**Introduction**

Within the NHSGGC Acute Division, it is recognised that our patients can experience high levels of stress & distress. This can result in patients behaving in ways that staff may find challenging to manage and that can have a negative impact on the therapeutic relationship. One way that staff can promote the therapeutic relationship and keep the patient safe is by working with them on a 1 to 1 basis using Safe & Supportive Enhanced Observations and Engagement (SSEOE).

The aim of this note is to inform staff of their key responsibilities when using SSEOE.

**What are the different levels of SSEOE?**

There are 2 main types of Enhanced Observations that can be used:

1. Constant Observations: This level is used when the patients’ **exact** whereabouts need to be known **at all times.** An allocated nurse **must** be constantly aware of the patient’s whereabouts. This means that the nurse must be able to see **and** hear the patient at all times.   
   **NB:** sound only observations may be appropriate in some instances. These instances must be clearly reviewed and documented by the MDT including senior medical staff.
2. Special Observations: This level of observation is used where there is a need for staff to be **within one arm’s length of the patient and within sight & sound at all times.**

It is recognised that SSEOE goes beyond the level of General Observations which are applied to all patients on admission. Therefore, the decision to use any enhanced level of observations **must** be based on the risk of the behaviour manifesting itself as well as the risk this poses to the patient, the staff and others in the immediate environment.

**Behaviours associated with the need for SSEOE**

The following are examples of behaviours and conditions associated with the potential need for SSEOE in the Acute Division of NHSGGC:

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| --- | --- |
| * Violence & Aggression * Absconding * Self harm * Dementia * Delirium * Mental Illness | * Learning Disabilities * Brain Injuries * Intoxication * Falls risks * Increased & enduring confused/ agitated state |

**Essential Principles of SSEOE**

All patients being cared for through the use of SSEOE must:

* Be kept safe and protected from physical & psychological harm
* Have their dignity respected and be treated as individuals
* Receive care in the least restrictive environment possible.
* Where appropriate, have their patient/carer/named person/next of kin informed.
* Be involved as much as is possible and appropriate in therapeutic activities taking place within the area or as part of their care plan
* Receive a multi-disciplinary approach to care

**Legal Considerations**

Whilst SSEOE are designed to be as therapeutic as possible, it also acts as a restrictive intervention. The use of SSEOE **must** be justified & accounted for. The least restrictive option must be used. The following legislation and legal frameworks are most commonly associated with SSEOE:

1. **Common Law/Duty of Care – the principle of necessity**: It is reasonable in an emergency for any member of staff to take action to safeguard a person. However, any decision to use SSEOE through common law/duty of care must be immediately reviewed from relevant medical staff.
2. **the Human Rights Act 1998**
3. **The Adult’s with Incapacity (Scotland) Act 2000**
4. **Mental Health (Care & Treatment) (Scotland) Act 2003.**

**NB** Only RMNs or Learning Disability Nurse’s can make use of Section 299 of the Mental Health Act: ‘Nurse’s Power to Detain’ and they can only do so within mental health settings. There is no **Legal** requirement for SSEOE to be carried out by an RMN, even if the patient is detained under the Mental Health Act. Treatments warranted by sections of the act, for example, prescribed medications, can be administered by RGNs.

Staff must use the Common Law principle for SSEOE if immediate/emergency action is required and no authority from other legislation is in place.

For further information please refer to NHSGGC Restraint Policy & Associated guidelines 

**Responsibilities of Staff**

Any decision to increase or decrease the levels of SSEOE for a patient must be based on the risk factors involved.

Staff **must** complete the ‘Enhanced Observation Notification for Patients Displaying Challenging Behaviour’ document.



Considerations around the **Clinical** need for mental health nursing support must be assessed via the MDT & the Psychiatric Liaison Service. A clear rationale for this need must be documented. Please refer to the Psychiatric Liaison Service Standard OperatingProcedure 

Decisions regarding which level of SSEOE is to be used must be appropriately and accurately documented in the patient’s notes. This must include a description of the risk, the rationale for the level of observations being applied, details of caring/therapeutic interventions and a plan for review.

Senior Medical Staff and the MDT should decide which members (and in which circumstances) of the MDT can be responsible for reviewing and reducing the level or SSEOE. This must be clearly documented in the patient’s notes & care plan. This can allow for nursing staff to reduce the level of SSEOE when an enhanced level can no longer be justified.

Nursing staff are capable of increasing the levels of observations if this is required. Any decision to do so must be documented and appropriate changes be made to care plans

The Nurse in Charge should ensure that there is sufficient staff on duty to ensure needs of **all** patients are met. (The nurse in charge should contact relevant on call manager if assistance is required)

The staff undertaking SSEOE should:

* be rotated at least every 2 hours, ideally every hour
* be competent in doing so, aware of the risks present and be able to raise the alarm if required.
* record and document the patient’s progress as required.
* communicate any concerns about the patient to the wider MDT.
* use Datix to report any significant incidents or adverse events

The level of observation should be reviewed by the MDT regularly. Best practice guidelines would recommend this occurs at least once in every 24 hours.

**References**

* Adults with Incapacity (Scotland) Act 2000
* Human Rights Act 1998
* Mental Health (Care & Treatment) (Scotland) Act 2003
* The Scottish Executive Clinical Resource and Audit Group (CRAG) Engaging People: the observation of people with acute mental health problems – a good practice statement 2002
* NHSGGC Restraint Policy
* NHSGGC Mental Health Service Safe and Supportive Observation Policy and Practice Guidance
* NHSGGC Guidelines for the Observation of Patients with Acute Behavioural Disturbance in Acute Division Wards
* The Mental Welfare Commission: Right to Treat? 2011
* The Mental Welfare Commission: Advice Notes, Nurse’s power to Detain Section 299 2013