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Patient Engagement and Observation – Forensic Hospital and Long Bay Hospital Mental Health Unit

Policy Number 1.319

Policy Function Continuum of Care

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Summary This policy provides health staff in the Forensic Hospital and Long Bay Hospital Mental Health Unit with direction in relation to the allocation, review and undertaking of patient engagement and observations. Responsibilities when carrying out these roles are also outlined.

Responsible Officer Executive Director Clinical Operations

Applicable Sites

- ☐ Administration Centres
- ☐ Community Sites (e.g. Court Liaison Service, Community Integration Team, etc.)
- ☐ Health Centres (Adult Correctional Centres or Police Cells)
- ☐ Health Centres (Juvenile Justice Centres)
- ☒ Long Bay Hospital
- ☒ Forensic Hospital

Previous Issue(s) Policy 1.319 (May 2018, June 2016; Jul 2014; Nov 2008)

Change Summary

- Ministry of Health policy directive PD2017_025 *Engagement and Observation in Mental Health Inpatient Units* replaces previous guidance on mental health nursing observations within Suicide Risk Assessment and Management Protocols- Mental Health Inpatient Unit (NSW Department of Health, 2004);
- The addition of a clearer description of requirement of observation during sleeping hours. Emphasising that the staff member must assess for respirations and signs of life; including but not limited to observation of body movement, snoring and/or a regular and continuous rise and fall of the chest. This must be documented in the health record;
- Changes to health record documentation requirements for Level 3 observations from two hourly documentation to at least two

contemporaneous documented assessments per shift through the outcome of active engagement by nursing staff;

- Addition of the option of two observation levels if the treating psychiatrists in consultation with the MDT, determine it may be appropriate to use lower levels of observation. For example in some situations less intrusive forms of observation may enable better sleeping patterns;
- GL2017_019 *Physical Health Care of Mental Health Consumers* has been rescinded and replaced by GL2021_006 *Physical Health Care for People Living with Mental Health Issues;*
- PD2012_035 *Aggression, Seclusion & Restraint in Mental Health Facilities in NSW* has been rescinded and replaced by PD2020_004 *Seclusion and Restraint in NSW Health Settings;*
- PD2013_049 *Recognition and Management of Patients who are Clinically Deteriorating* has been rescinded and replaced by PD2020_018 *Recognition and Management of Patients who are Clinically Deteriorating*;
- JH&FMHN Policy 1.322 *Recognition and Management of Patients who are Clinically Deteriorating: Implementation Guide – Ministry of Health PD2013_049* has been rescinded and replaced by JHFMHN Policy 1.322 *Recognition and Management of Patients who are Clinically Deteriorating: Implementation Guide – Ministry of Health PD2020_018;*
- JH&FMHN *Psychotropic Medication- Guideline for Prescribing and Monitoring Use within Custodial and Forensic Mental Health Settings 2017* has been rescinded and replaced by Guidelines for Psychotropic Medication 2020 ;
- JH&FMHN Policy 1.441 *Emergency Sedation Forensic Hospital and Long Bay Hospital Mental Health Unit for the observation level required in the case of emergency sedation* has been rescinded and replaced by JHFMHN Policy 1.441 *Acute Sedation - Forensic Hospital and Long Bay Hospital Mental Health Unit;*
- Forensic Hospital Procedure *Replacement of Nursing Staff* replaced by Forensic Hospital Procedure *Replacement of Nursing Staff and Fatigue Management ;*

TRIM Reference POLJH/1319

Authorised by Chief Executive, Justice Health and Forensic Mental Health Network

1. Preface

Observation through engagement is the purposeful gathering of information from a patient to inform clinical decision making. It is a formal structured process and is therefore fundamentally different from the normal monitoring of patients within a unit or care setting.

Increased observation is the process that ensures close monitoring of and engagement with a patient who requires intensive care and support for a period of time. The key purpose of increasing the level of observation for a patient during periods of distress where they are at increased risk of harm to themselves and/or others is to provide a period of safety. Increased levels of observation may also be useful when a patient is physically unwell and requires a higher level of monitoring.

Spending time with patients, whether engaged in activity, discussion or simply being with them, allows close assessment and monitoring of behaviour and mental state. It therefore may meet many of the needs of observation but is not adequate in itself.

It is essential to have clear, unambiguous instructions regarding a patient's observation level and need for increased levels of observation. This policy acknowledges that nurses, particularly those in charge of the unit, remain the major professional body responsible for the role of observation. However all members of the multidisciplinary team (MDT), have significant roles and responsibilities, including allied health and medical staff, particularly during individual and group therapy sessions.

The integral principles of observation are to provide therapeutic safety to a patient through a supportive framework that is gender and culturally sensitive, acknowledging past experiences of trauma and that is recovery focused.

2. Policy Content

The allocation of appropriate observation levels based on the assessed risk of a patient will ensure that the health and wellbeing of patients and others is not compromised and that all patients are treated in a safe, effective and professional manner.

The objectives of this policy are to:

- Ensure that all patients within the Forensic Hospital (FH) and Long Bay Hospital Mental Health Unit (MHU) have a designated level of observation at all times, consistent with their current mental state and level of assessed risk;
- Ensure accurate, purposeful and therapeutic observation of all patients within the FH and MHU;
- Ensure observation is grounded in therapeutic engagement with the patient;
- Ensure the safe management of patients at risk of harm to self or others, with clear understanding of the actions required when there is an escalation of risk;
- Ensure that the observation level of each patient, the reasons for the observation level and reviews of the observation level are clearly documented in the patient's health record, and within the utilised Treatment and Management Plan. For the purpose of this policy the Treatment and Management Plan will be referred to as the Care Plan within the MHU and the TPRIM within the FH;

- Ensure that the observation level of each patient, the reasons for the observation level and assessment and reviews of the observation level are clearly communicated among the MDT during clinical handovers;
- Ensure that the observation level of the patient, the reasons for the observation level, assessment and reviews of the observation level are clearly communicated to the patient and where appropriate their designated carer/principle care provider;
- Maintain the privacy, rights, dignity, and autonomy of patients to the fullest extent possible consistent with safe and effective care and an understanding of the actions required when there is an escalation of risk;
- Ensure gender and cultural sensitivity is maintained, along with sensitivity to previous traumatic experiences;
- Provide direction to staff allocated to the role of Level 1, 2, 3 and 4 observations;
- Ensure the practice of observation is integrated with therapeutic recovery focused care;
- Ensure staff are aware of the audit requirements in relation to this policy.

2.1 Mandatory Requirements

2.1.1 All admitted patients within the FH and MHU must;

- have a designated level of observation at all times, consistent with their current mental state and level of assessed risk;
- have their designated level of observation clearly documented in their health record by the MO;
- have their designated level of observation clearly documented in their Care plan/TPRIM by a delegated member of the MDT;
- have their designated level of observation regularly reviewed in line with this policy;
- have shift by shift contemporaneous documentation within their health record in line with their designated level of observation as per this policy;
- have their designated level of observation and engagement recorded daily on the JUS110.110 *Mental Health Observation and Engagement Chart*, which must be filed in the observation section of the patient's health record when completed.

2.1.2 Audits of observation levels and engagement practice must be conducted as outlined within section 4 of this policy.

2.2 Implementation – Roles and Responsibilities

Multidisciplinary Team (MDT)

The MDT may consist of a consultant psychiatrist, psychiatry registrar, care coordinator (CC), associate care coordinator, allocated nurse and allied health clinicians. The MDT is responsible to:

- Ensure appropriate level of observation is determined following a thorough risk assessment.
- Ensure the patient's MDT meeting includes review of their observation level.

- Ensure communication occurs with the patient (and designated carer/principle care provider) about the level of observation prescribed, and the circumstances that would permit a reduction in an observation level.
- Ensure where possible and practicable the purpose for the level of observation and restrictions are determined in consultation with the patient.
- Ensure communication occurs amongst the team, and decisions are clearly documented in the health record and Care Plan/TPRIM.

Medical Officer (MO) (Psychiatry Consultant / Psychiatry Registrar/ on call Psychiatry Consultant/ Psychiatry Registrar) are responsible to:

- Ensure appropriate level of observation is determined following a thorough risk assessment.
- Ensure levels of observations, restrictions and reviews of observations are clearly documented in the patient's health record.
- Ensure levels of observations and restrictions are reviewed as outlined in this policy.
- Ensure that decisions to reduce the level of observation are made in consultation with the MDT, or where necessary for the on call psychiatry registrar in consultation with the duty consultant and nurse in charge (NiC).
- Ensure all decisions relating to patient observation level changes are documented clearly in the patient's health record and Care Plan/TPRIM as they occur.

Nursing Unit Manager (NUM) is responsible to:

- Ensure the levels of observation set for patients on their unit are appropriate and are reviewed as outlined in this policy.
- Assign adequate staffing and resources to enable implementation of this policy.
- Evaluate compliance with this policy by ensuring required audits are completed.
- Completing or delegating completion of random unit visits to ensure observations are being undertaken and documented as prescribed.

Nurse in Charge (NiC) is responsible to:

- Assign responsibility to roles of observation and policy implementation.
- Ensure workplace practices are consistent with policy.
- Ensure changes to observation and patient presentation are communicated to the MDT as soon as practicable.
- Ensure the observation level, engagement and resulting assessment forms part of each clinical handover.
- Ensure JUS110.110 *Mental Health Observation and Engagement Chart* are completed as per observation level requirement.

Observing Clinician (OC) (normally the allocated nurse) is responsible to:

- Ensure observations are conducted and are consistent with policy.

- Ensure detailed clinical handover of patient's presentation, assessment, observation level and reason for observation levels between members of the MDT.
- Ensure any changes in observation are updated on the patient's Care Plan/TPRIM in a timely manner ideally by the end of shift.
- Ensure clear documentation is completed as per policy requirements.
- Ensure JUS110.110 *Mental Health Observation and Engagement Chart* are completed as per observation level requirement.

Allied Health Professional (AHP) is responsible to:

- Ensure this policy is adhered to in all clinical interactions, including 1:1 and group therapy sessions.
- Ensure documentation and communication of salient information is consistent with policy.

3. Procedure Content

3.1 General Principles of Observation and Engagement

The general principle to be followed is that the level of observation should be individualised and set at the least restrictive level within the least restrictive setting necessary for the safe delivery of care. Observation is linked with clinical assessment. All observations must be purposeful and include engagement with the patient as well as visual observations. All information relating to levels of observation of a patient must be communicated during clinical handover and clearly documented in the patient's health record and Treatment and Management Plan (Care Plan/TPRIM).

Observation is only one aspect of caring for people during periods of high distress, and must be both safe and therapeutic. Whatever the cause of this need, the patient requires safety, compassion, understanding and appropriate treatment. A clear explanation should be given to the patient and where appropriate their designated carer/principal care provider, regarding the level of observation prescribed by the MDT, and the circumstances that would permit a reduction in an observation level.

Where additional staff are required for the most acutely at risk patients when no other less restrictive option is appropriate only the most skilled and knowledgeable observing clinicians must be allocated to this role. A skilled and knowledgeable mental health clinician based on the unit should be used as the observing clinician and existing or agency/casual staff should be used to backfill the unit role if additional resources are required.

Regular attention to the needs of the observing clinician allocated to conduct observations especially Level 1 (arm's length or visual) and Level 2 should be provided. The observing clinician should be relieved, at a minimum every two hours for a short comfort break (except for meal breaks, which will be longer). This comfort break provides the opportunity for contemporaneous documentation in the patient's health record, feedback to other team members and a personal comfort break.

Observation of patients in seclusion must be in accordance with NSW Ministry of Health (Ministry) PD2020_004 *Seclusion and Restraint in NSW Health Settings*.

The physical health needs and physical observations of a patient should also be considered in line with:

- NSW Ministry GL2021_006 *Physical Health Care for People Living with Mental Health Issues;*

- NSW Ministry PD2017_033 *Physical Health Care within Mental Health Service;*
- NSW Ministry PD2020_018 *Recognition and Management of Patients who are Clinically Deteriorating*,
- JHFMHN Policy 1.322 *Recognition and Management of Patients who are Clinically Deteriorating: Implementation Guide – Ministry of Health PD2020_018,*
- JHFMHN Policy 1.078 *Care Coordination, Risk Assessment, Management Planning and Review Forensic Hospital.*

For observations of patients following Emergency Sedation staff should refer to:

- Guidelines for Psychotropic Medication 2020
- JHFMHN Policy 1.441 *Acute Sedation - Forensic Hospital and Long Bay Hospital Mental Health Unit*

3.1.1 Observation Levels – Forensic Hospital and Mental Health Unit

The Ministry of Health policy directive PD2017-025 *Engagement and Observation in Mental Health Inpatient Units* outlines five levels of observations (Levels 1-5). Within the FH and MHU, Level 5 Observation which requires observation of the patient at a minimum every two hours will not be used and therefore is not outlined in this policy.

The four levels of observation used within the FH and MHU are:

General Observations

- Level 4: Observations at a minimum every 60 minutes;

Increased Observations

- Level 3: Observations at a minimum every 30 minutes;
- Level 2: Observations at a minimum every 15 minutes;
- Level 1: Constant Observations (arm's length or visual).

3.1.2 Responsibilities of the Observing Clinician – Forensic Hospital and Mental Health Unit

- The observing clinician will normally be the allocated nurse, however at times observations may be allocated to another clinician on the team.
- The NiC in the FH, and NiC in the MHU, are responsible for ensuring that patients requiring an increased level of observation are allocated to staff skilled to undertake this duty.
- In the case of Level 1 observations (arm's length or visual), the observing clinician must not under any circumstances or for any period of time, no matter how short leave the immediate area or discontinue the observation requirements, unless another staff member has taken over the observation role.
- It is recommended that staff occasionally undertake additional rounds between the prescribed times so that patients cannot discern a pattern or set routine.
- Clinical handover must be carried out before and after every period of observation to ensure that staff are briefed regarding the patient's current presentation, and rationale for the prescribed level of observation.
- Where the patient being observed is particularly challenging, the observing clinician should be rotated between several members of the team at two hourly intervals to ensure adequate relief from the role.

- The observing clinician must document contemporaneously in the patient's health record in line with the requirements listed within this policy
    - the level of observation;
    - assessment of the patient's mental state;
    - current risks or concerns; and
    - patient activity and engagements they have had with the patient.
- The observing clinician must complete the JUS110.110 *Mental Health Observation and Engagement Chart* as per observation level requirement and ensure this chart is placed in the observation section of the patients' health record upon completion.
- Where an observation has been missed, the reason must be documented on the patients JUS110.110 *Mental Health Observation and Engagement Chart* by the observing clinician that missed the observation and the NiC informed.

3.1.3 Documentation and Communication– Forensic Hospital and Mental Health Unit

Clear and effective communication is an integral component of patient care, increases optimal patient outcomes and strengthens safety and security. Thorough and relevant information must be shared to all staff managing patient's observation levels during clinical handover, patients review, MDT meetings and in-depth case reviews.

Clear, concise and contemporaneous documentation must be utilised when documenting the patient's care. The patient's observation level must be clearly documented in the patient's health record by the MO and within the Care Plan/TPRIM by a delegated member of the MDT.

The observing clinician must document contemporaneously the patients level of observation, assessment of the patient's mental state, current risks or concerns, the patient activity and engagements they have had with the patient in the patient's health record in line with the requirements of the patient allocated observation level.

Throughout each shift, documentation of observations are to be recorded on the individual JUS110.110 *Mental Health Observation and Engagement Chart* at the time of the observation. Each level of observation (1, 2, 3, and 4) requires a separate JUS110.110 *Mental Health Observation and Engagement Chart*. These charts must be filed within the observation section of the patient's health record when completed.

Clinical handover for each patient must include the level observation, the engagement and assessment undertaken to ensure safe transfer of care and clear understanding of the patients plan.

3.1.4 Observations during sleep hours – Forensic Hospital and Mental Health Unit

When deciding upon observation levels, senior nurses and treating psychiatrists should determine whether it may be appropriate to use lower levels of observation. In some situations less intrusive forms of observation may enable better sleeping patterns in people who are hypervigilant and who may awaken or be startled. If observation levels are dependent on the time of the day or the activities of people (for example, awake or asleep), such details should be adequately recorded within the TPRIM/Care Plan and nurses should be made aware of the observation requirements. The person being observed should also be made aware of what type of observation will occur at night.

When observing a patient who is sleeping, the staff member must assess for respirations and signs of life; including but not limited to observation of body movement, snoring and/or a regular and continuous rise and fall of the chest. These observations and signs of life must be documented on the observation form upon each check. In the circumstance whereby the observing staff member's ability to observe respirations or signs of life is impeded by blankets or clothing, then the observing staff member must consider entering the room to confirm signs of life. If entering the room is required within the Forensic Hospital, staff must conduct a safety huddle and document it in the patients' health record and no less two staff must enter the room. Room entries are to be completed in a respectful and minimally disruptive manner. Any concerns or safety issues relating to the observation of patients should be escalated to a manager as soon as possible.

Within the MHU Corrective Service New South Wales (CSNSW) Officers are responsible for coordinating access to all patients. Cell entry must be negotiated through CSNSW.

3.2 Observation Levels – Forensic Hospital

The close proximity inherent in observation and the risk of patients feeling aggrieved or anxious during prolonged periods of observation may increase the probability of violence. The decision regarding the level of observation to be used must be based on a variety of factors. Central to the decision must be the risk assessment of that patient's current dynamic risk factors. Risk assessment and management is a complex process involving objective information (such as patient history, behaviour, etc.), collateral information and the clinical judgement of the MDT and must be consistent with the Risk Assessment and Management Framework set out in JHFMHN Policy 1.078 *Care Coordination, Risk Assessment, Management, Planning and Review Forensic Hospital*. One of the key areas of clinical practice in acute psychiatric care is deciding what level of care and observation is needed for individuals.

The four levels of observation used within the FH are:

General Observations

- Level 4: Observations at a minimum every 60 minutes;

Increased Observations

- Level 3: Observations at a minimum every 30 minutes;
- Level 2: Observations at a minimum every 15 minutes;
- Level 1: Constant Observations (arm's length or visual).

3.2.1. General Observations - Forensic Hospital

Observation Level 4 is considered general observations. This is the baseline level of observations within the FH and is intended to meet the needs of most patients for most of the time. This level of observation should be compatible with giving patients a sense of responsibility for their use of free time in a carefully planned and monitored way. Patients on this level of observations are considered not to pose any significant risk of harm to self or others and should be actively engaged in the unit program.

3.2.1.1 Level 4 Observations – minimum every 60 minutes- Forensic Hospital

Description of the level of supervision	Documentation requirements	Review
Level 4 observation is the baseline level of observation utilised in the FH; it is intended to meet the needs of most patients for most of the time. It should be compatible with giving patients a sense of responsibility for their use of free time in a carefully planned and monitored way. Patients on Level 4 observations are considered not to pose any significant risk of harm to self or others. Patients on Level 4 observations should be actively engaged in the unit program and as a result regularly seen and engaged with throughout each shift by multiple clinicians. The observing clinician (normally the allocate nurse) for an individual patient must know their general whereabouts at all times, whether in or out of the unit. This level of observation must include a check of the location and activity of the patient preceding and following nursing handover and at a minimum of every 60 minutes thereafter.	The observing clinician must ensure that there is a documented (utilising the SOAP documentation methodology or an approved systematic documentation practice) assessment in the health record during each shift through the outcome of active engagement. Documentation must include the level of observation, salient aspects of the patient's mental state, current risks or concerns, their activity and engagements they have had with the patient. During sleeping hours the observing clinician are required to confirm that the patient is in their room and that they are breathing. The staff member must assess for respirations and signs of life; including but not limited to observation of body movement, snoring and/or a regular and continuous rise and fall of the chest. This must be documented in the health record. Documentation of observations are to be recorded on the JUS110.110 *Mental Health Observation and Engagement Chart*	The patient's level of observation must be reviewed at least weekly by the responsible MO in collaboration with the MDT, NUM or delegate. The agreed observation level must be documented in the patient's health record by the MO and TPRIM by the delegated member of the MDT. The patient's observation level, engagement and assessment undertaken must be discussed at the clinical handover, patient reviews, MDT meeting and in-depth case review

3.2.2 Increased observations Forensic Hospital

Level 1, 2 and 3 observations are considered increased observations and should be used for patients who have been assessed as posing some risk to self and/or others and who cannot be appropriately managed on an alternative level of observation.

Any member of the MDT may increase a patient's observation level to provide closer observation in response to deterioration in the patient's mental state or increase in risk. This decision must be made in consultation with the NiC with notification to the NUM or After Hours Nurse Manager (AHNM). The NiC must consult with the MO as soon as practical for further review of the patient.

Detailed documentation as to why the increased observation occurred should be documented in the patient's health record. At the commencement of the increased observation level the MO must document the following information in the patient's health record:

- The patient's current mental state and presentation;
- The patient's current identified risks;
- What strategies have been utilised/are in conjunction with the increased level of observation to manage this risk;
- The patient's current observation level and minimum interval of observation;
- The rationale for the observation level;
- Interventions and clinical management;
- Changes to the patient's management ie. visits management, meals (finger food, no cutlery), toileting and showering, access to items, attendance at therapeutic activities and groups;
- Description of interactions that have occurred;
- Any observation of ongoing or decreased risk factors in behaviour;
- Evaluation of effectiveness of observation level;
- Expected time of next review; and
- That the designated carer and or the principal carer provider have been informed of the observation level change where practicable.

The observing clinician must ensure the following information is documented in the patient's TPRIM as soon as practicable as and not later than the end of shift:

- The patient's current observation level;
- Changes to the patient's management i.e. visits management, meals (finger food), no cutlery, toileting and showering, access to items, attendance at therapeutic activities and groups;
- Strategies to be utilised to manage the patient during this time of crisis;
- Timeframe for documentation in the patient's Health Record.

The NiC must ensure all staff on shift are aware of the changes to a patient's level of observations. The NiC must ensure that the observing clinician has appropriate time provided to document the changes in the patient TPRIM.

3.2.2.1 Level 3 Observations- minimum every 30 minutes- Forensic Hospital

Description of the level of supervision	Documentation requirements	Review
Level 3 observations are considered increased observations. This level of observation must include a check of the location and activity of the patient preceding and following nursing handover and at a minimum every 30 minutes thereafter. The following must be considered when developing the management strategies to manage the patient: • Staff must be mindful that staggering and random observations are required to mitigate risks associated with predictable intervals of observation. • During periods of distress, patients require high levels of observation; sighting alone is not sufficient, engagement with the patient is required. • Since the patient has been assessed to pose some risk to self and/or others, the patient where possible should be managed in a highly visible area of the unit. • Ground access must be restricted to at least supervised or escorted status. The MDT must review and determine the number of staff required to escort the patient on both ground and external leave. • All visits must be supervised during the period the patient is on increased observation.	The observing clinician must ensure that there is a documented (utilising the SOAP documentation methodology or an approved systematic documentation practice) assessment in the health record at least two contemporaneous documented assessments per shift through the outcome of active engagement by nursing staff. The observing clinician must document changes to the patient's management strategies in the patient's TPRIM. Documentation must include the level of observation, salient aspects of the patient's mental state, current risks or concerns, their activity and engagements they have had with the patient. During sleeping hours the observing clinician are required to confirm that the patient is in their room and that they are breathing. The staff member must assess for respirations and signs of life; including but not limited to observation of body movement, snoring and/or a regular and continuous rise and fall of the chest. This must be documented in the health record. Documentation of observations are to be recorded on the JUS110.110 *Mental Health Observation and Engagement Chart*	The patient's level of observation must be reviewed at least weekly by the responsible MO in collaboration with the MDT, NUM or delegate. The agreed observation level must be documented in the patient's health record, by the MO and TPRIM by the delegated member of the MDT. The patient's observation level, engagement and assessment undertaken must be discussed at the clinical handover, patient reviews, MDT meeting and in-depth case review.

3.2.2.2 Level 2 Observations – minimum every 15 minutes- Forensic Hospital

Description of the level of supervision	Documentation requirements	Review
Level 2 observations are considered increased observations. This level of observation should only be used infrequently due to the challenge it poses to regular engagement and the pattern of this observation becoming easily identifiable by the patients who may use the time between observations opportunistically and impulsively. This level of observation must include a check of the location and activity of the patient preceding and following nursing handover and at a minimum every 15 minutes or less (as determined by the MDT) thereafter. The following must be considered when developing the management strategies to manage the patient: • Staff must be mindful that staggering and random observations are required to mitigate risks associated with predictable intervals of observation. • During periods of distress, patients require high levels of observation; sighting alone is not sufficient, engagement with the patient is required. • Since the patient has been assessed to pose some risk to self and/or others, the patient where possible should be managed in a highly visible area of the unit. • Ground access must be restricted to at least supervised or escorted status. The MDT must review and determine the number of staff required to escort the patient on both ground and external leave. • All visits must be supervised during the period the patient is on increased observation.	The observing clinician must ensure that there is a documented (utilising the SOAP documentation methodology or an approved systematic documentation practice) assessment in the health record at least every two hours through the outcome of active engagement. The observing clinician must document changes to the patient's management strategies in the patient's TPRIM. Documentation must include the level of observation, salient aspects of the patient's mental state, current risks or concerns, their activity and engagements they have had with the patient. During sleeping hours the observing clinician are required to confirm that the patient is in their room and that they are breathing. The staff member must assess for respirations and signs of life; including but not limited to observation of body movement, snoring and/or a regular and continuous rise and fall of the chest. This must be documented in the health record. Documentation of observations are to be recorded on the JUS110.110 *Mental Health Observation and Engagement Chart*.	The MO must review the level of observation at least 24 hourly unless documented otherwise by the consultant psychiatrist. The MO review timeframe must be clearly documented in the patient's health record. The agreed observation level must be documented in the patient's health record, by the MO and TPRIM by the delegated member of the MDT. The patient's observation level, engagement and assessment undertaken must be discussed at the clinical handover, patient reviews, MDT meeting and in-depth case review.

3.2.2.3 Level 1 Constant Observation (Visual) – Forensic Hospital

Description of the level of supervision	Documentation requirements	Review
Level 1 constant observation (visual) must be used for patients considered to pose a significant and imminent risk to self and/or others. The indication and outcome of this level of observation is constant assessment. This observation requires a minimum of 1:1 staff: patient allocation. Where the risk of harm to others posed by a patient is high to extreme, consideration should be given to the use of more than one clinician to continuously observe the patient. The observing clinician must be aware at all times of the patient's precise whereabouts and maintain an unobstructed line of sight of the patient. The observing clinician must not leave the immediate area and must maintain continuous and direct observation of the patient at all times. The patient must never be unsupervised under any circumstances or for any period of time, no matter how short. The following must be considered when developing the management strategies to manage the patient: • Since the patient has been assessed to pose significant risk to self and/or others, consideration must be given to managing the patient in a highly visible area of the unit. • Ground access must be restricted and only occur during an emergency situation. The MDT must review and determine the number of staff required to escort the patient on external medical leave, if such leave is determined to be essential or in the case of a medical emergency. • The MDT must give careful consideration during this type of observation as to whether patient visits should occur. If visits are to occur, they must be supervised during the period the patient is on this observation. These and other restrictions determined on an individual basis must be communicated to the patient, designated carer and visitors where appropriate, and documented clearly in the patient's health record and TPRIM. • Prior consideration and planning must be undertaken and clearly documented in the patient's TPRIM in regards to observation required when performing activities of daily living such as showering and toileting. This planning should where possible be inclusive of gender and culturally appropriate allocation of staff and must take into consideration the patient's risk, trauma history and the effect of the observation requirements on the individual.	The observing clinician must ensure that there is a documented (utilising the SOAP documentation methodology or an approved systematic documentation practice) assessment in the health record at least every two hours through the outcome of active engagement. The observing clinician must document changes to the patient's management strategies in the patient's TPRIM Documentation must include the level of observation, salient aspects of the patient's mental state, current risks or concerns, their activity and engagements they have had with the patient. During sleeping hours the observing clinician are required to confirm that the patient is in their room and that they are breathing. The staff member must assess for respirations and signs of life; including but not limited to observation of body movement, snoring and/or a regular and continuous rise and fall of the chest. This must be documented in the health record. Documentation of observations are to be recorded on the JUS110.110 *Mental Health Observation and Engagement Chart*.	The MO must review the level of observation at least 24 hourly unless documented otherwise by the consultant psychiatrist. The MO review timeframe must be clearly documented in the patient's health record. The agreed observation level must be documented in the patient's health record by the MO and TPRIM by the delegated member of the MDT. The patient's observation level, engagement and assessment undertaken must be discussed at the clinical handover, patient reviews, MDT meeting and in-depth case review.

3.2.2.4 Level 1 Constant Observation (Arm's Length) – Forensic Hospital

Description of the level of supervision	Documentation requirements	Review
Level 1 Constant Observation (Arm's Length) are implemented when the patient is considered to be at very high immediate risk and cannot be safely managed on Level 1 Constant Observation (Visual) observations. The indication and outcome of this level of observation is constant assessment. This observation requires a minimum 1:1 nursing allocation. The patient should be within arm's reach (at least 1 metre) of a member of staff at all times and in all circumstances. Where the risk of harm to others posed by a patient is high to extreme, consideration should be given to the use of more than one clinician to continuously observe the patient. The following must be considered when developing the management strategies to manage the patient: • Since the patient has been assessed to pose significant risk to self and/or others, consideration must be given to managing the patient in a highly visible area of the unit. • Ground access must be restricted and only occur during an emergency situation. The MDT must review and determine the number of staff required to escort the patient on external medical leave, if such leave is determined to be essential or in the case of a medical emergency. • The MDT must give careful consideration during this type of observation as to whether patient visits should occur. If visits are to occur then staff are to maintain special observation throughout the visit. These and other restrictions are determined on an individual basis. The patient, the designated carer, and visitors where appropriate should be informed. These decisions must be documented clearly in the patient's health record by the MO, and TPRIM by a delegated MDT member. • Prior consideration and planning must be undertaken and clearly documented in the patient's TPRIM in regards to observation required when performing activities of daily living such as showering and toileting. This planning should where possible be inclusive of gender and culturally appropriate allocation of staff and must take into consideration the patient's risk, trauma history and the effect of the observation requirements on the individual.	The observing clinician must ensure that there is a documented (utilising the SOAP documentation methodology or an approved systematic documentation practice) assessment in the health record at least every two hours the outcome of active engagement. The observing clinician must document changes to the patient's management strategies in the patient's TPRIM. Documentation must include the level of observation, salient aspects of the patient's mental state, current risks or concerns, their activity and engagements they have had with the patient. During sleeping hours the observing clinician are required to confirm that the patient is in their room and that they are breathing. The staff member must assess for respirations and signs of life; including but not limited to observation of body movement, snoring and/or a regular and continuous rise and fall of the chest. This must be documented in the health record. Documentation of observations are to be recorded on the JUS110.110 *Mental Health Observation and Engagement Chart*.	The MO must review the level of observation at least 24 hourly unless documented otherwise by the consultant psychiatrist. The MO review timeframe must be clearly documented in the patient's health record. The agreed observation level must be documented in the patient's health record, by the MO and TPRIM by the delegated member of the MDT. The patient's observation level, engagement and assessment undertaken must be discussed at the clinical handover, patient reviews, MDT

		meeting and in-depth case review.

3.2.3 Reducing Observation Levels

- A decision to reduce the level of observation must only be made by a Medical Officer. The MO must review the patient's progress notes and TPRIM, receive a handover from the NiC regarding the patient's presentation and assess the patient's current risks.
- The cessation of an increased level of observation must be agreed by the MO, observing clinician and NiC/NUM and the reasons for this should be clearly recorded in the patient's health record by the MO.
- The patient's mental state and current risk factors must be assessed and alternative management strategies must be implemented prior to the cessation of increased observation consistent with the clinical risk assessment and management framework set out in Justice Health and Forensic Mental Health Network (JHFMHN) Policy 1.078 *Care Coordination, Risk Assessment, Management, Planning and Review Forensic Hospital,*
- To ensure patients are not left on an inappropriately high level of observation, it is recommended that forward planning occurs, particularly in respect to weekends. The MDT, where possible, should specify the circumstances that would permit a reduction in an observation level; for example 'review need for constant observation if patient exhibits an improved engagement with staff in conversation and denies any thoughts of self-harm for more than a 24 hour period'. This planning must be documented in the patient's health record.
- The observing clinician must update the patient's TPRIM when the observation level change occurs, they must also document the management strategies implemented to manage the patient on a lower level of observation. . This must be completed as soon as practicable as and not later than the end of shift.
- The NUM/NiC must ensure that the observing clinician has appropriate time provided to document the changes in the patient TPRIM.
- The observing clinician must handover the observation changes during clinical handover.
- The NiC must ensure all staff on shift are aware of the changes to the level of observations.
- Once it has been determined that the patient no longer requires an increased level of observation additional staffing (if was necessary) must be discontinued immediately. There is no need for any additional staff members rostered on to the unit to complete their shift where casual/agency staff or overtime is being utilised.
- The designated carer and or the principal carer provider should be informed of the observation level change by the MO or delegate where practicable.

3.2.4 Request for Additional Staff – Forensic Hospital

The patient's MDT must comprehensively assess the risks posed by the patient and the nominated MDT member must update the patient's TPRIM to manage the identified risks. In doing so there may be occasions where an increased level of observation necessitates a requirement for additional staff.

In considering the use of additional staff, the MDT must consider:

- The risks identified, where the risk involves risk of harm to self or others;
- The safety of staff performing an increased level of observation;

- The effectiveness of any other less restrictive strategies that have been, or could be, implemented in order to manage the identified risks;
- The purpose for which additional staff are required and shifts for which the nurse is required;
- The indicators for when the additional staff will no longer be required;
- The current staffing levels;
- The current skill and gender mix of staff;
- The overview of unit acuity.

The MDT must determine the necessity of an increased level of observation and the use of additional staff. The MDT request must be recorded by the unit consultant or delegate psychiatry registrar in consultation with the NUM on the *Request for Additional Staff Form – Patient Observations* (CNS500) and forwarded to the DDoN or FH AHNM on a shift by shift basis, or as negotiated between the NUM and DDoN/AHNM. The DDoN/AHNM must consider the following when approving the need for additional staff:

- What other strategies have been utilised to manage the patient need for increased observation;
- Current staffing levels on the unit;
- Current skill and gender mix of staff;
- Unit acuity;
- Number of other patients requiring increased observations on the unit;
- Number of patients requiring the use of additional staff on the unit;
- Anticipated length of time the additional staff will be required to perform increased observations;
- Planned admissions/discharges;
- Planned external escorts;
- Unit routine;
- Financial implications to the unit's budget; and
- Forensic Hospital Procedure *Replacement of Nursing Staff and Fatigue Management* is adhered to when allocating additional staff.

The NiC must inform the MO of this decision as soon as practicable. The signed original copy of the *Request for Additional Staff Form – Patient Observations* form (CNS500) must be placed into HPRM by the DDoN or AHNM and forwarded to the NUM for rostering purposes. The cessation of additional staff and the reasons for this must be clearly documented in the patient's health record and on the *Request for Additional Staff Form – Patient Observations* form (CNS500) by the MO.

If the decision is made not to support additional staff, the reasons for that decision must also be noted in the patient's Health Record and an appropriate alternative TPRIM must be documented and implemented.

3.3 Observation Levels – Mental Health Unit (MHU)

The four levels of observation used within the MHU are:

General Observations

- Level 4: Observations at a minimum every 60 minutes;

Increased Observations

- Level 3: Observations at a minimum every 30 minutes;
- Level 2: Observations at a minimum every 15 minutes;
- Level 1: Constant Observations (Arm's length or Visual).

Policy 1.350 *Aggression, Seclusion & Restraint in Mental Health Facilities – Long Bay Hospital Mental Health Unit* and Policy 1.360 *Segregated Custody and Mandated Protection* also highlights consideration when managing patient's observations levels.

3.3.1 General Observations Long Bay Hospital, Mental Health Unit

Observation Level 4 are considered general observations. This is the baseline level of observations within the MHU and is intended to meet the needs of most patients for most of the time. This level of observation should be compatible with giving patients a sense of responsibility for their use of free time in a carefully planned and monitored way. Patients on this level of observations are considered not to pose any significant risk of harm to self or others and should be actively engaged in the unit program.

3.3.1.1 Level 4 Observations- at a minimum every 60 minutes – Long Bay Hospital, Mental Health Unit

Description of the level of supervision	Documentation requirements	Review
Level 4 observation is the baseline level of observation; it is intended to meet the needs of most patients for most of the time. It should be compatible with giving patients a sense of responsibility for their use of free time in a carefully planned and monitored way. Patients on level 4 observation are considered not to pose any significant risk of harm to self or others. Patients on Level 4 observations should be actively engaged in the unit program and as a result regularly seen and engaged with throughout each shift by multiple clinicians. The observing clinician (normally the allocated nurse) for an individual patient must know their general whereabouts at all times, whether in or out of the unit. This level of observation must include a check of the location and activity of the patient preceding and following nursing handover and at a minimum every 60 minutes.	The observing clinician must ensure that there is a documented (utilising the SOAP documentation methodology or an approved systematic documentation practice) assessment in the health record during each shift through the outcome of active engagement. Documentation must include the level of observation, salient aspects of the patient's mental state, current risks or concerns, their activity and engagements they have had with the patient. During sleeping hours the observing clinician are required to confirm that the patient is in their room and that they are breathing. The staff member must assess for respirations and signs of life; including but not limited to observation of body movement, snoring and/or a regular and continuous rise and fall of the chest. This must be documented in the health record. Documentation of observations are to be recorded on the JUS110.110 Mental Health Observation and Engagement Chart (health record form). The NiC must ensure that the individual Health Problem Notification Form (HPNF) is updated to inform CSNSW of the current patient risks.	The patient's level of observation must be reviewed at least weekly by the MO, in collaboration with the MDT, NUM or delegate. The agreed observation level must be documented in the patient's health record by the MO. The patient's observation level, engagement and assessment undertaken must be discussed at the clinical handover, patient reviews and case review.

3.3.2 Increased Observation - Long Bay Hospital, Mental Health Unit

Level 1, 2 and 3 observations are considered increased observations and should be used for patients who have been assessed as posing some risk to self and/or others and who cannot be appropriately managed on an alternative level of observation.

Any member of the MDT may increase a patient's observation level to provide closer observation in response to deterioration in the patient's mental state or increase in risk. This decision must be made in consultation with the allocated nurse and NiC. The allocated nurse must consult with the MO as soon as practical for further review of the patient.

Detailed documentation as to why the increased observation occurred should be documented in the patient's health record. At the commencement of the increased observation level the MO must document the following information in the patient's Health Record:

- The patient's current mental state and presentation;
- The patient's current identified risks;
- What strategies have been utilised/are in conjunction with the increased level of observation to manage this risk;
- The patient's current observation level and minimum interval of observation;
- The rationale for the observation level;
- Interventions and clinical management;
- Changes to the patient's visits management, meals i.e. finger food, no cutlery, toileting and showering, attendance at therapeutic activities and groups;
- Description of interactions that have occurred;
- Any observation of ongoing or decreased risk factors in behaviour;
- Evaluation of effectiveness of observation level;
- Expected time of next review; and
- That the designated carer and or the principal carer provider have been informed of the observation level change where practicable.

The NiC must ensure:

- The NUM and all staff on shift are aware of the changes to the level of observations.
- That the individual Health Problem Notification Form (HPNF) is updated to reflect the patients increased level of risk and has sought approval for access to the patient from the Functional Manager (FM).

3.3.2.1 Level 3 Observations – at a minimum every 30 minutes- Long Bay Hospital, Mental Health Unit

Description of the level of supervision	Documentation requirements	Review
Level 3 observations are considered increased observations This level of observation must include a check of the location and activity of the patient preceding and following nursing handover and at a minimum every 30 minutes. The following must be considered when developing the management strategies to manage the patient: • Staff must be mindful that staggering and random observations are required to mitigate risks associated with predictable intervals of observation. • During periods of distress, patients require high levels of observation; sighting alone is not sufficient, engagement with the patient is required. • Since the patient has been assessed to pose some risk to self and/or others, the patient where possible should be managed in a highly visible area of the unit.	The observing clinician must ensure that there is a documented (utilising the SOAP documentation methodology or an approved systematic documentation practice) assessment in the health record at least two contemporaneous documented assessments per shift through the outcome of active engagement by nursing staff. Documentation must include the level of observation, salient aspects of the patient's mental state, current risks or concerns, their activity and engagements they have had with the patient. During sleeping hours the observing clinician are required to confirm that the patient is in their room and that they are breathing. The staff member must assess for respirations and signs of life; including but not limited to observation of body movement, snoring and/or a regular and continuous rise and fall of the chest. This must be documented in the health record. Documentation of observations are to be recorded on the JUS110.110 *Mental Health Observation and Engagement Chart* (health record form). The NiC must ensure that the individual Health Problem Notification Form (HPNF) is updated to inform CSNSW of the current patient risks.	The patient's level of observation must be reviewed at least weekly by the responsible MO in collaboration with the MDT, NUM or delegate. The agreed observation level must be documented in the patient's health record by the MO. The patient's observation level, engagement and assessment undertaken must be discussed at the clinical handover, patient reviews and case review.

3.3.2.2 Level 2 Observations – at a minimum every 15 minutes- Long Bay Hospital, Mental Health Unit

Description of the level of supervision	Documentation requirements	Review
Level 2 observations are considered increased observations. This level of engagement should only be used infrequently due to challenge it poses to regular engagement and the pattern of this observation becoming easily identifiable by the patients who may use the time between observations opportunistically and impulsively. This level of observation must include a check of the location and activity of the patient preceding and following nursing handover and at a minimum every 15 minutes. The following must be considered when developing the management strategies to manage the patient: • Staff must be mindful that staggering and random observations are required to mitigate risks associated with predictable intervals of observation. • During periods of distress, patients require high levels of observation; sighting alone is not sufficient, engagement with the patient is required. • Since the patient has been assessed to pose some risk to self and/or others, the patient where possible should be managed in a highly visible area of the unit.	The observing clinician must ensure that there is a documented (utilising the SOAP documentation methodology or an approved systematic documentation practice) assessment in the health record at least every two hours through the outcome of active engagement. Documentation must include the level of observation, salient aspects of the patient's mental state, current risks or concerns, their activity and engagements they have had with the patient. During sleeping hours the observing clinician are required to confirm that the patient is in their room and that they are breathing. The staff member must assess for respirations and signs of life; including but not limited to observation of body movement, snoring and/or a regular and continuous rise and fall of the chest. This must be documented in the health record. Documentation of observations are to be recorded on the JUS110.110 *Mental Health Observation and Engagement Chart* (health record form). The NiC must ensure that the individual Health Problem Notification Form (HPNF) is updated to inform CSNSW of the current patient risks.	The MO must review the level of observation at least 24 hourly unless documented otherwise by the consultant psychiatrist. The MO review timeframe must be clearly documented in the patient's health record. The agreed observation level must be documented in the patient's health record by the MO The patient's observation level, engagement and assessment undertaken must be discussed at the clinical handover, patient reviews and case review.

3.3.2.3 Level 1 Constant Observation (Visual) – Long Bay Hospital, Mental Health Unit

Description of the level of supervision	Documentation requirements	Review
Level 1 constant observation (visual) must be used for patients considered to pose a significant and imminent risk to self and/or others. The indication and outcome of this level of observation is constant assessment. This observation requires a minimum of 1:1 staff: patient allocation. Where the risk of harm to others posed by a patient is high to extreme, consideration should be given to the use of more than one clinician to continuously observe the patient. The observing clinician must be aware at all times of the patient's precise whereabouts and maintain an unobstructed line of sight of the patient. During lock down times this is done via the observation windows of the cell and whilst the patient is out of their cell the visual observation of the patient must be maintained depending of the patient activity. The observing clinician must not leave the immediate area and must maintain continuous and direct observation of the patient at all times. The patient must never be unsupervised under any circumstances or for any period of time, no matter how short. The following must be considered when developing the management strategies to manage the patient: • Since the patient has been assessed to pose significant risk to self and/or others, consideration must be given to managing the patient in a highly visible area of the unit. • Prior consideration and planning must be undertaken and clearly documented in the patient's health record in regards to observation required when performing activities of daily living such as showering and toileting. This planning should where possible be inclusive of gender and culturally	The observing clinician must ensure that there is a documented (utilising the SOAP documentation methodology or an approved systematic documentation practice) assessment in the health record at least every two hours through the outcome of active engagement. Documentation must include the level of observation, salient aspects of the patient's mental state, current risks or concerns, their activity and engagements they have had with the patient. During sleeping hours the observing clinician are required to confirm that the patient is in their room and that they are breathing. The staff member must assess for respirations and signs of life; including but not limited to observation of body movement, snoring and/or a regular and continuous rise and fall of the chest. This must be documented in the health record. Documentation of observations are to be recorded on the JUS110.110 *Mental Health Observation and Engagement Chart* (health record form).	The MO must review the level of observation at least 24 hourly unless documented otherwise by the consultant psychiatrist. The MO review timeframe must be clearly documented in the patient's health record. The agreed observation level must be documented in the patient's health record by the MO. The patient's observation level, engagement and assessment undertaken must be discussed at the clinical handover, patient reviews and case review.

appropriate allocation of staff and must take into consideration the patient's risk, trauma history and the effect of the observation requirements on the individual.	The NiC must ensure that the individual Health Problem Notification Form (HPNF) is updated to inform CSNSW of the current patient risks.	

3.3.2.4 Level 1 Constant Observation (Arm's Length) – Long Bay Hospital, Mental Health Unit

Description of the level of supervision	Documentation requirements	Review
Level 1 Constant Observation (Arm's Length) are implemented when the patient is considered to be at very high immediate risk and cannot be safely managed on Level 1 Constant Observation (Visual). The indication and outcome of this level of observation is constant assessment. The patient should be within arm's reach (at least 1 metre) of a member of staff at all times and in all circumstances. This observation requires a minimum 1:1 staff: patient allocation. Where the risk of harm to others posed by a patient is high to extreme, consideration should be given to the use of more than one clinician to continuously observe the patient. The NUM/AHNM must negotiate with CSNSW in relation to patient access and CSNSW supervision requirements. The following must be considered when developing the management strategies to manage the patient: • Since the patient has been assessed to pose significant risk to self and/or others, consideration must be given to managing the patient in a highly visible area of the unit. • Prior consideration and planning must be undertaken and clearly documented in the patient's health record in regards to observation required when performing activities of daily living such as showering and toileting. This planning should where possible be inclusive of gender and culturally appropriate allocation of staff and must take into consideration the patient's risk, trauma history and the effect of the observation requirements on the individual.	The observing clinician must ensure that there is a documented (utilising the SOAP documentation methodology or an approved systematic documentation practice) assessment in the health record at least every two hours through the outcome of active engagement. Documentation must include the level of observation, salient aspects of the patient's mental state, current risks or concerns, their activity and engagements they have had with the patient. During sleeping hours the observing clinician are required to confirm that the patient is in their room and that they are breathing. The staff member must assess for respirations and signs of life; including but not limited to observation of body movement, snoring and/or a regular and continuous rise and fall of the chest. This must be documented in the health record. Documentation of observations are to be recorded on the JUS110.110 *Mental Health*	The MO must review the level of observation at least 24 hourly unless documented otherwise by the consultant psychiatrist. The MO review timeframe must be clearly documented in the patient's health record. The agreed observation level must be documented in the patient's health record by the MO. The patient's observation level, engagement and assessment undertaken must be discussed at the clinical handover, patient reviews and case review.

	Observation and Engagement Chart (health record form). The NiC must ensure that the individual Health Problem Notification Form (HPNF) is updated to inform CSNSW of the current patient risks.	

3.3.3 Reducing Observation Levels- Long Bay Hospital, Mental Health Unit

- A decision to reduce the level of observation must only be made by a Medical Officer. The MO must review the patient's progress notes, receive a handover from the NiC regarding the patient's presentation and assess the patient's current risks.
- The cessation of an increased level of observation must be agreed by the MO, allocated observing clinician and NiC and the reasons for this must be clearly recorded in the patient's health record by the MO.
- The patient's mental state and current risk factors must be assessed by the MO and alternative management strategies must be implemented prior to the cessation of increased observation.
- To ensure patients are not left on an inappropriately high level of observation, it is recommended that forward planning occurs, particularly in respect to weekends. The MDT, where possible, should specify the circumstances that would permit a reduction in an observation level; for example 'review need for constant observation if patient exhibits an improved engagement with staff in conversation and denies any thoughts of self-harm for more than a 24 hour period'. This planning must be documented in the patient's health record by MO.
- The observing clinician/ delegated MDT member must update the patient's Care Plan when the observation level change occurs. This must be completed as soon as practical, and not later than the end of shift.
- The NUM/NiC must ensure that the observing clinician has appropriate time provided to document the changes in the patient Care Plan.
- The observing clinician must handover the observation changes during clinical handover.
- The NiC must ensure the NUM and all staff on shift are aware of the changes to the level of observations.
- Once it has been determined that the patient no longer requires an increased level of observation additional staffing (if was necessary) must be discontinued immediately. There is no need for any additional staff members rostered on to the unit to complete their shift where casual/agency staff or overtime is being utilised.
- The designated carer and or the principal carer provider should be informed of the observation level change by the MO or delegate where practicable.

3.3.4 Requests for Additional Staff – Long Bay Hospital, Mental Health Unit

The MDT for a patient must comprehensively assess the risks posed by the patient and develop a management plan to manage the identified risks. A recommendation to use additional staff for continuous observation may be made by the nurse in consultation with the psychiatrist and/or the psychiatry registrar. Additional staff must not be requested unless the recommendation has been approved by the NUM/NiC or CMH NUM3 Long Bay Complex/AHNM, in consultation with the MO. In considering the use of additional staff, the following must be considered:

- Where the risk involves risk of harm to others, careful consideration must be given to ensure the safety of staff performing an increased level of observation;

- The effectiveness of any other less intrusive strategies that have been, or could be, implemented in order to manage the identified risks;
- The purpose for which additional staff is required; and
- The indicators for when the additional staff will no longer be required.

The NUM/NiC must determine the need for any additional resources. If additional staff are required, the NUM/NiC must complete the *Request for Additional Staff – Patient Observations* form (CNS500) and forward it to the CMH NUM3 Long Bay Complex/AHNM after each review. The cessation of additional staff and the reasons for this must be clearly documented in the patient's Health Record and on the *Request for Additional Staff – Patient Observations* form (CNS500).

The basis for the decision must be recorded by the NUM/NiC on *Request for Additional Staff – Patient Observations* form (CNS500). If the decision is made not to support additional staff, the reasons for that decision must also be noted in the patient's Health Record by the NUM/NiC and an alternative risk management plan must be documented and implemented.

Approval for the use of additional staff must be given by the CMH NUM3 Long Bay Complex or the AHNM.

Additional staff for patient observation must be ordered according to the criteria set out in this policy. If there are any medical concerns about a mental health patient which necessitate frequent physical observations, the patient should be referred to a MO.

Additional staff used for patient observations must not be used to accompany patients on a transfer unless approved by the relevant Executive Director. The safety and security of a mental health patient during a transfer are the responsibility of Corrective Services NSW, except in the case of a forensic patient who is being transferred to a mental health facility on discharge from the MHU where JHFMHN Policy 1.407 *Transport of Forensic Patients from LBH, MRRC and SWCC* applies.

An operational decision regarding the nursing resources to be utilised must be made by the NUM/NiC in conjunction with the CMH NUM3 Long Bay Complex /AHNM.

3.3.5 Safety Considerations in the Mental Health Unit

Ideally, the nurse conducting the Level 1 constant observation should be within sight of other nurses on the unit at all times. Where this is not possible, the NUM/NiC must ensure that the nurse conducting the Level 1 constant observation is sighted at regular intervals not exceeding 15 minutes. Where the risk of harm to others posed by a patient is high to extreme, consideration should be given to the use of more than one clinician to continuously observe the patient.

4. Monitoring and Evaluation FH and MHU

Observations and Engagement must be monitored and evaluated; FH and MHU must have an auditing process in place to ensure compliance to this policy.

Compliance to this policy will be monitored via audits of the health records.

Random inpatient unit visits must be completed by the NUM/ AHNM to ensure compliance to the JUS110.110 *Mental Health Observation and Engagement Chart* (health record form).

Audits will be monitored and reported through the FH and Custodial Mental Health Clinical Governance Committee.

5. Definitions

Must

Indicates a mandatory action or requirement.

Should

Indicates a recommended action that needs to be followed unless there are sound reasons for taking a different course of action.

6. Legislation and Related Documents

Legislations	*Mental Health Amendment (Statutory Review) Act 2014* *Mental Health Act 2007* *Mental Health and Cognitive Impairment (Forensic Provisions) Act (2020)*
NSW MoH Policy Directives and Guidelines	PD2017_025 *Engagement and Observation in Mental Health Inpatient Units.* PD2019_020 *Clinical Handover* PD2020_004 *Seclusion and Restraint in NSW Health Settings.* PD2020_018 *Recognition and Management of Patients who are Clinically Deteriorating,* GL2021_006 *Physical Health Care for People Living with Mental Health Issues* PD2017_033 *Physical Health Care within Mental Health Services*
JHFMHN Policies and Procedures	1.078 *Care Coordination, Risk Assessment, Management, Planning and Review Forensic Hospital.* 1.075 *Clinical Handover Implementation Guide – Ministry of Health PD2009_060* 1.322 *Recognition and Management of Patients who are Clinically Deteriorating: Implementation Guide – Ministry of Health PD2020_018,* 1.350 *Aggression, Seclusion & Restraint in Mental Health Facilities – Long Bay Hospital Mental Health Unit* 1.360 *Segregated Custody and Mandated Protection* 1.407 *Transport of Forensic Patients from LBH, MRRC and SWCC* 1.249 *Leave Grounds Access and SCALE Forensic Hospital* 1.441 *Acute Sedation - Forensic Hospital and Long Bay Hospital Mental Health Unit* Guidelines for Psychotropic Medication 2020 Forensic Hospital Procedure *Patient Counts and Patient Absconding*

	Forensic Hospital Procedure *Replacement of Nursing Staff and Fatigue Management*
	Forensic Hospital Procedure *Seclusion and Restraint Process*
JHFMHN forms	CNS500 *Request for Additional Staff Form – Patient Observations*
	JUS110.110 *Mental Health Observation and Engagement Chart*
External Resources	NHS Scotland 2002 *Engaging People: Observation of People with Acute Mental Health Problems*
	Standing Nursing And Advisory Committee 1999 *Practice Guidance – Safe and Supportive Observation of Patients At Risk*