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VISIT AND MONITORING REPORT

Enhanced Observation 2014/15

Enhanced Observation Report
September 2015

Contents

What we do

We protect and promote the human rights of people with mental health problems, learning disabilities, dementia and related conditions.

We do this by

- Checking if individual care and treatment are lawful and in line with good practice
- Empowering individuals and their carers through advice, guidance and information
- Promoting best practice in applying mental health and incapacity law
- Influencing legislation, policy and service development

Why we carried out these visits

These visits follow our earlier report, from 2012, when we visited all adult acute mental health admission wards in Scotland[1]. At these visits, some patients told us about the levels of enhanced observation they were subject to and other restrictions. Many of the comments we heard were negative, and we recommended that service managers review the potential restrictions that people admitted were subject to, and ensure that any restrictions applied were individually assessed, proportionate and justifiable.

Although we had not set out to ask specifically about levels of enhanced observation at that time, we found that the national good practice guidance on observation, *Engaging People*[2] did not reflect changes in practice. The guidelines could be interpreted in such a way that people were subject to potentially restrictive levels of observation for longer than was necessary. We recommended that the Scottish Government commission a review of *Engaging People*.

We are pleased to report that the Scottish Government have commissioned Healthcare Improvement Scotland (HIS) to review the national good practice guidance and this review is underway at the time of writing this report. Observation is by its nature intrusive and can have a negative impact on the privacy and dignity of

- [1] Mental Welfare Commission for Scotland (2013) *Adult acute ward visits 2012* http://www.mwcscot.org.uk/media/126149/adult_acute_2012.pdf

- [2] Clinical Resource and Audit Group (CRAG) NHS Scotland (2002) Engaging People: Observation of people with acute mental health problems. A Good Practice statement. "Engaging People" is a revision of the CRAG document "Nursing Observation of Acutely Ill Psychiatric Patients in Hospital" (1995) and is relevant to all who provide or receive acute psychiatric care

the person being observed. Observation may place restrictions on patients, and all staff need to be aware about the possibility of de facto detention.

De facto detention is when a patient is not giving valid consent to their admission to hospital but is not detained under the Mental Health (Care and Treatment) (Scotland) Act 2003 (the Act). If it is the patient's perception that they are not allowed to leave, or restrictions are limiting their opportunity to leave, then that would be considered to be de facto detention and potentially a breach of Article 5 of the European Court of Human Rights (ECHR) (deprivation of liberty). The same would be true if the patient perceived that if they asked to leave, it was unlikely that they would be allowed to do so.

If not carried out sensitively, observation could be a breach of Article 8 of the ECHR (respect for private and family life) and/or Article 3 (prohibition against inhumane and degrading treatment or punishment) in some circumstances.

We decided that we should take a closer look at the issue of enhanced observation, particularly in relation to dignity, respect and the rights of the person being observed. We decided to carry out these visits to look specifically at this.

Key messages from our visits

Enhanced observation can unintentionally result in distress for the patient and a balance needs to be struck between maintaining patient safety whilst respecting privacy and dignity.

Observation was often viewed as a "one size fits all" process rather than an integral part of a plan of care.

Too few patients had a regularly reviewed 'person-centred' care plan in relation to their enhanced observation. Patient participation in, and understanding of, their care plan was inconsistent.

Enhanced observation provides an opportunity for therapeutic intervention, but was perceived by some patients as intrusive. Staff and patients had views about how the experience of enhanced observation could be improved.

There is variation in practice across Scotland as to who in the health care team has the authority to reduce levels of enhanced observation. It is best practice for this to be part of multidisciplinary discussion but this is not always possible and can result in patients remaining on levels of enhanced observation for longer than necessary.

Enhanced observations can amount to de facto detention in some cases and this was often not being considered. Generally, patient consent to enhanced observation had not been adequately addressed.

Staff training in enhanced observation was inconsistent and often inadequate.

Recommendations from our visits

We recommend that in anticipation of the new guidance that will be published once HIS have completed their review of 'Engaging People', hospital managers consider and address the following recommendations.

Hospital managers should review their local policies and make sure that staff know about and understand these policies. They should ensure that enhanced observation is carried out sensitively and discreetly and that patients are not subject to enhanced levels of observation for longer than is clinically indicated.

Hospital managers should ensure patients subject to enhanced observation have a person centred care plan in place that follows a clear risk assessment process. This must take into account the particular needs of the individual patient and ensure patient participation wherever possible in their care plan and review.

Ward staff should provide verbal explanation and written information for patients and visitors/named persons that explain enhanced observation and what to expect.

Hospital managers should ensure that staff have the support and resources to ensure therapeutic activity during the period of observation. Hospital managers should ensure consistent processes are in place to review staffing levels in response to changing levels of enhanced observations.

Hospital managers should ensure that the enhanced observation policy allows for an early review of observation status and a reduction in level of observation where this is clinically indicated.

Where nursing staff are reducing levels of observation, there needs to be a clear policy and guidance in place to support this.

Hospital managers should ensure patient consent to enhanced observation is assessed, recorded and regularly reviewed, and appropriate action – such as considering the need for detention – is taken where patients are not consenting to its use.

Hospital managers should ensure access to independent advocacy is easily available.

What is enhanced observation?

The key purpose of observation is to provide a period of safety for patients during temporary periods of distress when they are at risk of harm to themselves and/or others. A raised level of observation is frequently used when staff have assessed that the risk of self harm or risk to others is increased, either within a ward environment and/or if the patient were to leave the ward.

Engaging People defines the following levels of observation:

General Observation

This level of observation is intended to meet the needs of most patients for most of the time. The staff on duty should have knowledge of the patients' general whereabouts at all times, whether in or out of the ward. Patients on general observation are considered not to pose any serious risk of harm to self or others.

Constant Observation

This level of observation is used for those considered to pose a significant risk to self or others. An allocated member of staff should be constantly aware at all times of the precise whereabouts of the person being observed through visual observation or hearing .It is recommended that appropriate members of the multi-disciplinary team (generally a minimum of the nurse in charge and duty doctor) review the need for constant observation at least every 24 hours.

Special Observation

This level of observation is used when a person is clinically assessed as requiring intensive and skilled intervention as a consequence of their very serious mental and/or physical state. The person being observed should be in sight and within arm's reach of a member of staff at all times and in all circumstances.

When in this report we talk about people on enhanced observation, we mean people who are being cared for on a constant or special level of observation.

How we carried out these visits

We visited each ward on an unannounced basis. One of the Commission's practitioner officers attended the ward and asked a senior member of nursing staff about the current level of occupancy and to identify any patients who were on an enhanced level of observation at the time. We also asked some general questions about how the observation policy operated.

We visited some wards more than once. Details of where we visited and how often can be found at appendix 1.

We met with patients on enhanced observation where it was possible and appropriate, and where the individual patient agreed to meet us. We asked the patient on enhanced observation a series of questions about their understanding and experience of enhanced observation.

We also looked at the records to collect key information, including looking at evidence of reviews, and the level of detail in each patient's care plan.

We completed a questionnaire with the patient's named person if they had one, and when it was possible for us to speak with them. A named person is someone who will look after the person's interests if he or she has to be treated under the Act.

We asked the named person if they had been given information about the enhanced observation and the reasons for this.

In addition to the unannounced visits to hospital wards, we also contacted all health boards and asked them to provide us with a copy of their observation policies.

Key information we collected

Between 08/04/14 and 24/09/14 we visited 60 wards across 12 health board areas in Scotland.

We spoke to 186 patients who were subject to enhanced levels of observation, to look at their care and treatment, in 53 of these wards across 10 health board areas. Forty four wards were for adult mental health admission, and nine were admission wards for people with learning disability.

We also spoke with 23 named persons.

At the time we visited the wards, 48 of the 60 wards had at least one patient on enhanced observations. The highest number of patients on enhanced observations on a ward at the time of our visit was six. We were told that staffing levels had been increased in 22 of these 48 wards to cover the enhanced observation.

Of the 186 patients we met with, 108 were female and 78 were male. The age range was from 13 to 79.

126 patients were subject to detention under the Act, and sixty were not.

Status of patients seen	Number of patients
Informal	60
Detained	126
Total	186

Type of order (detained patients)	
Short Term Detention Certificate (STDC)	68
Compulsory Treatment Order (CTO)	47
Emergency Detention Certificate (EDC)	7
Interim CTO	2
CTO and STDC	1
Criminal Procedure (Scotland) Act Order	1
Total detained	**126**

Of the 186 patients, 162 were on constant observation and 24 were on special observation.

Reason for enhanced observation status

The most common reason given by staff for an individual being on enhanced observation was the risk of absconding, as shown in the table below.

Reason for enhanced observation	Number of patients*
Risk of absconding	67
Risk of suicide	58
Risk of deliberate self harm	48
Risk to others	46
Threats made	14
Substance misuse	9
Other reasons (including sexual disinhibition, vulnerability)	59
Total number on enhanced observation	**186**

- The count is more than the total of 186 patients as more than one reason could be given for each individual.

Further Action

As a result of our visits to patients, we often take action, either immediately or shortly after the visit. During this series of visits we took action on the day of the visit for 24 patients, or shortly after the visit for five patients.

In terms of immediate follow-up action, the most common courses of action were raising an issue with the ward manager or nursing staff, or giving advice to the person visited. The most frequent issue discussed was the use of constant observations for an informal patient.

In the five cases where we took action after a visit, we contacted the patient's Responsible Medical Officer (RMO). In two cases, this was to raise the issue of possible de facto detention. Other issues raised were the use of special observations for an informal patient (who was reportedly agreeing to this level of observations); specified person restrictions;[3] and a request for information about a critical incident on a ward.

[3] The Mental Welfare Commission for Scotland (2014) *Specified Person monitoring*

http://www.mwcscot.org.uk/media/192163/final_specified_persons.pdf

What patients told us

Seventy three of the 186 patients we spoke to remembered being told about enhanced observations starting. Of them, 60 patients recalled someone explaining to them what it would involve. Sixty five patients remembered being told why enhanced observations were being started. Only 24 patients said that they had been told how often their observation level would be reviewed.

We asked patients for their comments about the reason they were given for being put on enhanced observations, but only a few people gave us information about this. Ten patients said that they had been informed that it was for their own safety. Five people told us that they had not been informed that they were on enhanced observations or told why this decision had been taken. Only one person told us that they had been given written information.

We also asked patients how they felt about being on enhanced observations. 85 people gave us information about this. 43 patients told us that they were generally happy about being on enhanced observations. Some particular comments were:

> *"They have been respectful and tried to engage with me."*
>
> *"It makes me feel safer."*
>
> *"They have tried to give me as much privacy as possible."*
>
> *"I like the company."*

34 patients told us that they were unhappy (to varying degrees) about being on enhanced observations. People commonly told us that it was intrusive. Other comments were:

> *"It's horrible being watched and followed all the time."*
>
> *"It's very restrictive – it feels like being a child."*
>
> *"I struggled with it – it's very difficult."*
>
> *"It feels very restrictive and intrusive, like being in prison."*

Some patients told us that the experience was unpleasant but they accepted the need for it.

We asked patients if anything could be done differently to make being on enhanced observations a better experience. There were 23 responses which suggested changes to observation practices, rather than general comments such as "just leave me alone" or "let me go home".

Suggested comments to improve the observation experience included:

- more time off the ward,
- more staff on duty,
- more opportunities to go out for a cigarette,
- more privacy when going to the toilet,
- more privacy when making phone calls,
- being able to choose the nurse that carried out the enhanced observations, and
- staff involving patients in activities.

One patient would have preferred it if there was not someone in his room when he was sleeping, and another wanted staff to be behind his door, rather than in his room. A further patient thought that wards should use cameras rather than staff "*so you can have your own space*."

> *"The nurse explained that they were worried about me and because I was threatening to kill myself and feeling so mixed up that someone being with me to keep an eye on me would be good. They check how I'm doing all the time and I'm seeing the doctor today."*
>
> *"When I tried to harm myself ,everything was taken off me and my only strategy is to draw and write, but I wasn't allowed even a pencil to do my university work, so that was unfair"*
>
> *"I did not like someone in the room with me waking me when I was asleep. I did not understand why there was not even a simple lock on the toilet door. I found not having a lock more anxiety provoking"*
>
> *"Staff change hourly. Some staff talk to you, some play games, some don't interact at all "*
>
> *"Bit more of a handover, so you don't have to go through things again, especially if you're quite upset... you don't want to go over the same things again".*
>
> *"Some nurses moan about work and being on observation.... it's ok, but not fair on a patient who has their own stuff to deal with... you feel a bit of a burden, it's hard".*
>
> *"I think there should be some boundary for privacy, maybe making a phone call if I'm upset or something"*

Information from staff and our review of records

Evidence of review and care planning

We asked staff how often patients on enhanced observations had that status reviewed. On 45 of the wards, we were told status was reviewed on a daily basis and on another two at least every 48 hours. Nine of the wards reviewed observation status on a weekly basis (all of them learning disability wards). There were some other intervals specified for reviews, and some wards reviewed status ‘as required by the individual patient’ or on an “ad hoc” basis.

We looked for written evidence of review of observation status in patient records. We found this in 168 cases out of 186 (90%). These records showed that enhanced observation status was most commonly reviewed on a daily basis (104, 62%). Less frequent review was seen in some cases: review every 48 hours (17, 10%); twice weekly review (4, 2%); and weekly review (27, 16%). On some wards review was sporadic. For five patients, constant observations were not reviewed as it had been decided that they would remain on this level of observations for policy reasons (an example of this being an under 16 year old on an adult ward which we considered to be good practice, given their vulnerability).

We also asked staff about who generally reviewed enhanced observation status. The most common answer was that review was carried out by the Responsible Medical Officer (RMO), nursing staff and other medical staff, such as a specialty doctor or appropriately trained specialty registrar. On some wards we were told that the decision was solely made by the RMO. Staff said that the multi disciplinary team (MDT) was involved in half (30) of the decisions.

Patient records confirmed that observation status was most commonly reviewed by the Responsible Medical Officer (RMO) and nursing staff, often with input from other members of the multidisciplinary team.

Staff comments indicated considerable variation across wards in how reviews of enhanced observations were documented; often the review might be noted in more than one document. Reviews were most commonly noted in a separate enhanced observations recording sheet/prescription (21); medical notes (19), nursing notes (18) or multi-disciplinary (12) notes.

We asked staff if enhanced observations were ‘care planned’ for. By that we meant; was there a specific care plan that detailed the enhanced observation; what that involved and how this was being managed and reviewed.

Ward staff told us that this was the case on 51 (85%) of the 60 wards.

On 21 of these 51 wards the relevant care plan would be reviewed daily. On three wards, the care plan would be reviewed every two days, and on 25 wards it would be

reviewed on a weekly basis. Three of the wards did not state their frequency of review.

When we looked at individual records, we were concerned to find that there was a care plan in place for the use of enhanced observations for just 95 (51%) patients.

Where specific care plans were in place, we regarded these as person-centred in 80% -76 of the 95 - instances. By person centred we mean that the particular needs of the individual patient had been assessed and planned for; the care plan was not just a generic enhanced observation template with the patient's name inserted.

Patient participation

We were keen to find out if patients were involved in reviews of their observation status. We were told that patients were involved in reviews on 51 out of the 60 wards.

We were interested in the processes followed by staff when patients were put on enhanced observations. We looked in case notes for evidence of patients being told about this, and found written evidence in 112 cases out of a total of 186 (60%). We then asked patients if they had been told. As noted earlier, 73 patients informed us that they had been told about enhanced observations being started.

We asked staff how patients were informed about changes to their observation levels. On all of the wards we visited, patients were informed verbally, by nursing or medical staff. In addition, on 29 wards patients were also given written information, such as a leaflet explaining observation levels. One ward (learning disability) used pictorial augmentation to assist the doctor and nurse explaining changes in observation levels to patients.

We asked if patients are given the opportunity to discuss their experience of enhanced observations after the event. Staff on 38 wards told us that patients were given this opportunity. This opportunity for discussion was most commonly within "one to one" sessions with nursing and/or medical staff, as described on 24 wards. Other opportunities were within multidisciplinary team meetings or during a weekly discussion with the "named nurse". One learning disability ward used "talking mats" to enhance communication following the use of enhanced observations.

Staff processes and understanding

When we visited the wards, we asked if staff had access to an observations policy. We would expect that all wards would be able to consult the relevant documentation. We asked to see this, and on 58 of the wards we visited staff told us that there was an observations policy; we were able to see this document on 47 of the wards.

We asked about the processes involved when a patient's observation status was changed, and who could increase the level of observations for a patient.

The most common answer (with 43 occurrences) was that observation levels could be increased by the Responsible Medical Officer (RMO) or nurse or other doctor. On 13 wards we were told that this would be the decision of the RMO or nurse.

We also asked who could decrease observation levels. On 19 wards this was solely a decision for the RMO, while on another 19 wards the decision could be taken by the RMO or another doctor. On 14 wards the observation level could be reduced by the RMO, nurse or another doctor, and on six wards the decision could be taken by the RMO or nurse.

Traditionally it has been usual practice that only medical staff can decrease levels of enhanced observation. Occasionally this results in patients being on an enhanced levels of observation for longer that clinically necessary (e.g. remaining on enhanced level of observation over a weekend period until return of RMO at start of the week).

Some wards have changed their practice so that some nursing staff can decrease levels in certain circumstances and we welcome this initiative.

Which staff can make changes to a patient's observation status (count by ward n=60)		
	Increase	Decrease
RMO only	1	19
RMO or other doctor		21
RMO or nurse or other doctor	46	14
RMO or nurse	13	6

We wanted to know how differences of opinion regarding observation levels were addressed. The most common approach to resolving differences of opinion involved compromise and discussion – this was described by half the wards. The second most common answer was that the RMO could overrule other staff after discussion; this was described on 19 of the wards. Six of the wards told us that any difference of opinion on this subject was rare. Two wards indicated that additional risk assessment would take place in this situation.

On all wards, enhanced observations were undertaken by registered nurses or nursing assistants. On some wards they were also undertaken by student nurses (36) or others (17) including, occupational therapists, psychologists, medical staff and family members. Student nurses would usually be in their third year, supervised,

and undertaking observations for a short period only e.g. an hour. Other professional and family involvement in observations was subject to risk assessment.

We asked about training for staff on the use of enhanced observations. By training, we meant instruction or education either on the ward by their own staff, or by someone else. On 32 wards we were told that training on enhanced observations had not taken place. On 13 wards, we were told training had taken place in the last year. On eight wards, training had taken place more than a year ago. Five wards said they provided relevant training as part of the induction for staff.

As a final question to staff, we asked about changes they would like to see relating to the use of enhanced observations. The most common answer, from one in six staff, was that they would like to see increased staffing on the ward when there were patients on enhanced observations. We heard on six wards that it would be helpful if the observations policy could be reviewed and updated.

Other changes wanted by staff included:

- making enhanced observations more therapeutic where possible,
- providing more accessible information for patients,
- having quicker reviews of enhanced observations,
- allowing nurses to reduce observation levels, and
- making improvements to the ward environment that could make observations more effective for patients and staff.

Less frequently mentioned possible improvements included providing more information for relatives and named persons (including written information); ensuring consistency in the approach to named persons, providing more staff training and making sure that enhanced observations are used more consistently. Other suggestions were scheduling a discussion with the patient after use of enhanced observations, undertaking research on the patient experience of enhanced observations and improved recording of reviews of observation status.

Locked doors and de facto detention

We were interested in finding out if the wards we visited had locked main doors. We found that over a third (22) of the wards had locked main doors during the day. We asked about the effect this had on observation levels. On 14 wards we were told that having a locked door reduced the need to use enhanced observations to address “absconding risk”. On two wards we heard that the process of undertaking enhanced observations was made easier if the ward door was locked. On two other wards, we were told that having the main door locked had no effect on observation levels.

We are often asked about whether or not patients should be detained under the Act because they are on a heightened level of observation.

We do not think that all patients on enhanced observations need to be detained.

If the reasons for enhanced levels of observation are made clear, and the patient is able to and agrees with the plan, there is no need to detain. If the patient demonstrates resistance to enhanced observation, then detention should be seriously considered; particularly if the enhanced observation is because of a risk of absconding, then this may be a deprivation of liberty and detention should be considered.

There is a danger in accepting people's consent to such a deprivation of liberty and interference with their right to privacy. For example, we advise that staff should know about and let the patient know where appropriate about the section 291 provisions under the Act for appeal to the Mental Health Tribunal (the Tribunal) in relation to unlawful detention.

Access to independent advocacy should be readily available to all patients and this is particularly important when enhanced observation is being considered.

Over a third of patients we identified on enhanced observations were subject to short term detention, and had the right to ask the Tribunal to appeal their detention.

Our review of local policies

Following our visits, we wrote to each health board to ask for a copy of their observation policy. We received policies from eleven boards.

We found variation across these policies in how the national observation guidance, *Engaging People*, was being implemented.

Although all boards were using three traditional levels of observation, we found that one board had a modified constant/special level of observation and also a group observation level, with a maximum of four patients to one allocated nurse.

All observation policies allowed nurses to raise levels of observation, but some also allowed nurses to reduce the levels of observation in certain circumstances. We support this practice where nurses are adequately supported and resourced to do this.

Seven policies that we looked at allowed nurses to reduce levels of observation at weekends and out of normal working hours if there had been an earlier note from the responsible medical officer giving reasons where reduction would be appropriate.

One board had a ‘blue flag’ system where nurses had a high degree of autonomy to raise and lower levels of observation unless the patient was ‘blue flagged’ and then observation could only be reduced following a full multi-disciplinary review.

All but three of the policies contained information leaflets to be given to patients though some were more detailed than others. Some also included information leaflets for visitors, which we believe is good practice.

Not all policies were clear about who could carry out observations, although the consensus seemed to be that it was acceptable for third year student nurses to do this, and also health care support workers if they had the appropriate level of experience and training.

All policies said that there should be a maximum time limit of one or two hours for staff who are engaging in special observations.

We found that there were varying levels of attention paid in the policies to therapeutic engagement during periods of observation. One health board had incorporated a planned activity section into the enhanced observation care plan recording sheet.

We noted that only one observation policy had clear guidance about consent to observation and capacity, and about possible issues of de facto detention.

Named persons

A “named person” is someone who can help protect the interests of an individual who is subject to the Mental Health (Care and Treatment) (Scotland) Act 2003. The named person has to be informed and consulted about certain aspects of care and treatment. The named person can also make some applications under the 2003 Act.

Of the 186 patients seen during these visits, 102 had named persons identified. Named persons can be nominated by the patient or appointed by default and this group of 102 was split almost equally between these two categories.

The most common reason for not having a named person was that the patient was informal .Other reasons included the named person status being revoked by the patient, and the inability to identify any relatives or carers. Some did not have a named person specifically but had a next of kin named in the notes.

Of the 102 patients with named persons, we wrote to 80 named persons, asking them to contact us so we could carry out a telephone interview. We only wrote to 80 because in some cases the patient stated that the named person should not be contacted. In other cases it was not possible to approach the named person due to them being ill or otherwise unavailable.

23 (29%) of those invited agreed to an interview. Although we would have liked this figure to be higher, this is a reasonable response rate to a postal invitation to be interviewed.

Eleven of the 23 named persons interviewed were parents of the relevant patient, seven were siblings, and three were spouses, and one a child. Just one named person was not a relative.

We asked named persons if they had been told about the relevant patient being started on enhanced observations. Eighteen of the 23 had been told, most commonly during a visit to the ward, less frequently by a telephone call. Of the 18 who had been informed, all of them had been given the reason for the use of enhanced observations. However, only 13 out of this group of 18 had been told what the enhanced observations would actually entail.

We asked the 18 named persons who had been informed about the enhanced observations if they were told about the process for reviewing observation status. Only four of the named persons recalled being given information about this.

We asked the 23 named persons we interviewed if the use of enhanced observations had made a difference to their visits. Fifteen of the 23 said that there had been no effect on their visits. Comments included

> "Nurses very helpful and flexible about visiting"
>
> "Nursing staff leave during visits".

The other eight named persons did report an effect on their visits. Impacts included;

- visits being of restricted duration (3),
- not being able to take their relative off the ward (1)(patient was detained),
- Having to ask staff before doing this (1).

One named person stated that he had to use a ward interview room or the ward "family room" if he wished to spend some time with his wife without a nurse being present, but there could be other people using these rooms during his visits.

Another named person told us that there was no private time during visits as staff were always present.

These examples show that enhanced observations can have a major effect on the nature of visits to patients.

We asked the named persons we interviewed if they thought that additional information on the use of enhanced observations would have been helpful. Although most (12) did not have suggestions, there was some call (8) for more specific rather than generalised information. An example of this was a named person who said that

he would have liked an explanation about why his relative was on enhanced observations, a discussion about his relative's deteriorating mental health, and information on how the level of observations would be reviewed. Two named persons mentioned specifically that they would have valued the opportunity to discuss with ward staff the use of enhanced observations for their relatives. One person stated that she would have liked written information in addition to the verbal communication, and also expressed that she would have liked staff to communicate more proactively.

We also gave the named persons we interviewed the opportunity to raise any other comments with us. Eleven commented on the general care and treatment being delivered. One named person told us that he and other family members had been left to tell their relative that he was on enhanced observations and to give him the reasons why staff had made that decision. Another told us that she was unhappy with the lack of consultation from ward staff, as she was both named person and welfare guardian with power to consent or withhold consent to medical treatment, and, therefore, had the legal right to be consulted.

We asked staff how changes in observation levels were communicated to the named persons of patients subject to compulsory measures. On 45 wards we were told that the named person would be contacted by the RMO or a member of nursing staff, either by phone or in person. Only 3 of these 45 wards explicitly mentioned that this would depend on the patient's wishes. On 10 wards, we heard that named persons are not routinely contacted about changes to observation levels. On one ward, we heard that the decision to inform the named person would depend on how often the named person visited the patient. We were told by staff that written information was provided to named persons on 16 wards.

Conclusion

Enhanced observation can be an essential part of a person centred care plan to keep patients safe during periods of acute illness and distress. This requires specialist and skilled intervention by competent staff.

We heard positive reports from many patients about how valuable this intervention had been during their admission but it must be carried out in a sensitive and dignified manner for as short a time as necessary.

Staff involved in making decisions about initiating enhanced levels of observation and carrying out those observations must be aware of its intrusive nature and effect on the individual patient.

We found that there is variation in practice across Scotland in how enhanced observation is carried out and reviewed and this can have a negative effect on care.

The Scottish Government have commissioned Healthcare Improvement Scotland to review the national good practice guidance and this review is underway at the time of writing this report. We are confident that this guidance will address many of the issues raised in this report.

References

Clinical Resource and Audit Group (CRAG) NHS Scotland (2002) Engaging People: Observation of people with acute mental health problems. A Good Practice

The Mental Welfare Commission for Scotland (2013) Adult *acute ward visits 2012* http://www.mwcscot.org.uk/media/126149/adult_acute_2012.pdf

The Mental Welfare Commission for Scotland (2014) *Specified Person monitoring* http://www.mwcscot.org.uk/media/192163/final_specified_persons.pdf

Appendix 1

Where we visited

Health Board	Hospital	Ward	Patient
Ayrshire and Arran	Ailsa	Park	4
	Arrol Park	House 6 (LD)	1
	Crosshouse	1d	4
		1e	6
Borders	Huntlyburn House	Acute	2
Fife	Lynebank	Mayfield	1
	Queen Margaret	2	1
	Stratheden	Lomond	1
	Whytemans Brae	Ravenscraig	2
Forth Valley	Forth Valley Royal	3	1
	Lochview	Lochview	1
Grampian	Dr Grays	4	2
	New Craigs	Morar	1
	Royal Cornhill	Brodie	3
		Corgarf	5
		Crathes	4
		Drum	3
		Elmwood, Bracken	2
Greater Glasgow & Clyde	Dykebar	East	9
		North	8
	Gartnavel Royal	Henderson	1
		McNair	3
		Rutherford	1
		Claythorn House	6
	Inverclyde Royal	AAU	3
	Leverndale	3	3
		4a	8
		4B	5
	Parkhead	1	5
		3	13
	Stobhill/Mackinnon	Armadale	2
		Broadford	3
		Struan	2
Highland (HB)	Argyl & Bute	Succoth Ward	1
	Newcaigs	Maree	3
		Morar	**1**
		Willows	**2**
Lanarkshire	Hairmyres	19	11
		20	7
	Kirklands	LD Admissions	2

Health Board	Hospital	Ward	Patient
	Monklands	24	4
		25	2
	Wishaw General	1	15
		3	1
Lothians	Royal Edinburgh	Hermitage	3
		Meadows Female	5
		Meadows Male	1
		William Fraser Centre	2
	St Johns	17	2
Tayside	Carseview Centre	1	1
		2	2
		LDAU	2
	Murray Royal	Moredun	2
	Stracathro Hospital	Mulberry	1
TOTAL			**186**


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national
preventive
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mentalwelfare
commission for scotland

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Mental Welfare Commission (Sept15)