Policy:

NPCS 001 OBSERVATION (SUPPORTING and Engaging)

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Summary of policy
This policy provides comprehensive guidance to staff that have responsibility for prescribing, and/or reducing and carrying out the safe and supportive observation of patients in inpatient settings or community care settings.

Target audience	All staff working in inpatient or community care settings.

Keywords	Enhanced observation, reducing restrictive practice, supportive, engagement, therapeutic intervention, collaborative.

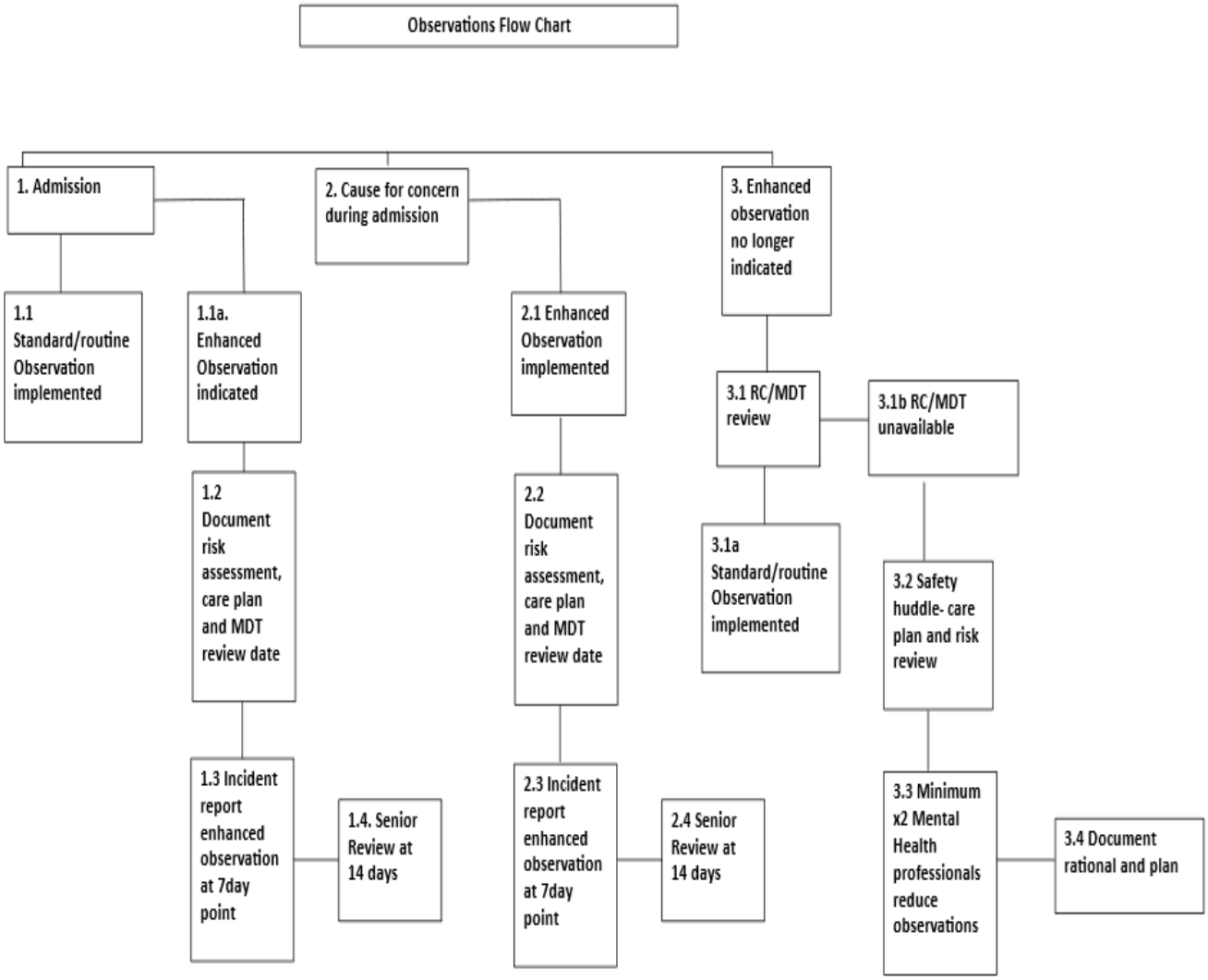
Storage & Version Control

Version 1.0 of this policy is stored and available through the SHSC intranet/internet. This version of the policy supersedes the previous version. 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)
3.0	Full review completed as per schedule	10/2022	Version 3 of the Safe, Supportive Engagement of Inpatients (General and Enhanced) policy reviewed
4.1	New draft policy created	01/2025	New Observation policy developed
5.0	Approval and issue	04/2025	Amendments made during consultation, prior to ratification.

Contents


Observations Flow Chart
1. Admission
2. Cause for concern during admission
3. Enhanced observation no longer indicated
1.1 Standard/routine Observation implemented
1.1a. Enhanced Observation indicated
2.1 Enhanced Observation implemented
3.1 RC/MDT review
3.1b RC/MDT unavailable
1.2 Document risk assessment, care plan and MDT review date
2.2 Document risk assessment, care plan and MDT review date
3.1a Standard/routine Observation implemented
3.2 Safety huddle- care plan and risk review
1.3 Incident report enhanced observation at 7day point
1.4. Senior Review at 14 days
2.3 Incident report enhanced observation at 7day point
2.4 Senior Review at 14 days
3.3 Minimum x2 Mental Health professionals reduce observations
3.4 Document rational and plan

1 Introduction

1.1 Ensuring our service users are safe and free from harm is a key component of a high-quality service. We use observation as a part of this. An enhanced level of observation is used when staff have assessed that the risk of self-harm or risk to others is increased, either within a ward environment and/or if the patient were to leave the ward. Although any type of observation provides an opportunity for therapeutic intervention, they can be perceived as intrusive and can result in distress for the patient as they feel their privacy and dignity is compromised. It is therefore vital that patient observations are carried out professionally, attentively and in a way that conforms with this policy.

2 Scope

2.1 This policy is intended for use in clinical and residential services where standard and enhanced observations are utilized to safeguard the Service Users well-being. Enhanced observation is a form of restrictive practice and should only be implemented following risk assessment. It is acknowledged that in deciding to increase the level of observation for an individual there may be a need for an immediate dynamic risk assessment before more considered planning and assessments can be undertaken. All forms of observation are an opportunity for detailed assessment and meaningful therapeutic engagement.

3 Purpose

3.1 This Policy explains:

(a) why this Policy is necessary

(b) when intermittent and enhanced observations should be used

(c) which staff are best placed to carry out these observations

(d) responsibilities for ensuring enhanced observations is used for the least amount of time clinically required

(e) the process to be followed for assessing the level of risk for each service user, agreeing the appropriate level of observation, carrying out and recording observations and regularly reviewing the level of observation

4 Definitions

4.1 The practice of supportive observation – this can be defined as observing the service user attentively whilst minimising the extent to which they feel that they are under surveillance. It requires staff to be caringly vigilant and inquisitive and have a thorough knowledge of the service users in their care, the service users' current care plans and their observational requirements. Unusual circumstances and noises should always be investigated.

4.2 Levels of supportive observation – are defined as standard observations (level 1, including zonal observations), intermittent observations (level 2); within eyesight (level 3); and within 2 arm lengths (level 4). Decisions about what level of supportive observation a service user requires will be based on and supported by documented evidence of assessed current need.

4.3 Standard Observation (Level 1, sometimes referred to as 'routine') – this is the minimum level of observation for all service users in inpatient and community care areas. Staff should know the location, safety and wellbeing of all service users in their area, but service users need not be kept in sight. Service users subject to standard observations will normally have been assessed as being a low risk to themselves or others. Their location, safety and wellbeing will be visibly checked at a minimum of hourly intervals (2 hourly at night) and a record made. In specialist and forensic areas there may be a need to increase frequency of these standard observation intervals.

4.4 Zonal Observations –should be considered a standard or level 1 observation. This is an approach a ward or community care area (e.g. Nursing Home) may take to enhance observation of a group of service users within a specific area of a ward or environment, e.g. a lounge or dining room in a nursing home. A staff member may be assigned to observe and engage with an individual/s using specified zones within the ward area. Any ward intending to introduce this type of observation should first refer to Appendix 5.

4.5 Intermittent Observation (Level 2) – this means that the service user's location and safety must be visibly checked at specified intervals. These intervals may range from fifteen minutes to a maximum of every thirty minutes. This is for service users who pose a potential, but not immediate risk. The specified frequency of observation will be recorded in the Care Plan. Observing service users at predictable times can potentially provide service users with the opportunity to plan or engage in harmful activities. This should be taken into account when determining the frequency of observation required.

4.6 Within Eyesight (Level 3) – this means a nominated staff member will be allocated to each individual being supported on this level of observation and the service user must be kept within continuous eyesight at all times. This is for service users who could, at any time, make an attempt to harm themselves or others, or where a service user is perceived as being vulnerable. In circumstances where the service user is only a risk to others consideration may be given to reducing this observation for bedroom or bathroom privacy, however this decision should be clearly outlined in the care plan. On rare occasions, it may be necessary that more than one nurse is required to implement this level of observation safely. In the absence of the Responsible Clinician and/or Multidisciplinary team any decision to reduce or end the level of observation from eyesight must be made by two registered mental health practitioners following a safety huddle. The Responsible Clinician must be informed at the earliest opportunity, and the decision and rational documented in the service users clinical notes and clearly identified in the care plan. Without this, the service user must remain in eyesight at all times.

4.7 Within 2 Arm Lengths (Level 4, sometimes referred to as 'close, constant') – this means a nominated staff member will be allocated to observe the service user in close proximity (i.e. within 2 arm lengths). This is for service users who pose the highest level of risk of harm towards themselves or potentially to others, and it has been determined that this level of risk can only be supported by close proximity of the service user with staff. In circumstances where the service user is only a risk to others consideration may be given to reducing this observation for bedroom or bathroom privacy, however this decision should be clearly outlined in the care plan. In the absence of the Responsible Clinician and/or Multidisciplinary team any decision to reduce or end the level of observation from within 2 arm lengths must be made by two registered mental health practitioners following a safety huddle. The Responsible Clinician must be informed at the earliest opportunity, and the decision and rational documented in the service users clinical notes and clearly identified in the care plan. Without this, the service user must remain within 2 arm lengths at all times.

5 Detail of the policy

Any level of observation undertaken by staff should be seen as an opportunity for therapeutic engagement, collaboration and detailed holistic assessment. Observation requires preparation, meticulous risk assessment, care planning and documentation and expertise on the part of the observer. It must be recognised that this observation policy is only **one** aspect of caring for people during periods of increased risk. It is clearly not enough to simply observe people. The process must be both safe *and* therapeutic. People who need this level of help are often going through a *temporary* period of increased need. Whatever the cause of this need they, at that moment, require safety, compassion, understanding and appropriate treatment. They must still be engaged in a positive and therapeutic relationship with staff after observation levels return to normal.

6 Duties

6.1 Board of Directors – is responsible for overseeing the reduction of restrictive practice within its services, recognising enhanced observations should only be used for the least amount of time clinically required. They have a responsibility for ensuring there is an appropriate and adequate infrastructure to support the observation and engagement of service users and that service users are safeguarded, and their equality and human rights are not compromised.

6.2 Executive Director of Nursing, Professions and Quality – is accountable to the Trust Board for the development, consultation, implementation and monitoring of compliance with this Policy, which promotes supportive observations, engagement of service users and safeguards against unnecessary use of restrictive practice.

6.3 Heads of Nursing and Heads of Service – have clinical and operational responsibility for clinical directorates' compliance with this Policy and will ensure mechanisms are in place within each service 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 observations receiving orientation to the content of this Policy

(c) monitoring the clinical directorate's compliance and consistent application of the Policy

(d) ensuring that all service users subject to prolonged periods of constant enhanced level 3 and 4 observations are reviewed after 7 days and then at least once per calendar month by clinicians independent of the service user's care and with the involvement of the Respect team

(e) ensuring prolonged periods of enhanced observation or any that extend beyond two weeks are recorded in the service user's health care record.

6.4 Responsible Clinician – has a legal and professional responsibility for the care and treatment of the service user. As part of that responsibility, they must have a thorough knowledge of the service users in their care, input into the service users' current care plans and observational requirements and provide advice when uncertainty arises regarding level of observation required.

6.5 Matrons – are accountable to the Heads of Nursing for providing assurance that their respective wards are compliant with the requirements of the Policy.

6.6 Ward/Service Managers - have overall accountability for the management of their ward or community care setting and must ensure:

(a) they understand their own and their staff's role in initiating and reviewing supportive observations

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

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

(d) deployment of the available resources to safely deliver this 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, in collaboration with the Respect team and Human Rights Officer occurs when service users are subject to constant observations for longer than 7 days

6.7 The Multidisciplinary Team – have a responsibility to understand their role in initiating and reviewing supportive observations. They must 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. Levels of observation and risk should be regularly reviewed by the Multidisciplinary team and a record made of decisions agreed in relation to increasing or decreasing the observation. The teams must consider how enhanced observation can be undertaken in a way which minimises the likelihood of individuals perceiving the intervention to be coercive and how observation can be carried out in a way that respects the individual's privacy as far as practicable and minimises any distress. In particular care plans should outline how an individual's dignity can be maximised without compromising safety when individuals are in a state of undress, such as when using the toilet, bathing, showering, dressing etc. A robust care plan based on identified risk should be in place at times usually associated with the need for privacy. When enhanced observations are used for longer than 7 days, the team should use the skills of the entire team to support service users' recovery.

6.8 Nurse in Charge/Shift Manager - is responsible for identifying the staff (by their profession and grade) who are best placed to carry out enhanced observation and under what circumstances. This selection should take account of the individual's characteristics and circumstances (including factors such as experience, ethnicity, sexual identity, age and gender). They should ensure staff allocated to undertake increased observations have been assessed as competent to do so as per Appendix 6. The Nurse in Charge should also be checking observations are undertaken in line with the prescribed observation level, and in accordance with the agreed care plan.

6.9 All Registered inpatient clinical staff have a responsibility to:

(a) understand their role in initiating, carrying out and reviewing supportive observations

(b) carry out that role in line with the Policy

(c) complete the care plan for their named service user

(d) inform each service user of the level of observation they are subject to and the reasons for this

(e) review the level of observation based on recorded clinical need and risk review;
(f) ensure the care plan is implemented

(g) ensure the periods of observation are viewed and used as opportunities to build a therapeutic relationship

(h) Ensure that all prolonged incidences of enhanced level 3 and 4 observations are incident reported after 7 days

(i) complete all the required documentation

(j) fully familiarise themselves with the policy

6.10 Non-registered staff have a responsibility to:

(a) understand their role in carrying out supportive observations

(b) carry out observations in line with the observation level prescribed

(c) ensure the periods of observation are viewed and used as opportunities to build a therapeutic relationship

(d) be familiar with, and implement, the service user's care plan

(e) complete the required documentation accurately and contemporaneously

(f) report any relevant information that would assist the effective review of the service user's needs

(g) Ensure that all prolonged incidences of enhanced level 3 and 4 observations are incident reported after 7 days

(h) fully familiarise themselves with this Policy

7 Procedure

7.1 Restriction of Liberty- The least intrusive level of observation that is appropriate to the situation should always be adopted so that due sensitivity is given to the service user's dignity and privacy whilst maintaining the safety of those around them. It is recognised that clinical services will at times adopt harm minimisation and positive risk-taking approaches, for example with service users who self-injure. Where these approaches are used, the clinical strategies employed should be clearly documented in the individual service user's clinical notes and care plan, so as to communicate the appropriate information to all staff working with those individuals. All decisions about the specific level of observation should take into account:

(a) the service user's current mental state

(b) any prescribed medications and their effects

(c) the current assessment of risk should include the service user's ability to perceive potential risk

(d) the views of the service user

7.2 Communication and engagement- All clinical team members who have responsibility for the delivery of this policy must have a proper awareness of its implications and an understanding of any role they have in initiating, carrying out, and reviewing supportive observations. In addition, service users who may be subject to this policy framework need to be fully informed as to the process by which the policy is applied and reviewed and be given the opportunity to discuss any concerns or questions they may have with an appropriate member of the multi-disciplinary team.

7.3 Human Rights issues- The European Convention on Human Rights (ECHR) has been enshrined in United Kingdom law since 2000. The provisions indicate that everyone has the right to respect for his/her private life (Article 8). No service user should therefore be subject to unnecessarily intrusive observations in a way that would breach this right. In order for this policy to comply with the law observation must be justified: the ECHR permits qualifications 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 is 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 circumstances.

7.4 Prescription of Supportive Observations- The decision to introduce or increase the frequency of observations may in the first instance be appropriately taken by a registered nursing staff or mental health practitioner in response to an immediate risk or safety concern. Where possible the decision should be made in conjunction with medical staff and the service user, and in response to an assessed risk. Ideally, decisions about the level of supportive observation required by an individual service user should be jointly made by the multidisciplinary team.

7.4.1 The actual practice of delivering supportive observation is largely, though not exclusively, a nursing responsibility. However, the Responsible Clinician has legal and professional responsibility for the care and treatment of individual service users. This authority is exercised through appropriate delegation of responsibilities within the multidisciplinary team. Decision making in respect of the authority to change practice should be described within the care plan, so that responsibilities for managing risk are well understood. Decision making can therefore be appropriately delegated to the nurse in charge of a ward or area. The risk assessment and rationale for all changes must be clearly documented in the service user's care plan and clinical notes.

7.4.2 On admission to a ward or a community care service (i.e. nursing home or step-down bed), the appropriate level of observation 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 on observation higher than level one should not be automatically excluded from off ward therapy, education or leisure. As part of this initial assessment clinical staff will need to consider the following areas:

(a) Current information and contemporary risk assessment

(b) information available from key workers, if known to services

(c) expressed intentions

(d) information shared by relatives and carers

(d) 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 or others

(i) recent loss or bereavement

(j) past or current problems with drugs or alcohol

(k) poor adherence to prescribed medication

(l) marked changes in behaviour or medication

(m) risk of falls (Appendix 7 A & B) The FOLID tools are primarily for use in older adult services where service users are at an increased risk of being subject to enhanced observation due to falling.

(n) risk of physical vulnerability

7.4.3 In relation to on-going care needs and appraisal of risk, observing staff will be required to observe and record service users functioning at team level, including their:

(a) interaction with others

(b) emotional state

(c) attitudes

(d) external triggers

(e) ability to work within boundaries that have been collaboratively agreed

(f) level of insight

(g) potential risk of absconding

7.4.4 The MDT should be aware of the potential risks associated with prolonged use of constant observations.

7.5 **Managing care for service users subject to supportive observations-** Supportive observation must be used as an opportunity for supportive and therapeutic interaction to meet the holistic needs of service users. It is therefore imperative that during supportive observations the service user should be engaged in dialogue and useful activities appropriate to their needs. Such activities need to be collaboratively identified with the service user and documented a care plan, which should be reiterated at each hand over. If for any reason, engaging the service user in dialogue and activities during supportive observation is not possible, then the reasons for this needs to be clearly recorded.

7.5.1 The collaborative, person centred, and holistic assessment is an opportunity to identify and plan care which takes into account the equality needs of service users protected characteristics which are:

(a) age

(b) race

(c) disability

(d) gender identity, gender reassignment

(e) marriage and civil partnership

(f) religion and belief

(g) sex

(h) sexual orientation

(i) maternity and pregnancy

7.5.2 Staff undertaking supportive observation should be familiar with the environment and the policy for emergency procedures and potential risks in the environment or with individual service users and their planned care.

7.5.3 The clinical team should continually review risk in developing an effective care plan for a service user subject to supportive observations. A consideration of any tools or instruments that could be used to harm themselves or others should be made and where appropriate such items removed for safekeeping. It may be necessary to search the service user and their belongings in line with the Trust's search policy, to ensure no potential means to inflict injury are hidden on the service user’s person.

7.5.4 Nursing staff, and in particular the nurse-in-charge/shift co-ordinator, ward manager or their deputy, must be aware of the observation levels at all times, ensuring there are adequate numbers and grades of staff available for current and future shifts. Observation status must be discussed during ward/team handover to ensure continuity of care.

7.5.5 Staff are expected to interact with the service users they engage in supportive observation with. This interaction should include an evaluation of their mood and behaviours associated with identified risk. A record of these interactions should be recorded at least once a shift, and more frequently if the clinical or ward team deem

this appropriate. All interactions therefore need to be documented and used in the overall assessment of the service user. Staff who are tasked with providing supportive observation should be aware of the focus of their assessment, as well as the activities and interactions to be engaged in.

7.5.6 An appropriate assessment and care plan should be established - considering clinical risk and a review of relevant history / case notes - with every service user on admission to an acute inpatient area/PICU/place of safety. This review should include direct dialogue with the service user and significant other/s as well as a consideration of any Advanced Statements and Decisions that have been established. The risks associated with all service users within the clinical environment need to be considered when making decisions about supportive observation. Particular emphasis should be placed on vulnerability in terms of gender, age, sexuality, ethnicity and capacity to give informed consent. The information gathered should be used to inform the clinical decision regarding supportive observation.

7.5.7 Where a service user is required to be observed whilst involved in intimate personal care, the support must be provided by a practitioner of the same gender unless there is a specific clinical risk. An hourly summary of the service user's condition, risk behaviours, significant events and any therapeutic interventions must be recorded.

7.5.8 Supportive observations of service users do not stop at night. There is a duty of care to ensure that signs of life are checked and that service users are safe and not in distress either physically or emotionally. It is recognised that service users expect a greater level of privacy after retiring to bed. Observations undertaken at night and during the day need to include checking for signs of life and an assessment of the individual's wellbeing with any area of concern or doubt being explored. A shift by shift, nominated member of the nursing team must therefore ensure that each service user is assessed through regular monitoring to ensure they remain safe, and that any individual's distress or abnormal movement is explored further.

7.5.9 The frequency and extent of the monitoring should be led by the level of supportive observation or based upon individual requirements. The Mental Health Act Code of Practice, (2015) states that: "Staff must balance the potentially distressing effects on the service user of increased levels of observation, particularly if these levels of observation are proposed for many hours."

7.5.10 Where supportive observation at level 2 or above has been decided upon, consideration needs to be given as how this can be maintained during times when personal/ intimate activities need to be undertaken. The way that supportive observations are undertaken should be based on the assessed needs of the service user. Any decision to reduce supportive observation from levels 2 and above during visiting times or intimate times such as bathing should be based on a robust documented risk review that includes MDT discussion and is clearly documented within the service user's clinical notes and supportive observation care plan.

7.6 Service users on observation in off ward areas- Continuity of meaningful activity and engagement will remain a high priority for Service Users on increased levels of observation. They should not therefore be automatically excluded from off ward treatments/activities.

7.6.1 Service Users may wish to take part in faith/religious activities such as praying or meditation within a multi-faith area of the ward or within hospital grounds. Service users should be supported to attend to their faith needs where possible taking into account the service users' risk assessment.

7.6.2 Decisions regarding attendance should be based on individual risk assessment and not the level of observation the service user is receiving. The individual risk assessment should:

(a) consider the environmental risk in the area being proposed for the service user to attend, e.g. observation line, glazing in windows, furniture

(b) consider the treatment/activities within the area

(c) include a/the member of staff from the area where it is proposed the service user will attend

(d) consider if a ward-based staff needs to escort the service user in order to undertake the observation, or whether this can be safely done by a member of staff from the areas the service user is attending

(e) record the details in the service user's health care record.

7.6.3 Where the responsibility for undertaking the observation is transferred to a member of staff from the area where it is proposed the service user should attend; the observation record should also be transferred to that staff.

7.7 **Increasing Supportive Observations-** Decisions about supportive observations should be made as far as possible via multi-disciplinary discussion, based on the on-going assessment of the service user's needs as described above. This process should include the service user wherever possible. Registered nursing staff with delegated responsibility for a ward area have the authority to implement an increase in the level of observation in the first instance. Any such decision should be reviewed by the senior nurse on duty in the area and/or medical staff at the earliest opportunity.

7.8 **Decreasing Supportive Observations**-In acute inpatient settings, the decision to reduce the level of observations should normally be taken by registered nursing staff or mental health practitioner in conjunction with the MDT. However, delegation of authority to decrease level of observation can occur in the absence of the Responsible Clinician and wider MDT. This can only be completed by a minimum of two registered practitioners following a safety huddle if the Responsible Clinician is unavailable. The observations plan of care should identify under what circumstances changes can be made (i.e. related to the needs, behavioural presentation and or mental state of the service user). This must be clearly documented in the service users record.

7.8.1 In community care settings (e.g. Nursing Homes) the decision to reduce the level of observations should be completed by a minimum of two qualified practitioners following a safety huddle. This must be clearly documented in the service users record.

7.8.2 Wards teams should look to plan ahead and ensure that the plan of care for each service user outlines the conditions and observed behaviours that would facilitate a prompt reduction in observation levels.

7.8.3 Where the Responsible Clinician feels that observations should not be reduced without medical consultation this requirement should be clearly recorded in the clinical record and communicated verbally to all members of the multi-disciplinary team. If necessary, any out-of-hours concerns can be addressed through the on-call consultant.

7.8.4 It is also recognised that long-term care needs and dynamic risk assessment enables clinical teams in conjunction with service users to develop care plans which adjust the level of observations during the course of the day, based on service user need and the known risks associated with a given activity and the environment of care. With the full agreement of the clinical teams, care plans can be routinely adjusted to reflect the required level of observation afforded a service user during the course of the day provided this is underpinned by a robust assessment and care plan and that the care team regularly reviews the plan and allows practitioners to modify the plan in the event of changes to a service user's presentation.

7.9 Skills and responsibilities of staff undertaking supportive observations

7.9.1 The registered nurse or mental health practitioner with overall responsibility for a given environment remains accountable for the decision to delegate supportive observational roles to non-registered nurses or students in training, and for ensuring that they are knowledgeable and competent to undertake this role.

7.9.2 Student nurses would not normally be expected to undertake any supportive observation, except where this is an agreed part of their learning objectives and all parties are satisfied with their level of competence, all must have completed the competency assessment. **First year students can only undertake level 1 observations**, the focus of this should be on developing their skills in approaching, engaging and communicating with service users**.** Second/third year BSc and first/second year MSc students should only undertake level 2 observations. Students should not be engaged in supportive observations for more than 60-minute periods. All students will have immediate support available to them and be in receipt of supervision that would enable them to withdraw from this role with immediate effect should the need arise.

7.9.3 It is recognised that providing supportive observation for service users is stressful and therefore staff should rotate regularly. It is therefore recognised that generally a member of staff should not undertake a continuous period of observation above the general level for more than a maximum of 2 hours, unless it is seen as appropriate following consultation with the member of staff in question.

7.9.4 When supportive observation is being handed from one member of staff to another, the nurse-in-charge/shift co-ordinator needs to ensure that the member of staff taking over the responsibility is aware of the focus of their assessment; the plan of care; the information documented during the previous shift and the expected activities and interactions to be engaged in. Wherever possible such handover should involve the service user, so that they are involved in key decisions about their care. The handing over member of staff should fully brief the member of staff relieving them on the current situation.

7.10 Service user and carer information and involvement

7.10.1 Levels of observation and the reason for their use must be explained to service users, and their carers or relatives in an appropriate format where applicable. Staff should assess whether the service user and or their relative have understood the rationale and implications of using supportive observation and this should be clearly documented.

7.10.2 Where a service user, and or their relative, experience difficulty in understanding the rationale and implications of supportive observation then this should be appropriately reiterated and clearly documented in the clinical notes.

7.11 Reviewing observation levels

7.11.1 Observation status must be formally reviewed at regular intervals. This will be a minimum of daily for Level 2 and 3. Within 2 arm lengths (level 4) should be reviewed at least twice a day, once in the morning and once in the evening. Service users who remain on Level 2, 3 and 4 observations continuously for more than 1 week should have observation levels reviewed at a multi-disciplinary Team review.

7.11.2 In the case of Forest Lodge which provides long-stay care for individuals who pose specific risks to themselves and others a variation to these review schedules may be applied. Within Forest Lodge whenever supportive observation has been introduced a multi-professional review of any Level 4 observations will be undertaken on a daily basis. Where Clinical Teams develop substantive care plans to manage longer-term risk, the schedule for review of the care plan and associated level of observation can be undertaken on a weekly basis within the care team setting.

7.11.3 Any increases in observations levels can be done by the nurse on duty if they form the view that the risks have escalated and that increasing observations is an appropriate response. The decision must be recorded contemporaneously giving a rationale for the change.

7.12 Recording of supportive observations

7.12.1 Any decision to utilise an enhanced level of observation must always be fully documented in the service user's clinical records, the record should indicate that due consideration has been given to the service user's human rights. Such a consideration needs to be explicitly documented at all the subsequent review schedules described. Delivering enhanced levels of observation is a complex and at times difficult clinical intervention. The process of engagement and interactions, if appropriately adopted, should enable an accurate picture of a service user's well-being, mental health and potential risk to emerge. The assigned staff should sit down and engage with the service user to formally evaluate and assess their mental state, mood, behaviour and risk.

7.12.2 Delivering interventions to service users requiring constant observations should not be restricted to members of the nursing team. All members of the Multidisciplinary should engage in targeted interventions intended to aid the service user's recovery.

7.12.3 It is important to accurately record the individual's mental health and identify any clinical indicators of risk in the service user's clinical notes. All records specifically utilised in services in support of this policy must be fully completed with any individual timed observations being captured accurately and contemporaneously. In addition, the following information needs to be detailed within the service user's clinical record:

(a) a current risk assessment and care plan

(b) date and time that the observation level was instigated, altered or reviewed

(c) explicit record made of the current observation level in force and any specified timescales to be applied, or environments which are restricted

(d) any specific instructions and rationale related to individual service user needs

(e) reasons for current observation levels

(f) indicators of risk or relapse

(g) approach adopted in providing appropriate level of support and identification of number and gender requirements of staff assigned to provide care

(h) clear information regarding expected engagement and therapeutic interventions

(i) the possible or anticipated reaction of the service user being cared for

(j) Risk Assessment & Management Plan (on inpatient wards)

7.13 Observation in an alternative hospital setting

When a service user is transferred from inpatient services to an alternative NHS facility, such as an Acute General Hospital, there is a requirement to review the risk assessment prior to transfer and an appropriate level of observation will be allocated based on identified risk, during their stay at another NHS facility. It is the responsibility of Sheffield Health and Social Care NHS Foundation Trust to provide the required supportive observation during the stay at the alternative NHS facility. However, if a client known to mental health services is being cared for routinely in an NHS facility and requires supportive observation to meet their mental health needs but has not been transferred from a mental health inpatient setting, then it is the responsibility of the NHS facility to provide this intervention. Where enhanced observation takes place within an alternative hospital setting it is recommended that the level and duration of observation is discussed, in line with clinical indicators and the risk assessment, and agreed at the start of each shift. Due to the geographical implications, it is recommended that allocated staff members support the service user up to 4 hours at a time unless negotiated otherwise with the NIC.

7.14 Resource Management

Directorates and clinical areas should have local protocols in place to guide clinicians through the process of increasing and decreasing staffing levels as and when required.

7.15 Reporting Incidents

When a service user subject to supportive observation is involved in a serious incident it is important that a post incident review occurs. The Responsible Clinician and local service manager will ensure that all such reviews are undertaken in a safe supportive environment to ensure improvements – if appropriate – are identified to limit the prospects of any similar incident occurring in the future.
The action to be taken in reporting incidents should be in line with the process outlined in the Trusts Patient Safety Incident Response Framework (PSIRF) Policy which is available on the Trust website.

8 Development, Consultation and Approval

This policy was developed in line with best practice and the nationally recognised policy developed by Mersey Care NHS FT. A wide range of stakeholder were consulted in the development of this policy including subject matter experts and experts by experience. The policy was approved by the Clinical Quality and Safety Group. Consultation took place between December 2024 and April 2025.

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
Competency compliance 7 day Incident reporting	Audit	Ward/Service managers	3 yearly	Reducing Restrictive Practice subgroup	Reducing Restrictive Practice subgroup	Clinical Quality and Safety Group

This policy will be reviewed every three years or earlier where legislation dictates or practices change. The policy will be reviewed in April 2028

10 Implementation Plan

- This policy will be stored on the internet
- Ward and service managers are responsible for ensuring all staff are familiar with this policy
- Competency check will be completed for all staff expected to carry out enhanced observations
- All new starters, students and bank/agency staff will be subject to competency checks
- Time for competency checks will be allocated within each shift where enhanced observation is being undertaken
- The competency checklist will be

The implementation plan should be presented as an action plan and include clear actions, lead roles, resources needed and timescales. The Director of Corporate Governance team can provide advice on formats for action plans however; an example layout for the plan is shown below:

Action / Task	Responsible Person	Deadline	Progress update
Upload new policy onto intranet and remove old version	Communication Team		
Ensure the team are aware of new policy	Ward/Service manager	01/15/2025	

11 Dissemination, Storage and Archiving (Control)

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

12 Training and Other Resource Implications

All staff undertaking enhanced observation must be deemed competent to do so. The competency checklist, contained in the appendix of this policy must be completed for all substantive staff, student nurses and bank/agency staff. Competency checks will be completed within the resource allocation for safe staffing numbers.

13 Links to Other Policies, Standards (Associated Documents)

Absent Without Leave and Missing Patient Policy (OPS 002 V5)
Capacity and Consent to Care Support and Treatment Policy (NP 023 V7)
Clinical Risk and Management of Harm Policy (NP 035 V2)
Deprivation of Liberty Safeguards Policy (NPCS 003 V8)
Duty of Candour and Being Open Policy (MD 010 V6)
Establishing and Maintaining Therapeutic Relationships with Service Users/Patients/Carers (NP 025 V2)
Falls Inpatient Policy (OPS 016a V3.1)
Inpatient and Service User Escort Policy (V3)
Management of Individuals at Risk of Using Ligatures to Self Harm or Complete Suicide Policy (NP 038 V2)
Mental Health Act, Equality and Human Rights Policy (NPCS 010 V4)
Patient Safety Incident Response Policy (MD023 v6)
Seclusion and Segregation Policy (NPCS 009 V9.2)
Section 19 Procedure for the Transfer of Patients Detained under the Mental Health Act 1983 to another Hospital or Unit Policy (NP 032 V2)
Use of Force Policy (NP 030 V6.1)

14 Contact Details

Title	***Name***	***Phone***	***Email***
Head of Clinical Quality	Vin Lewin	07890320983	vin.lewin@shsc.nhs.uk
Deputy Director of Nursing	Emma Highfield	07989355026	emma.highfield@shsc.nhs.uk
Senior Matron	Naomi Hebblewhite	07973944354	naomi.hebblewhite@shsc.nhs.uk

Appendix 1

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:
April 2025

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	**No**	**Yes, the use of enhanced observations for older people at risk of falls can be reduced.**	**No**
Disability	**No**	**Yes, Staff are guided to consider disability within the policy document.**	**No**
Gender Reassignment	**NO**	**Yes, staff are guided to consider protected characteristics within the policy.**	**No**
Pregnancy and Maternity	**No**	**Yes, staff are guided to consider the needs of patients from a pregnancy and maternity perspective.**	**No**

Race	**No**	**Yes, staff are guided to consider the protected characteristics of Race.**	**No**
Religion or Belief	**No**	**Yes. Staff are guided to consider the protected characteristics of religion or belief.**	**No**
Sex	**No**	**Yes, staff are guided to consider the protected characteristics of sex.**	**No**
Sexual Orientation	**No**	**Yes, staff are guided to consider the protected characteristics of sexual orientation.**	**No**
Marriage or Civil Partnership	**No**		

Please delete as appropriate: - no changes made.

Impact Assessment Completed by: Head of Clinical Quality

Name /Date April 2025

Appendix 2

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?	N/A
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 3

Sheffield Health and Social Care NHS Foundation Trust

Policy Governance Group (PGG)

Date	28 April 2025	**Item Ref**	TBC

TITLE OF PAPER	**OBSERVATION (SUPPORTING and Engaging)**
TO BE PRESENTED BY	Vin Lewin, Head of Clinical Quality
AUTHOR	Vin Lewin, Head of Clinical Quality

1. Purpose

For approval	For assurance	For collective decision	To seek input	To report progress	For information	Other (Please state)
√						

2. Summary

The attached Policy has been consulted on across the network:

- CQ&SG
- Heads of Nursing
- Occupational therapy leadership
- Nursing Leadership Group
- Various expert by experience groups
- Multiple professional groups including medics
- Restrictive practice group
- Ward development day
- Observation and engagement steering group

- The author confirms that the policy reflects current national guidance and best practice as a CQC 'Must Do' requirement.

- The author confirms that cross referencing to other policies has been undertaken and the appropriate section of the policy reflects this.

- The author confirms that the policy follows the governance process: -

1. Ensuring appropriate internal and external expertise and adherence to good practice, and that the existing policy has;

2. been circulated for consultation to appropriate groups as described above;

3. dissemination of the policy and training implications have been considered
   The policy dissemination is being overseen and planned by the observation steering group
4. arrangements for implementation have been considered

3 Next Steps

Following approval by the Policy Governance Group, Corporate Governance to arrange for the to be submitted to the appropriate Board Committee for ratification.

4 Required Actions

The Policy Governance Group are asked to approve the attached policy because the current version has reached the date for review

5 Monitoring Arrangements

The policy implementation and any future review will be overseen by the Reducing restrictive practice steering group and the Clinical Quality and Safety Group.

6 Contact Details

Vin.lewin@shsc.nhs.uk

Appendix 4

PLEASE ADD TO THIS TEMPLATE BUT DON'T LEAVE ANYTHING OUT AS THIS COULD MEAN THE POLICY ISN'T APPROVED, PLEASE REMOVE PROMPTS (including this box) AND TURN RED TEXT TO BLACK.

All black text needs to stay

Policy Governance Group

Date	Insert Date of PGG Meeting	**Item Ref**	**TBC**

TITLE OF PAPER	**Extension To Review Date ~ Insert Name of Policy Here**
TO BE PRESENTED BY	Name and Job Title of Person presenting the policy to PGG
AUTHOR	Name and Job Title of Author

1. Purpose

For approval	For assurance	For collective decision	To seek input	To report progress	For information	Other (Please state)
✓						

2. Summary

Policy	Author	Old review date	New review date
Insert	Insert	Insert	Insert

Rationale

The current policy expires on insert date here. The current policy is 'fit for purpose' and the author confirms that extending the review date to DD/MM/YY is low risk.

Insert text as appropriate.

PGG are asked to approve this request to extend the review date, as per the full rationale above, and are asked to note that the new review date requested, also takes into account the requirement to submit such requests to the XXXX Committee (insert which Board Committee the policy will be ratified by).

- The author confirms that, by the new review date, they will (1) undertake thorough review of the policy; (2) consult with various stakeholders / relevant managers / Staff Side / other Groups; (3) present for approval by PGG; (4) present for ratification by the Workforce & OD Committee; (5) arrange for the policy to be replaced on the intranet/website and in Connect.
- The new review date takes into account all rationale and the extended governance process.
- The author confirms that governance processes will be followed to review the policy – (1) ensuring appropriate internal and external expertise and adherence to good practice, and that the policy has
  (2) been circulated for consultation to appropriate groups
  (3) dissemination of the policy and training implications have been considered
  (4) arrangements for implementation have been considered
- The author also confirms that the policy will –
  (5) reflect latest guidance

  (6) feature relevant equality impact assessments (EIA)

  (7) be effectively and appropriately consulted upon and;

  (8) consider any wider implications.

3. Next Steps

Once the new review date is approved by PGG, a recommendation for ratification will be submitted to . XXXX Committee (insert which Board Committee the policy will be ratified by.

Once ratified –

- Policy Governance to work with the author to ensure that the front sheet of the current policy is amended to reflect the new review date.
- Policy Governance to arrange for the amended policy to be replaced on the intranet and internet. A message will not need adding to Connect in this instance.

4. Required Actions

PGG are asked to agree to the above extension to review date, taking into account all rationale.

5. Monitoring Arrangements

Complete as appropriate

6. Contact Details

For further information, please contact:

- ADD AUTHOR'S DETAILS (using format below)