)potential risk of absconding

The MDT should be aware of the risk of dependency developing in those subjects to constant observations for prolonged periods.

10 Resource Management

10.1 Each Clinical Directorate will be expected to adhere to Safe Staffing Escalation Standard Operating Procedure (SOP) for wherever circumstances require that clinicians and managers need to consider and upgrade staffing levels. This incorporates systematic evaluation and review of any additional resources allocated for this purpose.

10.2 Where additional resources are required to provide an appropriate level of support to service users, clinicians involved in their care must utilise the SOP to ensure managers and other senior professionals can provide support to facilitate this. This must include the governance arrangements that need to be in place to arbitrate and obtain consensus around risks identified should variances of professional opinion occur within clinical services.

11 Development, Consultation and Approval

11.1 This policy has been shared across both Community and Acute Services and Rehabilitation and Specialist Services. This includes all healthcare professionals within those services. Current guidance has been followed and the Policy has been aligned to the Mental Health and Learning Disability Forum, Safe and Supportive Observation Policy (2018), The Mental Health Act Code of Practice and Least Restrictive Practice Guidance.

11.2 The title of the Policy has been amended as described above and has included Service User Engagement Groups and reflected in the Equality Impact Assessment.

11.3 The policy was sent to Patient Experience Group and Least Restrictive Practice Group, Mental Health Legislation Committee, as well as Ward Managers meeting to obtain views and comments.

12 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
Matron audit of record keeping related engagement	Matron report	Matrons	Monthly	Matrons/General managers	Heads of Nursing	Heads of Nursing
Record of staff received training for engagement policy.	Ward Mangers recording staff compliance.	Ward Managers	Monthly	Modern Matrons	Heads of Nursing	Heads of Nursing
Audit of clinical risk assessment and management plans	Bi-annual Trust-wide audit. Additional audits at team-level if necessary	Clinical Effectiveness Team and Service Leads	Bi-annual	All clinical services and their appropriate governance lines	Clinical service managers / clinical leads / matrons	Clinical service managers / clinical leads / matrons

Policy documents should be reviewed every three years or earlier where legislation dictates or practices change. This policy is to be reviewed July 2024.

13 Implementation Plan

Action / Task	Responsible Person	Deadline	Progress update
Upload new policy onto intranet and remove old version		October 2022	
Make team aware of new policy	Ward Managers and Clinical Risk and Patient Safety Advisor	September 2022	Completed through Ward Manager Meeting attendance.
Contribute to development of policy to involve all inpatient services and ward managers	Clinical Risk and Patient Safety Advisor	September 2022	Completed through Ward Manager Meeting attendance plus individual ward discussions.
Identify lead to implement per directorate	Matrons	October 2022	

14 Dissemination, Storage and Archiving (Control)

This policy is available on the Trust's intranet and available to all staff. Version 3 to be deleted and Version 4 to be uploaded to the intranet/extranet.

Version	Date added to intranet	Date added to internet	Date of inclusion in Connect	Any other promotion/ dissemination (include dates)
1.0				
2.0				
3.2				
4.0	November 2022	November 2022	November 2022	

15 Training and Other Resource Implications

15.1 Training will be required for the development of Safe, Supportive and Engagement policy change for each staff member undertaking within inpatient settings.

15.2 The implementation of this Policy will enable therapeutic engagements and use of meaningful activities, which may promote the reduction in the length of time patients remain on engagement levels and improve both patient and staff experience.

15.3 A short training PowerPoint will be developed for Ward Managers to train their respective teams where the changes for the old and new policy are highlighted. This should be rolled out during the policy inception and continually on new starters as part of the induction.

15.4 Advanced Clinical Practitioners and Allied Health Professionals to work with ward staff to develop activities and support for engagement observations.

16 Links to Other Policies, Standards (Associated Documents)

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

17 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 and community settings (NG10) May 2015

Mental Health and Learning Disability Forum (2018) Safe and Supportive Observation Policy.

Mersey Care NHS Foundation Trust (2017) Supportive Observation Policy.
Cumbria, Northumberland, Tyne and Wear NHS Foundation Trust (2020) Engagement and Observation Policy.

South London and Maudsley NHS Foundation Trust (2020) Engagement and Observation Policy.

Ashmore, R (2020), *Engagement and Observation: A review of local policies in England and Wales.*

Bowers, L., Dack, C., Gul, N., Thomas, B. and James, K. (2011), *"Learning from prevented suicide in psychiatric inpatient care: An analysis of data from the National Patient Safety Agency",* International Journal of Nursing Studies, Vol., 48 No. 12, pp.1459-65.

Buchanan-Barker, P. and Barker, P. (2005), *"Observation: the original sin of mental health nursing?",* Journal of Psychiatric and Mental Health Nursing, Vol. 12 No.5, pp.541-49.

Chu, S., Lambert, K. and Baker, A. (2020), *"What to look for during constant observations: Expert consensus and a tool for observations recording",* Journal of Psychiatric Mental Health Nursing, Vol. 27, pp. 77-86.

Dodds, P. and Bowles, N. (2001), "*Dismantling formal observation and refocusing nursing activity in acute inpatient psychiatry: a case study",* Journal of Psychiatric and Mental Health Nursing, Vol. 8 No.2, pp. 183-88.

The European Convention on Human Rights and Fundamental Freedoms 1950

18 Contact Details

Title	***Name***	***Phone***	***Email***
Clinical Risk and Patient Safety Advisor	Grace Kinsey-Oxspring	Via Skype	Grace.ks@shsc.nhs.uk

Appendix A

Equality Impact Assessment Process and Record for Written Policies

Stage 1 – **Relevance** - Is the policy potentially relevant to equality i.e. will this policy potentially impact on staff, patients or the public? This should be considered as part of the Case of Need for new policies.

NO – No further action is required – please sign and date the following statement. **I confirm that this policy does not impact on staff, patients or the public.**	***I confirm that this policy does not impact on staff, patients or the public.*** Name/Date: Grace Kinsey-Oxspring. 14th June 2022	**YES,** Go to **Stage 2**

Stage 2 Policy Screening and Drafting Policy - 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 and Flow Chart.

Stage 3 – **Policy Revision** - Make amendments to the policy or identify any remedial action required and record any action planned in the policy implementation plan section

SCREENING RECORD	Does any aspect of this policy 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	**Yes**	**This policy promotes safety, privacy, dignity, choice and respect for all patients**	**No negative impacts identified at this stage of screening**
Disability	**Yes**	**This policy promotes safety, privacy, dignity, choice and respect for all patients**	**No negative impacts identified at this stage of screening**
Gender Reassignment	**Yes**	**This policy promotes safety, privacy, dignity, choice and respect for all patients**	**No negative impacts identified at this stage of screening**
Pregnancy and Maternity	**Yes**	**This policy promotes safety, privacy, dignity, choice and respect for all patients**	**No negative impacts identified at this stage of screening**

Race	**Yes**	**This policy promotes safety, privacy, dignity, choice and respect for all patients**	**No negative impacts identified at this stage of screening**
Religion or Belief	**Yes**	**This policy promotes safety, privacy, dignity, choice and respect for all patients**	**No negative impacts identified at this stage of screening**
Sex	**Yes**	**This policy promotes safety, privacy, dignity, choice and respect for all patients**	**No negative impacts identified at this stage of screening**
Sexual Orientation	**Yes**	**This policy promotes safety, privacy, dignity, choice and respect for all patients**	**No negative impacts identified at this stage of screening**
Marriage or Civil Partnership	**Yes**		

Please delete as appropriate: - Policy Amended / Action Identified (see Implementation Plan) / no changes made.

Impact Assessment Completed by:
Time/Date: Grace Kinsey-Oxspring. 14th June 2022

Appendix B

Review/New Policy Checklist

This checklist to be used as part of the development or review of a policy and presented to the Policy Governance Group (PGG) with the revised policy.

		Tick to confirm
	Engagement	
1.	Is the Executive Lead sighted on the development/review of the policy?	√
2.	Is the local Policy Champion member sighted on the development/review of the policy?	√
	Development and Consultation	
3.	If the policy is a new policy, has the development of the policy been approved through the Case for Need approval process?	√
4.	Is there evidence of consultation with all relevant services, partners and other relevant bodies?	√
5.	Has the policy been discussed and agreed by the local governance groups?	√
6.	Have any relevant recommendations from Internal Audit or other relevant bodies been taken into account in preparing the policy?	√
	Template Compliance	
7.	Has the version control/storage section been updated?	√
8.	Is the policy title clear and unambiguous?	√
9.	Is the policy in Arial font 12?	√
10.	Have page numbers been inserted?	√
11.	Has the policy been quality checked for spelling errors, links, accuracy?	√
	Policy Content	
12.	Is the purpose of the policy clear?	√
13.	Does the policy comply with requirements of the CQC or other relevant bodies? (where appropriate)	√
14.	Does the policy reflect changes as a result of lessons identified from incidents, complaints, near misses, etc.?	√
15.	Where appropriate, does the policy contain a list of definitions of terms used?	√
16.	Does the policy include any references to other associated policies and key documents?	√
17.	Has the EIA Form been completed (Appendix 1)?	√
	Dissemination, Implementation, Review and Audit Compliance	
18.	Does the dissemination plan identify how the policy will be implemented?	√
19.	Does the dissemination plan include the necessary training/support to ensure compliance?	√
20.	Is there a plan to i. review ii. audit compliance with the document?	√
21.	Is the review date identified, and is it appropriate and justifiable?	√

Appendix C

Sheffield Health and Social Care NHS Foundation Trust

Inpatient Environmental Induction

(Including Ligature Risks)

All new Clinical and Support staff must have an induction to the ward and must read this document prior to commencing work on shift

Applicable to:

Permanent staff

Bank and Agency Workers

Locums and Interims

Students

Housekeeping and Admin Staff

This leaflet is designed for all staff that will provide care on an inpatient area within SHSC.

Information is contained within this leaflet that will help you understand how we manage the clinical environment to provide the best possible care for our patients.

It is essential that you read and follow the instructions and information below.

Inductee and inductor please sign the attached register once the induction has taken place

Clinically Managed Risks

These are risks that we manage in everyday practice on the ward.

There are 2 documents you must familiarise yourself with:

1. Environmental Risk Assessment
2. Individual risk/collaborative care plans for each Service User.

Each service has their own environmental risk assessment and an up-to-date copy of this is kept in the Health and Safety file in the ward office.

You must also ensure you familiarise yourself with the individual risk management plans and Collaborative Care-Plan for each Service User, as these are our key tools for identifying and managing risk for safety and wellbeing.

Ligature Anchor Points (LAP) and Ligature Anchor Point Assessments

We cannot eliminate all ligature anchor points in Service User accessible rooms; it is therefore essential that staff remain vigilant to Service User risks and changes in presentation. All ligature anchor points, regardless of height, in rooms where Service Users could be unattended for significant periods, are categorised as high risk. Examples of these areas are bedrooms and bathrooms/toilets. Although main communal areas are not isolated, potential ligature risks are still present.

Assessment outcomes and actions are filed in the Health and Safety folder located in the ward office and there is an individual heat map for your service attached to this template. If you are unable to locate this, please speak to the nurse in charge or a manager.

Alarm Systems

There are two differing alarm sounds that you may hear within the ward.

The nurse call is an electronic alarm sound. A constant sound indicates that there is an emergency that needs immediate attention. A more intermittent sound means that a patient

has pressed their Nurse Call button. There are panels in various locations on the ward which will tell you where the alarm has been raised, you will be shown where these panels are as part of your induction.

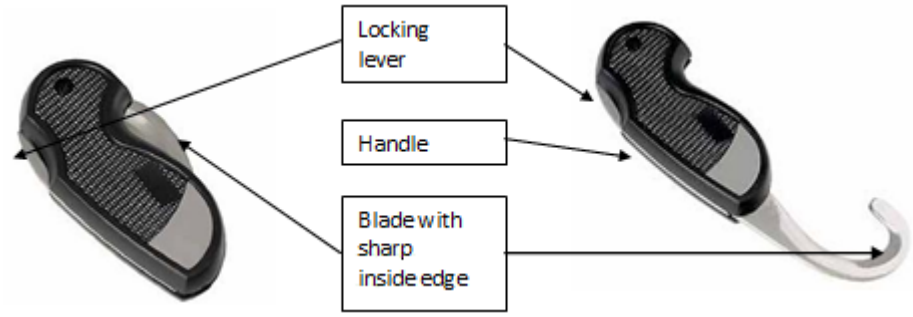
The fire alarm is a traditional bell-type sound. Similar to the nurse call, a constant sound indicates that there is a fire within the ward and a more intermittent sound means that there is a fire in the building but not located within the ward area.

Anti-barricade doors

Some rooms may not have anti-barricade door; however, all Service Users will have had a risk assessment completed in relation to using the room.

For the rooms that have an anti-barricade door, the key will be on the ward keyring. Please ask someone to show you this.

Ligature Cutters



Ligature Cutters are in the clinic room, in the emergency red bag which is also highlighted on the heat map with a

There will also be Tough-Cut Sci

ssors:

There are two Trust policies relating to Ligature risk management. These are stored on the Trust intranet Jarvis and the links to these are:

- https://jarvis.shsc.nhs.uk/documents/ligature-and-blind-spot-risk-reduction-policy-and-procedure-md-003-v4-october-2019

Observation levels for service users

- You need to be aware of which observation level your service users are on and understand what this means

Routine	Reduced Nights	Enhanced -Intermittent	Enhanced -Constant	Enhanced -Close Constant
• An hourly check throughout a 24-hour period	• On an individually risk assessed basis, between 21.30hrs and 07.30hrs, the MDT may agree to reduce the frequency of engagements **and or** to the purpose of the engagements being to check whereabouts only.	• 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 -30 minutes	• The patient to always remain within eyesight of nominated observing staff at all times unless it is agreed by the MDT that privacy is to be allowed in specified circumstances. • The MDT may agree the circumstance under which a patient may leave the ward during the period of constant engagement	• The patient to always remain at an arm's length of the observing staff unless it is agreed by the MDT that privacy is to be allowed in specified circumstances. • The patient should not ordinarily leave the ward during the periods of constant engagement. • The level of each individual engagement will be documented in the Service User's Care Plan

Supervised Areas

These rooms may only be accessed under the supervision of staff and should therefore be locked if not in use, such as:

- Garden
- Activity Room
- Clinic room
- De-escalation room
- Laundry room

Non-Service User Access Rooms

Please check with your local area regarding which areas these are but they may be:

- Cleaning Cupboards
- Kitchen
- Staff Office
- Admin Office
- Linen Cupboard

Fire Alarms Systems

During your induction you will be shown the location of:

- The units fire points
- Fire extinguishers
- Main exits
- Procedure in the event of a fire

Banned and Restricted Items

Throughout the ward there will be posters informing of which items are banned or restricted. You will need to familiarise yourself with these items.

This list is not meant to be exhaustive and only acts as a guide to staff and Service Users. Any other items brought onto the ward that may be considered to be a risk item will be discussed with individuals at time. The needs of each patient will be assessed on an individual basis and any item may be removed if the nursing staff believe that it poses a credible threat to safety.

Blanket Restrictions

Each service has a list of Blanket Restrictions, with posters on the walls to identify these.

Mobile Phones

Mobile phones are allowed on the ward and are an extremely important tool for communication between family and friends. We do however request that Service Users refrain from using them in an inappropriate manner such as using their mobile phone to make audio recordings, taking photographs and/or video of other services users, visitors, staff, or images of Trust premises

Please see mobile phone and recording policies for further advice in the event that someone is using their phone inappropriately.

https://jarvis.shsc.nhs.uk/documents/mobile-phone-policy-service-users-ops-015-v2-may-2020

https://jarvis.shsc.nhs.uk/documents/recording-policy-imst-010-v12-january-2020

WIFI

WIFI is provided to Service Users and the use of this requires them to request a guest daily password. Once connected the Service Users are able to use the WIFI freely; however, staff should be vigilant in ensuring any observed inappropriate use is shared with the nurse in charge.

Raising Concerns

If at any time you are concerned about the care provided on the unit you can raise this in any of the following ways:

- With the nurse in charge of the shift, medical team or ward manager.
- If out of hours, the Out of Hours Coordinators
- With our Freedom to speak to up lead. Wendy.Fowler@shsc.nhs.uk
- Our Safeguarding team
- Students may wish to talk to their Learning Environment Mentor, their link lecturer or university placement support officer.
- Volunteers to discuss any concerns/issues with the volunteer co-ordinator

If you feel you wish to discuss your concerns with someone not directly connected with the ward you may contact:

- Safeguarding
- CQC
- FTSU
- Heads of Nursing

Heads of Nursing

Acute and Older Adult:
emma.highfield@shsc.nhs.uk

Community:
christopher.wood@shsc.nhs.uk

Rehab and Specialist Services:
Simon.barnitt@shsc.nhs.uk

CareQuality Commission

National Guardian
Freedom to Speak Up

List of items to be included in the induction pack:

1) Detailed LAP assessment
2) LAP Summary
3) Heat Map
4) Ward Environmental Assessment
5) Signature register for Inductor and Inductee

Name of Inductor	Name of Inductee	Date & Signatures of induction

Appendix D

Common indicators that suggest the need for engagement and support 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 Engagement

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

- **Increased periods of risk** for service user self-harm and suicide may be **during** the evening and night. This policy provides for flexible and informed approaches to engagement through the night for service users managed through general and enhanced engagement, informed by individual service user 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 engagement**. Teams and staff should be mindful of this, and while formal approaches to support may have been reduced or discontinued, appropriate levels of active service user engagement and monitoring should continue for a period of time.

- **Changes in nursing staff allocated** to undertake increased levels of engagement, 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 general or enhanced engagement should not discontinue their responsibilities until actively relieved by a colleague.

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