Tees, Esk and Wear Valleys
NHS Foundation Trust

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***Please note v4 has been temporally withdrawn and v3.4 has been reinstated to allow complete implementation of new processes. Effective 03 June 2025.**

Supportive Observations and Engagement Procedure

CLIN-0017-001-v3.4*

Status: Ratified

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Overarching policy: Harm Minimisation (Clinical Risk Assessment and Management) Policy

Contents

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, but this procedure applies to all Tees, Esk and Wear Valleys NHS Foundation Trust inpatient service users. The effective and appropriate implementation of supportive observations and engagement 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 observation and engagement and the process for ensuring adequate review and clinically informative record keeping.
- Details recommendations for the recording of interventions, contact and review of observation and engagement procedures in both in-patient and residential services
- Identifies the skills staff will need to deliver evidence based observation and engagement 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 should be recognised however that if carried out well, that Supportive Observation is important as a supportive mechanism, for the purpose of engaging positively with the service user.

Supportive observation and engagement, over and above the lowest level of observations and engagement, is a therapeutic intervention aimed at reducing factors which contribute to increased risk and promoting recovery. It should focus on engaging the person therapeutically and enabling them to address their difficulties constructively.

It is important that staff balance the distressing effect and potential long term harm of being on high level of observations and engagement (e.g. loss of skills, loss of autonomy) against the risk of immediate harm (e.g. serious self-harm or violence). As this will change over time, this balance will need to be continually assessed.

2.2 Human rights

The use of supportive observation and engagement must not breach The European Convention on Human Rights, and in particular the right to have private life respected (Article 8). No service user should be subject to unnecessarily observations in a way that would breach this right. In order for this policy to comply with the law observations must be justifiable and proportionate. Clinicians therefore need to make sure that the use of supportive observation is no more intrusive – nor continues longer – than is required by the circumstances. Therefore they need to ensure that the right to life (Article 2) is sufficiently threatened to make the use of observations justifiable. The use of increased observation

levels should never be regarded as routine practice, but must be based on assessed and current need.

Supportive observations and engagement should be recognised as a restrictive practice and may be perceived by service users as a coercive intervention. It should therefore only be implemented after positive engagement with the service user has failed to reduce the risk to self or others and only used for the least amount of time clinically required.

2.3 NICE Guidance

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

At times of distress or pronounced ill-health some service users may become a serious risk of harm to themselves or others. Supportive observations and engagement may be required for management of behavioural disturbance or during periods of distress to prevent harm to self or others.

It should be an integral part of the care plan, to ensure the safe and sensitive monitoring of the service user's behavior and mental well-being, enabling a rapid response to change, whilst at the same time fostering therapeutic relationships between staff and service users.

3 Principles of Supportive Observation and Engagement

Supportive Observation and Engagement is more than just watching a person. It is the active and sensitive support of an individual when at their most vulnerable or when harm is most likely to arise. What keeps people safe is not the act of being under surveillance (observation); rather it is the quality of engagement between that individual and staff. Supportive engagement is therefore underpinned by continuous attempts for compassionate and therapeutic interaction to meet the holistic needs of a service user. Staff should be approachable and listen to the service user and be able to convey to the service user that they are valued.

It is essential that during supportive observation and engagement the service user should be given the opportunity to talk and take part in activities meaningful to them and appropriate to their needs and recovery. Such activities need to be collaboratively identified and regularly reviewed with the service user and documented in the care plan, which should be reiterated at each handover. If for any reason involving the service user in dialogue and activities during supportive observation and engagement is not possible or desirable, then the reasons for this needs to be clearly recorded.

4 Observation and Engagement levels

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

4.1 Who should set the Levels of Observation and Engagement?

- The prescribing of observation and engagement levels should, wherever possible, be the result of an assessment by the Multi-Disciplinary Team. Nursing staff may need to initiate a level of observation and engagement above general level on admission or following a rapid change in the patient's clinical presentation before discussion with the wider Multi-Disciplinary Team and/or medical staff can take place. Where possible this should be done in collaboration with the service user and their families or carers.

4.2 When Should Observation and Engagement Levels be set?

- Assessing levels of observation and engagement is an integral part of the patients admission process
- A specific observation and engagement care plan is required for all levels above general and all service users will, have a night time observation plan. The staff member responsible for carrying out the prescribed observations and engagement over the period must document a brief summary at the end of the period of observation of the service user's behaviour, mental state and general well-being.
- Staff should remember that engaging with service users at predictable times can provide the service users with the opportunity to plan or engage in potentially harmful activities, this should be taken into account when determining the frequency and type of observation and 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 Multi-Disciplinary team to clarify the appropriateness of supportive observation and engagement where the risk assessment indicates that the service user can attend without an escort. Where it is clear that observation and engagement above general level remains appropriate then it is the responsibility of the nursing staff to ensure that the staff member completing the observation and engagement is competent to do so. If the service user is attending group activity this will **not** be the person leading the delivery of the group activity. If it is a one to one activity the observation and engagement maybe undertaken by a suitably competent member of trust staff.

4.3 General Observation and engagement

This is the minimum level for all service users. It will therefore apply to the majority of service users who are considered to be at low risk of vulnerability, suicide, self- harm or harm from others.

- Throughout the span of staff's duty there will be a number of opportunities for staff to be aware of the wellbeing and location of all service users on general observations and engagement; in particular during shift handovers, when informally engaging with service users, meal times and medication times.
- Additionally to support the well- being of all patients, 'care rounds' will be completed as the general level of observation and engagement. All service users whereabouts and well- being will be ascertained at least once an hour this will also be an opportunity to engage with the service users and support any immediate need. Nice Guidance (NG 10) states that 60 minute observations should be considered the least frequent observation and engagement level for inpatients. In exceptional individual service user circumstances, after completing a full MDT risk assessment and to support a good sleep pattern at night, it may be appropriate to reduce

the frequency of care rounds/ general observations when a service user is asleep. This would only apply in service areas such as; rehabilitation and secure inpatient rehabilitation/ long stay areas.

- 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 and dressing.
- At least once during the day (24 hour period), the nurse in charge should ensure that they delegate and allocate time aside to review the mental and physical state of all service users on the ward ensuring that there is positive and active engagement (as per NG 10). The level of observation and engagement should be appropriate to meet individual needs, however, if the clinical risk escalates then use of increased observation should be considered.
- An evaluation of the patient's mental state and behaviours should be documented following this in accordance with this policy. This will facilitate and support effective handover of service users' needs.
- The location of all patients on day and night duty should be known to staff but not all patients need to be kept within eyesight, however at the commencement and end of each shift the Nurse in Charge should always ensure that at the care round a verbal and or physical response has been established from each service user present on the ward. This will also inform a robust handover process.
- The intended whereabouts of service users who are on leave from the ward should also be known at all times.

4.4 Intermittent Observation and Engagement

- Intermittent observation and engagement is appropriate for service users '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 and engagement level reviewed by the Multi-Disciplinary Team and reduced.
- A specific observation and engagement care plan is to be formulated and agreed by the multi-disciplinary team and it is required that the plan details either the exact intervals at which the observations and engagement should be carried out or a specific number of times within a specified time frame that the patient should be observed. This care plan can include individual protective factors which may influence the level or frequency of observations and engagement.
- The care plan should be developed in collaboration with service users and minimally detail a summary of the service user's condition, risk behaviours and significant events, potential re traumatization as well as suggested therapeutic interventions and activities to engage with them. Where a patient cannot be seen from the doorway or through the observation panel to their bedroom then the care plan should specify whether the patient's room should be entered before looking elsewhere on the ward.
- Appropriately competent members of staff are responsible for carrying out intermittent observations and engagement over the prescribed period, they will have an awareness of the service users whereabouts at all times and will observe the patient either at specified intervals ranging from **5 to 30 minutes** (the 5 minute intermittent observations are only to be used in secure inpatients) or a specified number of times in an hour and the allocated staff member must ensure they document this accordingly at the point of

observation and engagement.

- For some service users in order to enhance safety intermittent observations and engagement 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 the shift.
- To ensure that positive observations and engagement can take place, consideration needs to be given to the number of service users 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 service user observation and engagement.
- Leave taken outside of the ward area should be considered in relation to the Trust's 'Leave of absence under s17 MHA 1983 and time away from the hospital' policy, however responsibility for observation and engagement of the patient remains with a member of Trust staff at all time unless specifically care planned and agreed with the multi-disciplinary team and where necessary families.

4.5 Within Eyesight Observation and Engagement

- This level would usually be prescribed when the service user is assessed as being a **significant risk** which would be reflected both in the risk assessment and individual care plan. The service user must remain within eye sight at all times, unless the care plan specifically states otherwise.
- A specific observation and engagement care plan is required. The staff member responsible for carrying out the prescribed observations and engagement over the period must document a brief summary at the end of the period of observation and engagement of the patient's behaviour, mental state and general wellbeing.
- Appropriately competent members of staff are responsible for carrying out the observation and engagement over a prescribed period.
- Issues of privacy and dignity, gender, religion and environmental dangers should be discussed and incorporated in the care plan to maintain service user safety.
- The care plan must stipulate what the observing nurses are required to do to support the individual during these situations to maximise patient dignity and safety.
- The care plan should be developed in collaboration with service users and minimally detail a summary of the service user's condition, risk behaviors' and significant events, potential re traumatization as well as suggested therapeutic interventions and activities to engage with them
- Consideration should be given to whether the patient may only require 'within eyesight observation and engagement' 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 care plan.
- The allocated nurse will provide one to one support throughout the whole period of prescribed 'within eyesight observation and engagement'. On specified occasions more than one member of staff may be required to carry out this level of observation and engagement. The care plan will stipulate the number of staff required.
- The responsibility for within eyesight observation and engagement 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.

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

4.6 Within Arm's Length Observation and engagement

- This level of observation and engagement will be prescribed for service users at the **highest levels of risk** and thus they will need to be nursed in close proximity and be clearly visible at all times to the observing staff member.
- A care plan will be required detailing the observation and engagement plan. 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.
- Appropriately competent members of staff are responsible for completing the period of observation and engagement.
- The service users allocated nurse will provide one to one support throughout the whole period of prescribed 'within arm's length observation and engagement'. On specified occasions more than one member of staff may be necessary to carry out this level of observation and engagement. The observation and engagement care plan will stipulate the number of nurses required
- Issues of privacy, dignity and the consideration of gender and religion in allocating staff, and environmental risks need to be discussed and incorporated into the care plan to maintain service user safety.
- The care plan should be developed in collaboration with service users and minimally detail a summary of the service user's condition, risk behaviors' and significant events, potential re traumatization as well as suggested therapeutic interventions and activities to engage with them
- 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, and dressing.
- Consideration should be given to whether observations can be reduced to 'within eyesight' once the patient has retired to bed and is asleep. This should be fully discussed within the multi-disciplinary team and reflected in the observation and engagement care plan.
- Leave taken outside of the ward area should be considered in relation to the Trust's 'Leave of absence under s17 MHA 1983 and time away from the hospital' policy, however responsibility for observation and engagement of the patient remains with a member of Trust staff at all times.
- Consideration should also be given to a period of observation and engagement 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 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).
- 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 observation and engagement. 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)
- All records will be made contemporaneously by the staff member allocated to the duty of providing supportive observation and engagement 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 observation and engagement 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

4.7 Night time observations

Regardless of their level of observation and engagement, a service user will have a plan for night time observations this may be incorporated into their individual care plan for observation and engagement. (If the service user is on general observations they will need a specific night time plan)

- 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 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 assistive technology such as bed sensors or remote physiological observations may also be considered within the individual care plan but it must be remembered that for some service users it may be more appropriate to retain some level of night time observation.

5 Supportive Observations and Engagement during special circumstances

5.1 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.

5.2 Zonal observation and engagement

The zonal model aims to ensure appropriate observation and engagement 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 increased observation and engagement. The Trust therefore recognises that under certain circumstances a ward or clinical area may wish to operate a zonal observation and engagement model. The decision to implement zonal observation and engagement 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 observation and engagement. The checklist should be used as evidence as part of the request for support for implementation from the relevant QuAG.

6 Decision making process

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

Only after positive engagement with the service user has failed to mitigate the risk of harm should a person move on to supportive observations and engagement, and only then if that identified risk can be effectively managed through doing this. Levels of observation and engagement 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 engagement, and what that level is
- How it will be carried out and the importance of positive observation and 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 being utilised 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 in the safety plan.

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. If the service user agrees, explain to carers the aims and level of observation and engagement. Involvement of advocates should always be considered.

6.1 On admission to a ward or clinical area

Upon admission, an immediate and appropriate level of observation and engagement 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 care plan.

6.1.1 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 observation and engagement will be identified according to individual multi-professional assessment which is reviewed regularly.

6.2 Initiating supportive observation and engagement levels above general

When initiating supportive observation and engagement levels above general, a minimum of two practitioners from the clinical area can initiate observation and engagement levels; this is due to the need to balance the possible level of intrusion for the patient and the need to maintain patient safety. At least one must be a registered nurse who has personally undertaken a clinical risk assessment review of the service user. Ideally the second registered practitioner should 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), however it may be necessary to utilize the role of the Duty nurse coordinator or doctor on call out of hours. The role of the second practitioner is also to ensure that all alternatives to increasing observations and engagement have been fully explored. Whilst this review is being undertaken patient safety must be maintained.

6.3 Increasing and decreasing supportive observations and engagement.

Decisions about supportive observations and engagement 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 observation and 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 current risks and how the level of observation and engagement is being used to manage that risk should also be documented in the safety 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 and engagement 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 and engagement.

6.4 Review of observations and engagement

Observation and engagement practice will be reviewed at a minimum once every shift at handover or multi-disciplinary discussion. There will be ongoing review with the service user which recognises the dynamic nature of risk.

6.4.1 If intermittent, within eye sight or within arm's length observation and engagement continues for 1 week or more

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

7 Involving the service user

Every effort should be made to discuss, inform and explain to the service user about the level of observation and engagement and any requirements to assist in implementation. With some service users it may be necessary to use a range of resources to explain this. Service users should be offered the opportunity to talk to a member of the Multi-Disciplinary Team re any concerns or questions they have with regards to the level of observation and engagement. Ideally service users should co-produce the observation and engagement care plan with a member of staff. The service user should also be offered a copy of their care plan and the service user information leaflet detailing observations and engagement and this should also be communicated with the service users consent and approval to the nearest relative/carer/friend.

Levels of observation and engagement should be discussed and/or negotiated with the service user and (whilst taking into consideration patient consent, confidentiality and capacity issues) their carer/family wherever possible. Staff must clearly explain the reasons

for the level of observation and engagement. This will be based on a rigorous ongoing risk assessment, which is reactive to dynamic risk factors.

8 Record keeping

8.1 Writing care plans

Decision making in respect of the authority to change the level of observation and engagement 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 safety plan.

The safety plan will specify:

- The rationale for supportive observations and engagement, including a consideration of which immediate harms are being addressed and any potential harm that being on observations may cause.
- Intermittent observation and engagement should always specify the type and frequency of engagement.
- Intermittent observation should specify whether the patient's bedroom should be entered where they cannot be seen from the doorway before looking elsewhere on the ward
- Within eyesight or within arm's length supportive observations and engagement should always specify the number of staff on observation and their position alongside the service user. 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 observation and engagement if not the nurse in charge.
- Any details on how observation and engagement may vary depending on the service user's presentation.

Due to the dynamic nature of risk, the level of observations and engagement 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 observations and engagement within eyesight at all times when Mrs. Smith is awake and whilst the ward has open access. Use intermittent of observations every 30 minute intervals for Mrs. Smith when the ward has locked access and general observation 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 period of observations and engagement on the ward daily planner or equivalent so that a record can be maintained. If a patient is on intermittent or continuous observation this should be recorded on the care round sheet and the intermittent or continuous recording sheets used as the record for the patient.

The staff who are allocated to complete the general level of observation and engagement

will record on the care round sheet. (Appendix 5/ 6).

The staff who are allocated to deliver intermittent, continuous within eyesight or continuous within arm's length observation and engagement will record on the observation and engagement recording sheet (Appendix 3).

All records will be made contemporaneously by the staff member allocated to the duty of providing supportive observations and engagement; it is the individual staff member's responsibility to complete their recording in a contemporaneous manner.

The care plan will specify how often, for all service users requiring intermittent supportive observation/engagement that a written record outlining the service's users presentation. Additionally the contemporaneous paper record needs to be maintained. (Appendix 3)

For those service users requiring continuous supportive observation and engagement a written evaluation of behavioral presentation and/or mental state should be made at the end of the supportive observation and engagement period. Additionally the contemporaneous paper record needs to be maintained. (Appendix 3)
All records will be made contemporaneously by the staff member allocated to the duty of providing supportive observation and engagement and held in the service user's health record and that these records will be reviewed by Multi-Disciplinary teams.

A clear record of the roles (e.g. Nurse in charge, MDT team) of the staff responsible for carrying out the review of the observation and engagement levels including when the review will take place should be made in the care plan

9 Who should carry out supportive observations and engagement

The actual practice of delivering supportive observation and engagement 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 4)

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 observation and engagement 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 and 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 and agency are well known to certain service users as they work regularly into some clinical environments.

Modern Matrons and /or Locality/ Service Managers should regularly be consulted in relation to staffing levels, skill mix and competencies required to implement observation and

engagement. 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 observations and engagement 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 observation and engagement.
- 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 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 observations and engagement must have the knowledge and skills to do so and be assessed as competent, and be familiar with the patient and their particular safety needs.

The skills of staff to deliver evidenced based supportive observation and engagement 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 behavior that challenge
- Knowledge of the systems of reporting, communication and record keeping.

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

Mandatory training will be provided in line with the Trust Staff Development Policy.

The competency assessment will be completed at ward level, by the ward manager (or deputy) or modern matron. This should be reviewed 3 yearly or more frequently should an issue arise.

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 and engagement 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 observation and engagement 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 policy also refers to:-

- Positive approaches to supporting people whose behaviour is described as challenging
- Harm Minimisation (Clinical Risk Assessment and Management) Policy
- 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
- Young People Admitted to Adult In-Patient Wards Policy.
- Procedure for In-patient Service Users Who Require Care In the Local Acute Hospital
- Leave of absence under s17 MHA 1983 and time away from the hospital’

13 Document control

Date of approval:	01 August 2023	
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This document replaces:	CLIN-0017-001-v3.3 Supportive Observation and Engagement Procedure	
Members of working party:	Name	
	CQC Risk Response RPIW 01 Feb 2021 (v3.2)	
This document was approved by:	Name of committee/group	Date
	Chief Nurse	01 August 2023
This document was ratified by:	Name of committee/group	Date
	Management Group (retrospective formal ratification)	16 August 2023
An equality analysis was completed on this document	04 October 2019	

Change record

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

3.00	Effective date: 18 Dec 2019 (As agreed at EMT 06 Nov2019)	• Section 4 updated to reflect changes to the titles and the levels of observations • Section 4.3 proposal to incorporate care rounds in to general observations • Section 6.1 changed to an immediate and appropriate level of observation and engagement • Section 7 is the introduction of a service user leaflet to be shared with service user at the point of the development of the care plan, this is currently being created. • Section 9.1 writing of care plans has changed to reflect the revised language Section 9.2 recording of observations and engagement has been updated to reflect the increased recording requirement • Section 10 the inclusion that all members of staff that undertake supportive observation and engagement must be assessed as being competent and additionally future proofing document to reflect cito language of care plan. • Addition of: appendix 3 observation recording tool, appendix 4 competency assessment, appendix 5 generic care round sheet, appendix 6 forensic care round sheet	Withdrawn – (Effective 18 Dec 2019)
3.1	23 Dec 2019	Minor amendment to wording, includes 1 & 6.2	Withdrawn
3.2	07 April 2021	Review and updates to procedure:- section 6.1 - On admission to a ward or clinical area - emphasis of Trust wide procedure section 6.3 -Increasing and decreasing supportive observations and engagement - emphasis of primacy of documenting in safety plan section 8.1 - Writing care plans - emphasis of primacy of recording risk in safety plan. section 8.2 - Recording of observations and engagement - direction on use of care round sheet and continuous recording sheets	Withdrawn
3.3	25 Oct 2022	Minor amendment to clarify practice:- • Section 4.4 Intermittent Observation and Engagement, added: *Where a patient cannot be seen from the doorway or through the observation panel to their bedroom then the care plan should specify whether the patient's room should be entered before looking elsewhere on the ward.* • Section 8.1 Writing care plans, added: *Intermittent observation should specify whether the patient's bedroom should be entered where they cannot be seen from the doorway before looking elsewhere on the ward* Note: this version v3.3 was published immediately on approval by *Executive Director of Nursing and Governance and Deputy Chief Executive* on 25 October 2022. This version v3.3 received formal retrospective ratification at Executive Directors Group meeting of 12 April 2023.	Withdrawn
3.4	01 Aug 2023	Minor amendment to "Appendix 5 – Care Round Record Sheet" to mandate return time, "**Patients on leave (No Identified bed) due to return (date and time)".** Approved for immediate publication by Chief Nurse to manage clinical risk – recording of when patient is due back on the ward	Withdrawn

		from leave/time away from the ward. Went to MG for information and formal retrospective ratification 16 August 2023.	
3.4	12 June 2024	Review date extended until 31 October 2024	Withdrawn
3.4	17 Jan 2025	Review date extended until 31 May 2025	Withdrawn
4	20 May 2025	New version approved, ratified and published	Withdrawn
3.4	03 June 2024	At the request of the Chief Nurse previous version v3.4 reinstated. A placard added to front page stating: "Please note v4 has been temporally withdrawn and v3.4 has been reinstated to allow complete implementation of new processes. Effective 03 June 2025." Note review date extended from 31 May 2025 till 31 October 2025	Published

Appendix 1 - Zonal Observations and Engagement

Zonal nursing allows an alternative method of observation and engagement 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 and engagement 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 supportive observation and engagement. The Trust therefore recognises that under certain circumstances a ward or clinical area may wish to operate a zonal observation and engagement model. The decision to implement zonal observation and engagement 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 observation and engagement as outlined in the wider procedure and the assigned nurse should carry out the observations and engagement and make the associated records at the assigned times.

Zones - Not all ward lay outs are appropriate for Zonal Observation and Engagement. Any introduction of zonal observation and engagement 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 Observations and Engagement

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 and engagement 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 and engagement 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.

Observations and Engagement Staff (Zone staff) will:

- Know their zone.
- Know who they are to observe and engage.
- Be familiar with the observation and engagement 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.

Questions	Yes	No	n/a any other comments
Is there evidence of MDT discussion regarding implementation of zonal observation?			
Is there a clear rationale for the use of zonal observations?			
Is the use of zonal observation for: one individual, a particular group of service users			
Are there clear zones identified within the ward area?			
Is there an identified process for allocating staff to zones?			
Is there clear guidance as to times in which the zones will be operated			
Is there clear guidance as to how observation levels will changes as service users move between areas and at different times?			
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)			
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			
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			
Is there evidence of individualised care/safety plans which identify how zonal observations will be used?			
Is there evidence that the service user(s) have been involved in the decision making process?			
Is there an activity plan for the service user(s) which identifies meaningful activity and planned time for engagement with allocated staff?			

Appendix 2 - Equality Analysis Screening Form

Please note; The Equality Analysis Policy and Equality Analysis Guidance can be found on InTouch on the policies page

Name of Service area, Directorate/Department i.e. substance misuse, corporate, finance etc.	Quality & Risk, Nursing Directorate					
Name of responsible person and job title	Ahmad Khouja (Policy Lead) and Ann Marshall (Deputy Director of Nursing)					
Name of working party, to include any other individuals, agencies or groups involved in this analysis	Members of Harm Minimisation Steering Group, Recovery Steering Group including experts by experience					
Policy (document/service) name	Supportive Observation and Engagement Procedure					
Is the area being assessed a…	Policy/Strategy		Service/Business plan		Project	
	Procedure/Guidance			√	Code of practice	
	Other – Please state					
Geographical area covered	Trustwide					
Aims and objectives	• 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
Start date of Equality Analysis Screening (This is the date you are asked to write or review the document/service etc.)	03/10/2019
End date of Equality Analysis Screening (This is when you have completed the equality analysis and it is ready to go to EMT to be approved)	October 2019

You must contact the EDHR team if you identify a negative impact. Please ring Sarah Jay on 0191 3336267/3046

1. Who does the Policy, Service, Function, Strategy, Code of practice, Guidance, Project or Business plan benefit?

This procedure benefits the organisation, clinical staff, service users and their carer's. 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 whilst always maintaining patient safety.

2. Will the Policy, Service, Function, Strategy, Code of practice, Guidance, Project or Business plan impact negatively on any of the protected characteristic groups below?

Race (including Gypsy and Traveller)	~~Yes~~/No	**Disability** (includes physical, learning, mental health, sensory and medical disabilities)	~~Yes~~/No	**Sex** (Men, women and gender neutral etc.)	~~Yes~~/No
Gender reassignment (Transgender and gender identity)	~~Yes~~/No	**Sexual Orientation** (Lesbian, Gay, Bisexual and Heterosexual etc.)	~~Yes~~/No	**Age** (includes, young people, older people – people of all ages)	~~Yes~~/No
Religion or Belief (includes faith groups, atheism and philosophical belief's)	~~Yes~~/No	**Pregnancy and Maternity** (includes pregnancy, women who are breastfeeding and women on maternity leave)	~~Yes~~/No	**Marriage and Civil Partnership** (includes opposite and same sex couples who are married or civil partners)	~~Yes~~/No

Yes – Please describe anticipated negative impact/s

No – Please describe any positive impacts/s

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.

3. Have you considered other sources of information such as; legislation, codes of practice, best practice, nice guidelines, CQC reports or feedback etc.? **If 'No', why not?**	**Yes**	√	**No**	

Sources of Information may include: • Feedback from equality bodies, Care Quality Commission, Equality and Human Rights Commission, etc. • Investigation findings • Trust Strategic Direction • Data collection/analysis • National Guidance/Reports	• Staff grievances • Media • Community Consultation/Consultation Groups • Internal Consultation • Research • Other (Please state below) • NICE guidance NICE Clinical Guideline 10: Violence and aggression: short-term management in mental health, health and community settings (2015) • Mental Health Forum – Nurse Director (MHLD)

4. Have you engaged or consulted with service users, carers, staff and other stakeholders including people from the following protected groups?: Race, Disability, Gender, Gender reassignment (Trans), Sexual Orientation (LGB), Religion or Belief, Age, Pregnancy and Maternity or Marriage and Civil Partnership

Yes – Please describe the engagement and involvement that has taken place
Engagement previously took place at development group and is in line with the CQC recommendations.
No – Please describe future plans that you may have to engage and involve people from different groups

5. As part of this equality analysis have any training needs/service needs been identified?

Not in relation to Equality and Diversity, updates will be required re case notes.

Yes/No	Please describe the identified training needs/service needs below Update session to be held at localities with support of the harm minimization trainer, heads of nursing and modern matrons.

A training need has been identified for;

Trust staff	Yes/~~No~~	Service users	~~Yes~~/No	Contractors or other outside agencies	~~Yes~~/No

Make sure that you have checked the information and that you are comfortable that additional evidence can provided if you are required to do so

The completed EA has been signed off by: You the Policy owner/manager: Type name: Ahmad Khouja Type name: Ann Marshall	 Date: **11.10.2019** **04/10/2019**
Your reporting (line) manager: Type name: Elizabeth Moody	 Date: 11/10/2019
If you need further advice or information on equality analysis, the EDHR team host surgeries to support you in this process, to book on and find out more please call: 0191 3336267/3046	

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Appendix 3 – Observation and engagement recording

Patient Name and Paris ID	
Date of recording	
Intermittent (exact levels) **Within eye sight** **Within arm's length**	

Risk behaviour(s)

Risk factors

Intermittent Observation/Engagement*

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

Within eyesight/ within arm's length Observation/Engagement*

The observation record should be completed for the period of observation at the point of handover to the next staff member; a summary for every period of observation should then be entered onto the clinical record (PARIS).

*These summaries will then be discussed with the MDT.

Date	Time	Risk behaviours(s) factors identified during observations	Signature/designation of member of staff carrying out observation	Signature/designation of member of staff carrying out receiving handover

Date	Time	Risk behaviours(s) factors identified during observations	Signature/designation of member of staff carrying out observation	Signature/designation of member of staff carrying out receiving handover

Continuation sheet used to complete a 24 hour period of observation

Date	Time	Risk behaviours(s) factors identified during observations	Signature/designation of member of staff carrying out observation	Signature/designation of member of staff carrying out receiving handover

Date	Time	Risk behaviours(s) factors identified during observations	Signature/designation of member of staff carrying out observation	Signature/designation of member of staff carrying out receiving handover

Appendix 4 – Competency Tool – Supportive Observation and engagement

Performance Criteria	Assessment Method	Meets Standard	Does not meet Standard	Comments
The staff member demonstrates awareness of the policy	Verbal			
The staff member can describe their overall responsibilities in relation to the policy	Verbal			
The staff member demonstrates an understanding of the categories of the observation and engagement	Verbal			
The staff member is able to outline some of the general principles of observation and engagement	Observation/Verbal			
The staff member demonstrates an understanding of how and who can increase and decrease levels of observation and engagement.	Verbal			
The staff member can describe how levels of observation and engagement are allocated	Verbal			
The staff member can explain the procedure for giving patients information regarding levels of observation and engagement	Observation/Verbal			
The staff member demonstrates an understanding of record keeping in relation to the policy	Observation/Verbal			
The staff member can describe the role and responsibilities of the member of staff undertaking observation and engagement	Verbal			
The staff member can explain the importance of effective communication to other staff in relation to the policy and can describe how and when such communication would take place)	Verbal			
The staff member can demonstrate the need for assessing changes in observation and engagement	Verbal			
The staff member can explain how to hand over the responsibility for observation and engagement.	Verbal			

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Appendix 5 – Care Round Record Sheet

AM CARE ROUND: C= COMMUNICATE A = ASSESS R = RESPOND E = ENVIRONMENT DATE: .....

Initial	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
SIGN																																													

✓ = Completed O/W = Off Ward X = Missing 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) due to return (date and time)	❺
❶	❻
❷	❼
❸	❽
❹	❾

C= COMMUNICATE A = ASSESS R = RESPOND E = ENVIRONMENT DATE: .....

PM CARE ROUND:

Initial	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
SIGN																																															

✓ = Completed O/W = Off Ward X = Missing 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) due to return (date and time)	❺
❶	❻
❷	❼
❸	❽
❹	❾

Appendix 6- Forensic Care Round Recording Sheet

FORENSIC SERVICE HOURLY CARE ROUNDS RECORD

Date: Ward:

DAY SHIFT

Room number	Patient Initials	After handover	08.00	09.00	10.00	11.00	12.00	13.00	14.00	15.00	16.00	17.00	18.00	19.00
1														
2														
3														
4														
5														
6														
7														
8														
9														
10														
11														
12														
13														
14														
15														
16														
17														
18														
19														
20														
Staff Initial														

KEY: If present on the ward then please tick the corresponding box for their bedroom number and the time of the care round. If off the ward the following codes should be used:

L	**Leave**	**INT**	**Integration**
H/C	**Health Centre**	**SEC**	**Patient in seclusion**
RE	**Resource**	**HOSP**	**Hospital Appointment.**
O/N	**Overnight Leave**		

FORENSIC SERVICE HOURLY CARE ROUNDS RECORD

Date: Ward:

NIGHT SHIFT

Room number	Patient Initials	After handover	20.00	21.00	22.00	23.00	00.00	01.00	02.00	03.00	04.00	05.00	06.00	07.00
1														
2														
3														
4														
5														
6														
7														
8														
9														
10														
11														
12														
13														
14														
15														
16														
17														
18														
19														
20														
Staff Initial														

KEY: If present on the ward then please tick the corresponding box for their bedroom number and the time of the care round. If off the ward the following codes should be used:

L	**Leave**	**INT**	**Integration**
H/C	**Health Centre**	**SEC**	**Patient in seclusion**
RE	**Resource**	**HOSP**	**Hospital Appointment.**
O/N	**Overnight Leave**		