Kingston Hospital NHS Trust

Policy and Procedure
For the
Management and Secondary Prevention of Adult Patients with Self Harm
Or
With a History of Self Harm

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Contents

1. Introduction

Kingston Hospital NHS Trust has a duty to ensure that as far as possible appropriate and reasonable safeguards are in place to protect patients who are at risk from Self Harm (SH) or have a previous history of SH. These guidelines have been produced in consultation with the Liaison Psychiatry Team and other allied health professionals (Appendix 6).

The policy relates directly to adult patients with SH or who have a history of SH who are admitted to Kingston Hospital for acute hospital care or who are discharged directly from the Emergency Department (ED).

2. Objective

This policy seeks to clarify how employees and the Trust respond to patients who are admitted following self-harm or who have a history of SH for whom the Trust has responsibility. The following procedure is to assist the organisation to respond in a co-ordinated uniform manner to ensure the safety of patients under our care.

This policy forms part of Kingston Hospital Trust's commitment to create a positive culture of respect for all individuals including staff, patients, their families and carers as well as community partners. The intention is to identify, remove or minimize discriminatory practice in the areas of race, disability, gender, sexual orientation, age and 'religion, belief, faith and spirituality' as well as to promote positive practice and value the diversity of all individuals and communities.

3. Scope

This procedure extends from the patient's presentation to the ED through to discharge. The procedure will apply without exception to all staff within the Trust who are involved in providing services to patients attending the ED and to inpatients.

4. Roles and responsibilities (also see Section 9 on Admission Roles)

Key personnel who have responsibility for implementing the "*Self-Harm Procedure"* are:

- ED Staff
- Medical Staff
- Nursing Staff
- Liaison Psychiatry Team
- Duty Psychiatry
- Advanced Site Practitioners
- Duty Manager
- Local managers

The Health and Safety at Work Act 1974 (1) requires employers to provide a safe environment for employees and members of the public. Kingston NHS Trust will ensure that it provides a safe environment by having in place a procedure to deal with the management of patients admitted following self-harm or with a history of SH.

Under Common Law there are occasions when treatment can be given in the absence of consent:

- The treatment must be immediately necessary to save life.

- The treatment must be immediately necessary to prevent harm to others.
- The treatment must be immediately necessary to prevent a serious deterioration.
- Intervention must be the minimum necessary

These principles can be applied when the need to detain or constrain a SH patient arises.

5. Definitions

Self-Harm

This policy uses the definition of self-harm as "self-poisoning or self-injury, irrespective of the apparent purpose of the act". (2)

Para suicide

"An act with non-fatal outcome, in which the individual deliberately initiates a non-habitual behaviour that, without intervention from others, will cause self-harm or deliberately ingests a substance in excess of the prescribed or generally recognised therapeutic dosage, and which is aimed at realizing changes which the subject desired via the actual or expected physical consequences. (3)

It has been generally accepted that the words "deliberate" or "intentional" to pre-fix self-harm and "commit" to pre-fix suicide have a negative effect and are not acceptable to service users.(2)

It needs to be recognised that self-harm and Para-suicide is an issue that needs to be considered by the whole of the healthcare community in both primary and secondary care: It is not an issue solely for specialist mental health services.

Mental Capacity

Mental capacity is the ability of a person to make decisions for himself/herself. This means that the person is able to:

- Understand information given to him/her about particular issues;
- Retain that information long enough to be able to make a decision;
- Weigh up the information available to make a decision;
- Communicate that decision. This could be by any possible means, such as talking, writing, using sign language or even simple muscle movement such as blinking an eye or squeezing a hand

The concept of mental capacity is central to determining whether treatment and care can be given to a person who refuses it. The test requires that the person has received sufficient information about the seriousness and nature of the problems associated with the episode of self-harm in a form that he/she could be expected to understand. A person may be mentally incapable of making the decision in question because of either long-term mental disability or because of temporary factors such as unconsciousness, confusion or the effects of fatigue, shock, pain, anxiety, anger, alcohol or drugs. If a person is mentally capable of making the decision, then his or her decision must be respected; even if a refusal may risk permanent injury or death to that person.

Moderate supervision
Moderate supervision is where a patient is placed in an area that is consistently visible to nursing staff. Further details of levels of supervision see Appendix 4 and 5.

6. Consent

Staff often face difficult decisions about whether they should intervene to provide treatment and care to a person who has self-harmed and then refuses help. For any concerns around consent issues, the Trust's Consent Policy should be followed.

All staff who have contact, in the emergency situation, with people who have self-harmed should have an understanding of the principles of the Mental Capacity Act 2005, and to make decisions about when treatment and care can be given without consent. Triage nurses and emergency department medical staff should assess and document mental capacity as part of routine assessment of people who have self-harmed. Staff should endeavor to obtain relevant information from key people in order to inform that decision, and normally any treatment decisions are made in consultation with other HCP's. Mental capacity should be assumed unless there is evidence to the contrary. Staff should give full information and make all efforts necessary to ensure that someone who has self-harmed can give, and has the opportunity to give, meaningful and informed consent. If a person is assessed as being mentally incapable, staff have a responsibility, under the Mental Capacity Act (2005) (3) to act in that person's best interest. This can include giving treatment against the person's wishes. If, the patient does not have capacity, compulsory treatment can include medical and surgical treatment for the physical consequences of self-poisoning or self-injury if the self-poisoning or self-injury can be categorised as either the consequence of, or a symptom of, a patient's mental disorder. Such a diagnosis would require verification by the psychiatric liaison practitioners, and in such circumstances, security staff are able to restrain the patient if required according to the Trust's Restraint Policy, as instructed by clinical / psychiatry staff.

Consideration needs to be given as to whether the patient needs to be assessed for eligibility under the Mental Health Act (1983) for treatment of their presenting mental health needs in hospital.
When an individual is admitted to hospital under compulsion, for treatment of a mental disorder, it is commonly known as "being sectioned".
In order to be detained under the Mental Health Act three people must agree that an individual requires this intervention (there are exceptions in urgent situations). The three people would usually consist of an Approved Mental Health Professional (AMHP) or nearest relative as specified by the Act, a doctor with specialist training, and a registered medical practitioner. If possible, one of the doctors should already know the individual. The two doctors must agree that the individual has a mental disorder of a nature or degree which warrants detention in a hospital for assessment or treatment and that this is in the interests of the individual's own health, their own safety or with a view to the protection of other people. (Mental Capacity Act 2005 Deprivation of Liberty Safeguards (3) (see Deprivation of Liberty code, forms and leaflet on DATIX).

There may be rare occasions where an individual;

1) Lacks the mental capacity to consent to treatment
2) is assessed as not eligible for treatment under the Mental Health Act
3) Is in hospital but demonstrating a wish to leave

In such circumstances use of the Mental Capacity Act Deprivation of Liberty safeguards must be considered. In exceptional circumstances some people who lack the mental capacity to consent to

treatment may require carers to restrict their freedom of movement in hospital in order to provide care or treatment which, if they were not detained, would place them at risk of significant harm. It should be borne in mind that the Deprivation of Liberty Safeguards authorisations are not designed for short term admissions. For this reason they may not be appropriate for admissions around self-harm issues. Any concerns regarding the application of the Mental Capacity Act Deprivation of Liberty safeguards should be discussed with the Kingston Hospital lead for the Mental Capacity Act * or the Royal Borough of Kingston Adult Safeguarding & Mental Capacity Act Team during office hours (Tel: 020 8547 4735, email adult.safeguarding@rbk.kingston.gov.uk, fax 020 8547 6142)'.

7. Aims of procedure

Following presentation of Self Harm or with a history of Self Harm, in ED, all patients when medically fit will be assessed to ascertain the risk of further suicide attempts within the framework of a full psychiatric assessment:

- To ensure Trust staff liaise with the Liaison Psychiatry Team and that a psychiatric assessment is completed according to clinical need.
- To facilitate effective communication between the Emergency Department, admitting ward, Liaison Psychiatry Team and any significant others, specifically with regard to the assessment of risk and recommended level of supervision/ observation required.
- To provide an appropriate level of observation and support for each patient.
- To clarify roles and responsibilities within the management process

8. General Principles of Patient Admission and Risk Assessment

- Where the patient is medically fit, but showing signs of increased anxiety, the doctor in charge of the patient will be informed by nursing staff. The doctor must review the patient as soon as possible to assess the need for immediate psychiatric assessment.
- Where the patient is medically **unfit,** staff should assume that the patient is a ***moderate risk*** where ***moderate supervision*** is required until the patient is stable enough to be assessed by the Liaison Psychiatry Team / duty psychiatrist.
- Patients admitted with SH will not be permitted to leave the ward or department prior to the psychiatric assessment, unless they are accompanied by a member of staff. The nurse in charge must always be informed of the patient's whereabouts. The security team may assist with ensuring the patient remains in the department.
- All SH patients, prior to psychiatric assessment must be supervised if they go into bathrooms etc. in wards /departments. This means that doors should not be locked and there should be an awareness of the activities of the patient.
- The admitting ED nurse will ensure that he/she has recorded the patient's demographic details correctly, including a description of the patient. This is important if the patient absconds from the ward / department.
- A SH observation chart (appendix 3) will be commenced by the admitting ED / ward nurse for all SH patients, and any actions undertaken carefully documented.
- All information received about the patient must be recorded in the patient records and communicated to the multi-disciplinary team caring for the patient.

- Relatives may have information which is relevant to the patient's psychiatric wellbeing. Medical, psychiatric and nursing staff must maintain channels of communication with relatives whilst maintaining patient confidentiality.
- All SH patients deemed medically fit for discharge must be seen or discussed with Liaison Psychiatric Team or duty psychiatrist and discharged from their care prior to the patient's discharge from hospital.

9. Admission Roles

Emergency Department

The majority of patients who have attempted suicide or self-harm will present via ED. Most of these patients will be triaged by a nurse initially; patients presenting with major illness by the Dr in the Emergency Department. If the patient is medically fit enough to respond to the casualty officer's questions, the SH assessment framework (appendix 1) will form the basis of assessment of the patient. Completion and submission of the assessment needs to be made within the patient record.

If a SH or suspected SH or a patient with a relevant history of SH (e.g. overdose), the patient is to be admitted to hospital the ED nurse must inform the ASP as part of the admission process.

ED Staff or the admitting Medical team, as deemed appropriate, are required to forward details of the patient's admission to the Liaison Psychiatry Team.

Where the patient is medically unfit and no psychiatric assessment has been completed; staff should assume that the patient is a ***moderate risk*** requiring **moderate supervision** until assessed by the Liaison Psychiatry Team or duty psychiatrist, available on bleep 509

Advanced Site Practitioners (ASP)

The individual who organises the bed will need to be informed in order that an appropriate location is identified for the SH patient. They must consider the following criteria:

- All patients presenting with SH, assessed as ***moderate risk*** will require a bed within easy view of the nursing staff, this will be discussed with the ward staff.
- SH patients will ***not*** be placed in side rooms/ cubicles until the patient has been assessed by the Liaison Psychiatry Team / duty psychiatrist.
- Any SH patient or inpatient showing signs of acute anxiety, having been assessed as ***high risk*** must be placed within the Acute Assessment Unit as soon as the next bed becomes available.
- Staffing levels must be sufficient to support observation of the patient – See "level of Specialling" Risk Assessment Form, Appendix 8
- All patients who require admission due to being medically unfit must be admitted to AAU.

Ward Staff (Nursing and Medical)

It is the responsibility of the clinical team to promote the safety of the patient and others. This involves monitoring the patient's activities, promoting patient engagement in activities, communication and the maintenance of accurate records. Whilst under different levels of

supervision (appendix 2), attempts should be made to engage the patient's and relatives' co-operation and involvement in the supervision process.

During supervision and observation, medical and nursing staff will note any of the following factors as they may indicate that the patient might attempt a further self-harming act whilst an inpatient.

- Previous psychiatric history including previous suicide attempts.
- The patient does not comply with prescribed medical treatments.
- Continued signs of the patient wanting to self-harm.
- Patient demonstrates agitation and marked changes in behaviour.
- The patient is very quiet and withdrawn.
- Patient expresses a wish to self-discharge.
- Refusal of treatment and intent to leave the ward

If, following nursing and /or medical assessment the patient gives cause for concern, the nurse or doctor must contact the Liaison Psychiatry Team/duty psychiatrist for urgent patient review. If the patient is attempting or, is discovered to have left the ward area, the Duty Manager and Security staff must be called. (Refer to Missing Patient's Policy)

Once the patient is deemed to be medically fit for discharge, the patient's doctor must make the referral to the Liaison Psychiatry Team who will then go on to discharge the patient.

NB. Responsibilities in supporting the SH patient for both the ward nurse and the designated Registered Nurse (Mental health) **if indicated through the risk assessment are outlined within appendices 4 & 5.**

General Note:
In the case of a general inpatient, being treated for a medical/ surgical condition: and where the Patient shows signs of a psychiatric emergency, the nurse in charge will contact the Liaison Psychiatry Team or duty psychiatrist. (Contactable via switchboard) for advise and assessment.

Liaison Psychiatric Team/ Duty Psychiatrist

All medically admitted SH patients will be assessed by either the Liaison Psychiatry Team or the psychiatrist. This will take place at the first available opportunity when the patient is medically fit for discharge (usually within 24 hours). In the case as noted previously, where a patient shows signs of a psychiatric change/ deterioration, the Liaison Psychiatry Team will respond immediately.

- The Liaison Psychiatric Team/ Duty Psychiatrist will include the observations and findings of ward staff and the medical team caring for the patient within the assessment process. The assessment will be documented formally within the patient records, available on the "rio" system, and discussed with key nursing and medical staff. The Liaison Psychiatric Team should be able to decide the **levels of support** and supervision.
- When the patient requires HIGH or MODERATE supervision, the Liaison Psychiatry Team are available upon request to reassess the patient should their condition or suspected level of risk alter.

10. Transfer and Discharge

Patients who self-harm may be transferred within the hospital during the same episode of care depending on clinical need.

Transfer between wards within Kingston Hospital.

Where it is necessary to transfer the patient to a different ward the following procedures must be applied:

- The nurse in charge of the ward from which the patient is being transferred must inform the ASP in order to identify an appropriate placement.
- The transferring ward nurse must contact the receiving ward, relevant medical staff including the Liaison Psychiatry Team /duty psychiatrist at the earliest point after the decision has been made.
- The handover of patient details must include:
    - The level of supervision required, as per appendix 2.
    - Completed observation chart (appendix 3).
    - the psychological and emotional condition of the patient
    - Any future plans regarding the inpatient episode.

Prior to actual transfer nursing and medical notes will be updated. The transfer must be discussed with the patient to avoid causing additional distress.

Transfer to a Psychiatric Unit

It is the responsibility of the Specialist Registrar to confirm that the patient is medically fit prior to transfer to a Psychiatric Unit whether the transfer is informal or the patient has been sectioned under the Mental Health Act. This must be documented in the patient's records. All handover requirements outlined above must be adhered to. The Liaison Psychiatric Team will initiate and arrange the bed with the Duty Manager/ Bed Manager of the receiving hospital. Patients who are detained under a section of the Mental Health Act will normally be discharged to a psychiatric facility. The Duty Manager must be contacted to organise transfer of the section (Form H4) to the Mental Health facility. All original section papers must accompany the patient on transfer.

Transport

Voluntary patients requiring transfer to a psychiatric facility must travel with a 2 man crew following a telephone handover and a qualified nurse escort. Please refer to patient transfer policy.

Discharge

Patients who are deemed medically fit must be seen by the Liaison Psychiatry Team prior to discharge home.

11. Contact Numbers

Liaison Psychiatry Team &Duty Psychiatrist		Bleep 509
Advanced Site Practitioners	Bleep 504	24 hours a day
Security	Bleep 111	24 hours a day
Kingston Hospital lead for the Mental Capacity Act		Sarah Loades via Switch

12. Implementation

This policy will be disseminated to all staff who are likely to come into contact with patients who may have self-harmed, and it will be available on Datix.

13. Monitoring

Element to be monitored	Lead	Tool	Frequency	Reporting arrangements	Acting on recommendations and lead	Changes in practice and lessons shared
In line with Policy objectives in Section 2	Consultant ED	Audit tool to be devised	At least 3 yearly	ED audit meeting Safeguarding Adults Group	Consultant ED in consultation with Safeguarding Adults Group	Required changes to practice will be identified and actioned within a specified timeframe. A lead member of the team will be identified to take each change forward where appropriate. Lessons will be shared with all relevant stakeholders

14. Associated Documentation

Kingston Hospital NHS Trust 'Consent Policy'

Kingston Hospital NHS Trust "Missing Patient Guidelines"

Kingston Hospital NHS Trust 'Missing Person's Policy'

Kingston Hospital NHS Trust 'Paediatric Self Harm Policy and Guidelines'

Kingston Hospital NHS Trust 'Restraint' Policy

Kingston Hospital NHS Trust "Policy and Procedure for Patient Transfer"

15. References

1. Health and Safety at Work Act 1974

2. NICE Clinical Guideline 16 'Self Harm'

3. Mental Capacity Act 2005 Deprivation of Liberty Safeguards.

Appendix 1

PSYCHIATRIC ASSESSMENT OF SH PATIENTS

This assessment framework is to support the psychiatric assessment of patients who present at Kingston Hospital following an act of self-harm or with a history of SH. The assessment can be applied by the general clinician, if the patient is medically fit, the Liaison Psychiatry Team or the on call psychiatrist.

A. HISTORY

1. Brief history of the Self Harm event

a. What were the precipitating events?

b. What were the motives of the act?

c. What were the circumstances of the act?

d. Were any precautions taken against discovery?

e. Were there any preparatory acts?

f. How violent was the method?

g. How lethal (potentially) were the drugs or poison used?

h. Have there been symptoms of depression preceding the act?

i. Is there any sign of use or abuse of alcohol?

2. GENERAL PSYCHIATRIC and MEDICAL HISTORY

a. Have there been any previous acts of SH?

b. What was the nature of any previous psychiatric disorder, and how was it treated?

c. Is there a family history of depression or other psychiatric disorder?

d. Is there evidence of present or previous psychiatric illness?

3. SOCIAL CIRCUMSTANCES

a. Housing – does the patient live alone?

b. Does the patient have a job?

c. What is the reaction of family and friends to the SH act?

d. The quality of family relations – is there evidence or history of physical, sexual or emotional abuse?

e. Is there a social worker or a probation officer involved with the patient?

f. Are difficulties likely to worsen or improve following the act of DSH?

4. BACKGROUND

a. Is there any relevant family and personal history?

b. Is there an extended history of excessive drinking or drug abuse?

c. Is there a premorbid personality problem or disorder?

d. If the patient has a criminal record, what are the details?

B. MENTAL STATE

a. Consider whether the patient is of dejected appearance, agitated, restless or depressed?

b. Ask specifically whether the patient is depressed on waking and whether the mood lifts during the day

c. Does the patient have impaired sleep?

d. Is the patient experiencing feelings of guilt, unworthiness, or self-blame?

e. Is the patient suffering impaired appetite with weight loss?

f. Ask specifically about suicidal thoughts and intentions

g. Is the patient pessimistic about his/her ability to resume and cope with – normal life?

h. Is another psychiatric disorder present?

C. FORMULATION

a. Why the overdose was taken or episode of SH committed?

b. Psychiatric diagnosis (illness and personality)

c. Assessment of risk of suicide or non-fatal repetition after recovery from SH.

d. Problem areas bearing on further care.

e. Action to be taken – establish goals.

Risk and Supervision Chart **Appendix 2**

Level of Risk	Level of Supervision and Management criteria	Clinical signs
HIGH Patients will either be admitted under the Mental Health Act (1983) or have agreed to be admitted informally	**HIGH** These patients require a Registered Nurse (Mental health) special. • Patients in this category must be placed as near as possible to the nursing station. • Must have a Registered Nurse (Mental health) special providing maximum supervision. The responsibilities and duties of the Registered Nurse (Mental health) are detailed in **appendix 4** of this document. • The Registered Nurse (Mental health) special must be able to see and be at arm's length of the patient at all times including bathrooms and toilet areas. • Supervision chart to be completed hourly. **(Appendix 3)** • At no time must there be a physical barrier between the patient and the Registered Nurse (Mental health). • If the patient attempts to leave the ward, the Registered Nurse (Mental health) together with ward staff should attempt to detain the patient and the nurse in charge must inform the duty psychiatrist, medical team, site manager and security. Reasonable steps must be taken to maintain both staff and patient safety. • If the patient threatens to self-discharge, the nurse in charge will inform the doctor who will request an emergency psychiatric assessment. • **Patient to be reviewed <u>daily</u> by Liaison Psychiatry Team**	• The suicide attempt was deliberately premeditated and no one was informed of attempt • Past history of DSH attempts • Patient expresses active suicide intent or the wish to die. • Recurrent violence to self and others • Inability to communicate coherently with others; avoidance to others
MODERATE All SH or with a history of SH patients directly admitted through ED prior to having received a SH assessment will fall under this category	**MODERATE** • SH patients admitted as ***"moderate risk"*** do not require a Registered Nurse (Mental health) special but need to be closely observed and supervised by ward staff. • Moderate risk patients must not be placed in 1-2 bedded side rooms. Patients in this category will, where possible, be placed in easy view of the nursing station. • The patient must be checked by the allocated ward/department nurse every 15 minutes when awake and 30 minutes during the night. Face to face contact is required on each occasion. The nurse will document each patient contact and document on the SH observation chart in **appendix 3** • Nurse must report any concerns for the patient's safety or change in their mental state to the nurse in charge, who will assess the patient and, if necessary, request medical or psychiatric assessment. The responsibilities and duties of the ward nurse are detailed in **appendix 5** of this document. • The patient must not be allowed to leave the ward unescorted. In normal circumstances the patient will be accompanied by a nurse or a relative/carer. This must be clearly recorded in the patient's records. • If the patient attempts to leave the ward or absconds, the nurse in charge must inform the psychiatric liaison team, medical team, bed manager and security. • **Patient to be reviewed <u>daily</u> by Liaison Psychiatry Team**	• Recent history of DSH attempt • No clear intentions or wish to die • Patient appears depressed or very flat in mood • Some difficulty in communicating and social interaction • Panic attacks or appears stressed with an inability to cope
GENERAL Where there are some concerns re: the patient's mental health, but no obvious immediate risk factors, would not normally need immediate psychiatric liaison referral unless the mental state deteriorates.	**GENERAL** • Patients in this category should, where possible, be placed in easy view of the nursing station, and checked by the allocated ward/department nurse every 1 hour when awake, 30 minutes during the night. Face to face contact is required. The responsibilities and duties of the ward nurse are detailed in **appendix 5** of this document. • The allocated nurse must document each patient contact and follow psychiatric care plan regarding the level of observation and risk management.**(Appendix 2)** • The allocated nurse to report any concerns she/he has for the patients' safety or change in their state to the nurse in charge, as per care plan, who will assess the patient and, if necessary, request psychiatric or medical assessment. • The patient will be asked to inform the allocated nurse if she/he wishes to leave the ward. The nurse will discuss where the patient wishes to go and agree a time period for return.	• Some mild anxiety • No clear intentions or wish to die • No plans to commit future self-harm • Able to cope • Low Mood

Kingston Hospital NHS Trust

SELF HARM OBSERVATION CHART **Appendix 3**

Date:

Patient Name: **Patient Number:**

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Appendix 4

HIGH LEVELS OF MANAGEMENT

General Ward Staff Responsibilities

- When employing an Registered Nurse (Mental health) special to observe and supervise patients designated as HIGH risk, the nurse in charge of the ward needs to ensure that the Registered Nurse (Mental health is fully aware of the psychiatric assessment of the patient and the risks he/ she represents to him or herself and others.
- The Registered Nurse (Mental health) must be given a copy of this protocol and the Registered Nurse (Mental health duty list to read. (Outlined below).
- The nurse in charge will ensure that the Registered Nurse (Mental health fully documents his or her contact with the patient and provides a written shift handover as well as an oral report.
- If at any point the nurse in charge is concerned about the competency of the Registered Nurse (Mental health) special she/he must inform the local manager at Kingston Hospital.

Registered Nurse (Mental health) Special Responsibilities

Indications for engaging a Registered Nurse (Mental health) Special:

- Requested by Liaison Psychiatry Team/ duty psychiatrist.
- All patients detained under the Mental Health Act and patients considered to be "*high risk*" but have agreed to stay informally, require a Registered Nurse (Mental health) special.

Registered Nurse (Mental health)

The Registered Nurse (Mental health) nurse with responsibility for HIGH supervision must:

- Keep the patient within sight, and within arm's length, with no physical barrier, at all times.
- Make appropriate and safe interventions should the patient make any attempt to leave the ward, or harm him/herself or others.
- Be aware of systems of summoning help in ward / department areas.
- Accompany the patient to the bathroom and toilet. (If the Registered Nurse (Mental health) special is not of the same sex, a same sex general ward nurse to accompany patient when he/she is undertaking personal care.)
- Continuously monitor the patient's mental state, their general behavior, and conduct.
- Engage the patient, as much as possible in a therapeutic relationship, and provide opportunities for the patient to discuss their problems.
- Complete the Supervision Record Document every hour documenting the patient's current mental state and record any relevant communications they have had with the patient.
- Liaise with, and report to, the ward staff responsible for the physical care of the patient. In addition to the written report, a verbal handover will take place at the end of the ward shift and/or the Registered Nurse (Mental health) shift.

Appendix 4

HIGH LEVELS OF MANAGEMENT - continued

Registered Nurse (Mental health) **(continued)**

- Inform the nurse in charge of any concerns they have for the patient's safety and if the patient indicates that they wish to leave the ward, to contact the duty psychiatrist or SH team.
- Ensure their duties are covered at all times by a ward nurse for their breaks or if they need to leave the patient for any reason.

Appendix 5

MODERATE and GENERAL levels of supervision

General Ward Staff Responsibilities

1. The nurse in charge must designate a nurse to be responsible for the observation and supervision of patients who require either MODERATE or GENERAL levels of supervision. The nurse in charge must take into account the following:
    - The skills and experience of the nurse.
    - The nurse's knowledge of the policy
    - The patient's needs.
    - The patient's relationship with the nurse.
    - The nurse's competency to undertake the duty.
    - The sex of the patient and supervising nurse (issues about toileting and bathing)

2. The nurse with responsibility for MODERATE and GENERAL supervision must:
    - Ensure that he/she is aware of the patient's whereabouts at all times.
    - Make face to face contact with the patient as indicated in the levels on the Supervision/ Observation Chart.
    - Record observations on the chart for each occasion patient has been observed.(appendix 3)
    - Provide reasonable measures to prevent the patient leaving the ward unescorted.
    - Alert individuals (Bed Manager, Security, Liaison Psychiatry Team, Clinicians, Family, Police).
    - Ensure that his/ her responsibility for observation is formally communicated at hand over to another nurse (designated by the nurse in charge) for rest periods and change of shifts.
    - Make a full entry in the nursing record at the end of the shift on the patient's condition and any changes to the level of supervision and observation as agreed by the multi-disciplinary team.

Appendix 6

Consultation Process

The following people/groups were consulted in the writing of this policy:

Alan Kashora, Liaison Psychiatry team

Clare Parker, Head of PALS and Litigation

Sophie Newcombe, Sister, Emergency Department

Hazel Murphy, Lead Emergency Department Nurse

Emma Duffy, Operational Manager, Emergency Department

Anne Jones, Head of Clinical Audit and Effectiveness

Audit and Clinical Effectiveness Committee

Safeguarding Adults Group

Appendix 7

Summary of the Mental Capacity Act (MCA) 2005

The five statutory principles

The five principles are outlined in the Section 1 of the Act. These are designed to protect people who lack capacity to make particular decisions, but also to maximise their ability to make decisions, or to participate in decision-making, as far as they are able to do so.

1. A person must be assumed to have capacity unless it is established that he/she lacks capacity.

2. A person is not to be treated as unable to make a decision unless all practicable steps to help him/her to do so have been taken without success.

3. A person is not to be treated as unable to make a decision merely because he/she makes an unwise decision.

4. An act done, or decision made, under this Act for or on behalf of a person who lacks capacity must be done, or made, in his/ her best interests.

5. Before the act is done, or the decision is made, regard must be had to whether the purpose for which it is needed can be as effectively achieved in a way that is less restrictive of the person's rights and freedom of action.

Summary of other key elements of the Act

- The Act makes provision for people to plan ahead for a time when they may need support. This introduces advanced decisions to refuse treatment.
- The Act is decision specific in that it deals with difficulties a person may have with a particular issue.
- The Act upholds the principle of Best Interest for the individual concerned.
- A Court of Protection will help with difficult decisions. The Office of the Public Guardian (formerly Public Guardianship Office), the administrative arm of the Court of Protection, will help the Act work.
- An Independent Mental Capacity Advocate (IMCA) service will provide help for people who have no intimate support network.
- The Act makes it a criminal offence to willfully neglect someone without capacity.
- The Act generally applies only to those over the age of 16 years, although may apply to some younger people if it is supposed that their capacity will continue to be impaired into adulthood.

LEVEL OF SPECIALLING – RISK ASSESSMENT

(ADULT GENERAL WARDS) ***Complete and file in patient's notes***

Patient details:

(Affix Addressograph)

SECTION 1: IMMEDIATE ACTIONS TO ASSESS AND REDUCE RISKS

Please tick - **Yes** or **No**

	Yes	No	
Recent medical / medication review?			If No – Request review
Behavioural chart completed?			If No – Chart behaviour and record triggers
▪ Have the appropriate referrals been made to the multi-disciplinary team? ▪ Is there a clear multi-disciplinary management plan?			If No – Make referrals and use behavioural chart / triggers to develop a management plan
Is there a current substance (including drug and alcohol) misuse problem?			If Yes – Refer to the Alcohol Liaison Nurse Team
Have environmental concerns been considered?			If No – Reduce environmental stimuli / Move to a more observable position etc.
Has the Falls screening tool and risk assessment been completed?			If No – Complete assessment (consider ultra-low bed / mats etc.)
Is a mental health assessment required?			If Yes – Refer to Liaison Psychiatry (adult / older people or on-call if urgent)
Can the patient's care be safely maintained within usual staffing levels?			**If No – Proceed to Section 2**

SECTION 2: RISK REASON & SPECIALLING RECOMMENDATION

Please tick appropriate risk

No.	Risk / Reason	Tick	Recommended Level of Specialling
1	Acutely ill / Complex care requiring constant observation and intervention by RGN		**1:1 RGN**
2	Preventable falls requiring 1:1 observation (as per Falls Risk assessment)		**1:1 HCA**
3	Confused and wandering presenting risks to self and others (patients and staff)		**1:1 HCA** (ideally Conflict Resolution trained)
4	Pulling lines /tubes that may result in significant harm		**1:1 HCA** (ideally Conflict Resolution trained)
5	Expressing intent or recently attempted to self-harm / suicidal ideation		**1:1** Registered Nurse – Mental Health (to assess, plan, deliver and evaluate mental health care)
6	**Extreme** challenging behaviour (violence & aggression)		**1:1** Registered Nurse – Mental Health (to assess, plan, deliver and evaluate mental health care)

Print Name: **Designation:**

Sign: **Date:** **Time:**

p.t.o. for continued assessments

LEVEL OF SPECIALLING – RISK ASSESSMENT

CONTINUATION SHEET

RE-ASSESS RISK REASONS EACH SHIFT HANDOVER				
Date	**Time**	**Can the patient's care be safely maintained within usual staffing levels?** (circle appropriately)	**If NO – Indicate Risk Reason number (1-6)**	**Sign**
		YES / NO		
		YES / NO		
		YES / NO		
		YES / NO		
		YES / NO		
		YES / NO		
		YES / NO		
		YES / NO		
		YES / NO		
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		YES / NO		
		YES / NO		
		YES / NO		

Authors: Fergus Keegan – Deputy Director of Nursing, Hazel Murphy – Lead ED Nurse, Emma Duffy – ED Operational Manager