CLINICAL POLICY
Observation and Engagement (in Mental Health and LD Services)

Policy Number	CLP229
Version:	V10
Purpose:	To outline the Trust's procedures for the observation of patients within MH and LD inpatient facilities
Consultation:	MH/LD Matrons, Clinical Policy Group consultation
Approved by:	Clinical Policy
Date approved:	14/02/2024
Author / Reviewer:	Reviewed by: [redacted] Clinical Development Manager Wotton Lawn Hospital
Date issued:	29/02/2024
Review date:	01/02/2027
Audience:	All staff in Mental Health and LD Services
Dissemination:	The policy will be published on the GHC intranet, and its update will be listed on the Clinical Policy News bulletin
Impact Assessments:	This Policy has been subjected to an Equality Impact Assessment. This concluded that this policy will not create any adverse effect or discrimination on any individual or particular group and will not negatively impact upon the quality of services provided by the Trust.

Version History

Version	Date Issued	Reason for Change
V4	June 2011	[redacted] September 11
V5	March 12	Format change
V6	May 2013	Policy review – [redacted]
V7	September 2015	Policy update – [redacted], [redacted], [redacted] [redacted]
V8	October 2016	Full policy update by [redacted] in line with Nice Guidance 10 (NG10, 2015).
V8.1	August 2017	Amendments to section 14.2.9.2
V8.2	Nov 2018	Policy update to reflect practice changes
V8.3	July 2019	Format Update
V9	22/12/2020	Policy Review – [redacted]
V9.1	23/08/2022	Section on New and Existing Technologies added
V10	29/02/2024	Policy Review – [redacted]

SUMMARY
Observation and Engagement within acute inpatient Mental Health and Learning Disability

services is integral to delivering safe and supportive care.

The purpose of supportive observation is to ensure the safe and sensitive monitoring of the service user's behaviour, mental state and physical health well-being; enabling a rapid response to any change, whilst at the same time fostering positive therapeutic relationships between staff and service users. This will be achieved by establishing good rapport with service users, promoting their coping skills and being aware of their individual needs.

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Attachment 7	**Practice Re-Iteration for the Undertaking of General Observations**

ABBREVIATIONS

Abbreviation	*Full Description*
DoLS	Deprivation of Liberty Standards
EPR	Electronic Patient Record
GHC	Gloucestershire Health and Care NHS Foundation Trust
INOP	Infrared Night Observation Panels
MCA	Mental Capacity Act
MDT	Multidisciplinary Team
MHA	Mental Health Act

1. INTRODUCTION

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

Every inpatient who is receiving care and treatment on Trust premises is observed at some level as a necessary part of their care. Where there are specific risk concerns inpatients may need to be placed on higher levels of observation for periods of time. The clinical records must specify the level of observation for all inpatients.

2. PURPOSE

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

3. SCOPE

This policy applies to all Trust staff, who have a duty to abide by and promote the use of this policy.

4. DUTIES

General Roles, Responsibilities and Accountability

Gloucestershire Health and Care NHS Foundation Trust (GHC) aims to take all reasonable steps to ensure the safety and independence of its patients and service users to make their own decisions about their care and treatment.

In addition, **GHC** will ensure that:

- All employees have access to up to date evidence based policy documents.
- Appropriate training and updates are provided.
- Access to appropriate equipment that complies with safety and maintenance requirements is provided.

Managers and Heads of Service will ensure that:

- All staff are aware of, and have access to policy documents.
- All staff access training and development as appropriate to individual employee needs.
- All staff participate in the appraisal process, including the review of competencies.

Employees (including bank, agency and locum staff) must ensure that they:

- Practice within their level of competency and within the scope of their professional bodies where appropriate.
- Read and adhere to GHC policy
- Identify any areas for skill update or training required.
- Participate in the appraisal process.
- Ensure that all care and consent complies with the Mental Capacity Act (2005) – see section on MCA Compliance below.

5. MENTAL CAPACITY ACT COMPLIANCE

Where parts of this document relate to decisions about providing any form of care treatment or accommodation, staff using the document must do the following: -

- Establish if the person able to consent to the care, treatment or accommodation that is proposed? (Consider the 5 principles of the Mental Capacity Act 2005 as outlined in section 1 of the Act. In particular principles 1,2 and 3) Mental Capacity Act 2005 (legislation.gov.uk).
- Where there are concerns that the person may not have mental capacity to make a specific decision, complete and record a formal mental capacity assessment.
- Where it has been evidenced that a person lacks the mental capacity to make a specific decision, complete and record a formal best interest decision making process using the best interest checklist as outlined in section 4 of the Mental Capacity Act 2005 Mental Capacity Act 2005 (legislation.gov.uk).
- Establish if there is an attorney under a relevant and registered Lasting Power of Attorney (LPA) or a deputy appointed by the Court of Protection to make specific decisions on behalf of the person (N.B. they will be the decision maker where a relevant best interest decision is required. The validity of an LPA or a court order can be checked with the Office of the Public Guardian) Office of the Public Guardian - GOV.UK (www.gov.uk).
- If a person lacks mental capacity it is important to establish if there is a valid and applicable Advance Decision before medical treatment is given. The Advance Decision is legally binding if it complies with the MCA, is valid and applies to the specific situation. If these principles are met it takes precedence over decisions made in the persons best interests by other people. To be legally binding the person must have been over 18 when it was signed and had capacity to make, understand and communicate the decision. It must specifically state which medical treatments and in which circumstances the person refuses and only these must be considered. If a patient is detained under the Mental Health Act 1983 treatment can be given for a psychiatric disorder.

6. POLICY DETAIL

The practice of undertaking systematic 'observation' is aimed at preventing potentially suicidal, violent or vulnerable patients from harming themselves or others. In certain situations, it can also assist in preventing accidents such as falls. It also provides a valuable source of information useful in the continuing assessment process. 'Observation' is not simply an activity to support a custodial approach. Undertaking 'Observation' provides an

opportunity for clinicians to interact in a therapeutic manner with the patient. It also enables targeted recordings of a patient's presentation when on high level observation in order to evaluate the service user's response and rationale for continued observation.

Cultural diversity and gender must be respected at all times and must be carefully considered when a patient is placed on closer levels of observation. Wherever possible the need for observation must be discussed with the inpatient and relatives.

Due to the complexity of managing risk and observations, each service user will have an individualised care package including care plans detailing observation interventions. This policy highlights current best practice from NICE Guidance 10, Safe Wards, and Relational Security.

On admission inpatients will be assessed by both a Nurse and a Doctor and as admitting Nurse and Doctor they will jointly agree an initial level of 'observation' based on the identified levels of risk and the views of the referring clinician. The service users' needs will be considered and appropriate care plans developed which will include therapeutic activity and engagement, as well as detailing the level of observation. Details should be recorded in the Care Planning Section of the service user's health and social care record i.e. EPR. For high level observations recordings must be specific to the reason for observation to enable in depth information to inform reviews.

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

LEVELS OF OBSERVATION (NICE GUIDANCE 10: Section 1.4.11)

Low-Level Intermittent Observation

The baseline level of observation in inpatient settings. The frequency of observation is once every 30–60 minutes. Service user's do not need to be within eyesight, but their whereabouts need to be known.

High-Level Intermittent Observation

Usually used if a service user is at risk of becoming violent or aggressive, but does not represent an immediate risk. The frequency of observation is once every 15– 30 minutes.

Continuous Observation

Usually used when a service user presents an immediate threat and needs to be kept within eyesight or at arm's length of a designated one-to-one nurse, with immediate access to other members of staff if needed.

Multi-Professional Continuous Observation

Usually used when a service user is at the highest risk of harming themselves or others and needs to be kept within eyesight of 2 or 3 staff members and at arm's length of at least 1 staff member.

SETTING AND REVIEWING OBSERVATION LEVELS

The need for observation is informed by a comprehensive mental and behavioural state assessment, robust risk assessment/risk management and positive risk-taking processes, the service user's narrative / preferences, and an appreciation of the benefits but also potentially damaging effects of close observations on clinical outcomes.

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

Admitting staff will identify any risk behaviours (e.g. risk to self, others and self-neglect) and assign a level of risk as per the Trust's Assessment and Management of Risk and Safety Policy (MH and LD). This should be recorded in the appropriate section of the EPR. The Risk Assessment will involve identifying Changeable and Unchangeable factors, Acute/Trigger Factors, Actuarial Indicators Clinical Indicators and Protective Factors.

Actual levels of violence should be recorded using the Assaultive Rating Scale (ARS) (Lanza, 1991) as follows: -

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

(Refer to CLP249: Assessment and Management of Risk and Safety Policy MH / LD for further guidance).

Risk Levels are used as a guide to the level of observation to be prescribed. Generally lower levels of risk dictate lower levels of observation, and higher levels of risk require greater observation levels. However, there will be exceptions to this guideline where close observations clearly increase clinical risks and, in these cases, clinicians will discuss and record positive risk-taking strategies where lower levels of observation and sophisticated engagement strategies are used to manage risk instead of close observations.

Observation levels will be discussed at each shift handover. A formal review and documentation in the EPR of all observation levels will take place in the weekly multi-disciplinary review. Very close observations are incredibly challenging and the evidence suggests that when a service user is placed on continuous observations, a review of that level of observation should be undertaken daily by the Nursing team and by the MDT within 72 hours (Gleary 1999).

The service users Named Nurse has responsibility for keeping an overview of observation process and will incorporate the service user's response and narrative into the weekly mental and behavioural examination assessment. The Named Nurse will also ensure that there is logical progression between documented risk, clinical discussions, risk management plans and the assigned observation level.

Where members of the clinical team have differences of opinion upon an observation level then all efforts should be made to negotiate agreement. If agreement cannot be reached, the issue must be escalated until all parties reach a consensus of opinion.

Every effort should be made to involve the service user in the development of their own care plans and any level of observation prescribed. Give the service user information about why they are under observation, the aims of observation, how long it is likely to last and what needs to be achieved for it to be stopped. If the service user agrees, tell their carer about the aims and level of observation. In circumstances where this is not appropriate, for example where a person does not have capacity or where the person has capacity but there are reasons it would be detrimental to the person to be involved, the team may decide not to do so. The rationale for this decision should be recorded within the relevant observation care plan section of their health and social care record.

Use the least intrusive level of observation necessary, balancing the service user's safety, dignity and privacy with the need to maintain the safety of those around them. Observers must be sensitive to the service user's response to observations, particularly the effects on clinical presentation, risks and rapport. Recognise that service users sometimes find observation provocative, and that it can lead to feelings of isolation and dehumanisation.

Observational levels should be reviewed at the earliest opportunity post restraint, particularly if the service user has received rapid tranquilisation medication (refer to CLP117: Prevention and Management of Risk Incidents (including Violent and Aggressive Behaviour) Clinical Policy and CLP158: Use of Rapid Tranquilisation Policy for further guidance).

The Nurse co-ordinating the shift (Shift Coordinator) is responsible for ensuring that adequate resources are available for implementing observations within the ward. In addition, they will ensure that levels of observation are adjusted in response to changes in a service user's risk profile, mental state, ward environment and when a patient receives unexpected and bad news. It is always good practice to discuss risk and observation levels as a team and within a multi-disciplinary discussion, however during unsociable hours when staffing levels and diversity of profession is low (especially in isolated units) a multi-disciplinary discussion may not be possible and the nursing team will need to be responsive and adjust observation levels accordingly (increasing/decreasing). It is good practice to inform the service user's psychiatrist or on-call doctor as soon as possible if observation above the general level is implemented.

Where possible high-level continuous observations (often termed Specialling or 1:1) will be managed via the teams existing staff compliment or from available resources drawn from adjacent wards. Where additional staffing may be required, a clinical discussion must take place between the shift co-ordinator and the matron or if out of hours between the shift co-ordinator and the on-call clinical manager. Both Matrons and on-call managers will discuss staffing solutions and where additional staffing is required they will seek approval from the trust executive team where high cost off framework options become necessary. A series of questions regarding effective use of current resource will need to be considered at this point. High level observations are notoriously resource hungry and linked to service user dissatisfaction and should be reduced at the earliest opportunity following correct risk management protocol.

It is essential that observation levels set are evidence based and logical. For example, if a

service user is high risk of self harm and is being observed every 15 minutes when awake, it would not be logical to reduce the observations to hourly checks at night on the premise that they might be asleep when we know that the commonest room used for suicides is the bedroom. Inversely for externally directed aggression it might be appropriate to reduce observations when a service user goes to bed because of reduced interpersonal conflict. Sometimes observations are only part of the solution to a clinical challenge and need to be supplemented by positive risk taking and use of specialist equipment and environmental adaptions as in falls management. High level observations may not be required to be in place for a full 24-hour period. In these circumstances high level observations should be agreed for a specific time period / or specific situation / presentation. For the period in the day where a high-level observation is not required a clear care plan should be in place to ensure monitoring requirements and agreed interventions are in place.

INDIVIDUALISED OBSERVATION FOR A MORE POSITIVE SERVICE USER EXPERIENCE

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

There will be times when same gender observers are essential. Also, there will be times when observations need to be sensitive to a service user's religious, spiritual and cultural needs.

Observations are an excellent opportunity to monitor fluctuations in mental and behavioural state, to monitor interactions between service users and family members and record functions such as sleeping, eating and drinking.

Implementation of observations must never be custodial in nature and every effort should be made to either make observations discrete or otherwise an opportunity to develop therapeutic rapport or engage in therapeutic activity. Observation is an opportunity for engagement whilst being mindful of the potential for 'over interaction' where service users on close observations become distressed by constant interpersonal communication. Good practice dictates that a programme of structured individual and group activities should be available to service users as part of any care plan and therapeutic milieu. These alternative risk management and engagement strategies could preclude the need for enhanced observation.

Within the Trust inpatient facilities service users are offered 1:1 time with their allocated nurse per shift. This is not always practical or achievable during night shifts when sleep is promoted. Additionally, all inpatients have an individual activity programme.

The Trust endorses the Safe Wards and Relational Security models within its inpatient care settings in order to increase rapport and engagement, to reduce risks and subsequently reduce levels of observation.

OBSERVATIONAL PRACTICE

Staff undertaking observations should take an active role in engaging positively with the service user, be appropriately briefed about the service user's history, background, specific risk factors and particular needs, be familiar with the ward, the ward policy for emergency procedures and potential risks in the environment, be approachable, listen to the service user and be able to convey to the service user that they are valued.

Ideally the observer will already know the service user, however with staffing challenges it is accepted that this is not always possible. Particular care should be taken when delegating observation duties to students and also to temporary staff. Students who have received appropriate trust approved training and are deemed confident / competent by their mentors may take part in undertaking observations with appropriate support and opportunity to debrief.

Observation levels will be verbally 'handed over' at every shift change. Should a level of observation prove to be counterproductive and in need of being reduced then the Nursing team should agree such a decision during a handover period. All decisions and rationale should be recorded and in accordance with Trust's Clinical Risk Assessment and Management procedures and updated in the relevant area of the EPR.

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

Ensure that an individual staff member does not undertake a continuous period of observation above the general level for longer than 2 hours. If observation is needed for longer than 2 hours, ensure the staff member has regular breaks and is replaced by another member of staff during these breaks if required. The Registered Nurse delegating observation duty must be mindful of confidence, competence, the need for regular breaks and the impact of close observation duties on the staff team.

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

If during the undertaking of prescribed observations, a service user is discovered to be missing, a thorough search of the immediate environment must be undertaken. This involves checking all rooms within the ward/unit paying particular attention to "blind spots" within rooms e.g. behind doors, underneath beds, in wardrobes/cupboards etc, before widening the search throughout the hospital/unit. When staff are satisfied that the service user is not on site, the "Procedure for Missing Persons (AWOL) within Mental Health and LD inpatients" should be instigated (refer to CLPr102: Procedure for Missing Persons Within Mental Health and Learning Disability Services (AWOL and Absconding) for further details).

At the point of shift handover, a member of staff from the outgoing and incoming shift will jointly conduct a ward 'walk around'. This will be to check the whereabouts and safety of service users and an environmental check. Completion of this walk around can be recorded on the shift handover sheet provided in Attachment 5. This handover 'walk about' can be viewed as an enhanced hourly check.

If service users are at risk of absconding, harming themselves or others it is essential that during observations a positive identity of the service user is made and that you are confident that they are breathing, that their airway is not occluded and that there is no imminent threat to their life or safety and this may include checking under bed covers if risks are high.

Best practice requires staff to ensure they introduce themselves to the patients they will be responsible for during the shift as early as possible at the start of their shifts. This, alongside any interaction during the shift should be clearly documented in the individuals electronic clinical record.

RECORDING OBSERVATIONS

On the observation recording sheet staff will record the patient's location, an exact time of the observation (within the second, i.e. 18:17.33), date and sign the observation sheet. All forms used must be uploaded to EPR. The record of observation stipulates the time the observation was due and the exact time the staff member observed the patient both sections of the observation record **must be accurately recorded**.

It could take a significant period of time to check the whereabouts of high numbers of service users in larger wards and therefore it is logistically necessary to build in a 15-minute flexible margin for the actual time that hourly checks are undertaken. For higher level observations, consideration should be given by staff carrying out intermittent observation on varying the exact timings (randomisation of observation in line with best practice guidance) so that, for example, 15-minute checks take place 4 times/hour, at relatively evenly divided intervals, rather than precisely every 15 minutes. The exact time the observation took place will be recorded on the observation record.

Level of Risk	NG10 Observation Level	Practice description	Supportive detail	Forms for recording this observation Level
Low	Low Level intermittent observation level.	Hourly checks day and night.	The minimum acceptable level of observation for all in-patients. The location of all service users should be known to staff, but not all service users need to be kept within sight. At least once a shift staff should attempt to engage positively and set aside dedicated time to assess the mental and behavioural state of the service user. Ideally the hourly checks will be discrete and / or naturally take place during activity or therapeutic engagement.	Attachment 1
Medium	High – Level intermittent observations	Usually used if a service user is at risk of becoming violent or aggressive but does not represent an immediate risk. The frequency of observation is once every 15–30 minutes.	The service user's location should be checked every 15 to 30 minutes and recorded. This level is appropriate when service users are potentially, but not immediately, at risk of disturbed/violent behaviour. Service users who have previously been at risk of harming themselves or others, but who are in a process of recovery, require this intermittent observation level. Consideration should be given by staff carrying out intermittent observation on varying the exact timings (randomisation) so that, for example, 15-minute checks take place 4 times/hour, at relatively evenly divided intervals, rather than precisely every 15 minutes. The exact time the observation took place will be	Attachment 3 (15 minute) checks register) Attachment 4 (30 minute checks register)

			recorded on the observation record.	
High	Continuous observation	Usually used when a service user presents an immediate threat and needs to be kept within eyesight or at arm's length of a designated one-to-one nurse, with immediate access to other members of staff if needed.	The service user should be kept within eyesight and accessible at all times, by day and by night and, if deemed necessary, any tools or instruments that could be used to harm themselves or others should be removed. It is required when the service user could, at any time, make an attempt to harm themselves or others. It may be necessary to search the service user and their belongings, while having due regard for the service user's legal rights and conducting the search in a sensitive way.	Attachment 5 is both a 5-minute randomised register but also by grouping the check times you can use this form for continuous observation records.
High	Multi-professional continuous observation	Usually used when a service user is at the highest risk of harming themselves or others and needs to be kept within eyesight of 2 or 3 staff members and at arm's length of at least 1 staff member.	Needed for service users at the highest levels of risk of harming themselves or others, who should be supervised in close proximity. Issues of privacy, dignity and the consideration of gender in allocating staff, and the environmental dangers need to be discussed and incorporated into the care plan. Positive engagement with the service user is an essential aspect of this level of observation.	Recorded directly into EPR progress notes

OTHER SYSTEMS OR TECHNOLOGY USED TO SUPPORT OBSERVATION AND ENGAGEMENT

INOP System:

- Infrared Night Observation Panels, this system is present in some inpatient areas within GHC including: Greyfriars Psychiatric Intensive Care Unit and Montpellier Low Secure Unit. This bespoke technology aim is to offer the patients an unobtrusive approach, which facilitates sleep. INOP is not recorded and patients are able to ascertain when cameras are on from their bedroom. INOP will only be used by healthcare professionals at prescribed observation times for the minimum duration needed to establish need/intervention required. Each patient will have been offered the option of use of INOP but are able to decline and revert back to traditional methods of observation.

Intastop Ligature-Reduction Door Technology:

- This technology has pressure bars that are alarmed and fitted to top and bottom of patient outer bedroom doors. This system can notify staff if a patient may be using their bedroom door as a ligature point, an alarm will alert staff who will act upon this and assist the patient immediately.

Systems as described can be helpful in supporting staff, help prevent serious harm to patients and improve safety. It is important to highlight that this technology can be used to support risk management, but cannot be solely relied upon. Staff must ensure they continue to assess risk and ensure the risk assessment is updated regularly and contemporaneously. Observations

must be prescribed accordingly. Regular risk and observation reviews in ward handovers, MDT and professionals' meetings must be completed as documented within this policy and form the basis for determining the clinical approach to the prescription of observation and engagement plans.

Any technology system that fails to work correctly should be reported to the Estates Department immediately as 'urgent'.

LEGISLATION RELATING TO OBSERVATION

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

NB: a service users relatives / significant others have a legal right to be consulted on the best interest decisions for a person who lacks capacity. (see Trust MCA policy, procedures and guidance). The clinician should also use this time with the service user to ascertain if the service user understands what is involved and answer any questions the service user may raise. This would be documented within the care plan in the patients' health and social care record i.e. EPR.

All attempts should be made to engage the service users regarding the intervention, whether the service user has capacity to consent or not to the intervention. However, at times it is recognised that one-to-one discussion is difficult to achieve due to the service user's clinical presentation. All attempts at engagement regarding the decision should be documented within the patients' health and social care record i.e. EPR.

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

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

The Supreme Court ruling of 2014 identified that there will be a deprivation of liberty if a person is under continuous supervision and control and is not free to leave, and the person lacks capacity to consent to these arrangements. (Supreme Court 2014). If a deprivation of liberty is necessary, it can only be authorised by a procedure set out in law, which enables the lawfulness of that deprivation of liberty to be reviewed. Legal authority to deprive the person of their liberty may be obtained under the Deprivation of Liberty Safeguards (DoLS) in the

MCA or the MHA. Each regime provides a procedure to authorise deprivation of liberty. Ref Trust MCA and DoLS policy, procedure and guidance.

See Section 5 for further information on Mental Capacity Act Compliance.

7. DEFINITIONS

Definitions of the x4 levels of Observation (NICE NG10, 2015)

Low-level intermittent observation

The baseline level of observation in inpatient settings. The frequency of observation is once every 30–60 minutes.

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Multi-professional continuous observation

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8. PROCESS FOR MONITORING COMPLIANCE

Are the systems or processes in this document monitored in line with national, regional, trust or local requirements?	YES

Monitoring Requirements and Methodology	Frequency	Further Actions
An audit of the implementation of this document will be undertaken every two years. This will involve auditing a random sample of in-patient clinical records. The audit criteria will include assessing compliance against the following standards: Process for observation at differing levels / Record Keeping	2 yearly	The results of the audit will be presented to the Quality Assurance Group, who will be responsible for the development and monitoring of any identified actions within the scope of the audit.
Annual targets for staff attendance at statutory and mandatory training will be set and monitored routinely by the Resources Committee		

9. INCIDENT AND NEAR MISS REPORTING AND REGULATION 20 DUTY OF CANDOUR REQUIREMENTS

To support monitoring and learning from harm, staff should utilise the Trust's Incident Reporting System, DATIX. For further guidance, staff and managers should reference the Incident Reporting Policy. For moderate and severe harm, or deaths, related to patient safety

incidents, Regulation 20 Duty of Candour must be considered and guidance for staff can be found in the Duty of Candour Policy and Intranet resources. Professional Duty of Candour and the overarching principle of 'being open' should apply to all incidents.

10. TRAINING

Training and information for staff will be given initially on induction to the Trust and annually thereafter. Line Managers should ensure all appropriate staff members are aware of the local implementation of the policy.

11. REFERENCES

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

Dack, C; Ross, J; Bowers, L. The relationship between attitudes towards different containment measures and their usage in a national sample of psychiatric inpatients. Journal of Psychiatric and Mental Health Nursing, 2012, 19, 577–586.

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

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

National Confidential Inquiry into Suicide and Safety in Mental Health 2023

NICE Guideline NG10 (2015) Violence and Aggression Short-term management in mental health, health and community settings

12. ASSOCIATED DOCUMENTS

GHC Incident Management Policy (Clinical Governance Policy CGP001)

GHC Health Records and Clinical Record Keeping Policy (CLP005)

GHC Missing Persons (AWOL) within Mental Health and LD inpatients (CLPr102)

GHC Assessing and Managing Clinical Risk and Safety MH / LD (CLP249)

GHC Prevention and Management of Risk Incidents (including Violent and Aggressive Behaviour) Clinical Policy (CLP117)

MCA and DoLS policy, procedure and guidance (2015)