Board Relay Standard Guidance

<table>
<tr><th colspan="2">Change Idea (Board Relay)</th></tr>
<tr><td>Please describe the change idea</td><td>This idea is based on the concept of a baton relay – you never let go of the baton until you pass it onto the next person.

The board relay is related to general observations and intermittent observations only (1:1 observation are physically handed over). The process is below and shown in appendix one as a process map

• Step 1: At the beginning of each shift, the nurse in charge will explain to the team the number of service users on observations, the number of staff on duty and the reason why people are on observations. They will also explain to bank staff how the board relay works and what is expected of them throughout the shift
• Step 2: The night staff will hand over the observations board to the day staff and each sign the observation checklist indicating handover has been completed (see Figure 2)
• Step 3: Staff member who was handed over the board will complete observations and keep hold of the board until the next hour
• Step 4: On the next hour they will hand the board over to the next staff member allocated to do observations. This will include a verbal handover of how each service user presented in the previous hour and any important information that will help the next staff member to conduct the observations safely and therapeutically. Both staff members will sign the sheet to say handover has occurred (see appendix 2)
This process will continue throughout the day at hourly intervals.

In addition to this, a poster with key information about how to ensure observations are safe and high quality is visible on the ward (see appendix 3) and can be used to reorientate staff to the purpose of observations and the expectation of them.</td></tr>
<tr><td>What is the theory behind this and problem being solved?</td><td>• Our data indicated that we had a problem with missed observations and the falsification of observation records.
• We predicted that if staff didn't put the observation checklist board down, we wouldn't miss any observations and there would also be no gaps in recording.
• We also predicted that if staff gave a verbal handover to the person they were handing the observations over to, this would help staff engage therapeutically and create a safer, more well-informed environment on the ward.</td></tr>
<tr><th colspan="2">What was the context the idea was tested in?</th></tr>
<tr><td colspan="2">• Ward: Rosebank (Female PICU)
• Bed size: 13 beds
• Staffing numbers: Shifts should have 2 RMNs and 5 HCAs, with staffing numbers increasing depending on number of service users on observations</td></tr>
</table>

What is the standard work involved in this?		
What	**Who**	**When**
Explain to the team the number of service users on observations, the number of staff on duty and the reason why people are on observations	Nurse in charge	Beginning of each shift
Explain to bank staff how the board relay works and what is expected of them throughout the shift	Nurse in charge	Beginning of each shift
Staff hand over observation board to each other	Registered and non-registered nurses	Every hour
Staff give verbal handover of how each service user presented in the previous hour and any important information that will help the next staff member to conduct the observations safely and therapeutically	Registered and non-registered nurses	Every hour
Staff sign observation sheet indicating observations have been handed over	Registered and non-registered nurses	Every hour

Measurement

- Number of missed observations
- Number of Datix reports related to missed observations.
- Number of Datix reports related to staff holding the board for more than an hour.

Changes to infrastructure (environment, policies, way people work)

- Put poster about observations on ward wall.
- We also had conversations with our staff around consequences of falsification of observation records.

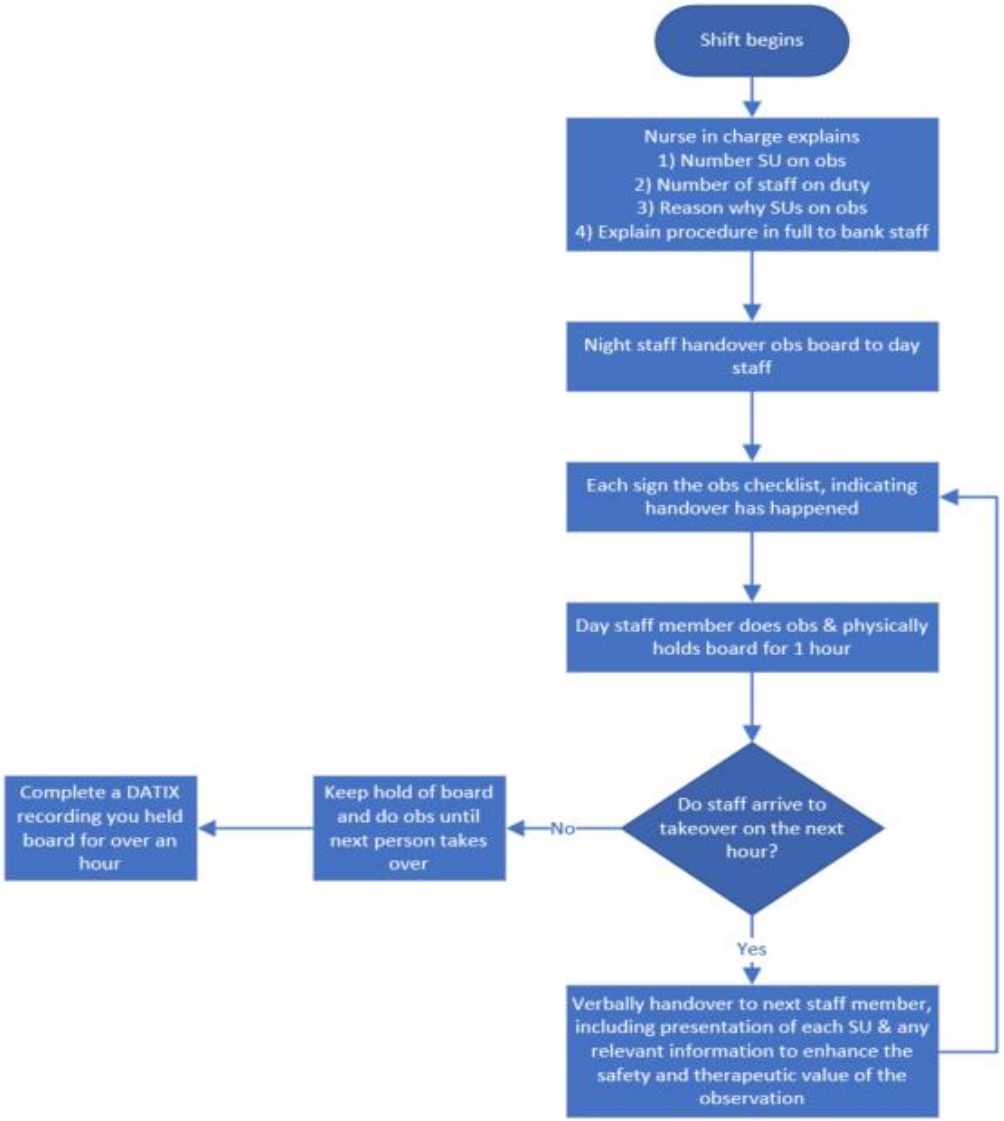
Outcomes

- We haven't missed an observation since February.
- Staff are happy that handover is being given to them when they take over observations. They report that the ward feels safer and they feel more aware of what to do Having the verbal handover ensures that staff have a conversation about observations and the needs of service users on observations every hour.

Challenges you needed to overcome

Challenge: Bank/agency staff not being familiar with the process Mitigation: Nurse in charge explains how the board relay works and what is expected of them throughout
Challenge: Due to pressures people may hold the board for more than the allocated hour Mitigation: We asked people to record on Datix if this happened, but so far we haven't had any recorded incidences of this happening.

Appendix 1 - Flow Chart of board relay



Appendix 2 – Observation checklist

Rosebank General Observations and Checks DATE:

Security: (AM/PM) (N) Response: (AM/PM) (N) NIC: (AM/PM) (N)

ON WARD						OFF WARD					
1	BEDROOM AWAKE	5	QUIET ROOM	9	CONSULTATION ROOM	13	LAUNDRY	17	RLH/ TRIBUNAL	21	
2	BEDROOM ASLEEP	6	GARDEN	10	TREATMENT ROOM	14	SECLUSION	18	OTHER WARD/FAMILY	22	
3	CORRIDOR	7	SENSORY ROOM	11	BATHROOM	15	ESCORTED LEAVE	19	OFFICE	23	
4	COMMUNAL AREA	8	MEETING ROOM	12	TV LOUNGE	16	OT DEPT/ GYM	20		24	

Room No.	Patients Name	Visual Check	08:00	09:00	10:00	11:00	12:00	13:00	14:00	15:00	16:00	17:00	18:00	19:00	Visual Check	20:00	21:00	22:00	23:00	00:00	01:00	02:00	03:00	04:00	05:00	06:00	07:00
1																											
2																											
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8																											
9																											
10																											
11																											
12																											
13																											
Enhanced Obs Handover		Signature																									
Enhance Obs received		Signature																									
M= MISSED		M																									
Key ckeck performed																											
Kitchen																											
Laundry																											
Treatment Room																											
Main Garden																											
Main Garden Back exit																											
Nursing office																											
Rear secure garden																											
De-escalation room																											
Meeting Room																											
Quiet Room																											
Sig of staff checking																											
Sig of shift coordinator																											

Appendix 3 – Observations poster

WHAT WE NEED TO DO TO IMPROVE OUR OBSERVATIONS ON ROSEBANK WARD

Personal responsibility:	• Identify, respond and where necessary escalate any areas of non-compliance with observation policy. • Follow agree plans for handover, formal review and consider changes in level of risk • Not leaving observation board idle at any given time. • Consider additional interventions such as, random search, anti-ligature risks, ongoing risk posed by the environment– **REPORT** if considered • Attend to observations in a proactive and focused manner, acting upon any concerns and reporting risks immediately • Ensure mobile phones are kept away and not in use when carrying out observation. • Handover observation board to the next staff due to carry out the observation. • Staff to observe and record patients functioning, presentation and mental state - It is not considered acceptable to simply note the location of patients
Our Commitment to Change:	• Staff carrying out observation have been assessed to be competent to do so.

	• Observation levels must be discussed during ward handover to ensure continuity of care. • Nurse-in-charge will ensure staff undertaking observation have appropriate understanding of the observation care plan for each patient. • Staff must understand the importance of therapeutic engagement and patient involvement in observation. • Do NOT falsify observation documentation or completing observation retrospectively. • Complete a Datix to indicate why observation was missed so us we can learn and put action plan to effect.
What help do you need, and if you can think about it from who?	• Adequate staffing to carry out observations effectively • MDT will ensure effective communication which enables responsive and informed clinical decision making about the use of therapeutic observations. • Where therapeutic observations are to continue over the weekend MDT must make a clear plan detailing circumstances where observations can be reduced and who can make this decision.

Zonal Observations: Standard Guidance

Change Idea - Zonal Observations	
Please describe the change idea	• Zonal observations allows an alternative method of observation, which involves designating the ward into different zones where allocated staff observe and engage with patients individually and as groups for set periods of time. This is to allow for continuous engagement with patients and monitor environment and patient dynamics over a 12hour shift. • Zonal observations can be plotted against certain times or functions dependent on the ward layout and key tasks relevant to the service user group. Individual needs assessment will inform individual care plans and individual observation levels. This means that patients could still be managed under existing enhanced observations if deemed necessary. Staff should proactively engage patients in that zone as long as this does compromise the staff member's ability to view the whole zone and leave a zone unattended. • Zonal Engagement & Observations must be service user focused at all times. The Service has a duty for safety and security to the service users, staff and visitors. This care must be provided in an environment and manner that reflects the least level of restriction possible for the safe and supportive management of the service user. Zonal Observation and Engagement should therefore be seen as one method of reducing risk and enhancing the service user experience. It is integral part of a wider risk assessment and contextual management process.
What is the theory behind this and problem being solved?	• This means patients have equal access to staff resources and are subject to less restrictions. We are also ensuring that patients are kept safe with staff presences in all areas of the ward. • Learning lessons from previous safeguards and 48hr/SI have pointed out the need to document any patient activity in day areas so that we can ensure that if any complaints or concerns patients raise can easily be followed up on and it reassures managers, commissioners and service users that due process has been followed. • Documenting zonal observations has also been helpful in the use of CCTV. We are able to break down incidents better on where and what happened.
What was the context the idea was tested in?	
The idea was tested in a male PICU (Crystal Ward).	

Standard Work		
What	**Who**	**When**
Specify designated ward zones - these must have explicitly defined rooms, corridors, and spaces within them. The zone should be described clearly with defined boundaries as to where the zone starts and ends.	Ward manager or matron	Before starting
Create a folder for each zone, for allocated staff members to document patient activity in that zone every hour.	Ward manager or matron	Before starting
Staff on shift are allocated on the handover sheet the same way enhanced observations are allocated.	Nurse in charge	Beginning of the shift
Staff are allocated slots for up to one hour at a time. (Staff should remain in a zone for a maximum of two hours at any one time.)	Nurse in charge	Beginning of the shift
Ensure that known and relevant risks are communicated to the observing nurse(s);	Nurse in charge	Beginning of the shift
Allocated staff will: • know their zone; • know who they are to observe; • be familiar with the observation status of all service users in their observation zone; • be vigilant to monitor safety of ward and be confident to intervene or summon help when needed. • facilitate interaction and communication with the service user; • provide a handover for the nurse taking over from them; • report any changes in the service users behaviour considered significant to the nurse in charge; • report any concerns to the nurse in charge.	Allocated staff	During allocated observation period

The documentation has to include any patient presence in that zone but staff are to ensure that any incidents or concerns are followed up as a Rio entry.	Allocated staff	During allocated observation period
Zonal observations are reviewed daily in safety huddles with MDT input.	MDT	Daily
Zones are also reviewed on away day with discussions on how appropriate the boundaries are and if teams want any changes.	MDT	When required
Discussions are held with service users in Community meetings to explain and review the process.	Ward Manager	Weekly

Measurement

- Daily observation audit – zonal obs allocation and documentation
- Number of service users on intermittent observations
- Feedback at MDT safety huddle and community meetings
- Datix incidents

Changes to infrastructure needed

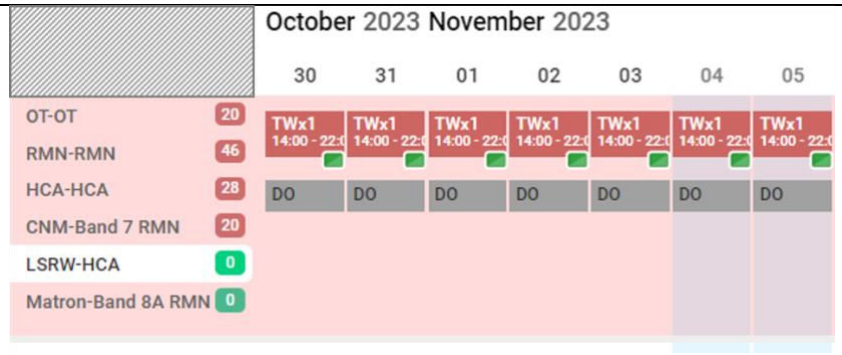
- Team can consider increasing staffing levels in a zone due to acuity.
- Nursing and MDT members can call for a safety huddle and review staffing.

Outcomes seen

- Reductions in violence and aggression, use of rapid tranquilisation, use of seclusion

Life Skills recovery Worker on twilight shift (2-10pm): Standard Guidance

Change Idea: Life Skills Recovery Workers on twilight shift	
Please describe the change idea	LSRWs are to offer therapeutic interventions in the form of activities to service users on the ward. **Staffing Requirements:** • There should be a minimum of three hour-long therapeutic interventions per shift, 7 shifts per week • LSRWs will work in collaboration with an MDT (Multidisciplinary Team) of Nurses, OTs, Doctors, and Psychologists to ensure that the therapeutic offering is diverse and well targeted. • Management staff should work collaboratively with LSRWs, using regular meetings and away days to allow for feedback, continuous improvement, and additional support. • Risk should be assessed prior to each session with nurse in charge – discuss the group and its aims, materials, and services users' presentations. • Some wards may benefit from having timetabled activities (e.g., movie evenings or a weekly craft session), but LSRWs should be prepared to be flexible with the activities happening on that day. • LSRWs are supernumerary, they are not counted in the nursing numbers and their work is ring fenced, there is a specific shift on HealthRoster:



Resources:

- Materials should be sourced after planning meeting (£50 per week budget - ward admin to manage the petty cash).

Attendance:

- Groups should be open to all service uses and be aimed at all levels (within reason).
- Groups should be planned so that the last session of the day promotes good sleep hygiene (i.e.: meditation, mindfulness, pamper session, movie night).
- Group activities and their attendance should be recorded locally, this can be brought to HSCG, Managers and Matrons meeting and displayed in the CQC best practice folder.

Suggested Shift Structure (14:00 – 22:00, 7.5 hours exc. break):

- 2pm – 3pm - Plan the day meeting with service users to identify what sessions the service users would like to see.
- 3pm – 4pm – Source materials needed for sessions.
- 4pm – 5pm – 1st group
- 5pm – 6pm – Notes/support SUs with individual tasks (community leave/1:1 session)
- 6pm – 7pm – 2nd group
- 7pm – 8pm - Notes/support SUs with individual tasks (community leave/1:1 session)
- 8pm – 9pm - 3rd group – Low impact/low intensity group.
- 9pm – 10pm – Notes to summarise intervention – using RiO notes structure provided at the end of the document.

What is the theory behind this, and problem being solved?	Originally, we tested LSRWs carrying out 9-5 shifts, however, many incidents occur in the evening when there are less activities on the ward. By bringing more activities and structure throughout the entire day, service users will be less bored, more engaged and incidents will be reduced. Furthermore, less incidents will allow staff to carry out their observations more comprehensively.

What was the context the idea was tested in?

- Ward: Crystal Ward (Female –18 Bed), Townsend Court (Female – 20 bed), Onyx (Male – 20 bed)

We did not test on older people's wards as they tend to go to bed earlier; having LSRWs working until 22:00 would be a waste of staff resource.

Standard Work

What	Who	When
Introduction of new shift pattern to HealthRoster within the 24/7 working directive	DBLN & HealthRoster Team	Before testing change
Train current and new LSRWs on new working pattern	Senior Management Team	Ongoing
Plan with service users and source materials for activities	LSRW & Ward Managers	Beginning of each shift
Carry out risk assessment for all activities	Nurse in charge	Before activity commences
Run three activities per shift	LSRW	Every shift
Record RiO notes for service users, using notes structure below	LSRW	Final hour of shift
Record group type and attendance	LSRW	After each activity or end of shift
Management meeting regarding LSRWs – check in	Managers/Matrons	Once a fortnight

Measurement

- Violence and Aggression Incidents
- Number of interventions per day and what they were
- Service user and staff feedback
- Observation Completion

Changes to infrastructure

- New shift pattern introduced, this will need reflecting within HealthRoster and require discussions with ward staff to determine acceptability.
- There will need to be designated spaces to carry out the activities on the ward.
- One away day every quarter with senior management and LSRWs to share best practice and continuously improve the work.

Outcomes

- Service users are more engaged in the afternoons and evenings than they previously were, they have reported feeling less bored and staff have reported improved morale on the ward.
- We have seen reduced violence and aggression incidents.

- The biggest improvement was felt on female wards. As we had reduced self-harm incidents, we did not need extra staff to do A&E trips. As staff were able to complete responsibilities on their shift as opposed to handing over, productivity increased. LSRWs also allowed for more co-facilitation in group sessions.

Challenges

- Additional cost with unsocial hours: 8pm – 10pm
- Managers may need to "mix and match" shifts amongst the LSRW group of staff – not for one LSRW to facilitate activities the entire week, this will increase buy-in from staff
- Adds an additional working day, where traditionally a LSRW is defined to 3 or 4 Long Days/Nights
- To overcome these challenges, in future we would like to extend the change concept to other bands, such as Band 3 HCAs, to enable confidence building and skills training to undertake activities

Appendix One - Life Skills Recovery Worker RiO notes structure

1. **Title:** 'Life Skills Recovery Session' and then name and duration of session/interaction.
   E.g., Life Skill Recovery Baking Group (9.30am-11am)

   Aim: To encourage and promote therapeutic engagement and activities for service users on the ward.

2. **Intervention:** This section includes whether the service user gave consent to attend the session and how they did this e.g., verbal/written consent. This also includes what was observed within the session/interaction.
   E.g., Intervention: *Name* made multiple requests to prepare himself a light meal which was facilitated upon staff availability. He chose to prepare beans on toast. *Name* appeared orientated in the (room on ward) as he was aware of where to look to find items he required. He expressed some difficulties in using the toaster however managed independently with perseverance. *Name* also took time to work out how to use the microwave but again managed independently eventually.

Name appeared calm in mood and engaged well in conversation with staff. He expressed that he enjoys eating lighter meals like beans on toast but is not often able to cook them on the ward. He thanked LSRW for facilitating his meal before returning to the ward.

3. **Risk:** This section is where any risk that was observed can be recorded. This is only reflective of risk within the session/interaction.
   E.g., Risk: None observed during the session.

4. **Signed and role identified.**
   E.g., Written by Alice Hearn (Life Skills Recovery Worker)

All notes should include:

- Consent is gained and recorded for assessment, intervention, information gathering and sharing.
- The duration of the intervention is captured.
- All entries are signed off and your role is identified.
- Assessments including risk assessments outcome/implication recorded.
- Notes are person centred and service user wishes/goals are recorded.
- All communication/discussion (including third party) and referrals to other services are recorded.
- Records are completed within 24 hours after intervention occurred.