Worcestershire Acute Hospitals NHS Trust

In-Patient Enhanced Observation Guideline – Adults

This guidance does not override the individual responsibility of health professionals to make appropriate decision according to the circumstances of the individual patient in consultation with the patient and /or carer. Health care professionals must be prepared to justify any deviation from this guidance.

Introduction:
To provide a framework for all observation, but also heightened levels of observation - when patients may be considered "at risk" of harm to themselves and/or others and/or are considered to have an unstable mental condition which may deteriorate.

This guideline is for use by the following staff groups :
This guideline applies to all employees of Worcestershire Acute Hospitals NHS Trust in all locations, including temporary employees, agency staff, bank workers, contractors, locum staff, patients, visitors and any other person who may be affected by its undertaking.

Lead Clinician(s)

Deborah Narburgh Head of Safeguarding

Kate Knight Professional Development Lead

Approved at Clinical Governance Group on: 15th November 2021

Review Date: 24th December 2025
This is the most current document and should be used until a revised version is in place

Key amendments to this guideline

Date	Amendment	By:
November 2018	Replacement of Therapeutic Observation Guidelines	Kate Knight Deborah Narburgh
October 2021	Update 'Stay in the Bay' – level 3 observations Changed quick reference flow chart to decision making tool Refined definition for Level 3 to include reference to NEWS 2 chart and Level 4 on Assessment Criteria Tool	Donna Kruckow Kate Knight Louise Pearson Alice Elderton Deborah Narburgh
January 2025	Change of owner to Andy Fryer/Deborah Narburgh. 6 months extension to allow for thorough review	Debbie Narburgh
June 2025	Document extended whilst NHSE are running ETOC programmed and ensure staff are trained	Debbie Narburgh

Introduction

This guideline is based on National guidance for patient observation issued by the National Institute for Health and Clinical Excellence (2006). The Patient Safety Observatory at the NPSA has published evidence that good observation can prevent death or serious harm.

The Trust has stated that it is committed to improving standards of care by delivery of service that is of the highest quality possible. This includes ensuring there is a system of monitoring in place applicable to patients needs and responsive to alterations in risk, whilst cost effective and efficient. Nurse staffing ratios / establishments have traditionally reflected bed occupancy not dependency/acuity of patients. Levels of observation above level 1 may have an impact on standard staffing/skill mix numbers and require extra controls and reporting and additional staffing.

Many different terms are used to describe the use of additional staff to maintain patient safety; Specialling, enhanced observations, one to one care, constant or close observation/supervision.

The objective of this policy is to provide a framework for all observation, but also heightened levels of observation - when patients may be considered “at risk” of harm to themselves for example through a risk of falls or due to dementia or confusional states; they may present a risk to others through violent or aggressive behaviour or are considered to have an unstable mental condition which may deteriorate.

It outlines the responsibilities of staff at all levels to provide a clear pathway of care including review of triggers, indicators, and behaviours, or changes in mental state.

It outlines the process by which levels of observation are determined, recorded, and reviewed.

It promotes a person centred care approach to determining observation levels and enhances the safety of individuals at risk.

It promotes evidence based practice.

It identifies a review process for the use of extra staffing.

Details of Guideline

Level 1 - General Observations

The location of the patient should be known to staff at all times, but they are not necessarily within sight. At least twice per shift, the patient’s allocated registered nurse will endeavour to communicate with the patient and an entry of the outcome of any assessment will be made in the patients nursing notes or medical records. At the beginning and end of every nursing shift the whereabouts and general condition of all patients should be part of the handover.

Level 2 - Intermittent Observation

This is an increased level of observation for patients, who after assessment, may be deemed to be a potential risk of falls, have behavioural and psychological symptoms of dementia (BPSD), mild symptoms of delirium or disturbed and/or violent behaviour.

This may include those who have a history of previous risk but are in the process of recovery. Patients, who have attempted suicide and/or have suicidal ideation, should be placed on ground floor locations/wards where possible. Patients assessed to be within this category should have an "enhanced observation" care plan which should clearly indicate; the intervals at which observations should be carried out, (5, 10, 15, 30 minutes etc.). Exact times should be specified in the care plan. High risk activities and times of the day should also be planned for, example going to the toilet when at risk of falls, the needs of patients at night when lighting is subdued and staff numbers are decreased.

The need for an assessment by the registered nurse of the patient on each shift and a summary of the patient's behaviour, physical and mental state should be recorded in the nursing records/patients notes at the end of each shift. All staff on that shift and those who are responsible for intermittent observation should be consulted prior to taking over and handing over care to the next shift.

Level 3 - Within Eyesight Observation

Following a risk assessment, these patients are at 'high risk' for example with a history of falls, moderate BPSD, symptoms of delirium, new onset of confusion (NEWS 2), have regular episodes of agitation or liable to make an attempt to harm themselves or others at any time. They may be "at risk" of absconding, pacing that would result in getting lost or are considered to have an unstable physical or mental condition i.e. mood disorder, psychosis, mental health condition, which may deteriorate and requires continuous assessment. They should be within eyesight and accessible at all times, day and night. These special observations are carried out on a one nurse to one patient basis. They should have a care plan for special observations contained within their notes.

Any equipment or instruments deemed harmful that could be used should be removed if necessary. This may warrant searching of the service user and their belongings. This should be done with consideration given to the legal rights of the service user and conducted in a sensitive manner. If patient lacks capacity ensure that patient's best interests are documented.

It is the responsibility of the nurse in charge to consider if the patient is being deprived of their liberty by the safety measures put in place. If there are concerns that the patient is being deprived of their liberty then appropriate action should be taken in accordance with Trust policy

The care plan must state if the patient does not require observation whilst using the toilet or bathroom, or attending another department for tests or investigations. A regular summary of the patient's condition, care and treatment must be entered on the enhanced observation care plan. This must include changes in mental state, physical, psychological, emotional and social behaviour, pertinent development, and significant events. Positive engagement with the patient is essential.

Reducing harm from inpatient falls requires multidisciplinary interventions targeting multiple risk factors. Awareness of these risks is discussed at ward handovers and safety huddles. Especially useful to reduce unwitnessed falls is constant vigilance as this will help to determine causes and risks, and thus target interventions accurately.

'Stay in the Bay' is a falls prevention initiative adopted by WAHT following a pilot Initiative in 2018. An identifiable staff member will remain in a designated (bay/area) on a ward to supervise/have a constant presence the patients in that area for that purpose. Badges, armbands and tabards can be used to identify this person.

It is encouraged that wards/departments involve the whole MDT in 'Stay in the Bay' if the 'bay watch' needs to be of assistance behind curtains or outside of the bay where the responsibility can be handed over temporarily.

It is recognised that staffing does not always allow for this and therefore clinical judgement in conjunction with these guidelines should be used at all times to establish safe levels of observation when the 'bay watch' has care priorities such as toileting/hygiene.

Level 4 - Within 'Arm's Length' Observation

This is the highest level of observation for patients liable to suicide attempts or harm to themselves or others. They may be at "significant-risk" of falls have severely altered cognitive function/confusion, have an unstable physical, emotional, mental health or psychological condition or have severe symptoms of dementia or delirium, have regular and frequent episodes of agitation/distress or have a condition which may deteriorate and require continuous assessment.

They should be supervised with close proximity, with due regard for safety, privacy, dignity, gender and environmental dangers. Issues of privacy and dignity, consideration of gender issues and environmental dangers should be discussed and incorporated into their care plan.

It may be necessary on rare occasions to use more than one member of staff and or specialist support i.e. RMN. A regular summary of the patient's condition, care and treatment must be entered into the enhanced observation care plan. This must include changes in mental state, physical, psychological and social behaviour, pertinent developments and significant events. Positive engagement with the patient is essential.

It is the responsibility of the nurse in charge to consider if the patient is being deprived of their liberty by the safety measures put in place and take appropriate action.

Assessment

The primary purpose of any planned level of observation will be to either:-

a) Ensure the safety of the observed person.
b) Ensure the safety of others from the observed person.
c) In some circumstances, both of the above.

The level of observation assessed as required must result from a risk assessment using the Trusts risk assessment tool (Appendix 4). As with all care, a multi-disciplinary approach must be taken.

On admission, each patient will be assessed by medical and registered nursing staff. The level of observation will be agreed in conjunction with specialist advice and the assessment will be recorded in the nursing records/patients notes. A care plan should be instigated (Appendix 3) and observations recorded on the observation chart (Appendix 4)

Assessment of mental capacity will be carried out; where the patient is deemed to have mental capacity, an agreement with the patient should be sought; the reasons behind any observation level and/or limits set should be explained to the patient and carers and relatives in terms and methods compatible with their understanding. Where the patient is deemed to lack mental capacity, decisions should be made in accordance with their "Best Interests".

Relatives and carers play an important role in the process of information gathering and assessment. Relatives and carers should be encouraged to be involved with the patient care as much as possible with 'Johns Campaign' supported if they wish to continue their caring role to support the patient whilst in hospital. In particular, explanations should be given sensitively about why limits of enhanced observation are being set.

Relatives and carers should not be made responsible for the observations. It is the responsibility of the nurse in charge to determine the level of observation, ensure observer assigned has the necessary skills to undertake observations and to document the plan of care.

The risk assessment process and subsequent multi-disciplinary team discussion must include the views of the carer/relative.

For patients with a diagnosed Learning Disability carers and relatives should be engaged in assessing the person's risk. Assessment should be carried out using the 'Risk, Dependency and Support Assessment Tool' for patients with a learning disability.

The reason for the level of observation and when the next review is due will be specified, recorded and signed in the medical records. Level 3 and 4 will be reviewed and the review recorded and documented every 24hours by the Senior Nurse of the ward in conjunction with Matron, safeguarding lead and /or specialist practitioner as appropriate.

Practice of Enhanced Observation

Observation of the patient will always be carried out in such a way as to enhance the safety of the patient whilst preserving his/her dignity and privacy as much as possible.

Levels of observation required should distinguish between those necessary when the patient is awake and those required when they are asleep.

The contemporaneous clinical notes should clearly indicate that the specified level of observation being carried out.

Along with other important aspects of care, the level of observation the person is receiving must be communicated at each handover of staff in order to promote continuity of care. This should also include whether Deprivation of Liberty Safeguards are required.

A specific and skilled element of nurse observation, in relation to protecting patients, staff, and others is the detection of signs of impending aggression or violence. Staff can refer to the Policy for the Management of Violence and Aggression.

Staff must exercise particular vigilance during "danger times" these include:-

a) After admission, during staff handovers.
b) During the early stages of recovery.

c) Following patients using non-prescribed drugs or alcohol.
d) Following a visit from a relative.
e) "Sun-downing" in a person with dementia – also known as "late day confusion"
f) In the event of a clinical emergency within the department

The following features should be observed and any changes documented:-

a) Appearance and dress.
b) General behaviour, level of co-operation, acceptance of help.
c) Orientations, awareness, memory.
d) Morbid ideas, violent thoughts/fantasies.
e) Self-blame, hopelessness and suicide intent.
f) Mood and attitudes.
g) Insight into current situations.
h) Hallucinations/delusions.
i) Substance misuse.
j) Mental Health Act status, in particular restriction orders.

Staff allocated to a patient (levels 3 and 4) should not perform this function for longer than two hours at a time without receiving a break. This is in order to minimise staff stress. The 2 hour break in observation of the patient may incorporate other duties on the ward area. The nurse in charge must ensure adequate staff are available to deliver care appropriately and if a shortfall is identified then this should be escalated as appropriate.

A mechanistic approach to the observation process, which may be seen as "watching the doors" or "guarding the patient" is totally inadequate and unacceptable practice.
Where external stimuli appear to be affecting the patient's behaviour then moving the patient to a side room or alternative area should be considered.

Observation should be used as an opportunity to develop a rapport and build up a relationship, utilising 'About Me' booklets if required. This may include engaging the observed person in some constructive and therapeutic activity or intervention, offering support and comfort in order to strengthen the relationship between the observer and the person being observed. Activities should be changed, at minimum, on observer change-over (every 2 hours).

Therapeutic activities may include:-

Cognitive activity

- Reading a newspaper
- Completing a crossword/quizzes
- Completing a jigsaw
- Reading a book together
- Utilising digital reminiscing equipment

Physical Activity

- Walking around the ward
- Moving from bed to chair
- Moving legs and arms in bed
- Reaching for items on the tables
- Twiddle-muffs for restless hands

Social activity

- Talking about current affairs
- Talking about families
- Talking about hobbies and interests
- Social interaction with family members
- Staff are permitted to eat and drink with patient

Personal Hygiene

- Encourage to shower, assisting where necessary
- Brushing teeth in the morning and before bed
- Washing hands before meals
- Brushing hair
- Assisting with shaving
- Changing clothes and bedding

Rest

- Although important for recuperation, this should not happen all day, but instead reflect the patient's normal resting patterns. This should help keep the patient in a routine following discharge.

Calming

- Listening to music
- Looking at pictures
- Reading a story

Under NO circumstances are staff permitted to use mobile phones for personal use during therapeutic observations

Documentation/record keeping

It is the responsibility of the Nurse in Charge to ensure that the level of observation as detailed in the care plan is appropriately maintained at all times. A thorough assessment of the patient should have been performed prior to deciding on the level of observation required. This should be evaluated on a regular basis – at least every 24 hours or sooner should the patient require more invasive monitoring.

The Registered Nurse has the authority to increase the level of observation offered to an in-patient if in their clinical judgement, it is necessary to do so. Such action must be recorded in the medical records. The decision will then be jointly reviewed between designated medical and nursing staff at a mutually agreed time.

If a situation arises where medical and nursing staff cannot agree the appropriate level of observation, the in-patient will remain on, or be nursed on the higher level of observation.

Concerns regarding financial implications of staffing should be directed via line management route.

Consent & Mental Capacity

The Mental Capacity Act 2005 (the Act) provides the legal framework for acting and making decisions on behalf of individuals who lack the mental capacity to make particular decisions for themselves. Everyone working with and/or caring for an adult who may lack capacity to make specific decisions must comply with this Act when making decisions or acting for that person, when the person lacks the capacity to make a particular decision for themselves. The same rules apply whether the decisions are life-changing events or everyday matters.

The Act's starting point is to confirm in legislation that it should be assumed that an adult (aged 16 or over) has full legal capacity to make decisions for themselves (the right to autonomy) unless it can be shown that they lack capacity to make a decision for themselves at the time the decision needs to be made. This is known as the presumption of capacity. The Act also states that people must be given all appropriate help and support to enable them to make their own decisions or to maximise their participation in any decision-making process.

The underlying philosophy of the Act is to ensure that any decision made, or action taken, on behalf of someone who lacks the capacity to make the decision or act for themselves is made in their best interests.

Mental Health Act

Further advice and support is available from Mental Health Liaison Service – bleep 1234(ALEX), bleep 195 (WRH).

Duty to consult with others

If it is practical and appropriate to do so, consult other people for their views about the person's best interests and to see if they have any information about the person's wishes and feelings, beliefs and values. In particular, you should consult:

- Anyone previously named by the person as someone to be consulted on either the decision in question or on similar issues.
- Anyone engaged in caring for the person.
- Close relatives, friends or others who take an interest in the person's welfare.
- Any attorney appointed under a Lasting Power of Attorney or Enduring Power of Attorney made by the person.
- Any deputy appointed by the Court of Protection to make decisions for the person.

Use of restraint

Restraint (physical, chemical, psychological and mechanical) should only ever be used as an ***absolute last resort*** once all other alternatives have been considered.

Any action intended to restrain a person who lacks capacity will not attract protection from liability unless the following two conditions are met:

- The person taking action must reasonably believe that restraint is necessary to prevent harm to the person who lacks capacity, and
- The amount or type of restraint used and the amount of time it lasts must be a proportionate response to the likelihood and seriousness of harm.
  A Datix should be submitted for any intervention requiring the use of restraint.

- Guidance on the management of patients with delirium can be found in the delirium policy.

Deprivation of Liberty Safeguards (DoLS)

The Deprivation of Liberty Safeguards (DoLS) are part of the Mental Capacity Act 2005. The safeguards aim to make sure that people in care homes and hospitals are looked after in a way that does not inappropriately restrict their freedom /rights. The safeguards set out a process that hospitals and care homes must follow if they believe it is in the person's best interests to deprive a person of their liberty, in order to provide a particular care plan.
A deprivation of liberty occurs when:-

- a person is under continuous supervision and control in a care home or hospital, and
- is not free to leave, and
- the person lacks capacity to consent to these arrangements.

Note: A deprivation of liberty can still occur even if a patient is not physically trying to leave an area.

Review

Review and reassessment during a patient's admission must be undertaken where any change in the individual is noted and at planned review dates.

Reassessment must be undertaken where any clinician involved in the patients care considers it appropriate. This must include appropriate rationale for any changes to level of observation, evidenced through the risk assessment and recorded in the patient's medical record.

The Registered Nurse has the authority to increase the level of observation offered to an in-patient if in their clinical judgement, it is necessary to do so. Such action must be recorded in the medical records. The decision will then be jointly reviewed between designated medical and nursing staff at a mutually agreed time. If a situation arises where medical and nursing staff cannot agree the appropriate level of observation, the in-patient will remain on, or be nursed on the higher level of observation. The Nurse in Charge is responsible for communicating any changes to multidisciplinary team members, involved professionals and family/carers.

Training and awareness

It is the responsibility of the individual professional to ensure that they are aware of the contents of this policy. It is the responsibility of Matrons to identify and respond to any identified training needs. Training may be given in the clinical area by senior staff already competent in this skill and via the Mental Health Liaison Team. Other relevant training such as personal safety, managing violence and aggression, caring for patients with dementia should also be considered dependent on the client group.

Observing patients at risk is a highly skilled activity. Ideally the Trust will endeavour that nursing staff (registered, unregistered, other clinical staff) have access to appropriate training. Essential components of adequate training include:-

- Risk Assessment
- Management and engagement of patients at risk of harming self and others

- Indications for observation
- Levels of observation
- Attitudes to observation
- Therapeutic opportunities in observation
- Roles and responsibilities of the multi-disciplinary team
- Making the environment safe
- Recording observation
- The use of reviews and audit
- Deprivation of Liberty Safeguarding
- Mental Capacity Act & Advocacy

Competence must be reviewed annually as part of the Trust personal development review process (PDR).

All staff employed by the Trust are required to attend the mandatory and statutory training that is relevant to their job role and to ensure they meet their own continuous professional development.

Supporting documents /supplementary information sources

- Safeguarding – Mental Capacity Act, Mental Health Act, Deprivation of Liberty Safeguards, Advocacy
- Learning Disability –"My Hospital Passport" booklet
- Dementia/Delirium Care Bundle; 'About Me'/'What Matters to Me' sheet and 'Abbey Pain Tool'
- Slips, Trips and Falls Policy for Staff, Visitors and Contractors - WAHT-CG-718
- Guidelines to Prevent and Treat Delirium in Hospital WHAT-MED-011
- Policy for the Management of Violence and Aggression
- Alcohol Liaison team –via switchboard
  Consent Policy
  Missing inpatient guideline

Monitoring Tool

Senior Sisters/Charge Nurses/Matrons are responsible for monitoring compliance with this policy by ensuring that:

- Staff have received appropriate training and have been assessed as competent are performing this role.
- Competence is reviewed annually as part the personal review process

It is the responsibility of the individual undertaking this role to ensure that they comply with the policy.

Item	%	Exceptions
1. Risk Assessment completed	100%	None
2. Procedure followed	100%	None
3. Correct level of observation	100%	None
4. Documentation	100%	None

How will monitoring be carried out?	Random 10 pts over 1 month period observed
When will monitoring be carried out?	Yearly
Who will monitor compliance with the guideline?	Senior Sisters/Charge Nurses/Matrons

Contribution List

Key individuals involved in developing the document

Name	Designation
Deborah Narburgh	Head of Safeguarding
Kate Knight	Professional Development Lead

Circulated to the following individuals for comments

Name	Designation
Vicky Morris	Chief Nurse
Jackie Edwards	Deputy Chief Nursing Officer
Lisa Miruszenko	Deputy Chief Nursing Officer
Louise Pearson	Workforce Lead
Georgina Carter	Dementia CNS Lead
Alice Elderton	Falls Lead
Ross Golightly	Learning Disability Liaison Nurse

Circulated to the following CD's/Heads of dept for comments from their directorates / departments

Name	Directorate / Department
Divisional Directors of Nursing	Medicine/Surgery
Matrons	Medicine/Surgery
General Managers	Medicine/Surgery

Circulated to the chair of the following committee's / groups for comments

Name	Committee / group
Chief Nursing Officer	Safeguarding Committee
Chief Nursing Chief/Medical Officer	CGG

Appendix 1

ENHANCED OBSERVATION DECISION MAKING TOOL

Nominated Registered Nurse/members of team to assess the patient ensuring due consideration to

- Issues of mental capacity
- 'About Me' for patients with dementia /My Hospital Book for patients with a learning disability
- Duty to consult with others e.g LPA, Court Appointed Deputy etc.

↓

Patient identified as **at risk,** requiring additional nursing support - determine level of observation 2, 3, or 4. Consider whether DoLS application is appropriate.

↓

Make comprehensive entry in nursing notes. Verbally inform patient or their representative and ensure this is documented.

LEVEL 1
Additional support not required

LEVEL 2 & LEVEL 3
Determine whether observation level required can be supported from existing staff complement or whether additional staff is required.

LEVEL 4
Benefit of specialist support clearly identified e.g. RMN

Nurse in Charge

- Consider overall ward dependencies
- Possibility of cohorting patients (those requiring same level of observation, in the same ward area)
- Discuss with Matron/Matron on call

Existing staff adequate

Additional staffing required

Request additional staffing as required according to Trust guidance

↓

Additional staffing to be formally reviewed and documented at least every 24 hours or sooner if appropriate.

Nurse looking after patient

- Ensure risk assessment is completed, and outcome clearly documented in nursing records.
- Ensure 'About Me'/My Hospital Book is completed where relevant
- Delegate observation/care to staff with a comprehensive handover
- Ensure Enhanced Observation Care Plan / Observation Chart are available for documentation
- Maintain a safe working environment with appropriate comfort breaks (at least two hourly)
- Formal discussion of patient at **handover** and **written entry in nursing records**.

Appendix 2:

Assessment Criteria for Level of Enhanced Observation

Level of Enhanced Care		Inclusion Criteria
Level 1: **General observations** (routine care)	Location of the patient must be known to staff at all times Patient does **NOT** necessarily need to be within sight Re-assess patient on every shift or if change in mental state/cognition	• Low risk of falls; no history of falls • Calm / passively confused • Very occasional restlessness • Post-operative • No evidence of challenging behaviour • Low risk of deterioration • Low risk of self-harm
Level 2: **Intermittent Observation**	Commence Enhanced Observations Chart (5, 10, 15 or 30 minute observations) Consider if MCA 1, MCA 2 & DoLs if required	• At risk of falls; no history of falls • Mild confusion/Occasional restlessness • Occasional episodes of agitation, or attempting to leave clinical area • Low risk of deterioration • At risk/has history of self-harm • Mild Cognitive impairment • Distressed/challenging behaviour • Intoxication • Overdose
Level 3: **Constant Observation** (within eyesight at all times)	Enhanced Observations in place High Observation Bay (cohorting) - minimum of 2 staff per bay of 4 patients or 1:1 Care (additional staffing resources maybe required) If patient lacks capacity MCA 1, MCA 2 & DoLs required	• At high risk of falls; history of falls • New onset confusion (score 3 on NEWS 2 Chart)/frequently restless, requiring regular reassurance • Moderate cognitive impairment (e.g. dementia/delirium) • Regular episodes of agitation or frequent attempts to leave clinical area • Patient acutely unwell and at risk of deteriorating • Identified as being at risk of self-harm or risk of harming others; history of self-harm • Considered to have an unstable physical or mental health problem
Level 4: **Enhanced Observation** (continuous observation within arm's length)	Additional staffing resources required for 1:1 Care If patient lacks capacity MCA 1, MCA 2 & DoLs required	• Significant risk of falls; actual fall has occurred • Regular and frequent episodes of distress • Regular and frequent episodes of agitation, violent behaviour, at risk of absconding • Patient acutely unwell and requiring constant clinical care to maintain safety •
Level 4: **Enhanced Observation**	Consider specialist support i.e RMN If detained under the MHA then MHL should be notified immediately	• Serious risk of self-harm; suicidal ideation, self-harm incident has occurred/Sectioned under the Mental Health Act • Severe cognitive impairment (e.g. dementia/delirium)

*If patient has been in the armed forces this may increase the risk

Appendix 3

Affix patient label here or record

NAME.....

NHS NO:

HOSPITAL NO:

D.O.B: / / MALE: FEMALE:

Enhanced Observation Care Plan

Evaluation must be completed guided by assessment undertaken and according to changes in the patient's condition. Agreed MDT frequency of monitoring must be recorded on the Enhanced Observation Chart

Summary of main problem / area of need

Level of Observation required: 1 ☐ 2 ☐ 3 ☐ 4 ☐

Monitoring should take place every: 5 mins ☐ 10 mins ☐ 15 mins ☐ 30 mins ☐ Continuous ☐

	Goal objective - all levels To maintain safety, privacy and dignity To engage in therapeutic activity whenever possible	Level of Obs	Evaluation Date	Print name & Signature
1.	A clear statement of risk and its management plan will be documented in the medical notes following a review by the nurse-in-charge, matron, specialist advice and MDT. The level of observation required should be reviewed daily and any change in patient should be reviewed and acted upon.	ALL		
2.	Inform next of kin, if required.	ALL		
3.	Administer medication as prescribed.	ALL		
4.	Staff undertaking Enhanced Observation should be for a period no longer than 2 hours at any one time.	ALL		
5.	Document the nature and content of any significant interaction in the medical records on the observation chart.	ALL		
6.	Monitor environment to ensure the patients safety and maintain an awareness of factors that may contribute to an increased risk.	ALL		
7.	Record all observations undertaken on the relevant observation chart. Timings may be altered to reduce patient's ability to predict when they are carried out.	2		
8.	Consider MCA1, MCA2 and DoLs.	2		
9.	Document clothing at the start of each shift or if patient changes clothes during the day.	2, 3 & 4		
10.	Patient to be in visual range as per required level of monitoring.	3		
11.	Patient can go into the toilet and bathroom unaccompanied. The door must not be locked and the member of staff is outside the door at all times and maintains verbal contact with the patient.	3		
12.	Implement MCA1, MCA2 and DoLs.	3 & 4		
13.	Environment ligature risks should be considered and location of the patient e.g. ground floor.	3 & 4		
14.	Consider additional staffing resources that may be required.	3 & 4		
15.	Patient to be within arm's reach of the nominated nurse at all times.	4		
16.	Patient to be accompanied into the toilet and bathroom at all times.	4		

For specialist advice please contact the relevant teams

Dementia Team – ext. 36752 / Bleep WRH 308 ALEX 0321
Drug and Alcohol Liaison Team – Bleep WRH 565 ALEX 0340
Safeguarding – ext. 33735
CAMHS - 01905 768 300
Learning Disabilities – ext. 38363 / Bleep WRH 150 ALEX 0113
Mental Health Liaison Team – Bleep WRH 195 ALEX 0234
Security – ext. 39902

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Appendix 4

Affix Patient Label here or record:

Name: .....

NHS No: | | | | | | | | | | |

Hosp No: | | | | | | | | | | |

D.O.B: D D / M M / Y Y Y Y Male ☐ Female ☐

*Patient Observation Key:	Calm – C	Agitated – A	Sleeping – S	Off Ward – O
Time:	5 Mins ☐	10 Mins ☐	15 Mins ☐	30 Mins ☐	Continuous ☐

Time	Therapeutic Intervention / response	*POK	Print / Sign Name	Time	Therapeutic Intervention / response	*POK	Print / Sign Name

Supporting Document 1 - Equality Impact Assessment Tool

To be completed by the key document author and included as an appendix to key document when submitted to the appropriate committee for consideration and approval.

Please complete assessment form on next page;

NHS Worcestershire Acute Hospitals NHS Trust

Herefordshire & Worcestershire STP - Equality Impact Assessment (EIA) Form
Please read EIA guidelines when completing this form

Section 1 - Name of Organisation (please tick)

Herefordshire & Worcestershire STP		Herefordshire Council		Herefordshire CCG	
Worcestershire Acute Hospitals NHS Trust	X	Worcestershire County Council		Worcestershire CCGs	
Worcestershire Health and Care NHS Trust		Wye Valley NHS Trust		Other (please state)	

Name of Lead for Activity	**Kate Knight**

Details of individuals completing this assessment	**Name**	**Job title**	**e-mail contact**
Date assessment completed	**16/11/2021**		

Section 2

Activity being assessed (e.g. policy/procedure, document, service redesign, policy, strategy etc.)	**Title:** **In-Patient Enhanced Observation Guideline - Adults**			
What is the aim, purpose and/or intended outcomes of this Activity?	See body of document			
Who will be affected by the development & implementation of this activity?	❑ ❑x ❑ ❑	Service User Patient Carers Visitors	❑x ❑ ❑ ❑	Staff Communities Other _____

Is this:	❑x Review of an existing activity ❑ New activity ❑ Planning to withdraw or reduce a service, activity or presence?
What information and evidence have you reviewed to help inform this assessment? (Please name sources, eg demographic information for patients / services / staff groups affected, complaints etc.	See body of document
Summary of engagement or consultation undertaken (e.g. who and how have you engaged with, or why do you believe this is not required)	See body of document
Summary of relevant findings	

Section 3

Please consider the potential impact of this activity (during development & implementation) on each of the equality groups outlined below. **Please tick one or more impact box below for each Equality Group and explain your rationale**. Please note it is possible for the potential impact to be both positive and negative within the same equality group and this should be recorded. Remember to consider the impact on e.g. staff, public, patients, carers etc. in these equality groups.

Equality Group	Potential positive impact	Potential neutral impact	Potential negative impact	Please explain your reasons for any potential positive, neutral or negative impact identified
Age				N/A
Disability				N/A
Gender Reassignment				N/A
Marriage & Civil Partnerships				N/A
Pregnancy & Maternity				N/A
Race including Traveling Communities				N/A
Religion & Belief				N/A
Sex				N/A
Sexual Orientation				N/A

Equality Group	Potential positive impact	Potential neutral impact	Potential negative impact	Please explain your reasons for any potential positive, neutral or negative impact identified
Other Vulnerable and Disadvantaged Groups (e.g. carers; care leavers; homeless; Social/Economic deprivation, travelling communities etc.)				N/A
Health Inequalities (any preventable, unfair & unjust differences in health status between groups, populations or individuals that arise from the unequal distribution of social, environmental & economic conditions within societies)				N/A

Section 4

What actions will you take to mitigate any potential negative impacts?	Risk identified	Actions required to reduce / eliminate negative impact	Who will lead on the action?	Timeframe
		.		
How will you monitor these actions?				
When will you review this EIA? (e.g in a service redesign, this EIA should be revisited regularly throughout the design & implementation)				

Section 5 - Please read and agree to the following Equality Statement

1. Equality Statement

1.1. All public bodies have a statutory duty under the Equality Act 2010 to set out arrangements to assess and consult on how their policies and functions impact on the 9 protected characteristics: Age; Disability; Gender Reassignment; Marriage & Civil Partnership; Pregnancy & Maternity; Race; Religion & Belief; Sex; Sexual Orientation

1.2. Our Organisations will challenge discrimination, promote equality, respect human rights, and aims to design and implement services, policies and measures that meet the diverse needs of our service, and population, ensuring that none are placed at a disadvantage over others.

1.3. All staff are expected to deliver services and provide services and care in a manner which respects the individuality of service users, patients, carer's etc, and as such treat

them and members of the workforce respectfully, paying due regard to the 9 protected characteristics.

Signature of person completing EIA	
Date signed	16/11/2021
Comments:	Completed on behalf of owner
Signature of person the Leader Person for this activity	
Date signed	
Comments:	

Supporting Document 2 – Financial Impact Assessment

To be completed by the key document author and attached to key document when submitted to the appropriate committee for consideration and approval.

	Title of document:	Yes/No
1.	Does the implementation of this document require any additional Capital resources	NO
2.	Does the implementation of this document require additional revenue	NO
3.	Does the implementation of this document require additional manpower	NO
4.	Does the implementation of this document release any manpower costs through a change in practice	NO
5.	Are there additional staff training costs associated with implementing this document which cannot be delivered through current training programmes or allocated training times for staff	NO
	Other comments:	NO

If the response to any of the above is yes, please complete a business case and which is signed by your Finance Manager and Directorate Manager for consideration by the Accountable Director before progressing to the relevant committee for approval