Humber Teaching
NHS Foundation Trust

Supportive Engagement Policy (N-003)

Policy currently under review – please continue to use this version until it is replaced by the next approved version

Version Number:	1.03
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Name of approving committee:	Quality and Patient Safety Group
Date approved:	6 July 2021
Date Ratified at Trust Board:	N/A (minor amendments)
Next Review date:	July 2024

Contents

1. INTRODUCTION

This policy and associated Guidelines provides a framework that has transformed culture, leadership and professional practice to deliver care and support which keeps people safe, and promotes recovery.

This document sets out the policy of Humber Teaching NHS Foundation Trust for the provision of increased levels of support and engagement to all service users receiving in-service user care across the Trust, which keeps people safe, and promotes recovery. The primary purpose of supportive engagement is to maximise service user safety, minimise risk and to initiate and build supportive therapeutic relationships.

This policy offers guidance on carrying out supportive engagement in a way that involves minimal restriction on a person, minimises conflict, increases therapeutic engagement and promotes dignity by working collaboratively with the service user. These principles are embedded within this policy and Supportive engagement Guidelines and are guided by the updated Mental Health Act Code of Practice (2015), and national guidance; specifically NICE Guidance for Violence and aggression: short term management in mental health, health and community settings National Guideline 10 (NG10, 2015).

Formal observation systems should not be seen as inflexible and rigid and it is important that policy and clinical practice developments are not restricted.

This guidance refers to any increased 'supportive observation' as 'supportive engagement'

The Humber Teaching NHS Foundation Trust's unequivocal position is taken from Crag (2002)
'The key purpose of observation is to provide a period of safety for people during temporary periods of distress when they are at risk of harm to themselves and/or others. It is essential to ensure this period is therapeutic and, although it may be perceived as not needed at the time, that it will generally be seen as a positive experience by the service user in time. It can also be used to provide an intensive period of assessment of a person's mental state.'

The primary purpose of supportive engagement is to maximise service user safety, minimise risk and to initiate and build supportive therapeutic relationships.

These are important components of effective skilled nursing in an environment which offers the full programme of activities and specific time with individual staff members which is more likely to have a beneficial emotional and psychological impact on the service user and the staff. This is actively being taken forward in **safe wards**. There are several potential benefits in using this approach, decreasing levels of disturbance on the ward and increasing levels of motivation and stimulation for service users, and increased job satisfaction for staff.

The use of empathy, listening skills and initiating meaningful conversation, and the use of silence, discussing with service user's their feelings and thoughts which will inform their behaviours giving clear information back to the service users about those feelings and thoughts, and naming them for the service user and helping them to discover ways of making those feelings and thoughts less distressing.

Service users are supported in finding ways to manage their symptoms and treatment perhaps through some discussion about their medication and how this can alleviate some of the symptoms. Using the supportive engagement time in a meaningful way is probably the most important decision a clinician can make, helping the service user with practical tasks for the day can also help communication.

The National Service user Safety Agency (2006) stated: that staff must develop trusting therapeutic relationships with service users, in which service users who are at risk to themselves or others can

talk openly about how they feel and develop strategies together with staff about how to manage their feelings and behaviours.

During a time of increased distress or risk a Service user may require a temporary period of an enhanced level of supportive engagement to maintain safety for him/her or others while the level of distress or risk is reduced. This will be achieved by establishing a good rapport with the Service users, promoting their coping skills and being aware of their individual needs. As such all staff engaged in the activity of supportive engagement should have received adequate training, have the required experience and be identified as competent to do so.

Supportive engagement as an intervention is grounded in therapy with care and recovery from crisis at the core. The primary aim is to engage positively with the service user in order to mitigate any assessed risk that the service user presents to themselves or others. This intervention is expected to be non-punitive and is anticipated to be a supportive intervention during difficult and challenging experiences of the service user. It is acknowledged that the practice of observations may conflict with the service users‟ wishes. Staff members should be aware that service user sometimes find observation provocative, and that it can lead to feelings of isolation and even de-humanisation therefore positive and supportive engagement provides an effective means of ‘observation’.

National guidelines identifies that supportive engagement is an intervention that aims to empower service users to actively participate in their care. Rather than 'having things done to' them, service users negotiate the level of engagement that will be most therapeutic (NICE NG10, 2015). The process involves the frequent and active engagement of service user with the aim of;

- Assessment of the service user’s mental state
- Identify risk indicators for self-harm, suicide and violent behaviour
- Motivating and supporting the service user to engage and attend agreed activity and treatment strategies (i.e. psychological interventions, art therapy, individual key working sessions) that promote new ways of expressing and accepting feelings, support ways of relating to others

It has been identified that the use of interpersonal skills to motivate and support the service user to engage in interventions should be recognised as part of a risk management and therapeutic strategy in the care of severe mental ill health (NG10, May 2015, NICE CG77, 2013; NICE CG178, 2014; NICE CG185, 2016; NICE CG155, 2016).

NICE guidelines (NG10, May 2015), “Violence and aggression: short-term management in mental health, health and community settings” provides clear guidance for the underpinning evidence of the development of this policy. It is recognised that not all supportive observation is used in the management of aggression; in addition it is used to reduce risk and prevent harm to service users in all areas of care and practice.

Observation can be a restrictive intervention; therefore every effort should be made to use the least intrusive level of observation necessary, balancing the service user's safety, dignity and privacy with the need to maintain the safety of those around them.

The successful implementation of supportive engagement to maximise service user safety and minimise risk is based on effective multidisciplinary team working that relies on there being dedicated time set aside each shift for the nurse to assess the mental state of, and engage positively with, the service user. This must be complimented by a clinical environment and ethos that offers each service user a programme of activities, therapies and/or specific time with individual staff members which meets their emotional and psychological needs.

Supportive engagement is a dynamic therapeutic intervention, through which service users with acute mental health problems or cognitive behavioural needs will receive ongoing assessment and

intervention with any identified risks relating to their personal safety, or risk to self or others being managed consistently by the multi-disciplinary team.

Therapeutic engagement involves healthcare professionals spending quality time with service users and aims to empower the service user to actively participate in their care.

The focus for staff is in engaging the service user therapeutically, instilling hope in the service user and enabling them to address their difficulties constructively.

Clinical decisions need to be made in line with Mental Health Act (2007), the Mental Capacity Act (2005) and Deprivation of Liberty Safeguards (www.dh.gov.uk).

2. SCOPE

These guidelines apply to all clinical staff in in-patient areas where increased levels of support and intervention are required. This policy applies to all clinical staff working with people admitted into in in-patient services across the Trust and applies to all in service users voluntary or detained.

These guidelines aim to ensure that all service users on the wards within the Trust have a level of supportive engagement which will be allocated appropriate to their needs and that there is a consistent and effective approach to supportive engagement within inpatient settings across the Trust.

The supportive engagement detailed in these guidelines differs from physical vital observations, the use of which is detailed in the Physical Health Monitoring Protocol.

However, staff should note that supportive engagement includes the observations of a service user's physical condition and where this is observed to be deteriorating the Physical Health Monitoring Policy.

3. POLICY STATEMENT

This policy should be read in conjunction with Supportive Engagement Guidelines and the safe wards model.

This policy will provide a clear structured framework to promote the good practice of supportive engagement in the on-going assessment, management and therapeutic care throughout the 24 hour period of in service users and day service users receiving services with the Trust.

4. DUTIES AND RESPONSIBILITIES

The executive director of nursing is responsible for the clinical risk management and will ensure the policy is reviewed and monitored.

Divisional Clinical Leads, Modern Matrons and Service Managers will:

- Ensure the policy is implemented within their Care Group
- Bring the policy to the attention of all clinical staff.

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Team Managers and Charge Nurses and Deputies will:

- Ensure that the service users supportive engagement is part of the local induction of clinical staff including temporary, Bank and Agency staff
- Ensure care plans identify the current level of supportive engagement.
- Ensure adherence to the policy in practice.
- Ensure a documented risk assessment and service user engagement safety plan accompanies the decision made on the level of supportive engagement

It is the responsibility of the senior nursing staff on the ward to work collaboratively with the Responsible Clinicians to ensure that there is regular multidisciplinary review of each service user's care and progress. This should occur at least weekly; enhanced supportive engagement and update of appropriate risk assessments and engagement safety plans plan as required.

Consultant Psychiatrist

- Ensure service users engagement safety plan or keeping safe care plan (CAMHS only) identifies the current level of supportive engagement
- Ensure all service users are medically admitted within four hours
- Ensure adherence to the policy in practice
- Ensure a documented risk assessment accompanies the decision made on the level of supportive engagement

It is the responsibility of the Responsible Clinician (as lead clinician) to ensure that there is regular multidisciplinary review of each service users care and progress. This should occur at least weekly, and update of appropriate risk assessment and engagement safety plan as required.

Registered Staff

- Complete engagement safety plan or keeping safe care plan (CAMHS only) for their named service user and for other service users in their care as the need arises
- Inform each service user of the level of supportive engagement they have been identified and the reasons for this
- Review any service user's level of supportive engagement based on clinical need/risk assessment (ensure that the engagement safety plan or keeping safe care plan (CAMHS only) is implemented)
- Ensure that periods of supportive engagement are viewed as opportunities for therapeutic engagement and relationship building
- Review the engagement safety plan or keeping safe care plan (CAMHS only) on a regular basis.
- Complete documentation as specified
- Ensure robust handover of information relating to engagement safety plans or keeping safe care plan (CAMHS only) at inter shift changeover and during individual staff changeover within the observation period

Non-Registered Staff

- Ensure that periods of supportive engagement are viewed as opportunities for therapeutic engagement and relationship building
- Be familiar with and implement the engagement safety plan or keeping safe care plan (CAMHS only) for each individual in their care
- Complete documentation contemporaneously as specified
- Report any relevant information to assist the effective review of service users' level of supportive engagement

All Clinical staff including all Allied Health Professionals

- All members of the multi-disciplinary team should spend quality time with service users and aim to empower the service user to actively participate in their care
- If a clinician wishes to interview the service user in private, the nurse in charge must make it clear to the colleague making the request that they take full responsibility for maintaining the agreed level of supportive engagement, and at the end of the interview they must ensure that they have formally handed over the service users care/supportive engagement level to another member of the clinical team allocated by the nurse in charge.

All staff are responsible to familiarise themselves with the supportive engagement policy and act in accordance with the stated requirements

5. PROCEDURES

General Principles – Keeping Service Users Safe
The "timed check" form of observation is seen as unsafe and should not be used as a means of meeting a need for increased level of observation (CRAG 2002).

Evidence has shown that the majority of attempts of suicide/self-harm were stopped by the actions of staff. Of these attempts the majority of service users were found because of staff being **caringly vigilant and inquisitive**.

Remember be alert, be aware, and trust your instincts: Check without hesitation.

Staff must be aware of the prescribed level of supportive engagement for individual service users, however they must also be **caringly vigilant and inquisitive** in order to keep service users safe and be alert to the times of potential high risk and concern with regard to self-harm and suicide which may be:

- Service users newly detained under the Mental Health Act and those during the first 24 hours of transfer of care.
- Those experiencing Depression and Self-harm attempts (including repeated episodes), are more likely to be linked to completed suicide.
- Evenings and night time periods are identified as high risk periods of suicidal behaviour.
- The majority of attempts may occur in the bedroom.
- The majority of service users attempt to take their own life by strangulation.
- There are significant differences in the number of attempts for each month of the year.
- More women than men attempted to take their own life by high risk methods.
- Males are three times more likely to die by suicide as females.
- There is a negative correlation between age and severity score in men.

The following practice will be followed:

- Noticing a service user's absence
- Noticing that a service user appears physically ill
- Following a service user in distress
- Noticing that a service user is taking a long time in the toilet
- Noticing suspicious actions- Attend to obvious and subtle cues
- Listening carefully to safety calls
- Responding to an unusual noise
- Increasing checks in the evening and during handover
- Target bedrooms, bathrooms and toilets
- If other members of the staff have concerns regarding the safety of the service users they will inform the nurse in charge, and ensure that a member of staff stays with the service user and await a decision.

If other members of the staff have concerns regarding the safety of any service user they will inform the Nurse in Charge, and ensure that a member of staff stays with the service user and await a decision regarding clinical response.

The Service User's safety plan or keeping safe care plan (CAMHS only) and levels of supportive engagement will also be reviewed/re-assessed at the following stages:

- Emergence of significant increases in risks
- During the first 24 hours of transfer of care.
- All service users must be assessed by a doctor within 4 hours of transfer from external health care provider or upon initial admission to a unit. Internal transfers a medical review is required within 2 working days (Discharge and Transfer Policy and Procedure (Inpatient)

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- Transfers of care
- Transitions of care
- Due to any known physical health problem (see physical health policy and associated guidance)

5.1. Care Rounds

The **Care Round** -sometimes referred to in the literature as 'Intentional Care Rounding'- a system of delivering supportive care to the most vulnerable people in a clinical setting and increasing care interventions to minimise risk and harm

The Care Round is a system where staff, usually nurses, ensure that the service user's needs are met by assessing their needs each shift. There is evidence that the Care Round approach reduces the number of service user complaints and significantly improves service user satisfaction levels. More than a head count the Care Round looks at the service user as a whole and promotes therapeutic engagement and a review of the supportive engagement and observation levels for the service user.

At least once during each shift a nurse should set aside dedicated time to assess the mental state of, and engage positively with, the service user as part of the Care Round.

As part of the assessment, the nurse should evaluate the impact of the service user's mental state on the risk of violence and aggression, and record any risk in the notes.

Staff are asked to consider changes in mental state, risk and isolation. Physical health care needs, dietary intake and pain should be included in these assessments along with the service user being asked if they feel safe and comfortable on the unit. Staff should actively promote engagement in clinical and therapeutic activiti.es and ensure the service user is aware of their rights and care plan objectives.

A registered nurse will meet with the service user at least once every shift, or sooner if their presentation changes, to assess and evaluate the service user's mood, behaviour and mental health, including any risk indicators and risk potential.

This evaluation will be recorded in the "clinical record" and communicated in 'handovers'.
This interaction can be recorded by any staff member who is completing the daily clinical record. The daily clinical record may also include interactions by any staff member with the service user. This record must comply with NMC standards and Trust polices on record keeping.

The aim of this regular 'care round' is to ensure that service users are provided with a routine where help and care is provided. We are ensuring that service user centred care is delivered as part of the wards routine to all vulnerable service users all of the time, Care Rounds provides assurance, prompts fundamental care, ensures early response to a service users changing clinical condition and promotes independence while maintaining safety.

5.2. Levels of Supportive Engagement – see guidelines

Levels of supportive engagement are an opportunity to enhance the development of a therapeutic relationship with the service user and all effort should be made to engage the service user, encouraging their active involvement in decision making with regard to their pathway.

There are three defined levels of Supportive Engagement:

- General Level
- Intermittent Level

- Constant Level

5.2.1. General Level

The general level is intended to meet the needs of majority of service users for most of the time. It should be compatible with giving service users a sense of responsibility for their use of free time in a carefully planned and monitored way. The staff on duty should have knowledge of the service users' general whereabouts at all times, whether in or out of the ward. This could be achieved by establishing a service user allocation system whereby the nurse in charge is kept informed of each service user's whereabouts.

Service users on this level are considered not to pose any serious risk of harm to self or others and are unlikely to leave the ward area or other treatment departments without prior permission, escort, or at least informing staff of their planned destination. Any limits set should be determined in conjunction with the service user, documented and updated in their service user engagement safety plan (Appendix 1) as necessary.

Transfer of Care

The implementation of supportive engagements should begin immediately at the point of transfer of care.

If the service user is not known to services they should be placed on intermittent hourly engagements as a **minimum** until they are reviewed collaboratively with the medic, registered professional and service user. Consideration should be given to not only the services mental health but also physical health needs and any treatment needs i.e. alcohol withdrawal etc.

If **the service users is known to services** they should as a **minimum** be supported on the general level of supportive engagement and staff will support and engage all service users' and be aware of their movements with regard to their safety and security. Consideration should be given to not only the services mental health but also physical health needs and any treatment needs, e.g. alcohol withdrawal etc.

The frequency of the supportive engagement level required may also change at specific times or during specific events such as during the night or during periods where harmful outcomes are more probable. Any such agreed changes in supportive engagement level must be clearly recorded in the service user Engagement safety plan and the clinical records.

Transfer of care for physical health care consideration needs, e.g. HRI/Castle Hill or external acute hospital.

When a patient in the care of Humber Teaching NHS Foundation Trust, requires a transfer to an acute trust for their physical health care consideration needs; and this is required as part of the ongoing care and treatment provided by the inpatient unit.

- A patient transferred to an acute trust may require a member of staff with them at all times and this will be covered by the Trust, namely the inpatient unit involved in the patient's care.
- If the patient doesn't require a member of staff with them at all times during their stay at the acute trust, then an MDT discussion must be undertaken in regards to ongoing assessment and support for the patient around their mental health and be clearly documented. This should include contact with the ward, planned nursing and medical reviews and any contingency plans if there is a change in the patient's presentation.
- If out of hours then the rationale must be documented by the nurse in charge with an initial plan. The plan then must be reviewed by the MDT at the earliest opportunity

5.2.2. Intermittent Level

This level is appropriate when **service users are potentially, but not immediately at risk of harm to themselves, to others or in acute distress**. It is not appropriate for service users believed to be actively suicidal (as opposed to being at risk of self-harm). It is also not suitable for service users who are believed to be a high risk of absconding and a risk to themselves and/or others, unless it is supported by the unit being locked.

5.2.3. Constant Supportive Engagement

When a decision is made to increase the level of supportive engagement, staff should consider the need to undertake a search of both the service user, and their room, based on risk so that any items which could be used by the service user to harm themselves or others can be removed. Staff must refer to and follow the procedure as set out in the Trust policy and procedure for the searching of a person, (service users and visitors) or their property. In the event that a decision is made not to undertake a search the reason for this is to be recorded in the service user's clinical records.

This is for service users at the highest level of risk of harm to themselves and/or others, or in acute distress. A designated member of the clinical team will be in close proximity to the service user, giving high levels of support, engagement and observation to the person continuously (use Appendix 3 Constant Supportive Engagement Record Sheet).

It may be necessary to stipulate that they are to be kept "within arm's length" which if defined as close observations so that staff can physically intervene to keep them safe if needed. This stipulation should be used with caution in relation to service users thought to be a risk to others. The environment dangers need to be discussed and incorporated in the service user Engagement safety plan. N.B. this should occur throughout the 24-hour period.

5.3. Flexible Supportive Engagement/Pre-Agreed Plans

Flexible supportive engagements span the range of general, intermittent and constant supportive engagements as described above. The use of flexible supportive engagements may include periods of one to one supportive engagements but these are reduced because a level is specified in the service user's Engagement safety plan to respond to variations in their needs.

To allow a shift in emphasis away from constant one-to-one supportive engagement and towards engaging with each service user to devise a supportive service user Engagement safety plan. Staff should facilitate therapeutic conversations in which each service user's experiences and feelings are validated and attempts made to organise the service user's feelings, to make sense of them and to be able to put them into words. Then problem-solving and distraction from painful emotions through shared activities and the acquisition of coping skills can be introduced.

The process of developing an engagement safety plan and using flexible supportive engagement is informed by the shared understanding of the service users risk formulation and relapse and recovery signature.

Review of supportive engagement levels is triggered by a change in the service user's presentation, based on an understanding of the service users risk formulation and relapse and recovery signature. The perceived risk is matched with the appropriate supportive engagement level. For example, a service user who becomes withdrawn and uncommunicative when coping with stress may benefit from a period of five-minute supportive engagements, which can revert to 30 minutes when the crisis is passed and the service user and nurse have agreed an alternative coping strategy. This helps the service user to feel safe and secure while working out a coping plan.

5.4. Changing the Level

The review of any service user's levels of supportive engagements is an integral component of their package of care and, as such, as many members of the multi-disciplinary team providing care for that service user will contribute to any review. It is good practice to involve a full multi-disciplinary team in review of supportive engagement levels and this should be done where possible.

The purpose of any review is to assess the service user's mental state, level of risk and their response, if any, to any treatment or intervention. The outcome of all reviews will be recorded within the service user's clinical records and service user Engagement safety plan.

It is expected that all service users will receive a review at the following intervals:

- A ward-based nursing and therapy review at each handover or if any significant change in presentation occurs
- A weekly review by the MDT/or as stated in the service user Engagement safety plan

Changes which result in a reduction to a service user's level of supportive engagements can be made by an MDT, RC or nominated member of senior staff when there is an agreed MDT flexible supportive service user engagement safety plan.

In the case of service users who have made specific threats to harm a named individual and that person wishes to be notified of changes to the level of supportive engagement they are to be informed as soon as a decision is made to reduce the supportive engagement level.

Exceptions to this, for older people's mental health services, may be when supportive engagement is for falls risk or because of risks associated with BPSD (behavioural and psychological symptoms of dementia); whilst it is still expected that medical and other MDT staff are involved in review and that review occurs regularly, the frequency and nature of this will be determined by the MDT.

Exception to this would be when the level of supportive engagement was increased due to a service user's poor physical health.

The nurse in charge of the unit may at any time increase the level of supportive engagement and the reasons for this are to be documented in the service user's clinical records.

5.5. Focused Support (Environmental/Care Zoning)

Focused Support (Environmental or Recovery) is a method that can be utilised to define the level of intervention service users require in a systematic process. The implementation of focused support involves assessment of service user need and risk after which the individual is allocated a particular zone, which is defined by a certain area or criteria, and best, fits their level of that need or risk.

The aims of focussed support are:

- The environment is less restrictive
- It is conducive with delivering therapeutic interventions
- Activities and engagement can be increased allowing staff to develop protected time and introduce structured programmes for service users in the ward.
- Enables a culture of positive decision making
- Supports recovery for service users

Traditionally, service users who intermittently present an increased level of risk have been placed on continuous observations by one or more members of the nursing team. The level of risk and the necessary observation level often vary between different environments (e.g. service user's bedroom, communal day area etc.). However, this model of observation is resource intensive and does not always result in a positive clinical outcome for either the service user being observed or staff observing the service user. Focused support gives staff some flexibility in roles and approaches and is conducive with delivery of better therapeutic interventions.

The alternative system of focused support: is considered less intrusive and allows greater privacy for the service user than traditional methods. Focused support (zonal) systems have been introduced successfully in other secure and adult mental health services.

Environmental (zoning) focused support aims to ensure appropriate observation of individual service users without the need to assign a particular nurse to be in close proximity to the service user for long periods. Identified staff will be responsible for all service users within a particular area of the ward.

When employing environmental focused support, staff are allocated to specified areas in the ward rather than being assigned to an individual service user.

Via an established 'focused support' system service users are allocated an individual risk assessment, service users can move between areas and be monitored discretely.

Implementation of Focused support will offer a safe, caring and protective environment to service users who are unable to maintain their risk to themselves or others, enabling staff to manage risk and maximise safety.

Care (zoning) focused support is another method of support, whereby the service users are placed in groups according to risk and current level of recovery and a staff member is allocated to each group of service users. This staff member co-ordinates the activities, supports the service users as per individual Supportive Engagement Safety Plan etc. (For their allocated group of service users for a specified time, e.g. half or full shift).

When utilised as a therapeutic intervention recovery focused support can reduce risk factors and promote recovery with a focus on engaging service users to help them develop coping strategies.

Maister Lodge-See Guidelines
All service users at Maister Lodge will be nursed within the zonal engagement model, the ward is divided into zones, male (West), female (East), main foyer/lounge and the Maister Hub, there will be staff in each of these zones at all times that these are being used by service users, when service users are in other areas of the ward; toilets, bedrooms, garden staff will document the service users activity on the zonal engagement documentation.

5.6. Night Time

The intensity of supportive engagement **must not be reduced** based on the time of day but on an updated assessment of risk.

Carrying out supportive engagement at night should be given special consideration. Mental health often impact upon sleep and many service users experience greater fears, anxieties and level of arousal at night.

For some service users it may be appropriate to carry out a different level of supportive engagement at night or when they are asleep than during the day or when they are awake.

When these levels are reduced, staff must ensure that there is an appropriate assessment of the service users sleep pattern and sleep behaviour so that the transition from sleeping to waking can be appropriately monitored i.e. attempts to feign sleep. These issues should be discussed openly with the service user as part of the risk assessment and care plan.

5.7. Leave

Staff members considering leave for a service user must refer to the Leave Standard Operating Procedure.

Any service user who is nursed on constant supportive engagements **must not** be permitted **unescorted** leave unless there is a robust MDT management plan to support this. Escorted leave on constant level of engagement is appropriate where an MDT decision has been made that engagement off the unit is in the service user's best interests and has therapeutic benefit/supports social inclusion.

When considering leave on any other level of engagement the staff member should consider that any increased level of engagement is indicative of an increased risk. A thorough risk assessment prior to leave and discussion with the service user following leave should be completed and recorded on Lorenzo. This information should be documented in the communications tab in clinical charts under the filter of **notes** – then sub headings:

- Leave – Evaluation with service user on return
- Leave – Risk assessment prior

Staff should consider how long the service user will be off the unit, e.g. a service user on hourly engagements should not be permitted leave for any longer than one hour unless this has been pre agreed as part of the safety plan or there is an MDT decision. The service user should be encouraged to stay on the unit or the level of engagement should be reviewed in line with policy, i.e. by a medic and a nurse at the very least. Consideration should be given to the use of the Mental Health Act.

Informal service users who are on an increased level of supportive engagement and are likely to request leave from the unit alone should have a plan in place from the MDT which supports decision making around leave.

5.8. Documentation/Record Keeping

The medic/Registered Nurse/Allied Professional should record all decisions regarding supportive engagement levels in the service user's main clinical notes, supportive engagement record sheets (Appendices 2 and 3) and engagement safety plan (Appendix 1). Records must be updated every shift and include:

- Rationale for supportive engagement level
- Current mental state
- Current assessment of risk
- The agreed level of supportive engagement to be implemented
- Timescales and review
- Clear direction regarding therapeutic approach
- Service users compliance
- The care plan should include the agreed interventions which may be used to engage with the service user
- Use SOAPP The SOAPP note (an acronym for subjective, objective, assessment, and plan, plan+) is a method of documentation employed by health care providers

6. EQUALITY AND DIVERSITY

An Equality and Diversity Impact Assessment has been carried out on this document using the Trust-approved EIA. (This should be completed and submitted with the procedural document and will be put on the Trust's intranet).

7. MENTAL CAPACITY

The Trust supports the following principles, as set out in the Mental Capacity Act and has applied them in the development of this policy:

1. A person must be assumed to have capacity unless it is established that they lack capacity.
2. A person is not to be treated as unable to make a decision unless all practicable steps to help him to do so have been taken without success.
3. A person is not to be treated as unable to make a decision merely because he makes an unwise decision.
4. An act completed, or decision made, under this Act for or on behalf of a person who lacks capacity must be done, or made, in his best interests.
5. Before the act is completed, or the decision made, regard must be had as to whether the purpose for which it is needed can be as effectively achieved in a way that is less restrictive of the person's rights and freedom of action.

8. BRIBERY ACT

The Bribery Act 2010 makes it a criminal offence to bribe or be bribed by another person by offering or requesting a financial or other advantage as a reward or incentive to perform a relevant function or activity improperly performed.

The penalties for any breaches of the Act are potentially severe. There is no upper limit on the level of fines that can be imposed and an individual convicted of an offence can GRiST a prison sentence of up to 10 years.

For further information see http://www.justice.gov.uk/guidance/docs/bribery-act-2010-quick-start-guide.pdf.

If you require assistance in determining the implications of the Bribery Act please read the Trust Bribery prevention policy available on the intranet or contact the Trust Secretary on 01482 389194 or the Local Counter Fraud Specialist on telephone 01482 866800 or fraud@humber.nhs.uk.

The Bribery Act applies to this policy.

9. IMPLEMENTATION

This policy will be disseminated by the method described in the Policy and Procedural Documents Development and Management Policy.

10. MONITORING AND AUDIT

Standard/Process/Issue		Monitoring and Audit			
		Method	By	Committee	Frequency
1	Documentation of service users on enhanced supportive engagement will be completed.	1. Audit of clinical notes. 2. Audit of documentation of supportive engagement.	Ward level		Monthly Perfect Ward
2	Staff will receive appropriate education.	Training records will be maintained of attendance at workshops/team days, education days.	Unit managers		Ongoing

11. REFERENCES/DEFINITIONS/BIBLOGRAPHY

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12. RELEVANT POLICIES/PROCEDURES/PROTOCOLS/GUIDELINES

Absconding from Inpatient User Units – Managing the Risk Policy

Clinical Risk Management Policy

Mental Health Act Code of Practice

Humber Leave Standard Operating Procedure

Appendix 1: Document Control Sheet

This document control sheet, when presented to an approving committee must be completed in full to provide assurance to the approving committee.

Document Type	Policy – Supportive Engagement Policy (N-003)		
Document Purpose	This policy and associated Standard Operating Procedure provides a framework that has transformed culture, leadership and professional practice to deliver care and support which keeps people safe, and promotes recovery.		
Consultation/ Peer Review:	Date:	Group / Individual	
list in right hand columns consultation groups and dates	July 2021	QPaS	
Approving Committee:	QPaS	Date of Approval:	6 July 2021
Ratified at:	N/A (minor amendments)	Date of Ratification:	N/A (minor amendments)
Training Needs Analysis: *(please indicate training required and the timescale for providing assurance to the approving committee that this has been delivered)*		Financial Resource Impact	
Equality Impact Assessment undertaken?	Yes [✓]	No [ ]	N/A [ ] Rationale:
Publication and Dissemination	Intranet [✓]	Internet [ ]	Staff Email [ ]
Master version held by:	Author [ ]	HealthAssure [✓]	
Implementation:	*Describe implementation plans below*		
	• Dissemination to staff via Global email • Teams responsible for ensuring policy read and understood		
Monitoring and Compliance:			

Document Change History:			
Version Number / Name of procedural document this supersedes	*Type of Change i.e. Review / Legislation*	*Date*	*Details of Change and approving group or Executive Lead (if done outside of the formal revision process)*
1.00	*Review*	*Sept 14*	*Replaces Supportive Observation policy P078*
1.01	*Review*	*Dec 17*	*Review in line with NHS Improvement workshops: best practice in supportive observations Additional section on managing leave (5.8), Reduction of policy document, SOP and training package*
1.02	*Full Review*	*October 2019*	*Full review including staff survey, QPAS, Clinical Governance, matrons forum and medics*
1.03	*Full Review*	*May 2021*	*Full review of the policy, including an amendment to state that all service users must be assessed by a doctor within four hours of transfer from external health care provider or upon initial admission to a unit. Internal transfers a medical review is required within two working days (Discharge and Transfer Policy and Procedure (Inpatient)*

Appendix 2: Equality Impact Assessment (EIA) Toolkit

For strategies, policies, procedures, processes, guidelines, protocols, tenders, services

1. Document or Process or Service Name: Supportive Engagement Policy

2. EIA Reviewer (name, job title, base and contact details): Jeanette Jones-Bragg, Service Manager, Mental Health Response Service & Avondale, Miranda House, Gladstone Street, Hull HU32RT. Tel: 01482 301701

3. Is it a Policy, Strategy, Procedure, Process, Tender, Service or Other? Policy

Main Aims of the Document, Process or Service
The emphasis of these guidelines is centred on the use of trained staff being sensitive to the needs of service users and using the essential elements of empathy, non-judgemental approach and effective communication skills to develop an effective therapeutic relationship with the service user. This leads to the identification of risk factors and the co-production of safety/care plans to mitigate risks.
Please indicate in the table that follows whether the document or process has the potential to impact adversely, intentionally or unwittingly on the equality target groups contained in the pro forma

Equality Target Group	Is the document or process likely to have a potential or actual differential impact with regards to the equality target groups listed?	How have you arrived at the equality impact score?
1. Age 2. Disability 3. Sex 4. Marriage/Civil Partnership 5. Pregnancy/Maternity 6. Race 7. Religion/Belief 8. Sexual Orientation 9. Gender re-assignment	Equality Impact Score Low = Little or No evidence or concern (Green) Medium = some evidence or concern(Amber) High = significant evidence or concern (Red)	a) who have you consulted with b) what have they said c) what information or data have you used d) where are the gaps in your analysis e) how will your document/process or service promote equality and diversity good practice

Equality Target Group	Definitions	Equality Impact Score	Evidence to support Equality Impact Score
Age	Including specific ages and age groups: Older people Young people Children Early years	**Low**	
Disability	Where the impairment has a substantial and long term adverse effect on the ability of the person to carry out their day to day activities: Sensory Physical Learning Mental health (including cancer, HIV, multiple sclerosis)	**Low**	
Sex	Men/Male Women/Female	**Medium**	**The experience and preferences of the service user may require gender matched to staff for the delivery of supportive engagement. The guidelines set out the appropriate adjustments required**
Marriage/Civil Partnership		**Low**	

Equality Target Group	Definitions	Equality Impact Score	Evidence to support Equality Impact Score
Pregnancy/ Maternity		**Low**	
Race	Colour Nationality Ethnic/national origins	**Low**	
Religion or Belief	All religions Including lack of religion or belief and where belief includes any religious or philosophical belief	**Low**	
Sexual Orientation	Lesbian Gay Men Bisexual	**Low**	
Gender Reassignment	Where people are proposing to undergo, or have undergone a process (or part of a process) for the purpose of reassigning the person's sex by changing physiological or other attribute of sex	**Low**	

Summary

Please describe the main points/actions arising from your assessment that supports your decision above Effective Supportive Engagement relies of staff being trained and being sensitive to all areas of the service user's need particularly areas of equality – The approach requires adequate adjustments in the delivery of supportive engagement and observation where the service user feels the approach is burdensome. Specific issues are outlined in the guidelines with regards to being sensitive to the needs of service users and where indicated matching service user/staff genders to ensure supportive engagement is maximised.	
EIA Reviewer: Jeanette Jones-Bragg	
Date completed: October 2019	Signature: J Jones-Bragg