Supportive Engagement and Observations Procedure

CLIN-0017-001 v2.3

Status: Ratified
Contents
1 Purpose .......................................................................................................................... 3
2 Why we need this procedure ....................................................................................... 3
2.1 Harm minimisation and recovery .............................................................................. 3
2.2 Human rights ............................................................................................................. 3
2.3 NICE Guidance ......................................................................................................... 3
3 Principles of supportive engagement ........................................................................... 3
4 Engagement and observation levels ............................................................................ 4
4.1 General engagement and observation ...................................................................... 4
4.2 Enhanced Engagement ............................................................................................. 4
4.3 Continuous supportive engagement and observation within eyesight or at arm’s length ................................................................. 5
4.4 Zonal engagement and observations ...................................................................... 6
5 Decision making process .......................................................................................... 6
5.1 On admission to a ward or clinical area .................................................................... 7
5.1.1 Young person under 18 years of age admitted to an adult ward ...................... 7
5.2 Initiating supportive engagement and observation levels above general .............. 7
5.3 Increasing and decreasing supportive engagement and observations.................... 7
5.4 Review of engagement and observations .................................................................. 8
5.4.1 If enhanced or continuous engagement and observation continues for 1 week or more 8
6 Night time observations ............................................................................................. 8
7 Supportive engagement and observations during special circumstances ................. 8
7.1 Use of observation during seclusion ........................................................................ 8
7.2 Family and carer responsibility for observations ................................................... 9
7.3 Observation in general hospital settings ................................................................... 9
8 Record keeping ........................................................................................................... 9
8.1 Writing care plans ................................................................................................. 9
8.2 Recording of observations and engagement ............................................................ 10
9 Who should carry out supportive engagement and observations ............................ 10
10 Skills of staff .......................................................................................................... 11
11 Support and supervision of staff ............................................................................. 11
12 Related documents and reference .......................................................................... 11
13 Document control ..................................................................................................... 13
Appendix 1 - Zonal Engagement & Observations .......................................................... 14
1 Purpose

The Trust is committed to providing a safe and supportive environment to all service users wherever their care is provided. Those admitted into acute care settings are often deemed at their most vulnerable. The effective and appropriate implementation of supportive engagement and observations is fundamental to discharging our duty of care in these circumstances.

This procedure:-
- Provides direction as to the decision making process to determine the type, level and use of engagement and observation.
- Details recommendations for the recording of interventions, contact and review of engagement and observation procedures in both in-patient and residential services
- Identifies the skills staff will need to deliver evidence based engagement and observation practice

2 Why we need this procedure

2.1 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 is important that staff balance the distressing effect and potential long term harm of being on high level observations (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.

2.2 Human rights

The use of supportive observations 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 engagement 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.

2.3 NICE Guidance

This procedure is consistent with NICE Clinical Guideline 10: Violence and aggression: short-term management in mental health, health and community settings (2015) which defines levels of observation that can be used when clinical risk levels are high.
3 Principles of supportive engagement

Supportive 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 observations 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. If for any reason involving the service user in dialogue and activities during supportive engagement is not possible or desirable, then the reasons for this needs to be clearly recorded.

4 Engagement and observation levels

All service users in a ward environment will be allocated a level of engagement and observation. There are three levels, which have different responsibilities attached.

4.1 General engagement and observation

- Staff will be aware of the general location of all service users for whom they are responsible.
- At least once during each shift a nurse should set aside dedicated time to assess the physical and mental wellbeing of the service user (in certain clinical areas this may be more frequent).
- As part of the assessment, the nurse should evaluate the impact of the service user’s mental state on the risk of harm, and record any risk in the notes.

4.2 Enhanced Engagement

- Where it is clear from the assessment that the patient will not benefit from the application of enhanced observations but requires a higher level of contact than if on general observations enhanced engagements will be implemented. This level of observation can also be applicable to people with vulnerability issues such as the risk of falling, exploitation and disorientation.
- The number and frequency of engagements a patient requires during a span of duty to manage the risks identified through risk assessments, will be identified and an intervention plan will describe the times, frequency and aims of each engagement (interventions) for that patient. The frequency and content of these enhanced engagement meetings will be fully recorded in the safety/care plan or PARIS care record.
- It should be remembered that engaging with service users at predictable times can provide service users with the opportunity to plan or engage in harmful
activities. This should be taken into account when determining the frequency of and type of engagement required.

- In the event that the service user is to attend a therapeutic activity off the ward then a decision must be made by the multidisciplinary team to clarify the appropriateness of enhanced engagement where the risk assessment indicates that the service user can attend without an escort. Where it is clear that enhanced engagement remains appropriate then it is the responsibility of the ward to provide staff to carry out this function. If the service user is attending group activity this will **not** be the person leading the delivery of the group activity.

### 4.3 Continuous supportive engagement and observation within eyesight or at arm’s length

- Continuous Supportive Engagement and Observations are used when a service user presents an immediate risk of serious harm to self or others and needs to be kept within eyesight or at arm’s length of a designated one-to-one member of staff, with immediate access to other members of staff if needed.

- Some individuals may require the support of more than one member of staff. In this circumstance each member of staff must have clearly defined roles in carrying out both engagement and observations.

- Consideration should be given to whether the person may be alone for short periods (e.g. personal care needs, whilst sleeping or for other reasons of privacy and dignity) which would be detrimental to their mental health and risk of harm is manageable. This should be clearly documented within the safety / care plan.

- Consideration should also be given to a period of observation following ingestion of one or more foreign objects (recent or current) to enable close monitoring of any physical side effects but also to monitor if foreign bodies are passed through stools. This should be documented within the patient’s intervention plan.

- It may be necessary to search the patient and their belongings. If it is required, it must be done with due regard for the person’s legal rights and conducted in a sensitive way. (See Trust [[Searching of patients, their property, the environment and visitors policy]](https://www.example.com/searching-policy)).

- In certain circumstances the service user may need to leave the ward e.g. to attend physical health appointments. Alternatively short breaks in the grounds or building (e.g. to the cafe, garden or therapy suite) may be useful and/or necessary. These decisions must be part of the risk assessment process and be discussed with the multi-disciplinary team. This should only take place in the company of a suitably qualified and experienced practitioner and only when the risks have been assessed. It may be decided that additional members of staff should accompany the person to reduce the risk of harm. Staff should have means of contacting the ward/unit for immediate assistance if there are difficulties in returning with the service user.

- Staff will ensure any pertinent information is handed over verbally when ending a period of continuous supportive engagement and observation. The service user should also be involved in the handover discussion wherever possible and appropriate. (If agreed alternative ways of recording support required can be documented within the care plan)

- Best practice would be that staff who are allocated to deliver continuous engagement and observation would be involved with the service user for a maximum of 2 hours and are supported to take breaks where required. It is
acknowledged that clinical demand and promotion of continuity of care for the
service user may not always make that possible

4.4 Zonal engagement and observations

The zonal model aims to ensure appropriate observation of individual service users without
the need to assign a particular practitioner to be in close proximity to the service user for
long periods. Instead a staff member is assigned to observe and engage with individuals
within specified zones within the ward area. It can be used for an individual or a particular
group of service users within a specific ward or environment.

In certain circumstances this can be considered less intrusive and allow greater privacy for
the service user than enhanced engagement. The Trust therefore recognises that under
certain circumstances a ward or clinical area may wish to operate a zonal observation
model. The decision to implement zonal engagement and observation and agreeing
procedures and practice for any particular ward or clinical area will lie with the relevant
Quality Assurance Group (QuAG). Appendix 1 contains guidance and a decision making
checklist for the development of the rationale and implementation plan required of any ward
area considering introducing zonal engagement and observations. The checklist should be
used as evidence as part of the request for support for implementation from the relevant
QuAG.

5 Decision making process

Multi-disciplinary assessment and collaborative risk formulation with the service user
represent best practice in determining the appropriate use of engagement and observation.

Only after positive engagement with the service user has failed to mitigate the risk of harm
should a person move on to supportive engagement and observations, and only then if that
identified risk can be effectively managed through doing this. Levels of observation should
be set in the least restrictive form, within the least restrictive setting to protect the safety of
the patient, safety of others and to promote positive therapeutic engagement. It is necessary
to balance the service user's safety, dignity and privacy with the need to maintain the safety
of the service user and those around them.

Shared decision making should be utilised whenever possible, leading to a co-produced care
plan which will identify for the service user:

- Why they are under observation, and what that level is
- How it will be carried out and the importance of positive engagement
- What the clinical team and service user will be looking for in assessing
  whether the risk of harm has lessened
- How long it is likely to last
- The review process

Where positive risk taking is incorporated into a safety management plan it should be made
explicit within the plan that the actions prescribed can be overridden should the clinical risks
and circumstances dictate. All such decisions to clinically override will be fully documented.

Even if the service user has not been involved in the development of the plan, they should
be informed of the above, and this be documented on PARIS. If the service user agrees,
explain to carers the aims and level of observation. Involvement of advocates should always
be considered.
5.1 On admission to a ward or clinical area

Upon admission, an appropriate level of engagement and observation will be introduced to reflect the risk of harm as identified following a thorough risk assessment by the admitting team, and including the service user whenever possible. The review period will be identified within the initial intervention plan.

There may be ward-specific guidance on engagement and observations, which staff should always make themselves familiar with.

5.1.1 Young person under 18 years of age admitted to an adult ward

If service users under the age of 18 years of age are admitted to an adult environment reference MUST be made to the Young People Admitted to Adult In-Patient Wards Policy. Levels of supportive engagement and observation will be identified according to individual multi-professional assessment which is reviewed regularly.

5.2 Initiating supportive engagement and observation levels above general

A minimum of two practitioners in the clinical area can initiate engagement and observation levels above general. At least one must be a registered nurse who has personally undertaken a clinical risk assessment review of the service user. The second practitioner may be any member of the multi-disciplinary team that has been involved in the clinical risk assessment of that service user (which may include the assessment of risk as part of shift handover).

5.3 Increasing and decreasing supportive engagement and observations.

Decisions about supportive engagement and observations should be made as far as possible via multi-disciplinary discussion, based on the on-going assessment of the service user’s needs. This process should include the service user wherever possible.

Registered nursing staff with delegated responsibility for a ward area has the authority to implement an increase or decrease in the level of observation once the person is above general engagement levels. Any such decision should be reviewed by the senior nurse on duty or senior clinician at the earliest opportunity. Best practice remains that the decision-maker consults as widely as feasible in helping them come to a decision; the service user should always be involved.

The rationale supporting the decision to increase or reduce the levels of engagement and observation should be documented in the case notes. The current risks and how the level of observation is being used to manage that risk should also be documented in the case notes section supported by an appropriate intervention plan.

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

The nurse in charge must ensure the rest of the care team and the service user are informed of any change in the level of observation.
5.4 Review of engagement and observations

Engagement and observation practice will be reviewed at a minimum once every shift handover. There will be ongoing review with the service user which recognises the dynamic nature of risk.

5.4.1 If enhanced or continuous engagement and observation continues for 1 week or more

At least once a week a full review of observation levels must take place by the MDT (or care team if on a nurse led unit) and the discussion outcome recorded in PARIS.

6 Night time observations

Regardless of their level of engagement and observation, a service user will have an individual plan for night time observations.

- The level of night time observation will be risk assessed and reviewed by the MDT/care team, in collaboration with the service user whenever possible. The care plan will clearly state what the risks are and what staff should be mindful of when carrying out observations at night when the person is in their bedroom.
- Staff will have discussed with the person the reason for the level of observation and how this will be undertaken over the 24 hour period.
- The member of staff undertaking the observation should be able to clearly see the person’s head and that they are breathing, and be assured that there is nothing impeding the person’s breathing.
- If the staff member undertaking the observation is unable to see the person clearly they should enter the room to ensure there is no risk to the person.
- If there are any concerns about the person’s mental state or physical wellbeing a top-toe check may be required to see if the person is moving freely and not restricted in anyway - this would be at the discretion of the nurse in charge who would refer to specific care plans or handover agreements about the type and nature of the night time observation.
- The use of technology such as bed sensors may also be considered within the individual care plan but it must be remembered that for many service users it may be more appropriate to retain some level of night time observation.

7 Supportive engagement and observations during special circumstances

7.1 Use of observation during seclusion

(See Seclusion and Segregation Procedure)

Upon the commencement of seclusion the nurse in charge must ensure a suitably skilled professional, competent to carry out visual observations, is positioned outside the seclusion room at all times. The aim is to safeguard the service user, monitor the condition and behaviour of the service user and to identify the earliest time at which seclusion can be terminated. Consideration should be given to the gender of the observer informed by the patient’s existing relationships with staff, current presentation and trauma history.
If the person has received rapid tranquillisation or where clinical risk indicates physical observations are necessary, vital signs must be monitored as outlined in the **Rapid Tranquillisation policy** (Including prescribing, post administration monitoring and remedial measures) and recorded in the Paris Seclusion Record. Refusal must also be documented.

### 7.2 Family and carer responsibility for observations

With consent, or in the absence of capacity in the person’s best interest, families and carers should be involved in the development of service user care plans, including those that specify Supportive Engagement and Observations. Reasons for none or limited involvement of carers and their families should be evidenced in the clinical record and regularly reviewed.

Requests from families and carers to take responsibility for the observation of service users will be dealt with on an individual basis. The situation will be risk assessed and the decision making process clearly documented in the clinical record.

### 7.3 Observation in general hospital settings

When a service user is transferred from TEWV to another NHS facility, such as an Acute Hospital, there is a requirement to review the risk assessment prior to transfer and an appropriate level of observation will be allocated based on identified risk during their presence at another NHS facility. Trust [Procedure for In-patient Service Users Who Require Care In the Local Acute Hospital](#) identifies the processes staff will follow within Tees, Esk and Wear Valleys Trust to ensure that each organisation is clear with regard to accountability for the service user’s care and expectations where the responsibility for different aspects of care is shared. This document should be used in conjunction with any other locally agreed procedures which have been agreed with the acute trust.

### 8 Record keeping

#### 8.1 Writing care plans

Decision making in respect of the authority to change the level of observation should be described within the care plan, so that responsibilities for managing risk are well understood. Decision making is generally delegated to the nurse in charge of a ward or area unless the care plan specifies other arrangements. The risk assessment and rationale for all changes must be clearly documented in the service user’s care plan and clinical notes.

The care plan or patient record will specify:

- The rationale for supportive engagement and observations, including a consideration of what immediate harms are being addressed and any potential harms that being on observations may cause.
- Enhanced engagement should always specify the type and frequency of engagement.
- Continuous supportive engagement and observations should always specify the number of staff on continuous observation and their position (within eyesight or at arms-length). If more than one staff is on the observations, this should be made clear and their respective roles should be explicit.
- The protocol for night time observations.
• Who has delegated authority to increase or decrease the level of engagement and observation?

• Any details on how engagement and observation may vary depending on the service user’s presentation.

Due to the dynamic nature of risk, the level of observations during the course of the day may vary, based on service user need and the known risks associated with a given activity and the care environment. Specific reference should be made to variance, conditions or timing of the particular interventions identified, for example:

"Use continuous engagement and observations within eyesight at all times when Mrs. Smith is awake and whilst the ward has open access. Use enhanced engagement of 30 minute intervals for Mrs. Smith when the ward has locked access and enhanced engagement of 60 minute intervals during her sleep period."

8.2 Recording of observations and engagement

Record clearly the names and titles of the staff responsible for carrying out a review of observation levels and when the review should take place.

The staff who are allocated to deliver continuous observation will record in the contemporaneous clinical record their involvement, time of their involvement, any evaluation based on the time spent with the service user and whom they handed responsibility over to. The service user should always have the opportunity to contribute to the discussion and what is being recorded.

9 Who should carry out supportive engagement and observations

The actual practice of delivering supportive observation is largely, though not exclusively, a nursing responsibility. This authority is exercised through appropriate delegation of responsibilities within the multidisciplinary team.

Attention should be paid to meeting the service user’s need for support and therapeutic engagement by providing a member of staff with whom they can develop rapport and feel comfortable, taking into account wherever possible gender, background and other attributes. The individual's perceptions and views should be considered and responded to. If this is not possible an explanation should be offered.

The implementation of supportive engagement and observation levels may have an effect on the workload for the ward team. Every effort should be made so that a member of staff who knows the service user is implementing supportive engagement, with additional support from other members of the team as necessary. The use of skilled staff that are familiar to the area, the type of clinical work, and the service users is preferable to unskilled and unfamiliar staff.

Agency and bank staff should not be used to undertake observation/engagement of patients unless it is clear that they have the relevant skills and knowledge (as defined within their own competency frameworks). It is recognised however that many bank staff are well known to certain service users as they work regularly into some clinical environments.

Modern Matrons and /or Locality Managers should regularly be consulted in relation to staffing levels, skill mix and competencies required to implement engagement and observational practice. Members of staff will be required to work flexibly, across and within all areas, to support clinical need and safely manage clinical risk.
Before delegating engagement and observation to any staff, including agency or bank staff, the nurse-in-charge must ensure that the staff member:

- Is clear about the reasons why the patient is on their particular level of supportive engagement and observation.
- Has been briefed about the service user's history, background, specific risk factors and particular needs of the patient’s intervention plan(s).
- Is familiar with the ward and potential risks in the environment, and how to gain rapid access to assistance if required.
- Is clear how to positively engage with the service user, including preferred communication style, how the service user will feel valued and the types of activities that will aid recovery and minimise harm.

10 Skills of staff

The member of staff undertaking supportive engagement and observations must have the knowledge and skills to do so, and be familiar with the patient and their particular safety needs.

The skills of staff to deliver evidenced based supportive observation practice include:

- Knowledge of principles and techniques of harm minimisation, recovery and force reduction
- Skills in engagement and therapeutic communication, using empathetic, sensitive and compassionate approaches.
- Skills in the practice of clinical observation
- Knowledge of mental health symptoms and presentations
- Knowledge of physical health presentations.
- Knowledge and skills in the management of behaviours that challenge
- Knowledge of the systems of reporting, communication and record keeping.

Development of skills and knowledge in the practice of engagement and observation will be integrated into the educational programmes for Harm Minimisation and Force Reduction/Positive Behavioural Support

Mandatory training will be provided in line with the Trust Staff Development Policy. Attendance is monitored via human resources and reports sent to local managers to ensure mandatory training needs are met.

11 Support and supervision of staff

All practitioners should be participating in their own professional, clinical and line management supervision in accordance with Trust policy. In addition, it is noted that delivery of continuous supportive observation can be stressful and practitioners will be offered additional support, supervision and critical analysis and guided reflection as determined by individual need in a timely manner.

It should be recognised that less experienced or skilled staff will require more support to ensure therapeutic engagement and observation is being delivered in contrast to the model of “watching” or surveillance.

12 Related documents and reference
The Harm Minimisation Policy defines the principles of risk assessment and management which you must read, understand and be trained in before carrying out procedures described in this document.

This procedure also refers to:-

- Positive approaches to supporting people whose behaviour is described as challenging
- Policy for Harm Minimisation: A recovery-orientated approach to clinical risk assessment and management
- Rapid Tranquillisation Policy
- The Care Programme Approach and Standard Care
- Minimum Standards for Clinical Record Keeping
- Staff Development Policy
- Information Governance Policy
- Confidentiality and sharing information policy
- Supervision Policy
- Admission, Transfer and Discharge of service users within hospital and residential settings
- Searching of Patients, Patients Property, Patient Areas and Visitors
- Human Rights Equality & Diversity Policy
# 13 Document control

<table>
<thead>
<tr>
<th>Date of approval:</th>
<th>29 March 2017</th>
</tr>
</thead>
<tbody>
<tr>
<td>Next review date:</td>
<td>31 December 2019</td>
</tr>
<tr>
<td>This document replaces:</td>
<td>CLIN-0017-001-v1 Engagement and Observation Procedure</td>
</tr>
<tr>
<td>Lead:</td>
<td>Name</td>
</tr>
<tr>
<td>Dr Ahmad Khouja</td>
<td>Deputy Medical Director</td>
</tr>
<tr>
<td>Members of working party:</td>
<td>Name</td>
</tr>
<tr>
<td>Denise Colmer, Vanessa Cunliffe, Allison Brabban, Mark Allan, Andy Dove, Lorraine Ferrier, Matt Houton, Alex Irvine, Susan Raw, Pamela Ridings, Graham Salkeld, Sally Smith (Expert by Experience), Victoria St Denis, Paul Walker, Richard Wanless, Kelly Woodier, Emma Williams, S Hollett (Student nurse), Gillian Woodrup</td>
<td></td>
</tr>
<tr>
<td>This document has been agreed and accepted by:</td>
<td>Name</td>
</tr>
<tr>
<td>(Director)</td>
<td>Elizabeth Moody</td>
</tr>
<tr>
<td>This document was approved by:</td>
<td>Name of committee/group</td>
</tr>
<tr>
<td>Quality and Assurance Committee</td>
<td>June 2016</td>
</tr>
<tr>
<td>This document was ratified by:</td>
<td>Name of committee/group</td>
</tr>
<tr>
<td>Executive Management Team</td>
<td>29 March 2017</td>
</tr>
<tr>
<td>An equality analysis was completed on this document</td>
<td>1 April 2016</td>
</tr>
</tbody>
</table>

## Change record

<table>
<thead>
<tr>
<th>Version</th>
<th>Date</th>
<th>Amendment details</th>
<th>Status</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Jan 2015</td>
<td></td>
<td>Obsolete</td>
</tr>
<tr>
<td>2</td>
<td>21 Jun 2016</td>
<td>Reviewed in line with NICE Clinical Guidelines</td>
<td>Obsolete</td>
</tr>
<tr>
<td>2.1</td>
<td>24 Aug 2016</td>
<td>4.3 amended to include observations following ingestion of foreign objects</td>
<td>Obsolete</td>
</tr>
<tr>
<td>2.2</td>
<td>14 Oct 2016</td>
<td>4.4 amended and appendix 1 added</td>
<td>Obsolete</td>
</tr>
<tr>
<td>2.3</td>
<td>29 Mar 2017</td>
<td>All references to intermittent observation changed to enhanced engagement with new wording at section 4.2</td>
<td>Published</td>
</tr>
<tr>
<td>2.3</td>
<td>04 Jun 2019</td>
<td>Review date extended to 31 Dec 19 whilst document is under review</td>
<td>Published</td>
</tr>
</tbody>
</table>
Appendix 1 - Zonal Engagement & Observations

Zonal nursing allows an alternative method of observation involving boundaries and time restrictions for certain ward areas, and are supported by staff who observe and engage with patients individually and as groups, for set periods. This means patients have equal access to staff resources and are subject to less restrictions in a ‘managed’ environment (Clarke 2007) and should not be confused with the ‘zoning focused support’ or ‘traffic light’ approaches (Gamble et al 2009, Gamble 2006), which rely on the targeted allocation of staff resources to patients categorised by risk.

The zonal model aims to ensure appropriate observation of individual service users without the need to assign a particular practitioner to be in close proximity to the service user for long periods. Instead a staff member is assigned to observe and engage with individuals within specified zones within the ward area. It can be used for an individual or a particular group of service users within a specific ward or environment. This decision will always be based on clinical need and not be financially driven.

In certain circumstances this can be considered less intrusive and allow greater privacy for the service user than enhanced engagement. The Trust therefore recognises that under certain circumstances a ward or clinical area may wish to operate a zonal observation model. The decision to implement zonal engagement and observation and agreeing procedures and practice for any particular ward or clinical area will lie with the relevant Quality Assurance Group (QuAG).

Principles guiding the implementation of Zonal Engagement & Observation

- Zonal Engagement & Observations must be service user focused at all times.
- The Service has a duty for safety and security to the service users, staff and visitors.
- Care must be provided in an environment and manner that reflects the least level of restriction possible for the safe and supportive management of the service user.
- Zonal Observation and Engagement should therefore be seen as one method of reducing risk and enhancing the service user experience. It is integral part of a wider risk assessment and contextual management process.
- Care and support of the service user will be addressed specifically within an individualized care plan. Service users will be assigned a level of engagement and observation as outlined in the wider procedure and the assigned nurse should carry out the engagement and observation and make the associated records at the assigned times.

Zones - Not all ward lay outs are appropriate for Zonal Engagement and Observation. Any introduction of zonal observation in a ward area should be agreed with the wider clinical team, including discussion with service users and users and carers where appropriate. The decision should be informed by data and reported incidents and monitoring of its effectiveness should include incidents being plotted against the ward zone chart with the date, time and precise location as well as service user feedback.

Zones should have explicitly defined rooms, corridors and spaces within them. The zone should be described clearly with defined boundaries as to where the zone starts and ends. Example of a zone may be: Zone 1 – day area/Courtyard/Group Room/small interview room.
Staff assigned to these areas must explicitly understand that they are not observing simply the physical space but rather are on hand to engage and intervene where necessary to maintain safety within that zone.

Professional Roles in Zonal Engagement & Observations

The Ward Manager or their Deputy will:
- Determine the resources needed to manage the ward.
- Review the service users’ needs daily
- Consider and act appropriately in respect of any complaint the service user may have about their observation status and management.
- Be responsible for ensuring that risk recognition and management of service users is discussed at each handover.
- Ensure that a risk assessment process is used by the clinical team to agree that a zonal approach is used by patients.
- Instruction on how and when zonal observation is implemented and reviewed.
- Ensure that there are appropriate Safety/Care Plans.

The Nurse in Charge will:
- Delegate staff to the zone(s). (Staff should remain in a zone for a maximum of two hours at any one time);
- Ensure that known and relevant risks are communicated to the observing nurse(s);
- Discuss the care and management with the service user;
- Review the level of observation as per policy.
- Ensure that there are appropriate Safety/Care Plans.

Engagement and Observation Staff (Zone staff) will:
- Know their zone.
- Know who they are to engage and observe.
- Be familiar with the engagement and observation status of all service users in their observation zone.
- Facilitate interaction and communication with the service user.
- Provide a handover for the nurse taking over from them.
- Report any changes in the service users behaviour considered significant to the nurse in charge.
- Report any concerns to the nurse in charge.
Decision making checklist

The ward area considering the use of zonal observations should have a clear rationale and implementation plan which covers the following area. The following checklist can be used to develop the plan as well as assisting QuAG to support the decision.

<table>
<thead>
<tr>
<th>Questions</th>
<th>Yes</th>
<th>No</th>
<th>n/a any other comments</th>
</tr>
</thead>
<tbody>
<tr>
<td>Is there evidence of MDT discussion regarding implementation of zonal observation?</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Is there a clear rationale for the use of zonal observations?</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Is the use of zonal observation for: one individual, a particular group of service users</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Are there clear zones identified within the ward area?</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Is there an identified process for allocating staff to zones?</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Is there clear guidance as to times in which the zones will be operated</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Is there clear guidance as to how observation levels will changes as service users move between areas and at different times?</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Is there evidence that staff assigned have had clear guidance and instruction as to the use of zonal observations (including harm minimisation and safety planning)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Is there evidence that the roles of all staff members have been clearly defined and that staff are clear on their roles and responsibilities? This includes bank/agency staff</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Is there evidence of a process to escalate concerns regarding the use of zonal observations and a clear process for discontinuing in cases of concern</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Is there evidence of individualised care/safety plans which identify how zonal observations will be used?</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Is there evidence that the service user(s) have been involved in the decision making process?</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Is there an activity plan for the service user(s) which identifies meaningful activity and planned time for engagement with allocated staff?</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>