Trust HQ
Rikenel
Montpellier
Gloucester
GL1 1LY

Direct Tel: 01452 894266
E-mail: 2gnft.Information-Freedom@nhs.net
Website: www.2gether.nhs.uk

8 May 2017

Freedom of Information Request – Ref: FOI 007-1718

Thank you for your recent Freedom of Information request about patient observations. Please find the documents requested attached.

(1) Please provide a copy of your observation policy for mental health inpatients that are identified as at-risk; and

(2) Please provide a copy of any information sheet that is given to patients about observation.

Should you have any queries in relation to our response in this letter, please do not hesitate to contact me. If you are unhappy with the response you have received in relation to your request and wish to ask us to review our response, you should write to:-

Anna Hilditch
Assistant Trust Secretary,
2gether NHS Foundation Trust
Rikenel
Montpellier
GLOUCESTER GL1 1LY
Tel: 01452 894165
E-mail: anna.hilditch@nhs.net

If you are not content with the outcome of any review, you may apply directly to the Information Commissioner's Office (ICO) for further advice/guidance. Generally, the ICO will not consider your case unless you have exhausted your enquiries with the Trust which should include considering the use of the Trust's formal complaints procedure. The ICO can be contacted at: The Information Commissioner's Office, Wycliffe House, Water Lane, Wilmslow, Cheshire SK9 5AF.

Yours sincerely,

Lisa Evans

LISA EVANS
Information Governance Officer
2gether NHS Foundation Trust

Guidelines and Procedure for Engagement and Observation

Version:	Version7
Consultation:	Matron Managers and Practice Policy Group Locality Directorates
Ratified by:	Director of Quality and Performance, notified to Governance Committee
Date ratified:	September 2105
Name of originator/author:	Alan Metherall, Richard Hutson , December 2005
Date issued:	September 2015
Review date:	2 years
Audience	This procedure applies to all inpatient areas of the Trust in Gloucestershire and Herefordshire.

Version History

Version	Date	Reason for Change
4	June 2011	Vikki Tweddle September 11
5	March 12	Format change
6	May 2013	Policy review – Richard Hudson
7	02/09/15	Policy update – John Trevains, Chris Betteridge, Ian Bloore, Steve Ireland.

1. Policy Statement

Engagement with a patient, including the observation, reporting and recording of a patient's mental state, well being and behaviour is central to the role of inpatient staff. Observation enables staff to learn about patients in their care, to assess their needs and to engage with them.

2. Introduction

Every inpatient who is receiving care and treatment on Trust premises is observed at some level as a necessary part of their care.

Where there are specific concerns the patient may need to be placed on higher levels of observation for periods of time. The clinical record of the patient must specify the level of observation for that person.

3. Purpose

To outline the Trust's procedures for the observation of patients within inpatient facilities

4. Scope

This procedure applies to all inpatient areas of the Trust in Gloucestershire and Herefordshire. Care Practice policies are posted on the trust intranet site..

5. Context

The practice of undertaking systematic 'observation' is aimed at preventing potentially suicidal, violent or vulnerable patients from harming themselves or others. It also provides a valuable source of information useful in the continuing assessment process. 'Observation' is not simply an activity to support a custodial approach. Undertaking 'Observation' provides an opportunity for health and social care staff to interact in a therapeutic manner with the patient.

There may however, be instances where someone is assessed as high risk but placed on general or intermittent observation for clinical reasons. The rationale for this will be recorded in the health record/ RIO, and care planned accordingly.

Cultural diversity must be respected at all times and must be carefully considered when a patient is placed on closer levels of observation. Wherever possible cultural needs must be discussed with the patient or the patients relatives, so that information and advice on cultural needs can be obtained. Gender of staff undertaking the observation must be a consideration.

6. Duties

Responsibility for the development, maintenance, review and ratification of this document lies within the **Director of Quality and Medical Director**. The Director of Quality has board level responsibility for the development of this document and may delegate this responsibility to a subordinate.

6.1 The Governance Committee

The Governance Committee will be notified when this policy has been approved by the Director of Quality and made aware of any amendments.

6.2 All In-Patient Staff

All inpatient staff who have contact with service users are responsible for delivering the policy correctly to ensure patient safety.

6.3 Core Tasks

On admission the patient will be assessed by both a Nurse and a Doctor and as admitting Nurse and Doctor they will jointly agree an initial level of 'observation' based on the identified levels of risk and the views of the referring clinician.

The patients needs will be considered and appropriate care plans developed which will include therapeutic activity and engagement, as well as detailing the level of observation.

The Nurse co-ordinating the shift is responsible for ensuring that adequate resources are available for implementing observations within the ward. In addition the Nurse co-ordinating the shift will also ensure that levels of observation are adjusted in response to changes in a patient's mental state, ward environment and when a patient receives unexpected and bad news in conjunction with the multi-disciplinary team.

7. Definitions

^{2}gether – ^{2}gether NHS Foundation Trust
ECtHR – European Court of Human Rights

Definitions of the x4 levels of Observation (NICE, 2005)

General observation is the minimum acceptable level of observation for all in-patients. The location of all patients should be known to staff, but not all patients need to be kept within sight. At least once a shift as a minimum, a nurse should set aside dedicated time to interact with each patient to assess their mental state and to positively engage. The aim of this should be to develop a positive, caring and therapeutic relationship with the patient. This interaction should always include an evaluation of the patient's moods and behaviours associated with risks of disturbed/violent behaviour and these should be recorded in the notes.

Intermittent observation means that the patient's location and safety must be checked every 15 to 30 minutes (exact times to be specified in the care plan and notes). Checks need to be carried out sensitively in order to cause as little intrusion as possible. However, this check should also be seen in terms of positive engagement with the patient. This level is appropriate when patients are potentially, but not immediately, at risk of disturbed/violent behaviour. Patients who have previously been at risk of harming themselves or others,

but who are in a process of recovery, require intermittent observation.

Within eyesight is required when the patient could, at any time, make an attempt to harm themselves or others. The patient should be kept within eyesight and accessible at all times, by day and by night and, if deemed necessary, any tools or instruments that could be used to harm self or others should be removed. It may be necessary to search the patient and their belongings while having due regard for the patient's legal rights and conducting the search in a sensitive way (refer to the Trust's policy on searching for further guidance). Positive engagement with the patient is an essential aspect of this level of observation.

Within arms length Patients at the highest levels of risk of harming themselves or others, may need to be supervised in close proximity. On specified occasions more than one member of staff may be necessary. Issues of privacy, dignity and the consideration of gender in allocating staff, and the environmental dangers need to be discussed and incorporated into the care plan. Positive engagement with the patient is an essential aspect of this level of observation.

8. Ownership & Consultation

Responsibility for the development, maintenance, review and ratification of this document lies within the **Director of Quality and Medical Director**; however this has been delegated to the Deputy Director of Nursing.
Each policy is sent to locality and clinical directors alongside a wider identified group of professionals for consultation. This will be for a one month period. This will then be notified to the Trust Governance Committee.
Where a review only results in very small changes to a policy or procedure there will be no formal consultation and the review will be uploaded on to the intranet and notified at the next update.

9. Ratification Details

The Director of Quality has the authority to ratify polices. This can be delegated to the Deputy Director of Nursing. The Governance Committee will be notified of any care practice policy reviews.

10. Release Details

Care Practice Policies are not routinely placed on the trust public website. Upon request most are available to members of the public if requested.
This policy is on the trust intranet under Clinical Policies/ Inpatients.

11. Review Arrangements

The policy will be reviewed every 2 years to ensure that it is contemporaneous to modern mental health care.

12. Process for Monitoring Compliance

To ensure compliance of this guidance an audit of the implementation of this document will be undertaken every two years, commissioned by the Director of Quality. This will involve auditing a random sample of in-patient clinical records. The audit criteria will include assessing compliance against the following standards.

- Duties
- Process for observation at differing levels

- Record Keeping

It is expected that all clinical records audited will comply with this guidance. The results of the audit will be presented to the Governance Committee who will be responsible for the development and monitoring of any identified actions within the scope of the audit.

Annual targets for staff attendance at statutory and mandatory training will be set and monitored routinely by the Delivery Committee, and will reflect the requirements identified within the Training Needs Analysis

13. Training

Training in this subject area is mandatory for inpatient practitioner staff.
This training will be delivered as part of local induction where staff will receive training in the trust observation policy.

14.0 Main body of policy/guideline.

14.1 Making Observation and Engagement Supportive

The service user (and/or carer) should be fully involved as far as possible in the decision to implement this aspect of care with an emphasis on maintaining as much personal responsibility and engagement as possible, taking into account any **Advance Statements/ Care Plans** the person may have made about his/her aspects of care. The reasons and practicalities of observation and any special restriction imposed should be fully explained to the individual and documented within the care plan.

A capacity assessment should be completed where there are concerns about a person's ability to understand, consider and weigh up information relating to the planned observation level and what this means. Where a capacity assessment identifies a lack of capacity in this area of decision making, then the observations and associated tasks will be care planned in the best interests of the person.

NB: a person's relatives/significant others have a legal right to be consulted on the best interest decisions for a person who lacks capacity. (See Trust MCA policy, procedures and guidance).

The clinician should also use this time with the service user to ascertain if the service user understands what is involved and answer any questions the service user may raise. This would be documented within the care plan on RIO or equivalent.

All attempts should be made to engage the service users regarding the intervention, whether the person has capacity to consent or not to the intervention.

However, at times it is recognised that one-to-one discussion is difficult to achieve due to the service users clinical presentation. All attempts at engagement regarding the decision should be documented on RIO or equivalent.

14.2 Procedure for Observation

Observations are an opportunity to develop rapport and a positive therapeutic relationship. Observers must have consideration for personal needs, be sensitive and responsive to fluctuations in mental state, promote adaptive coping and engagement in activities, monitor interactions between patient and family members and record functions such as sleeping, eating and drinking. The underlying general principle is that staff are expected to know where patients are at all times. To support this overall principle there are formalised observation levels and procedures as outlined below.

- On admission the patient will be assessed by both a Nurse and a Doctor. Note key findings from Inpatient suicide Inquiry (appendix 6) which highlight increased risks in the first 7 days of admission.

- The admitting staff will identify any risk behaviours (risk to self, others and self neglect) and the associated level of risk. This will involve identifying actuarial indicators and clinical indicators. Actual levels of violence should be recorded using the Assaultive Rating Scale (Lanza, 1991) as follows :-

    1. Threat of assault but no physical contact
    2. Physical contact but no physical injury
    3. Mild soreness / surface abrasion / scratches / small bruises
    4. Major soreness / cuts / large bruises
    5. Severe lacerations / fractures / head injury
    6. Loss of limb / permanent physical disability
    7. Death

- Appendix 3 (taken from Nice 25, p39) describes possible antecedents for future disturbed behaviour and indicates where observation levels above general level should be considered.

- The need for observation depends on a balanced judgement taking into account the complete mental health assessment including risk assessment, the wishes of the patient, principles of promoting autonomy/responsibility, positive risk taking and the possible beneficial and adverse effects of close observations.

- The admitting Nurse, Doctor (and where possible referring agent) will jointly agree an initial level of ‘observation’ based on the identified levels of risk. (see Appendix 1 for NICE guidance on how risk levels relate to the x4 nationally agreed levels of observation).

- Where the members of the clinical team have differences of opinion upon an observation level then all efforts should be made to negotiate an agreement and this should be escalated to the clinical lead for the team in order for an agreed plan to be identified. .

- Registered Nurses are professionally responsible / accountable for the implementation of observations. They can delegate responsibility to competent non-registered colleagues who have undertaken appropriate training.

- Particular care should be taken when delegating observation duties to students and also to temporary staff. Students who have received appropriate training may take part in undertaking observations, however only third year students can undertake visual and arms reach observations. Half of all inpatient deaths occur when observation is carried out by less experienced staff or staff unfamiliar with the patient (appendix 6). However we should not be complacent with lower observation levels as 91% of Inpatient deaths occur during intermittent observations (see appendix 6). The best scenario is that close observations will be undertaken by regular, permanent staff who have rapport and are clinically up to date with risks and care plans. In the absence of permanent staff, regular bank staff with rapport and knowledge of the service user will be used.

- All clinical staff are responsible for ensuring observations levels are regularly reviewed and recorded in the Nursing Care Plan, in particular the Named Nurse who will ensure that reviews are taking place. Normally reviews will take place during multi-disciplinary meetings and all levels of observation above *General observations* should be reviewed at least weekly.

- Observation levels are 'handed over' at every shift change (see Appendix 5 for example handover sheet). Should a level of observation prove to be counterproductive and in need of being reduced then the Nursing team should agree such a decision during a handover period. All decisions and rationale should be recorded and in accordance with Trust's Clinical Risk Assessment and Management procedures.

- Wherever possible decisions to increase / decrease observations should be made following multi-professional discussions. There will however be times particular during unsociable hours and in more isolated units when this may not be possible and a prompt unilateral nursing decision may be required.

- The evidence suggests that when a patient is placed on 1:1 Observations, a review of that level of observation should be undertaken daily by the Nursing team and by the MDT within 72 hours. (Gleary, 1999)

- Where possible the Patient should be involved in the development of their care plans and any level of observation prescribed. In circumstances where this is not appropriate, for example where a person does not have capacity (see section 14.1), or where the person has capacity but there are reasons it would be detrimental to the person to be involved, the team may make a decision not to do so. The rationale for this decision should be recorded.

- The Nurse co-ordinating the shift is responsible for ensuring that adequate resources are available for implementing observations within the ward. In addition the Nurse in Charge will also ensure that levels of observation are adjusted in response to changes in a patient's mental state, ward environment and when a patient receives unexpected and bad news.

- Any unresolved staffing issues should be reported to the Modern Matrons/Lead Nurses, nominated deputy or on call manager as an absolute last resort.

- Where 15 minute observations or higher (up to 1:1) have been prescribed then a Record of Observation Form (Appendix 2) should be maintained. Some wards at Charlton Lane , Stonebow, Hollybrook and Westridge find it useful to incorporate a 'RAG' rating into the recording of observations to look for patterns in behaviours displayed. This can be helpful for people with dementia and learning disabilities. Once completed the RAG record should be filed in the health record.

- It is important to balance safety, privacy and dignity in toilet, bathroom and bedroom areas both to promote privacy and to reduce conflict. Evidence suggests that Observation levels are frequently and unofficially reduced whilst a patient is in a toilet or bathroom area. All decisions to reduce the prescribed level of Observation in these scenarios should be recorded with the rationale. It is important to note that the most common room used for suicide is the patient's bedroom and the most common method is by hanging (appendix 6).

- Before commencing any period of observation and engagement the observer must be given clear verbal information detailing the specific risk e.g. suicide or aggression, the level of observation required, any particular risk factors or safeguards which may be necessary and any behaviour patterns that may warn of changing mood, the current mental state of the patient and any interventions which have proved effective in the past.

- Avoid use of jargon in communication with patients – use of language such as 'you are on obs' or 'you are on level 3' can be confusing and unhelpful. It is preferable to use ordinary language in describing the specific arrangements

- Ideally the nurse responsible for carrying out observations will know the patient, The staff member will understand the patients Nursing care plans including known risk factors and will have received training in the undertaking of 'observations'. This training should be included in all ward / unit inductions programmes and applies to all disciplines.

- ^{2}gether Trust advocates that staff should not undertake 1:1 observations for greater than one hour and ideally between 30 mins to 1 hour. Staff should then have a break from undertaking 1:1 observations for at least an hour.

- Undertaking of patient 'Observation' is an opportunity for engagement to take place but must be balanced with ensuring patients are not subject to 'over interaction' as a result of being under high levels of observation. 'Intentional rounding' where observations are combined with a brief 'how are you?' How are you feeling? Do you need anything?' is an ideal method of making observations more interactive and making a brief mental state examination.

- At times staff from professional groups other than Nurses will assume responsibility for the patient e.g. Occupational Therapist when engaged in therapy programmes. Any staff member undertaking observations must receive training in 'Inpatient Observation'.

- During a night shift, patients within the Wotton Lawn, Charlton Lane and Stonebow Unit will be observed hourly. This is a minimum standard. A number of units including some Specialist Services are of a residential or rehabilitative nature. Patients residing within those units may have observations set at a level lower than this, following appropriate assessment of

risk and risk taking procedures. Any deviation away from traditional levels / methods of observing service users must be fully discussed within the MDT and rational for decisions made fully recorded.

- Observational levels should be immediately reviewed post restraint, particularly if the service user has received rapid tranquilisation medication (refer to the Trust's policy on control and restraint for further guidance).

- If during the undertaking of prescribed observations a patient is discovered to be missing, a thorough search of the immediate environment must be undertaken. This involves checking all rooms within the ward/unit paying particular attention to "blind spots" within rooms e.g. behind doors, underneath beds, in wardrobes/cupboards etc, before widening the search throughout the hospital/unit. When staff are satisfied that the patient is not on site, the *"Guidelines/Procedure for Missing Persons (AWOL and Absconded Patients)"* should be instigated. A half of all Inpatient deaths under constant observation occur off the ward after absconding (appendix 6).

14.3 Regard for Staff Undertaking Observation and Engagement

There must be due regard for observing staff, not exposing them to situations that may have an impact on their health. The Shift Co-ordinator should assess the situation and take some possible actions to support the staff. For example, when observing a highly distressed patient the shift co-ordinator should consider allocating qualified staff. If this is not possible the shift co-ordinator should consider allocating regular non-qualified staff preferably for a shorter observation period.

No continuous period of observation of any individual patient, particularly for those at close levels by a member of staff should be longer than 1 hour.

At the end of each constant observation period, the nurse should have a break from enhanced observations of at least an hour.

The Shift Coordinator and ward managers need to support staff involved in this difficult and demanding task.

14.4 Record Keeping

All decisions taken concerning the application of observation as described above will be documented within the clinical record, particular reference is made to the following:

Where 15 minute observations or higher (up to 1:1) have been prescribed then a Record of Observation (Appendix 2) should be maintained. Once completed the supervision record should be filed in the clinical record.

Should a level of observation prove to be counterproductive and in need of being reduced then the Nursing team should agree such a decision during a handover period, involving other disciplines as required. All decisions and rationale should be recorded and in accordance with Trust's Risk Assessment Procedures.

14.5. Supporting Engagement Activities

Good practice dictates that a programme of structured individual and group activities should be available to service users as part of any care plan and therapeutic milieu. These alternative risk management and engagement strategies could preclude the need for enhanced observation.

Within [2]gether NHS Foundation Trust inpatient facilities patients are offered 1:1 time with allocated nurse per shift. Additionally all inpatients have an individual activity programme.

All inpatients are subject to 'general observations' as a minimum level and therefore the patient / environment checklist (appendix 4) formalises checks and recording throughout the 24 hour period. These checks are an opportunity for interaction and therapeutic engagement during 'walkrounds' at handover times and during medication rounds.

2gether trust endorses the use of "Safewards" and anti-absconding measure to increase rapport, engagement, to reduce risks and subsequently levels of observation.

14.6 Deprivation of Liberty Safeguards

The use of observations in a mental health hospital which allows the monitoring of a person's whereabouts at all times constitutes continuous supervision and control. Where a person is not subject to the MHA and the person lacks capacity to consent to being in hospital for the purpose of receiving care and treatment, a DoLS authorisation will need to be considered. The DoLS were incorporated in the MCA to ensure that there is a procedure for authorising deprivation of liberty in hospitals and care homes for adults who lack capacity to consent to admission or treatment for mental disorder.

The Supreme Court ruling of 2014 identified that there will be a deprivation of liberty if a person is under continuous supervision and control and is not free to leave, and the person lacks capacity to consent to these arrangements. (Supreme Court 2014). If a deprivation of liberty is necessary, it can only be authorised by a procedure set out in law, which enables the lawfulness of that deprivation of liberty to be reviewed. Legal authority to deprive the person of their liberty may be obtained under the Deprivation of Liberty Safeguards (DoLS) in the MCA or the MHA. Each regime provides a procedure to authorise deprivation of liberty. Ref: [2]gether Trust MCA & DoLS policy, procedure and guidance.

15. References

Betteridge, C. (2015) Promoting service user satisfaction in close observations. Mental Health Practice Journal. May 2015, Vol18, No8.

Department of Health (1999) Practice Guidance: Safe and Supportive Observation of Patients At Risk, Standing Nursing and Midwifery Advisory Committee

Department of Health (2006) Violence: Short term management of disturbed/violent behaviour. National Institute of Clinical Excellence

Lanza M, Cambell R (1991) Patient Assault: A Comparison of Reporting Measures, Quality Assurance,5,60-68

National Confidential Inquiry into suicide and homicide by people with Mental Illness March 2015

National Institute of Clinical Excellence (2005) The Short Term Management of Disturbed Behaviour in Psychiatric in-patient settings and emergency departments. NICE clinical guidance no.25

National Institute for Mental Health England (2004) Mental health Policy Implementation Guide: Developing Positive Practice to Support the Safe and Therapeutic Management of Aggression and Violence in Mental Health In-patient Settings

[2]gether NHS Foundation Trust documents:
Policy and Procedure for Reporting Incidents (including the Management of Serious Untoward Incidents
Health & Social Care Records Policy
Guidelines/Procedure for Missing Persons (AWOL and Absconded Patients)"
Clinical Risk Assessment & Management policy
[2]gether MCA & DoLS policy, procedure and guidance (2015)

15. Associated Documentation

Equality Impact Assessment for this policy
Training Needs Analysis

Appendix 1 – Risk Categories / suggested observation levels (NICE 25, p37-38)

Identified Risk Level	Suggested National Level of Observation	Implementation Detail
Low (Little or no risk)	'General Observations' Level 4 (See appendix 4(a) & 4(b) for local recording form)	The minimum acceptable level of observation for all in-patients. The location of all service users should be known to staff, but not all service users need to be kept within sight. At least once a shift a nurse should set aside dedicated time to assess the mental state of the service user and engage positively with the service user. This assessment should always include an evaluation of the service user's mood and behaviours associated with risks of disturbed behaviour.
Medium Risk	'Intermittent Observations' Level 3 (See appendix 2 for local recording form)	The service user's location should be checked every 15 to 30 minutes (exact times to be specified in the notes). This level is appropriate when service users are potentially, but not immediately, at risk of disturbed/violent behaviour. Service users who have previously been at risk of harming themselves or others, but who are in a process of recovery, require intermittent observation
High Risk	'Eyesight' Level 2 (See appendix 2 for local recording form)	The service user should be kept within eyesight and accessible at all times, by day and by night and, if deemed necessary, any tools or instruments that could be used to harm themselves or others should be removed. It is required when the service user could, at any time, make an attempt to harm themselves or others. It may be necessary to search the service user and their belongings, while having due regard for the service user's legal rights and conducting the search in a sensitive way.
High Risk	'Arms Length' Level 1 (See appendix 2 for local recording form)	Needed for service users at the highest levels of risk of harming themselves or others, who should be supervised in close proximity. On specified occasions more than one member of staff may be necessary. Issues of privacy, dignity and the consideration of gender in allocating staff, and the environmental dangers need to be discussed and incorporated into the care plan. Positive engagement with the service user is an essential aspect of this level of observation.

Appendix 2

PATIENT'S NAME: (PAS Label)

RECORD OF OBSERVATIONAL ENGAGEMENT

Date ……

This form should be used where a level of observation of 15 minute checks or higher has been prescribed. The care plan must detail the frequency of observations and whether they are within eye contact or within arm's reach. Any exceptions for example discretion in the bathroom or at night when in bed must be discussed with MDT and recorded in care plans. Be mindful of reductions of observations at night as bedrooms are the most high risk environment. RAG rating is not essential however recording may be appropriate at times to evaluate patterns/ times and antecedents to behaviours.

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07.30				
07.45				
08.00				
08.15				
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COMPLETED SHEETS TO BE FILED IN THE HEALTH RECORD

Appendix 3 (Nice Guidance 25, p39)

Possible antecedents or warning signs that observation above general level is required

Observation above a general level should be considered if any of the following are present:

- history of previous suicide attempts, self-harm or attacks on others
- hallucinations, particularly voices suggesting harm to self or others
- paranoid ideas where the service user believes that other people pose a threat
- thoughts or ideas that the service user has about harming themselves or others
- threat control override symptoms
- past or current problems with drugs or alcohol
- recent loss
- poor adherence to medication programmes or non-compliance with medication programmes
- marked changes in behaviour or medication

Appendix 4(a)

GENERAL OBSERVATIONS SERVICE USER & ENVIRONMENT CHECKLIST

Room No.	Name	AM	8:00	12:00	PM	18:00	Night	22:00
1								
2								
3								
4								
5								
6								
7								
8								
9								
10								
11								
12								
Dining Room	Kept tidy							
Bathroom	No toiletries, skip emptied, inc. new bag							
Day Room	Bins and papers emptied No cups							
Kitchen	Clean & tidy sides Supply tea/coffee & sugar							
	Staff Signature							

COULD STAFF PLEASE ENSURE THAT PATIENTS ARE PRESENT AND RESPONSIVE E.G. BREATHING, & VERBAL RESPONSE ETC.

X = WHERABOUTS UNKNOWN
O/L = ON LEAVE
TICK = ON WARD

Appendix 4 (b) General Observations Sleep Chart Date:

Room	Name	23:00	00:00	01:00	02:00	03:00	04:00	05:00	06:00
Rm 1									
Rm 2									
Rm 3									
Rm 4									
Rm 5									
Rm 6									
Rm 7									
Rm 8									
Rm 9									
Rm 10									
Rm 11									
Rm 12									
Rm 13									
Rm 14									
Rm 15									

SIGNED:…… DATE:…….

SIGNED: …… DATE: ……..

Appendix 5 – Handover sheet

(Please fill all fields out accurately and file securely for future clinical reference)

Date:…… **Shift (Please Circle)… E L N** **Shift Co-Ordinator:**…… **DEFIB BLEEP**……

Staff on previous shift:- …… **PMVA Bleep** ……

Staff taking over shift:- …… **MERT Bleep (or ILS for Stonebow**……

Number of empty beds:-…… **Number of MERT staff:-**…… **Number of PMVA staff:-**…… **FIRE WARDEN**……..

PATIENT SAFETY WALK ROUND:NURSE 1…… **NURSE 2**……

CLINIC FRIDGE TEMPERATURE A.M. **PAGERS…**…. **(please tick/or state how many……..**

Name & MHA /DoLS status	Risk Levels (L,M,H)	Obs Level	Leave Status	Physical Problems	Progress Summary (also refer to RIO progress summary, RIO green folder and Care Plans where necessary)	Outstanding Actions
	☐ Suicide ☐ Violence ☐ Self Harm ☐ Self Neglect ☐ Wandering ☐ Absconding ☐ Vulnerability ☐ Fall					
	☐ Suicide ☐ Violence ☐ SelfHarm ☐ Self Neglect ☐ Wandering ☐ Absconding ☐ Vulnerability ☐ Falls					

Appendix 6

Key Findings from National Confidential Inquiry into suicide and homicide by people with Mental Illness March 2015

1) There were on average 18 suicides by in-patients under observation per year in the UK over a 7 year study period. Ninety-one percent of deaths under observation occurred under level 2 (intermittent) observation.

2) Compared to in-patient suicides generally, patient suicides under observation were associated with personality disorder, alcohol and drug misuse, detention under mental health legislation and death in the first 7 days following admission.

3) A third of suicides under observation occurred off the ward. The commonest location for a death by suicide on the ward was the patient's bedroom and the most frequently used method was hanging.

4) Deaths under observation tended to occur when policies or procedures (including times between observations) were not followed, for example:

(a) when staff are distracted by other events on the ward
(b) at busy periods e.g. 7-9am
(c) when there are staff shortages
(d) when ward design impedes observation.

5) Half of deaths occurred when observation was carried out by less experienced staff or staff who were likely to be unfamiliar with the patient (e.g. health care assistants or agency staff).

6) Half of the deaths under constant observation occurred off the ward after absconding and were associated with a breach of procedure.

7) Patients have mixed views about observation, some describing the process as intrusive and some as protective.

8) Staff often do not see the purpose of observing the patient or how it links to the overall plan of risk management. They view the decision to start or stop observation as influenced by staffing levels and resources.

9) There is an increase in self harming and suicidal behaviour during busy times in the ward e.g. handover times.

Daily Observations

We observe you throughout the day and evening to make sure you are safe. We will make a note of what you are doing and where you are at particular times.

When observations are made when you are in bed, one of our nurses will take a quick look into your room to see if you are ok. We will try to make sure that you are not disturbed when this happens.

If you are awake and would like to speak with someone the nurse will arrange this for you – just ask.

Visitors

You may want friends and family to visit you during your stay with us. Visiting times are between 9.00am to 9.30pm everyday.

Sometimes it is difficult for your visitors to come to the hospital at certain times. So if that happens, we will try to be as flexible as possible.

We also ask that:

- your visitors try to avoid visiting during meal times, handover times and at times when therapies and activities are taking place.
- you try and plan any visits around any treatment programme you are taking part in.
- your visitors must leave the ward by 9.00pm
- all children under the age of 16 are supervised by an accompanying adult at all times

Please speak to a member of the nursing staff if you would like to meet with your visitors in a room off the ward. We will do all that we can to make a room available for you to use however at times, this may not be possible.

Leave

All leave from the ward needs to be negotiated and planned with the multidisciplinary team. Your named nurse will provide you with a copy of your **Leave Care Plan** that will state the conditions of any leave from the ward.