Public – To be published on the Trust external website

Engagement and Observation Procedure

Ref: CLIN-0017-001-v4.1

Status: Ratified
Document type: Procedure
Overarching Policy: Safety and Risk Management Policy

Contents

1 Introduction

This procedure supports Our Journey To Change (OJTC) as set out in Safety and Risk Management Policy.

A key part of our work within mental health and learning disability services is to work with people who are at risk of harm and to minimise the likelihood of actual harm. To be able to do this the best way we can, we have to listen to people who are in distress, or who are in unsafe situations due to other people, and to understand the many factors that may be affecting a person so we can work together to help people to be as safe as possible. This shared understanding should take account of a person's individual circumstances: be that life history, the social, financial and cultural context, as well as sexual orientations, gender identity, physical and mental disabilities, religion and spirituality, age, and any connection with armed forces. The Trust will respect and protect the Human Rights of all service users, staff and anyone else who has a relationship to the Trust.

The evidence shows that the best way to support people in distress is by forming a trusting working alliance. The procedure includes further information on how to approach this and guidance is also provided to support decision making to ensure harm is minimised where there are high levels of distress and vulnerability and when there is no option to avoid harm.

2 Purpose

This procedure outlines how we can, together, deliver on the organisations approach to prioritising the safety, well-being, and autonomy of people: working towards reduced harm, improved quality of life, and better mental health outcomes.

This procedure supports staff to promote well-being and recovery through therapeutic engagement when people have been admitted into our inpatient services, establishing a trusting working alliance, living our Trust values and applying the CHIME Factors. The effective and appropriate implementation of therapeutic engagement and observations is fundamental to discharging our duty of care in these circumstances.

This procedure gives a framework for staff that supports the use of least restrictive interventions being used for the least time possible, as part of a considered and collaborative intervention.

It: -

- Prioritises therapeutic engagement and ensures a compassionate, personalised approach to meeting people's needs.

- Identifies the skills staff will need to deliver both therapeutic engagement and least restrictive, evidence-based observation.
- Provides direction to the decision-making process to determine the type, level and use of observation, *as a restrictive practice.*
- And ensures the process for adequate review and informative, electronic patient record keeping.

CHIME Factors: **A trauma-informed, recovery focused approach to care.**

CONNECTEDNESS

Having positive relationships and being connected with other people in a positive way.

HOPE & OPTIMISM

That recovery is possible, motivation to change, positive thinking, valuing success, having dreams and aspirations.

IDENTITY

Regaining a positive self and identity – not a person with mental ill health.

MEANING & PURPOSE

Living a meaningful and purposeful life, living life, having real things to do, places to go, goals to achieve.

EMPOWERMENT

Having control over their life, focusing on strengths, making decisions, taking personal responsibility.

3 Who this procedure applies to

All employees of the Trust working into Inpatient services including peer workers, volunteers, temporary and bank staff, and locums. Families, significant others and patients must be central to this process to ensure agreed understanding of roles and responsibilities.

4 Related documents

The **Safety and Risk Management Policy** defines the principles of a proactive and recovery orientated approach to supporting people in our care which you must read, understand and be trained in before carrying out procedures described in this document.

- Mental Capacity Act Policy
- Mental Health Act (copy stored on TEWV intranet)
- Human Rights, Equality Diversity and Inclusion Policy
- Personalised Care Planning Policy

- Physical Health and Wellbeing Policy (Inpatients and Community).
- Privacy and Dignity Policy.
- Blanket restrictions: Policy on the use of Global Restrictive Practices (Blanket Restrictions) in Inpatient Units.
- Supporting Behaviours that Challenge (BtC) Policy.
- Safe Use of Long-Term Segregation (LTS) Procedure.
- Safe Use of Seclusion Clinical Procedure.
- Section 17 Leave for Detained Patients Policy.
- Time Away from the Ward for Informal Patients Policy.
- Admission, Transfer and Discharge Policy.
- Oxehealth Policy
- Oxehealth Procedure
- Young people admitted to adult inpatient wards policy
- Searching of patients, their property, the environment and visitors policy.
- Protocol for Hospital Transfers between TEWV NHS FT and Acute Hospitals

5 Promoting well-being and recovery through therapeutic engagement.

5.1 Engagement: What it is and what it might involve.

- Meaningful and dedicated time to build therapeutic relationships with people, which is conducive to creating a psychologically safe space.
- A compassionate, personalised approach to meeting people's needs.
- Being trauma informed and validating people's response to their experiences.
- Active engagement is key to co-creating meaningful plans, that support:
  - Developing and maintaining a meaningful, therapeutic relationships with people who use our services.
  - Longer term recovery outcomes.
  - Harm minimisation.
- Requires a consistent staff team to be able to deliver effectively.

5.2 Observation: What it is and what might it involve.

Observation is a restrictive intervention of varying intensity in which a member of the healthcare staff observes and maintains contact with the person to ensure their safety and the safety of others. There are different levels of observation, as defined in NG 10 recommendation 1.4.11 (see section 5.3 below).

People can experience increasing levels of distress or pronounced ill health that may put themselves or others at risk of harm. Observation may be required for the

management of behavioural disturbance or during periods of distress to prevent harm to self or others. At these time staff should be caringly curious, vigilant and inquisitive.

Being caringly curious, vigilant and inquisitive is…

1. **Noticing a patient's absence.**
2. **Noticing that a patient appears physically ill.**
3. **Following a patient in distress.**
4. **Noticing that a patient is taking a long time in the toilet.**
5. **Noticing actions out of the ordinary.**
6. **Responding to anything unusual.**

This is underpinned by NICE guidelines that say: -

- Staff should be aware of the location of all people for whom they are responsible, but not all service users need to be kept within sight.
- At least once during each shift a nurse or, with supervision, a delegated other should set aside dedicated time to assess the mental state of, and engage positively with, the person.
- As part of the assessment, the nurse should evaluate the impact of the person's mental state on the risk of violence and aggression and record any risk in the notes.

NG10: General principles

Good practice and professional guidance encourage and expect us all to be actively noticing and documenting how people are presenting. In essence, it's about being curious in every encounter and acting on this, remembering that we strive to coproduce care and documentation.

For a mental state assessment, staff should take note of a person's presentation and draw meaning from this so that the most appropriate course of action is taken, ensuring the persons needs are met and risks are addressed. That is, noticing and documenting through the lens of your professional role or task. The level of detail expected will therefore vary accordingly.

What we mean here with mental state assessment is noticing and documenting through the lens of your professional role or task, and the level of detail expected will therefore vary accordingly. This enables everyone to know how someone usually is, to see if there is anything significant or if something has changed which may influence next steps. In essence, it's about being curious in every encounter and acting on this, remembering that we strive to coproduce care and documentation.

All of us already intuitively perform many parts of this every time we interact with or observe others. For example, if you're chatting to a friend and they don't seem as smiley or talkative as usual, then you may pick up on this and interpret it as your

friend's mood being a little low. We are all doing this, consciously and unconsciously, every day, but as an organisation we recognise that we need to be better at documenting this.

The domains that are assessed when completing a full Mental State Examination (MSE) are useful as an aide memoire even if a full MSE is not the expectation. These domains can include, for example: - Appearance, Behaviour, Mood, Affect, Thinking, Motor Activity, Speech, Cognition, Perception & Insight.

For guidance on observations in acute care settings, staff should refer to 'Protocol for Hospital Transfers between TEWV NHS FT and Acute Hospitals'.

5.3 Definitions of levels of observation.

The Trust has adopted the terminology as outlined in NICE Clinical Guideline 25 (2005): 'Violence: short term management of disturbed/violent behaviour in psychiatric inpatient settings and emergency departments' due to it being more accessible, more inclusive, more holistic in approach, this procedure does not solely deal with violence and aggression. This variation is in accordance with NICE Guideline 10.

- General Engagement and Observation
- Intermittent Engagement and Observation
- Within Eyesight Engagement and Observation
- Within Arm's Length Engagement and Observation

When considering levels of observation multiple factors need to be considered.

To minimise risk, observation needs to be

- Unpredictable.
- Purposeful.
- Balance privacy, dignity and autonomy of the person with the need to maintain the safety of those around them.
- Use the least intrusive level of observation necessary for the least time possible.
- Must **not** be undertaken as a routine task.

Staff should use observation only after positive engagement with the person using our service has failed to dissipate the risks or presenting concerns.

Staff should recognise that service users sometimes find observation provocative, and that it can lead to feelings of isolation and dehumanisation.

When identifying a level of observation staff may also want to consider: -

- History of previous suicide attempts, self-harm or violence towards others.
- Hallucinations, particularly voices suggesting harm to self or others.
- Paranoid ideas where the person believes that other people pose a threat.
- Thoughts or ideas that the person has about harming themselves or others.
- Vulnerability of harm from others.
- Self-control is reduced.
- Past or current problems with drugs or alcohol.
- Recent loss.
- Poor adherence to medication programmes or non-compliance with medication programmes.
- Marked changes in behaviour, emotional state or medication.
- Known risk indicators including escape, absconding and going missing from the ward, risk/vulnerability, sexual behaviour

Patients under the age of 18 on adult wards, must be placed within eyesight observation (Young people admitted to adult inpatient wards policy).

This procedure should also be considered if any of the following risks are indicated: -

- Deterioration or exacerbation of physical health conditions
- Cognitive impairment
- Risk of falls

NICE CG25.

5.3.1 General Engagement and Observation

General engagement and observations (previously known as CARE Rounds) is the minimum level for all patients. It will therefore apply to the majority of patients who are considered to be at low risk of vulnerability, suicide, self-harm or harm of others.

Throughout the span of duty there will be a number of opportunities for staff to be aware of the wellbeing and location of all patients on general observations and at least hourly there will be positive engagement with the person e.g. saying hello, asking how the person is etc.. In particular during shift handovers, meal times and medication times they could form part of the visual handover of all patients on the ward

During night duty it is acknowledged that there are reduced natural opportunities to engage with patients. It is expected that each person using our service should be checked at a minimum of hourly intervals. Any individual exceptions to hourly intervals must be underpinned by a clear clinical rationale and fully discussed and supported by the Multi-Disciplinary Team. Oxehealth can be discussed as part of a MDT approach, if deemed appropriate. The exception must be based on a defensible risk assessment and have a resulting risk management plan in place. The risk management plan must be subject to regular review at timeframes specified in the plan.

We expect that the Nurse In Charge / Shift coordinator will ensure through their planning and co-ordination duties, that the whereabouts are known for all people admitted to their ward.

5.3.2 OXEHEALTH:

Oxehealth is an assistive technology (also referred to by its brand name “Oxevision”) that has been introduced across inpatient wards and seclusion rooms to improve patient care and safety, and works as an assistive tool alongside holistic, trauma informed and person-centred care.

Oxehealth technology has been installed into many inpatient ward areas to support patient safety. The system provides:

- **Activity alerts** – Real-time alerts based on continuous safety monitoring.
- **Vital Signs measurements** – Spot measurements that can be taken of pulse and breathing rate.
- **Activity reports** – Timeline summary of the persons activity detected in a room, including time in bed, room (but not in bed), out of room.

The use of Oxehealth for an individual person must be incorporated into the care planning process and co-created with the involvement of the patients. As with all interventions and aspects of care planning this needs to be a personalized, recovery focused approach with relational safety considerations being central to this.

5.3.3 Intermittent Engagement and Observation

This level is appropriate for patients potentially, but not immediately, at risk of disturbed/violent behaviour, increased vulnerability, suicide, self-harm and may include those who have previously been at higher risk and have had their observation level reviewed by the Multi-Disciplinary Team and reduced.

A specific engagement and observation plan is required that details either the exact intervals at which the observations should be carried out or a specific number of times within a specified time frame that the person using our service should be observed. This plan can include individual protective factors which may influence the level or frequency of observations.

An appropriately trained staff member (who has been assessed as competent by a qualified member of staff) responsible for carrying out intermittent observations over the prescribed period will have an awareness of the patients whereabouts at all times and will observe the person and use the agreed engagement strategies either at specified intervals ranging from 15 to 30 minutes or a number of times specified in the plan and document this accordingly.

For some patients in order to enhance safety, intermittent observations should be carried out at varied intervals within a time frame. The varied intervals should be agreed between the Nurse in Charge and the members of staff completing the periods of observation during any shift

To ensure that positive engagement can take place, consideration needs to be given to the number of patients a staff member is allocated to observe at any one time. Consideration needs to be given by the Nurse in Charge to the number of staff required for the physical environment and how positively this lends itself to engagement and observation with people who use our service.

Consideration should be given to how an individual's dignity could be maximised without compromising safety when individuals are in a state of undress, such as when using the toilet, bathing, showering, dressing, etc.

Leave outside of the ward area should be considered in relation to the Trust's Leave policies, however responsibility for engagement and observation of the person using our service remains with a member of Trust staff at all times unless specifically planned and agreed with the multi-disciplinary team and where necessary families.

5.3.4 Within Eyesight Engagement and Observation

This level would usually be prescribed when the person is assessed as being at significant risk which would be reflected both in the risk assessment and individual care plan.

A specific engagement and observation plan is required. The plan must stipulate what the observing nurses (or delegate) are required to do to support the individual during these situations. Issues of privacy and dignity, gender and environmental dangers should be discussed and incorporated in the care plan.

An appropriately trained staff member (who has been assessed as competent by a qualified member of staff) responsible for carrying out eyesight observations over the prescribed period will have the person within eyesight at all times.

The staff member responsible for carrying out the prescribed observations over the period must document an hourly brief summary of the persons behaviour, mental state and general wellbeing.

Consideration should be given to whether the person may only require 'within eyesight observation' at specific times or within specific environments, e.g. times using the bathroom and toilet within specific areas of the ward, at meal times, post visiting time or whilst in education. This should be based on clinical risk assessment and incorporated into the patient's individual plan.

The allocated nurse (or delegate) will provide one to one support throughout the whole period of prescribed 'within eyesight observation'. On specified occasions more than one member of staff may be necessary to carry out this level of observation. The plan will stipulate the number of nurses (or delegates) required.

The responsibility for within eyesight observation should not be transferred to family members, carers and friends; unless in exceptional circumstances which have been agreed, risk assessed and care planned by the multi-disciplinary team and where necessary families.

Leave outside of the ward area should be considered in relation to the Trust's leave policies however the person will be escorted at all times by a member of the Trust staff.

If patients under 18 years of age are admitted to an adult environment, they must be placed within eyesight observation or a higher level of observation on admission and for the duration of their stay (as per the Trust's policy Young People admitted to adult inpatients).

5.3.5 Within Arm's Length Engagement and Observation

This level will be prescribed for patients at the highest levels of risk and thus they will need to be nursed in close proximity. Where the care plan identifies a risk in relation to potential violence and aggression consideration must be given to maintaining a safe distance in line with training.

An appropriately trained staff member (who has been assessed as competent by a qualified member of staff) responsible for carrying out prescribed 'within arm's length observation' will provide one to one support throughout the whole period. On specified occasions more than one member of staff may be necessary to carry out this level of observation. The engagement and observation plan will stipulate the number of nurses (or delegates) required.

Issues of privacy, dignity and the consideration of gender in allocating staff, and environmental risks need to be discussed and incorporated into the plan. The staff member responsible for carrying out the prescribed engagement and observations

over the period must document hourly, a brief summary of the persons' behaviour and mental state.

Consideration should be given to whether observations can be reduced to 'within eyesight' once the person has retired to bed and is asleep. This should be fully discussed within the multi-disciplinary team and reflected in the engagement and observation plan.

Leave outside of the ward area should be considered, only in exceptional circumstances in accordance with the appropriate risk assessment in place, in relation to the Trust's leave policies, however the person will be escorted by a member or the appropriate number of Trust staff at all times.

Consideration should also be given to a period of engagement and 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 care plan.

It may be necessary to search the person using our service and their belongings. This may be in circumstances like attending a physical health appointment. If it is required, it must be done with due regard for the person's legal rights and conducted in a sensitive way. 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.

All records will be made contemporaneously by the staff member allocated to the duty of providing observation and held in the service user's health record, and these records will be reviewed by multi-disciplinary teams.

Best practice would be that staff who are allocated to deliver continuous engagement and observation would be involved with the person 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 person may not always make that possible.

5.4 Instigating, increasing, decreasing and review of observations.

Working with people were there are no risk-free options is one of the biggest challenges that faces staff working with people who are distressed and unwell. One of the most difficult conversations we will be involved with is how we will protect someone from harm whilst also enabling them to live life to the full, therefore

sometimes making a decision to reduce or increase observations has to be considered within this context. Making a clear record of the decision-making process and the current plan ensures everyone takes time to understand the nuance, detail and factors that have been considered.

5.4.1 Initiating engagement and observation levels on admission.

- On admission, an immediate and appropriate level of engagement and observation will be allocated.
- This level of observation should be decided by the MDT/care team, in collaboration with the person using our service and family/carers at every opportunity.
- This will reflect the risk of harm as assessed by the risk assessment of the admitting team.
- For out of hours admissions the decision regarding allocation of observations will be determined by the Nurse-In-Charge (NIC) and admitting team where appropriate. NIC to include Medic if appropriate and Duty Nurse Co-ordinator (DNC) in the decision, to support the decision-making process.
- The level of engagement and observation will be prescribed in the observations plan, supported by completion of Safety Summary.
- To support initial assessment, Oxehealth will be switched on for a minimum of 72 hours with an MDT decision being taken about whether this is detrimental.

5.4.2 Increasing engagement and observation levels.

- If there is a change to a person's mental state or wellbeing, they may require a change/increase of their engagement and observation levels.
- This level of observation should be decided by the MDT/care team, in collaboration with the person and family/carers at every opportunity.
- If this is not possible, the decision can be made by a registered nurse (who has personally undertaken a risk review of the person), and a member of the care team/MDT that knows the person well (who has been involved previously in the clinical risk assessment of the person).

5.4.3 Decreasing engagement and observation levels.

- If there is a change to a person's mental state or wellbeing, they may require a reduction of their engagement and observation levels.
- This level of observation should be decided by the MDT/care team, in collaboration with the person and family/carers at every opportunity.
- If this is not possible, the decision can be made by a registered nurse (who has personally undertaken a risk review of the person), and a member of the care team/MDT that knows the person well (who has been involved previously in the clinical risk assessment of the person).

All changes to a person's engagement and observation plan should be clearly documented and supported by a review of their Safety Summary and Safety Plan found in the Safety and Risk Management tab on the electronic patient record.

5.4.4 Observations whilst sleeping – supporting good sleeping habits.

Regardless of whether it is day or night and their level of engagement and observation, the person using our service will have a plan for when they are asleep. This will be incorporated into their individual engagement and observation plan. The levels of observation will be discussed with the person and if clinically appropriate, how often they would like to be checked can be agreed.

- The level of observation when a person is asleep will be risk assessed and reviewed by the MDT/care team, in collaboration with the person and family/carers at every opportunity.
- If the person has declined to engage in this process the appropriate assessed level of observation will be discussed with them and significant others, and this will be regularly reviewed.
- If the staff member undertaking the observation is unable to see the person clearly, or has any concerns about the persons physical health or mental wellbeing, they should enter the room to ensure there is no risk to the person.
- The use of assistive technology such as bed sensors, Oxehealth or remote physiological observations may also be considered by the MDT and within the individual care plan. This will need to be regularly assessed in accordance to a person's presentation and individual needs. This must be clearly documented in all cases.

5.4.5 Patients under the influence of alcohol or other substances.

Any person who is suspected to have consumed alcohol or other substances or is appearing intoxicated must have their physical needs assessed by a suitable clinician based on their presentation and an appropriate medical intervention offered. If this assessment is not completed by a medic, the assessing clinician must discuss and agree the plan with the medic. Following assessment an MDT discussion should inform the level of engagement and observation required, in line with medical recommendations including what changes in presentation would indicate a review of the ongoing need and rationale for observations. All assessments, plans and levels of engagement, should involve the patient, where possible, as well as their family member to ensure collaborative engagement in their care.

5.4.6 Who should do the observations.

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

All members of staff carrying out observations and engagement need to be assessed as competent every three years or more frequently if required using the Competency

Appendix Tool (Appendix 5) Attention should be paid to meeting the persons 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 person 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 people using our service, is preferable to unskilled and unfamiliar staff.

Agency and bank staff should not be used to undertake engagement and observation 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 and agency are well known to certain service users as they work regularly into some clinical environments.

Modern Matrons and /or Service Managers should regularly be consulted in relation to staffing levels, skill mix and competencies required to implement engagement and observation. 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 person is on their particular level of engagement and observation.
- Has been briefed about the service user's history, background, specific risk factors and particular needs of the patient's care 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 person will feel valued and the types of activities that will aid recovery and minimise harm.

5.5 Review of Observations – how often reviews should take place

Observation levels should be reviewed daily (e.g. in any MDT meeting held that day).

For observation levels higher than general observation, the review should be done every 24 hours in collaboration with the person using our services, and others where appropriate. Best practice for this would be in the daily report out meetings or if this is not an option by a Registered Nurse on duty and documented on the electronic patient record.

If intermittent, within eye sight or within arm's length engagement and observation continues for 1 week or more, at least once a week a full review MDT (or care team if

on a nurse led unit of engagement and observation levels must take place and the discussion's outcome recorded in the electronic patient record.

6 Staff support

There are numerous structures in place for ongoing staff support for example Clinical Supervision, reflective practice supervision, and de-brief.

As part of ensuring safe and compassionate care, teams should prioritise time for ongoing reflective practice and clinical supervision.

7 Definitions

Term	Definition
Duty of care	Organisations must maintain an appropriate standard of care in their work and not be negligent. People who have mental capacity to make a decision and choose voluntarily to live within a level of risk, are entitled to do so. In this case the law considers the person to have consented to the risk and there is thus no breach of duty of care and the organisation or individual cannot be considered negligent.
Human rights	All public authorities and bodies have a duty not to act incompatibly with the European Convention of Human Rights. A balance needs to be struck between risk and the preservation of rights.
Health and safety	There is a legal duty on all employers to ensure, as far as reasonably practicable, the health, safety and welfare of their employees as well as the health and safety of those who use services. Health and Safety legislation should not block reasonable activity.
Mental capacity	This is concerned with a person's ability to make decisions for themselves, and the principle enshrined in the Mental Capacity Act, 2005 is that they must be assumed to have capacity unless it is established that they do not. People with capacity may make unwise decisions. For those who lack capacity, decisions made on their behalf must be made in their best interests and with the least restriction.

Fluctuating mental states and neurological conditions such as, but not restricted to, dementia	The choices and wishes of people with fluctuating mental states and dementia must be respected and their risk agreements monitored and reviewed regularly. In these circumstances it is important to engage with families and carers.

8 How this procedure will be implemented

- This procedure will be published on the Trust's intranet and website.
- Line managers will disseminate this policy to all Trust employees through a line management briefing.

8.1 Training needs analysis

Staff/Professional Group	Type of Training	Duration	Frequency of Training
All clinical staff	Mandatory e-learning	1.5 hours	For staff new to TEWV
All clinical staff where competency in clinical risk assessment, formulating and management is required in their role	Mandatory face to face learning	3 hours	Every 2 years

9 How the implementation of this procedure will be monitored

Number	Auditable Standard/Key Performance Indicators	Frequency/Method/Person Responsible	Where results and any Associate Action Plan will be reported to, implemented and monitored; (this will usually be via the relevant Governance Group).

1	85% of clinical staff will have completed mandatory training	Service Improvement Delivery Groups (SIDG) to monitor via IIC Mandatory Training Report for compliance and exceptions on a monthly basis	SIDG and Care Group Boards to monitor.
2	Completion of and adherence to safety plans is monitored in the Quality Assurance (QA) Schedule.	QA tool schedule results are reviewed monthly at Care Group Fundamental Standards groups.	Strategic Fundamental Standards Group and Quality Assurance Committee will monitor.

10 References

- Mental Health Act 1983: Code of Practice.
- NICE. NG 10: Violence and aggression: short-term management in mental health, health and community settings.
- NICE. CG 25: Violence: short-term management for over 16s in psychiatric and emergency departments
- Standard Nursing and Midwifery Advisory Committee: Safe and Supportive Observation of Patients at Risk.
- Staff and patient perspectives on therapeutic engagement during one-to-one observation. Insua-Summerhays et al. 2018.
- Engagement and observation: a review of local policies in England and Wales. Ashmore, R. 2020.

11 Document control (external)

To be recorded on the policy register by Policy Coordinator

Required information type	Information
Date of approval	20 May 2025
Next review date	20 May 2028
This document replaces	CLIN-0017-001-v3.4 Supportive Observations and Engagement Procedure

This document was approved by	ECLS
This document was approved	16 April 2025
This document was ratified by	Management Group
This document was ratified	20 May 2025
An equality analysis was completed on this policy on	08 January 2025
Document type	Public
FOI Clause (Private documents only)	n/a

Change record

Version	Date	Amendment details	Status
4.	20 May 2025	Undertaken literature review to identify examples of best practice and establish evidence base. Renamed the 'Engagement and Observation' procedure. All references throughout changed to prioritise engagement, in recognition that first and foremost, meaningful engagement is at the heart of our therapeutic, core offer. Endorses CHIME factors as a trauma informed, recovery focused approach to care. Acknowledges observation as a restrictive practise - advocating for least restrictive practice for the least amount of time necessary. Cites the relevant NICE Guidance 10: Violence and aggression: short-term management in mental health, health and community settings as the evidence base. Also explains the rationale for variation i.e. instead using NICE Clinical Guidance 25: Violence: short-term management for over 16's in psychiatric and emergency departments as the basis for the definitions in used in the procedure. Introduces the concept of 'caringly curious, vigilant and inquisitive'.	withdrawn

		Introduces guidance on standards around mental state assessment (not examination) – consistent with the overarching 'Safety & Risk Management' policy. Removed the term 'care rounds' and replaced throughout with 'General engagement and observation'. Establishes 'General engagement and observation' as the minimum requirement for all people accessing inpatient services. Removed '5-minute intermittent observations' as a category, to ensure care is delivered with appropriate safeguards and levels of review in place. Changed 'night-time observations' to 'observations while sleeping' to better personalise care planning. Removed section summarising observations during seclusion and segregation procedures, instead included in 'Related Documents' section. Ensuring staff access the correct and full information they need Added section on patients under the influence of alcohol or other substances, as a means of supporting staff in these situations. Added section on Oxehealth, outlining the role of assistive technology. Removed reference to 'zonal observations'. Added instead as an appendix which outlines the zonal model as an alternative method of engagement and observation, including guidance to consider prior to implementing. Introduced a 'zonal model decision-making checklist' as an appendix. Guiding staff to establish and document a clear rationale for its use, duration, location and clarify the route to follow for well governed decisions. Included the concept of working with people when there are no harm-free options, consistent with the overarching 'Safety and Risk Management' policy. Removed a separate section on record keeping, as instead, standards for good clinical record keeping are referenced throughout the document. Added the requirement for teams to prioritise time for ongoing reflective practice,	

		as an integral part of ensuring safe and compassionate care.	
v4.1	27 Jun 2025	Minor change to formatting of Appendix 4 – Engagement and Enhanced Observation Recording to make printing more readable. Note – formal approval not required As pages 2-4 of Appendix 4 are titled 'Summary of engagement' – the term (Summary Recording) has been added to specifically indicate what document is meant when setting a 'frequency of documentation'.	Published

Appendix 1 - Equality Impact Assessment Screening Form

Please note: The Equality Impact Assessment Policy and Equality Impact Assessment Guidance can be found on the policy pages of the intranet

Section 1	Scope
Name of service area/directorate/department	Clinical – Trustwide
Title	Engagement and Observation Procedure
Type	Procedure
Geographical area covered	Trustwide
Aims and objectives	This procedure supports staff to promote well-being and recovery through therapeutic engagement when people have been admitted into our inpatient services, establishing a trusting working alliance, living our Trust values and applying the CHIME Factors.
Start date of Equality Analysis Screening	30/08/2024
End date of Equality Analysis Screening	08/01/2025

Section 2	Impacts
Who does the Procedure benefit?	People who use our services, their families and carers, staff and partner agencies.
Will the Procedure impact negatively on any of the protected characteristic groups? Are there any Human Rights implications?	• **Race** (including Gypsy and Traveller) **NO** • **Disability** (includes physical, learning, mental health, sensory and medical disabilities) **NO** • **Sex** (Men and women) **NO** • **Gender reassignment** (Transgender and gender identity) **NO** • **Sexual Orientation** (Lesbian, Gay, Bisexual, Heterosexual, Pansexual and Asexual etc.) **NO** • **Age** (includes, young people, older people – people of all ages) **NO** • **Religion or Belief** (includes faith groups, atheism and philosophical beliefs) **NO** • **Pregnancy and Maternity** (includes pregnancy, women / people who are breastfeeding, women / people accessing perinatal services, women / people on maternity leave) **NO** • **Marriage and Civil Partnership** (includes opposite and same sex couples who are married or civil partners) **NO** • **Armed Forces** (includes serving armed forces personnel, reservists, veterans and their families) **NO** • **Human Rights Implications YES** (Human Rights - easy read)
Describe any negative impacts / Human Rights Implications	When people are acutely unwell then their human rights may have to be balanced and care may even need to be offered at times when there are no harm free options.
Describe any positive impacts / Human Rights Implications	This procedure seeks to better enable a holistic view of the person receiving our services, with a focus on recovery, independence, quality of life and well-being.

Section 3	Research and involvement
What sources of information have you considered? (e.g. legislation, codes of practice, best practice, nice guidelines, CQC reports or feedback etc.)	NICE Guidance 10: Violence and aggression: short-term management in mental health, health and community settings. NICE Clinical Guidance 25: Violence: short-term management for over 16s in psychiatric and emergency departments
Have you engaged or consulted with service users, carers, staff and other stakeholders including people from the protected groups?	Yes.
If you answered Yes above, describe the engagement and involvement that has taken place	The procedure has been coproduced with Peer workers and our involvement members. We will also be actively seeking their views as part of the consultation process.
If you answered No above, describe future plans that you may have to engage and involve people from different groups	

Section 4	Training needs
As part of this equality impact assessment have any training needs/service needs been identified?	No
Describe any training needs for Trust staff	N/A
Describe any training needs for patients	N/A
Describe any training needs for contractors or other outside agencies	N/A

Check the information you have provided and ensure additional evidence can be provided if asked.

Appendix 2 – Approval checklist

To be completed by lead and attached to any document which guides practice when submitted to the appropriate committee/group for consideration and approval.

Title of document being reviewed:	Yes / No / Not applicable	Comments
1. Title		
Is the title clear and unambiguous?	Y	
Is it clear whether the document is a guideline, policy, protocol or standard?	Y	
2. Rationale		
Are reasons for development of the document stated?	Y	
3. Development Process		
Are people involved in the development identified?	Y	
Has relevant expertise has been sought/used?	Y	
Is there evidence of consultation with stakeholders and users?	Y	
Have any related documents or documents that are impacted by this change been identified and updated?	Y	
4. Content		
Is the objective of the document clear?	Y	
Is the target population clear and unambiguous?	Y	
Are the intended outcomes described?	Y	
Are the statements clear and unambiguous?	Y	
5. Evidence Base		
Is the type of evidence to support the document identified explicitly?	Y	
Are key references cited?	Y	
Are supporting documents referenced?	Y	

6. Training		
Have training needs been considered?	Y	
Are training needs included in the document?	Y	
7. Implementation and monitoring		
Does the document identify how it will be implemented and monitored?	Y	
8. Equality analysis		
Has an equality analysis been completed for the document?	Y	
Have Equality and Diversity reviewed and approved the equality analysis?	Y	Ah 08/01/2025
9. Approval		
Does the document identify which committee/group will approve it?	Y	
10. Publication		
Has the policy been reviewed for harm?	Y	No harm
Does the document identify whether it is private or public?	Y	public
If private, does the document identify which clause of the Freedom of Information Act 2000 applies?	N/a	
11. Accessibility (See intranet accessibility page for more information)		
Have you run the Microsoft Word Accessibility Checker? (Under the review tab, 'check accessibility'. You must remove all errors)	Y	
Do all pictures and tables have meaningful alternative text?	Y	
Do all hyperlinks have a meaningful description? (do not use something generic like 'click here')	Y	

Appendix 3 – Engagement and General Observation Recording

Page remains blank on Purpose.

AM: Communicate Assess Respond Environment **Date:** _____

Room N°	O Y / N	Name	08.00				09.00				10.00				11.00				12.00				13.00				14.00				15.00				16.00				17.00				18.00				19.00			
			C	A	R	E	C	A	R	E	C	A	R	E	C	A	R	E	C	A	R	E	C	A	R	E	C	A	R	E	C	A	R	E	C	A	R	E	C	A	R	E	C	A	R	E	C	A	R	E
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✓ = Completed O/W = Off Ward X = Missing O = Oxehealth switched on Yes or No * (+ initials) = Intervention plan for time asleep S = Sleep

Time:	Actions taken:	Total On Ward This Hour	Due Back Within Hour
8am			
9am			
10am			
11am			
12noon			
1pm			
2pm			
3pm			
4pm			
5pm			
6pm			
7pm			

Patients on leave (No Identified bed) until (date)	
❶	❺
❷	❻
❸	❼
❹	❽
	❾

journey to change

NHS
Tees, Esk and Wear Valleys
NHS Foundation Trust

PM: Communicate Assess Respond Environment **Date:** _____

Room N°	O Y / N	Name	20.00				21.00				22.00				23.00				00.00				01.00				02.00				03.00				04.00				05.00				06.00				07.00			
			C	A	R	E	C	A	R	E	C	A	R	E	C	A	R	E	C	A	R	E	C	A	R	E	C	A	R	E	C	A	R	E	C	A	R	E	C	A	R	E	C	A	R	E	C	A	R	E
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✓ = Completed O/W = Off Ward X = Missing O = Oxehealth switched on Yes or No * (+ initials) = Intervention plan for time asleep S = Sleep

Time:	Actions taken:	Total On Ward This Hour	Due Back Within Hour
8pm			
9pm			
10pm			
11pm			
00.00			
1am			
2am			
3am			
4am			
5am			
6am			
7am			

Patients on leave (No Identified bed) until (date)	❺
❶	❻
❷	❼
❸	❽
❹	❾

Appendix 4 – Engagement and Enhanced Observation Recording

Patient name	
Paris ID	
Date of recording	

		x	***Frequency of intermittent observation, and Frequency of documentation (Summary Recording) - for all levels of observations.***
Level of Observations	Intermittent		
	Within eyesight		
	Within arm's length		

Risk behaviour(s):

Risk factors:

Intermittent, within eyesight, and within arm's length Engagement & Observation*

The observation record should be signed at the exact intervals that observations are carried out and a summary entered onto the clinical record (CITO) as outlined in the care plan.

This document should also be uploaded to the clinical record (CITO) via the

>Patient Portal >Safety and Risk Management >Additional Safety & Risk Documentation >Obs & Engagement

**These summaries will then be discussed with the MDT*

Patient Name: _____ Paris ID _____

Date	Time	Summary of engagement and observation *and/or* Risk behaviour(s) factors identified during observations	Signature/Designation of member of staff carrying out observation	Signature/Designation of member of staff carrying out receiving observation

Patient Name: _____ Paris ID _____

Date	Time	Summary of engagement and observation *and/or* Risk behaviour(s) factors identified during observations	Signature/Designation of member of staff carrying out observation	Signature/Designation of member of staff carrying out receiving observation

Patient Name: _____ Paris ID _____

Date	Time	Summary of engagement and observation *and/or* Risk behaviour(s) factors identified during observations	Signature/Designation of member of staff carrying out observation	Signature/Designation of member of staff carrying out receiving observation

Appendix 5 - Competency Tool

Performance Criteria. The staff member can…	Assessment Method	Meets Standard? Yes or No.	Comments
Demonstrate awareness of the Procedure.	Verbal.		
Describe their overall responsibilities in relation to the Procedure.	Verbal.		
Outline some of the general principles of engagement and observation.	Observation / Verbal.		
Explain the procedure for giving patients information regarding levels of engagement and observation	Observation / Verbal.		
Describe the role and responsibilities of the member of staff undertaking engagement and observation.	Verbal.		
Explain the importance of effective communication to other staff in relation to the Procedure and can describe how and when such communication would take place.	Verbal.		
Demonstrate an understanding of the categories of the observation levels.	Verbal.		
Describe how levels of engagement and observation are allocated.	Verbal.		
Demonstrate an understanding of how and who can increase and decrease levels of engagement and observation.	Verbal.		
Demonstrate an understanding of record keeping requirements in relation to the Procedure.	Observation / Verbal.		
Demonstrate the need for assessing changes in engagement and observation.	Verbal.		
Explain how to hand over the responsibility for engagement and observation.	Verbal.		

Appendix 6 - Engagement and Observation - Zonal Model

The Zonal Model allows an alternative method of engagement and observation involving boundaries and time restrictions for certain ward areas, supported by staff who engage and observe with people using our services individually and as groups, for set periods. The model 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 people categorised by risk.

Services have a duty for safety and security to the people using its services, staff and visitors. Care must be provided in an environment and manner that reflects the least level of restriction possible, considering the safety of everyone within that environment.

The Zonal Model aims to ensure appropriate engagement and observation of people using our services without the need to assign a particular practitioner to be in close proximity to them for long periods. Instead, a staff member is assigned to engage and observe with people within specified zones within the ward area. It can be used for an individual or a particular group of people within a specific ward or environment. This decision will always be based on clinical need and will not be financially driven.

In certain circumstances this can be considered less intrusive and allow greater privacy for the person than enhanced levels of engagement and observation. The Trust therefore recognises that under certain circumstances a ward or clinical area may wish to operate a zonal engagement and observation model to meet a clinical need, as agreed following discussion with the person, wherever possible, and the MDT.

The decision to authorise the Zonal Model for engagement and observation will lie with the relevant Service Improvement Delivery Group (SIDG) following an application from the ward / clinical area. 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 feedback from the person using our service.

Principles guiding the implementation

Zonal Engagement & Observation: -

- Must, at all times, be focused on the person at the centre.
- Should be seen as one of several methods for mitigating risk and enhancing the experience of people using our services. The model can be applied as part of a wider risk assessment, contextual management process and capable environment for a specified, time limited period.
- Relies on the environment in which it is to be applied. Not all ward' lay outs are appropriate for Zonal Engagement and Observation.
- Must have explicitly defined 'zones' - rooms, corridors and spaces within them. The zone should be described clearly with defined boundaries as to where the zone starts and ends.

Examples 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.

Decision making checklist
The ward / clinical area considering the use of zonal engagement and observations should have a clear rationale and implementation plan which covers the following area. The zonal model decision making checklist (Appendix 7) must be used to develop the plan as well as assisting SIDG to approve the decision.

Professional Roles in Zonal Engagement and Observation.
The Ward Manager or their Deputy will:

- Determine the resources needed to manage the ward.
- Review daily the needs of the people currently in services.
- Consider and act appropriately in respect of any complaint the person may have about their engagement and observation status and management.
- Be responsible for ensuring that risk recognition and management of people 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 people using our services.
- Instruction on how and when zonal engagement and observation is implemented and reviewed.
- Ensure that there are appropriate Safety Plans.
- Ensure robust processes are in place for allocating competent staff to engagement and observation responsibilities including clear guidance and instruction for staff on the use of zonal engagement and observation.

The Nurse in Charge will:

- Plan their shift to maximise opportunities for staff on duty to develop therapeutic relationships with the people using our services.
- Follow the established processes and delegate competent 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 their care and management with the person.
- Review the level of observation as per policy.
- Ensure that there are appropriate Safety/Care Plans.

Engagement and Observation Staff will:

- Facilitate interaction and communication with the person or group – following the agreed activity plan. Efforts should always be aimed at maximising the opportunity to develop therapeutic relationships.
- Know their zone. Know who they are to engage and observe.
- Be familiar with the engagement and observation status of all the people in their engagement and observation zone.
- Provide a handover for the nurse taking over from them.
- Record in the electronic patient record, details of the persons mental state, as assessed during the period of zonal observation and engagement, as per Engagement and Observation Procedure section 5.2.
- Report any concerns to the nurse in charge.

Appendix 7 - Zonal Model Decision-Making Checklist

Ward_____. Is the use of zonal engagement and observation for: -

Please Tick An individual ☐ A particular group ☐

Questions	Yes	No	n/a any other Comments
Does the ward / clinical area have a layout appropriate for implementation of zonal engagement and observation?			
Is there evidence of MDT discussion regarding implementation of zonal engagement and observation?			
Is there evidence that the person or group has been involved in the decision-making process?			
If not, is there evidence of a clinical rationale?			
Is there are clear rationale for the implementation of zonal engagement and observation?			
Does the rationale include clear zones identified within the ward / clinical area?			
Is there an identified process for allocating staff to the engagement and observation zones?			
Does the ward / clinical area have an up-to-date Competency Tool register, demonstrating that the staff to be allocated have been assessed as competent to undertake this responsibly? (including bank and agency staff).			
Is there clear guidance as to the times in which the zones will be operational?			
Is there clear guidance as to how engagement and observation levels will change as people move between areas and at different times?			
Is there clear guidance and instruction for staff on the ward / clinical area as to the use of zonal engagement and observations – including roles and responsibilities?			
Is there evidence that the staff allocated have received that guidance and instruction for their ward / clinical area – including roles and responsibilities?			
Is there an activity plan for time that zonal engagement and observations are implemented? Identifying meaningful activity and engagement with staff?			
Is there an indicated date for stepping down zonal engagement and observation with regular MDT review in place?			

Care Group / Specialty of SIDG approving Zonal Engagement and Observation	Date approved
This record should be kept with the ward restrictive practice record while the episode of zonal engagement and observation is in place and archived when it ceases.	