

Regional Guideline on the Use of Observation and Therapeutic Engagement in Adult Psychiatric Inpatient Facilities in Northern Ireland

November 2011

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1. Introduction

Special observation is a therapeutic nursing intervention with the aim of reducing the factors which contribute to an individual patient's risk to themselves and/or others and promoting recovery. There is limited evidence on the efficacy of special observation in the published literature. The use of special observation is often seen as custodial in nature and as a method of containment rather than engagement with the patient. There is a need for special observation to focus on engaging the patient therapeutically, instilling hope in the patient and enabling them to address their difficulties constructively.

Although special observation is generally seen as a nursing intervention, the decision to place patients on special observation is a multidisciplinary decision. There is a great deal of scope for variation in terms of levels of observation used and the decision-making process to place patients on observation and the review of that decision. In practice there are many different systems in place across Northern Ireland. This can cause confusion for staff, who move between facilities with different operational policies, hence the need for consistency of approach.

Most nursing budgets have some flexibility built into their baseline funding, in order to allow them to manage one or two patients requiring special observation. However, should more patients require special observation, this puts pressure on the nursing budget. In the current financial situation Trusts must break even, consequently inefficient use of special observations can place pressure on already overstretched budgets. It is therefore important that special observation is used effectively.

In order to promote consistency of approach, and to ensure optimal care is provided to patients, it was agreed by the Director of Nursing in the Public Health Agency and the Director of PMSI in the Health and Social Care Board that a review of the policy, in regard to special observation, should be undertaken on a multidisciplinary basis across Northern Ireland, with the input of users and carers.

The findings of this review are detailed in the accompanying '**Technical Document to Support Regional Guideline on the use of Observation in Psychiatric Inpatient Facilities in Northern Ireland**'. This document contains a review of the published literature on special observation and therapeutic engagement, with a full list of references. It highlights the main similarities and differences between the Special Observation Policies currently in operation in the five Trusts in Northern Ireland. It also details the main findings of a questionnaire completed by the Service Improvement Managers of the five Trusts in consultation with senior clinicians and nursing staff. This Regional Guideline is based on the published literature, the current policies and the views of the Service Improvement Managers.

2. Aims of Guideline

The aims of this Guideline are:

- To establish evidence-based approaches to special observation, based on the published literature
- To improve the therapeutic nature of special observation
- To define levels of observation
- To clarify the process for increasing, reviewing and decreasing the level of observation
- To clarify the responsibility of each discipline involved in the decision-making process
- To ensure a clearly-defined and recorded decision-making process
- To ensure regional consistency in the use of special observation

3. Scope of Guideline

This regional guideline applies to all inpatients in adult mental health inpatient units in Northern Ireland. It has been developed using the best available evidence in the published literature. The guideline will be kept under review on a yearly basis.

It should be noted that this guideline is intended to ensure regional consistency in the use of special observation. However, implementation of this guidance is subject to many localised environmental factors including building quality and security and staff skill mix. This guideline should be used to inform each Trust's Special Observation Policy and to ensure consistency across the region.

Note that any child admitted to an adult psychiatric ward must be observed as per that Trust's policy on admission of children to adult wards.

4. General Principles

Any enhanced level of observation for an individual patient should have a clearly stated rationale, purpose and goal. Observation should be used as an opportunity to engage with the patient, to develop rapport and to build a relationship. This may include engaging the observed person in some constructive and therapeutic activity or intervention, or offering support and comfort in order to strengthen the therapeutic relationship. The goal of observation should always be to reduce the factors which contribute to risk, and this should be the focus of the nurse-patient interaction during observation. As such, enhanced levels of observation should be used for as short a duration as necessary.

The appropriate level of observation for any patient should be based on the clinical risk assessment for that individual in keeping with the regional risk assessment guidance¹. This risk assessment should be documented on a Risk Screening Tool or Comprehensive Risk Assessment as per Trust protocol.

Risk assessment and decisions on level of observation should be carried out in collaboration with the patient. The patient should be fully informed and enabled to contribute fully to the process. All patients nursed on an enhanced level of observations should be provided with a written information sheet, detailing the nature and purpose of special observation.

Enhanced levels of observation can apply to both voluntary and detained patients. Enhanced observation may be utilised during periods of increased distress, agitation, arousal and self neglect to provide intensive nursing care. Therapeutic use of observation is dependent on the ability for observations to be used flexibly. Timely review and discontinuation of observations which are no longer necessary is essential to the process of engagement and its therapeutic value.

Higher levels of observation may represent a more restrictive environment and if a capacitous patient at any stage refuses to consent to engage, detention under the Mental Health Order² should be considered (Appendix 5).

As part of their treatment plan, all patients admitted to inpatient services should be requested to remain on the ward for a period of 48 hours for observation and assessment of risk. This includes both informal and detained patients. Any deviation from this should be based on the patient's individual risk assessment. If a patient requests to leave or spend time off the ward during this initial period, this must be discussed and agreed with the Responsible Medical Officer and documented in the patient's notes.

Each Trust should have their own policy on locked / lockable doors for inpatient wards. Although the use of locked doors may impact on the utilisation of special observation, this has not been incorporated into this regional guideline as the layout of each individual unit varies and would need to be taken into consideration in any decision.

In allocating staff to undertake enhanced observation, the Nurse in charge should take account of the importance of continuity of care and aim to allocate staff members with whom the patient has a trusting relationship.

5. Definition of Levels of Observation

There is significant variation in terms of the levels of observation defined in the Special Observation Policies currently in use in the five Trusts in Northern Ireland (see Technical Document for further details). NICE define four levels of observation in their 2005 guidelines on the management of violence³, namely general observation, intermittent observation, within eyesight observation and within arm's length observation. However, the recently published 'National Confidential Inquiry into Suicide and Homicide by People with Mental Illness: Northern Ireland Report 2011'⁴ recommends that in-patient services should abandon the use of intermittent observation due to the number of in-patient suicides that have occurred while patients have been on intermittent observation. As a result, intermittent observation has not been included in this guideline. Additionally, "Within eyesight" and "Within arm's length" observations have been combined into "Continuous Observation" in order to allow greater flexibility. This results in two levels of observation:

1. General Observation
2. Continuous Observation
 - a. Within eyesight
 - b. Within arm's length

5.1 General Observation

General Observation is the minimum acceptable level of observation for all in-patients. This level of observation is suitable for patients assessed as presenting a low to medium risk of suicide, deliberate self harm or harm to others.

The location of all service users should be known to staff, but not all service users need to be kept within sight. The exact location of each patient on general observation should be recorded no less than hourly. Individual Trusts may decide to record the exact location of each patient on general observation at shorter time intervals, for example every 15 minutes or every 30 minutes. In this case, the exact time interval must be specified in the Trust Special Observation Policy, and this must apply to ALL patients on general observation. More frequent checks should not be considered an enhanced level of observation.

At least once per shift, a registered mental health nurse should set aside dedicated time to assess the mental state of the patient and engage positively with them. This assessment should be documented in the patient's notes.

5.2 Continuous Observation

Continuous Observation involves 1:1 nursing observation. Continuous observation should be considered when the patient could, at any time, attempt to significantly harm themselves or others. It should be considered when a patient is assessed as presenting a high risk of suicide, deliberate self harm or harm to others. It may also be needed for patients who need constant assistance to maintain their safety.

There are two categories of continuous observation. The patient can be observed either within eyesight or within arm's length, depending on clinical need;

- a) **Within eyesight** observation requires that the patient is kept within eyesight and accessible at all times, by day and by night.
- b) **Within arm's length** observation should be considered for patients at the highest risk of harming themselves or others, and it involves supervising the individual in close proximity. On specified occasions, more than one member of staff may be necessary, particularly if the patient presents a risk of violence.

Positive engagement with the service user is an essential aspect of continuous observation.

Patients who are on continuous observation for risk of suicide or self harm should be supervised at all times without exception. Continuous observation should be continued at all times when visitors are present and when patients are attending therapies / activities, unless agreed as part of the Observation Prescription. Consideration could be made to changing continuous observation from 'within arm's length' to 'within eyesight' when visitors are present.

As a general principle, continuous observation should continue throughout the night whilst the patient is sleeping. However, it may be appropriate to position the observation nurse further than arm's distance, depending on environmental factors. If a difference is to be made between observation levels during the day and at night, this must be specified on the Continuous Observation Prescription Form.

Continuous observation requires additional expertise from the nurse, to work with patients who are most acutely distressed and who are presenting the highest levels of risk. Wherever possible, a nurse should not undertake continuous observation for longer than 2 hours consecutively.

The observation nurse should not replace the role of the Primary / Named nurse, who is responsible for daily assessment of mental state and implementation of a holistic nursing care plan. The observation nurse will support the Primary / Named nurse in assessment of risk and mental state and in engaging therapeutically with the patient.

6. Delegation to non-registered staff

In view of the high level of expertise required, continuous observation should be carried out by registered mental health nurses wherever possible. This ensures that patients are positively engaged and trained staff can utilise the time therapeutically.

However, in certain circumstances, it may be appropriate to delegate continuous observations to non-registered staff. In these instances the senior nurse who makes a decision to delegate⁵ continuous observations is accountable for ensuring that the non-registered member of staff is competent to undertake the role (Appendix 6). The individual staff member undertaking continuous observation must be satisfied that they have the appropriate knowledge, skills and experience to safely perform this task, including appropriate training in management of violence and aggression. All non-registered staff undertaking continuous observation must be aware of the patient's level of observations and the rationale for this by reading and understanding the care plan in the nursing notes.

7. Procedure for increasing the level of Observation

In most circumstances a decision to increase the level of observation will be taken by the multidisciplinary team. However, in matters of urgency, any member of the multidisciplinary team may commence a higher level of observation, if increased risk is suspected. This could be done by the named nurse, the nurse in charge, the duty doctor or the patient's responsible medical officer or nominated deputy.

Wherever possible, the patient should participate in decisions about the appropriate level of observation. Nurses should explain to the patient the reason for observation, how it will be provided and by whom. The patient should be given written information and should be asked to sign their Observation Prescription Form.

The decision on the level of observation must be documented in the medical and nursing notes and on the Observation Prescription Form.

8. Procedure for reviewing the level of Observation

All observation levels should be under continuous review, and aim to provide the least restrictive care needed to maintain safety. The observations of a patient subject to continuous observation should be reviewed by both a medical officer (consultant psychiatrist or nominated deputy) and senior nurse (named nurse or nurse-in-charge) on at least a daily basis.

At weekends and bank holidays, observation levels should be reviewed by a senior nurse and the duty doctor, with the duty consultant contacted by telephone if necessary.

All patients' level of observation must be reviewed formally at the weekly multidisciplinary team assessment meeting.

9. Procedure for reducing the level of Observation

Any reduction in a patient's level of observation must be a multidisciplinary decision and must always be based on a thorough clinical risk assessment. The level of observation can only be reduced following a joint assessment by a senior nurse (named nurse or nurse-in-charge) and the patient's consultant psychiatrist or their nominated deputy. When the treating medical team is unavailable, for example at weekends, the level of observation can be reduced by nursing staff in conjunction with the duty doctor, with the consultant-on-call contacted by telephone if necessary.

When observation levels are changed, the rationale for the decision must always be documented in the patient's notes. The Observation Prescription Form must be signed by the senior nurse or medical officer. It should clearly describe what has changed in terms of risk to warrant a change in observation.

If there is disagreement between individuals within the multidisciplinary team about any decision to increase or to reduce a patient's level of observation, this must be brought to the attention of those individuals' line managers. Staff should always choose the safest option for both the patient and staff.

10. Procedure for planning changes in Observation

At the weekly multidisciplinary team meeting, the patient's treating consultant psychiatrist may wish to specify certain conditions under which other staff may wish to consider changing the patient's level of observation. These conditions must be clearly documented in the patient's medical notes and the Observation Prescription Form. These conditions may help inform decisions when the treating consultant is unavailable, for example at weekends, evenings and bank holidays.

11. Documentation of Observations

11.1 Medical / Nursing Notes

Any decisions with regards to a patient's level of observations must be recorded in their medical and nursing notes. This must state clearly the level of observation, the rationale for the observation level, and when this will be reviewed.

The patient's named nurse should record a summary of the observations as part of their assessment in the nursing notes once per shift.

11.2 Continuous Observation Prescription Form (Appendix 1)

If a patient is commenced on Continuous Observation, a Continuous Observation Prescription Form must be completed and included in the patient's notes. This form should detail how observations will be implemented and reviewed, risk factors related to the observation level, known triggers which would increase risk, and rationale for reducing observation level. The Continuous Observation Prescription Form should also record any special circumstances or conditions, for example when the patient is in the bathroom or has visitors.

When Continuous Observation is stopped, the Continuous Observation Prescription Form must be updated and signed by the staff members making this decision. The rationale for this decision must be documented in the patient's notes and on the Continuous Observation Prescription Form, which must be discontinued.

11.3 Continuous Observation Care Plan (Appendix 2)

All Trusts should develop a pre-written care plan detailing the purpose of continuous observation, focusing on therapeutic input and personal responsibility, which the patient should be asked to sign to demonstrate their engagement in the process. The patient should receive a copy of this care plan. A possible template for this care plan, based on one currently in use in the Northern Trust, is included in Appendix 2. All staff on the ward must be made aware regarding the patient's level of observations and the rationale for this by reading and understanding the care plan in the nursing notes and during shift to shift handovers.

11.4 Continuous Observation Recording Sheet (Appendix 3)

For any patient on continuous observation, every hour the observing nurse should document a summary of the care given during that hour, emphasising the therapeutic input and highlighting any issues relevant to risk. This should be written on a Continuous Observation Recording Sheet, which must be filed in the patient's notes. Unqualified staff can complete this document but each of their entries must be countersigned by a qualified member of staff. This

information will be used by the patient's named nurse in their summary report in the nursing progress notes recorded every shift.

12. Monitoring and Audit

Trusts should develop processes for recording the number of patients being nursed under continuous observation and the number of staff required to cover this. This should be routinely monitored and audited.

A Record of Continuous Observation (Appendix 4) should be completed by the nurse in charge for every patient commenced on continuous observation. These records should be forwarded to the Nursing Services Manager to enable data to be collated and monitored.

13. References

1. Promoting Quality Care - Good Practice Guidance on the Assessment and Management of Risk in Mental Health and Learning Disability Services, DHSSPSNI, 2010.
2. Mental Health Order, Northern Ireland, 1986.
3. National Institute for Clinical Excellence. Violence – The short-term management of disturbed/violent behaviour in in-patient psychiatric settings and emergency departments, 2005.
4. National Confidential Inquiry into Suicide and Homicide by People with Mental Illness: Northern Ireland Report June 2011, DHSSPSNI, 2011.
5. Central Nursing Advisory Committee (CNAC) Operational Framework for Delegation Decision Making, September 2009

14. Appendix 1 – Continuous Observation Prescription Form

Name:		DoB:			Consultant:		
Please respond to all statements below		Yes	No	Sign/date	Update Sign/date	Update Sign/date	Update Sign/date
Patient to be within eyesight							
Patient to be at arm's length							
Observation when using bathroom	Eyesight						
	Arm's length						
Date plan commenced:				Time:			
Medical Staff: Print Name:				Signature:			
Nursing Staff: Print Name:				Signature:			
Patient Signature:							
Summary of risk factors relating to observation plan:							
Rationale for observation level:							
Known risk triggers / changes in behaviour which would increase risk:							
What would be the rationale for reducing observation levels (e.g. visitors, asleep)?							
Cessation of Continuous Observation							
Rationale for decision:							
Medical Staff: Print Name:				Signature:			
Nursing Staff: Print Name:				Signature:			
Date:				Time:			

Appendix 2 – Continuous Observation Care Plan

Date:	
Name:	
DoB:	
Primary Nurse:	
Consultant:	

Identified Need

Increased risk of:

Identified Goal:

To promote a risk free environment which seeks to re-establish self-care and independence.

Planned Interventions, Nursing / Self

1. Place on continuous observations, complete Continuous Observation Prescription Form and provide information leaflet.
2. Introduce self to patient
3. Proactively initiate and encourage communication in order to build up rapport with the patient
4. Encourage meaningful interaction with _____ attempting to promote open and honest discussion re prescription of continuous observations as outlined in the Observation Prescription Form.
5. Explore precipitating factors leading up to this situation and encourage ventilation of fears and anxieties.
6. Together with _____ attempt to identify any stressors or triggers.
7. Discuss the above factors and try to find ways of lessening or avoiding their reoccurrence.
8. Recognise and negotiate the right to time for privacy, relaxation and rest.
9. Review the level of observations on a daily basis with members of the multidisciplinary team, emphasising the promotion of responsibility, independence and therapeutic risk taking.
10. Consider appropriate use of medication and administer same as prescribed.
11. Encourage engagement in ward based activities where appropriate, involving Occupational Therapy and other key personnel.
12. Inform and involve relatives and carers in decisions regarding observations when practicable.
13. Ensure that all staff are aware of prescription of continuous observations and complete documentation accordingly.
14. Specific interventions to address this patient's particular difficulties.

Patient Signature: _____

If not signed, reason why: _____

Primary Nurse Signature: _____

Review Date: _____

Appendix 3 – Continuous Observation Recording Sheet - Template

Patient Name:		DoB:	Hospital No:
Ward:		Primary Nurse:	Consultant:
Date:			
Time	Sign & Date	Print Name	Comments
0800 - 0900			
0900 - 1000			
1000 - 1100			
1100 - 1200			
1200 - 1300			
1300 - 1400			
1400 - 1500			
1500 - 1600			
1600 - 1700			
1700 - 1800			
1800 - 1900			

Time	Sign & Date	Print Name	Comments
1900 - 2000			
2000 - 2100			
2100 - 2200			
2200 - 2300			
2300 - 0000			
0000 - 0100			
0100 - 0200			
0200 - 0300			
0300 - 0400			
0400 - 0500			
0500 - 0600			
0600 - 0700			
0700 - 0800			

Appendix 4 – Record of Continuous Observation

- The nurse in charge must complete this record for every patient commenced on continuous observation.
- This form must be completed even if no additional staff were required.
- When continuous observation ceases, this form must be signed and forwarded to the nursing services manager, who will arrange for the details to be recorded.

Patient details

Patient's name:
Date of Birth:

Ward:
Consultant:

Staffing

Number of staff currently on ward:

Number of patients on continuous observation:

Number of additional staff required on ward:

Date commenced: / / **Time commenced:** / /

Date finished: / / **Time finished:** / /

Duration of continuous observation (number of days):

Signed: _____

Designation of nurse: _____



To:
Chief Executive of HSC Trusts
Chief Executive of HSC Board (for cascade to
GPs and other relevant practitioners)
Chief Executive of PHA
Chief Executive of RQIA (for cascade to private
hospitals, clinics and other relevant
establishments and agencies)
Chief Executive of PCC
British Medical Association (NI)
Royal College of Nursing (NI)
Royal College of Psychiatry (NI)
British Association of Social Workers (NI)
College of Occupational Therapists (NI)

Castle Buildings
Belfast BT4 3SQ
Tel: 028 90520724
Fax: 028 90520725
Email: maura.briscoe@dhsspsni.gov.uk

Your Ref:

Our Ref: HSC/MHDP – MHU 1 /10 -
revised

Date: 14 October 2010

DEPRIVATION OF LIBERTY SAFEGUARDS (DOLS) – Interim Guidance

Purpose

1. The purpose of this circular is to provide interim guidance on the principles to be applied by those involved in taking decisions about an individual's care or treatment that may result in the deprivation of that individual's liberty. The guidance is issued pursuant to the European Court of Human Rights (ECtHR) judgement in 2004 in the "Bournewood" case (see Annexe 1) and is therefore an important element in the protection of Human Rights of patients as required under the European Convention of Human Rights. The guidance is intended as an interim solution based on the current legislative framework, the Mental Health (Northern Ireland) Order 1986 (the Order) and best practice, pending the introduction of new mental capacity legislation in Northern Ireland.
2. The guidance is intended for use by staff working in hospital and/or community care settings across all HSC organisations and relevant independent sector organisations where an individual may be subject to deprivation of their liberty.

A copy of this circular has been placed on the Department's website (www.dhsspsni.gov.uk).

3. This guidance revokes and replaces Circular Letter HSC/MHDP – MHU 1/10: DEPRIVATION OF LIBERTY SAFEGUARDS (DOLS) – Interim Guidance, issued by the Department on 1 March 2010.

The Case

4. Attached (annexe 1) is a summary of the Bournemouth judgement which involved HL, a man who had autism and learning disabilities who was admitted to Bournemouth Hospital for treatment. HL eventually took proceedings to the ECHR against the UK government, on the grounds that he had been unlawfully detained and deprived of his liberty in violation of Article 5(1) of the ECHR and that procedures available to him as an informal patient for the review of the legality of his detention (judicial review plus a writ for habeas corpus) did not satisfy the requirement of Article 5(4) of the ECHR. The summary conclusions of the ECHR are important and are attached.

Deprivation of Liberty

5. The European Court found that HL had been deprived of his liberty within the meaning of Article 5(1) of the Convention. It is important to note that the judgement does not concern the treatment of incapacitated patients generally. It was only concerned with the question of deprivation of liberty of an incapacitated person.
6. The European Court's judgement does not, therefore, mean that incapacitated patients admitted to hospital or to care homes are automatically deprived of their liberty, even if staff would prevent them leaving unescorted for their own safety.
7. There must be particular factors which provide the "degree" and "intensity" to render the situation one of deprivation of liberty. The factors might relate for example, to the type of care being provided, its duration, its effects and the ways in which admission came about.
8. In this case, the European Court said that:

"the key factor in this present case [is] that the healthcare professionals treating and managing the applicant exercised complete and effective control over his care and movements".

and, noting that HL had been resident with his carers for over three years the Court went on to say that

" the clear intention of Dr M and the other relevant health care professionals [was] to exercise strict control over his assessment, treatment, contacts and, notably, movement and residence: the applicant would only be released from hospital to the care of Mr and Mrs E as and when professionals considered it appropriate (paragraph 91).

9. Accordingly the Court found that "the concrete situation was that the applicant was under continuous supervision and control and was not free to leave" (paragraph 91).

10. The Court attached particular importance to the fact that HL had a settled home with his paid carers to which he was prevented from returning and that his contact with those carers was (to some extent) restricted by the staff of the hospital. The court did not consider the issue of whether the ward was "locked" or "lockable" to be determinative.

Lack of Procedural Safeguards

11. The European Court did not find that HL's rights had been breached simply because he was admitted to hospital on the basis of common law doctrine of necessity (i.e. in his "best interests"), rather than under specific statutory provisions (e.g. the Mental Health Order).
12. However, the Court did find that the absence of procedural safeguards surrounding his admission failed to protect him against "arbitrary deprivation of liberty on grounds of necessity and, consequently, (failed) to comply with the essential purpose of article 5(1) of the Conventions".
13. In this latter respect, the European Court was clearly influenced by the "lack of any fixed procedural rules by which the admission and detention of compliant incapacitated persons is conducted" when contrasted with "the extensive network of safeguards applicable to psychiatric committals covered by the (Mental Health Act 1983). Paragraph 120 is of relevance.

14. The European Court also said:

"the nomination of a representative of a patient who could make certain objections and applications on his/her behalf is a procedural protection accorded to those committed involuntarily under the 1983 Act and which would be of equal importance for patients who are legally incapacitated and have, as in the present case, extremely limited communication abilities" (paragraph 120)

By which it presumably had in mind the role of the nearest relative under current mental health legislation.

15. Above all, although it did not question their good faith, the Court seems to have been concerned that the hospital's health care professionals were able to assume "full control of the liberty and treatment of a vulnerable incapacitated individual solely on the basis of their own clinical assessments completed as and when they considered fit" (paragraph 21).
16. The Court did not say that HL should have been formally detained under the Mental Health Act. Nor, in the Department's view, does the judgement mean that procedural safeguards for people in HL's position must be identical to those patients detained under the current mental health legislation. However, it is accepted that to avoid further violations of Article 5(1), new procedural safeguards are required for patients who are not formally detained, but who are, in effect, deprived of their liberty in the best interests under common law doctrine.

Breach of Article 5(4)

17. The European Court also found a violation of his rights under Article 5(4) of the convention.

Next Steps

The following paragraphs outline the next steps to be taken by DHSSPS, HSC organisations and relevant independent sector organisations.

Proposals for new procedural safeguards

18. The Department will bring forward new safeguards in law via the proposed Mental Capacity (Health, Welfare and Finance) Bill.

Interim steps that might be taken by HSC bodies and relevant independent sector organisations.

19. Until these safeguards are established in law, the effect of the Bournemouth Judgement is that it would be unlawful for an HSC body (without the prior authorisation of the High Court) to arrange or provide care or treatment for an incapacitated patient in a way that amounted to deprivation of liberty within the meaning of Article 5 of the Convention unless the patient were detained under the Mental Health (NI) Order 1986.

20. Nonetheless, the HSC will need to continue to provide care and treatment for incapacitated patients, and it is important that neither the safety of those patients nor the quality of the care they receive is jeopardised during the interim period, both for their good, and, it follows, the care and protection of other patients.

21. Pending the development of new safeguards described above, HSC bodies will want to consider what steps they can take in the short-term to protect incapacitated people against the risk of arbitrary deprivation of liberty and minimise the risk of successful legal challenges.

22. The Department suggests that HSC bodies and relevant independent sector organisations will want to ensure they have systems in place so that when making arrangements to provide care to an incapacitated person which involves a restriction on the liberty of that person, consideration is given as to whether what they are proposing amounts in practice to a deprivation of that person's liberty within the meaning of Article 5 of the Convention, taking into account the range of factors identified by the Court set as described above and also contained within (a) to (f) in the Bournemouth Judgement attached. The same question will need to be asked when reviewing the circumstances of those people who they have already placed who may, in practice, be deprived of their liberty.

23. If patients are considered to be deprived of their liberty (or at risk of it), consideration should always be given to alternatives to ensure that they get adequate care but which falls short of deprivation of liberty. In particular, HSC bodies and independent sector organisations will want wherever possible, to avoid situations in which professionals may be said to take "full and effective control" over patients care and liberty.

24. Elements of good practice which are likely to assist in this, and in avoiding the risk of legal challenge, may include:

- ensuring that decisions are taken (and reviewed) in a structured way, which includes safeguards against arbitrary deprivation of liberty. There should, for example, be a proper assessment of whether the patient lacks capacity to decide whether or not to accept the care proposed, and that decisions should be taken on the basis of proper medical advice by a person properly qualified to make the judgement.
- effective, documented care planning and record keeping for such patients, including appropriate and documented involvement of family, friends, carers (both paid and unpaid) and others interested in their welfare and safety.
- ensuring that alternatives to admission to hospital or residential care are considered and that any restrictions placed on the patient while in hospital or residential care should be kept to the minimum necessary in all the circumstances of their case.
- ensuring appropriate information is given to patients themselves and to family, friends and carers. This would include information about the purpose and reasons for the patient's admission, proposals to review the care plan and the outcome of such reviews and the way in which they can challenge decisions (e.g. through the relevant complaints procedure). The involvement of local advocacy services, where these are available, should be encouraged to support patients and their families, friends and carers.
- taking proper steps to help patients retain contact with family, friends and carers, with proper consideration given to the views of these people. If, exceptionally, there are good clinical reasons why that is not in the patient's best interests, those reasons should be properly documented and explained to the people they affect.
- ensuring both the assessment of capacity and the care plan are kept under review. It may be helpful to include an independent element in the review. Depending on the circumstances, this might be achieved by involvement of social work or community health staff, or by seeking a second medical (or other appropriate clinical) opinion either from within the HSC Body/independent organisation, or elsewhere. Such a second opinion will be particularly important where family members, carers or friends do not agree with the organisation's decisions. But, even where there is no dispute, an organisation must ensure its decision making stands up to scrutiny.

25. If it is concluded that there is no way of providing appropriate care which does not amount to deprivation of liberty, then consideration will have to be given to using the formal powers of detention in the Mental Health (NI) Order 1986. However it is important to remember that:

- nothing in the judgement changes the requirements in the Mental Health Order which must be met before patients can be detained. It should not therefore be assumed that all patients who are to be subject to restrictions

which may amount to deprivation of liberty can be detained under the Order. (For example, it would be unlawful to detain patients under the Order if their mental disorder does not warrant detention in hospital, although reception into guardianship under the Order might be appropriate in some cases).

- there are dangers in using the Order simply to be “on the safe side”. Although it provides procedural safeguards, the use of the Mental Health Order will not necessarily be welcomed by their family, friends or carers, given the stigma that is often (wrongly) perceived to attach to it. Moreover, a significant increase in the use of the Mental Health Order will inevitably put considerable further pressure on approved social workers, the availability of second opinion appointed doctors (SOADs) and on the operation of the Mental Health Review Tribunal (MHRT).

Action Required

26. I should be grateful if Trust Chief Executives would bring this guidance to the attention of all relevant personnel; ensure the principles it contains are embedded into Trust's procedures; and, confirm to me by **10 December 2010** that this has been done.

Yours sincerely

[SIGNED]

DR MAURA BRISCOE

Director of Mental Health and Disability Policy

Appendix 6 – Delegation of Nursing Care Documentation (CNAC)

CENTRAL NURSING ADVISORY COMMITTEE OPERATIONAL FRAMEWORK FOR DELEGATION DECISION MAKING



In delegating, the nurse or midwife must ensure the appropriate assessment, planning, implementation and evaluation of the person's care. The process is continuous and based on the following:-

1. The right task

Delegation of care occurs following a written assessment of the individual person's needs and is supported by organisational policies and procedures.

2. The right circumstances

The specific circumstances in which care may, or may not be delegated are considered, taking account of the setting and availability of adequate resources.

3. The right person

Systems are in place to ensure the competency of the care giver is established and maintained and to provide ongoing monitoring and support. This will include knowing when to seek appropriate advice.

4. The right communication

The plan of care will include clear, concise description of the task, including expected and actual outcomes. Records are maintained of all aspects of the delegation process.

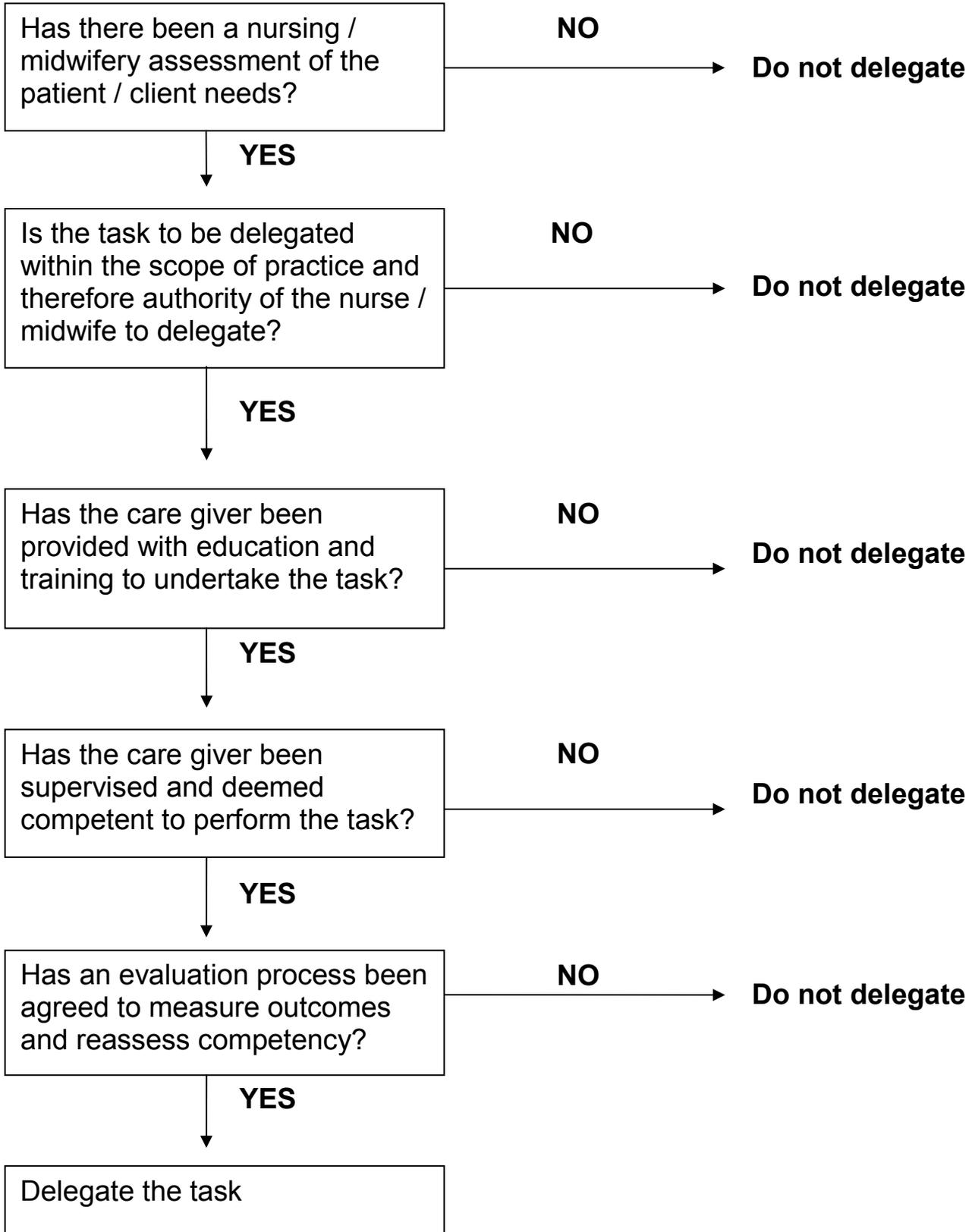
5. The right feedback.

A process for ongoing monitoring and support is established to ensure the delivery of safe and effective care. This will include an evaluation of the outcomes and the patients' experience.

This framework acknowledges the work undertaken by the National State Boards of America¹.

¹ National Council of State Boards of Nursing (America) 1995 Delegation: concepts and decision making process. (National Council Position Paper) available from www.ncsbn.org

Central Nursing Advisory Committee Delegation Decision Making Framework



Appendix 7

Responses from the consultation on Regional Guideline on the use of observation and therapeutic engagement in adult psychiatric inpatient facilities in Northern Ireland.

The majority of the responses received commended the paper and the regional consistency that it provided.

A number of comments and queries were raised that the group considered and agreed did not warrant reference in the document. These are listed below:

1. A number of Trusts commented on the potential additional administrative burden from recording observations. The group's view was that the recording form was intended to be the sole recording form, thus avoiding duplication. In addition it would be the member of staff carrying out the observation who would record the details hourly which would not create additional administrative tasks.
2. A number of comments were received in relation to learning disability and CAMH services. The group agreed that these comments would need to be considered separately to this specific guidance which focuses on mental health inpatient care and PICU. At this stage the guidance focuses on adult mental health services but the guidance does not preclude for use in other areas.
3. Some Trusts raised the issue of locked doors and the need to provide the least restrictive environment. The group agreed that this is an operational issue for individual Trusts to reconcile.

Appendix 8 – Members of the Working Group

Dr Rowan McClean	Locum Consultant Psychiatrist, Northern Health and Social Care Trust.
Dr Paul Bell	Consultant Psychiatrist, Belfast Health and Social Care Trust. Medical Advisor to PMSI.
Molly Kane	Regional Lead Nurse Consultant, Mental Health and Learning Disability, Public Health Agency.
Andrea Turbitt	Project Manager, Mental Health & Disability, Public Health Agency.
Denise Martin	Nursing Services Manager, Northern Health and Social Care Trust.
Briege Quinn	Nurse Consultant, Mental Health and Learning Disability, Public Health Agency.