Humber Teaching
NHS Foundation Trust

SUPPORTIVE ENGAGEMENT GUIDELINES

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

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VALIDITY – Guidelines should be accessed via the Trust intranet to ensure the current version is used.

CHANGE RECORD

Version	Date	Change details
1.00	May 2015	New Guidelines to be read in conjunction with Supportive Engagement Policy
1.01	June 2016	Additions to clarify who can record nurse rounds. Additional review section incorporated into the Supportive enagement Supportive Enagement Safety Plan.
1.02	October 2019	Full Review of guidelines
1.02	December 2019	Clerking in times on transfer of care within four hours(changed from two)
1.02	January 2020	CAMHS specific additions
1.03	May 2021	Addition to the service user's safety plan and levels of supportive engagement review/reassessement stages and to intermittent engagements

Contents

1. INTRODUCTION

This guidance and associated policies provide a framework to radically transform culture, leadership and professional practice to deliver care and support which keeps people safe and promotes recovery.

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'

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.

To comply with Clinical Governance/ Effectiveness, staff should make themselves familiar with the CRAG (2002) Engaging people: Observation of people with acute mental health problems: A good practice Statement.

The "timed check" form of supportive engagement is seen as unsafe and should not be used as a means of meeting a need for increased level of supportive engagement (CRAG 2002).

A past definition of nursing observation:

'Regarding the service user attentively', this however suggests that watching/looking at the service user even is a great skill. Service users have commented that it feels uncomfortable at best, de-humanising at worse to be watched over. To engage with the service users as an alternative to observe can offer a definable improvement to the service user's experience, the purpose of engagement is to interact with the service user encouraging communication, listening and conveying to the service user that they are valued and cared for.

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 the implementation of **safe** wards across all in patient units. 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) states: 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 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.

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.

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 (1983,2007), 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 has 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 in-patient settings across the Trust.

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

3. PROCEDURES

Evidence has shown that the majority of suicide and self-harm attempts 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 females than males 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 males

The following practice must be followed:

1. Noticing a service user's absence
2. Noticing that a service user appears physically ill
3. Following a service user in distress
4. Noticing that a service user is taking a long time in the toilet
5. Noticing suspicious actions- Attend to obvious and subtle cues
6. Listening carefully to safety calls
7. Responding to an unusual noise
8. Increasing checks in the evening and during handover
9. Target bedrooms, bathrooms and toilets
10. 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 and levels of supportive engagement will also be reviewed/reassessed 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 two working days (Discharge and Transfer Policy and Procedure (Inpatient)
- Transfers of care
- Transitions of care
- Due to any known physical health problem (see the Protocol for Physical Health Monitoring Policy: Mental Health and Learning Disability – Inpatient Services)

3.1. Care Rounds

The **Trust's 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 ward's routine to all vulnerable service users all of the time, CARE Rounds provides assurance, prompts fundamental care, ensures early response to a service user's changing clinical condition and promotes independence while maintaining safety.

The frequency/review of all CARE Rounds must be clearly documented in the Supportive Engagement Safety Plan.

- Any restrictions on a service user's movement must be documented in the supportive engagement safety plan and reviewed at the same time as the ongoing risk assessment.
- Service users who are restricted to ward areas only should be encouraged to participate in their agreed Supportive engagement safety plan and ward activities.
- Any service users who, through a full needs assessment and risk assessment, have been identified as requiring this level of support will be cared for on an individual basis.
- The level of supportive engagement is determined by the multi-disciplinary team in conjunction with the service user and their family or carer as appropriate and addressed through personalised Supportive engagement safety planning.

At a minimum the Supportive Engagement Safety Plan will detail:

- The identified needs for increased support and supportive engagement

- Frequency by which this will be provided
- The level and type of engagement
- Process and time frame for review
- Any significant changes that would indicate a need to increase the support and supportive engagement

3.2. General Level

The general level is intended to meet the needs of the 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 always have knowledge of the service users' general whereabouts, 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 Supportive engagement safety plan or Keeping Safe Care Plan (CAMHS only) (Appendix 1) as necessary.

Gournay & Bowers (2000) offer a useful description of general observation:

"General Observation can be thought of as the observation and monitoring of the physical geography of the ward and as a component of constant review of safety in the light of the opportunities the ward and its contents provide for harm to come to service users. This general observation should be an established part of the ward routine and followed rigorously and regularly by nurses, as part of their everyday practice to maintain the safety of the service users".

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, e.g. alcohol withdrawal etc.

If the service user 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 regarding 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

A registered nurse will participate in a 'care round' with each service user as stated in their Supportive engagement safety plan or keeping safe care plan (CAMHS only).

The nurse in charge will have systems in place to monitor and record service user movement as follows:

During waking hours
All service users will be supported and encouraged to engage in conversation throughout the shift. (Assess and evaluate with the service user their mood; behaviour and mental health, including any risk indicators and risk potential).

During sleeping hours
The intensity of supportive engagement must not be reduced based on the time of day but on an updated assessment of risk. During night duty it is acknowledged that there are reduced natural opportunities to engage with patients.

Carrying out supportive engagement at night should be given special consideration. Mental health often impacts 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 Safety Plan.

It is at the discretion of the nurse in charge should they assess checks are required more frequently.

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 Supportive Engagement Safety Plan or Keeping Safe Care Plan (CAMHS only) and the clinical records.

Transfer of care for physical health care consideration needs, e.g. Hull Royal Infirmary/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 the following 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 patients 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 regard to ongoing assessment and support for the patient around their mental health and the rationale be clearly documented. This should include frequency of 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 for the patient not being placed on a one to one 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

3.3. 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.

The nurse in charge will ensure a designated member of staff is available to implement the Supportive engagement safety plan or keeping safe care plan (CAMHS only).

and encourage occupation, support and engage with the service user at the specified time intervals and record all interactions and whereabouts in the service user's clinical notes.

At times it may be appropriate for intermittent engagements to be time specific for example hourly or two-hourly, however should be held at irregular intervals, on a specific number of occasions within the hour, for example four times an hour, however not at set times. Alternatively, a person on intermittent level may require engaging with two or three times a shift instead of time specific engagements. This will depend on the person's presentation and risk assessment at that specific time. Intermittent engagements will be shared equally amongst the team to allow service users to generalise attachments and minimise risk of dependency.

3.4. 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.

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 Supportive Engagement Safety Plan. N.B. this should occur throughout the 24-hour period.

- If this level needs to be implemented because of a clinical emergency, a discussion and/or attendance of a member of medical staff will take place within two hours of implementation. This is so the service user's mental state, medication and other clinical interventions can be reviewed and altered if necessary.
- At times certain levels of privacy can be negotiated with the service user or encouraged by staff (e.g. toilet, shower, dressing, visiting, sleeping etc.). These times need to be incorporated in the service user Risk Management and Supportive Engagement Plan including location of staff, doors closed/locked during these times.
- The nurse in charge if necessary, may override times of privacy. The decision will be made through assessment of risk potential.
- There will be no change to this level when a service user is in the company of visitors, unless stated in the Supportive engagement safety plan. The only exception to this may be when observation is for falls risk or because of risks associated with behavioural and psychological symptoms of dementia and another responsible adult (usually a relative) can safeguard the service user during their visit. Any such arrangement will be discussed with the relative and documented within the clinical record.
- A mechanistic approach to the observation process, which may be seen as 'watching the doors' or 'guarding the service user', is a totally inadequate and unacceptable practice. Observation of service users including those who are cognitively impaired is a skilled task involving assessment of the service user's mental state and cognitive impairment and the potential risk of both harmful and beneficial outcome of their actions.
- Supportive engagement should be used as an opportunity to develop a rapport and build a relationship. This may include engaging the service user in some constructive and therapeutic activity or intervention, offering support and comfort in order to strengthen the

therapeutic relationship between the staff and the service user; this may, i.e. include participation in group work/therapy.

In addition, it is an intervention which allows for the ongoing assessment of the service users:

- Orientation and memory
- Insight into current situation
- General appearance and mood
- General behaviour
- Ability to self-care and manage their treatment programme

For unqualified staff this will be under the supervision of the nurse in charge. It is also expected that the member of staff allocated will:

- Immediately try to dissuade or prevent the service user from behaving in a way that may lead to harmful outcomes for themselves or others, this may include attempts to leave the ward or unit.
- Raise the alarm as per local arrangement to help ensure that enough staff are available to prevent any escalation in behaviour.

In order to maintain the safety of staff and to allow them to summon assistance quickly all wards have personal alarm systems in place.

- At the beginning of each shift the nurse in charge of the ward will, devise a rota of staff to carry out service user supportive engagement/zonal duties. This rota will enable staff to plan their other duties around it and also identify who is responsible for the service user and at what time.
- Staff will not cease their duties unless relieved by another staff member. Should a change of staff be required, this will be recorded on the daily planning rota.
- A verbal handover will be given at each change of staff member.

At the end of each period of supportive engagement a record will be made in the 'Clinical Record 'including an assessment of the service user's mental state and level of engagement. Additional entries will be made if there is anything significant to record.

- Supporting service users for long periods of time can be very stressful and whilst every effort should be made to encourage the service user to participate in activities, this is not always possible. It is preferable that no staff member should spend more than an hour at a time with a service user who requires constant supportive engagement, but if the service user is attending any activity session, it may be desirable for staff to remain for the duration of the activity to prevent any disruption. Exceptions to this are anticipated should a service user be receiving care in an offsite hospital environment.
- Throughout any shift it is desirable that each single staff member should not spend more than half their shift with service users on constant supportive engagement although circumstances may dictate that in the short-term staff may have to spend longer periods with service users whilst alternative arrangements are being made.
- Staff should not be expected to move from constant supportive engagement of one service user directly to another without at least an hour's break.
- Every shift, or sooner if the presentation changes, a qualified nurse will risk assess and evaluate the service user's mood, behaviour, mental health and the risk potential.
- Professional judgment will have to be used if it is inappropriate to assess the service user, e.g. the service user is asleep. The assessment will take place as soon as possible. The reasons for the delay will be documented in the 'clinical record'
- If the service user is on a constant level of supportive engagement because of a clinical emergency, a full clinical review will take place at least every 72 hours and documented in the 'clinical record'

- If the service user has a chronic clinical condition with a propensity of continuous high clinical risk, which does not change and it is judged necessary for the service user to be on a constant level of supportive engagement, then the review will take place at a minimum of weekly.

CAMHS only

- Physical health monitoring for patients with eating disorders; the focus of the physical health monitoring procedure is to ensure that young people who meet the criteria as outlined below have their physical health monitored closely, that progress is monitored and that supportive engagements reflect the young person's current physical need in addition to mental state and presentation. The procedure should be used for young people who are at risk of the following:
  - Risk of Refeeding Syndrome.
  - Excessive purging, laxative misuse and water loading, excessive exercising.

Where there are two young people prescribed "physical health monitoring supportive engagements" for re-feeding syndrome/excessive purging etc., they will be nursed by one staff member and will be prescribed 12 in an hour checks. The aim is to have only two young people at any one time on this type of observation.

3.5. Flexible Supportive Engagement /Pre-agreed Plans (Record on the Supportive Engagement Safety Plan)

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 Supportive 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 in devising a supportive 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 a supportive 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.

3.6. 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 Supportive 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 Supportive engagement safety plan

Changes which result in a reduction to a service user's level of supportive engagements can be made by a minimum of two members of the care team/MDT, where there is an agreed MDT flexible supportive engagement safety plan which clearly describes the conditions and rationale required to reduce the level of supportive engagement. 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 or safeguarding issues are identified.

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.

3.7. Zone: Focused Support (Environmental/Care Zoning)

Environmental or Care Zoning is a method that can be utilised to define the level of intervention service users require in a systematic process. The implementation of zoning 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

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. Zoning gives staff some flexibility in roles and approaches and is conducive with delivery of better therapeutic interventions.

When used in conjunction with the principles of supportive engagement it can foster a culture of positive risk taking, supporting recovery, increase activity allowing staff to develop protected time and introduce structured programmes for people in the ward.

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

Environmental (Zoning) Focussed 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 (zone) of the ward.

Staff are allocated to specified zoned areas in the ward rather than being assigned to an individual service user.

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

Implementation of zoning 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.

The level of risk for some service users may be reduced by denying or limiting their access to certain areas of the ward, e.g. their bedrooms. Service users that fall into this category will have this specified in their Supportive Engagement Safety Plan, depending on their perceived level of risk.

Care (Zoning) Focussed Support is another method of support zoning, whereby the service users are placed in groups according to risk 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 engagement Supportive engagement safety plan etc. for their allocated group of service users for a specified time (e.g. half or full shift).

When used in conjunction with the principles of supportive engagement it can foster a culture of positive risk taking, supporting recovery, increase activity allowing staff to develop protected time and introduce structured programmes for people in the ward

Principals: Guiding the Implementation of Zone: Focused Support
Zoning must be service user-focused at all times. The views of the service user on the case being proposed or planned should, when possible, be sought. The service has a duty for safety and security to the service users, staff and visitors. Care must be provided in an environment and manner that reflect the least level of restriction possible for the safe and supportive management of the service user. The aim is to support the service user through a period of crisis regardless of its cause and in doing so maintain a therapeutic relationship and reduce the likelihood of risk behaviours occurring.

Zoning should therefore be seen as one method of reducing risk and an integral part of a wider risk assessment and contextual management process.

Care and support of the service user will be addressed specifically within an individualised Supportive engagement safety plan, this should attempt to anticipate service user's needs, identify short and long-term objectives.

Environmental Zoning Recording – the allocated zone nurse can document on the zonal charts (see Appendix 2). The service user's mood, behaviour, current level of engagement and risk level should be noted.

Care Zoning Recording – the allocated nurse for each care group of service users will record on the service users Individual recording sheets or clinical notes (if on general supportive engagement).

3.8. Maister Lodge

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 user's activity on the zonal engagement documentation.

For some service users it may be appropriate to carry out an enhanced level of supportive engagement due to risks/target behaviour; this may include a 1:1, 2:1 dependent on the need and the risks. The level of engagement will be discussed on Transfer of Care and regularly reviewed within the MDT.

Having a member of staff with a service user on a 1:1 engagement level is restrictive and intrusive and staff will take this into consideration. Service users may be nursed on a variable engagement level which means when settled/no signs of distress service users will be nursed within the zonal engagement model. During times of distress/target behaviours the engagement level may be increased to a 1:1, 2:1. All service users at Maister Lodge have a behaviour support plan and this gives information on early signs of distress and target behaviours to ensure that all staff are aware of when to increase the engagement level.

In order that the transition from sleeping to waking can be appropriately monitored all service users will have a bed sensor in situ. This will allow staff to go in and give assistance to service users on waking. Where possible, service users will be asked to consent to this. In the event that the service user lacks the capacity to consent, a capacity assessment will be undertaken and a best interest's discussion held with a member of the nursing team and service user's relative; this decision and discussion will be clearly documented on the service users care plan.

3.9. General Precautions

Leave arrangements for service users on constant supportive engagements
Service users identified as requiring constant supportive engagement are considered to pose a significant risk to themselves or others and for this reason would not normally be granted leave from the ward unless it is for an urgent medical appointment. In the event that a service user needs to go off site for an appointment whilst subject to this level of supportive engagements staff are to refer to the Trust policy and guidance on the granting of leave for service users (including section 17 guidance), and their area specific protocols for the safe transportation of service users.

Leave arrangements for service users on intermittent supportive engagement
Prior to leaving the ward area any service users who have intermittent supportive engagement defined within their Supportive engagement safety plan must have time scales agreed with them as to when they will return to the ward, e.g. every hour or at specified times. These details must be included as part of the Supportive engagement safety plan and documented. In the case of service users subject to detention under the Mental Health Act (1983,2007) staff are to also refer to the guidance on the granting of leave for in service users (including section 17 guidance).

3.10. Service user Centred Precautions

Generally, all service users will be allowed access to potential ligatures in the form of belts, shoelaces, clothing and audio headphones. Only if the service user is identified as an immediate risk of suicide and has been placed on a level of constant supportive engagement may the Registered Nurse in charge of the area decide to remove these items. A separate record of the items removed should be made and the items placed in safekeeping.

Once this action has been taken the Registered Nurse must fully document the reasons why and inform the service users RC as soon as is practicable.

The decision to continue to deny the service user access to their potentially dangerous belongings must be subject to a multi-professional review weekly and the items may only be returned with the agreement of the clinical team.

Removal of potential ligature should not be used instead of increasing supportive engagement levels.

- All new Transfer of Cares will have their belongings checked for dangerous items as set out in the contraband/ controlled items list.
- All residential areas will carry ligature scissors which are accounted for at each shift change.

3.11. Documentation/Record Keeping

The medic/Registered Nurse/Allied Professional should record all decisions/changes regarding supportive engagement levels in the service user's main clinical record, Service User Engagement Supportive Engagement Safety Plan (Appendix 1) and Zonal Record (Appendices 2 and 3).

Service user's individual safety engagement plan must be updated every shift and include:

- Rationale for supportive engagement level
- All care rounds completed
- 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 Supportive engagement safety 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

3.12. Night Time/or when Service Users are Asleep

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 impacts 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 Supportive engagement safety plan.

When a service user appears asleep the member of staff carrying out the supportive engagement must monitor their physical health noting changes in body position, breathing, etc. **Safety takes priority over privacy**. Staff must not assume that service users are sleeping and/or that they should not be woken. The consequences of safe practices will need to be explained and discussed with the service user who may be disturbed by staff entering their bedroom.

If the member of staff has not observed the service user moving or cannot observe the service user breathing, they **must ensure the service user is alive by**:

- Increasing lighting
- Getting close enough to observe breathing
- Checking for a pulse
- Rousing them
- Satisfying themselves the service user is breathing by other appropriate measures.

Where there is judged to be risk of violence, the member of staff carrying out the engagement must seek assistance before entering a service user's room to ensure the service user is alive.

3.13. Privacy and Dignity

Every attempt will be taken to respond to the specific and diverse needs of each Service user with consideration given to the need for same sex staff members whilst personal care is being undertaken. However, whilst there is a requirement to respect service user's cultural needs, the safe management of any identified risks will always take priority.

Where it is known or suspected that a service user has been subject to sexual abuse consideration **must** be given to the gender of the staff member carrying out the supportive engagement, and this must be documented on the Supportive engagement safety plan.

3.14. Employment of Additional Staff to Maintain Safe Staffing Levels on the Ward

The close supportive engagement of service users can have an effect on the amount of time staff have available to spend with other service users, and this disruption should be kept to a minimum. As highlighted above it is preferable that under normal circumstances staff spend no more than half their shift observing service users on constant supportive engagement, which means that if more than 2 service users are on these levels additional staff will need to be employed.

The responsibility for maintaining safe staffing levels lies with the nurse in charge of the ward. If it is not possible to secure the necessary additional staffing, other arrangements should be made as agreed locally via either the Modern Matron and/ or the Service Manager

Should an exceptional circumstance arise where nursing staff find they are unable to provide good care because of a lack of adequate resources, they will need to report their concerns to the matron and service manager. The NMC Code of Professional Conduct 2015 states that as a registered nurse or midwife, you are personally accountable for your practice, in caring for your service users and clients.

Non-permanent staff and supportive engagements (e.g. Bank or Agency staff)

As these staff do not work on the ward on a regular basis, they will not have an in-depth knowledge of the service users. If they are to observe service users on levels of supportive engagements, they are to be given a full handover by the nurse in charge of the ward, which will outline:

- Why the service user is on a specific level of supportive engagement
- Any risk factors, i.e. suicide, violence, verbal abuse
- Supportive engagement safety plan
- Action to take if service user attempts to leave or becomes suicidal, violent or verbally abusive
- The level of engagement from the service user and activity timetable.

The nurse in charge must be satisfied that any non-permanent staff members are familiar with this policy.

3.15. Student Nurses and Supportive Engagements

Student nurses can engage in this policy and guidance when their mentor/University lead agrees that they are competent and it is part of their learning outcomes. However, in order to enhance their learning experience, they can participate in supportive engagements with another member of staff under the guidance of a qualified nurse.

3.16. Information to the Service User

All service users admitted to the wards are to be given information about the arrangements that are in place for the monitoring of service users' whereabouts and the need for them to inform staff of their movements should they need to leave the ward for any reason.

If a decision is made to nurse a service user on levels of engagement and supportive, the service user is to be given the following information:

- Why a decision has been made to nurse them on this level of engagement and supportive

- What restrictions this imposes on them
- When the decision will be reviewed

Verbal explanations should be supplemented by the service user being given a copy of the either the leaflet or the ward information booklet (if this contains the same information as the leaflet around engagement and supportive).

3.17. Allocating Staff for Supportive Engagement Duties – the Responsibilities of the Nurse in Charge

The nurse in charge (NIC) should ensure that the actions of the person participating in supportive engagement allow the service user to maintain maximum dignity, respect and personal responsibility, exercise, therapeutic activity and social interaction that is possible while maintaining the required level of supportive engagement.

The NIC should liaise with the ward manager in the first instance and where this is not possible liaise with the Modern Matron to make sure that adequate numbers and grades of staff can be made available.

Supportive engagement is a skilled activity and ideally qualified permanent nurses should fulfil this role. In instances when this is not possible, the NIC retains accountability for the decision to delegate this responsibility to a non-registered or temporary member of staff and have the responsibility for ensuring they are sufficiently knowledgeable and competent to undertake the role.

Supervision to support the non-registered or temporary member of staff to fulfil his/her role must be available. It is unacceptable for an entire shift (period of duty) supportive engagements to be undertaken by non-qualified staff.

For **nursing students** and other **students on placement**, learning needs can be met by observing with a qualified member of staff or if agreed with their mentor that they are competent to participate in supportive engagement. Other related supportive engagement activities can be achieved under direct supervision of a qualified member of staff. Consent of the service user should be sought at all times.

The oncoming and outgoing NIC will physically check the ward environment together and count the service users to confirm details of the verbal handover, e.g. the number of service users off and on the ward.

All staff are responsible for carrying out general supportive engagement as a matter of their routine work. They must be caringly vigilant, inquisitive in order to keep service users safe and be alert to the times of service user high risk and concern with regard to self-harm and suicide. This also includes maintaining records and handing over at the end of shifts.

Nurses allocated supportive engagement duties should:

- Know the service user including their history, background, specific risk factors and current Supportive engagement safety plan.
- Be familiar with the unit, unit policies and procedures, and potential risks in the environment
- Be alert to all changes in the service user’s condition/behaviours
- Be prepared and ready to act (directly or non-directly)
- When carrying out continuous supportive engagements, only undertake supportive engagement duties and not be involved in other duties in the clinical environment, unless requested by the NIC or managers to assist in a crisis.
- Remain calm.
- Consider approaches/interventions that have been effective in the past in similar situations.
- Utilise distraction, diversion and de-escalation skills as required.

- Recognise own limitations and call for/seek assistance using when appropriate the ward personal alarm system. The observing staff must know how to use the personal alarm system before carrying out supportive engagement duties.

The nurse undertaking supportive engagement must attempt to involve the individual in activities as per Supportive engagement safety plan or in engagement strategies as outlined by the shift coordinator/named nurse. Supportive engagement duties cannot cease until another member of staff has taken over. 'No gaps' should occur during constant supportive engagements ("*Safety First*", 2001).

3.18. Making Supportive Engagement Supportive

Staff carrying out supportive engagement should not engage in other activities whilst carrying out this duty, for example, reading, watching television.

The service user (and/or carer) should be fully involved as far as possible in the decision to implement this aspect of care with an emphasis on maintaining as much personal responsibility and engagement as possible, taking into account any **Advance Statements** the person may have made about his/her aspects of care. The reasons and practicalities of supportive engagement and any special restriction imposed should be fully explained to the individual by the 'reviewing practitioner' for intermittent and constant supportive engagements and documented.

A Service user Information Sheet for Service users on enhanced supportive engagements has been developed with service users and user groups (Appendix 8). All service users on enhanced supportive engagement should receive written information regarding the intervention. Jones et al (2000) propose that information provision can be regarded as an important opportunity for involving service users in their care and can also be used as an opportunity for engagement and building on the therapeutic relationship.

The information sheet should not just be given to the service user. The nurse responsible for this task should sit and listen/observe the service user reading. The service user may have literacy, language difficulties and/or visual disturbances. In these cases, the nurse should read the information sheet with the service user and clarify and explain it as required. Where necessary, an interpreter should be arranged. Genuine consideration of the individual's needs, influenced by their religious and cultural beliefs, as well as ethnicity should be included when deciding on the most appropriate person to undertake supportive engagement.

If the staff member is not of the same gender as the service user but the level of supportive engagement and the particular needs of the service user require that genders are matched, arrangements must be made to meet these needs.

The member of staff should also use this time with the service user to ascertain if the service user understands what is involved and answer any questions the service user may raise. This would be documented in the clinical notes.

All attempts should be made to engage the service users regarding the intervention. However, at times it is recognised that one-to-one discussion is difficult to achieve due to the service user's clinical presentation. All attempts at engagement regarding the decision should be documented in the clinical notes.

Good practice dictates that a programme of structured individual and group activities should be available to service users as part of any Supportive engagement safety plan and therapeutic milieu. These alternative risk management and engagement strategies could preclude the need for enhanced supportive engagement.

To ensure the distress and discomfort that may be felt during raised levels of observation is minimised, a careful balance of activity, silence or privacy must be obtained. This balance will differ for each person and will vary across time. The availability of music, creative activities,

magazines/newspapers, board games, jigsaws, etc., as well as somewhere appropriate for using them is helpful. Activities can also offer an effective method of observing an individual's level of functioning, as is the chance to assess someone's mental state from the general conversation that often occurs around such activities. Being left alone in as private a setting as possible is also appropriate. A careful selection of the available activities is essential and should involve service user choice where appropriate.

Some practical suggestions are as follows.

On-Ward Activities

- Activities of Daily Living – encourage service users to choose activities and assist individuals to maintain self-care, maintaining some responsibility and dignity. Assist with bed-making, tidying room and doing personal laundry. As appropriate, write letters, make telephone calls.
- Social Interaction -respect a service user's right for silence. If a service user wishes to talk don't only talk about symptoms but introduce general conversation topics. Remember the habit of talking at the service user may be due to a staff member's personal difficulty with silence.
- Clinical Interaction - a spell of uninterrupted contact allows time for brief psychological interventions, focused on negative or intrusive thought patterns, reality-checking and problem solving, or self-harming thoughts. There is much therapeutic self-help written material available now, and it can be helpful for the service user to have some guidance in working through it
- Ask the service user what would be helpful to **them at that moment in time**. Is there anything in the service user's history which could be discussed further with benefit?
- Respect a service user's wishes within safety boundaries, and the level of observation in force. Open the door or sit outside the room if the service user's mental state is deteriorating as a consequence of the close proximity and constant observation that is in force.
- On-ward occupational therapy to assist service users in engaging in activities during the time of an acute onset.
- Nurse management systems should be aimed at increasing direct service user contact by ensuring staff are available to service users as much as possible. Appointment systems for named nurse sessions can ensure planned contact and give service users a chance to discuss concerns and frustrations.

Off-Ward Activities

- Engage in occupational therapy/other therapeutic opportunities.
- Walks around grounds or visiting hospital shop/social centre/chaplain/welfare department (assuming risk assessment allows).

3.19. The Ward Environment

Any tools or instruments that could be used to harm self or others should be removed. It may be necessary to search the Service user and their belongings whilst having due regard for service user's legal rights. Please refer to the Trust Personal Searches Procedures 414 (Appendix No 4 of Mental Health Act Legislation Policy).

Procedure for Personal Searches on Trust Premises of Service users and their Belongings.

Staff should remain vigilant to environmental risks whilst undertaking a period of supportive engagement and report any issues of concern immediately to the Nurse in Charge (NIC).

Regular environmental audits should be carried out in all mental health in service user service user settings. Environmental audits should identify actual and potential risks. It is the manager's responsibility to take forward recommendations made as a result of these audits.

Ward manager should ensure that all new staff including bank, agency and students are inducted to the personal alarm system before carrying out supportive engagements and ensure that the panic alarm system is working. Personal Alarms must be tested regularly.

3.20. Regard for the Staff Undertaking Supportive Engagement

In order for staff to provide support and create a safe climate, staff must feel safe and supported to carry out supportive engagement. It is important to develop collaborative and systematic approaches between staff, service users and managers to support all parties concerned in this intervention (Dodds and Bowles, 2001).

There must also be due regard for the observing staff, not exposing them to situations that may have an impact on their health. The NIC should assess the situation and take some possible actions to support the staff. For example, when observing a highly distressed Service user the NIC should consider allocating qualified staff, if this is not possible the NIC should consider allocating regular non-qualified staff preferably for a shorter supportive engagement period.

No continuous period of supportive engagement of any individual service user, particularly for those on constant supportive engagement by a member of staff should be longer than 1 hour. Observing service users for long periods of time can be very stressful and whilst every effort should be made to encourage the service user to participate in activities, this is not always possible. It is preferable that no staff member should spend more than an hour at a time with the service user on constant supportive engagements, but if the service user is attending occupational therapy, it may be desirable for staff to remain for the duration of the activity to prevent any disruption. Exceptions to this are anticipated should a service user be receiving care in an offsite hospital environment.

Throughout any shift it is desirable that each single staff member should not spend more than half their shift observing service users on constant supportive engagements although circumstances may dictate that in the short-term staff may have to observe service users for longer periods whilst alternative arrangements are being made.

The NIC and ward managers need to support staff involved in this difficult and demanding task.

Skills and Training

“Observing service users at risk is a highly skilled activity” (CRAG 2002). Staff must be trained in the skills and competencies required to practice supportive engagement and where necessary be supervised in their practice of this therapeutic activity as they would with any other form of treatment.

All new starters will complete the Staff Competencies assessment and will not participate in any supportive engagement (Appendix 9).
All staff will participate in an internal training session, which is delivered by staff within the Trust.

3.21. Use of Leave by Service users on Enhanced Supportive Engagement

Detained Service users

Should not be permitted to leave the ward whilst on constant supportive engagements without prior permission from the service users Clinician RC or MDT and documentation to this effect is within the clinical notes. Detained service users can access the ward/area garden whilst on supportive engagements in line with the restrictions identified in the supportive engagement safety plan. It is anticipated that if a service user requires leave from the ward during such times, it will only be in unusual circumstances, i.e. to attend appointments in another hospital or as part of an agreed therapeutic Supportive engagement safety plan. It is the responsibility of the Ward Matron or the nurse-in-charge in their absence to ensure that appropriate numbers of adequately skilled staff escort the service user on such occasions and that a full risk assessment has been undertaken in agreement with the multidisciplinary team.

For Intermittent levels appropriate permission can be given by the Responsible Clinician, Ward Doctor or the NIC to allow the service user to be escorted by at least one nurse to other departments within the same building.

It should be noted that enhanced supportive engagements should only be initiated for an individual where there are clear concerns about risk behaviours and therefore escorts outside of the clinical environment should be considered within the context of the risk behaviour. All section 17 leave should be authorised by the Responsible Clinician except for medical emergencies.

Those in service user service users who have been identified as being at risk of harming themselves (e.g. suicidal) and are under an enhanced level of supportive engagement, 'should not normally be allowed time off the ward or granted leave' (Safety First (SF), 2001). This should also apply to service users who have been identified as being at risk of harming others. In both cases, people cannot be prevented from leaving an inpatient unit, unless they have been detained under the Mental Health Act (2007).

Informal Service users
This principle should also apply to informal service users but they should not feel coerced into remaining on the ward with implied threats to use the Mental Health Act if they are unwilling to do so. Entries in the clinical notes should make it clear that if an informal service user attempts to leave the ward against clinical advice then their mental health state should be reassessed at that time and appropriate action taken, a Deprivation of Liberty Authorisation (DoLS) may be considered appropriate for some service users.

All service users whether detained or not must be reassessed prior to leaving the ward, in line with the dynamic ongoing nature of risk assessment. All re-assessments must be clearly documented in the service users' clinical record.

The phrase not to leave the ward must not be used within service user's records, but it should be recorded that prior to service user leaving the ward an assessment of their wellbeing be made and outcomes documented.

3.22. Visitors for Service users on Enhanced Supportive Engagements and Engagement
Negotiation and flexibility should form part of the therapeutic alliance between nurses and Service users, and it is important that staff try to be consistent with each other in their approach to the process of supportive engagement.

If another person wants to see the Service user, such as friends or relatives, the visitor should be given an explanation of the level of supportive engagement being maintained, and the nurse should maintain the supportive engagement throughout the visit. If the visitor requests to see the service user in private and the agreed level of supportive engagement prevent this, the request should be declined, the reasons explained and a note of the request made in the daily progress notes.

If a health or social care professional requests to see the service user in private, the observing staff (in agreement with the NIC and that professional) may hand over the role temporarily to that professional. It is then that professional's responsibility to accept full accountability and ensure the level of supportive engagement is maintained. Responsibility is returned to the original observer in the same way at the end of the interview and signed for in both instances.

Solicitors, other professionals (not mentioned above) and service user groups visiting service users cannot be delegated responsibilities to carry out enhanced level of supportive engagements. If a solicitor wants to see a service user on enhanced supportive engagement in private, this should be pre-arranged and agreed by the team or the shift co-ordinator. Otherwise, a new appointment should be arranged if it is not safe to facilitate this.

The ward manager must ensure a clear consistent system is in place to ensure important information is handed over from one shift to the next.

Handover will include any significant changes in mental state or behaviours, activities undertaken and those which might take place in the near future.

3.23. Clinical Risk Assessment Training (Incorporating Supportive Engagement Levels)

Staff responsible for carrying out engagement and observation must receive training so that they are equipped with the skills and confidence to engage with service users. Supporting a service user at risk is a highly skilled activity. Essential components of adequate training include developing knowledge and skills in:

- Risk assessment
- Positive risk taking
- Enhanced engagement and management of care for service users at risk of harming self and others
- Factors associated with self-harm and harm to others
- Indications for engagement and observation
- Establishing and maintaining a therapeutic relationship with the service user and their environment, including working alongside them
- Different intensities of engagement and observation
- Attitudes towards engagement and observation
- Therapeutic opportunities in engagement and observation
- Roles and responsibilities of the multi-disciplinary team in relation to engagement and observation
- Making the environment safe
- Recording engagement and observation in service user's clinical record
- The use of reviews and audit

3.24. Guidance on Risk Assessment/Management

Risk assessment should include an interview with the service user and carers, careful study of the service user's history, use of risk assessment tools and must take into account assessments of other professionals, e.g. psychiatrists, CPNs or CMHT. The service user's thoughts, feelings and wishes regarding suicide, self-harm and harm to others should be approached using direct and respectful questions.

Consideration also needs to be given to Advanced Statements/Directives. This can be a relief to service users who may not have been able to share such information with anyone else. The service user's notes are a vital source of information about past behaviour, as are relatives, friends and carers. A previous history of suicidal attempts or of attacks on others suggests that the service user should be observed until a full assessment can be carried out. When reading the history or gathering information from relatives or carers, it is important that nurses get as much detail as possible. There are also several simple and reliable tools that have been developed to appraise risk and these can form a useful adjunct to other methods of gathering information.

Factors which might indicate a need for increased levels of supportive engagement (Intermittent level and above) include:

- History of previous suicide attempts, self-harm or attacks on others
- Hallucinations, particularly voices suggesting harm to self or others
- Paranoid ideas where the service user believes that other people pose a threat
- Thoughts and ideas that the service user has about harming themselves or others
- Specific plans or intentions to harm themselves or others
- Past or current problems with drugs or alcohol
- Recent loss or bereavement
- Poor adherence to medication programmes

- Poor adherence to medication programmes or non-compliance with medication programmes
- Marked changes in behaviour or medication
- Known risk or relapse indications

It is recognised that a restrictive, risk adverse application of supportive engagement can become counter therapeutic. Therefore, it is appropriate that clinical teams ensure that the application of this policy generates a safe and therapeutic environment of care. For example, following an appropriate assessment, a clinical team may identify a risk of self-harm that is known and understood, but in their professional view this risk is most appropriately managed within a general supportive engagement or flexible supportive engagement approach. This policy is not designed to impose practices on clinical teams. Effective management of risk does not mean total eradication of risk. This policy requires clinical teams to demonstrate objectivity and rigour in their risk assessment process.

The MDT identifies the need for a flexible supportive engagement safety plan. a formulation of the service user's problem using the 'five 'P's'– is then developed, and the qualified nurse (CPA co-ordinator) and service user negotiate a flexible supportive engagement safety plan and agree thresholds for changing supportive engagement levels. Consider the following to ensure a robust Supportive engagement safety plan: five 'W's': what, where, when, why, who and the SMART principles (Specific, Measurable, Achievable, Relevant, Timely).

A flexible supportive engagement safety plan incorporates the triad of environmental, relational and procedural security. Environmental security might include the identification and removal of ligature points on the ward. Procedural security might include an individualised protocol for removing risky items from the service user's immediate environment such as CDs that they might use to self-harm. Relational security might include structured time with qualified nurses to explore thoughts and feelings, and covers positive attitudes and optimism that service users will develop alternative coping strategies.

Flexible supportive engagement safety plans promote engagement and shared responsibility for risk management. A key principle is that the Supportive engagement safety plans include the prescription of the least restrictive intervention to manage risk, as specified by the mental health act 2007 Code of practice.

Changing supportive engagement levels once a flexible supportive engagement safety plan has been implemented, increases and decreases in supportive engagement level are instigated by an 'MDT nominated senior nurse/Allied professional in collaboration with the service user. Increases in supportive engagements are managed by the nursing team. If one-to-one supportive engagement is applied, a Registered nurse meets with the service user to review their mood at intervals specified in their Supportive engagement safety plan – for example, hourly a Likert scale (1-10 scale) is used to measure changes in the service user's mood/urges to self-harm. Once the immediate risk has passed, intermittent supportive engagements are re-established.

Empowering nurses to increase or decrease supportive engagement level is a fundamental part of the flexible supportive engagement process.

Duncan et al. (2010) found that nurses make decisions about increasing supportive engagements but doctors make decisions about reducing them. Reynolds et al (2005) suggest that giving nurses the authority to adjust supportive engagement levels improved service users' experiences. Kettles and Paterson (2007) reported that when responsibility for changing supportive engagement levels was given to nurses and other members of the multidisciplinary team, there was a gradual shift away from high levels of supportive engagements and service users were nursed on constant one-to-one supportive engagements for shorter periods

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5. RELEVANT POLICIES/PROCEDURES/PROTOCOLS/GUIDELINES

Supportive Engagement Policy

Absconding from Inpatient User Units – Managing the Risk

Clinical Risk Management Policy

Management of Violence and Aggressive Behaviour Policy

Mental Health Act Legislation Policy

NICE Policy

Seclusion Policy

Appendix 1: Supportive Engagement Safety Plan

Supportive Engagement Safety Plan

Name: Click here to enter text.

Unit: Click here to enter text.

Date of Birth: Click here to enter a date.

Date of Transfer of Care: Click here to enter a date.

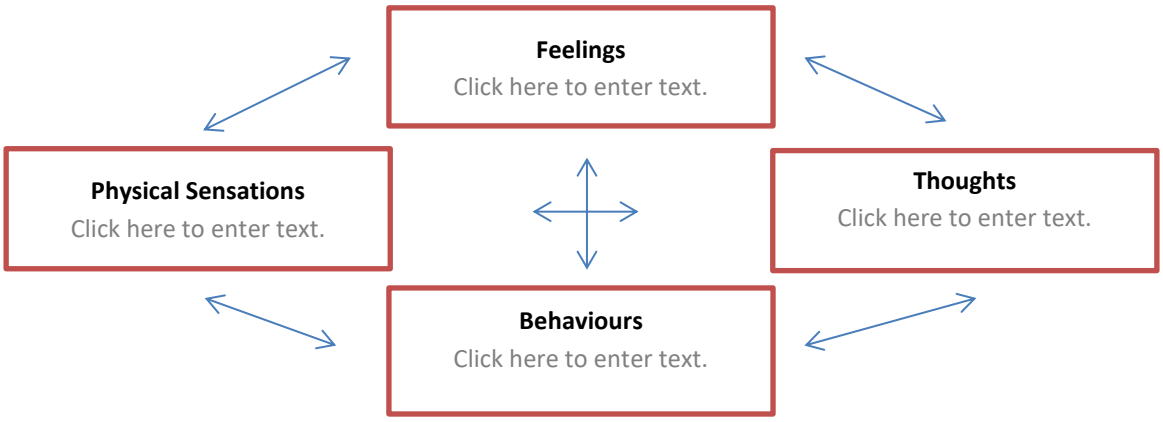
NHS No: Click here to enter text.

Legal Status: Click here to enter text.

Identified risks, projected risk factors/situations:

Triggers of risk behaviours/warning signs (consider factors influencing risk for self-harm, harm to others, offending behaviour – consider using available risk assessment information):

What happens when risk escalates for this individual?



Ways of working, what can reduce the impact of triggers (what strategies/approaches seem to work well):
Click here to enter text.

Protective factors/positive behaviours/management strategies:
Click here to enter text.

Predisposing Factors The distal internal and external factors that increase the person's vulnerability to the problem.	**Precipitating Factors or Triggers** The proximal internal and external factors that trigger the problem.
Click here to enter text.	Click here to enter text.
Protective Factors Internal and external factors that help the person cope with or recover from the problem.	**Perpetuating Factors** The internal and external factors that maintain the problem.
	Click here to enter text.

Engagement History (Information relating to how they relate to male/female staff, interests, previous engagement/interventions, cognitive impairment etc.):

Click here to enter text.

Agreed plan of care-interventions, level of supportive engagement. (Include agreed flexible levels and zonal information):

Click here to enter text.

Agreed plan of care-interventions, level of supportive engagement. (Include agreed flexible levels and zonal information):

	Sign (print)	Date/Time
Registered Nurse		
Medic		
Service user		
MDT agreed allocated staff member for Flexible Supportive Engagement.		

Review date of	RC to sign and print	Review date of	RC to sign and print

Complete within 2 hours of Transfer of Care and following ANY changes. To be reviewed weekly at MDT reviews

Supportive Engagement Safety Plan Reviews

Date of Review	Staff involved in review	Signature of staff	Alterations made to the Supportive Engagement Safety Plan

Appendix 2: Zonal Chart

Focused Support (Environmental/Care Zoning)

Unit……
Date ……..

Zone consists of:				
Time	**Full Name of Zone Nurse**	**Number of service users accounted for**	**Comments and/or evidence or risk indicated**	**Signature and designation**

Appendix 3: Maister Lodge Zonal Chart

Maister Lodge Zonal Chart

Date…….

Service users Formulation

Time	Score	Other Information	Use of PRN	Environment	Sign/Print Name
00:00-01:00					
01:00-02:00					
02:00-03:00					
03:00-04:00					
04:00-05:00					
05:00-06:00					
06:00-07:00					
07:00-08:00					
08:00-09:00					
09:00-10:00					
10:00-11:00					
11:00-12:00					
12:00-13:00					
14:00-15:00					

Time	Score	Other Information	Use of PRN	Environment	Sign/Print Name
15:00-16:00					
16:00-17:00					
17:00-18:00					
18:00-19:00					
19:00-20:00					
20:00-21:00					
21:00-22:00					
22:00-23:00					
23:00-24:00					

KEY – *please use 0 if asleep*	
1	
2	
3	
4	

Appendix 4: Procedure for the use of Vision Panels in Doors

Introduction

Safety, privacy and dignity are crucial issues for all service users within our services. This is particularly true in relation to service users who are admitted to our in service user facilities who are subject to general supportive engagement as defined within the Trust's Supportive Engagement Policy. The practicalities of this considers the unobtrusive supportive engagement of service users during the day who are in their bedrooms at the time that supportive engagement is due to take place as well as staff who wish to interact or communicate with service users who may have locked their doors in some situations.

All vision panels should be kept closed at all times unless a risk assessment has been completed on an individual and supportive engagement safety plan put in place that requires the panel to be open. This needs to be clearly documented in the nursing notes and reviewed on a daily basis.

General supportive engagement can be made by opening the panels and immediately closing them again once the service user has been observed to be safe. If it is not possible to observe in this way, i.e. there is no vision panel, it is too dark to safely observe etc. then the door must be opened to observe the service user.

Service users will have the use of vision panels explained to them as part of their induction to the ward.

Any decision to place a service user on enhanced supportive engagements must take into account the risks identified in the Supportive Engagement Safety Plan.

The following procedure sets out some basic guidelines for all staff to follow when using vision panels in bedroom doors to ensure that individual service user safety is balanced with the maintenance of privacy and dignity and so that therapeutic relationships are maintained.

Enhanced Supportive Engagement

Any service user subject to Enhanced Supportive engagements, that is, have been assessed as needing to be always within the eyesight of a staff member or within arm's length, must have the supportive engagement procedure clearly explained to them at the onset of the period of supportive engagement. For service users who need to be seen at all times the member of staff must find the best way for the supportive engagement to take place without exposing the service user to unwelcome attention from other parties. This should wherever possible be done with the involvement of the service user.

General Supportive Engagement

Where general supportive engagement is being undertaken, e.g. at least every hour, or where a nurse or other staff member is making contact with the service user for any other reason, for example, encouraging them to join a therapeutic group, the process is as follows:

- Nurse and/or other staff member to knock clearly on the service user's door.
- Wait for a couple of seconds for verbal acknowledgement from the service user.
- The member of staff should announce that they are going to either enter the room or open the vision panel, and then proceed.

At night time this is not always the best way to carry out supportive engagement as the service user would have difficulty sleeping. The nurse must however carry out these supportive engagements in strict accordance with the policy and therefore must try to reach an agreement with the Service user about how this can happen, e.g. sleeping with the light or night light switched on so that the nurse can observe through the vision panel or perhaps the nurse will shine a torch light through the open door or vision panel and establish the well-being of the service user.

If the nurse is unable to establish the rise and fall of the service user's chest to ensure that s/he is breathing the nurse will be required to enter the room to be certain that the service user's is breathing. It is understood that there will be occasions when service users will be reluctant to engage with staff, particularly to attend therapeutic groups, etc. Under these circumstances, clinical staff must rely upon the quality of the therapeutic relationship with the service user and use skilled interventions to engage the service user in their care and treatment.

Appendix 5: Semi-Structured Interview Schedule – A Risk of Violence

NAME: …….. DATE: ……...……...

What were you a) feeling and b) thinking before you became angry or hurt yourself?

What happened to make you feel this way?

What did you think of the support given to you?

How could this support be improved if needed in the future?

What makes you angry?

How might other people know you are getting angry?

How can we help when you are feeling angry?

How can we help when you are thinking about issues that lead to aggression?

How can we help when another person triggers angry thoughts and feelings?

What do you consider are your main reasons for you behaving aggressively?

What is unhelpful when you are trying to calm down?

Can you think of anything else that may have affected you becoming angry?

Completed by (initials/grade)_____

Date_____

Appendix 6: Semi-Structured Interview Schedule – A Risk of Suicide/Self-Harm

NAME: …….. DATE: ……...……...

What were you a) feeling and b) thinking before the recent incident?

What did you think of the intervention used?

How could intervention be improved if needed in the future?

Did you really intend to commit suicide?

Do you have any plans to take your own life?

Do you have any ideas about how you would do this?

Why do you feel that you have to do this?

What impact do you think your actions will have on your family/friends/others?

How do you feel about yourself? (e.g. like yourself, not like yourself)

What are your plans for the future? (e.g. optimism/pessimism, future goals, bright/dark)

Is there anything else that we have not discussed that is upsetting you?

Completed by (initials/grade)_____ Date_____

Appendix 7: Brief Psychiatric Rating Scale

Brief Psychiatric Rating Scale	Not Present	Very Mild	Mild	Moderate	Mod. Severe	Severe	Extremely Severe
SOMATIC CONCERN -preoccupation with physical health, fear of physical illness, hypochondriasis.			☐	☐	☐	☐	☐ ☐ ☐
ANXIETY -worry, fear, over-concern for present or future, uneasiness			☐	☐	☐	☐	☐ ☐ ☐
EMOTIONAL WITHDRAWAL - lack of spontaneous interaction, isolation, deficiency in relating to others.			☐	☐	☐	☐	☐ ☐ ☐
CONCEPTUAL DISORGANISATION - thought processes confused, disconnected, disorganised, disrupted.			☐	☐	☐	☐	☐ ☐ ☐
GUILT FEELINGS - self-blame, shame, remorse for past behaviour			☐	☐	☐	☐	☐ ☐ ☐
TENSION - physical and motor manifestations of nervousness, over-activation □			☐	☐	☐	☐	☐ ☐ ☐
MANNERISMS & POSTURING - peculiar, bizarre unnatural motor behaviour (Not including tic)			☐	☐	☐	☐	☐ ☐ ☐
GRANDIOSITY - exaggerated self-opinion, arrogance, conviction of unusual power or abilities.			☐	☐	☐	☐	☐ ☐ ☐
DEPRESSIVE MOOD - sorrow, sadness, despondency, pessimism. □			☐	☐	☐	☐	☐ ☐ ☐
HOSTILITY - animosity, contempt, belligerence, disdain for others □			☐	☐	☐	☐	☐ ☐ ☐
SUSPICIOUSNESS - mistrust, belief others harbour malicious or discriminatory intent.			☐	☐	☐	☐	☐ ☐ ☐
HALLUCINATORY BEHAVIOUR - perceptions without Normal external stimulus correspondence.			☐	☐	☐	☐	☐ ☐ ☐
MOTOR RETARDATION - slowed weakened movements or speech, reduced body tone.			☐	☐	☐	☐	☐ ☐ ☐
UNCOOPERATIVENESS - resistance, guardedness, rejection of authority □			☐	☐	☐	☐	☐ ☐ ☐
UNUSUAL THOUGHT CONTENT - unusual, odd, strange, bizarre thought content.			☐	☐	☐	☐	☐ ☐ ☐

BLUNTED AFFECT - reduced emotional tone, reduction in formal intensity of feelings, flatness. ☐ ☐ ☐ ☐ ☐ ☐ ☐

EXCITEMENT - heightened emotional tone, agitation, increased reactivity ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐

DISORIENTATION - confusion or lack of proper association for person, place, or time. ☐ ☐ ☐ ☐ ☐ ☐ ☐

GLOBAL ASSESSMENT SCALE (range 1 - 100)

Appendix 8: Information for Service Users on Supportive Engagement

Why supportively engage with service users?
Following Transfer of Care, or a recent incident, your level of supportive engagement will be discussed with you. It is used with the aim of reducing risk and preventing any serious event happening within in service user service user wards.

What is supportive engagement?
Supportive engagement/primary purpose is to maximise service user safely, minimise risk and to build up supportive therapeutic relationship. It is an opportunity for conversation, listening and making you feel valued and cared for. There are four different levels and you should be aware which of these might be relevant to you. This will depend on your level of need and risk.

What are the four levels?

- General – this is a minimum. Staff should know your whereabouts at all times, but you do not have to be kept within sight.
- Intermittent – a nurse will be monitoring you at times agreed by your Multi-Disciplinary Team.
- Constant (line of sight) – a nurse will have you within sight at all times and for safety may have to accompany you into the bathroom.
- Constant (arm's length) – a nurse will have you within arm's length at all times and for safety may have to accompany you to the bathroom.

During these times, staff are required to record your location, what you are doing and your mood/behaviour

How often are they reviewed?
These levels will be reviewed by your MDT at a time specified on your Supportive engagement safety plan. You should be involved and made aware of the decision and why.

If you need more information, please see a member of your team.

Appendix 9: Safe and Therapeutic Supportive Engagement of Inservice Users – Staff Competencies

Competence:

"The state of having the knowledge, judgement, skills energy, experience and motivation required to respond adequately to the demands of one's role and for some professional responsibilities" (Adapted from Roach, 1992).

The following competencies must be completed for all new starters to the ward/area and all bank staff / students who will be undertaking supportive engagement duties.

Should the staff member be unable to complete the competencies they must **not** undertake supportive engagements and an action plan agreed with timescales set to achieve the required competencies.
A copy of Bank staffs competency assessment must be sent to CBS.

All staff should be given the opportunity to read the Trust Policy on Engagement and Supportive engagement and receive training before completing the assessment.

Name of staff……..…….**Band**……...…….……

Name of Assessor…….……..……**Band**……..……..

Date of Assessment……..……**Ward/Area**……

Question	Criteria to meet	Achieved *Please circle*
Has the staff attended training and read the policy?	Can demonstrate attendance at training, locate the policy and reports they have read it.	YES/NO
Define the purpose of supportive engagement.	Staff can explain that supportive engagement minimises risk of harm to a service user and/or others and monitor mental state.	YES/NO
Outline the different levels of supportive engagement?	The staff can accurately describe levels of supportive engagement, general, intermittent and 2 levels of constant.	YES/NO
Who agrees the service user requires supportive engagement and how often should it be reviewed?	The multidisciplinary team (doctor and nursing staff as a minimum) agree supportive engagement and it should be reviewed daily or when staff note a change in mental health.	YES/NO
How should any change to supportive engagement be documented?	In the service user notes, in their Supportive engagement safety plan, in supportive engagement records on service user status boards.	YES/NO
How can supportive engagement be made therapeutic/supportive?	Informing the service user of the reason and level of supportive engagement, considering any cultural needs, introducing self. And engaging in interactions or activities.	YES/NO
Who is responsible for the supportive engagement of service users?	All team members have general responsibility but individual staff may be allocated to service user supportive engagement for a specified time.	YES/NO
When carrying out supportive engagements what environmental risks should be considered?	Staff can give examples, such as blind spots, ligature points, damaged equipment.	YES/NO
What should be documented whilst undertaking supportive engagements?	Mental and physical health, food and drink taken, medication offered/taken, interactions and activities.	YES/NO
What else should clearly be documented?	Service users name, NHS No. hospital number, the staff observing name and the span of supportive engagement.	YES/NO
How can continuity of supportive engagement be	An individual service user Supportive engagement safety plan is in place, levels of supportive engagement are	YES/NO

Question	Criteria to meet	Achieved *Please circle*
maintained?	handed over at every shift and to each observing staff.	
How long should you observe a service user for without a break?	One hour.	YES/NO
If a service user has taken excessive alcohol or illicit drugs, what level of supportive engagement should be considered as a minimum?	Intermittent.	YES/NO
If you notice someone who is not on supportive engagement is missing from the ward, what should you do?	Report it to the nurse in charge and conduct a thorough local search, discuss with the unit coordinator, carry out the missing person's procedure, inform relatives and the police.	YES/NO
What should you do with any information gained through conversations during supportive engagement?	Report to the identified nurse and document in the service users' notes. Ensure any relevant information is handed over to the nursing team.	YES/NO