

1<sup>st</sup> July 2026

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Further to your recent request for information made under the Freedom of Information Act (FOIA) 2000, I now set out our answers to your specific questions, and any clarifications sought and provided, as follows:

- 1. A copy of your Trust's current policy (or equivalent document) relating to enhanced observation of adult inpatients.**

**This may be titled differently locally, for example:**

- o **Enhanced Therapeutic Observation and Care (ETOC)**
- o **Enhanced observation**
- o **Specialling**
- o **One-to-one (1:1) care**
- o **Constant or close observation**

Please see the attached document - '276-02-Policy for the Introduction and Use of Enhanced Observations with Adult Patients' and note that this is currently being reviewed.

Please note that it is the Trust's FOI policy to only provide the names of staff that are grade 8a or above, therefore staff that are below that grade have been redacted from the attached document.

Please also note that we have redacted the names of the Trust's IT Systems and names of staff that no longer work for the Trust, and are applying Sections and 31(1)(a) and 40(2) respectively, please see below:

#### [Section 31\(1\)\(a\)](#)

Under Section 31(1)(a) of the Freedom of Information Act (FOIA), the Trust can confirm that it holds information relevant to your request, however, we are unable to disclose it for the reasons explained below.

Historically, we would disclose information relevant to the Trust's IT systems, infrastructure and software as part of our transparency agenda under the terms of the Freedom of Information Act (FOIA). However, in light of the recent cyber-attacks on NHS hospitals and the serious impact these have had on patient services and the loss of patient data, we are having to reconsider this approach. Please see several links to news articles about these recent cyber incidents provided below for your information.

- [NHS England — London » Synnovis Ransomware Cyber-Attack](#)
- [NHS England confirm patient data stolen in cyber attack - BBC News](#)
- [Merseyside: Three more hospitals hit by cyber attack - BBC News](#)

As a result of these attacks, thousands of hospital and GP appointments were disrupted, operations were cancelled, and confidential patient data was stolen which included patient names, dates of birth, NHS numbers and descriptions of blood tests.

When we respond to a Freedom of Information request, we are unable to establish the intent behind the request. Disclosure under the FOIA involves the release of information to the world at large, free from any duty of confidence. Providing information about our systems or security measures to one person is the same as publishing it for everyone. While most people are honest and have no intention of misusing information to cause damage, there are criminals who look for opportunities to exploit system weaknesses for financial gain or to cause disruption.

In the context of the FOIA, the term “public interest” does not refer to the private or commercial interests of a requestor; its meaning is for the “public good”. The Trust receives a significant number of requests each year regarding our IT systems, infrastructure and cyber security measures. Most of these requests are commercially driven and serve no direct public interest. Information relevant to our IT portfolio is often requested by consultancy companies who then pass on this information to their client base. Many of these requests are submitted through the FOI portal [whatdotheyknow.com](#) who publish our responses, making this information available to an even wider audience.

As a large NHS Trust we hold extensive personal data relevant to our patients and staff, much of which is considered very sensitive. A lot of this information is held electronically on various administration and clinical systems. We have a duty under the Data Protection Act 2018 and the UK GDPR to protect this personal information and take all necessary steps to ensure this data is kept safe. This means not disclosing information that could allow criminals to gain unlawful access to our systems and infrastructure. The Trust can be heavily fined should it be found to have acted in a negligent way which results in a personal data breach. We need to demonstrate that we comply with our legal obligations under data protection and freedom of information legislation, but we must be careful that too much transparency does not result in harm to our patients or staff, or cause disruption to our services.

Moreover, under the Network and Information Systems (NIS) Regulations Act 2018, operators of essential services such as NHS organisations like ours have a legal obligation to protect the security of our networks and information systems in order to safeguard our essential services. By releasing information that could increase the likelihood or severity of a cyber-attack, the Trust would fail to meet its security duties as stated in Section 10 of the Network and Information Systems Regulations 2018. Should we not comply with these requirements regulatory action can be taken against the Trust. Further information about the Network and Information Systems (NIS) Regulations Act 2018 can be found here – [The Network and Information Systems Regulations 2018: guide for the health sector in England - GOV.UK](#)

Your request asks for policy documents which unfortunately mention specific details regarding our IT Systems which, for the reasons explained above, would be inappropriate to release into the public domain. If disclosed, it is possible that patient data as well as other confidential information would be put at risk. Such disclosure could also impact on the security of our systems and result in serious disruption to the health services we deliver to the local community. Section 31(1)(a) of FOIA provides that information is exempt if its disclosure would, or would be likely to, prejudice (a) the prevention or detection of crime. In this case, disclosure would be likely to prejudice the prevention of crime by enabling or encouraging malicious acts which could compromise the Trust's IT systems and infrastructure. The Trust's capacity to defend itself from such acts relates to the purposes of crime prevention and therefore Section 31(a) exemption is applicable in these circumstances. For these reasons, the Trust considers disclosure of the information you are seeking to be exempt under Section 31(1)(a) [law enforcement] of the FOIA and the names of the IT systems within the policy is being withheld. The full wording of Section 31 can be found here: [Freedom of Information Act 2000](#)

Section 31 is a qualified exemption and therefore we must consider the prejudice or harm that may be caused by disclosure of the information you have requested, as well as apply a public interest test that weighs up the factors in maintaining the exemption against those in favour of disclosure.

In considering the prejudice or harm that disclosure may cause, as explained should the Trust release information into the public domain which draws attention to any weaknesses relevant to the security of our systems or those of a supplier, this information could be exploited by individuals with criminal intent. Increasing the likelihood of criminal activity in this way would be irresponsible and could encourage malicious acts which could compromise our IT systems or infrastructure, result in the loss of personal data and/or impact on the delivery of our patient services. We consider these concerns particularly relevant and valid considering the increasing number of cyber incidents affecting NHS systems in recent years and the view by government, the ICO and NHS leaders that the threat of cyber incidents to the public sector is real and increasing.

- [\*Organisations must do more to combat the growing threat of cyber attacks | ICO\*](#)

In the Government's Cyber Security Strategy 2022-2030, the Chancellor of the Duchy of Lancaster and Minister for the Cabinet Office states on page 7:

"Government organisations - and the functions and services they deliver - are the cornerstone of our society. It is their significance, however, that makes them an attractive target for an ever-expanding army of adversaries, often with the kind of powerful cyber capabilities which, not so long ago, would have been the sole preserve of nation states. Whether in the pursuit of government data for strategic advantage or in seeking the disruption of public services for financial or political gain, the threat faced by government is very real and present.

Government organisations are routinely and relentlessly targeted: of the 777 incidents managed by the National Cyber Security Centre between September 2020 and August 2021, around 40% were aimed at the public sector. This upward trend shows no signs of abating."

With this in mind, we then considered the public interest test for and against disclosure. It should be noted that the public interest in this context refers to the public good, not what is 'of interest' to the public or the private or commercial interests of the requester. In this case we consider the public interest factors in favour of disclosure are:

- Evidences the Trust's transparency and accountability
- Provides information relevant to the IT systems and applications the Trust uses
- Reassures the public and partners that the Trust procures these systems in line with Procurement legislation
- Reassures the public and partners that the Trust's IT infrastructure and systems are secure

Factors in favour of withholding this information are:

- Public interest in crime prevention
- Public interest in avoiding disruption to our health services
- Public interest in maintaining the integrity and security of the Trust's systems
- Public interest in the Trust avoiding the costs associated with any malicious acts (e.g. recovery, revenue, regulatory fines)
- Public interest in complying with our legal obligations to safeguard the sensitive confidential information we hold

In considering all of these factors, we have concluded that the balance of public interest lies in upholding the exemption and not releasing the information requested. Although disclosure would provide transparency about our software systems and IT infrastructure, this is outweighed by the harm that could be caused by people who wish to use this information to assess any vulnerabilities in our security measures and consequently use this information for unlawful purposes. Cybercrime can not only lead to major service disruption but can also result in significant financial losses. As a publicly funded organisation, we have a duty for ensuring our public funding is protected and spent responsibly. Moreover, as a public body the Trust must demonstrate that it keeps its confidential data and IT infrastructure safe and complies with relevant legislation, but at the same time we must be vigilant that transparency does not provide an opportunity for individuals to act against the Trust. In considering the impact that recent cyber-attacks have had on NHS services, including the cancellation of thousands of patient appointments and procedures as well as the loss of confidential patient data, we consider the overriding public interest lies in withholding this information. The private or commercial interests of a requester should not outweigh the public interest in protecting the integrity of our systems and continuity of our essential patient services. Although we appreciate there may be legitimate intentions behind requesting this information, we must take a cautious approach to requests of this nature and appreciate your understanding in this matter.

## Section 40(2)

I can confirm that we hold this information, but it is exempt under Section 40(2) of the Freedom of Information Act 2000 – Personal Information of third parties. This is because this information may allow the identification of individuals and disclosure would breach the principles of the Data Protection Act.

This is an absolute exemption and there is, therefore, no requirement to consider the public interest.

**2. If available, any associated patient information leaflet(s) that relate specifically to enhanced observation.**

East Sussex Healthcare NHS Trust does not have any associated patient information leaflet(s) that relate specifically to Enhanced Observation of Adult Patients.

Please see the link below for access to all patient information leaflets:

[Patient information leaflets – East Sussex Healthcare NHS Trust](#)

**3. The following details for the policy identified in question 1, if not contained within the document:**

- o **Date of approval (or current version date)**
- o **Date of last review**
- o **Planned review date**

Please see the attached document - '276-02-Policy for the Introduction and Use of Enhanced Observations with Adult Patients' and note that this is currently being reviewed.

**4. If the most recent policy is publicly available online, please provide the direct URL instead of attaching the document.**

Not applicable.

I trust this information is helpful in its detail or explanation however, if you are dissatisfied with the response, then you have the right to request an internal review. If you wish to seek an internal review, please write to the Freedom of Information Team at [esh-tr.foi@nhs.net](mailto:esh-tr.foi@nhs.net) quoting the above FOI reference number, within 40 working days. Please note the Trust is not obliged to accept a request for an internal review after this time period.

Yours faithfully

Freedom of Information (FOI) Team  
East Sussex Healthcare NHS Trust  
0300 131 4716  
Core Hours of Business: Monday to Friday 9.00am to 4.00pm

## Introduction and Use of Enhanced Observations with Adult Patients Policy

Document ID:	1170
Version:	V2
Ratified by:	Patient Documentation and Policy Ratification Group
Date ratified:	July 2019
Name of author and title:	Sue Allen, Assistant Director Nursing, Medicine
Date originally written:	June 2012
Date current version completed:	May 2023
Name of responsible committee/individual:	Professional Advisory Group
Date issued:	May 2023
Review date:	May 2026
Target audience:	All staff working with patients who may require enhanced observations.  All Registered Nurses, health care assistants, Registered Therapists, clinical site managers, medical staff, psychiatric liaison staff.
Compliance with CQC fundamental standard	Safe Care and Treatment
Compliance with any other external requirements (e.g. Information Governance)	N/A
Associated Documents:	Guidance for Staff on the Implementation of the Deprivation of Liberty Safeguards

Did you print this yourself?

Please be advised the Trust discourages retention of hard copies of procedural documents and can only guarantee that the procedural document on the Trust website is the most up to date version.

**Version Control Table**

<b>Version number and issue number</b>	<b>Date</b>	<b>Author</b>	<b>Reason for Change</b>	<b>Description of Changes Made</b>
V1 2009172 (Pathway/Guidance for the Management of Challenging Behaviours)	August 2009	[REDACTED]		
V2 2001120 (Assessment and Management of Confused Patients Who May Walk Around)	March 2011	[REDACTED]		
V1.0 2013164	January 2013	[REDACTED]	New document	Following documents to be archived, relevant content included within this new document: 1. Pathway/Guidance for the Management of Challenging Behaviours 2. Assessment and Management of Confused Patients Who May Walk Around 3. Guidelines for the Use and Implementation of Enhanced Observations
V1.1 2014034	February 2014	[REDACTED]	Update	Screening Patient Need for Enhanced Observation and Cohen-Mansfield Agitation Inventory removed; Risk Assessment and Poster added to appendices.
V1.2 2015074 (Patient Documentation & Policy Ratification Group – Chair’s Approval)	April 2015	[REDACTED] Beverly Mills	Update	Minor changes to Sections 5.1.2, 5.1.4, 5.3 and appendices
V1.3 Patient Documentation & Policy Ratification Group – Chairs Approval	July 2019	Sue Allen	Update	Minor changes in terminology from special observations to enhanced observations. Equality & Human Rights Analysis Risk Assessment added.
V2 Revision of language and requirement to update the escalation process.	May 2023	[REDACTED]	Update of escalation process	Amended Appendix A and D, minor amendments to text.

## Consultation Table

This document has been developed in consultation with the groups and/or individuals in this table:

Name of Individual or group	Title	Date
Director of Nursing/ Deputy Director of Nursing	[REDACTED]	Dec 2012
Assistant Directors of Nursing	[REDACTED] [REDACTED] [REDACTED]	Dec 2012
Heads of Nursing	All Clinical units	Dec 2012
Trust Nursing & Midwifery Committee		Dec 2102
Angela De La Motte	Safeguarding Lead	Dec 2012
[REDACTED]	Assistant Director of Nursing for Professional practice and standards	Dec 2012
Director of Nursing/ Deputy Director of Nursing	Vikki Carruth [REDACTED]	June 2019
Assistant Directors of Nursing	[REDACTED] Tina Lloyd Sue Allen [REDACTED] [REDACTED]	June 2019
Acting Safe Guarding Lead	[REDACTED]	June 2019
Heads of Nursing	All Divisions	June 2019
Professional Advisory Group		July 2019
Policy Ratification Group		August 2019
Penny Wright	HR Assistant Director: Workforce Systems, Planning & Insight	May 2023
Vikki Carruth	Chief Nurse	May 2023
Divisional Assistant Directors of Nursing		May 2023

## Table of Contents

1. Introduction.....	5
2. Purpose .....	5
2.1. Rationale .....	5
2.2. Principles .....	5
2.3. Scope.....	5
3. Definitions .....	6
4. Accountabilities and Responsibilities.....	6
4.1 Chief Nurse/Deputy Chief Nurse.....	6
4.1. Assistant Directors of Nursing .....	7
4.2. Heads of Nursing .....	7
4.3. Ward Matrons.....	7
4.4. Team Members.....	7
5. Procedures and Actions to Follow .....	7
5.1. Levels of Observation .....	7
5.1.1. Level 1 – General Observation.....	7
5.1.2. Level 2 – Intermittent Observation .....	7
5.1.3. Level 3 – Continuous Observation (Within Eyesight) .....	8
5.1.4. Level 4 – Continuous Observation (Within Arm’s Length) .....	9
5.2. Principles of Enhanced Observation.....	9
5.3. Core Principles .....	10
5.4. Delegation to Non-Registered Staff.....	11
5.5. Review and Alteration of Observation Status.....	11
5.6. Record Keeping .....	12
7. Equality and Human Rights Statement.....	12
8. Training .....	12
9. Monitoring Compliance with the Document.....	13
10. References .....	15
Appendix A: Enhanced Observation Risk Assessment .....	16
Appendix B: Observation Record Sheet .....	19
Appendix C: Enhanced Observation Competency Form .....	22
Appendix D: Standard of Care- Enhanced Observations.....	23
Appendix E: Essential Care Rounds.....	25
Appendix F: A Guide to Implementing Enhanced Observations .....	26
Appendix G: Process for Requesting Additional Shifts .....	27
Appendix H: EHRA.....	30

## 1. Introduction

Enhanced observations should be seen as an integral part of a therapeutic care plan/pathway. Patients who are on enhanced observations may feel restricted and will need the practice of observation to be carried out with sensitivity and regard for dignity.

## 2. Purpose

### 2.1. Rationale

The purpose of enhanced observation is to ensure the safe and sensitive monitoring of the patient's behaviours/activities and mental well-being, enabling a rapid response to significant change, whilst at the same time fostering therapeutic relationships between staff and patient through active interventions and interactions.

### 2.2. Principles

The aim of this policy is to:

Provide staff with an understanding of safer and more effective patient observation in order that they will provide a consistent and safer approach to patient observation within the broader care and treatment plan for the patient. The policy provides a framework to be used along with clinical judgement for heightened levels of observation (known as Enhanced Observation) when patients are assessed as being at serious risk of harm to themselves or others.

Every effort must be made to ensure patients can understand why the enhanced observation is being carried out, what it consists of and when it is changed or stopped. Written information must be made available to patients and families to accompany verbal information. Family members may be able to be involved with enhanced observations in some situations and open visiting should be considered.

**Patient safety is a core feature of observation. However, it is recognised risk can never be eliminated entirely. This must be communicated to the patient and families where possible, and the likely risks explained. Where needed and after other interventions have been evaluated; [ESHT Deprivation of Liberties Guideline](#) may need to be followed based on the outcome of a Mental Capacity assessment.**

### 2.3. Scope

Patient with these activities or behaviours may require enhanced observations (list not exhaustive):

- Suicide attempts, self-harm, or attacks on others
- Acting on hallucinations, particularly voices suggesting harm to self or others
- Acting on paranoid ideas where the patient believes that other people pose a threat
- Acting on thoughts or ideas that the patient has about harming themselves or others
- Marked changes in behaviour
- A range of disoriented behaviours or activities that suggest poor self or environmental awareness or safety awareness.

Known risk indicators:

- Vulnerable adult attempting to leave/abscond/self-harm
- History of suicide attempts
- Some patients assessed for Deprivation of Liberties (Use of Consent Form 4 and Screening tool)
- Potential /actual aggression - verbal or non-verbal to others (patients or staff)
- Disorientation, ambulant and wanting to leave
- Sectioned under Mental Health Act
- Severe cognitive impairment or disorders of the mind
- Learning Disabilities
- Repeated serious risk of falling. Prevention and Management of Patient, Slips, Trips and Falls. ([http://www.esht.nhs.uk/wp-content/uploads/2018/08/01285\\_P.pdf](http://www.esht.nhs.uk/wp-content/uploads/2018/08/01285_P.pdf))
- Serious risk of falling
- Actual falls sustaining injury
- Continued low or lack of safety awareness in self and/or environment
- Past or current problems with drugs or alcohol (see policy for use of covert medication)

Exception to this policy: critical physical acuity / medical instability or unpredictability

These patients may require one to one support to maintain a safe environment and may be additionally supported by the ITU Outreach team, and / or specific policies Tracheostomy Policy ([http://www.esht.nhs.uk/wp-content/uploads/2018/08/01045\\_P.pdf](http://www.esht.nhs.uk/wp-content/uploads/2018/08/01045_P.pdf)). This will be supported in liaison with the medical team and is not covered in this policy. Refer to [NICE Guideline 50: Acutely Ill Patients in Hospital](#).

### 3. Definitions

#### **First level nurse**

First level nurse refers to trained nurse who could be Ward Matron, Ward Sisters or Staff Nurse in charge.

#### **IPD**

IPD is the term use to cover Integrated Patient Documentation

#### **Patient**

Patient refers to any person who is in receipt of care.

#### **Team Member**

Team member can refer to Registered Nurse, Registered Nursing Associate, Health Care Assistant, Student Nurse, Doctor or Allied Healthcare Professional.

### 4. Accountabilities and Responsibilities

The first level Registered Nurse remains accountable for the decision to initiate enhanced observation.

#### **4.1 Chief Nurse/Deputy Chief Nurse**

Ensures that the standards set out in the policy are developed and shared with relevant staff. Delegates day to day responsibilities to Assistant Directors and Heads of Nursing.

#### **4.1. Assistant Directors of Nursing**

Ensures that the policy is implemented and reviews any audits supporting Heads of Nursing with implementation and developing action plans when required. Adheres to escalation additional shift request process (Appendix G).

#### **4.2. Heads of Nursing**

Working with Ward Matrons to ensure implementation of the policy in their areas. To undertake audits to support implementation and ensuring that the standards set out in the policy are being adhered to. Adheres to escalation additional shift request process.

#### **4.3. Ward Matrons**

Ensures that the policy standards are maintained in their clinical areas. Devises action plans to address any gaps and poor practice. Gives feedback at Speciality and Governance Meetings.

#### **4.4. Team Members**

The team member responsible for carrying out enhanced observations must assure themselves at every observation interval that the patient is present and is as safe as possible and that all identified risks are minimised. Staff delivering other interventions to a patient having enhanced observation must be aware of the level of observation and act accordingly. All staff must comply with informed consent and where applicable, with Mental Capacity Act and other related Trust policies.

### **5. Procedures and Actions to Follow**

#### **5.1. Levels of Observation**

For all levels of observation included in this policy a specific enhanced observation care plan is required within the Integrated Patient Care Document or relevant record of care even where an integrated care pathway document is in use.

Where it is deemed appropriate, patients and with their consent, families, must be included in decision making. For those patients who lack capacity in specific situations, the principles of the Mental Capacity Act (2005) must be followed:

##### **5.1.1. Level 1 – General Observation**

General observation is the minimum acceptable level of observation for all in-patients. The location of all patients should be known to staff, but not all patients need to be kept within sight.

On a regular basis (in line with [Essential Care Rounds guidance](#)), the patient's allocated nurse will communicate directly with the patient and an entry of the outcome of any assessment or conversation will be made in the patient's care records. At the beginning and end of every nursing shift the whereabouts of a patient is handed over, and the conditions of observation: i.e. frequency.

##### **5.1.2. Level 2 – Intermittent Observation**

This level of observation is when the allocated nursing team member checks, for themselves, on the whereabouts of the patient at specified intervals between 15 and 60 minutes

This level of observation is appropriate when patients are potentially, but not immediately, at risk as set out above (section 2.1). This may be because assessment is still in process.

Observation must be carried out even when the patient is resting or asleep.

Checks need to be carried out sensitively in order to cause as little intrusion as possible such as when the patient is resting or sleeping. At other times the observation checking should provide an opportunity to engage with the patients and assess any changes.

Patients having intermittent observation must have a specific care plan that clearly indicates:

- The nature of the therapeutic engagement to be offered
- The need for a cognition/mood and/or mental state assessment on each shift.
- A record of any reported untoward incidents.
- The intervals at which the observations should be carried out,

15 minutes – If the observations are required more frequently than this the level of observation should be increased to level 3 within eyesight observations.

60 minutes - If the observations are required less frequently then this the level of observation should be decreased to level one general observation.

A summary of the patient's behaviour/activities and mental state must be entered in the patients care records at the time of assessment or evaluation and if necessary at the end of each shift and any other staff contributing to aspects of care and treatment should also contribute to the care record before it is handed over to staff on the new shift.

### **5.1.3. Level 3 – Continuous Observation (Within Eyesight)**

Continuous (within eyesight) observation is when the allocated team member keeps the patient within eyesight and accessible at all times, day and night. This level of observation is required when the patient could attempt suicide or attempt to seriously harm themselves or others. A specific continuous observation record sheet (see [Appendix B](#)) MUST be used alongside the compliance with the required standards (see [Appendix D](#))

At this level it is necessary to decide if the patient does or does not require observation whilst using the toilet or taking a shower/bath.

At this level, it may be necessary to search the patient and their belongings to remove any objects such as tools or instruments which could be used to harm, whilst having due regard for the patient's privacy and legal rights. Any search must be discussed with the patient in advance, witnessed and recorded accurately.

In addition to the recordings made on the observation Record sheet (see [Appendix B](#)), a regular summary of the patient's condition, care and treatment must be entered in the patients care record. This must include changes in mental state, physical, psychological and social behaviours, pertinent developments and significant events. Contemporaneous recording is recommended (i.e. as close to the event as possible).

Patients and with their consent, families, must be included in decision making.

#### **5.1.4. Level 4 – Continuous Observation (Within Arm’s Length)**

This form of observation means the patient must be kept within close (i.e. in eye sight AND within arm’s length) at all times day and night. This highest level of observation is applied when a patient is assessed to be at a high level of risk of suicide / seriously harming themselves or others, absconding and thus needs to be nursed in close proximity, with due regard to safety, privacy, dignity, gender, cultural factors and environmental dangers.

In addition to the recordings made on the Observation Record sheet (see [Appendix B](#)), a regular summary of the patient’s condition, care and treatment must be entered in the patients care record. This must include changes in mental state, physical, psychological and social behaviours, pertinent developments and significant events. Contemporaneous recording is recommended (i.e. as close to the event as possible).

On rare occasions it may be necessary for more than one nurse to carry out this level of observation at the same time.

Teams will need to make decisions about how long any one nurse spends on the observation and how many team members contribute over the course of each shift. Building trust and engagement with the patient is vital.

### **5.2. Principles of Enhanced Observation**

Designated levels of observation should only be implemented after positive engagement with the patient has failed to reduce or remove the actual behaviours/activities or where the risk level remains extremely serious/high.

The decisions about enhanced observations should be made jointly by medical and nursing staff and involve other team members as helpful for the patients care. It should be made as a result of screening or other related assessments.

All patients should have a screening of need for enhanced observation carried out using the tool in [Appendix A](#). Where there is a risk of a suicide attempt and enhanced observation is commenced, Mental Health Practitioners should always be contacted to carry out a specialist assessment. They may decide to carry out a detailed risk assessment using an evidenced based tool.

The least intrusive level of observation that is appropriate to the situation should always be adopted so that due sensitivity is given to the patient’s dignity and privacy whilst maintaining the safety of those around them.

Decisions about observation levels should be recorded by both medical and nursing entries in the care record. The reasons for introducing and using observation should be clearly specified.

Intermittent, continuous and close observations (both types) will be carried out using the principles listed below.

### 5.3. Core Principles

The staff member responsible for carrying out enhanced observation will normally:

- Be a Registered Nurse, Registered Nursing Associate or a Health Care Assistant or a final year Student Nurse who is deemed to be competent by the Registered Nurse in charge.
- The staff member should be of the gender that the patient is most comfortable with
- In extreme cases where there is evidence that the patient's behaviours/activities are a threat to other patients or staff, the short term use of security staff can be considered for the provision of supported observation with a nurse. These staff are to be supervised by a Registered Nurse
- Know the patient, their history, background and risk factors
- Be familiar with the ward, the ward policy for emergency procedures and the potential risks within the environment
- The patient's views and needs should be considered when allocating an observer for older adults with cognitive impairments. Use of the 'This is Me' document is recommended.
- The Nurse in Charge of the shift should create a roster of nurses and the times they will deliver enhanced observations.

The nurse will be familiar with the patient's social context and significant events since admission.

There must be a specific observation care plan, formulated from the agreed standard (see [Appendix D](#)) preferably with multidisciplinary input, written in conjunction with the patient and/ or family representative (with patients consent) and includes all aspects of care / environment.

The team member must use the observation period to engage the patient and build a therapeutic relationship. Simply 'sitting with', 'looking at' the patient or 'watching' is not a therapeutic intervention.

If the patient is uncommunicative, the team member must convey a willingness to be present and to listen and initiate conversation as appropriate.

The patient must be informed verbally of the reasons for observation and offered written information.

Where necessary, the patient should receive a copy of the observation care plan translated into their own language.

The team member must reflect on their own values and beliefs about observation to ensure that this intervention is supportive and therapeutic.

The multi-disciplinary team must provide an open and supportive environment, to enable members of staff to discuss their values and beliefs and experiences about enhanced observation.

Where the patient consents, patient's next of kin and/or named family member must be involved and advised of all decisions about observations. Discussions about observation must take place with family members or carers to agree their level of involvement and this must be documented.

The aim is to provide continuity for the patient, so taking breaks and changes in staff needs to be planned with consideration of the patient's condition and needs. As a guideline, a team member should not carry out enhanced observations for longer than two hours without a break.

All documentation must pay regard to the patient's dignity and should accurately record behaviours.

#### **5.4. Delegation to Non-Registered Staff**

The first level Registered Nurse or Registered Nursing Associate remains accountable for the decision to delegate enhanced observation to an appropriate team member who has the necessary knowledge, skills and preparation i.e. Staff Nurse, Health Care Assistant or Student Nurse, and for ensuring that they are sufficiently knowledgeable and competent to undertake the role. The first level Registered Nurse remains responsible for care provided by non-registered practitioners and must provide these staff with appropriate supervision and support.

Where temporary workforce or agency staff are brought in to support numbers and skill mix, the Registered Nurse must decide who is best placed to carry out enhanced observation as this may be a team member already known to the patient rather than a temporary worker. Allocation of enhanced observations to a temporary worker must not be routine. A full discussion must take place to ensure that the patient has enhanced observations provided by the most appropriate staff member.

#### **5.5. Review and Alteration of Observation Status**

The patient's observation status will normally be reviewed by a Registered Nurse and Doctor at a minimum of every 24 hours or more frequently if required. The initial review should establish if any serious mental health needs are present and the appropriate referral made.

The first level Registered Nurse can and may initiate intermittent, continuous and close observation however this decision should be made following an assessment of need and in conjunction with the Senior Nurse on duty – or the Site Manager out of hours. This will be communicated with the medical team as soon as possible.

Decisions to alter the level of observation will normally be taken jointly between the Nurse in Charge and the Medical team and may involve advice given by a member of the Mental Health Liaison Team and Psychiatrist. Out of usual working hours, the Clinical Site Manager should be made aware when enhanced observation above the general level is implemented so that adequate numbers and skill mix can be planned for future shifts.

All decisions regarding observation will be recorded. This record should include:

- The patient's cognitive/mood and/or mental state
- An assessment of the current level of risk
- The specific level of observation to be implemented
- Clear directions regarding the therapeutic input within the observation period
- Taking into account the patients' perspectives:

The patient should be provided with information about why they are under observation, the aims of observation and how long it is likely to be maintained. The aims and level of observation should, where appropriate, be communicated with the patient's approval to the nearest relative, friend or carer. Documentation should include the patient's perspective and evaluation. Although difficult, where possible, the handover from one nurse or staff member to another should involve the patient so that they are aware of what is being said about them.

Review by a full clinical team should take place if observation above a general level continues for more than 72 hours. Patients may benefit from specialist assessment by a Nurse or Therapy Specialist/Consultant Practitioner.

A risk assessment for falls must be completed and the Trust Risk Assessment for this should be completed. Locate in Bedside Booklet B

The decision to cease enhanced observation must be recorded in the patient's notes.

Where there is a risk of a suicide attempt Mental Health Practitioners should be contacted. They may decide to carry out a specialist risk assessment.

## **5.6. Record Keeping**

A detailed record of the observation must be maintained. This must include:

- (i) The name of the person responsible and the times they commenced and concluded their period of observation;
- (ii) A record of the patient's behaviour, cognitive and/or mental state at the specified intervals.

A briefing will take place at the beginning of each shift, of all staff to be involved in observing a patient, based on the patient's needs, risks and strategies to be used including the best communication and relationship building interventions. Before taking over the patient's care, each team member to be involved will have familiarised themselves with the patient's background and recent care record. There will be a detailed handover from the team member completing the period of observation to the team member who will be commencing the observation.

## **6. Escalation Process for Requesting Additional Shifts**

See Appendix G

## **7. Equality and Human Rights Statement**

The Trust is committed to the provision of a service that is fair, accessible and meets the needs of all individuals.

This document has been assessed for Equality and Human Rights infringements and it is considered that it does not affect one group less or more favourably than another based on race, ethnic origin, nationality, gender, culture, religion or belief, sexual orientation, age or disability. Special consideration is given for a level 3 and 4 observation where the practitioner is in close proximity to the patient.

## **8. Training**

The enhanced observation competency checklist should be completed for all staff undertaking enhanced patient observations (See [Appendix C](#)). There is a guide to

implementing enhanced observations (See Appendix F) it is good practice for teams to regularly update their knowledge and skill on enhanced observations. Investment in developing skills can lead to more effective enhanced observations. Frequent episodes of enhanced observation may mean further learning and development is required. Ward Matrons should be observant for evidence that learning is needed.

Teams may need to have a debrief or after action review following intensive or prolonged episodes of enhanced observation. Clinical supervision may also be useful.

## **9. Monitoring Compliance with the Document**

There are no exceptions for compliance. All areas need to comply with guidance for enhanced observations.

:

**Document Monitoring Table**

<b>Element to be Monitored</b>	<b>Lead</b>	<b>Tool for Monitoring</b>	<b>Frequency</b>	<b>Responsible Individual/Group/ Committee for review of results/report</b>	<b>Responsible individual/ group/ committee for acting on recommendations/action plan</b>	<b>Responsible individual/group/ committee for ensuring action plan/lessons learnt are Implemented</b>
Number of falls serious incidents recorded on [REDACTED]	Trust falls group	Divisional Performance Reviews	Monthly	Nursing and Trust falls group	Assistant Director of Nursing, Heads of Nursing and ward matrons	Trust Falls Steering Group
Safeguarding alerts raised	Heads of Nursing Ward Matrons	Divisional Performance Reviews	Monthly	Reports from Safeguarding lead	Monitor for trends and cluster areas and develop action plans	Safeguarding group and social services
Injuries to staff and patients	Heads of nursing ward Matrons	Divisional Performance Reviews	Monthly	Reports from ward matrons	Monitor for trends and cluster area and develop action plans	Occupational health and WPSS
Complaints from families' relatives regarding care	Ward matrons Heads of Nursing	Divisional Performance Reviews	Monthly	Professional Advisory Group and Divisions.	Assistant Director of Nursing, Heads of Nursing and Ward Matrons	Divisional Leads and Patient Experience Group
Monitoring of safeguarding alerts and serious incidents	Ward matrons Heads of Nursing	Divisional Performance Reviews	Monthly	Reports from safeguarding lead and WPSS	Assistant Director of Nursing, Heads of Nursing and Ward Matrons	Safeguarding group and WPSS

## 10. References

- Alzheimer's society.org.uk *This is Me* Royal College of Nursing February 2010
- Department of Health 2007 *Deprivation of Liberty Safeguards and Mental Capacity Act 2005*
- Department of Health 2012 *Liberating the NHS no decision about me without me* Kings Fund.org.uk
- Dewing J (2012) Special Observation and Older Persons with Dementia/Delirium: A Literature Review and Implications for Practice. *International Journal of Older People Nursing*.
- Mencap the voice of learning disability 2011 *Shaping Our Future: Mencap's strategy*
- Nursing and Midwifery Council 2008: *The Code Standards of Conduct, Performance* NMC UK
- Bar Ilan University, Ramat Gan, Israel. jr827@columbia.edu
- Sandwell Mental Health and Social Care 2010: *Clinical Observations Policy* NHS Foundation Trust
- Sussex Partnership 2010 *Inpatient Risk Assessment* NHS Foundation Trust

## Appendix A: Enhanced Observation Risk Assessment

East Sussex Healthcare  
NHS Trust

### ENHANCED OBSERVATION RISK ASSESSMENT

This risk assessment should be completed in conjunction with the information, knowledge and understanding of the Policy for the Introduction and Use of Enhanced Observations with Adult Patients and using the screening checklist and known risk factors.

#### TASK

To determine the appropriate level of observations required to provide safe care for every patient.

#### HAZARD

Potential for an individual patient to harm themselves, others or the environment.

#### WHO MIGHT BE HARMED

Patient, others, the environment. See screening Check list and Known Risks

#### EXISTING CONTROL MEASURES

All in-patients receive Level 1 General Observation  
Patient Medical Record  
Information provided by the patient and/or their relatives, friends and carers  
Integrated Patient Document (IPD)  
Essential Care Rounds  
Mental Capacity Act, guidance and assessment  
Deprivation of Liberties, guidance and assessment  
Falls risk assessment  
Policy for the Introduction and Use of Enhanced Observations with Adult

#### LEVELS OF OBSERVATION

##### LOW = Level 1

General observation and Essential Care Rounds

##### MEDIUM = Level 2

Intermittent Observation (*Observation to be carried out every 15 – 60 minutes*)

##### HIGH = Level 3

Continuous Observation within eyesight (*The patient is within eyesight at all times*)

##### EXTREME = Level 4

Continuous observation within arm's length (*The patient is within eyesight and at arms length at all times*).

#### RISK RATING

LOW = 0-3 MEDIUM = 4-7 HIGH = 8-11 EXTREME 12-16

Likelihood →→→	Unlikely 1	Possible 2	Likely 3	Almost certain 4
Severity ↓↓↓				
Extreme (Catastrophic) → 4	Low level 1	Medium level 2	Extreme level 4	Extreme level 4
High (Major) → 3	Low level 1	Medium level 2	High level 3	Extreme level 4
Medium (Moderate) → 2	Low level 1	Low level 1	Medium level 2	High level 3
Low (Minor) → 1	Low level 1	Low level 1	Low level 1	Low level 1

NOTE: This matrix follows the NPSA Risk Matrix but negligible and rare have not been used as they are not relevant in this assessment.

**SCREENING CHECK LIST AND KNOWN RISK FACTORS** (not exhaustive)

Tick all that apply and use the risk rating scores above to determine level of enhanced observation required. Risk ratings must always be used with professional and clinical judgement.

<b>RISK FACTOR</b>	<b>Severity/ Likelihood</b>	<b>Level</b>
<b>e.g. repeated risk of falling</b>	<b>e.g. 3 x 4 = 12</b>	<b>e.g. Extreme = Level 4</b>
Vulnerable adult trying to leave (consider Deprivation of liberties)		
Self harm		
History of suicide attempts, verbalising or acting so as to suggest suicide attempts or ideology		
Acting on hallucinations, particularly voices suggesting harm to self or others		
Acting on paranoid ideas where patient believes that other people pose a threat		
Acting on thoughts or ideas that the patient has about harming themselves or others		
Marked changes in behaviour that appear bizarre		
A range of disoriented behaviours or activities that suggest poor self or environmental awareness or safety awareness		
Show a potential for physical aggression		
History of previous actual physical aggression		
History of verbal or non verbal aggression to others (patients or staff)		
Disorientation, ambulant and wanting to leave (consider Deprivation of Liberties)		
Risk of falling		
Actual falls sustaining injury		
Past or current problems with substances and/or alcohol		
Poor adherence or non-compliance to medication programmes or behaviour management		
Deprivation of Liberties restriction apply		
Severe cognitive impairment with temporary or permanent lack of capacity		
A patient with Learning Disabilities		
Sectioned under the Mental Health Act		
Medication known to have potential side effects resulting in patient temporarily not being in control of own physical or mental faculties, (i.e. anaesthesia , sedation)		
Medical condition known to result in patient potentially at risk of exhibiting abnormal behaviours which may put the patient at risk of harm i.e. uraemic syndrome (toxic), or brain injury		
Medical condition that is poorly controlled putting the patient at risk (i.e. diabetes)		
Mental Health issues poorly controlled (i.e. severe depression, clinical depression, under section)		
Other ( <i>please specify</i> )		
Other ( <i>please specify</i> )		
Other ( <i>please specify</i> )		

**DATE & TIME of 1<sup>st</sup> Assessment**    Date .... /.../.....    Time .....

**MANAGER RESPONSIBLE**

Print Name.....

Signature.....

**RISK ASSESSOR**

Print Name.....

Signature.....

**ACTION PLAN**

.....  
.....

**REVIEW DATE & TIME** *the level of observation will be reviewed every 24 hours based on the nursing and medical needs of the patient.*

Date .... /.../.....    Time.....  
Name & Signature.....

Date .... /.../.....    Time.....  
Name & Signature.....

Date .... /.../.....    Time.....  
Name & Signature.....

Date .... /.../.....    Time.....  
Name & Signature.....

Date .... /.../.....    Time.....  
Name & Signature.....

Date .... /.../.....    Time.....  
Name & Signature.....

Date .... /.../.....    Time.....  
Name & Signature.....

Date .... /.../.....    Time.....  
Name & Signature.....

Date .... /.../.....    Time.....  
Name & Signature.....

**Name of Patient:**  
**NHS Number**  
**Ward/Location:**  
**Name and Job title of practitioner**  
**Carrying out screening:**  
**Date and Time**

**Appendix B: Observation Record Sheet**

Transfer overall findings to patient's records and initiate or update a care plan and record any communications about need for Enhanced Observation.

**Monitoring Enhanced Patient Observation**

Date .....

Patient Name .....

Ward .....

Time		Level of observation	Behaviours observed	Interventions	Name and Signature
07	00				
	15				
	30				
	45				
08	00				
	15				
	30				
	45				
09	00				
	15				
	30				
	45				
10	00				
	15				
	30				
	45				
11	00				
	15				
	30				
	45				
12	00				
	15				
	30				
	45				
13	00				

Doc ID#1170 - Policy for the Introduction and Use of Enhanced Observations with Adult Patients

	15				
	30				
	45				
14	00				
	15				
	30				
	45				
15	00				
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16	00				
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21	00				
	15				
	30				
	45				
22	00				

Doc ID#1170 - Policy for the Introduction and Use of Enhanced Observations with Adult Patients

	15				
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23	00				
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24	00				
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01	00				
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04	00				
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	30				
	45				
05	00				
	15				
	30				
	45				
06	00				
	15				
	30				
	45				

Please ensure that these forms are kept in the patients' record

## Appendix C: Enhanced Observation Competency Form

### Enhanced Observation Competency Form

Staff must demonstrate competence in the Enhanced Observation intervention, then read, sign and date this form as evidence of their understanding before undertaking observation duties.

1. I have read and understood the Enhanced Observation Policy and appendices.
2. I understand my responsibilities regarding therapeutic interventions, risk management record keeping and related policies.
3. I understand the risk factors and the rationale for enhanced observation
4. I understand the different level of observations can that be applied
5. I understand why I am signing the observation record sheet for patients on enhanced observations (i.e. I am signing to say that I have seen the patient and that the patient is alive, breathing and responsive to simple commands or questions.
6. I understand the need to be aware of the contents of the patients care plan and risk management plan, and the need to receive a formal handover from the nurse in charge and be introduced to the patient.
7. I am aware of the importance of therapeutic engagement with the patient, and must attempt to engage with the patient at all times.
8. I understand observation includes looking for changes in presentation and behaviour, and reporting/recording any such changes to the Nurse in Charge.
9. I understand I am accountable for my practice, for the accuracy of my record keeping and that it is my responsibility to ensure compliance with the Enhanced Observation Policy

Name of Staff Member \_\_\_\_\_  
Job Title \_\_\_\_\_

Signature \_\_\_\_\_

Name of Peer \_\_\_\_\_  
Job Title \_\_\_\_\_

Signature \_\_\_\_\_

Date of both signatures \_\_\_\_\_

Please retain signed copies on the ward for inspection

## Appendix D: Standard of Care- Enhanced Observations

### Standard of Care: Enhanced Observations

- The decision to carry out enhanced observation will generally be made jointly by nursing and medical team members. In cases of high risk, however, and out of usual working hours the nurse in charge (or another senior clinical leader) may decide to commence a patient on a level of enhanced observation awaiting consultation with medical staff.
- A mental health referral must be made for all patients who require a risk assessment as per Appendix A. Patients with a high level of mental health needs must have an urgent referral.
- The reason for commencing a patient with enhanced observation may include serious risk of self-harm, high risk of absconding, extreme distress due to cognitive impairment, risk of serious falls and/or extreme physical aggression/violence.
- The decision to implement enhanced observations should be documented in the patient's record. The individual observation form should also be completed for each day enhanced observations are required.
- Every effort will be made to explain the policy to the patient and reasons why it is considered necessary to be carrying out enhanced observations.
- Depending on the level of enhanced observation commenced, a safety check may be made of the patient's room/bed area and associated day areas for any potential hazards e.g. ligature points and any potentially hazardous objects removed. It may be considered necessary to search the patient's room and property for concealed items.
- Nursing team members carrying out within arm's length enhanced observation will remain with the patient at all times. Observations of the patient in the toilet and during personal hygiene will be carried out, where possible, by a nurse of the same gender as the patient. At times this may need careful planning to ensure that a male nurse assists a male client and a female nurse assists a female client. Nurses involved in enhanced or close observation will do their utmost to respect the dignity of the patient.
- Nursing team members will be expected to carry out a period of enhanced observation of no more than two hours.
- During the period of enhanced observation the nurse team member concerned will keep an updated record of the enhanced observation including all assessments, planning and evaluation and the patient's perception.
- Carers and relatives may need an explanation of the need for the level of observation and support. In exceptional cases, with full discussion with the nursing and medical team, there may be a decision to leave the patient in the care of family and carers ensuring that the carer or relative understands the need for continuous contact with the patient. The decision to leave the patient in a relative's care will be recorded in the notes and the period of time that these arrangements are in place shown in the observation record.

- The level of observation will be reviewed every 24 hours by the nursing and medical team based on the patient's condition and needs. Decisions to discontinue observations should be mutually agreed and all reviews and changes to enhanced observation levels to be documented in the patient's records.
- If enhanced observation continues for more than two days, there should be a full care plan review as soon as possible involving senior members of the multidisciplinary team and other specialist practitioners as appropriate.
- The nurse in charge will allocate appropriately informed and supported members of the team to carry out enhanced observations.
- If the nurse in charge considers the nursing resources to be insufficient to an agreed level of observation, the relevant service manager/ Head of Nursing or on-call manager should be consulted. If concerns arise with regard to professional practice, the Head of Nursing/Midwifery should be informed.
- All staff involved in enhanced observations should ensure they have a full handover about the patient and be aware of this policy on observation. All staff should familiarise themselves with current care plans and know the reasons for the chosen level of observation. Staff carrying out enhanced observations should be aware that a patient does not need to be detained under a Section of the Mental Health Act 1983 to be placed on enhanced observation, but should understand the procedures to be followed in order that a patient can be lawfully detained and restrained in an extreme situation e.g. implementation of Deprivation of Liberty
- Consideration of the patient's mental capacity to maintain the safety of themselves and others should be taken as specified under the Mental Capacity Act.

## Appendix E: Essential Care Rounds

### ESSENTIAL CARE ROUNDS

#### **Essential Care Rounds occur with all patients.**

Written and verbal information needs to be offered on admission or as close to admission as possible. Explain process to patients and families.

Use key words such as **'our goal is to provide better than expected care'** or **'to ensure our RNs are more visible than you expect'** (each team to decide what it wants)

**Method:** The hourly rounds are co-ordinated by RNs. Personalised care by allocated RN must be maintained.

Patients are designated as needing 1 (high dependency) or 2 hourly essential care rounds (less dependent).

Nurses carry out hourly rounds on odd hours during their shift along with other team members as needed; HCAs and support staff carry out rounds on even hours.

#### **Essential Care Round Prompts:**

Begin by saying Who you are (i.e. Introduce yourself) and explain why you are there and what the care round is for:

Then cover these areas of essential care needs:

- Pain Assessment (Ask: Do you have any pain?)
- Contenance management (Ask: Do you need to use the toilet\*? (\*amend according to continence needs)
- Position and comfort (Ask: Are you comfortable? Do you want your position changed?)
- Nutrition (Ask: Are you hungry? Can I get you something to eat? Do you need a drink?)
- Check patient has access to their call bell (Ask: Can you reach your call bell to contact the Nurse?)
- Emotion and mood (Ask: How are you feeling? Do you need any information?)
- Carry out an environmental scan
  - Are there any fall hazards?
    - Check bed height/rails and clutter by the bedside/chairside
  - Ensure items are within reach: water, tissue, urinal, bedside table & call light within reach
  - Comfort: temperature of room, blankets, pillows noise and light
- Ask **"Is there anything else I can do for you whilst I am here."**
- Remind the patient that a nursing team member (**let them know who**) will be back in about an hour/ 2 hours to carry out further care with them again.

Document the care you offered on the Essential Care Round form by either A (Achieved) or E (Exception). Where there is an exception you must document more fully what this is and/or update the care plan as needed immediately. You can also record the patient's evaluation of the essential care round.

Please note:

You only carry out essential care rounds for patients you are allocated to.

You will need to adapt the method and questions according to patient's abilities (language, cognition etc).

Patients have a right to ring or ask for help in between rounds – do not ask them to wait.

ECR JD / BLOM Feb 2012

**Appendix F: A Guide to Implementing Enhanced Observations**

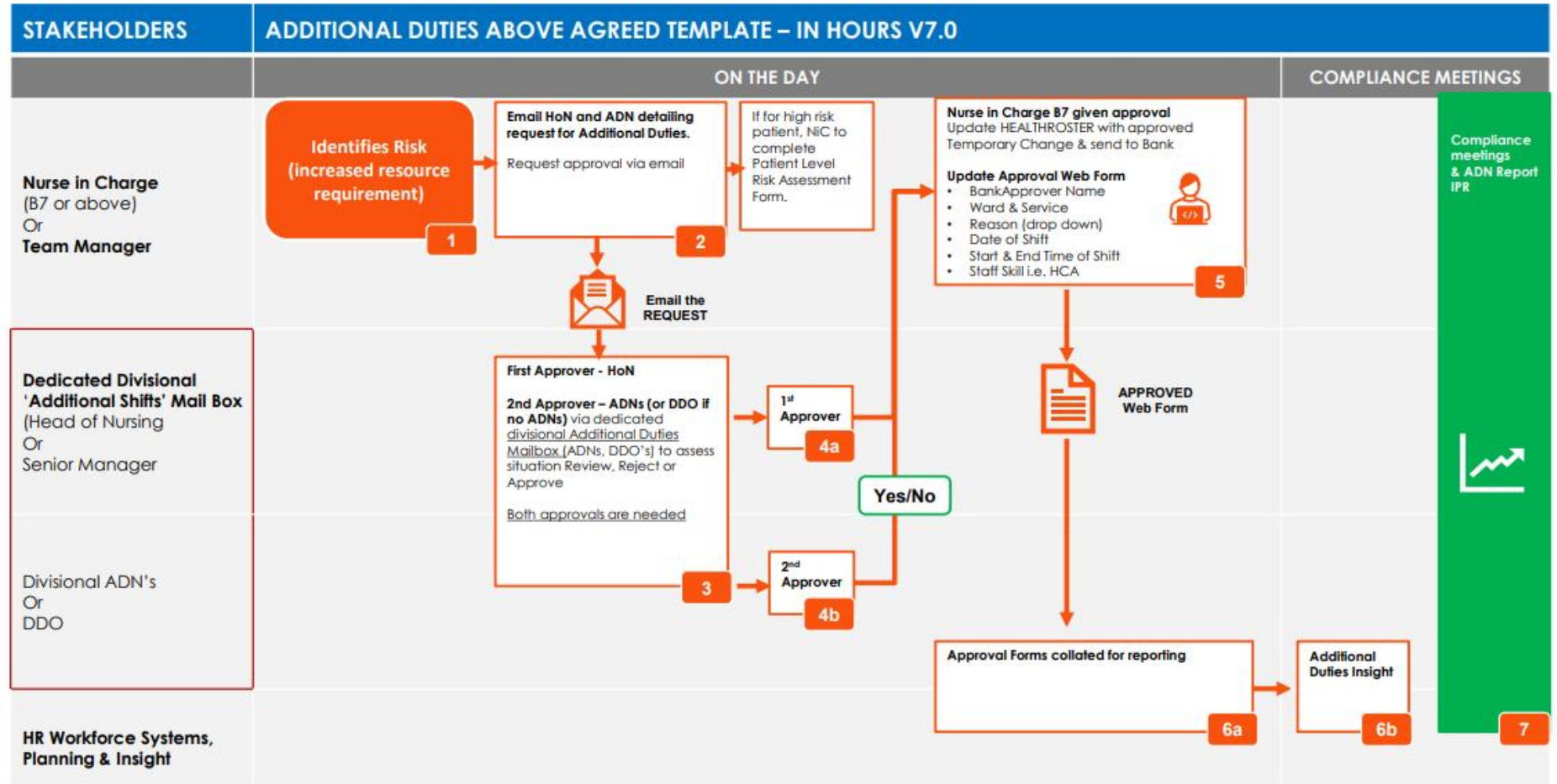
**A GUIDE TO IMPLEMENTING ENHANCED OBSERVATIONS**



APPENDIX G: Process for Requesting Additional Shifts

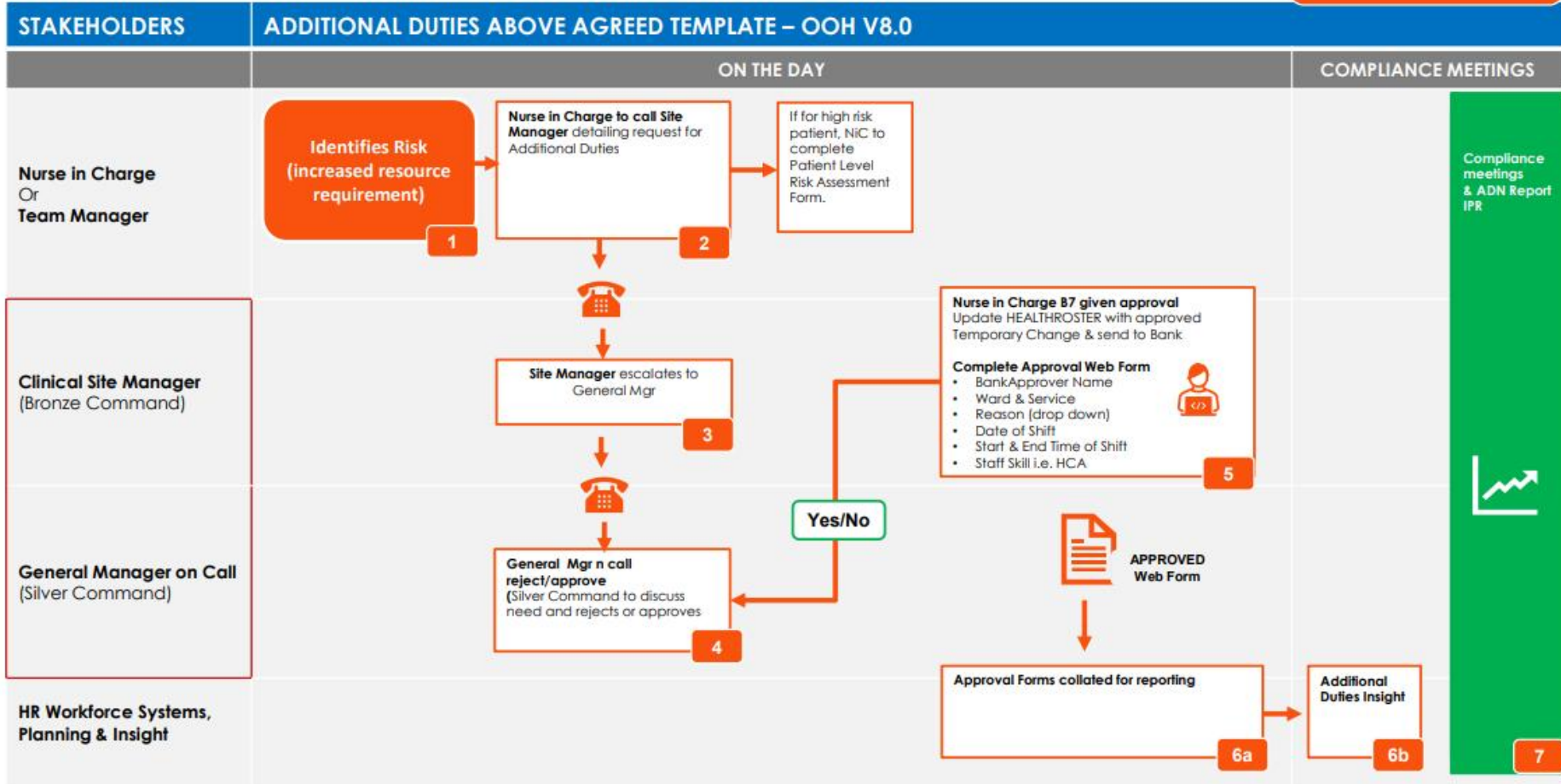
\*\*\* Weekend planning 'Enhanced Observations' to be submitted on Friday \*\*\*

IN HOURS



\*\*\* Weekend planning 'Enhanced Observations' to be submitted on Friday \*\*\*

IN HOURS



## **Additional Duties Above Agree Template (in hours) v1.0**

### **When should I request Additional Duties.....**

- Can you utilise your existing resources to cover your area?
- Have you checked whether you can gain support from other areas?

### **When should I request additional duties?**

- Higher acuity (patients are more unwell than planned as part of the agreed establishment)
- Increase in attention needed such as mental health challenges
- Increase in activity i.e. beds, wards, chairs etc
- Change in skill i.e. not an RN but need an HCA

### **When NOT to Use Additional Duties.....**

- Do not use AD for sickness as this shift will already be vacancy when you report an existing member of staff as sick
- Do not use AD for vacancy as this shift will already be vacant
- Do not use AD for annual leave as this shift will already be vacant
- Do not use AD for study leave as this shift will already be vacant
- Do not exceed your agreed template without formal approval

## Appendix H: EHRA

<b>Title of document: Policy for Introduction &amp; Use of Enhanced Observations with Adult Patients.</b>
<b>Who will be affected by this work? Staff, Patients and Visitors</b>
<b>Please include a brief summary of intended outcome: To ensure the safe and appropriate observations and outcomes for vulnerable patients, other service users and staff.</b>

		Yes/No	Comments, Evidence & Link to main content
1.	<b>Does the work affect one group less or more favourably than another on the basis of:</b> (Ensure you comment on any affected characteristic and link to main policy with page/paragraph number)		
	• Age	N	
	• Disability (including carers)	N	
	• Race	N	
	• Religion & Belief	N	
	• Gender	N	
	• Sexual Orientation (LGBT)	N	
	• Pregnancy & Maternity	N	
	• Marriage & Civil Partnership	N	
	• Gender Reassignment	N	
	• Other Identified Groups	NA	
2.	<b>Is there any evidence that some groups are affected differently and what is/are the evidence source(s)?</b>	Yes	See 2.3 page 5 &6
3.	<b>What are the impacts and alternatives of implementing / not implementing the work / policy?</b>		Potential for harm to patient, staff or others if not implemented.
4.	<b>Please evidence how this work / policy seeks to “eliminate unlawful discrimination, harassment and victimisation” as per the Equality Act 2010?</b>		Policies applies to all vulnerable and at risk groups. Gender is considered when determining the person carrying out the observations.
5.	<b>Please evidence how this work / policy seeks to “advance equality of opportunity between people sharing a protected characteristic and those who do not” as per the Equality Act 2010?</b>		Policy applies to all vulnerable and at risk groups irrespective of protected characteristics
6.	<b>Please evidence how this work / policy will “Foster good relations between people sharing a protected characteristic and those who do not” as per the Equality Act 2010?</b>		Policy applies to all vulnerable and at risk groups with or without protected characteristics. The policy recognises the possible preferences for some groups eg gender of person carrying out enhanced observations.
7.	<b>Has the policy/guidance been assessed in terms of Human Rights to ensure</b>	Yes	

	<b>service users, carers and staff are treated in line with the FREDA principles (fairness, respect, equality, dignity and autonomy)</b>	
<b>8.</b>	<b>Please evidence how have you engaged stakeholders with an interest in protected characteristics in gathering evidence or testing the evidence available?</b>	NA
<b>9.</b>	<b>Have you have identified any negative impacts or inequalities on any protected characteristic and others? (Please attach evidence and plan of action ensure this negative impact / inequality is being monitored and addressed).</b>	Privacy and dignity may be compromised during enhanced level observation but safety would override these considerations.