Cheshire and Wirral Partnership
NHS Foundation Trust

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Code: CP25
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Therapeutic observation policy for inpatients

Lead executive	Medical Director – Compliance, Quality and Assurance
Authors details	Consultant Nurse

Type of document	Policy
Target audience	All inpatient staff
Document purpose	This policy provides guidance relating to conducting therapeutic observations for patients to support mental health and physical health needs.

Approving meeting	Clinical Practice and Standards Sub Committee	Date 21/02/2019
Implementation date	07/05/2019	

CWP documents to be read in conjunction with	
HR6	Mandatory Employee Learning (MEL) policy
CP3	Health records policy
CP5	Clinical risk assessment monitoring policy
CP6	Management of violence and aggression policy (incorporating verbal threat to staff and offensive weapons)
CP12	The searching of patients and environments
CP14	Prevention and management of slips, trips and falls
CP35	Physical health pathway and policy
CP38	Seclusion policy
CP62	Procedure for the security of patient's cash and valuables on wards policy.
GR15	Environmental clinical risk assessment policy
MH1	Mental Health Law Policy Suite
MH8	Missing Person's Policy and Procedure

Document change history	
What is different?	- Daily Risk Review for Level 1 (General) and Level 2 (Intermittent) observations - Each ward to have an identified process to confirm inpatient whereabouts when off the ward and time of return. - Requirements if deviating from policy - Visitors within the context of observations and accompaniment - Requirements for student competency
Appendices / electronic forms	- Whereabouts signing in and out sheet - Student competency guidance for mentors
What is the impact of change?	Improvement in the delivery and recording of therapeutic observations of in-patients

Training requirements	Yes - Training requirements for this policy are in accordance with the CWP Training Needs Analysis (TNA) with Education CWP.

Document consultation	
Clinical Services	Consultation via staff focus groups, inpatient service improvement forum and Clinical Practice and Standards Sub Committee.
Corporate services	Consultation via inpatient service improvement forum and Clinical Practice and Standards Sub Committee.
External agencies	N/A

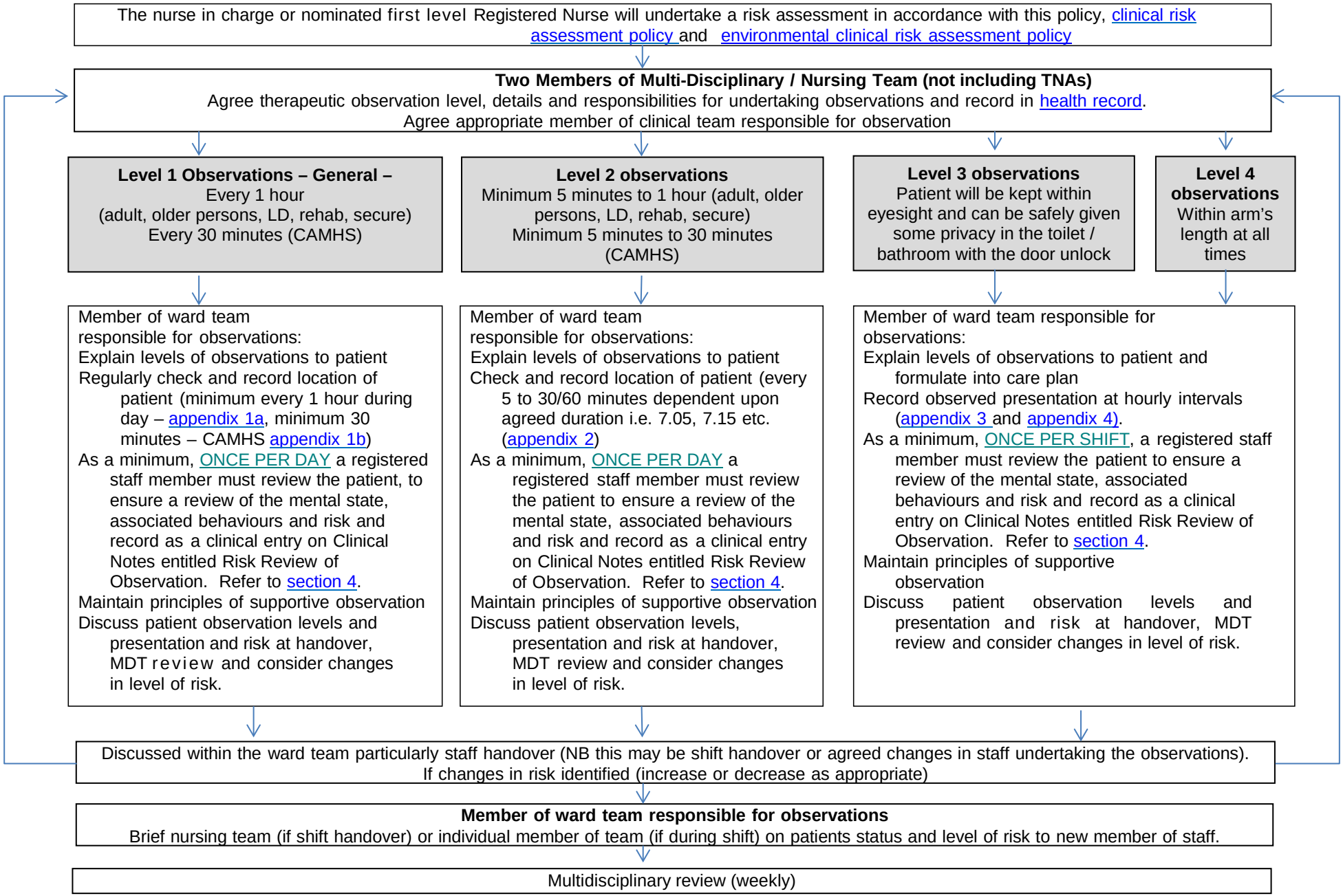
Financial resource implications	No

External references
1. https://improvement.nhs.uk/resources/safety-huddles/
2. https://improvement.nhs.uk/documents/1140/SLIDES_B3_W_Safety_huddles.pdf

Equality Impact Assessment (EIA) - Initial assessment	Yes/No	Comments
Does this document affect one group less or more favourably than another on the basis of:		
- Race	No	
- Ethnic origins (including gypsies and travellers)	No	
- Nationality	No	
- Gender	No	
- Culture	No	
- Religion or belief	No	
- Sexual orientation including lesbian, gay and bisexual people	No	
- Age	No	
- Disability - learning disabilities, physical disability, sensory impairment and mental health problems	No	
Is there any evidence that some groups are affected differently?	No	
If you have identified potential discrimination, are there any exceptions valid, legal and/or justifiable?		
N/A		
Is the impact of the document likely to be negative? - If so can the impact be avoided? - What alternatives are there to achieving the document without the impact? - Can we reduce the impact by taking different action?	No N/A N/A N/A	
Where an adverse or negative impact on equality group(s) has been identified during the initial screening process a full EIA assessment should be conducted. If you have identified a potential discriminatory impact of this procedural document, please refer it to the human resource department together with any suggestions as to the action required to avoid / reduce this impact. For advice in respect of answering the above questions, please contact the human resource department.		
Was a full impact assessment required?	No	
What is the level of impact?	Low	

Contents

Quick reference flowchart



1.0 Introduction

Supporting in-patients using clinical therapeutic observations is intrinsic to providing safe and effective care. Therefore, the purpose of this policy is to provide a framework for all CWP in-patient staff in the assessment and application of therapeutic observation levels. Included in this is clarity around roles, responsibilities and processes for undertaking therapeutic observations.

Therapeutic observations allow staff to assess and monitor the mental and physical health of patients who are at risk of harm towards themselves and/or others. It also takes account of patient vulnerabilities that may for example include increased monitoring of physical health conditions, falls management or post meal observation.

The therapeutic observation process provides ward staff the opportunity to engage with patients in a positive way. This can be achieved through constructive communication and activity with the patient to aid assessment and evaluate risk while assisting them to constructively address their difficulties.

2.0 Definition

The act of therapeutic observation involves regarding the patient attentively while minimising the extent to which they feel they are under surveillance. It requires staff to be caringly vigilant and inquisitive, and have a thorough knowledge of the patient in their care, the patient's care plan and their observational requirement.

Good practice includes investigating all unusual circumstances and noises. It also ensures that high level observations are only used for the least restrictive time necessary.

3.0 Considerations

This policy acknowledges that the use of therapeutic observations are most effective when tailored to the needs of the individual and in consideration of environmental risk, clinical risk, patient needs and strengths. This thereby permits in-patient staff to implement the most effective method of intervention to maintain safety and facilitate person centered care.

Decisions regarding levels of therapeutic observations should be based on the risk assessment, needs and strengths of the patient. Justifiably the enhancement of safety is a core feature of therapeutic observation. It is, however, recognised that risk can never be eliminated entirely.

Patients and their families/carers that use services will be involved in decision making relating to the use of therapeutic observations and will be offered a clear rationale for the level of therapeutic observation recommended. The discussion and outcome will be recorded in the care plan, in circumstances where it is not possible to involve patients and their families/ carers in such decisions; staff should refer to section 3.1 below.

At all times the patient's privacy and dignity must be considered as part of a decision to use therapeutic observations and the patient's care plan must reflect this. Should high level observations (Level 4) extend beyond 7 days a peer review should take place. A peer review should be undertaken by a Modern Matron, independent of the in-patient unit.

It is recognised that there may be individualised care needs that require deviation from this policy. In such circumstance this must be agreed by the MDT and clearly documented within the care plan and clinical notes.

It is expected that ward staff going off duty who are allocated to complete Level 1 and Level 2 observation checks to handover patient whereabouts to the ward staff coming on duty. e.g. Appendix 1a and 1b asks that checks are initialed by members of the day **AND** night duty staff.

There is the opportunity for the MDT to utilise a **Safety Huddle** to review clinical care including observation levels. A 'huddle' is a short briefing per day that focuses on patients' most at risk to agree actions to reduce harm. NHS Improvement highlights that safety huddles

- enhance teamwork through communication and co-operative problem-solving;
- share understanding of the focus and priorities for the day;
- improve situational awareness of safety concerns.

3.1 The Mental Health Act and The Mental Capacity Act including Deprivation of Liberty Safeguards (DoLS)

The legal status of a patient under the Mental Health Act 1983, the Mental Capacity Act 2005 or DoLS should always be taken into consideration and included in this are decisions regarding levels of therapeutic observations based on the risk assessment, needs and strengths of the patient. Therefore, where it is not possible to involve the patient in the decision making process due to a lack of capacity, the levels of therapeutic observations should be the least restrictive option and be in the patient's best interests and the interests of those around them. The rationale behind this decision should be fully documented in the care plan, and a clinical note entered in the clinical notes.

In considering the level of therapeutic observations for patients, the level of support required will be on the basis of risk assessments. If higher levels of observations (e.g. Levels 3 and 4) are felt necessary, consideration must be made to whether the patient meets the criteria for detention under the Mental Health Act or Deprivation of Liberty Safeguards (DoLS) applied in line with the Mental Capacity Act.

Restrictions imposed upon the patient by their treatment plan must be kept to a minimum and should be part of a therapeutic plan of care that must be reviewed regularly taking into account guidance from the MHA Code of Practice. Therapeutic Observations are not a custodial activity and they facilitate clinicians an opportunity to engage, communicate and convey to the patient that they are valued.

4.0 Observation Levels

On admission observation level will be agreed in line with risk assessment. There is no specified period for new admissions and all care is person centred.

Level 1(General Observations) Patients who are assessed as being a low risk to themselves or others	This is the minimum level of observation for patients in in-patient areas. Staff should know the location of all patients in their area, but patients need not be kept in sight. **See Section 4.4.1**
Level 2 (Intermittent Observations) who are assessed as posing a potential, but not immediate risk.	A patient's location and safety must be checked at specified intervals. These intervals may range from five minutes to every 30 minutes (five to 15 minutes for CAMHS). **See Section 4.4.2**
Level 3 (Continuous Observation) Patients who are assessed as posing a risk of harm at any time to	A nominated staff member will be allocated to observe the patient at all times, having them within eyesight. This should also be used as an opportunity to engage

themselves or others, or where the patient is perceived as vulnerable e.g. physically vulnerable to falls, postural hypotension etc.	positively with the patient and take part in therapeutic activities. **See Section 4.4.3**
Level 4 (Continuous Observation within arm's length) Patients who are assessed as posing the highest risk of harm at any time to themselves or others.	A nominated staff member will be allocated to observe the patient at all times in close proximity by being within arm's length of the patient. This should also be used as an opportunity to engage positively with the patient and take part in therapeutic activities. **See Section 4.4.4**

4.1 Assessment and Review of Observation Levels

Upon admission or transfer into the in-patient area and prior to the implementation of therapeutic observation levels, staff must undertake a review of clinical and environmental risk factors. Two members of the MDT will decide the level of therapeutic observation and formulate a risk management plan that shall be detailed within the patient's care plan. If there is disagreement about the level of therapeutic observations, the nurse in charge will make the decision.

At the first opportunity each day all patients will be asked by a member of the multi-disciplinary team how they are feeling, this will be prior to patients going off the ward. If there are any concerns about the patient at this stage, taking into account the patient's overall presentation and behaviour, a registered nurse will carry out a more comprehensive risk assessment and document the outcome, amending the risk management plan as appropriate.

Where there are communication difficulties with a patient staff will use their clinical expertise to assess and evaluate risk, including discussions with MDT and carers.

Prior to any observation levels being reduced, a 1:1 individualised assessment will take place by a registered member of the MDT. During this assessment the patient will be asked about risks and needs that have been identified in the Risk Assessment and Care Plan, including any suicidal thoughts, thoughts of harm to self or others and vulnerabilities that can increase risk.

For patients on **Level 1** and **Level 2** observations

- A Daily Risk Review will be completed and a note entered in the clinical records. This will take place following nursing staff contact with the patient.
- The daily risk review will be completed by a Registered staff member who must assess the patient to ensure a review of their mental state, associated behaviours and risk.
- The Registered staff member will make a clinical entry of the risk appraisal on clinical records entitled **RISK REVIEW OF OBSERVATIONS.**

For patients on **Level 3** and **Level 4** observations

- A Twice Daily Risk Review will be completed and as a minimum this will be once per shift. This will take place following nursing staff contact with the patient.
- This Risk Review will be completed by a registered staff member who must assess the patient to ensure a review of the mental state, associated behaviours and risk.
- The Registered staff member will make a clinical entry of the risk appraisal on clinical records

entitled **RISK REVIEW OF OBSERVATIONS.**

Any changes including reduction/increase in observation level will be reflected in the individual patient's risk management plan.

In secure services staff will record the review of observation within the day and night activity record as **DAILY ACTIVITY NOTE**.

4.2 Care Planning

Following an assessment of risk all patients will have a risk management plan that will summarise the patient risk including:

- Environmental risks including allocated bedroom and items that could be used to self-harm;
- Clinical presentation;
- Any increase/decrease of the level of observation;
- Whether the patient is to be escorted off the ward and by whom;
- Any other agreed strategies to reduce risk.

The risk management plan will be reviewed and amended to reflect any changes in presentation or alterations in observation levels

EXAMPLE
A patient on level 1 observation is presenting as settled and, following an MDT discussion and risk assessment, it has been agreed that they do not require hourly observation checks during the night, when they are asleep. This is discussed with the patient and fully reflected in the care plan.

The risk management plan will also incorporate reviews held as part of weekly ward rounds or MDT reviews.

4.3 Leave from the Ward

It is recognised that it can be essential to positive clinical risk management for patients under observation to have time off the ward. Leave from the ward forms part of the patient's care plan following risk assessment. If the patient is permitted leave from the ward staff must clarify with the patient their intended location and a time for their return to the ward. For guidance specific to section 17 leave for patients detained under the Mental Health Act (1983), please see the Mental Health Law Policy Suite.

Each ward will have in place a process of knowing a patient's whereabouts. This policy offers a Daily Signing In and Out (appendix 5) sheet that wards may choose to use for patients that independently enter and leave the ward.

If a patient's is not back at the time agreed the nurse in charge will refer to the Missing Person's Policy.

EXAMPLE
At 2.30 a patient tells staff that they are going to the local shops and expect to return at 3pm. They have not returned by 3.20pm. Staff should refer to the missing person's policy for guidance on next steps to be taken.

4.4 Observation at different levels including how observation is recorded

Observation levels should take into account that some patients may not be at risk of deliberate harm to themselves or others, but there may be aspects of their physical, emotional or sexual wellbeing which increases their vulnerability.

EXAMPLE

A patient on an older people's ward is unsteady on their feet and has a tendency to fall, particularly in the evening. Following a risk assessment, the MDT agree with the patient that they will be on level 2 observations (5 minute intervals) to monitor the risks and safety.

EXAMPLE

A patient on an acute adult ward is in the process of transitioning from male to female and has formally requested that they are recognised as female. The attitude of other patients on the ward is recognised as potentially abusive increasing the vulnerability of the patient who is transitioning. In discussion with the patient and the MDT, it is agreed to support the patient on level 2 observations (5 minute intervals).

4.4.1 Level 1 - General Therapeutic observation

Risk assessment identifies no or low *immediate* risk.

All in-patients will be observed at least once during the hour. Staff must be aware of the location of all patients but do not need to keep patients within sight. The patient's whereabouts will be checked at intervals of no longer than 1 hour throughout a 24 period and recorded in appendix 1a.

In CAMHS this is carried out at 30 minute intervals and recorded in appendix 1b.

A patient on level 1 observations will not necessarily be granted unescorted leave from the ward; these are two separate decisions both informed by clinical risk assessments.

A process of knowing a patient's whereabouts needs to be in place to identify whereabouts and if the patient is permitted leave from the ward then there must be verification of the intended location of the patient and a time for their return to the ward.

EXAMPLE

Informal patient on level 1 observations has been risk assessed and the MDT have agreed that they are encouraged to have time off the ward for up to an hour at a time. The patient indicates that they would like to leave the ward; staff ask where they are planning to go and what time they expect to be back. The patient is asked to complete the signing in and out form.

EXAMPLE

A patient is intending to go and visit their sister for 2 hours and plans to travel there by public transport. Staff ask the patient where they are planning to go and what time they expect to be back. It is also appropriate for staff, with the patient's permission, to contact the patient's sister to verify the plans for the patient's leave.

If patients are not back at the time agreed the nurse in charge will refer to the Missing Person's Policy and Procedure including AWOL and implement accordingly.

The MDT will assess the patient's level of risk and determine if therapeutic observation periods at night can be carried out less regularly whilst someone is asleep specifically considering vulnerability. The rationale needs to be documented in the risk management plan and communicated to the ward team.

4.4.2 Level 2 – Intermittent Therapeutic observation

Level 2 Therapeutic observation can range from a minimum 5 minutes to maximum 30minutes. The recording will be through using appendix 2.

Level 2 observation levels can vary in frequency and duration dependent upon identified risks and needs and to promote therapeutic risk management. The duration of frequency of observation must be clearly documented with rationale as to how that decision has been made.

It is clinically recognised that the allocation of level 2 intermittent observations may be used to promote a model of care of self-sufficiency for those patients who had been on higher level of observations as a result of risk.

The use of Level 2 therapeutic observations are to be employed to manage identified immediate risks either on or off the ward including

a) Harm to self;
b) Harm to others;
c) Absconding where (a) or (b) are an immediate risk and have been acted upon;
d) Vulnerability.

EXAMPLE (considering sexual safety)
A patient is on level 3 observations within eyesight when on the ward due to risk of sexual touching. When with family these risks decrease and level 3 observations are able to be set aside for the duration of the family visit. Level 3 observations will resume at the end of the visit unless there has been a change to the presentation of risk. The deviation from level 3 during visits would be reflected in the care plan and clinical notes.

EXAMPLE
A patient on level 2 observations is known to become more distressed with increased thoughts of self-harm and suicidal ideation after the weekly ward round. The clinical team agrees with the patient to increase level of observations to level 3 for 12 hours following the ward round to provide enhanced support for the patient. This is reflected within the clinical notes, risk assessment and care plan.

If the patient wishes to go off the ward, they must be escorted by a member of staff.

If the patient wishes to go off the ward with a relative or carer the nursing team should carry out a further assessment and document rationale in the care record.

The patient would return to their existing level of observation on return to the ward unless there has been a change to their risk presentation.

Staff must clearly communicate to the relative/carer what their role is when accompanying a patient and what to do in the event of an emergency whilst off the ward.

4.4.3 Level 3 - Therapeutic observation (observed within eye sight)

Significant immediate risk present or voiced by patient or has attempted:

a) Harm to self;
b) Harm to others;
c) Absconding where (a) or (b) are an immediate risk and have been acted upon;
d) Vulnerability.

At the point of agreeing level 3 observations a decision will be made as to the level of privacy that can be afforded to the patient dependent upon the environment and clinical presentation, the observation management plan will detail whether the patient can be safely given some privacy in the toilet/bathroom with the door unlocked. If the degree of privacy prevents eye contact with the patient, verbal communication should be maintained.

When completing level 3 observations healthcare professionals are encouraged to involve the patient by way of developing a positive therapeutic relationship including, for example, talking to the patient and participating in activities.

The patient will not leave the ward unless included as part of an MDT agreed care plan. Patients must be accompanied by appropriately experienced staff allocated by the nurse in charge.

Therapeutic observations do not prevent visits to the patient from family or carers. Agreed therapeutic observation levels must be carried out by the designated member of staff and should not be delegated to the visitor. Any deviations to this need to be individually care planned as part of a risk assessment and safety plan.

4.4.4 Level 4 - Therapeutic observation (1:1 at all times / arms reach)

Immediate and serious risk of:

a) Harm to self;
b) Harm to others;
c) Absconding where (a) or (b) are an immediate risk and have been acted upon;
d) Vulnerability.

Where the risk assessment shows that a patient presents with the highest risk of harming themselves or others they will need to be nursed in close proximity. Level of risk may result in more than one member of staff being on therapeutic observation duty.

The patient will be constantly within arm's length of the designated staff, including when the patient is using bathroom/ toilet areas. The patient's ability to move about their immediate environment may be limited and managed by designated staff to ensure safety of the individual and the safety and security of all, but must be the least restrictive alternative.

When completing level 4 observations healthcare professionals are encouraged to involve the patient by way of developing a positive therapeutic relationship including, for example, talking to the patient and participating in activities.

Patients on level 4 therapeutic observations will not routinely be allowed to leave the ward unless there is a clear clinical rationale. Visitor contact will form part of the risk assessment and a clear explanation of the need for level 4 therapeutic observations will be given to the visitor and the designated nurse will remain present at all times.

5.0 Specialist Services - specific therapeutic observations

5.1 Dementia wards

If patients with dementia are nursed on level 1 therapeutic observation on the ward but are required to be escorted off the ward, they can remain on level 1; this is with acknowledgement that there is increased staff support to maintain safety due to vulnerability. This decision must be documented and communicated to the escorting staff member.

5.2 Eating disorders

For patients with an eating disorder, the period after a meal/snack will result in increased level of therapeutic observation and therapeutic time for all patients. Staff will be allocated to this duty.

5.3 Learning Disabilities Health Respite

Patients who access health respite will have enhanced observation plans that are clearly documented within the LD Risk assessment and Care Plan. Person Centered intervention plans will describe the support and staffing levels needed for the individual. These plans will be discussed at the pre-admission contact with Carer and Client and updated for the planned respite stay. A post- stay contact call will be made to the Carer/client when the plan will be evaluated. During the stay the level of observation will be reviewed as per policy and record a review of observation within the day or night record (as opposed to separate entries). The level of observation may increase in line with changes to risk reviews. This will be monitored throughout the respite stay.

5.4 CAMHS

If young people are nursed on level 1 therapeutic observation but need to be escorted whilst off the ward, they can remain on level 1 therapeutic observations following risk assessment, including any required support from staff or carers. The rationale must be documented and communicated to the team.

6.0 Environmental risk

When allocating the level of therapeutic observation levels, members of the MDT will give due consideration to the environment that the person is being nursed within, including the allocation of a bedroom close to the nursing office for those patients at highest risk. Allocation of the level of therapeutic observation levels will also take into consideration the environment and potential vulnerability of patients in relation to mixed sex accommodation. The nurse in charge will ensure that prior to admission/transfer into a new bedroom that a visual inspection is conducted of the room and ward environment in accordance with the clinical risk presented by the patient. This review will be documented in the clinical record. This will also be documented in appendix 1a and appendix 1b (CAMHS). Staff should refer to GR15 Environmental clinical risk assessment policy and CP5 Clinical risk assessment policy for further guidance.

Hazardous items which may be used to harm self or others will be kept in a safe place following a comprehensive assessment of risk and discussion with the nurse in charge and patient. If any personal items or belongings are removed, staff should follow CP62 Procedure for the security of patients cash and valuables on wards policy. They will be provided by nursing staff and given to the patient when requested in consideration of a risk review. The member of staff that issues the item must ensure that the item is returned.

Other articles that could prove harmful should not be immediately available, and staff must be made aware of the need to be vigilant. Staff must consider the risks that personal items could pose and consider the requirement to remove such items in line with the clinical risk presented.

EXAMPLE
A patient is known to use various items of clothing to ligature with. To maintain the patient's dignity it is not appropriate to remove their clothing. Following an MDT discussion and discussion with the patient on how to manage risk, it is agreed that staff will use level 3 observations to maintain safety.

All decisions must be clearly explained to the patient and be reviewed and documented within the clinical notes, risk assessment and care plan.

8.0 Staff responsibilities

The Nurse in Charge will allocate observation duties to a member of the clinical team and ensure that individuals are clear about their responsibility and accountability. The therapeutic observation rota will be completed at the commencement of the shift (appendix 3).

Staff will be made aware of the agreed risk management plan as part of handover. This will include handover between shifts, ward to ward, changes to levels of observation and as part of admissions. Staff will ensure that they undertake the observation level outlined within the care management plan at all times when duties are allocated to them and understand the level of risk relevant to the patient they are observing.

Each member of staff will undertake Level 3 or 4 therapeutic observations for one hour only except in circumstances such as when building rapport with the patient, which is therapeutic to his or her intervention, providing support to patients in acute hospitals.

Responsibility for undertaking therapeutic observation levels will not be allocated to visitors. Following a risk assessment, staff may agree to suspend observations for a short period of time to allow some privacy with a relative or legal advisor. Staff should advise the visitor of any key indicators of risk and how to seek help in the event of a crisis.

9.0 Students

CWP acknowledges the different experiences and capabilities of students in training. We want to assist learning through exposure to various learning opportunities. However, there is a requirement to ensure that we support students in learning and reduce risks to the least possible. Therefore, mentors/supervisors of pre-registration students or trainees must with any task or duty delegate to others according to their own professional code of conduct and within the remit of the student learning proficiencies/outcomes, ensuring they complete an appropriate risk assessment of the task to be undertaken by the student and provide adequate supervision. A risk assessment guide is attached for mentors/supervisors of students in training (Appendix 6).

Appendix 1a - Therapeutic observation multipurpose nominal role (level 1 hourly observation) – adult mental health, learning disabilities, rehab, secure

Please note: Shaded times should be checked and initialed by members of the day **AND** night duty staff.																												
Please note: *Environmental Check – Staff to check all bedrooms, bathrooms and accessible communal areas for environmental risk (e.g. fire, ligature risks, sharp object and unlocked doors which should be locked)*																												
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Codes to be used				
A = Awake	S = Sleeping	G = Group therapy (on ward)	L = Leave	C = Consultation (on ward)
E = Education (on site)	O = Out (with permission)	X = Missing – Inform S/N	TRANSFER	DISCHARGE

Appendix 1b - Therapeutic observation 30 minute resident location record (CAMHS)

Please note: *Environmental Check – Staff to check all bedrooms, bathrooms and accessible communal areas for environmental risk (e.g. fire, ligature risks, sharp object and unlocked doors which should be locked)*																												
Date commenced																												
Room	**Name**	**08:00**	**09:00**	**10:00**	**11:00**	**12:00**	**13:00**	**14:00**	**15:00**	**16:00**	**17:00**	**18:00**	**19:00**	**19:30**	**20:00**	**21:00**	**22:00**	**23:00**	**00:00**	**01:00**	**02:00**	**03:00**	**04:00**	**05:00**	**06:00**	**07:00**	**07:30**
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Codes to be used				
A = Awake	S = Sleeping	G = Group therapy (on ward)	L = Leave	C = Consultation (on ward)
E = Education (on site)	O = Out (with permission)	X = Missing – Inform S/N	TRANSFER	DISCHARGE

Appendix 2 - Therapeutic observation (obs) record for individual patients (level 2)

Patient name		NHS Number		Date		Obs interval*		Room allocated	

	Int	***	Int	***	Int	***	Int	***	Int	***	Int	***	Int	***	Int	***	Int	***	Int	***	Int	***	Int	Nurse	Signature
00:00		05		10		15		20		25		30		35		40		45		50		55			
01:00		05		10		15		20		25		30		35		40		45		50		55			
02:00		05		10		15		20		25		30		35		40		45		50		55			
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07:00		05		10		15		20		25		30		35		40		45		50		55			
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17:00		05		10		15		20		25		30		35		40		45		50		55			
18:00		05		10		15		20		25		30		35		40		45		50		55			
19:00		05		10		15		20		25		30		35		40		45		50		55			
20:00		05		10		15		20		25		30		35		40		45		50		55			
21:00		05		10		15		20		25		30		35		40		45		50		55			
22:00		05		10		15		20		25		30		35		40		45		50		55			
23:00		05		10		15		20		25		30		35		40		45		50		55			

***** Intervals of 5, 10 15 mins etc | ****** Initials of nurse Please shade box if obs not required Leave blank if obs was required but not completed | ******* = minutes past the hour 30 = 1330hrs

Codes to be used

A = Awake	S = Sleeping	G = Group therapy (on ward)	L = Leave	C = Consultation (on ward)
E = Education (on site)	O = Out (with permission)	X = Missing – Inform S/N	TRANSFER	DISCHARGE

Appendix 3 - Therapeutic observation record for individual patients (Levels 3 and 4)

Name of patient		**Therapeutic observation level**	
NHS Number		**Date**	

Time of observation to be recorded in appropriate intervals *(15 mins, if in seclusion)*	**Designated nurse**	**Signature**	**Location / areas of concern / action / presentation supporting interventions**
!			
!			
!			

! If patient is being nursed in seclusion, this review must be a review by two registered nurses (1 independent of decision to seclude) and should be recorded into the service users clinical notes.

Time of observation to be recorded in appropriate intervals *(15 mins, if in seclusion)*	Designated nurse	Signature	Location / areas of concern / action / presentation supporting interventions
!			
!			
!			

! If patient is being nursed in seclusion, this review must be a review by two registered nurses (1 independent of decision to seclude) and should be recorded into the service users clinical notes.

Appendix 4 - Therapeutic observation rota for staff (all levels)

Name of ward		Date	

	LEVEL 1	LEVEL 2		LEVEL 3 and 4		
	All patients	Name	Name	Name	Name	Name
0700						
0800						
0900						
1000						
1100						
1200						
1300						
1400						
1500						
1600						
1700						
1800						
1900						
2000						
2100						
2200						
2300						
2400						
0100						
0200						
0300						
0400						
0500						
0600						

Comments/variations *(e.g. it is necessary for another member of staff to temporarily cover observations)*

Appendix 5 – Daily signing in and out sheet

Name of ward		Day and Date	

CWP ask that you sign in and out to help ward staff make sure that we know you are safe and we know where you are in the event of an emergency e.g. fire. If you haven't returned to the ward at the time expected back staff will try and contact you. If staff are not able to make contact with you they are asked to refer to the missing persons policy.

Patient name	Time leaving the ward	Intended Whereabouts	Time of expected return	Signature	Time of actual return

Appendix 6 – Risk Assessment Guide to assist mentors and supervisors' decision to delegate tasks to student nurses

Staff name		**Designation**	
Assessor		**Date**	

This guide is for mentors/supervisors of pre-registration students or trainees to jointly complete and forms part of an appropriate risk assessment with student learners before delegating any therapeutic observation task to them.

Delegation will be

- in accordance with the mentor/supervisors own professional code of conduct
- form part of the student's learning proficiencies/outcomes
- ensure adequate supervision of the task undertaken by the student learner

Prompts to consider	**Learner's comments**	**Mentor/supervisor's review**
What underpinning knowledge does the student retain in relation to the task? E.g. *Awareness of Therapeutic Observation policy, when to raise concerns, how to raise concerns, what is observation and why does it take place, what to do in an emergency. Has the student been introduced and familiar with the service user?*		
What training has the student completed in relation to the task? *E.g. person centered thinking, breakaway, risk assessment/management.*		
Which learning outcome/proficiency does this task relate to within the student assessment document?		
What is the year of training or level of the student and do they need to complete the task as part of their level of learning? *E.g. Do they need to observe and understand the task or be observed to complete the task?*		
Has the risk associated with the service user been		

Prompts to consider	Learner's comments	Mentor/supervisor's review
discussed and is it appropriate for the student to undertake the task? *E.g. CARSO reviewed including relapse signatures and events or alerts.*		
What clinical experience does the student possess? *E.g. Have they completed the task before under observation or indirect supervision? Do you need to stage the learning activity to provide reassurance of competence and confidence? Communication skills? Has the student worked in this clinical environment before?*		
How have you assessed student confidence and competence in relation to this task? *E.g. Questions and Answers, Direct Observation on a number of occasions?*		

Plan for learning activity following assessment:

Observation level	YES/NO	Level of supervision for the student	Action
Level 1	YES/NO		
Level 2	YES/NO		
Level 3	YES/NO		
Level 4	YES/NO		

Student Signature	
Mentor or Supervisor Signature	