Birmingham and Solihull Mental Health NHS Foundation Trust

# Supportive Observations and Therapeutic Engagement Policy

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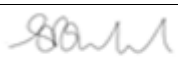
| **Policy number and category** | **C05** | **Clinical** |
| **Version number and date** | **5** | **March 2024** |
| **Ratifying committee** | **Clinical Governance Committee** | |
| **Date ratified** | **March 2024** | |
| **Next anticipated review** | **March 2027** | |
| **Executive director** | **Executive Director of Quality & Safety (Chief Nurse)** | |
| **Policy lead** | **Deputy Director of Nursing & Quality** | |
| **Policy author** | **Lead Nurse for Safer Staffing** | |
| **Exec Sign off Signature** |  | |
| **Disclosable under Freedom of Information Act 2000** | **Yes** | |

## Policy context

Intermittent and continuous observations are the most widely used form of intensive levels of support in the care, treatment and engagement of people presenting with high levels of distress or vulnerability on inpatient wards. Supportive observations are an important skill for all mental health professionals working within inpatient settings. This intervention can be intrusive and restrictive, therefore should only be used when clinically indicated to maintain safety and preserve an individual's dignity (NICE, 2015).

"There has got to be ways of helping a person feel safe and supported without reducing them to victims of voyeurism and seriously eroding away their basic human rights" (Bowles et al, 2002:256)

When supportive observations are delivered effectively, they improve safety of care and lead to better service user experience and improved clinical outcomes

The therapeutic engagement element inherent in supportive observations requires a mutually trusting, respectful, kind, partnership between a service user and a staff member, aimed at supporting recovery and wellbeing.

## Policy requirement

This Policy will inform the practice of supportive observations within the trust including: -

- When baseline and enhanced observations should be used
- Which staff are best placed to carry out these observations
- Responsibilities for ensuring enhanced observations are used for the least amount of time clinically required
- The process to be followed for assessing the level of risk for each service user, agreeing the appropriate level of observation, engagement, activity or intervention,
- The process for ensuring adequate review
- The process for ensuring clinically informative record keeping

## Contents

**1: Introduction**:

**1.1. Rationale**: Harm minimisation and recovery

- The prime purpose of mental health and learning disability services is to promote recovery. Observation of service users is by its very nature intrusive, particularly where it is for prolonged for many hours or even days, and if managed inappropriately can damage that recovery process. Moreover, service users have said that they find observations provocative and that it can lead to feelings of isolation and dehumanization. Therefore, it should be undertaken sympathetically and only when necessary. It should be recognised however that if carried out well, that Supportive Observation is important as a supportive mechanism, for the purpose of engaging positively with the service user.
- Supportive observations are useful to: prevent self-harm, harm to and from others and to prevent suicide, maintain patients' privacy and dignity at times of disinhibited behaviour and to manage clinical risks e.g. associated with declining physical health, those at risk of falls (NCISH, 2015), absconding (Bowers et al, 2000) choking, reduced nutrition and hydration.
- Supportive observation and engagement, over and above the lowest level of observations and engagement, is a therapeutic intervention aimed at reducing factors which contribute to increased risk and promoting recovery. It should focus on engaging the person therapeutically and enabling them to address their difficulties constructively.
- It is important that staff balance the distressing effect and potential long term harm of being on high level of observations and engagement (e.g. loss of skills, loss of autonomy) against the risk of immediate harm (e.g. serious self-harm or violence). As this will change over time, this balance will need to be continually assessed.
- Human rights: The use of supportive observation and engagement must not breach The European Convention on Human Rights, and in particular the right to have private life respected (Article 8). No service user should be subject to unnecessarily observations in a way that would breach this right. In order for this policy to comply with the law observations must be justifiable and proportionate. Clinicians therefore need to make sure that the use of supportive observation is no more intrusive – nor continues longer – than is required by the circumstances. Therefore they need to ensure that the right to life (Article 2) is sufficiently threatened to make the use of observations justifiable.
- NICE Guidance: This procedure is consistent with NICE Clinical Guideline NG10: Violence and aggression: short-term management in mental health, a health and community setting (2015) which describes levels of observation that can be used when clinical risk levels are high, however following consultation with service users and staff we will continue to use the observation levels outlined in the previous NICE guideline (CG 25). This is in line with national advice and feedback was significantly in favour of keeping levels 1 – 4 which are familiar, well understood and clearer than levels outlined in NG 10.
- Compliance with Chapter 26 of MHA Code of Practice (2015) A safe and therapeutic culture should be provided for all people receiving treatment for a mental disorder including those who may present with behavioural disturbance. The use of supportive observation and engagement must not breach the Mental Health Act Code of Practice (MHA CoP) and should adhere to the guiding principles of the MHA

**1.2. Scope (**when, where and who): This policy applies to all service users receiving inpatient care at BSMHFT with the following exceptions:

2. This policy does not apply to HMP Birmingham. Staff working in this service will work within the Assessment, Care in Custody and Teamwork (ACCT) framework.
3. A variation specifically available to the Mother and Baby In-Patient Unit is detailed in Appendix 2 with the acknowledgment that the broad scope of this policy still applies
4. There is a variation to the policy specifically for low secure and Steps to Recovery in appendix 3 with the acknowledgement that the broad scope of this policy still applies.

This policy acknowledges and pays due regard to the personal protected characteristics as defined in the Equality Act 2010. Staff members are expected to take these elements into consideration when planning, implementing, undertaking and reviewing observations.

**1.3. Principles**

- Supportive Observation and Engagement is more than just watching a person. It is the active and sensitive support of an individual when at their most vulnerable or when harm is most likely to arise. What keeps people safe is not the act of being under surveillance (observation); rather it is the quality of engagement between that individual and staff.
- Supportive engagement is therefore underpinned by continuous attempts for compassionate and therapeutic interaction to meet the holistic needs of a service user. Staff should be approachable and listen to the service user and be able to convey to the service user that they are valued.
- It is essential that during supportive observation and engagement the service user should be given the opportunity to talk and take part in activities meaningful to them and appropriate to their needs and recovery. Such activities need to be collaboratively identified and regularly reviewed with the service user and documented in the care plan, which should be reiterated at each handover. A suggested list of activities can be found in Appendix 3 Staff must also be respectful for individuals need for rest and silence and listen to what the service user finds most helpful. If for any reason involving the service user in dialogue and activities during supportive observation and engagement is not possible, then the reasons for this needs to be clearly recorded.
- The Trust positively supports individuals with learning disabilities and ensures that no-one is prevented from accessing the full range of mental health services available. Staff will work collaboratively with colleagues from learning disabilities services and other organisations, in order to ensure that service users and carers have a positive episode of care whilst in our services. Information is shared appropriately in order to support this.

**2**: **The policy**:

**2.1 Levels of observation**

An appropriate level of observation must be decided for each service user admitted to inpatient care which should be a collaborative process weighing up risks and benefits. Thereafter the level and plan for supportive observations will be

(a) Routinely considered at each MDT

(b) Outside of the MDT when the level of presenting risk changes

There are 4 approved levels of observation

| Observation Levels | |
|---|---|
| **Level One** | The person in charge will ensure that the shift team are aware of the whereabouts of service users at all times. Service users will be checked at a minimum of once per hour whilst on the ward |
| **Level Two** | Intermittent observations at between 15- and 30-minute intervals depending on level of risk identified and need.<br>When using 15 and 30 minute observations it is essential to vary observation times so the service user is observed at a minimum of every 15 or 30 minutes.<br><br>BSMHFT does not support 5 minute observations particularly for service users who present with a suicide risk or risk of harm to others. However Secure Care services by exception may utilise 5 minute observation to maintain the security of the unit and the patient. |
| **Level Three** | Continuous observation with the service user remaining in the full and uninterrupted vision of a designated member of staff (or team of staff) within the same room or vicinity |
| **Level Four** | Continuous observation with the service user remaining within arm's length of a designated member of staff (or team of staff) |

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For BSMHFT employed Nursing Apprentices (RNDA's and TNA') that are on work base days, they can complete Level's one, two, three and four observations if included in the staffing numbers. However, whilst on placement or considered supernumerary they can take part in therapeutic observations if deemed suitably trained by the person in charge. For Nursing Apprentices on placement that are external to the BSMHFT, it is recommended that they are not assigned to complete Therapeutic Observations but may shadow suitably trained staff as part of their competencies.

### 2.2 Observation and leave planning

Service users who are subject to either Level 1, 2 or 3 observations may have leave from the ward if approved by the MDT. Leave must be supported by a robust risk assessment and leave plan.

Consideration as to whether to completely rescind the level of observations to allow the leave or whether to suspend or continue the observations during the period of planned leave will be a matter for the MDT to decide. All decisions must be recorded in the service user's electronic record as follows:

- For service users who are detained under the Mental Health Act, any approved section 17 leave will require a Section 17 Leave Prescription signed off by their consultant and an accompanying Nursing Leave Record within Rio.
- For informal service users the leave plan will be recorded in the form of a care plan item.

- Service users subject to level 4 observations may not have leave from the ward unless it is specifically approved by the service user's RC for an exceptional circumstance such as the service user requiring medical attention at another hospital or to attend court.

### 2.3 Observation during periods of seclusion and long-term segregation

Full details on the standards for observation during periods of seclusion and long-term segregation can be found in the **SECLUSION AND LONG TERM SEGREGATION POLICY**

## 3: The procedure

### 3.1. Prescribing Supportive Observation

3.1.1 In order to determine the required level of observation for a particular service user, an up to date risk assessment is required which should be completed by an appropriate clinician using multi-disciplinary considerations. This assessment must be clearly documented on the service user's electronic record to demonstrate the factors considered and the rationale for decisions made. Where a registered practitioner has identified an immediate risk that the service user may harm themselves and evokes an increase in observation levels, then they are to remain with the service user and summon assistance using their alarm (where available). At no point, once level 3 & 4 observations have been evoked, is the member of staff to leave the service user on their own in order to summon help.

3.1.2 Any decision about observation must be discussed and agreed with the professional in charge of the ward where the service user is. The service user and carers (where appropriate) should be involved in discussions about risk, appropriate levels of observation and the meaning of these.

3.1.3 Each inpatient service user will have a Supportive Observations prescription on Rio. The prescription enables single document recording of the following:

(a) Details of approval for the current level of observation
(b) Details of the prescribed level of observation, clarity on whether toilet/bathroom privacy is indicated and whether observation can be varied at night

3.1.4 The Rio prescription form also includes the observation care plan. This must be completed – with the service user's involvement - to compliment the prescribed level of observation, in order for the observation to be carried out in a supportive way and geared toward meeting the individual needs of each service user.

(a) Purpose of observation: Explaining why the service user is being observed at the prescribed level
(b) Interventions –these might include direction as to how best to approach the service user, strategies to engage the service user, activities that the service user may enjoy, triggers for staff to look out for and how to respond and what to do if the person is observed to behaving in a particular way. Particular consideration will be required in order to designate staff appropriately to support the service user in meeting their cultural, gender and spiritual needs. It may be necessary to include directions for searching the service user and their belongings at times in order to promote safety (with due regard to the service user's legal rights and sensitivity.) It

will also be necessary to consider environmental issues such as which bedroom the service user will be placed in and whether to control access to ensuite facilities.

(c) Goals – what the observation plan is trying to achieve (again from the service user's perspective) and what will have to happen for observation level to be reduced. Safety would obviously be a key element. but it is also important to document what would constitute a good experience of observation/engagement for the service user

(d) Evaluation – when the observation next needs to be formally evaluated and what criteria will be used (linked to goals)

3.1.5 The Supportive Observations Prescription also has a section to record the service user's view

3.1.6 The service user must be offered a copy of their observation care plan. In such instances this should be recorded in the patient's care records.

### 3.2 Flexible Nursing Observations

Some inpatient teams – notably our Women's medium secure services- have adopted the use of 'Flexible Nursing Observations' which are intended to provide a collaborative alternative for the management of service users who have high risk behaviours that cause harm to themselves (for example self-injurious behaviour and suicide attempts.) Flexible nursing observations can only be applied if the following criteria are met:

1. The service user has an existing care plan regarding flexible observations.
2. The care plan is agreed by the clinical team, including the Responsible Clinician and the team's senior nurse.
3. The care plan must be regularly reviewed at the clinical team meeting every week.

Guidance on the use of Flexible Nursing Observations can be found in APPENDIX 3

### 3.3 Zonal Observation

Some wards have come to use the term 'zonal observation' to describe the practice of deploying staff to monitor activity in particular areas of the ward. Within this policy, the term observation relates to the supportive monitoring and engagement of individual service users and therefore the concept of 'zonal observation' is not recognised within this policy.

### 3.4 The practice of observation

3.4.1 Observation must always be carried out in such a way as to enhance the safety of the service user whilst preserving their dignity and privacy as much as possible. Individual and cultural issues in relation to observation (for example risks in relation to religious observance, wearing clothing which obscures the face or could allow self-harm to be unobserved, sensitivity to gender issues etc) must be considered when prescribing observation and allocating clinicians to carry it out.

3.4.2 When carrying out observation, the aim should always be to achieve active engagement with the service user as far as possible, particularly as the development of relationships can assist in risk reduction and improve the acceptability of observation to the service user. When more than one person is allocated to observe, one staff member will be designated as the lead for the observation and engagement of the service user for the designated span of observation.

3.4.3 Intermittent observations are a touchpoint to offer support and engagement, not to simply check on a service users' whereabouts. Intermittent observations should not be done routinely every 15 or 30 minutes but should be varied within the agreed timescale to ensure the observation is not predicted (which is known to increase risk). For example if a service user is on 15 minute observations they can be observed at any time within this 15 minutes and when entered onto the service user portal this will generate a new 15 minute timeframe.

3.4.4 Staff members must not discuss personal or professional issues with each other when carrying out observation the focus must be on the service user.

3.4.5 Level 3 or 4 continuous observations must not be carried out by the clinician for more than 2 hours at a time with the same service user in all but exceptional circumstances. This can be 1 hourly where practicable or more frequently if clinical need is greater.

3.4.6 The practitioner in charge should consider and plan for observation requirements for service users on escort from the ward.

3.4.7 More frequent rotation of observation may be required in situations where the interaction/level of attentiveness is especially intense

3.4.8 A handover must always take place between incoming and outgoing staff member. The content of this handover should at least reflect the current needs, behaviour and risks of the service user. The service user will be included, wherever practicable, which is a standard established by NICE NG10 (NICE, 2015).

3.4.9 Consideration needs to be given in services such as Older People Services that Level 3 or Level 4 can only be delegated to friends and family if the observation level is for a **risk of falls** following a risk assessment by the MDT. This is to be discussed with friends and family being involved and all parties are to be in agreement. Level 3 and Level 4 observations in all other clinical circumstances may not be delegated to friends and family.

### 3.5 Reviewing and amending observation levels

3.5.1 The level and plan for therapeutic observation must be considered at the point of admission to inpatient services, at the point of transfer between inpatient services and thereafter as set out below. All observation reviews must include the service users perspective.

3.5.2 Level one observation must be reviewed at a minimum of once per week.

3.5.3 Observations at Level Two, Three and Four must be reviewed at a minimum of once per shift by the Practitioner in Charge. If it is determined that the level of observation should remain unchanged this would constitute a 'review' and must be recorded as such on the progress notes in the service user's care record with the rationale for this decision.

3.5.4 For Level Two observations: If the Practitioner in Charge feels that the observation level can be reduced they must contact the ward doctor (or on-call cover.) Together they will then discuss the observation level and plan, and then update the Responsible Clinician with their decision. The risk assessment and the decision will be documented in the progress notes on RIO.

3.5.5 For Level Three and Four Observations: The Responsible Clinician (or their deputy who has delegated responsibility) must personally review the service user to reduce Level Three or Four observations, which must be recorded in service user's clinical record.

3.5.6 Where a period of Level Three and Level Four observation continues for more than one week a full multi-disciplinary review will take place.

3.5.7 Downgrading of observations under the flexible observations framework can only be made if there is a comprehensive and multi-disciplinary plan that clearly sets out the parameters and contingencies in such events.

### 3.6 Recording of discussions about therapeutic observation

3.6.1 All records relating discussions and carrying out of therapeutic observation must be completed at the time or as soon as possible after. If recording information sometime after then the entry must explain the delay.

3.6.2 The doctor or registered professional should record all discussions regarding observation levels in the service user's electronic record. Routinely the observation level and plan will be reviewed and recorded as part of the MDT meeting including

- Rationale for observation
- Current mental state
- Current assessment of risk
- The agreed level of observation to be implemented
- Clear direction regarding therapeutic approach and agreed interventions which may be used to engage with the patient
- Timescales and review
- Service user's perspective and engagement with observations
- Names and titles of staff involved in making the decision

3.6.3 There must be a record to evidence that observation has been carried out, which clearly identifies the member of staff undertaking the observation. This will be by means of a paper recording format or using an approved trust app designed for the purposes of point of care recording of observation. Please **click here** for Training Guides. It is a requirement that all substantive and temporary staffing solutions staff who work on out inpatient wards have completed the training. All agencies that we use have been asked to comply with the frameworks of observation training. This will provide us with assurance that staff are adequately trained on the wards.

3.6.3 Pertinent information of a more detailed nature will be recorded in the service user's progress notes by the observing staff member. At a minimum a summary entry will be made on the recorded at the end of each span of duty.

3.6.5 The service user's view will be recorded on the observation prescription initially and their views on their experience of observation will be recorded in the progress notes.

### 3.7 Observation at night and waking/sleeping observation

3.7.1 Direction for observation level at night is to be included on the Rio prescription form. Where observation levels are to be reduced during the night, nursing staff must ensure that there is an appropriate assessment of the patient's sleep pattern and sleep behaviour so that the transition from sleeping to waking can be appropriately monitored. This can be achieved through using the z function of the inpatient portal

3.7.2 Service users on level one observation must be checked at least once per hour during the night unless otherwise specified on their MDT agreed care plan. There may be exceptions in Steps to Recovery and Hillis Lodge, please refer to Appendix 4

3.7.3 Gender and cultural sensitivity must be observed when carrying out observations particularly at night

3.8 **Observation in general hospital settings**

3.8.1 There are occasions where inpatient service users on level 3 or 4 continuous observation require admission to a general hospital. In such cases the senior nurse for the BSMHFT ward will organise appropriate cover to carry out the observation for the initial 72hr period .

3.8.2 If the service user needs to stay in the acute hospital for longer than 72hrs, then the liaison psychiatry service may take over responsibility for their mental health care and will liaise with the acute trust to ensure that there is clear plan of care in place. Liasian Psychiatry and the host ward from BSHMFT will remain in regular contact in regard to the plan of care for the service use.

If the staff to be withdrawn their needs be clear communication between both trusts to ensure it is planned and safe.

3.8.3 The only exception to this will be those service users who are subject to Ministry of Justice restrictions. These service users will continue to be observed / escorted by BSMHFT staff at all times.

**4: Responsibilities**.

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| Chief Nursing Officer/Executive Director Quality and Safety | The Chief Nursing Officer/Executive Director Quality and Safety is accountable for clinical risk management and will ensure that there is a policy in place that supports the practice of therapeutic observation of inpatient services. |
| Associate Directors of Operations and Clinical Nurse Managers | • Ensure that the policy is implemented in their service areas.<br>• Bring the policy to the attention of all clinical staff<br>• Ensure that all identified staff receive training to fulfil the requirements of this policy (as per training Matrix) |
| Responsible Clinicians | The Responsible Clinician has overall responsibility for care and treatment for service users being assessed and treated under the Mental Health Act. |
| Matrons | • Matrons are responsible for ensuring that wards within their sphere of authority have arrangements in place to support and review the use of supportive observations.<br>• Matrons will be responsible for supporting staff in ensuring diversity is respected and carefully considered and helping staff action required care. |

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| | • Matrons should carry out periodic checks in their area to support staff and service users that observations are effective, supportive and engaging. |
| Ward Managers | • The Ward Manager is responsible for ensuring that their ward has a framework in place for organising and delegating supportive observations in accordance with this policy.<br>• The framework must ensure that cultural needs will be discussed with the service user and their relatives/ carers, so that information and advice can be obtained, for example regarding the gender of the staff carrying out observation duties or ability to have private time and space to carry out religious worship.<br>• The Ward Manager will routinely audit risk assessments and care plans to ensure that they appropriately identify the current level of observation<br>• The Ward Manager is also responsible for ensuring that their direct care team members are competent to carry out all levels of therapeutic observation and formally assessing this in regular management supervision and annual appraisal.<br>• The Ward Manager will ensure that local orientation procedures for temporary staff and student nurses include assessment of competence to conduct supportive observation in accordance with this policy.<br>• The Ward Manager is also responsible for liaising with service users to gather their views and feedback about their experience of therapeutic observation in order to improve practice in their area. |
| Person in charge of the ward | • The person in charge of the ward is responsible for ensuring that all planned supportive observations are organised for their span of duty. They must notify the Ward Manager (or senior manager in their absence) of any concern that the ward will not be able to meet the requirement to safely observe all of its service users<br>• Where a new plan of observation is instigated, the person in charge will ensure that the service user (and / or carer) if appropriate is informed, that they receive an explanation as to why observation is necessary, be given information as appropriate as well as the opportunity to discuss any concerns or questions they have with an appropriate member of the multi-disciplinary team. Different languages and communication methods should be considered to ensure the information is given appropriately.<br>• The person in charge must assure themselves that the staff members who will carry out the observations are competent to do so, that they understand the risks and purpose for the observation and the requirement to behave in a respectful manner as detailed in the section below.<br>• The person in charge will maintain oversight of all therapeutic observations conducted during the span of duty, including periodically checking with staff conducting the observation and taking direct feedback from each staff member at the end of the span of duty. |
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| Members of staff carrying out therapeutic observation | Staff members designated to supportive observations must ensure that they understand the purpose of the observation, the level of observation prescribed and the care plan requirements. If they are in any doubt they must approach the person in charge for clarity.<br><br>Staff must bring to the immediate attention of the person in charge any circumstance that affects their competence or ability to conduct therapeutic observations.<br><br>Observation should be underpinned by attempts to support and engage with service users. This requires developing trust and therefore staff members conducting observation must always treat the service user as an individual and respect diversity.<br>• Introducing yourself by name and role at the start of any period of observation<br>• Checking that the service user understands the purpose of the observation and establish what they would like to happen<br>• Staying alert and attentive to the service user at all times so<br><br>o Not reading newspapers, books or magazines (unless it is with the service user)<br>o Not using mobile phones or checking for messages<br>o Not speaking with colleagues or others as if the service user wasn't there<br>o Attempting to engage the service user in activity that they enjoy<br><br>Staff must provide a verbal handover to any member of staff taking over the observation of a service user from them. They will also document any pertinent observations in the service user's record and bring any concerns to the attention of the person in charge at the earliest opportunity and should include the service user.<br><br>All staff members must raise any concerns about poor or unsafe practice that they witness.<br><br>Level three or four observations may not be delegated to first year student nurses in any circumstance. They may shadow a suitably qualified or experienced staff member who is conducting level 3 or 4 observations with the service user's agreement for the purposes their own development.<br><br>First year students may participate in conducting level one and two observations if assessed and deemed competent to undertake the task by the person in charge.<br><br>Second and third year students may undertake level three and level four observations if assessed and deemed competent to do so by the person in charge delegating the observations. |

## 5: Development and Consultation process

This policy has been developed in consultation with staff and service users. Staff sessions were held over teams. A group of Experts by Experience have been collaboratively involved with the development and writing of this policy.

| Consultation summary | | |
|---|---|---|
| **Date policy issued for consultation** | November 2022 | |
| **Number of versions produced for consultation** | 1 | |
| **Committees / meetings where policy formally discussed** | **Date(s)** | |
| **PDMG** | November 2023 | |
| | | |
| **Where received** | **Summary of feedback** | **Actions / Response** |
| PDMG | Amendments to the job titles, EIA and family members completing observations | Amendments made to policy. |
| | | |

## 6: Reference documents


- Bowers, L. & Park, A. (2001) Special Observation in the care of Psychiatric Inpatients: A literature review. *Mental Health Nursing* 22; 8:769- 786
- Department of Health (2005) Mental Capacity Act. London: TSO
- Department of Health (2015) Mental Health Act (1983) Code of Practice – Revised 2015. London: TSO.
- Department of Health (1999) *the safe & supportive observation of patients at risk*. London: TSO.
- HM Government. Equality Act 2010. London: TSO.
- National Patient Safety Agency (2006) Patient Safety Observatory Report *with Safety in Mind: mental health services and patient safety*
- National Institute of Clinical Excellence (2015) *NG 10: Violence and Aggression: Short-term Management in Mental Health, Health and Community Settings. London: NICE Publications.*
- Nursing and Midwifery Council (2015) *The Code: Professional Standards of Practice and Behaviour for Nurses and Midwives*. NMC: London.

**8: Glossary** consisting of:

None

**9: Audit and assurance** consisting of:

| Element to be monitored | Lead | Tool | Frequency | Reporting Committee |
|---|---|---|---|---|
| Ensure that Care Plans appropriately identify the current level of observation. | Deputy Director of Nursing/ Ward Managers | Audit of observations | Daily/Weekly and Annually | Reporting to local CGC and Quality and Safety Committee |
| Percentage of staff compliant with Observation Training requirements | Deputy Director of Nursing/ Lead for L&D | Audit of Insight | Quarterly | Reporting to Performance Committee |
| Observations are correctly recorded. | Deputy Director of Nursing/ Ward Managers | Audit of observations | Daily/Weekly and Annually | Reporting to local CGC & Quality and Safety Committee |

**10. Appendices**

- Appendix 1 – EIA Assessment
- Appendix 2 - Variation for Mother and Baby Inpatient (Perinatal) Unit
- Appendix 3 – Practical Engagement
- Appendix 4 - Variation for Steps to Recovery Service and Hillis Lodge (Low Secure Mental Health)

**Appendix 1**

**Equality Analysis Screening Form**

A word version of this document can be found on the HR support pages on Connect

**http://connect/corporate/humanresources/managementsupport/Pages/default.aspx**

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|---|---|---|---|
| **Title of Proposal** | **Supportive Observation Policy** | | |
| **Person Completing this proposal** | Katie Atcherley | **Role or title** | Lead Nurse for Safer Staffing |
| **Division** | Corporate | **Service Area** | Corporate |
| **Date Started** | 01.11.2022 | **Date completed** | 01.11.2022 |
| **Main purpose and aims of the proposal and how it fits in with the wider strategic aims and objectives of the organisation.** | | | |
| The purpose of the policy is to ensure our service users are prescribed supportive observation levels whilst they are an inpatient in our care. Staff will be working will fulfil their full potential of working alongside the trust values of being inclusive, compassionate, and committed whilst they are supporting service users on observation levels. | | | |
| **Who will benefit from the proposal?** | | | |
| This policy applies to **all**, including applicants applying for a job, staff including agency, bank and volunteers, services users and carers, visitors, stakeholders, and any other third-party organisations who work in partnership with the Trust<br>Service users will benefit from being prescribed supportive observation levels to aide recovery whilst an inpatient. | | | |
| **Do the proposals affect service users, employees or the wider community?**<br>***Add any data you have on the groups affected split by Protected characteristic in the boxes below. Highlight how you have used the data to reduce any noted inequalities going forward*** | | | |
| The proposal will have a positive effect on services users, employees and wider community. | | | |
| **Do the proposals significantly affect service delivery, business processes or policy?**<br>***How will these reduce inequality?*** | | | |
| This is a new policy which will be aligned to the Trust 5 year strategy | | | |
| **Does it involve a significant commitment of resources?**<br>***How will these reduce inequality?*** | | | |
| The Trust is fully committed to ensure that we are working in a safe and effective manner on the wards. | | | |
| **Do the proposals relate to an area where there are known inequalities? (e.g. seclusion, accessibility, recruitment & progression)** | | | |

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|---|---|---|---|---|
| The proposal relates to Trust wide and will affect all areas/staff and service users in a positive way. | | | | |
| **Impacts on different Personal Protected Characteristics –** *Helpful Questions:* | | | | |
| *Does this proposal promote equality of opportunity?*<br>*Eliminate discrimination?*<br>*Eliminate harassment?*<br>*Eliminate victimisation?* | | | | *Promote good community relations?*<br>*Promote positive attitudes towards disabled people?*<br>*Consider more favourable treatment of disabled people?*<br>*Promote involvement and consultation?*<br>*Protect and promote human rights?* |
| **Please click in the relevant impact box or leave blank if you feel there is no particular impact.** | | | | |
| **Personal Protected Characteristic** | **No/Minimum Impact** | **Negative Impact** | **Positive Impact** | **Please list details or evidence of why there might be a positive, negative or no impact on protected characteristics.** |
| **Age** | | | √ | As part of the Equality Act – Age is a protected characteristic, however, is collated through our recruitment and admission process. It is anticipated that age will not have an negative impact in terms of discrimination as this policy ensures that all employees and service users should be treated in a fair, reasonable and consistent manner irrespective of their age. |
| Including children and people over 65<br>Is it easy for someone of any age to find out about your service or access your proposal?<br>Are you able to justify the legal or lawful reasons when your service excludes certain age groups | | | | |
| **Disability** | | | √ | WDES Data is showing **4.7%** colleagues across our Trust have long-term condition or illness. Currently we have the Disability and Neuro Diversity Staff Network Group who currently support staff with disability. We also support staff with Reasonable adjustment with the Government 'Access to Work' Grant. Therefore, it is anticipated that disability will not have an negative impact in terms of discrimination as this policy ensures that all employees should be treated in a fair, reasonable and consistent manner irrespective of their disability. This is dependent if the individual feel comfortable about being open about their disability especially where this may be a hidden disability or mental health issues.<br>A reasonable adjustment and further support can be implemented for service users |

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| Including those with physical or sensory impairments, those with learning disabilities and those with mental health issues<br>Do you currently monitor who has a disability so that you know how well your service is being used by people with a disability?<br>Are you making reasonable adjustment to meet the needs of the staff, service users, carers and families? | | | | |
| **Gender** | | | √ | It is anticipated that gender will not have an negative impact in terms of discrimination as this policy ensures that all employees should be treated in a fair, reasonable and consistent manner irrespective of their gender identity. Where identified service users will also have the staff on the observation to meet gender needs if required |
| This can include male and female or someone who has completed the gender reassignment process from one sex to another<br>Do you have flexible working arrangements for either sex?<br>Is it easier for either men or women to access your service and proposal? | | | | |
| **Marriage or Civil Partnerships** | | | √ | Although this is a protected characteristic, this is not recorded. It is anticipated that marriage or civil partnership will not have an negative impact in terms of discrimination as this policy ensures that all employees should be treated in a fair, reasonable and consistent manner irrespective of their marriage or civil partnership. This is dependent on staff feeling comfortable about being open about their Marriage or Civil Partnership |
| People who are in a Civil Partnerships must be treated equally to married couples on a wide range of legal matters<br>Are the documents and information provided for your service reflecting the appropriate terminology for marriage and civil partnerships? | | | | |
| **Pregnancy or Maternity** | | | √ | Although this is a protected characteristic, this is not recorded. It is anticipated that pregnancy and maternity will not have an negative impact in terms of discrimination as this policy ensures that all employees should be treated in a fair, reasonable and consistent manner irrespective of this. However, the Trust will provide necessary support and reasonable adjustment for an employee who is pregnant or on maternity, paternity or adoption leave and this may be pausing the procedure for a temporary time. Service users who are pregnant will have this reflected in the therapeutic observation prescription and will have additional support highlighted if needed. |

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| This includes women having a baby and women just after they have had a baby. This also includes miscarriage, still birth and neo natal deaths and this effects men as well as women.<br>Does your service accommodate the needs of expectant and post natal mothers both as staff and service users?<br>Can your service treat staff and patients with dignity and respect relation in to pregnancy and maternity? | | | | |
| **Race or Ethnicity** | | | √ | Our WRES Data is showing our black and minority ethnic workforce representation is **37%** and in 2021 we showed a small increase on the **35%** reported in 2020 **(+ive)**. There are current workstreams underway highlighting the disparities and the EDI teams are working with specific areas. It is anticipated that Race or Ethnicity will not have an negative impact in terms of discrimination as this policy ensures that all employees and service users should be treated in a fair, reasonable and consistent manner irrespective of this. |
| Including Gypsy or Roma people, Irish people, those of mixed heritage, asylum seekers and refugees<br>What training does staff have to respond to the cultural needs of different ethnic groups?<br>What arrangements are in place to communicate with people who do not have English as a first language to find out about your service or access your proposal? | | | | |
| **Religion or Belief** | | | √ | Although this is a protected characteristic,. The Trust will provide necessary support and reasonable adjustment for an employee and service users where applicable. We also have the Spiritual Care Team. It is anticipated that religion or belief will not have an negative impact in terms of discrimination as this policy ensures that all employees should be treated in a fair, reasonable and consistent manner irrespective of this. This is also dependent on staff and service users feeling comfortable about being open about their religion or belief. |
| Including humanists and non-believers<br>Is there easy access to a prayer or quiet room to your service delivery area?<br>When organising events – Do you take necessary steps to make sure that spiritual requirements are met?<br>Are there any barriers to people of religion or belief to finding out about your service or access your proposal? | | | | |
| **Sexual Orientation** | | | √ | Although this is a protected characteristic we have some recorded data and this is subject to staff completing this. We currently have LGBTQ Staff Network who meet regularly where information is shared. It is anticipated |

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| | | | | that sexual orientation will not have an negative impact in terms of discrimination as this policy ensures that all employees should be treated in a fair, reasonable and consistent manner irrespective of this |
| Including gay men, lesbians and bisexual people<br>Does your service use visual images that could be people from any background or are the images mainly heterosexual couples?<br>Does staff in your workplace feel comfortable about being 'out' or would office culture make them feel this might not be a good idea? | | | | |
| **Transgender or Gender Reassignment** | | | √ | Although this is a protected characteristic, this is not recorded. It is anticipated that Transgender or Gender Reassignment will not have an negative impact in terms of discrimination as this policy ensures that all employees should be treated in a fair, reasonable and consistent manner irrespective of this. This is also dependent on staff feeling comfortable about being open about their being Transgender or undergoing Gender Reassignment There is also a Trans and Non Binary Policy to support this. |
| This will include people who are in the process of or in a care pathway changing from one gender to another<br>Have you considered the possible needs of transgender staff and service users in the development of your proposal or service? | | | | |
| **Human Rights** | | | √ | This policy is written to promote equality and remove any discrimination to ensure that everyone can fulfil their full potential within a Trust that is inclusive, compassionate, and committed. This is keeping in line with our Trust values, the NHS People's Plan commitment to equality, diversity and inclusion and reflects the provisions of the Equality Act 2010.<br><br>This policy applies to **all**, including applicants applying for a job, staff including agency, bank and volunteers, services users and carers, visitors, stakeholders, an any other third-party organisations who work in partnership with the Trust |
| Affecting someone's right to Life, Dignity and Respect?<br>Caring for other people or protecting them from danger?<br>The detention of an individual inadvertently or placing someone in a humiliating situation or position? | | | | |

| **If a negative or disproportionate impact has been identified in any of the key areas would this difference be illegal / unlawful? I.e. Would it be discriminatory under anti-discrimination legislation. (The Equality Act 2010, Human Rights Act 1998)** | | | | |
|---|---|---|---|---|
| | **Yes** | **No** | | |
| **What do you consider the level of negative impact to be?** | **High Impact** | **Medium Impact** | **Low Impact** | **No Impact** |
| | | | | |
| If the impact could be discriminatory in law, please contact the **Equality and Diversity Lead** immediately to determine the next course of action. If the negative impact is high a Full Equality Analysis will be required.<br><br>If you are unsure how to answer the above questions, or if you have assessed the impact as medium, please seek further guidance from the **Equality and Diversity Lead** before proceeding.<br>If the proposal does not have a negative impact or the impact is considered low, reasonable or justifiable, then please complete the rest of the form below with any required redial actions, and forward to the **Equality and Diversity Lead.** | | | | |
| **Action Planning:** | | | | |
| How could you minimise or remove any negative impact identified even if this is of low significance? | | | | |
| Senior Nursing team will work with the organisation to reduce impact of any detriment experienced by reports of concerns | | | | |
| How will any impact or planned actions be monitored and reviewed? | | | | |
| Feedback from reporters of concerns, escalating concerns through governance routes.<br>Regular reviews of establishment and skill mix and communication to managers through Operational Meetings | | | | |
| How will you promote equal opportunity and advance equality by sharing good practice to have a positive impact other people as a result of their personal protected characteristic. | | | | |
| Senior Nursing Team plan and trust wide promotion in ways accessible to ALL staff without the reliance upon electronic communications | | | | |
| Please save and keep one copy and then send a copy with a copy of the proposal to the Senior Equality and Diversity Lead at **bsmhft.hr@nhs.net** . The results will then be published on the Trust's website. Please ensure that any resulting actions are incorporated into Divisional or Service planning and monitored on a regular basis | | | | |

**Appendix 2**

**Variation for Mother and Baby Inpatient (Perinatal) Unit**

Scope

The following has been agreed specifically for the Mother and Baby Inpatient Unit as an addition to the policy rather than a replacement. It describes the rationale and purpose of mother/infant observation. It describes the appropriate levels of observation available when assessing and planning care for mothers and their infants admitted to the Perinatal Inpatient Unit (Chamomile Suite, The Barberry).

Background

Women who need inpatient care for a mental health problem within 12 months of childbirth should normally be admitted to a specialist mother and baby unit, unless there are specific reasons for not doing so (Nice 2014).

Symptoms of mental illness may impact on a mother's capacity to parent and therefore meet their infant's physical, emotional and developmental needs. This may place infants on the ward at risk and therefore, in order to safeguard infants on the ward, the perinatal team have a duty to assess the risk posed to infants and intervene to mitigate these risks.

NICE recognises that some women with a mental health problem may experience difficulties with the mother–infant relationship. The perinatal service therefore has a duty to assess "the nature of this relationship, including verbal interaction, emotional sensitivity and physical care" and to "consider further intervention to improve the mother–baby relationship if any problems in the relationship have not resolved (Nice 2014).

Principles

The aim of conjoint admission to a Mother and Baby Unit is to prevent the separation of a mother from her infant as a result of their mental health presentation. This principle underlies the use of supportive observations with mothers and their infants, with the aim of keeping mother and their infant together on the ward whilst ensuring the infant's wellbeing is safeguarded at all times.

As with adult observations, infant observations should be meaningful, safe, grounded in trust and be supportive. Observation is a highly skilled task and is the responsibility of all staff providing care to the mother and her infant. Infant observation aims to encourage the development of therapeutic interaction with mothers whilst maintaining a balance between intrusion and safety.

The level of observation for each infant must be proportionate to the degree and immediacy of the risk posed. Risk might be intentional or unintentional or as a direct or indirect result of the mother's behaviour. These risks will be identified and described within the formal Level 1 Risk Assessment tool and supported by the use of perinatal specific assessments (e.g Louis MACRO).

All women admitted to Chamomile Suite will be assessed and prescribed an appropriate level of supportive observation as outlined in the Supportive Observation Policy (BSMHFT April 2014). All Infants accompanying their mother to Chamomile Suite will be assessed and prescribed an appropriate level of mother-infant observation as described in this variation.

The safety of infants is paramount and this may at times be in conflict with the mother's wishes. The rational for decisions about infant observations will be clearly documented and explained to patients verbally and in a written care plan.

Responsibility

The variation for Mother and Baby Inpatient (Perinatal) Unit has been formulated by clinicians working within the perinatal service.
The ward manager of the Perinatal Inpatient service will:

- Ensure that infant observation is included on the local induction of clinical staff.
- Ensure that care plans appropriately identify the current level of infant observation.
- Ensure adherence to the variation in practice.
- Ensure a documented risk assessment accompanies the decision made on the level of observation.
- Ensure staff have received the appropriate level of observation to carry out observations (see The Risk Management Training Policy)
- Ensure staff member's level of competency to undertake the duty is reviewed through the process of regular management supervision.
- The nurse-in-charge of each shift will:
- Ensure infant observations are reviewed regularly.
- Ensure that risk management plans and infant Observation plans are updated accordingly.
- Ensure that mothers on the unit are involved in decisions around mother-infant observations and understand the nature and purpose of these.
- Ensure that staff members allocated to infant Observations are appropriately inducted and are supported and supervised in carrying these out.
- Ensure infant observations are carried out according to the care plan.

Purpose
The purpose of infant observation and supervision is threefold:-
1. Assess the nature of the mother-infant relationship including the mother's ability to provide physical and emotional care of the infant.
2. To provide support and guidance to mothers if they are assessed to need support with any childcare tasks, be unable to keep their infant safe or meet their developmental and/or emotional needs.
3. To keep the infant safe and meet their developmental and/or emotional needs where the mother is unable to do this. This may be due to their presenting symptoms or their absence from the ward for health or social care purposes. Where there is the possibility of prolonged separation of mother-infant (e.g. a day or more) consideration should be given to the infant being collected by the other parent or other appropriate care giver, identified on admission.

Assessing and Managing Risk
All staff should consider the following parameters when assessing risk and carrying out infant observations:
Indirect risk of harm: potential or a history of actual risk through omission, lack of awareness or due to the chaotic nature of their presenting symptoms. For example, women experiencing mood disturbance may find it difficult to concentrate and complete care tasks safely or be less aware of environmental hazards to their infant.
Direct risk of harm(either intentional or unintentional): the potential or actual history of acting on thoughts/impulses to harm the infant, whether they be as a result of psychotic illness or other psychological processes, for example, command auditory hallucinations, delusional ideation or a factitious disorder. However, many mothers may experience difficult feelings or thoughts to their infants, but are able to maintain their infant's safety with support. The pattern of such thoughts and impulses are dynamic and need to be continually assessed by the MDT.

If a mother is able to verbalise such feelings or impulses and is freely working with staff, this can reduce risk. If women are not able to elaborate on their thoughts and engage therapeutically with the team regarding their safety to the infant, this should be seen as high risk and a higher level of observation implemented.
The immediacy of the risk and the impact on the infant: The level of support required to mitigate risks will depend on how immediately this risk is likely to occur and how immediate the impact on the infant is likely to be. For example, leaving the baby unattended on a changing table presents an immediate risk for which direct supervision is required to intervene to protect the baby from falling. On the other hand, failure to change a baby's nappy or feed baby is likely to lead to severe discomfort however could be managed by intermittent checks and prompting the mother.
The predictability of behaviour: the level of support and supervision required should be dictated by how predictable the mother's behaviour is. This must be based on a thorough assessment of her current mental state, observations of her behaviour and factors that affect this, her thoughts and feelings about her child and her current capacity to parent her child.
The Louis MACRO tool (reference) has been designed to support the assessment of a mother's capacity to meet the infant's needs in terms of safety, physical care and emotional care, whilst also considering the impact the Infant's characteristics and mother's mental state. Whilst no norms exist and therefore scoring in itself cannot dictate decisions around observation levels, the completion of the Louis MACRO tool can be used to support the risk assessment process.
The Level 1 risk assessment tool should be completed on admission and at any point of change in risk. This includes at any change to the observation level. The Risk to Children section will be used to document and record known risks to children, including the risk to the infant residing on the ward with the mother. The risk management plan will detail how these risks are to be managed and indicate an appropriate level of infant observation.
N.B. Where there is limited information and/or there has not been time to adequately assess the mother's current capacity to safely parent her child, this indicates that a higher level of support and infant observation being required.

Levels of Observation
These observation levels describe the level of monitoring and support prescribed whilst the mother is physically with her baby.

Level 1: General Observation and support.
This is the minimum level of observation for Infants on the ward. The mother will have been assessed as presenting no known risks of direct or indirect harm to their infant. She will be meeting all their physical, emotional and developmental needs.
The whereabouts and general wellbeing of the infant will be known to staff at all times. Staff must be able to account for all infants allocated to their care. Infants must be checked at least hourly, with the exception of infants residing in the semi-independent flat, who may be checked less frequently at night where this is risk assessed and care planned.
1:1 engagement will take place with the mother and infant each shift in order to assess mother-infant interaction and provide any support the mother needs. Regular support needs should be detailed in a care plan and be considered in discharge planning.

Level 2: Intermittent Observation and support
Any risk of harm is not assessed to be immediate enough to warrant constant supervision e.g mother may forget to feed or change baby however is willing and capable of doing so when prompted by staff.

Intermittent checks are made on the infant by an allocated staff member with the purpose of ensuring the infant's well-being and to aid the assessment of the care being provided and the mother-infant interaction taking place. This includes ensuring that the mother is meeting the infant's physical, emotional and developmental needs, and providing support where the mother is unable to do this. The minimum frequency of checks, the reason and the level of support required must be specified within the infant Observation plan. A member of staff must be allocated specifically to carry out this level of observation for each shift.
Typically intermittent observations will be prescribed for set periods of time, i.e. every 30 minutes, 15 minutes, 5 minutes depending on the assessment of risk and need for support. The frequency and level of support required will determine whether a dedicated staff member is required to carry out this observation or whether this can be managed as part of a group of allocated patients.
1:1 engagement will take place with the mother and infant each shift in order to assess mother-infant interaction and provide any support the mother needs. Regular support needs should be detailed in a care plan and be considered in discharge planning.

Level 3: Continuous Observation and support
The mother may have been assessed as presenting an immediate risk or the risk may be unpredictable, and therefore she is unable to keep their infant safe and/or meet their physical and emotional needs. The immediacy of this risk is such that the intermittent checks would be insufficient to safeguard the infant from this risk e.g. mother's lack of concentration leads to risk of leaving baby unattended on a changing table or has thoughts of harming baby and may act on these without immediate support.
This level of observation may be used where there is limited information about the parenting capacity of the mother or how their current thoughts about baby. This could therefore be used for period of time following admission as part of the initial assessment.
A member of the clinical team will maintain constant contact with the infant within the same room or area and within eyesight at all times. The staff member may provide care for the infant in order to ensure their physical and emotional needs are met however where able and safe to do so, the mother should be supported to provide care. The reason and the level of support required must be specified within the Infant Observation plan. A member of staff must be allocated specifically to carry out this level of observation.

Caring for Infants who are separated from their mother
At times it may be appropriate for a baby to be cared for by staff whilst being physically separated from their mother. This may be due to a mother being on leave from the ward, having care planned breaks from caring for her infant either in the crèche or in the nursery.
Staff can provide care for infants in the ward crèche at a ratio of 1 staff member to 3 infants. Consideration should be given to what access other patients have to this area and to the nursery nurse(s)'s ability to summon assistance should they require this (e.g. use of local alarm call system)– see crèche guidance.

Procedure and practice
The procedures for the management of adult observations, as described in Section 3 of Supportive Observation Policy, apply to infant observations.
Mother-infant observations are recorded on infant observation records (see below). Staff will use these sheets to make a record of their checks and provide brief description of the infant's presentation. This record can then be used to inform the mother's and infant's respective clinical notes.

Infant observations are prescribed and planned within the mother's care plan.
Staff carrying out all levels of observation should have read the mother's care plan and the infant's 'all about me' care plan, which provides information on the infant and their parent's preferences for their care.
Where documented in the care plan, it may be appropriate to vary the level of infant observations between level 1 and level 2 to manage risk appropriately whilst maintaining a balance between intrusion and safety. For example:
A mother may require support with her infant whilst he/she is awake, as described under level 2. At night however, her infant sleeps well and frequent checks would disturb their sleep. The mother accepts this need of support and consistently asks for further help when she needs it. Level 1 observation is therefore appropriate.
Where level 3 infant observations are required it is not appropriate to vary the level of observation.

Review of Infant Observations
All infants admitted to Chamomile Suite will be prescribed an appropriate level of Infant Observation as described above. This will be reviewed daily by the nursing staff and considered as part of all MDT or medical reviews of the patient.
Nursing staff can increase this level of infant observation at any time in response to a change in risk.
Any member of staff with concerns about an increase in risk or where the observation level is felt to be inadequate should immediately raise this with the nurse-in-charge. This will prompt a review of the observation level.
Decisions to decrease observations should involve a perinatal MDT discussion. Where there is the possibility of an observation level being decreased in the near future, the process for this review and the factors to be assessed in making this decision should be considered in an MDT review first and documented. Where this is not possible and the infant observation level is no longer required to manage risk and meet the needs of the infant, the nurse-in-charge can review this observation.
The following process should be followed for all reductions in infant observations:

- The mother is reviewed by the MDT, or nurse-in-charge, previous risk factors reviewed and considered with the mother.
- A team discussion takes place and opinion is sought from qualified nursery nurses and/or health care assistants who know the mother and infant.
- The Level 1 risk assessment tool is updated.
- Louis MACRO assessment is completed.
- A review of the notes takes place to ensure all MDT assessments have been considered.
- The rational for the change in observation is clearly documented in the progress notes.
- The written care plan should be amended, detailing the Infant observation level prescribed and the care plan for this level of observation.

Secondary Care givers
Depending on the nature of the risk and the family's understanding of this risk, it may at times be appropriate for secondary care givers to take over the care of the infant. Where an infant level 3 is in place, the secondary care giver is able to demonstrate that they understand this and are able to carry out this role, an arrangement can be made for them to provide this level of support during their visit to the ward. During this time, the Infant will be checked intermittently by nursing staff and arrangements made for passing back care to staff safely.
The following process should be followed and evidenced:

- A team discussion takes place and opinion is sought from qualified nursery nurses and/or health care assistants who know the mother, infant and secondary care giver.
- A qualified mental health nurse will meet with the secondary care giver to discuss the identified risk and the current Infant Observation plan.
- The views of the mother and secondary care giver should be sought and documented.
- The rational for the secondary care giver taking over the Infant observation level should be documented in the mother's progress notes.
- The mothers care plan should be updated to include the role of the secondary care giver within the infant observation.
- Arrangements for secondary care givers to provide this support should be specific to named individuals and should not include unspecified 'family member'.

Resources to meet observation

Consideration should be given to maintaining consistent care givers to infants. Where possible, the nurse in charge should minimise the number of different staff members allocated to observe individual infants throughout each shift, aiming for a maximum of two different staff members per infant each shift. This reduces the impact that multiple care givers can have on an infant.
Where the mother's presentation is such that remaining with the same mother and infant for more than an hour is not therapeutic and/or is highly challenging for the staff member, consideration should be given to changing the staff member hourly.

Staffing levels

The responsibility for setting staffing levels rests with the Clinical Nurse Manager and Ward Manager of Chamomile Suite. Out-of-hours this role is delegated to the nurse-in-charge in order respond to changing clinical need and make safe decision about accepting emergency admissions. The following guidance should be considered to help ascertain appropriate staffing levels to meet clinical need within defined ward budgets:

The Chamomile Suite staffing establishment (5 during the morning, 5 during the afternoon and 4 during the night) should under typical clinical circumstances have the capacity to safely manage one close observation (Level 3 or 4 of Supportive Observation Policy for inpatients or Level 3 Infant Observation) and provide care for the other mothers and their infants on the ward. Any additional close observations will require the increase of staffing levels by one staff member.

Infant level 2 observations may require an extra member of staff however this will depend on a variety of factors which may include:

- The frequency of checks required i.e. 5 minute checks must be carried out by one person and therefore requires an increase in staffing to meet this need.
- The level and quality of care a mother is providing for baby
- The mother's engagement with staff. Is she asking for help with particular tasks, is this predictable and what risk does it pose to the infant i.e. does a member of staff always need to be on hand to intervene or support or can this be negotiated at the time?
- How much time a mother needs away from caring for baby for her own mental health. A staff member will be required where breaks for the mother cannot be planned and the crèche utilised.
-

Child Protection Plans

If an infant is on the child protection register, the child protection plan should be in the care records and clearly outlined in the mother's nursing care plan and risk assessment. Child protection plans are produced in partnership with social care and other agencies involved with the family. The team should be aware of the parameters and specific conditions of the plan and act accordingly. Named nurses should make every effort to clarify child protection plans on admission, with the allocated social worker.

**Appendix 3**

**Practical Engagement**

- Activities of Daily Living — assisting individuals to maintain self-care, maintaining some responsibility and dignity. Assisting with bed making, tidying room and doing personal laundry. As appropriate; writing letters, making telephone calls.
- Social Interaction — (Respect patient's right for silence!). If patient wishes to talk, talk and introduce general conversation topics. Explore their previous or current hobbies or interests. Read a newspaper or magazine together and chat about an interesting article.
- Coping strategies - Ask the patient what would be helpful to them at that moment in time, what has helped in the past and what could you help them with to try now: distraction, breathing, relaxation, walking.
- Therapy – support access to on-ward occupational therapy activities,
- Walking – walking around the ward, garden or around the grounds.
- Active diversion– is a technique that is used to support the patient to understand their distress/agitation/anxiety etc. Therefore during the engagement with the patient identify what activity may help e.g. going for a walk, drawing, watch TV, conversation, gym, pool, squeezing objects, listening to music.

Engaging with patients that are very symptomatic and non-responsive is more difficult, however we can often still engage through the senses, connecting them to the world and to our care. For example:

- Engage in activities that elicit sensory-motor feedback and assist with orientation
- Mechanisms for Calming – going to a space that is less noisy and busy.
- Mechanisms for Soothing – music, sensory 'toys', weighted blanket.
- Mechanisms for distracting attention – music, sucking sweets, popping bubble wrap, colouring-in.
- Mechanisms for grounding – focusing on the sensory inputs of the here and now through physical body or describing in detail something that can be seen, heard, felt etc.
- Engage the patient in a physical activity (5 min) to either reduce arousal or activate.
- Engage the patient in a personal care activity (5 min) sensory, nutritional, self-awareness.
- Engage the patient in a self-care task (5 min) washing, dressing, make-up, hair.
- Engage the patient in a food/drink based task (5 min)
- Engage the patient in a sensory activity (5 min) such as self-massage, relaxation, soft music.

Appendix 4

Variation for Steps to Recovery Service and Hillis Lodge (Low Secure Mental Health)

Scope

The following has been agreed specifically for the Steps to Recovery Service and Hillis Lodge as an addition to the policy rather than a replacement. Endeavour Court will not be included this and they will continue to observe service users during the 24 hour period. Service users will be prescribed therapeutic observations levels as discussed in MDT, following NICE Guidance and based on risk assessment. Service users won't be observed overnight.

Background

Nice 2020 recognise in there 'Rehabilitation for adults with Complex Psychosis' Guidance 181 in healthy living. "Consider providing advice and support for good sleep hygiene and maximise opportunities for healthy sleep. For example, for inpatients, avoid barriers to sleep such as environmental factors or intrusive night-time checks."

Principles

Observation is a highly skilled task and is the responsibility of all staff providing care to the service user. Observation levels are to be discussed thoroughly at the MDT and the therapeutic observation prescription is to be updated.

When service users are transferred to Steps to Recovery or Hillis Lodge they will not be prescribed flexible observations straight away. There needs to be a period of assessment as discussed in MDT before flexible observations are considered and prescribed.

Responsibility

The variation of observations will be formulated by the MDT.

The ward manager of the Steps to Recovery wards and Hillis Lodge will:

- Ensure that all staff as are aware of the flexible observations for each service user
- Ensure adherence to the variation in practice.
- Ensure a documented risk assessment accompanies the decision made within MDT on the level of observation.
- Ensure staff have received the appropriate level of Training in observations to carry out observations safely (see The Fundamental Training Policy)
- Ensure staff member's level of competency to undertake the duty is reviewed through the process of regular management supervision.

The nurse-in-charge of each shift will:

- As part of the WHAT handover the observation levels prescribed for the individuals on the ward remain current and that all staff on duty are aware of the observation prescribed and why.
- If the service user presentation changes the nurse-in-charge is able to increase the observation and make the MDT aware

Purpose

The purpose of flexible observation is to promote wellbeing and independence for the service user.

1. When the MDT are planning on changing the observation level to meet 'safe + well checks' the service user should already be prescribed level 1, hourly observations and engaging well in their therapeutic activities.
2. The frequency of the safe and well observations (how often service users are going to be observed) will be agreed within the MDT.
3. It is to be discussed at MDT, the risk assessment and the therapeutic prescription including the care and safety plan need to be updated to reflect the changes in observations. Staff can increase (Observations outside of MDT where necessary, and where risks have increased) but cannot decrease without the MDT discussion. The service user is to support with writing the prescription. Whilst assessing the risk consideration will be needed around co – morbidities of the service user and documented accordingly.
4. Hillis Lodge will only prescribe flexible observation when a service user is working towards discharge, flexible observations will be discussed as part of a 6-month discharge plan.
5. Prior to the service user retiring to bed, it is important we encourage the service user to engage with staff on the ward to discuss how there day has been.