NHS Tayside has now considered your request dated 16 April 2019.

Extract from Request
“Please provide copies of all protocols, procedures, and guidance notes that were in issue between 1 January 2013 and today's date that relate or refer to the observation of patients voluntarily detained in open psychiatric units and in respect of whom there is a risk of suicide.”

Response
The following information is for the observation of patients within NHS Tayside In-Patient Mental Health and Learning Disability (LD) Services.

All staff within NHS Tayside Mental Health Services follow guidance contained in NHS Tayside Nursing and Midwifery Patient and Engagement Policy, this relates to all patients admitted to Mental Health & LD Wards. The policy was established in 2010 with regular review.

The latest review period has been extended until August 2019 to enable work to progress nationally on new guidance ‘From Observation to Intervention Framework’. The policy will be updated accordingly when this work is completed.

Please see the following documents appended below:
Appendix 1 - Patient Observation and Engagement Policy.
Appendix 2 - The second attachment is the Good Practice Statement of 2002 referred to in the above policy.


<table>
<thead>
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<th>Document Ref.</th>
<th>FOISA Exemption Applied</th>
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<tr>
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Under section 20 (1) of the Act, if you are dissatisfied with the way NHS Tayside has dealt with your request, you have a right to request a review of our actions and decisions in relation to your request, and you have a right to appeal to the Scottish Information Commission.

A request for an internal review must be made in writing no later than forty working days from receipt of this response and addressed to:

Tayside NHS Board Secretary  
Tayside NHS Board Headquarters  
Ninewells Hospital & Medical School  
Dundee  
DD1 9SY

If you are not content with the outcome of the internal review, you have the right to apply directly to the Scottish Information Commissioner for a decision. The Scottish Information Commissioner can be contacted at:

Scottish Information Commissioner  
Kinburn Castle  
Doubledykes Road  
St Andrews  
Fife  
KY16 9DS

Or via the online appeal service: www.itspublicknowledge.info/Appeal

If you have any queries about this correspondence, please contact:

Information Governance Team  
Maryfield House  
30 Mains Loan  
Dundee  
DD4 7BT

Telephone - 01382 424413  
E-mail: informationgovernance.tayside@nhs.net

Information Governance  
NHS Tayside  
6 May 2019
Nursing and Midwifery

PATIENT OBSERVATION AND ENGAGEMENT POLICY

<table>
<thead>
<tr>
<th>Policy Manager</th>
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<tr>
<td>James Kennedy</td>
<td>Mental Health Services</td>
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<th>Last Updated</th>
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This policy does / does not apply to Medical/Dental Staff (delete as appropriate)

UNCONTROLLED WHEN PRINTED
## Patient Observation and Engagement Policy

### Version Control

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<td>James Kennedy</td>
<td>21/10/14</td>
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<td>V3.0</td>
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Version Control was introduced in July 2011 and previous versions of this Policy, prior to this date, are available in the Electronic Document Store.
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Appendix 1 – Identified Risk Factors for Prescription of Constant/Special Observation & Record of Review of Observation Level

Appendix 2 – Observation Level Data Sheet

Appendix 3 – Nursing Observation Policy Information for Patients and Carers

Appendix 4 – Learning Disability Group Observation
Patient Observation Policy—Staff Interview Schedule
Patient Observation Policy Audit—Patient Record Schedule
Equality Impact Assessment
Policy/Strategy Approval Checklist
POLICY STATEMENT

The purpose of this policy is to set standards of nursing observation.

It is essential that the following text is read in conjunction with “Engaging People: Observation of People with Acute Mental Health Problems: A Good Practice Statement” 2002.

The Nursing Team are responsible for the management of prescribed observation levels. However, with the emphasis on multi-disciplinary working and the increased role of users and carers contributing to service delivery, it is essential to recognise the role that many disciplines, carers and users have in patient observations.

This Policy was reviewed by management team across NHS Tayside Mental Health Services in November 2012.
PREFACE

The level of observation is determined by the presenting psychiatric condition and behaviour of the patient as assessed by available risk assessments. In line with the principles of the Mental Health Care and Treatment (Scotland) Act 2003 the level of observation will be the least restrictive required to safeguard the well-being of the patient and/or others.

All patients in hospital receive observation by nursing staff. However, on occasion, and for many reasons, a patient may require a higher level of observation in order to safeguard the well-being of the patient and/or others.

When prescribing observation levels staff will take into account the requirements of equality and diversity legislation, and in particular:

- appropriate arrangements will be made to accommodate any cultural or religious beliefs held by the patient
- interpreter services will be accessed to ensure that patients and/or carers whose do not speak English are given appropriate information about the prescribed observation
- gender preferences will be considered when selecting staff to undertake observation
- appropriate arrangements will be made to deal with any disability issues experienced by the patient

The decision on the level of observation required is formalised in a prescriptive manner and will involve all nursing/medical staff within the ward. Patient observations will be prescribed at one of three levels:

1. General
2. Constant
3. Special
PSYCHIATRIC OBSERVATION - DEFINITIONS

GENERAL OBSERVATION

The general level of observation is intended to meet the needs of most patients for most of the time. It should be compatible with giving patients a sense of responsibility for their use of free time in a carefully planned and monitored way. **The nurses on duty should have knowledge of the patients’ general whereabouts at all times, whether in or out of the ward.** This could be achieved e.g. by establishing a patient allocation system whereby the Nurse in Charge of the Ward would be kept informed of each patient’s whereabouts. There are other methods considered to be good practice in determining the whereabouts of patients such as roll call books, General Observation sheets and signing in/out sheets, each area should determine which method works best for their environment and patients.

Specific checks should be carried out at mealtimes, during medicine rounds and at shift changeover times, or at other appropriate intervals as agreed by the clinical team.

Patients on general observation should be considered not to pose any serious risk of harm to their self or others and as being unlikely to leave the ward area or other treatment departments without prior permission, escort, or at least informing nursing staff of their planned destination.

Limits set may include agreements relating to a patient’s accompanied or unaccompanied time out of the ward. Any designated appropriate member of the clinical team and/or responsible family member may provide accompanied time out of the ward. Limits may also include agreements based on distance, geographical location and/or by limit of time. Any limits set should be determined in conjunction with the patient, documented and updated in the care plan.

CONSTANT OBSERVATION

The constant level of observation should be used for patients considered to pose a significant risk to their self or others. **An allocated member of staff should be constantly aware at all times of the precise whereabouts of the patient through visual observation and/or hearing.** The hearing method of observation is only to be used as the primary method of observation when personal privacy is required. Respect for privacy should be an important consideration, but a balance should be struck on the side of safety in all matters such as escorting to the toilet, bathroom, or public telephone, etc.

**Constant observation does not mean that in all situations one nurse is required to observe one patient at all times.** Where agreed by the multi-disciplinary team a single designated nurse can supervise a maximum of three clients in a single area, eg dining room, TV lounge. **Should a patient wish, or require, to leave the area then an additional designated member of staff should supervise them.** The multi-disciplinary team should identify circumstances/areas of the ward where one nurse can observe the patient along with other patients. **Any decision reached by the multi-disciplinary team should be recorded in the care plan.** The patient will normally only be permitted to leave the ward or other clinical area in the company of an escorting nurse or other informed professional worker, or appropriate relative.

These observations need to be safe and therapeutic and consideration needs to be given to the use of: activity; distraction: and discussion processes as well as the recognition that there may be times where there is the need for a quiet and relaxed atmosphere.
This level of observation will be and is subject to review every 24 hours and will involve the Ward’s nursing and medical teams.

**Permanently Locked Wards**

Where Wards are permanently locked, and there are some modest additional security facilities in these Wards, patients who would be under constant observation because of problems of absconding or wandering in the open ward setting, might be appropriately managed under general observation in these settings.

**SPECIAL OBSERVATION**

The special level of observation will generally be prescribed rarely.

The patient should be clinically assessed as requiring intensive and skilled intervention as a consequence of their very serious mental and/or physical state as they are deemed to be a high risk to their self or others.

**The patient should be in sight and within arms reach of a allocated nurse at all times and in all circumstances.** Considerations of privacy would be subordinated to those of safety.

In some situations more than one nurse may be required to carry out special observation. In the event of allowing the patient to leave the Ward whilst under special observation, this would necessitate a decision being taken by the Ward’s nursing and medical team to agree the number of appropriately trained escorts required to accompany the patient.

As this form of observation is potentially very intrusive, it should only be used when judged strictly necessary by the Ward’s nursing and medical team. This level of observation will be and is subject to review every 24 hours involving the Ward’s nursing and medical teams.

These observations need to be safe and therapeutic and consideration needs to be given to the use of: activity; distraction; and discussion processes as well as the recognition that there may be times where there is the need for a quiet and relaxed atmosphere.

A system should be in place for dealing with the increased demand on nursing resources which special observation creates. Only nurses familiar with the condition of the patient on special observation should normally be deployed on this demanding work.

**Nurses allocated to special observations should not undertake any other duty at that time except in emergency circumstances such as cardiac arrest, staff assault or Fire**

**Time Limitations (Staff within the Psychiatric Hospital Environment)**

The allocated member of staff should not undertake the constant or special observation of a patient for more than one hour at a time and should not return to observation duty until a further thirty minutes has elapsed. However as part of the therapeutic engagement process, and in particular where a patient is undertaking a therapeutic activity a nurse may undertake constant/special nursing to a maximum of 2 hours, this needs Multi-disciplinary agreement, and requires to be recorded on the risk management plan and in the case notes.
Similarly where there are risks associated with the patient or the patients' mental health presentation, the nursing team may deem it more appropriate for the allocated staff member/s to undertake the observation for less than an hour. If this is the case it should be clearly recorded in the patients risk management plan and case notes.

**MODIFIED CONSTANT/SPECIAL NURSING OBSERVATION**

There may be occasions where it is necessary to modify constant observations in achieving a balance between maintaining the patient's safety as well as promoting positive risk taking. **This should not be common practice.** The patient, relatives (if possible) and MDT should all be involved in the decision.

Any modification to the normal Constant/Special nursing procedure must be recorded clearly on the Identified Risk Factors for Prescription of Constant/Special Observations (Appendix 1) and within the patient’s Risk Management Plan. The Nurse in Charge of the Ward and the Responsible Medical Officer must sign both these documents.

The reason for any modification must be clearly stated, identifying the risk factors that prevent normal Constant/Special Observation being used.

Any modification is subject to review every 24 hours. Any exceptions to this need to be clearly recorded on the prescription sheet and in the patients notes, with the agreed alternative review date recorded.

Examples of reasons for modification are:

- **Learning Disability Service:**
  
  When it is necessary for a patient to be observed using constant observations, the staff member can observe by sound only, as repeated eye contact could result in an increased level of challenging behaviour.  
  Learning Disability: Group Observation (appendix 4)
  
  If it is necessary to vary a patient’s observation level during the day due to specific risks or challenging behaviours.

- **General Adult Psychiatry/Psychiatry Of Old Age**
  
  When it is necessary to place the patient under constant observation overnight prior to ECT due to the patient’s mental state, as they may not fast properly, thereby preventing the application of ECT treatment the following day.

**STAFF MANAGEMENT**

It is recognised that within the normal ward establishment there should be sufficient staff to undertake one increased patient observation (constant/special observation), however patient, self and others as well as ward environment needs to be taken into consideration for any increased observation.
Where increased staffing is required due to risk or the number of patients on increased observations then the following should be applied

- Clear concise risk management plans for each individual patients stipulating where and why increased staffing is required, positive risk taking and therapeutic engagement.
- Daily Multi-disciplinary review of all patients on increased observations
- Daily discussion with nurse management regarding need for increased staffing this should include updated risk assessment, risk management, environmental factors, positive risk taking, therapeutic engagement and exit strategy.

PATIENT TRANSFERRED TO GENERAL HOSPITAL WHILST IN THE CARE OF MENTAL HEALTH SERVICES: PATIENT ON CONSTANT/SPECIAL NURSING

It is the responsibility of the Mental Health Services to undertake these observations whilst the patient is in a General Hospital. However, due to the necessity for Mental Health Services staff to have a break during these long periods of observation it will be a requirement for General Nurses to undertake these observations during these times.

The following procedure must be followed in order that a General Nurse can undertake these observations during a break period.

- Copies of the Identified Risk Factors for Prescription of Constant/Special Observations, the Observation Level Data Sheet (Appendix 2) and Risk Management Plan is taken to the General Hospital.

- The Mental Health Services Nurse clearly explains to the General Nurse the duties that they must undertake during the break period e.g. constant observation is where they must be able to hear/see the patient at all times, special observation is where the patient must be within arms length at all times.

- It MUST be made explicit to the General Nurse that they are not allowed to undertake any other duties during this time of observation or leave the patient unattended for any reason.

- A record of this explanation should be recorded, signed, dated and timed within the Observation Level Data Sheet ‘Comments’ box at the time of handover.

THERAPEUTIC ENGAGEMENT

Observation of patients is a highly skilled activity and should be provided, based on principles of recovery and person centred care, by meaningful nurse-patient engagement. Patients need “organisation of therapeutic and recreational programmes” (Sainsbury Centre 1998), whilst accounting for their level of incapacity brought about by current ill health. When a patient is ill they continue to be able to make decisions about what affects them although it is acknowledged that illness may affect some judgements and thus the nurse should then employ skilled negotiation.

If a patient’s observation status is changed at any time it should be explained openly and honestly with the patient, as our aim is to gain trust. Employing transparency and encouraging collaboration with the patient can aid this.
All staff undertaking patient observations should undertake TESC (NES 2011) (ten essential shared capability) and/or Realising Recovery (SRN 2007) training or equivalent training in their speciality and practice recovery care planning/person centred care planning in order to promote person centred holistic care, and evidence “therapeutic and recreational activity designed to promote recovery” (MWC 2012).

Patients need to feel safe and therefore require staff to engage with them, communicate what is happening and what is likely to happen in an environment of mutual respect and privacy. Silence can breed fear, mistrust and hinder recovery. However, there may be occasions where a less stimulating, quiet and relaxed atmosphere may be deemed therapeutic e.g. when a patient is in a manic state.

Whilst under constant/special observation, patients should not be precluded from joining in activities in or out of the ward, and by being subject to therapeutic observation this must not restrict their day-to-day life whilst in hospital in any way.

Staff should consider patient’s feelings and wishes at all times and should encourage them to be self-determining regards their care and observation.

Observation employs care not custody and should be about “refocusing” (Dodds & Bowles 2001, 2002) towards that care and away from control.

**POLICY AUDIT**

An audit of patient’s case notes must evidence that any patient who is on higher level observations has:

- An up to date Risk Management Plan and Recovery Care Pan in place identifying their individual needs and interventions with evidence of positive risk taking and therapeutic activities

- engaged in at least one formal (e.g. 1:1 interview, group activity, recreational activity, structured therapy session) therapeutic activity on a daily basis

- been informed of any change in their observation status

- had their views and wishes, with regard to their observation status, recorded.
REFERENCES


ADDITIONAL READING MATERIAL

A Capability Framework for Working in Acute Mental Health Care –The values, skills and knowledge needed to deliver high quality care in a full range of acute settings NHS Education for Scotland 2008

Promoting Excellence: A framework for all health and social services staff working with people with dementia, their families and carers NHS Education for Scotland 2011

Realising Potential –An Action Plan for Allied health professionals in mental health NHS Scotland 2010

Realising Recovery –A National Framework for Learning and Training in Recovery Focussed Practice SRN 2007


The Ten Essential Shared Capabilities for Mental Health Practice: Learning Materials (Scotland) NHS Education for Scotland 2011

Working with people who have a Learning Disability and Complex Needs – the essentials NHS Education for Scotland 2011
PATIENT OBSERVATION PRESCRIPTION

• PRESCRIPTION

On admission, all patients and/or relatives will be provided with a verbal explanation and receive the Nursing Observation Policy Information for Patients and Carers leaflet (Appendix 3). If due to a patient’s cognitive impairment they are unable understand the verbal explanation/leaflet, this should be clearly recorded in the patients record. In this circumstance the patients’ relative/next of kin will be given the information, where there is a requirement for increased observations only.

When a patient's psychiatric condition indicates the use of either constant/special observation, the level will be decided by the Ward team, with the ward Doctor or prescribing nurse completing a Identified Risk Factors for Prescription of Constant/Special Observations and Record of Review of Observation Level in full. The reasons for level of observation must be documented.

Clear entry must be made in the Nursing/Medical notes (Integrated Care Pathway where in place) by the nursing/Medical staff, stating:

- The level of observation. e.g constant, special or constant under certain circumstances and special at other times.

- The reason for the patient’s observation level.

- The circumstance that would permit a reduction in observation level.

- The circumstances and risks that require the patient to have their movements restricted to a particular area.

- Specific details of nursing alerts, e.g. Suicide risk
  Fire risk
  Absconding Risk
  Risk of harm to self or others

- Those involved in the decisions taken regarding the patient's observation level.

- The necessity to remove certain patient belongings, eg razor/belt, or the need to modify their physical environment, eg removal of bedroom locker, due to the risk that the patient presents to themselves or others. This information also requires to be recorded within the patient's Risk Management Plan, highlighting the benefit of such procedures.

- That a Risk Management Plan will be developed which will describe all actions that are required to be taken to minimise the risk(s), including positive risk taking and will also include the planned therapeutic engagement during the period of observation. Where appropriate the patient/carer should be given the opportunity to be involved in the planning of their health and treatment needs, especially with regards to recognised techniques and therapeutic activities that will reduce their identified risk(s). Risk Management Guidelines are available to enable the risk assessment/management process
- Any Risk Management Plan should be used in conjunction with the patients individual Recovery Care Plan in order to promote a recovery focussed, person centred therapeutic holistic approach.

It is the responsibility of the Nurse in Charge of the Ward to notify the patient and all grades of staff in the Ward of the prescription of constant/special observation, or any change in the patient’s observation status.

**REPORTING**

It is the responsibility of all Mental Health Service staff who have undertaken a period of constant/special observation to inform the Nurse in Charge of the Ward of any changes to the individual patient’s mental health including the topics of conversations, their observations of the patient, any increase/decrease in identified risks and any therapeutic activity the patient has undertaken during that period.

**RECORDING**

Once a patient has been prescribed constant/special observation, the Observation Level Data Sheet must then be brought into use. The Nurse-in-Charge of the Ward will then delegate observation duties to appropriately trained members of staff.

A new psychiatric Observation Level Data Sheet will be initiated if the patient’s observation level increases or decreases between constant and special observations. A trained member of staff must countersign all student nurse signatures on Observation Level Data Sheets.

**REVIEW**

Nursing and medical staff will document the result of the review of observation levels within the 24 hour period using the Record of Review of Observation Level (within Appendix 1).

Where a patient has been placed on increased observations due to behaviours e.g. aggression, disinhibition associated with their cognitive impairment and is deemed non life threatening, and the behaviour is extremely unlikely to change due to the level of impairment, then a weekly review of the patient is acceptable. This should be clearly documented on the prescription sheet and in the patients’ notes/MIDIS.

**REDUCTION/DISCONTINUATION**

Both constant and special observation levels may only be reduced/discontinued by the Nurse in Charge of the Ward in accordance with the plan previously agreed by medical staff and the ward team. Medical staff must have a minimum of six months experience working in psychiatry. The circumstances under which the observation level can be reduced by the Nurse in Charge of the Ward must be recorded on the form “Identified Risk Factors for Prescription of Constant/Special Observation”.

The decision to reduce/discontinue either level of observation is based on clinical judgement. To ensure that the patient is not left on increased observations inappropriately, the Ward nursing and Medical team should plan ahead, particularly at the weekends, again clarifying the circumstances that would enable a reduction in the patient’s observation level.
Once the decision to reduce/discontinue has been taken, a clear entry must be made in the patient’s care plan by the nursing team. The Nurse in Charge of the Ward will then notify the patient and all staff of this decision.

The written entries in the patient’s notes (Integrated Care Pathway or MIDIS) must state:

- The time and date that the decision was taken to reduce/discontinue the patient’s observation level.
- The reason the decision was taken.
- Any relevant information regarding time out of the ward, etc.
- Names of nursing and medical staff involved in decision taken.

**PHYSICAL ENVIRONMENT**

The Senior Charge Nurse/Health and Safety System Workbook Holder will ensure that risk assessments of the physical environment are performed and adhere to Safety Action Notices.

**STAFF INDUCTION/TRAINING**

All new staff to the service, or bank staff who have not previously undertaken patient observations must read the Patient Observation and Engagement Policy, following this they will be asked a series of questions by the nurse in charge to acknowledge their understanding of the policy (appendix 3). These forms should be kept for audit purposes. **It is the responsibility of the nurses in charge to ensure that any new staff/bank nurse fully understands the policy and procedure for undertaking observations prior to commencing observations directly with patients.**

The undertaking of observations should not rely on this policy alone staff may require additional training to understand risk e.g. Management of Aggression training, Suicide Prevention Training, Dementia Related Training. It is also essential that all staff undertaking observations have received a ward report, in order to gain a better understanding of patients current mental state, triggers and potential responses to being under increased observations, in addition to this to understand other patient and environmental risks in the ward at that given time.

**STUDENT NURSES**

**Student nurses can only undertake patient observations as per Abertay and Dundee University Policy for Student Nurses 2014**

**AUDIT AND EVALUATION**

Adherence to this policy is mandatory. Audits will be undertaken in each locality across NHS Tayside Mental Health Services at agreed times using the audit tool contained within this Policy. (appendix 3)

**CLINICAL SUPERVISION**

Staff involved in observing patients on constant or special observation should have access to clinical supervision.
IDENTIFIED RISK FACTORS FOR PRESCRIPTION OF CONSTANT/SPECIAL OBSERVATION

(To be completed at each review)

PATIENT NAME

__________________________________________________________

DATE OF BIRTH/CHI

__________________________________________________________

HOSPITAL/WARD

__________________________________________________________

*CONSTANT/SPECIAL OBSERVATION (please delete as appropriate)*

NAME OF PERSON PRESCRIBING:

__________________________________________________________

NAME(S) OF ANY OTHERS INVOLVED IN DECISION:

__________________________________________________________

Please state the identified risk factors for prescription of constant/special observation; modified constant/special observation; or reasons for reduction to general observation:

PATIENTS PERCEPTION:


Circumstances under which observation the nurse in charge can reduce level:

Signature of Nurse: __________________________ Date: ________________

Signature of Medic: __________________________ Date: ________________

TO BE RETAINED IN PATIENT’S NURSING NOTES
# RECORD OF REVIEW OF OBSERVATION LEVEL

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<td>Observation Level</td>
<td>Reviewers Signature</td>
<td>Outcome</td>
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OBSERVATION LEVEL DATA SHEET

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<th>7</th>
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</thead>
<tbody>
<tr>
<td>Date</td>
<td>Allocated Nurse (Print Name)</td>
<td>Grade of Nurse on Duty</td>
<td>Time of Commencing Observation Duty</td>
<td>Signature of Allocated Person Commencing Duty</td>
<td>Time of Completion of Observation Duty</td>
<td>Evidence of therapeutic activities (e.g. 1:1 interview, Group session, recreational activities)</td>
</tr>
</tbody>
</table>

All Student Nurse signatures to be countersigned by First Level Nurse.

In constant observations, if a staff member's presence is not required due to a relative being present the relative's name should be recorded under column 2. Columns 4 and 6 should also be completed.

**PLEASE USE SEPARATE DATA SHEET FOR CONSTANT/SPECIAL OBSERVATIONS**
<table>
<thead>
<tr>
<th>Date</th>
<th>Allocated Nurse (Print Name)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Grade of Nurse on Duty</td>
</tr>
<tr>
<td></td>
<td>Time of Commencing Duty</td>
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<tr>
<td></td>
<td>Signature of Allocated Person Commencing Duty</td>
</tr>
<tr>
<td></td>
<td>Time of Completion of Observation Duty</td>
</tr>
<tr>
<td></td>
<td>Evidence of therapeutic activities e.g. 1:1 interview, Group session, recreational activities</td>
</tr>
</tbody>
</table>
The Ward Team is available to discuss any concerns you have regarding your care. This information leaflet was developed in conjunction with Penumbra.
Observation plays a very important part in the assessment and
treatment of mental health problems. For most people
admitted to hospital, nursing observation will be fairly
unobtrusive and easily accepted. However, some people may
need levels of observation which require Nursing Staff to be in
their company at all times. This is to ensure the safety and
wellbeing of the patient and others, a situation which some may
find difficult.

This information leaflet seeks to reduce any general concerns,
which you may have regarding the use of nursing observation.
Any specific queries regarding observations should be directed
to the Ward Nurses and Doctors who are responsible for the
care of patients.

Most patients admitted to hospital will receive General
Observation.

Patient safety and wellbeing is of high importance to nursing
staff, therefore they need to know the whereabouts of patients
at all times. Patients should inform staff of destinations prior to
leaving the ward. At times nursing staff may ask you to remain
in the ward for a period of time, or visits out of the ward will
be arranged in the company of staff or with particular friends
and relatives.

Additionally, periods out of the Ward may be limited by time
and/or distance. Nursing staff will explain the reasons as to
why this decision has been reached

On occasions, some patients may require extra observation for
a period of time. This is generally required to ensure the safety
and wellbeing of the patient and others. Two further levels of
observation are provided for this purpose.

**Constant Observation is used with patients who are
considered a significant risk to themselves and/or others.**
This level of observation requires that a Nurse be allocated to
keep you within their sight and/or hearing at all times. Personal
privacy, especially when using the toilet or bathroom, will
normally be respected, although particular circumstances may
require a Nurse to remain within sight – the reasons for this will
be explained to you. If you are to leave the Ward, it will usually
only be in the company of a Nurse, other health care
professional or your relative/carer.

**Special Observation is used with patients who are
considered a high risk to themselves and/or others.**
This level of observation is infrequently used and demands that
an allocated Nurse remains within arm’s reach of you at all
times, whatever you are doing.

Please remember that such limitations are in place due to
concern over your health.

The Ward Team (i.e. Doctors, Nurses and any other
appropriate professionals) review the observation levels for
each patient regularly.
PATIENT OBSERVATION AND ENGAGEMENT POLICY
NEW STAFF/BANK STAFF INTERVIEW SCHEDULE

All nurses involved in the observation of patients will verbally demonstrate full understanding of the Tayside Primary Care NHS Trust ‘Patient Observation Policy’.

<table>
<thead>
<tr>
<th>Ward</th>
<th>Date of Audit</th>
<th>Name of Auditor</th>
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</table>

**a.** Ask the nurse to describe their responsibility under the following categories of observation.

(i) General Observation

(ii) Constant Observation

(iii) Special Observation

**b.** Ask the nurse who has responsibility for the following.

(i) Determining an appropriate level of observation following admission/transfer

(ii) Increasing the level of observation

(iii) Decreasing the level of observation
c. Ask the nurse what their responsibilities are in relation to verbal and written communication.

Auditor’s Signature ........................................
NHS Tayside

PATIENT OBSERVATION AND ENGAGEMENT POLICY AUDIT

PATIENT RECORD SCHEDULE

**Standard Statement 2** – *Nursing records will demonstrate that decisions relating to observation levels are recorded and that all ‘Patient Observation Policy’ pro forma (Appendices 1, 2 and 3) have been completed for each patient following commencement of Constant modified constant or Special Observation.*

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<th>Ward</th>
<th>Date of Audit</th>
<th>Name of Auditor</th>
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</table>

a. Has the level of observation been assessed and recorded in the patients risk management care plan/s?

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<th>Ward</th>
<th>Date of Audit</th>
<th>Name of Auditor</th>
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</table>

b. Where Constant or Special Observation has been necessary, has the form ‘Identified Risk Factors for Prescription of Constant/Special Observations been completed for each patient?’

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<th>Ward</th>
<th>Date of Audit</th>
<th>Name of Auditor</th>
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<td>c.</td>
<td>Is there evidence within the continuation notes that the patient has been informed of a change in the Observation status and that their wishes and views in relation to this have also been recorded?</td>
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<td>d.</td>
<td>For each patient, has the level of observation been reviewed every 24 hours and recorded on the rear of the form ‘Identified Risk Factors for the Prescription of Constant/Special Observations’? Are the factors influencing decisions recorded in the care plan? Where there is an MDT agreement not to review every 24hrs is this clearly recorded on the Prescription</td>
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<td>e.</td>
<td>For each patient, has the ‘Observation Level Data Sheet’ been completed? Does it cover all periods where Constant or Special Observations have been prescribed</td>
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<td>f.</td>
<td>Has each patient and their carer been issued with the leaflet ‘Nursing Observation Policy’ – ‘Information for Patients and Carers’?</td>
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</table>
g. Has each patient have an Up to date Risk Management Plan and Recovery Care Plan in place identifying their individual needs and interventions with evidence of positive risk taking and therapeutic activities?

h. Does the Observation Data Level Sheet (Column 7) have evidence that the patient has engaged in at least one formal therapeutic activity on a daily basis?

Auditor’s Signature ……………………………
LEARNING DISABILITY GROUP OBSERVATION

Group Observation

Where is has been agreed at the multidisciplinary meeting that an individual requires increased level of observation, but does not require specific 1:1 observation as per Patient Observation and Engagement Policy, then group observation may be considered.

Group observation can only be implemented after agreement by the multi-disciplinary team and can only be for a maximum of 4 patients per staff member and only for a designated group activity which must be recorded on the prescription sheet and reviewed within the multi-disciplinary team meeting.

When considering group observation the following must be considered and recorded on the prescription sheet, individual risk management plan and case notes

- The number of individuals within the group
- The reason for consideration of group observation as opposed to increased observation
- The ability to relieve staff undertaking group observation for breaks/toilet breaks
- The maintenance of communication with staff member carrying our group observation
- Where the group activity is taking place
EQUALITY IMPACT ASSESSMENT

Manager
James Kennedy

Group
All Mental Health Services

Established
November 2012

Last updated
November 2016

Review / Expiry
November 2018

UNCONTROLLED WHEN PRINTED
Section 1 (This is mandatory and should be completed in all cases)

Part A – Overview

Name of Policy, Service Improvement, Redesign or Strategy:

Patient Observation and Engagement Policy

Lead Director of Manager:

Karen Ozden

What are the main aims of the Policy, Service Improvement, Redesign or Strategy?

Patient Safety and therapeutic engagement

Description of the Policy, Service Improvement, Redesign or Strategy –
What is it? What does it do? Who does it? And who is it for?

Observation and Engagement policy for all patients admitted to any mental health service in NHS Tayside, Policy stipulates observation levels for all patients admitted to hospital, level of observation based on risk to patient and/or others. The policy directs any member of staff to their responsibilities prescribing and undertaking observations

What are the intended outcomes from the proposed Policy, Service Improvement, Redesign or strategy? – What will happen as a result of it? - Who benefits from it and how?

To ensure that all patients are safe, that risk to themselves and/or others are minimised, that there is clear benefit for the patient placed under increased observations, and that they continue to receive therapeutic engagement at all times

Name of the group responsible for assessing or considering the equality impact assessment? This should be the Policy Working Group or the Project team for Service Improvement, Redesign or Strategy.

Responsibility is all mental health services
### SECTION 1 Part B – Equality and Diversity Impacts
Which equality group or Protected Characteristics do you think will be affected?

<table>
<thead>
<tr>
<th>Item</th>
<th>Considerations of impact</th>
<th>Explain the answer and if applicable detail the Impact</th>
<th>Document any Evidence/Research/Data to support the consideration of impact</th>
<th>Further Actions required</th>
</tr>
</thead>
</table>
| 1.1  | Will it impact on the whole population? Yes or No.  
If yes will it have a differential impact on any of the groups identified in 1.2.  
If no go to 1.2 to identify which groups | No this only effects patients admitted to psychiatric inpatient wards within NHS Tayside | see references and additional reading material contained in policy | None |
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<th>Item</th>
<th>Considerations of impact</th>
<th>Explain the answer and if applicable detail the Impact</th>
<th>Document any Evidence/Research/Data to support the consideration of impact</th>
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<tr>
<td>1.2</td>
<td>Which of the protected characteristic(s) or groups will be affected?</td>
<td>This effects all patients admitted to psychiatric inpatient wards within NHS Tayside who may or may not have one or more of these protected characteristics</td>
<td>see references and additional reading material contained in policy</td>
<td>None</td>
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<td>• Minority ethnic population (including refugees, asylum seekers &amp; gypsies/travellers)</td>
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<td>• Women and men</td>
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<td>• People in religious/faith groups</td>
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<td>• Disabled people</td>
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<td>• Older people, children and young people</td>
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<td>• Lesbian, gay, bisexual and transgender people</td>
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<td>• People with mental health problems</td>
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<td>• Homeless people</td>
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<td>• People involved in criminal justice system</td>
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<td>• Staff</td>
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<td>• Socio- economically deprived groups</td>
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<tr>
<td>Item</td>
<td>Considerations of impact</td>
<td>Explain the answer and if applicable detail the Impact</td>
<td>Document any Evidence/Research/Data to support the consideration of impact</td>
<td>Further Actions required</td>
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<td>1.3</td>
<td>Will the development of the policy, strategy or service improvement/redesign lead to</td>
<td>No this policy is designed to ensure equity and equality of patient care and treatment within all mental health setting</td>
<td>see references and additional reading material contained in policy</td>
<td>None</td>
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<td></td>
<td>• Discrimination</td>
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<td>• Unequal opportunities</td>
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<td>• Poor relations between equality groups and other groups</td>
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<td></td>
<td>• Other</td>
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</table>

No this policy is designed to ensure equity and equality of patient care and treatment within all mental health setting.

See references and additional reading material contained in policy.
SECTION 2 – Human Rights and Health Impact.  
Which Human Rights could be affected in relation to article 2, 3, 5, 6, 9 and 11.  (ECHR: European Convention on Human Rights)

<table>
<thead>
<tr>
<th>Item</th>
<th>Considerations of impact</th>
<th>Explain the answer and if applicable detail the Impact</th>
<th>Document any Evidence/Research/Data to support the consideration of impact</th>
<th>Further Actions required</th>
</tr>
</thead>
</table>
| 2.1  | On Life (Article 2, ECHR)  
• Basic necessities such as adequate nutrition, and safe drinking water  
• Suicide  
• Risk to life of / from others  
• Duties to protect life from risks by self / others  
• End of life questions | This policy aims to protect all patients admitted to psychiatric wards who may be at risk to themselves and/or others | see references and additional reading material contained in policy | None |
| 2.2  | On Freedom from ill-treatment  
(Article 3, ECHR)  
• Fear, humiliation  
• Intense physical or mental suffering or anguish  
• Prevention of ill-treatment,  
• Investigation of reasonably substantiated allegations of serious ill-treatment  
• Dignified living conditions | This policy sets out clear guidance on the appropriateness of observations, with clear guidance for staff in relation to observations and therapeutic engagement | see references and additional reading material contained in policy | None |
<table>
<thead>
<tr>
<th>Item</th>
<th>Considerations of impact</th>
<th>Explain the answer and if applicable detail the Impact</th>
<th>Document any Evidence/Research/Data to support the consideration of impact</th>
<th>Further Actions required</th>
</tr>
</thead>
</table>
| 2.3  | **On Liberty (Article 5, ECHR)**  
- Detention under mental health law  
- Review of continued justification of detention  
- Informing reasons for detention | There will be restrictions on liberty in relation to specific observations placed on any patient if they are a risk to themselves or others whether they are informal or detained under the mental health act. However there is specific guidance in relation to this within the policy | see references and additional reading material contained in policy | None |
| 2.4  | **On a Fair Hearing (Article 6, ECHR)**  
- Staff disciplinary proceedings  
- Malpractice  
- Right to be heard  
- Procedural fairness  
- Effective participation in proceedings that determine rights such as employment, damages / compensation | Not applicable | Not applicable | Not applicable |
<table>
<thead>
<tr>
<th>Item</th>
<th>Considerations of impact</th>
<th>Explain the answer and if applicable detail the Impact</th>
<th>Document any Evidence/Research/Data to support the consideration of impact</th>
<th>Further Actions required</th>
</tr>
</thead>
</table>
| 2.5  | On Private and family life (Article 6, ECHR)  
- Private and Family life  
- Physical and moral integrity (e.g. freedom from non-consensual treatment, harassment or abuse  
- Personal data, privacy and confidentiality  
- Sexual identity  
- Autonomy and self-determination  
- Relations with family, community  
- Participation in decisions that affect rights  
- Legal capacity in decision making supported participation and decision making, accessible information and communication to support decision making  
- Clean and healthy environment | This policy does not prevent relations with family, but limitations may be set with family due to the risks to the patient. The policy details this and information sheet about observation available to patient and family | see references and additional reading material contained in policy | None |
<table>
<thead>
<tr>
<th>Item</th>
<th>Considerations of impact</th>
<th>Explain the answer and if applicable detail the impact</th>
<th>Document any Evidence/Research/Data to support the consideration of impact</th>
<th>Further Actions required</th>
</tr>
</thead>
</table>
| 2.6  | On Freedom of thought, conscience and religion (Article 9, ECHR)  
• To express opinions and receive and impart information and ideas without interference | Not applicable | Not applicable | Not applicable |
| 2.7  | On Freedom of assembly and association (Article 11, ECHR)  
• Choosing whether to belong to a trade union | Not applicable | Not applicable | Not applicable |
| 2.8  | On Marriage and founding a family  
• Capacity  
• Age | Not applicable | Not applicable | Not applicable |
| 2.9  | Protocol 1 (Article 1, 2, 3 ECHR)  
• Peaceful enjoyment of possessions | Possessions may be temporarily removed from patient if the place the patients at risk to themselves and or others at a time of increased observations | see references and additional reading material contained in policy | None |
## SECTION 3 – Health Inequalities Impact
Which health and lifestyle changes will be affected?

<table>
<thead>
<tr>
<th>Item</th>
<th>Considerations of impact</th>
<th>Explain the answer and if applicable detail the Impact</th>
<th>Document any Evidence/Research/Data to support the consideration of impact</th>
<th>Further Actions required</th>
</tr>
</thead>
</table>
| 3.1  | What impact will the function, policy/strategy or service change have on lifestyles? For example will the changes affect:  
• Diet & nutrition  
• Exercise & physical activity  
• Substance use: tobacco, alcohol or drugs  
• Risk taking behaviours  
• Education & learning or skills  
• Other | Impact of this policy is too reduce risk and minimise risk taking behaviours, therapeutic aspect of policy to promote daily life | see references and additional reading material contained in policy | None |
| 3.2  | Does your function, policy or service change consider the impact on the communities? Things that might be affected include:  
• Social status  
• Employment (paid/unpaid)  
• Social/family support  
• Stress  
• Income | Policy only impacts inpatients to service, not the wider community | None | None |
<table>
<thead>
<tr>
<th>Item</th>
<th>Considerations of impact</th>
<th>Explain the answer and if applicable detail the Impact</th>
<th>Document any Evidence/Research/Data to support the consideration of impact</th>
<th>Further Actions required</th>
</tr>
</thead>
</table>
| 3.3  | Will the function, policy or service change have an impact on the physical environment? For example will there be impacts on:  
• Living conditions  
• Working conditions  
• Pollution or climate change  
• Accidental injuries/public safety  
• Transmission of infectious diseases  
• Other | Not applicable | Not applicable | Not applicable |
| 3.4  | Will the function, policy or service change affect access to and experience of services? For example  
• Healthcare  
• Social services  
• Education  
• Transport  
• Housing | This policy is used in conjunction with other mental health policies, and protocols  
Its main aim to promote patients recovery by reducing risks to patient and/or others | see references and additional reading material contained in policy | None |
<table>
<thead>
<tr>
<th>Item</th>
<th>Considerations of impact</th>
<th>Explain the answer and if applicable detail the Impact</th>
<th>Document any Evidence/Research/Data to support the consideration of impact</th>
<th>Further Actions required</th>
</tr>
</thead>
<tbody>
<tr>
<td>3.5</td>
<td>In relation to the protected characteristics and groups identified:</td>
<td>• What are the potential impacts on health?</td>
<td>see references and additional reading material contained in policy</td>
<td>None</td>
</tr>
<tr>
<td></td>
<td>• Will the function, policy or service change impact on access to health care? If yes - in what way?</td>
<td>• Will the function or policy or service change impact on the experience of health care? If yes – in what way?</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>The policy aims to have a positive impact on the patients experience by reducing the risks to the patient and/or others. Access to everyday services within the inpatient setting may be limited during increased observations if clinically appropriate The overall experience is to promote recovery by reducing and minimising risk to the patient and/or others</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
## SECTION 4 – Financial Decisions Impact
How will it affect the financial decision or proposal?

<table>
<thead>
<tr>
<th>Item</th>
<th>Considerations of impact</th>
<th>Explain the answer and if applicable detail the Impact</th>
<th>Document any Evidence/Research/Data to support the consideration of impact</th>
<th>Further Actions required</th>
</tr>
</thead>
</table>
| 4.1  | • Is the purpose of the financial decision for service improvement/redesign clearly set out  
     • Has the impact of your financial proposals on equality groups been thoroughly considered before any decisions are arrived at | Not applicable | Not applicable | Not applicable |
| 4.2  | • Is there sufficient information to show that “due regard” has been paid to the equality duties in the financial decision making  
     • Have you identified methods for mitigating or avoiding any adverse impacts on equality groups  
     • Have those likely to be affected by the financial proposal been consulted and involved | Not applicable | Not applicable | Not applicable |
<table>
<thead>
<tr>
<th>Item</th>
<th>Considerations of impact</th>
<th>Explain the answer and if applicable detail the Impact</th>
<th>Document any Evidence/Research/Data to support the consideration of impact</th>
<th>Further Actions required</th>
</tr>
</thead>
<tbody>
<tr>
<td>5.</td>
<td>Involvement, Consultation and Engagement (IEC)</td>
<td>Policy and leaflets have been discussed and improved with mental health service users from Mental health voluntary organisation Penumbra</td>
<td>Not applicable</td>
<td>None</td>
</tr>
<tr>
<td></td>
<td>1) What existing IEC data do we have?</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Existing IEC sources</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Original IEC</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Key learning</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>2) What further IEC, if any, do you need to undertake?</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Item</td>
<td>Considerations of impact</td>
<td>Explain the answer and if applicable detail the Impact</td>
<td>Document any Evidence/Research/Data to support the consideration of impact</td>
<td>Further Actions required</td>
</tr>
<tr>
<td>------</td>
<td>--------------------------</td>
<td>------------------------------------------------------</td>
<td>-----------------------------------------------------------------</td>
<td>------------------------</td>
</tr>
</tbody>
</table>
| 6.   | Have any potential negative impacts been identified?  
     • If so, what action has been proposed to counteract the negative impacts? (if yes state how) 
     For example:  
     • Is there any unlawful discrimination? 
     • Could any community get an adverse outcome? 
     • Could any group be excluded from the benefits of the function/policy? (consider groups outlined in 1.2) 
     • Does it reinforce negative stereotypes? (For example, are any of the groups identified in 1.2 being disadvantaged due to perception rather than factual information?) | There is the potential of implementing the part of the policy in relation to increased observations to be stressful for the patient, due to their mental health at the time, however this is counterbalanced that the policy is designed to protect, reduce and minimise the risk to the patient and/or others and ensure there is therapeutic engagement with the patient during this time | see references and additional reading material contained in policy | None |
<table>
<thead>
<tr>
<th>Item</th>
<th>Considerations of impact</th>
<th>Explain the answer and if applicable detail the Impact</th>
<th>Document any Evidence/Research/Data to support the consideration of impact</th>
<th>Further Actions required</th>
</tr>
</thead>
<tbody>
<tr>
<td>7.</td>
<td>Data &amp; Research</td>
<td>At time of review new guidance available will be implanted based on new national guidance and evidence</td>
<td>None</td>
<td>None</td>
</tr>
<tr>
<td></td>
<td>• Is there need to gather further evidence/data?</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Are there any apparent gaps in knowledge/skills?</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>8.</td>
<td>Monitoring of outcomes</td>
<td>Audit tools contained within the policy Patient records can be audited</td>
<td>Not applicable</td>
<td>Not Applicable</td>
</tr>
<tr>
<td></td>
<td>• How will the outcomes be monitored?</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Who will monitor?</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>• What criteria will you use to measure progress towards the outcomes?</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>9.</td>
<td>Recommendations</td>
<td>Implement policy</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>State the conclusion of the Impact Assessment</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Item</td>
<td>Considerations of impact</td>
<td>Explain the answer and if applicable detail the Impact</td>
<td>Document any Evidence/Research/Data to support the consideration of impact</td>
<td>Further Actions required</td>
</tr>
<tr>
<td>------</td>
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<td>--------------------------------------------------------</td>
<td>-------------------------------------------------------------------</td>
<td>--------------------------</td>
</tr>
<tr>
<td>10.</td>
<td>Completed function/policy • Who will sign this off? • When?</td>
<td>Policy has been agreed across all mental health services. Policy will be implemented November 2014</td>
<td>Not applicable</td>
<td>None</td>
</tr>
<tr>
<td>11.</td>
<td>Publication</td>
<td>Openness and transparency in relation to care and treatment of patients</td>
<td>Not applicable</td>
<td>None</td>
</tr>
</tbody>
</table>
## Conclusion Sheet for Equality Impact Assessment

<table>
<thead>
<tr>
<th>Positive Impacts</th>
<th>Negative Impacts</th>
</tr>
</thead>
<tbody>
<tr>
<td>(Note the groups affected)</td>
<td>(Note the groups affected)</td>
</tr>
<tr>
<td>Clear policy and direction to all staff working in mental health in relation to patient observations and therapeutic engagement. Thereby promoting recovery and reducing and minimising the risks to the patient and/or others</td>
<td>Potential for stress to the patient under increased observation due to their mental health at time increased observations, this is mitigated by positive impacts</td>
</tr>
</tbody>
</table>

**What if any additional information and evidence is required**

None

**From the outcome of the Equality Impact Assessment what are your recommendations?**

(refer to questions 5 - 10)

Implement Policy

This conclusion sheet should be attached to the relevant committee report.

**MUST BE COMPLETED IN ALL CASES**

Manager’s Signature

Date

James Kennedy

18/11/16
**NHS TAYSIDE – POLICY APPROVAL CHECKLIST**

This form must be completed by the Policy Manager and this checklist must be completed and forwarded with the policy to the Executive Team, Clinical Quality Forum or Area Partnership Forum for approval and to the appropriate Committee for adoption.

**POLICY AREA:** Nursing and Midwifery  
**POLICY TITLE:** Patient Observation and Engagement Policy  
**POLICY MANAGER:** James Kennedy

<table>
<thead>
<tr>
<th>Why has this policy been developed?</th>
<th>To reduce the risks to patients through observation of all patients within mental health environment</th>
</tr>
</thead>
<tbody>
<tr>
<td>Has the policy been developed in accordance with or related to legislation? – Please give details of applicable legislation.</td>
<td>Has regard to Mental Health Care and Treatment (Scotland) act 2003 and takes into account equality and diversity legislation</td>
</tr>
<tr>
<td>Has a risk control plan been developed and who is the owner of the risk? If not, why not?</td>
<td>Already in place as policy has existed for number of years, NHS Tayside has overall responsibility</td>
</tr>
<tr>
<td>Who has been involved/consulted in the development of the policy?</td>
<td>Already in place</td>
</tr>
<tr>
<td>Has the policy been Equality Impact Assessed in relation to:-</td>
<td>Has the policy been Equality Impact Assessed not to disadvantage the following groups:-</td>
</tr>
<tr>
<td>Age</td>
<td></td>
</tr>
</tbody>
</table>
Disability | Yes |
Gender Reassignment | Yes |
Pregnancy/Maternity | Yes |
Race/Ethnicity | Yes |
Religion/Belief | Yes |
Sex (men and women) | Yes |
Sexual Orientation | Yes |
| Please indicate Yes/No for the following: | People with Mental Health Problems  
Homeless People  
People involved in the Criminal Justice System  
Staff  
Socio Economic Deprivation Groups  
Carers  
Literacy  
Rural  
Language/Social Origins |
<p>| Does the policy contain evidence of the Equality Impact Assessment Process? | Yes |
| <strong>Is there an implementation plan?</strong> | Policy already in place, no changes have been made to this version |
| Which officers are responsible for implementation? | Policy already in place, no changes have been made to this version, is standard for all mental health and learning disability services |
| When will the policy take effect? | Already in place |
| Who must comply with the policy/strategy? | All Staff |
| How will they be informed of their responsibilities? | On induction |
| Is any training required? | Yes |
| If yes, attach a training plan | Training plan not required, staff are required to read policy and answer questions within audit tool contained in policy only |</p>
<table>
<thead>
<tr>
<th>Question</th>
<th>Answer</th>
</tr>
</thead>
<tbody>
<tr>
<td>Are there any cost implications?</td>
<td>No</td>
</tr>
<tr>
<td>If yes, please detail costs and note source of funding</td>
<td>N/A</td>
</tr>
<tr>
<td>Who is responsible for auditing the implementation of the policy?</td>
<td>Each individual clinical area that uses this policy</td>
</tr>
<tr>
<td>What is the audit interval?</td>
<td>Yearly</td>
</tr>
<tr>
<td>Who will receive the audit reports?</td>
<td>Service Managers</td>
</tr>
<tr>
<td>When will the policy be reviewed and provide details of policy review period (up to 5 years)</td>
<td>November 2018</td>
</tr>
</tbody>
</table>

POLICY MANAGER: James Kennedy        DATE: 16/12/16
APPROVAL COMMITTEE TO CONFIRM: Clinical Quality Forum
ADOPTION COMMITTEE TO CONFIRM: Clinical and Care Governance Committee
ENGAGING PEOPLE
OBSERVATION OF PEOPLE WITH
ACUTE MENTAL HEALTH PROBLEMS:
A Good Practice Statement
This summary highlights key messages from the above Good Practice Statement published by CRAG. Copies of the full report are available from John Wilson (0131 244 2346) or online (www.show.scot.nhs.uk/crag).

**What is observation?**
It is a process that ensures close monitoring of and engagement with, someone who needs (for a period of time) intensive care and support. It is a formal structured process and therefore is fundamentally different from the normal monitoring of patients within a ward or care setting.

**Why observe?**
Formal observations should be introduced as a result of a risk assessment system that has identified increased concerns about the patient's mental state.

**Who should observe?**
Observation can be carried out by any appropriate person who has the right skills and training. This would normally be a member of the Mental Health Multi-Disciplinary Team but is not purely a responsibility of the nursing staff. Anyone carrying this responsibility must know exactly what they are being asked to do and have guidance and support in this process. The role of non-professionals is one for local discussion and consideration.

**Communication**
It is essential that all members of the Mental Health Team and all people caring for the patients are aware of the level of raised observations being used. The patient must be informed of this process starting and be given written information as well as the opportunity to discuss any concerns they would have or questions with an appropriate member of the multi-disciplinary team.

**Engagement**
Observation must be both safe and therapeutic. Consideration should be given to the use of activity, discussion and distraction processes, but recognition should also be made of the need for silence and as much privacy as is safely achievable.

**Levels of observation**
The report recommends three levels of observation:

- **General** The staff on duty should have knowledge of the patients’ general whereabouts at all times, whether in or out of the ward.
- **Constant** The staff member should be constantly aware of the precise whereabouts of the patient through visual observation or hearing.
- **Special** The patient should be in sight and within arm’s reach of a member of staff at all times and in all circumstances.

A general principle is that observation should be set at the least restrictive level, for the least amount of time within the least restrictive setting.

**Decisions regarding levels of observations**
Decisions regarding the introduction of raised levels of observation must be based on a risk assessment of the patient's mental health at that time. Ideally such decisions should be made by the multi-disciplinary team with involvement of as many members of the team as possible. It is recognised that in some circumstances decisions have to be made quickly regarding this practice and that the nurse in charge of the ward and appropriate medical staff are key in this process.

The key standards which organisations are expected to follow from this report are detailed on the rear of this summary sheet.
• Each local service should have a system of observation practice in place that is flexible and responsive to patient need and based upon Millan’s ten principles.

• Policies implementing each component of observation practice should be clear and unambiguous in terms of:
  • role
  • responsibility
  • reaction
  • reporting
to safeguard all those involved in the observation process.

• The environment in which observation practice is carried out should be shown to be safe and suitable through a system of regular audit within the Trust’s risk management and clinical governance processes.

• Staff should be trained in the skills and competencies required to practise observation and be supervised in their practice of this therapeutic activity. An understanding of both risk assessment and psychological interventions is required by all staff, and the Trust should be able to demonstrate that this is regularly reviewed and attended to.

• A system of recording must be in place that enables clear communication between staff members and ensures regular assessment and recording of risk. The system must allow immediate comprehension of the process as it applies at any moment to an individual and support an audit trail, which enables the review of clinical incidents.

• Written patient information on the principles and practice of observation should be drawn up locally and provided to each patient.
ENGAGING PEOPLE

OBSERVATION OF PEOPLE WITH
ACUTE MENTAL HEALTH PROBLEMS:
A Good Practice Statement
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<td>23</td>
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<td>Annex 2 Membership</td>
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<td>Annex 6 Millan’s Ten Principles</td>
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</tbody>
</table>
This report has been prepared by a group of mental health professionals and service users from a broad range of disciplines who have an interest in improving the quality of acute psychiatric care including the crucial role of observation. The group has consulted widely with Trust Chief Executives, service users, nursing and other staff and has developed a good understanding of the main issues in observation. As a result, I believe that this report will have an impact on the areas where improvements can be made whilst continuing to support the good practice that has been identified as already being in place.

One of several crucial elements identified by the group in this revision is the emphasis on ensuring that observation is experienced as a *therapeutic experience* by the recipient. For this to be achieved staff must have adequate support and training but also must operate within a service culture where there is an acknowledgement of the paramount importance of a caring engagement with service users. Since the publication of the original report much good practice has developed in this area. However, it is now timely to revise, review and reflect on the changes in mental health care that have occurred. I hope this report assists those who provide and receive psychiatric care in this process.

David Bertin  
Chair, Observation of Acutely Ill Patients in Psychiatric Hospital Review Group  
June 2002
“Engaging People” is a revision of the CRAG document “Nursing Observation of Acutely Ill Psychiatric Patients in Hospital” (1995) and is relevant to all who provide or receive acute psychiatric care. The general principles of the document can also be adapted to support care of other client groups requiring comparable care.

This report is a key document and should be made available to all staff who provide care in an acute psychiatric setting.

The report recommends three levels of observation:

- **General**: The staff on duty should have knowledge of the patients’ general whereabouts at all times, whether in or out of the ward.
- **Constant**: The staff member should be constantly aware of the precise whereabouts of the patient through visual observation or hearing.
- **Special**: The patient should be in sight and within arm’s reach of a member of staff at all times and in all circumstances.

After much discussion the group agreed that **timed observations do not contribute** to the safety of the observation process although being aware of a patient’s whereabouts contributes to good general nursing practice.

It is clearly not good practice to simply “watch or guard” patients. Observation of patients is a **therapeutic engagement**; all staff involved in the process should be suitably trained in psychological intervention skills and risk assessment to maximise this process. The report lists the appropriate skills required to undertake observation. Excessive use of untrained temporary staff can impede the patient’s progress and can increase the vulnerability of everyone involved in the observation process.

Whilst general observation is a multi-professional task, constant and special observation should be managed by named members of nursing staff who have 24-hour contact with the patient plus the clinical understanding of their condition. **Relatives, carers and other professionals can be involved in observation** at a general level and can often provide a helpful insight into the patient’s condition. The report recommends **some practical suggestions** as to how to improve the observation process.

All local Trusts should develop **local policies** based upon the new national guidance; local observation systems should be flexible and patient-centred; the environment that observation is carried out in must be fit for purpose.
Patients undergoing observation should be kept informed at all times; **written patient information** should be made available for all patients and relatives involved. Local user groups should be encouraged to be involved in the drafting of such documents.

Following consultation with the Royal College of Psychiatrists about procedures for the reduction of observation level, it has been agreed that out-of-hours a named senior nurse can reduce the observation level in consultation with the junior on-call doctor, providing a written patient-specific plan is pre-agreed with the Senior Medical Officer.

**Recording systems** should provide a complete clinical picture and enable audit trails to monitor the effectiveness of the intervention and, if necessary, support Critical Incident Reviews (CIRs) and Fatal Accident Inquiries. The effectiveness of observation is also a key issue for **Clinical Governance Committees**.
• Each local service should have a system of observation practice in place that is flexible and responsive to patient need and based upon Millan’s ten principles.

• Policies implementing each component of observation practice should be clear and unambiguous in terms of:
  
  • role
  • responsibility
  • reaction
  • reporting

  to safeguard all those involved in the observation process.

• The environment in which observation practice is carried out should be shown to be safe and suitable through a system of regular audit within the Trust’s risk management and clinical governance processes.

• Staff should be trained in the skills and competencies required to practise observation and be supervised in their practice of this therapeutic activity. An understanding of both risk assessment and psychological interventions is required by all staff, and the Trust should be able to demonstrate that this is regularly reviewed and attended to.

• A system of recording must be in place that enables clear communication between staff members and ensures regular assessment and recording of risk. The system must allow immediate comprehension of the process as it applies at any moment to an individual and support an audit trail which enables the review of clinical incidents.

• Written patient information on the principles and practice of observation should be drawn up locally and provided to each patient.
1 INTRODUCTION

1.1 This is a revision of the CRAG Good Practice Statement “Nursing Observation of Acutely Ill Psychiatric Patients in Hospital” (1995). It sets out guidance on the care of people with acute mental health problems who require observation and special care. The guidance will be relevant to NHSScotland Trusts (including the State Hospital) who provide acute psychiatric care, staff (of all disciplines), users and carers. Much of the content will be of use to other providers of mental health care.

1.2 The focus of this document is on the clinical practice within acute psychiatric settings. However, patients may become acutely ill in other types of wards or facilities, or in the community. If someone requires care and observation due to acute psychiatric illness then the suggestions and principles contained within this document apply. The review group did not specifically examine the issues of observation of people with learning disabilities or patients suffering from dementia, but believes much of this document would have relevance for these clinical conditions. The management of mental health patients in general hospitals and the management of patients in general hospitals awaiting referral to mental health services have not been addressed in this report.

1.3 Apart from guiding clinical practice this document will assist organisations to comply with the standards produced by the Clinical Standards Board for Scotland (CSBS) and the Quality Indicators from the Scottish Health Advisory Service (SHAS, 2001). It is relevant specifically to Standard 1 (Patient Focus) and Standard 2 (Safe and Effective Clinical Care) within the CSBS Generic Standards and Standard 5 (Transferring Care) within the CSBS Schizophrenia Standards, and to Quality Indicator 2 (the Delivery of Care) from SHAS.

1.4 The report focuses on the practice of observation of the patient but it must be recognised that observation policies and procedures are only one aspect of caring for people during periods of high distress. 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 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.

1.5 This document examines the issue of who should take the major role in observation. With the emphasis on multi-disciplinary and multi-agency working and with the increased role of users and carers in contributing to service delivery, it is timely to develop the observation role into a process in which many disciplines, carers and users have a role to play. However, it must be acknowledged that nurses, and particularly the nurses in charge of wards, remain the major professional players involved.

1.6 This document outlines both clinical and policy issues for consideration, debate and implementation at a local level. It is prescriptive only where clear, unambiguous guidance is seen to be appropriate.
In May 2000 the Mental Health & Well-Being Support Group invited CRAG to revise the CRAG Working Group on Mental Illness document entitled “Nursing Observation of Acutely Ill Psychiatric Patients in Hospital”. The original document published in 1995 had been well received by the Service and the principles of good practice were largely adopted. However, some work was required to bring it in line with current clinical practice and policy developments.

A working group was established to carry out the review. The full remit of the group is given in Annex 1 and membership is listed in Annex 2. This group met on eight occasions and an editorial subgroup met twice. To ensure that the work of the group was based on the experience of the Service, three preparatory exercises were undertaken:

- a review of Trust observation protocols
- a survey on the impact and barriers to implementing the original good practice statement on observation
- a brief survey of Service users’ experiences of observation.

The information and views received through these consultations were added to the main group discussion and many are incorporated into the document. The details of these consultations are given in Annex 3.

The original report was prompted by several issues including a comment within the Annual Report from the Mental Welfare Commission for Scotland in 1992, which noted that considerable variation existed in the definition and application of observation levels throughout Scottish hospitals. The original CRAG document attempted to standardise these levels. A review, undertaken by the current working group, identified that the recommended three levels of observation are now in use in the vast majority of Trusts in NHSScotland. Furthermore, it is clear that the report is well known, generally well integrated into care and many of the changes suggested in the responses by clinicians and users around Scotland were, in fact, already largely referred to in the original text.

These findings supported the strong opinion within the group that the original report had strong validity within clinical practice, the good practice described within it was still largely relevant, and the report would be revised only if the amendments would add strength and depth to the document. The working group identified several key issues requiring attention:
- to move from observation being seen as a purely nursing responsibility to a multi-disciplinary model
- to clarify the role of relatives and other non-clinicians in observation
- to make links to current service issues such as establishing and implementing standards, continuing quality assurance, and risk management within clinical governance processes
- to review relevant literature and clinical practice to establish if a change was required to the three levels of observation
- to review and suggest training needs
- to highlight need and methods for observation to be therapeutic
- to clarify the process for the increase/decrease of observation levels and how it is to be recorded.
3.1 Purpose of Observation

3.1.1 The key purpose of observation is to provide a period of safety for people during temporary periods of distress when they are at risk of harm to themselves and/or others. It is essential to ensure this period is therapeutic and, although it may be perceived as not needed at the time, that it will generally be seen as a positive experience by the patient in time. It can also be used to provide an intensive period of assessment of a person’s mental state. Acute admission facilities and intensive psychiatric care settings are the areas most involved in the practice of raised observation.

3.1.2 It has been reported in recent years that acute environments have seen a significant change in the profile of patients within their care. This would seem to indicate that most acute admission facilities are dealing with a patient population that is generally staying for a shorter duration than in the past but is more acutely ill or distressed. The implications of this are that more patients at any point in time may need raised levels of observation and therefore the need for clear guidance and policies on this issue may be even more essential than previously.

3.1.3 Formal observation systems should not be seen as inflexible and rigid and it is important that policy and clinical practice developments are not restricted. It is essential that clinical services feel able to develop new methods of engaging with high-risk patient behaviour. However, it is essential that such developments are carefully designed and researched to assist in developing the evidence base for dealing with this complex issue. The Chief Scientist Office, Nursing and Midwifery Practice Development Unit and CRAG may be able to support such projects.

3.1.4 It must be remembered that the process of observation can be distressing for patients and can be considered an imposition on their freedom and dignity. It has an impact on the use of the available staff resource, and thus on the care of other patients. Clinical teams should not hesitate to use increased levels of observation when their judgement indicates it is needed. However they should be clear about its purpose and aware of the wider effects of this decision.

A general principle is that observation should be set at the least restrictive level, for the least amount of time within the least restrictive setting.

3.1.5 In its review of the Mental Health (Scotland) Act (2001), the Millan Committee offered ten principles that have equal relevance and importance to this document. The ten principles are set out in full in Annex 6. The principles of participation and respect would lead us to involve patients in decisions regarding levels of observation and give clear, comprehensive answers to questions and requests. The principle of reciprocity should ensure that if we restrict patient freedom (because of observation requirements) then we are obliged to give high quality care and engagement with the patient. At the time of preparation of this report the exact content of the forthcoming mental health bill, based on the Millan Report, is not known.
3 ELEMENTS OF GOOD PRACTICE

3.1.6 It is important that all involved in the practice of observation comply with the principles of the European Convention on Human Rights, especially Article 5, which states that

"5.1 Everyone has the right to liberty and security of person. No-one shall be deprived of his liberty save in the following cases, and in accordance with a procedure prescribed by law . . .

(e) The lawful detention of . . . persons of unsound mind

5.4 Everyone who is deprived of his liberty by arrest or detention shall be entitled to take proceedings by which the lawfulness of his detention shall be decided speedily by a Court and his release ordered if the detention is not lawful."

In practice, the issue is that observation must take place on the basis of engagement and dialogue with the patient consenting, as long as that individual is capable. If the basis for such agreement no longer holds, then informal coercion on the basis of what staff members see as the immediate risks may contravene Article 5. Recourse to the provisions of the Mental Health (Scotland) Act 1984 will have to be considered if the relevant criteria can be met.

3.1.7 Spending time with patients, whether engaged in activity, discussion or simply being with them may allow close assessment and monitoring of behaviour and mental state. It therefore may meet many of the needs of observation but is not adequate in itself. At times it is essential to have a clear, unambiguous instruction regarding a patient’s need for close or special procedures. Formal, standardised observation systems ensure clarity of the process for both patient and staff.

3.1.8 The key issue is to devise systems and processes that balance patient safety and well being with their therapeutic needs. It must be seen as unacceptable if adequate, caring, patient contact is only achieved by the utilisation of a formal observation system.

3.2 General Principles of Observation

3.2.1 The process of observation must not be seen as a low-level or less-skilled “task”. It requires considerable skill and effort and can be most demanding and tiring for both parties. Therefore it is essential that there is:

- staff with competence in a broad range of clinical skills
- a suitable environment
- a broad range of available activities
- a culture that values and respects the role of observation
- a clinical supervision process for staff
- a good planning of staff breaks
- access to full written explanations of the process for patients/carers
- access to advocacy for patients who may feel discontent with the level or process of observation
- a clear system for Critical Incident Reviews in the event of mishap
- an audit trail on the use of observation procedures.
3.2.2 Observation should be seen as a partnership between the multi-disciplinary team and the patient and carers. It must not be punitive or custodial. To assist in achieving this partnership both the reasons for, and the process of, observation should be transparent to all parties and discussed openly.

3.2.3 A mechanistic approach to the observation process, which may be seen as “watching the doors” or “guarding the patient” is totally inadequate. Observation of patients who are acutely ill must be seen as a skilled task involving assessment of the patient’s mental state and the development of a rapport and therapeutic relationship with the person being observed. The process should be open, transparent and well communicated. All staff who undertake observation should be specifically trained to do so, understand the importance of the duty they are carrying out and have the skills to deliver brief psychological and practical interventions to benefit the patient. Excessive use of temporary and casual staff can impede the development of good rapport between staff and their patients and the quality of treatment afforded.

3.2.4 Research into the use of untrained nursing staff in the process of observation has demonstrated that, as staff changed on an hourly basis, patients were repeatedly asked the same questions (Duffy 1994). Lessons can be learned from this that can improve the quality of care, e.g. handover reports should be carried out before and after every period of observation. This will avoid unnecessary duplication and improve continuity of care. The observational task can be delegated to unqualified members of staff, but the qualified nurse delegating this duty must ensure that the unqualified colleague knows why they are observing the patient and what the purpose of the observation is. The nurse in charge of a particular shift is responsible for ensuring that individuals requiring extra observation are allocated a member of staff skilled to undertake this duty.

3.2.5 For staff, one specific and skilled element of observation, in relation to protecting oneself and others, is the detection of signs of impending aggression. The close proximity inherent in observation and the risk of patients feeling aggrieved or anxious during prolonged periods of observation may increase the probability of violence. It is therefore essential that all staff should receive training in techniques for the detection, de-escalation and management of aggression prior to being involved in raised levels of observation. (This requirement is detailed within the CRAG Good Practice Statement on “The Prevention and Management of Aggression”, 1996.)

3.3 Making Observation Work

3.3.1 To ensure the distress and discomfort that may be felt during raised levels of observation is minimised, a careful balance of activity, silence or privacy must be obtained. This balance will differ for each person and will vary across time. The availability of music, creative activities, magazines/newspapers, board games, jigsaws, etc., as well as somewhere appropriate for using them is helpful. Activities can also
offer an effective method of observing an individual’s level of functioning, as is the chance to assess someone’s mental state from the general conversation that often occurs around such activities. Being left alone in as private a setting as possible is also appropriate. A careful selection of the available activities is essential and should involve patient choice where appropriate.

3.3.2 Some practical suggestions are as follows.

On-Ward Activities:

- **Activities of Daily Living** – assist individuals to maintain self-care, maintaining some responsibility and dignity. Assist with bed-making, tidying room and doing personal laundry. As appropriate write letters, make telephone calls.

- **Social Interaction** – respect a patient’s right for silence. If a patient wishes to talk don’t only talk about symptoms but introduce general conversation topics. Remember the habit of talking at the patient may be due to a staff member’s personal difficulty with silence.

- **Clinical Interaction** – a spell of uninterrupted contact allows time for brief psychological interventions, focused on negative or intrusive thought patterns, reality-checking and problem solving, or self-harming thoughts. There is much therapeutic self-help written material available now, and it can be helpful for the patient to have some guidance in working through it (see paragraph 10.2).

- Ask the patient what would be helpful to **them at that moment in time**. Is there anything in the patient’s history which could be discussed further with benefit?

- Respect a patient’s wishes within safety boundaries, and the level of observation in force. Open the door or sit outside the room if the patient’s mental state is deteriorating as a consequence of the close proximity and constant observation that is in force.

- **On-ward occupational therapy** to assist patients in engaging in activities during the time of an acute onset.

- **Nurse management systems** should be aimed at increasing direct patient contact by ensuring staff are available to patients as much as possible. Appointment systems for named nurse sessions can ensure planned contact and give patients a chance to discuss concerns and frustrations.
Off-Ward Activities:

- Engage in occupational therapy/other therapeutic opportunities.
- Walks around grounds or visiting hospital shop/social centre/chaplain/welfare department (assuming risk assessment allows).

Spending time with patients, whether engaged in activity, discussion, or simply being with them, allows close assessment and monitoring of behaviour and mental state. It is the basis of all good clinical practice and can meet many of the needs of observation, but may not be adequate in itself to reduce risk. At times it is essential to have a clear, unambiguous instruction regarding a patient’s need for close or special procedures. Formal, standardised observation systems ensure clarity of the process for both patient and staff.

3.4 Involvement and Engagement

3.4.1 “Building relationships” is a generally accepted premise upon which psychiatric care is based, and high-quality care is considered to be that which takes note of the individual needs of patients (Altschul 1972, Cormack 1976, Reynolds 1985, Beck et al 1988 and Peplau 1988). Caring for acutely-ill psychiatric patients is no different in this respect, and the research evidence shows that promoting a therapeutic environment and culture is crucial in the care of “at risk” and suicidal patients. As the Mental Welfare Commission stated, the challenge for the psychiatric nurse (and other professions) is “to create a balance between care and control” (Mental Welfare Commission, 1993).

3.4.2 Observation of a patient is clearly patient-centred, but should be seen as part of an overall “holistic approach” to care. Multi-disciplinary teams should take the lead in determining the style and content of staff-patient interaction, making every attempt to create an environment which is therapeutic and which treats patients with respect and dignity. While intensive levels of observation may be unavoidably restrictive, observation must never become a form of de facto detention for voluntary patients. As far as possible, the team should seek the consent and understanding of the patient being observed.

3.5 The Context and Setting of Observation

3.5.1 As previously stated, observation policy and practice is only one element of acute psychiatric care. Having policies and procedures that ensure safety alone is not sufficient. Acute psychiatric care is challenging and demanding both for staff and patients alike. To achieve a high-quality, comprehensive service, acute units need to address many issues including the following:
3 ELEMENTS OF GOOD PRACTICE

– clarity of purpose
– philosophies that are patient-focused
– systems of supporting and developing clinical practice
– management systems that provide clear leadership to the Service
– robust communication between clinical team members
– range of therapeutic evidence-based treatments available
– practices which identify sources of risk and minimise them proactively
– respect for, and involvement of, patients and their carers
– consistent, skilled multi-disciplinary staff who feel valued and supported
– appropriate physical environments with space and privacy.

The physical environment in which observation occurs can influence both the frequency and intensity of its usage. Poor ward design and layout can lead to problems of carrying out General Observation leading to increased levels of observation. Inadequate or inappropriate facilities may well be a clinical governance issue for services to consider. Even in older buildings, the ward manager should have the opportunity to work with the Estates Department (or similar) to reduce any obvious hazards. The environment must be made to be fit for purpose, therapeutic, and all environments must be specifically audited for availability of ligature points as detailed in recent Safety Notices (reference no. SAN(SC) 98/49 & SAN(SC) 01/21).

3.5.2 It is the case that on occasion patients in need of raised levels of observation may be cared for in an Intensive Psychiatric Care Unit (IPCU). These wards generally have increased staff:patient ratios and locked doors and can offer an extra level of safety and care. The fact that these ward doors are locked should not mean patients are denied appropriate engagement and one-to-one staff attention. The therapeutic component of observation must be in place whatever the setting.

3.5.3 The locking of any ward doors outwith an IPCU must only be done within clear local protocols and subject to frequent, regular review and audit. Locking of doors would only be required in exceptional circumstances. The Mental Welfare Commission (1999) recommends that a local protocol is developed which requires authority from senior clinical staff and hospital managers and ensures that clear information is made available to patients and their relatives. There are practice implications too, arising from the European Convention on Human Rights, for other patients whose freedom is restricted unnecessarily (see paragraph 3.1.5).

3.5.4 Observation is used for patients who require extra monitoring. Patients under observation are either very ill and/or distressed and are thought at that point in their care to pose a significant risk to themselves or others. It therefore follows that there will be a risk to a patient leaving a ward area even with staff in attendance. However, there are times when the patient may wish to simply get fresh air or attend a department outwith the ward. It must be acknowledged that the feeling of containment felt by some patients under observation may lead to deterioration in their behaviour if
their needs are not addressed. However, like all risk assessment decisions this judgement must consider the risks and benefits of all options. It is unlikely that a rigid policy regarding patients leaving the ward would meet individual needs.

3.5.5

Outwith a hospital setting the need for formal observation is less relevant. However, it is essential to consider two key areas where increased vigilance is needed. The first is at the time of the organisation of an admission to hospital where the patient has been assessed and it is agreed that inpatient care is required. This decision often happens in a primary care, day care or domiciliary setting, where staff or carers may not be so prepared for constant observation practice. Mental health services must ensure there are clear protocols on managing these situations including, where needed, providing training and support to primary care or in other community settings in which people may wait pending admission arrangements being made. The other risk time is within the immediate period after discharge or leave of absence. The Safety First Report (2001) from the Confidential Inquiry into Suicide and Homicide by People with Mental Illness highlights the risk of self-harm in this period. It recommends follow-up for patients within seven days of discharge (where the patient suffers from severe mental illness or has a history of self-harm within the previous three months). Clear discharge plans that allow community services time to organise a response are essential in minimising this risk.
The decision to use an increased level of observation is based on a variety of factors. Central to it must be the risk assessment of that patient’s mental state at that moment in time. Risk assessment/management is a complex process involving both objective data (such as patient history, behaviour, etc.), data from third parties, and the judgement of the clinicians involved. The recently published report “Risk Management” (2000) offers comprehensive guidance on this subject and also acknowledges that the process is difficult and may have to be repeated frequently if the patient’s clinical state is fluctuating.

It is important to note that in the original report it was observed that:

“Few, if any, properly validated risk assessment tools are available and the group sees an urgent need to conduct audit and research into the most clinically effective ways of assessing risk and prescribing the appropriate level of nurse observation.”

It is relevant to note that this position, in many ways, has not fundamentally changed in that any value of formal rating scales and check lists must be tempered by the central role of clinical judgement of an experienced professional. Simple checklists of questions/prompts are valid in guiding less-experienced staff in carrying out a risk assessment. An example is given in the “Risk Management Report” and is included in Annex 5 of this report. The key issue in sound risk assessment is that there is open and in-depth dialogue between all members of the clinical team and with appropriate others including relatives, carers and the patient themselves and that risk assessment is a dynamic process that requires constant review.

Ideally a multi-disciplinary team should always make these decisions. However, on many occasions (particularly at weekends and evenings) decisions may have to be made by a doctor and the ward nursing team. Such decisions should always be reviewed at the first available opportunity with a larger number of the full team.

Local policies must clarify the procedure for increasing levels of observation in emergencies. This decision should be able to be made by the senior nurse in charge of the unit on their own initiative but followed up by consultation with appropriate medical staff as soon as possible. Staff must feel empowered to raise levels of observation and be supported in this action (even if this increase is subsequently reduced following a broader team discussion). Teamwork and trust between team members are essential to safe decision making and safe practice.

The reduction in the level of observation should ideally be a team decision. To ensure patients are not left on an increased level inappropriately it is recommended that teams plan ahead, particularly at weekends, clarifying the circumstances that would enable a reduction in observation level. As part of this process there should be a clear local policy on the acceptability of the authority of the nurse in charge to reduce observation levels. There should be a generic policy at Trust level, which sets out the
broad principles including a clear statement of support for nursing staff implementing these decisions. There must also be a specific plan for each patient, which outlines the agreed changes in behaviour that would facilitate a reduction in observation level and the exact procedure for this decision to be actioned. It must detail the role of duty medical staff or senior nurses in this process. It may be appropriate for the policy to differentiate between the procedure for the reduction of the observation level from special to constant compared to a reduction from constant to general.

The following guidance from the Royal College of Psychiatrists clarifies the role of medical staff in the decision-making process regarding levels of observation:

Deciding on observation levels should be a process in which the multi-disciplinary teams should all contribute. The Scottish Division of the Royal College of Psychiatrists state (consultation response, January 2002) that they see no problem in non-medical members of the team being able to reduce observation levels as long as (the circumstances which would allow) a future reduction in observation levels could be specified at (multi-disciplinary) ward rounds and documented in the case notes in advance. Nursing staff usually know the patients better and are in quite a strong position, for instance, at weekends to decide if observation levels can be reduced. The on-call junior doctor should be involved in examining the patient’s mental state and discussing the risk with the senior nurse on duty before the decision to reduce observation is made. Where there is any doubt the decision should be discussed with the on-call consultant or postponed until the next opportunity when the full team, including the patient’s Responsible Medical Officer (RMO), is present. The RMO retains final responsibility.

There should always be a record of decisions regarding observation kept within the patient’s notes including an explanation as to why an increased level is used. It is recommended that a simple record is kept to allow auditing of the frequency, level and duration of increased levels of observation as well as the clinical reason(s) behind the choice. The record must clearly show the perceived risks which led to the decision, who was involved in the decision, and the patient’s opinion of the need for increased observation. This audit trail provides key information both in monitoring the frequency of the usage of raised levels of observation and in Critical Incident Reviews (see paragraph 12.3).
One of the key areas of clinical practice in acute psychiatric care is deciding what intensity of care is needed for individuals. The original document refers to three levels:

- general
- close
- special.

In three NHSScotland Primary Care Trust policies we examined, reference is made to the use of a fourth level. This involves the use of a specified time period (such as every 15 minutes) at which the whereabouts of the patient must be “checked”. The group gave this issue considerable debate and sought views from outwith the group as it is clearly a contentious issue and one on which a clear unambiguous statement must be given.

A summary of the points for and against is given below.

Positive:
- allows an intermediary level between intense one-to-one observation and general observation (particularly when reducing the level of observation)
- is less intrusive for person being observed
- is less staff-intensive
- may be used to comply with general observations requirements.

Negative:
- high risk as patient able to carry out risk behaviour during gaps in observation
- maybe used as “easier” option when constant observation is really indicated
- encourages a mechanistic process of care
- does not fulfil the purposes of observation.

The group decided that the original three levels of observation are still the most appropriate and that on balance the risks inherent within “timed checks” outweigh the possible benefits. This view is upheld within “Safety First” (5-Year Report of the National Confidential Inquiry into Suicide and Homicide by People with Mental Illness, 2001) which highlights the risks inherent within “timed” or what they term “intermediate” observation. It recommends that “alternatives to intermediate level observations be developed for patients at risk” referring to intermediate-level observations as “of unproven benefit”. Being aware of the patients’ whereabouts supports good nursing practice but should not be considered part of the observation process.

The “timed check” form of observation is seen by the group as unsafe and should not be used as a means of meeting a need for an increased level of observation.
It was clear that the majority of Trusts and staff consulted considered that the original recommendations regarding levels of observation were well implemented, useful and well integrated into the care package; comments received by the group during consultation were supportive of this view. There seemed no requirement therefore to alter terminology or the major aspects of clinical practice. The three levels of observation suggested in the original report remain valid and should continue to form the basis of local policy.

With this in mind, we continue to recommend that the following categories of observation be used:

- **General**
- **Constant**
- **Special**

### General Observation

The general level of observation is intended to meet the needs of most patients for most of the time. It should be compatible with giving patients a sense of responsibility for their use of free time in a carefully planned and monitored way. The staff on duty should have knowledge of the patients' general whereabouts at all times, whether in or out of the ward. This could be achieved by establishing a patient allocation system whereby the nurse in charge is kept informed of each patient's whereabouts. Patients on general observation are considered not to pose any serious risk of harm to self or others and are unlikely to leave the ward area or other treatment departments without prior permission, escort, or at least informing staff of their planned destination. Any limits set should be determined in conjunction with the patient, documented and updated in the care plan as necessary.

Gournay & Bowers (2000) offer a useful description of general observation:

> “General Observation can be thought of as the observation and monitoring of the physical geography of the ward and as a component of constant review of safety in the light of the opportunities the ward and its contents provide for harm to come to patients. This general observation should be an established part of the ward routine and followed rigorously and regularly by nurses, as part of their everyday practice to maintain the safety of the patients.”

### Constant Observation

The constant level of observation should be used for patients considered to pose a significant risk to self or others. An allocated member of staff should be constantly aware at all times of the precise whereabouts of the patient through visual observation or hearing. The method and purpose of maintaining observation must be clearly determined and stated at the time of review. Respect for privacy should be an important consideration, but a balance should be struck on the side of safety in all matters such as escorting to the toilet, bathroom, or public telephone, etc. In some
circumstances the patient may be permitted to leave the ward or other clinical area in the company of an escorting nurse, other informed professional worker or appropriate relative. This decision must be part of the risk assessment process and the comments referred to in the previous section should be noted. Appropriate members of the multi-disciplinary team (generally a minimum of the nurse in charge and duty doctor) should review the need for constant observation at least every 24 hours.

5.10 Special Observation

The special level of observation will generally be rarely prescribed. The patient should be clinically assessed as requiring intensive and skilled intervention as a consequence of their very serious mental and/or physical state. The patient should be in sight and within arm’s reach of a member of staff at all times and in all circumstances. Considerations of privacy would be subordinated to those of safety. In some situations more than one staff member may be required. In the event of the patient leaving the ward an appropriate number of escorts should accompany the patient. As this form of observation is potentially very intrusive, it should only be used when judged strictly necessary by the clinical team, and this level of observation should be subject to frequent review (at least every 24 hours) involving appropriate members of the team. A system should be in place for dealing with the increased demand on staff resources which special observation creates. Only staff familiar with the condition of the patient on special observation should normally be deployed on this demanding work.
6 ROLE OF THE PROFESSIONS IN OBSERVATION

6.1 It must be acknowledged that it is primarily psychiatric nurses who provide 24-hour care and who will, therefore, carry the majority of the responsibility for the observation of the patients. However, with the emphasis on multi-disciplinary team-working and the increasing role of users and carers, consideration should be given to the role of these groups within this area of care. It seems correct that in appropriate situations other professionals (apart from nurses) should be involved and have responsibility for the observation of a patient. Indeed, it is clear from our consultation that this practice is already in use to some degree and that guidance on it would be welcomed.

6.2 For non-nursing staff to be involved in observation the following issues must be addressed:

- there must be a fool-proof system of staff knowing who is responsible for the observation of a patient at all times
- there must be a simple way of communicating between staff members all changes in the level of observation
- all staff must accept the responsibility for carrying out the observation to local standards
- all staff must receive appropriate training in this role especially staff for whom this role is new.
7 ROLE OF THE NURSE IN CHARGE

7.1 As the only profession which has 24-hour contact with patients, nurses are in a key position to ensure robust safety and therapeutic care. As stated, it is still nurses who will remain the staff group predominantly involved in observation and their experience in this skilled task must be recognised and utilised by the other professions. The nurse in charge of the ward or unit should retain responsibility for co-ordination of decisions regarding observation levels. For clarity only one individual must be charged with this duty and be seen as the person who should always know both who is being observed (at a raised level) and which staff member is responsible for a given time period. That person is the nurse in charge.
8 ROLE OF USERS AND CARERS

8.1 Caring for someone in distress is not a process to which only professionals can contribute. Anyone with a suitable approach and awareness can, at times, help and may, on occasions, be more appropriate than the professional. Clearly it is neither safe nor fair to expect a carer or fellow patient to shoulder the full responsibility of caring for someone in severe distress. However, in many settings the patient being observed may welcome the company of a relative, friend or fellow patient and it may not be appropriate to have a staff member present during such occasions.

8.2 During general observation there would appear to be no conflict, whereas during special observation it would not be appropriate to leave a patient without a member of staff present. However, constant observation is more complex. There will be situations where it is reasonable and appropriate, and others where it would be unsafe and unfair. The risk assessment process and subsequent multi-disciplinary team discussion must include decision making; agreement should be reached on the appropriate level of observation and who can offer the greatest level of support to the patient.
9.1 Patients and their carers/relatives should be informed of the observation policies and procedures in use within the service. If observation is to be a true partnership then clear, honest and open dialogue must take place regarding the reasons for an increased level of observation. Written information regarding observation policies and practice must be given to all patients. Specific information regarding a patient’s current level of observation must also be given. It is recommended that this information is developed in conjunction with local service user groups.

9.2 Although it is not appropriate for a formal “appeal” (as in the Mental Health Act) patients should have access to an advocacy service to assist and guide them in disagreements about any restrictions on their freedom that observation may lead to. Written explanations should be given to both patient and carer/relative about the level of observation in use and its purpose. Patients should also be offered an opportunity to discuss their concerns with a senior member of staff.

9.3 If the process is designed to be truly collaborative and crucially “feels” this way to the patient then the chances of the patient disagreeing with the decision are reduced. Patients must have the right to discuss formally their views on their observation level with staff and, if they desire, involve someone (such as from an advocacy service or friend/relative) in these discussions. To facilitate this collaborative process local user groups should be encouraged to become involved in the development of local observation policy, written information and staff training.
The need for high-quality training was highlighted in the original document. It would appear from our review that training in the practice of observation is still seen by many as an issue requiring more attention. The specific need for training non-nurses in observation responsibilities has already been referred to in this document. It should be noted that although nurses are traditionally the profession most closely associated with observation it would appear that few have received specific training. The review group was not aware of any current formal courses but recommend that local services develop training plans for all staff involved in observation. This training should include input from users and should explore both the practicalities of the local observation procedure and the philosophy underpinning it.

The training must also include clinical skill training as needed to enable staff to have the necessary “tool-box” of psychological and practical interventions to help patients cope with their distress and illness. Skills such as distress tolerance, suicide thought reduction, psychotic thought management, problem solving and anxiety management are appropriate to include. These two elements of the training should be aimed at ensuring the process of observation is therapeutic and safe.

The recent Leadership Development Programme is one route through which to identify key players in implementation of local observation protocols. Reference should be made to “Learning Together – A Strategy for Training and Lifelong Learning” (1999).

Training must not be seen as a “one-off” as, apart from ongoing updates, all staff working in psychiatric units need continuing organisational support in their clinical work. This may be through a system of clinical supervision, mentorship or preceptorship. The recent Nursing Strategy “Caring for Scotland – The Strategy for Nursing and Midwifery in Scotland” (2001) emphasises the important role of clinical supervision in nursing. The need for clinical supervision applies to all professional groups and must be seen as an integral part of good quality care and not an optional extra. It is also part of supporting the process of learning or reflective practice that comes from both formal audit and critical incident reviews and contributes to the continuing professional development that is essential to all professionals.
11.1 Much can be learned through careful analysis by the multi-disciplinary team of the management of particular incidents which should not have occurred. Critical Incident Reviews (CIRs) are considered to be a valuable learning tool for staff, as well as a supportive forum. All wards/units caring for acutely-ill patients should adopt the practice of carrying out reviews when untoward incidents occur (the “critical” applies to the seriousness of the event for the organisation’s overall purpose and not to an expressed intent to pin the “blame” on somebody). Although CIRs are associated with the investigation of suicides, suicide attempts and incidents of violence and aggression, the process is mentioned here as a means of looking at “near-misses”. By these are meant any failure of systems or failures to apply the correct procedures. Therefore, when an event occurs which constant or special observation was designed to avert, it is worth examining to see how in future the team (and the organisation) can ensure a better outcome. A protocol for conduct of the CIR is described in “Risk Management”. To ensure they are useful learning tools, CIRs should be conducted in a learning mode, separate from and not linked to disciplinary procedures, and should be carried out in a manner that facilitates development both on a personal and organisational level.

11.2 If CIRs occur frequently then there may be something wrong with the organisation’s ability to learn and incorporate lessons into its risk management processes. More can be gained from looking honestly at occasions when things did not go well, but there is a delicate balance of formal and informal systems applied in a human context. This issue is explored within “An Organisation with a Memory – Report of an expert group on learning from adverse events in the NHS” (Department of Health 2000) and the follow-up document “Building a Safer NHS for Patients” (Department of Health 2001).
12.1 Clinical Governance is defined as “corporate accountability for clinical performance”. A key purpose of Clinical Governance is to improve quality of care and to ensure that wherever possible poor performance is identified and addressed. Locally, Trust Clinical Governance Committees are expected to ensure that their organisations put in place systems to allow for learning from complaints or critical incidents. It is essential that observation practice, along with the risk management inherent within it, is seen as a key mental health issue for examination through the Clinical Governance process.

12.2 Simple auditing of the frequency and duration of observation practice across wards is an essential tool in monitoring the effectiveness and usage of this procedure. For an example of this approach see Porter, McCann & Kettles (1998). The audit process must also ensure that feedback from users is gathered and used to shape both policy and training.

12.3 Recording systems must be designed to allow a clear audit trail. The record must be simple and quick to complete but should include: the level of observation used, the presenting clinical picture, who is involved in these decisions, the views of the patient and carer, information given to the patient and carer, and any specific plans for possible reduction of level of observation. Pending the development of electronic recording of practice data, a simple paper record will suffice. Such records are essential components in the discussions at Critical Incident Reviews and in the defence of professional practice in the event of a Fatal Accident Inquiry.
Caring for people experiencing periods of acute mental illness or distress is challenging and demanding – experiencing it must be even more difficult. Comprehensive care involves both ensuring the patient’s safety and offering therapeutic help and support. One without the other is incomplete. The risk is that services pay considerable attention to the safety component but perhaps less to making the observation experience healing and compassionate. To ensure both are achieved staff must feel valued and supported and given the time and skills to truly engage with the patient. The process must be a partnership approach between staff and patient where the needs of the patient are recognised and respected. There is much one group may learn from the other in how safe, therapeutic observation can be developed and delivered.
REMIT OF WORKING GROUP

The Group was established in July 2000 with the following remit:

To develop a framework of practice for clinical teams in acute inpatient units to set and implement patient observation levels in ways that

- reduce the risk of untoward incidents to both patients and staff
- combines the practice of observation levels with the proper assessment, treatment and therapeutic engagement with patients
- maintains a balance between the patient’s dignity and the need to ensure that he/she does not come to avoidable harm.

Aims:

- to encourage the integration of observation practice into good quality inpatient ward therapeutic care
- to provide standards for clinical practice, enabling the processes of:
  - audit
  - skill definition
  - training
  - supervision
  - quality improvement to occur.

Objectives:

- to review the development of policy and practice as it has occurred over the last five years since the publication of Nursing Observation of Acutely Ill Psychiatric Patients in Hospital (1995)
- to incorporate recent policy developments and practice into a revised good practice guideline to facilitate:
  - clinical governance
  - clinical risk management
  - continuous organisational learning through examination of practice such as critical incident reviews.
WORKING GROUP MEMBERSHIP

Mr David Bertin (Chairman)
Clinical Nurse Manager – Lomond and Argyll Primary Care Trust

Mrs Susan Bishop
Chief Pharmacist – Forth Valley Primary Care Trust

Ms Joan Blackwood
Practice Development Facilitator/Research Associate – Mackinnon Unit, Stobhill Hospital

Dr Keith Brown
Consultant Psychiatrist – Forth Valley Primary Care Trust

Ms Moira Cossar
Clinical Nurse Manager – Crichton Royal Hospital

Dr Tim Dalkin
Consultant Psychiatrist – Royal Edinburgh Hospital

Mr Bob Gillies
Intensive Psychiatric Care Unit – Gartnavel Royal Hospital

Mr Michael Hughes
Ward Manager – State Hospital

Ms Elaine Hunter
Trust Advisor in Occupational Therapy – Royal Edinburgh Hospital

Ms Ruth Lockwood
CRAG Secretariat – Scottish Executive Health Department

Dr John Loudon
Principal Medical Officer – Scottish Executive Health Department

Mr Jamie Malcolm
Nursing Officer – Mental Welfare Commission for Scotland

Ms Jackie Meikle
Ward Manager – Royal Edinburgh Hospital

Mrs Alison Meiklejohn
Head Occupational Therapist – Royal Edinburgh Hospital
Ms Corinna Penrose  
Senior Advocacy Worker – Advocacy Matters

Dr Linda Pollock  
Nursing Director – Lothian Primary Care NHS Trust

Mr Colin Poolman  
Royal College of Nursing Professional Officer – RCN Scottish Board

Mr Robert Samuel  
Nursing Adviser – Scottish Executive Health Department

Mr Mark Simpson  
Clinical Nurse Manager – Royal Dundee Liff Hospital

Mrs Frances Smith  
Director of Nursing and Quality – Clinical Standards Board for Scotland

Ms Lesley Wilkes  
Adviser, Mental Health, Scottish Health Advisory Service
CONSULTATION PROCESS

To ensure that the work of the group was based upon the experience of the Service three consultation exercises were undertaken:

- a review of Trust observation protocols
- a survey on the impact and barriers to implementing the original good practice statement on observation
- a brief survey of service users’ experiences of observation.

1 REVIEW OF TRUST PROTOCOLS

In October 2000 Chief Executives of Primary Care Trusts were invited to submit their current protocols to enable the group to develop an understanding of the impact on observation of the 1995 “CRAG Nursing Observation of Acutely Ill Psychiatric Patients in Hospital” report. Comments were invited on the original publication and implementation issues.

The vast majority of protocols refer to three levels of observation and were broadly in line with the suggestions in the original document although different terminology had developed; some policies referred to “close” observation as opposed to “constant” and some referred to “intensive” observation as opposed to “special”. Three documents made specific recommendation to a fourth level of observation that sat between “general” and “constant” observation. One reply indicated that this level of observation had been left in due to a resistance from staff to alter this practice.

Recurring themes requiring greater clarity were: guidance on the observation role of other professionals and relatives, training, recording, post-incidence reviews and supervision, risk assessment, patient rights, and the therapeutic nature of observation.

2 OBSERVATION OF ACUTELY ILL PSYCHIATRIC PATIENTS IN HOSPITAL QUESTIONNAIRE

In December 2000, a questionnaire was sent out to Chief Executives of every Primary Care Trust seeking responses from senior nurses in acute wards and IPCUs. A total of 80 responses was received representing every Primary Care Trust. The purpose of the questionnaire was two-fold:

(a) to understand the impact and obstacles to implementing the 1995 nursing observation good practice statement

and

(b) to ensure that the views and experience of the Service were incorporated into the revised document.
In regard to the three levels of observation recommended, does your service policy broadly fall in line with these?

Virtually all respondents stated that their observation levels corresponded with the CRAG recommendations. 5/15 respondents commented that they used a fourth level of observation that tended to be “general with conditions”.

What type of training, if any, has been carried out for staff regularly involved in observation of patients?

Training varies from Trust to Trust; 25% had received some training in observation as part of an induction package; 10% noted some awareness training and two noted on-going training courses and regular team discussions. Only 6% were required to reach a competence level before being considered competent to carry out observation and 15% reported no training at all.

What particular problems have there been with implementing your observation policy and procedure?

Resource implications. Almost half of the respondents reported staffing problems, in particular low and decreasing numbers of trained staff and untrained bank staff unfamiliar with the ward. This leads to no cover during nurse breaks. Some concern was expressed that staffing restraints led to custodial rather than therapeutic care that compromises patients’ privacy and dignity. Low staffing can have a negative impact upon other ward activities if there are high numbers of patients under observation. Others identified environmental issues as particular concerns. 16% reported problems with recalling medical staff to carry out medical reviews/reduce levels, particularly at weekends. Two respondents expressed concern that the observation policy is misused. Concerns were also expressed at the use of other professionals (mainly Occupational Therapists) to observe acutely-ill patients. 11% reported no problems.

What are the current issues and concerns within your own area at the moment regarding observation of patients?

Major problems are resource implications and lack of qualified staff. 14% reported difficulties contacting medical staff to approve lowering of observation levels. Several respondents highlighted issues of risk and risk assessment – lack of training and lack of confidence, anxieties that individual staff will be blamed/involved in legal actions if problem occurs. Staff fatigue working full time on observation. Seven respondents reported local environmental issues. Only four reported no problems or concerns.
If observation was to be moved from a purely nursing responsibility to one that could be shared among other professionals and potentially relatives, what would your views be on this and what concerns or issues would you like the group to address?

One-fifth reported that shared observation is already happening although not all wards extend this to relatives and carers. A third would welcome future involvement of other professionals, more than half of this group would also welcome some involvement with relatives but cautioned that training and guidelines would have to be provided to ensure observation retained its therapeutic role. Many were concerned about relinquishing responsibility and decision making on behalf of the patient. Only 10% would not welcome the involvement of other professions and relatives stressing that observation was a skilled nursing intervention based upon professional experience.

Any other concerns, questions or information that you feel would influence the group?

There was a great interest in more tailored training to support nursing staff – topics identified were risk management, symptom identification, team working, record keeping and liability. There was a call for additional research/audit and a request for a sample audit tool to support new guidance. It was noted that returning responsibility to patient can be disruptive – this should be dealt with sensitively.

3 Survey of Users’ Views

Question One: During either your current stay in hospital or on a previous occasion, have you been placed on a “Nursing Observation Level”?

Question Two: Were you given a clear and understandable verbal explanation of:

- Why you were being observed?
- How it would be carried out?
- By whom?
- For how long?
- Your rights?
- Told of any restrictions on your movements?
- Were you given written information?

Question Three: Can you recall what type of observation level had been prescribed for you?
Question Four: Describe what happened during the observation?

- Did the nurses talk with you?
- Did you have an opportunity to talk about how you were feeling?
- Could you leave the ward?
- Could you attend planned activities, OT, or participate in group work with other service users?
- Did you remain in your room or generally within the ward area?

Question Five: In your own words describe how you felt whilst on an observation level?

Question Six: What, if anything, could have made this experience better for you?
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THE ASSESSMENT OF RISK
(ROYAL COLLEGE OF PSYCHIATRISTS COUNCIL REPORT CR53 (1996))

The essentials of this report are as follows.

There are four general principles:

- information from a single source is never going to be enough to assess risk, and corroboration will always have to be sought;
- similarly one person alone cannot perform an adequate risk assessment, and access to the network of people surrounding an individual is crucial;
- people who present a risk to others are also likely to be vulnerable to self-harm, self-neglect or exploitation; (in other words the perception of others should not be allowed to blot out the possibility of that individual also needing protection);
- factors such as age, gender and ethnicity are unreliable predictors of risk to harm to others.

In the history taken from an individual being assessed, certain items must be sought:

- previous violence or suicidal behaviour;
- “social restlessness” – few relationships, frequent changes of address or employment;
- evidence of poor engagement with mental health services;
- presence of substance misuse;
- a social background promoting violence;
- any precipitants or changes in mental state or behaviour that have occurred prior to previous episodes of violence or relapse;
- recent change in any of these risk factors;
- evidence of recent severe stress, especially major losses;
- evidence that medication has recently been discontinued.

It is important to identify potential victims, particularly those who figure in abnormalities in the patient’s mental state (for example, the focus of delusions or the apparent source of hallucinations). In the patient’s mental state the emotionality with which the patient presents (for example irritability, anger, hostility or suspicion) is important, as are specific threats made by the patient. Also, beliefs of threat, or persecution or control of mind or body by external forces are noteworthy.
In recording the assessment the following points have to be noted:

- how serious is the risk?
- is the risk specific to one person or situation, or is it general?
- how immediate is the risk?
- how volatile is the risk?
- what potential factors increase the risk, and what might decrease it?
- what specific treatment, and which management plan can best reduce the risk?

In managing risk, there are two basic principles:

- a person working within a mental health service, having identified the risk of dangerous behaviour, has a responsibility to take action with a view to reducing that risk and managing it effectively; and
- in managing risk, the emphasis should be towards safety. That starts by engendering a relationship with the patient which makes him or her feel safer and less distressed.

Considerations for managing risk include:

- does he or she require admission as an inpatient?
- should he or she be detained under the Mental Health (Scotland) Act 1984?
- what level of physical security is likely to be needed?
- what level of observation is required?
- what medication should be used?
- it should be understood clearly by ward staff how the medication is to be employed;
- if there is another episode of violence, how should it be managed?

If the patient is being managed in the community, other questions come to the fore:

- is there a place for the Care Programme Approach?
- can the Mental Health (Scotland) Act be used, or is there a case for a community care order?
- what community supports are available, how effective might they be, and how can they best be assisted?
- do the carers and family have access to appropriate support and help?
- have the carers – in the family, and in other agencies – been adequately informed about the situation, how it is likely to develop, and what help they can expect to receive?
Fundamental to the management of any situation is:

- the plan of management clearly recorded in an accessible place, in legible writing;
- the date for review of the assessment and management plan should be set down, after agreement with all those involved. That date needs to be passed on to all those who need to know;
- the patient’s general practitioner must be informed;
- individuals who should or are entitled to receive information should be identified and responsibility assigned to carry this out;
- the threshold for breaching confidence to ensure public safety has been defined;
- if responsibility for the management of a plan of action is being passed on to another team or individual, it must be accepted explicitly. The information passed on must include all relevant details.

Responsibilities

The Clinician

- to respond as rapidly as possible when concern is expressed by a colleague or member of staff from a partner agency about an increased risk from a patient;
- always to make a systematic assessment;
- always to consult as widely as is possible and appropriate;
- not only to make a decision on what needs to be done, but to make explicit the reasons for that decision and to write them down;
- to make a management plan based on the assessment;
- to record details of the management plan;
- to share the management plan as appropriate with all those who have a legitimate concern with its implementation;
- to make no assumptions about what other people will do – if their co-operation is required in carrying out a management plan, make sure that there is explicit consent;
- to make an appropriate arrangement for monitoring the management plan, making sure that a date is set and kept for subsequent review.
Clinical Teams

- should have an agreed protocol for responding to patients showing significant risk. This protocol should identify:
  - the appropriate senior clinicians to be contacted to conduct assessment or re-assessment;
  - the means by which they should be contacted must be clear;
  - if the identified person is not contactable, a subsidiary route should be available;
  - to have agreed protocols for follow-up and review of patients;
  - to establish and maintain links with other agencies, based on mutual respect for the contribution which can be made, to involve them in the care and management of patients who present a significant risk.

Service Managers

- the effective assessment and management of people presenting increased risk of harm should be of the highest priority for allocation of resources;
- risk assessment and clinical risk management is time-consuming and expensive. The appropriate resources should be made available;
- proper assessment and management of clinical risk cannot take place in an unsafe environment or within inadequate facilities;
- senior staff must be expected always to be available to take responsibility for decisions about assessment and management of risk;
- training must be supported and adequately resourced;
- alliances and partnerships with other agencies should be maintained, and mechanisms put in place to ensure their maintenance.
MILLAN’S TEN PRINCIPLES
(from “New Directions”: Report on the Review of the Mental Health (Scotland) Act* 1984)

1. **Non-discrimination**
   People with mental disorder should, whenever possible, retain the same rights and entitlements as those with other health needs.

2. **Equality**
   All powers under the Act* should be exercised without any direct or indirect discrimination on the grounds of physical disability, age, gender, sexual orientation, race, colour, language, religion or national or ethnic or social origin.

3. **Respect for Diversity**
   Service users should receive care, treatment and support in a manner that accords respect for their individual qualities, abilities and diverse backgrounds and properly takes into account their age, gender, sexual orientation, ethnic group and social, cultural and religious background.

4. **Reciprocity**
   Where society imposes an obligation on an individual to comply with a programme of treatment and care, it should impose a parallel obligation on the health and social care authorities to provide appropriate services, including ongoing care following discharge from compulsion.

5. **Informal Care**
   Wherever possible care, treatment and support should be provided to people with mental disorder without recourse to compulsion.

6. **Participation**
   Service users should be fully involved, to the extent permitted by their individual capacity, in all aspects of their assessment, care, treatment and support. Account should be taken of their past and present wishes, so far as they can be ascertained. Service users should be provided with all the information necessary to enable them to participate fully. All such information should be provided in a way which renders it most likely to be understood.

7. **Respect for Carers**
   Those who provide care to service users on an informal basis should receive respect for their role and experience, receive appropriate information and advice, and have their views and needs taken into account.

8. **Least Restrictive Alternative**
   Service users should be provided with any necessary care, treatment and support both in the least invasive manner and in the least restrictive manner and environment compatible with the delivery of safe and effective care, taking account where appropriate of the safety of others.

9. **Benefit**
   Any intervention under the Act* should be likely to produce for the service user a benefit which cannot reasonably be achieved other than by the intervention.

10. **Child Welfare**
    The welfare of a child with mental disorder should be paramount in any interventions imposed on the child under the Act*.

* The Act refers to the new Act, which will arise from the report, not the existing 1984 Act.