The Royal Wolverhampton NHS Trust

CP66
Policy For Care of Patients Requiring Enhanced Care

Contents

1.0 Policy Statement (Purpose / Objectives of the policy)

There are several circumstances where patients, both adult and children, may require enhanced care, such as:

- the patient is at risk of self-harm and, or presents a risk to others,
- the patient is likely to abscond from the ward and is at risk to him or herself., the patient is confused, agitated, aggressive or violent towards others,
- the patient has a history of falls or is assessed as at high risk of falling, and
- the patient has delirium and behaviour compromising dignity.

This is not an exhaustive list. The policy has been developed to facilitate the assessment of all patients who may require enhanced care to ensure patient safety is maintained.

1.1 To ensure that resources are appropriately allocated through robust assessment and escalation processes.

1.2 To reflect and support other related policies that are integral to patient safety, patient liberty and patient experience.

1.3 To assist staff with the decision making required to support patients who may require enhanced care to keep them safe.

1.4 To ensure that one to one nursing is not the immediate solution to every clinical Scenario, and that an individual risk assessment (see Appendix 2, 7 and 8) is completed before the decision is taken to utilise the type of resource. See Appendix 1 for support contact details.

1.5 To ensure that all the following controls and safety measures have been considered and or put in place.

- Moving or locating the patient(s) closer to the nurses' station for observation or consider a side room or bay furthest from the entrance to reduce stimulation and
  enable rest as guided by the individual risk assessment (see Appendix 2).
- Where there are several patients of the same sex on a ward who may require close observation, consider the benefits of moving them into the same room (also known as cohorting) or moving to a different area or are causing a disturbance to each other.
- Using patient safety equipment and, or assistive technology to lower the risk to

the patient e.g.,

- ❖ lowering the bed,
- ❖ bed safety rails,
- ❖ nasal bridles or safety mittens (CP59) to prevent dislodgement of feeding tubes or cannulae and catheters.

- Consider a staff member allocated to a bay of four to six patients to include the patient who has been risk assessed as requiring additional observation within existing resources and establishment and the use of Tag Nursing to ensure there is always a member of staff in the bay. See Appendix 5 for description of Tag Nursing.
- Ensure that the surroundings are safe. This may include removing obstacles, making sure call bell, walking aids, glasses, hearing aids and footwear are within reach, although it may include removing any items that may be used as a ligature such as the call bell cord. Therefore, actions must be indicated by the individual risk assessment (see Appendix 2) and documented in the patient notes.

- In adhering to this Policy, all applicable aspects of the Conflicts of Interest Policy must be considered and addressed. In the case of any inconsistency, the Conflict of Interest Policy is to be considered the primary and overriding Policy.

2.0 Definitions

Enhanced care where a patient or cohort of patients require an increased level of nurse-to-patient care due to their complexity or acuity. Enhanced care is defined as "watching the patient attentively" while minimising the extent to which they feel that they are under surveillance. Encouraging communication, listening, and conveying to the patient that they are valued and cared for are important components of skilled nursing observation.

- **All Patients** is defined as, all adult, maternity and paediatric patients in any inpatient care setting. Patients in the Emergency Portals will follow the Emergency Care Risk assessment for either Adult or Paediatric patients. See Appendices 7 and 8.
- **Patient Safety** is about working to prevent events that can cause harm to patients.
- **Harm** in this context means the patient is at risk of self-harm and, or presents a

risk to others.

- **Vulnerable** is defined as a confused patient, at risk of harm to themselves or others, or physically frail with the potential for fall injury.
- **A patient is deprived of their liberty** for the purposes of Article 5 of the European Convention on Human Rights (points 1-3 are as defined by the Deprivation of Liberty Safeguards (2009) and would need to be read in conjunction with the CP02 (DoLS policy) if they:

1. have been assessed as lacking the capacity to consent to their care or treatment arrangements,
2. are over the age of 18 years old,
2. are under continuous supervision and control, and
3. are not free to leave.

- **Tag Nursing** is a model of nursing whereby the designated patient or area is not left unattended by a staff member. Changeover of staff MUST occur within the designated area and staff who are deemed to be Tag Nursing must not abandon their post. See Appendix 5 for Tag Nursing standard operating procedure.
- **'At Arm's Length'** definition is that patients at the highest levels of risk of harming themselves (or others) are nursed within arm's length of the staff looking after them (i.e., no further away from the member of staff allocated to closely observe them by a distance equal to the length of their arm).

- **Levels of Observation**

Score 0-3 Blue: *General observation* is the minimum acceptable level of observation for all in-patients. The location of all patients should be known to staff, but not all patients need to be kept within sight. This includes checking all elements on the intervention chart.

Score 4-7 Green: *Intermittent observation* means that the patient's location must be checked at frequent intervals, exact times must be specified on the enhanced care assessment.

This level is appropriate when patients are potentially but not immediately at risk. Observation record must be completed for each patient (see Appendix 3).

Score 8-11 Amber: *Within eyesight* is required when the patient could, at any time, try to harm themselves or others. The patient should be always kept within sight, by day and by night, and any tools or instruments that could be used to harm themself

or others must be removed. An observation record must be completed for each patient (see Appendix 3).

Score 12-15 Red: *Within arm's length.* Patients at the highest levels of risk or harming themselves or others may need to be nursed in proximity. On rare occasions, more than one nurse may be necessary. Issues of privacy, dignity and consideration of the gender in allocating staff, and the environment dangers must be incorporated into the care plan. An observation record must be completed for each patient (see Appendix 3).

3.0 Accountabilities

3.1 Chief Executive Office

Responsible for ensuring the policy is implemented across the Trust.

3.2 Chief Nursing Officer

Manages and co-ordinates the assurance processes at an organizational level, working in support of the Chief Executive, and is the Director with overall responsibility for the management of risk, clinical governance and for the management of complaints within the Trust.

3.3 Medical Team with responsibility for the care and treatment of the patient

- Where Mental Health problems have previously been identified, liaise with the psychiatric team that is usually responsible for the care and treatment of the patient.
- Participate in undertaking and documenting agreement with the enhanced care risk assessment to determine appropriate level of observation.

3.4 Divisional Heads of Nursing and Midwifery

- Review budget detail and incidents.
- Will spot check adherence to policy.

3.5 Matron

- Ensure compliance with the policy and accurate monitoring of incidents.
- Review requests for enhanced care and allocate staff from other areas or, if there are none available, authorise bank nurse cover.

- Review patients receiving enhanced care with the Nurse in Charge to ensure that the risk identified in the individual risk assessment still applies and if enhanced care is still required.

3.6 Staffing Bleep Holder

- Where requested by a Sister, Charge Nurse or Shift Leader, during 5pm to 8am and at weekends and bank holidays, the on call manager will review a request for enhanced care and consider moving staff from other areas if temporary staff are required.
- Where it has been assessed that temporary staffing is required, the staffing bleep holder will approve the request for the 24 hours following a Bank Holiday or weekend.

3.7 Band 7 Ward Manager

- Responsible and accountable for ensuring all staff are aware of and adhere to the policy and are adequately trained in enhanced care.
- Responsible for monitoring assessments and numbers of patients requiring enhanced care.
- Ensuring the ward environment is calm and clutter free.
- Ensuring that the Matron is made aware of the need for enhanced care.

3.8 Nurse in Charge of Shift

Where the Nurse in Charge has identified that a patient requires enhanced care, she or he will do the following.

- Employ alternative strategies and controls to manage the individual patient as indicated by the individual risk assessment.
- During 8am-5pm weekdays, escalate needs for enhanced care to the Matron for inclusion in the ward RAG rating. If it is agreed that temporary staffing is required, consider what competencies and skills are required to care for the patient safely.
- Where temporary staffing is required for enhanced care at Amber or Red level, nurse bank requests are made.
- During 5pm-8am liaise with the Directorate or Division Staffing bleep holder, and at weekends and on Bank Holidays, liaise with the Temporary Staffing Bank to update the

ward RAG rating with the requirement for enhanced care.

- Ensure that staff providing enhanced care at Amber or Red level receive a full report on the patient's condition, the rationale for this level of care, and a summary of concerns and risk factors.
- Ensure cover for breaks are provided to the staff member providing enhanced care at Amber or Red level.
- Ensure no period of enhanced care at Amber or Red level by a member of staff will be longer than 2 hours except in very exceptional circumstances.
- Ensure that support and assistance for the staff allocated to enhanced care is available from other members of the team as required.
- Ensure that the patient understands why enhanced care at Amber or Red level is being given. If they do not have capacity, it is essential that relatives and, or carers are kept informed of the care and the reasons why enhanced care is required and the reasons why this may be adjusted.
- Ensure that staff are aware that they must avoid any situation which jeopardises their own safety.
- It is important to note that the registered nurse remains accountable for the decision to delegate enhanced care to a support worker or student in training.
- In the instance that extra staff are not available to provide the level of enhanced care, the nurse in charge will delegate duties on the ward to provide the safest level of care possible.

3.9 Staff performing enhanced care at Amber or Red level (see Appendix 6 for staff leaflet)

- Will be aware of the needs assessment and the plan of care drawn up by the multi-disciplinary team.
- Be familiar with the ward environment and layout, ward policy for emergency procedures, and potential risks in the environment.
- Enhanced care at Amber or Red level is an opportunity for one-to-one interaction. The nurse must show the patient positive regard. If a patient is uncommunicative, the nurse can initiate conversation and convey a willingness to listen using principles of VERA (Validation, Emotion, Reassure, Activity), a framework that describes a stage by stage process for nurses to provide compassionate and caring communication. (Appendix 4).

- Some patients will prefer to be active or may just want to pass the time. It is important that the nurse elicits the patient's preferences, for example, in music, TV or reading, and provides them.
- The patient is entitled to information about why they are receiving enhanced care at Amber or Red level, how long it will be maintained, and what may happen.
- The aims and level of enhanced care should be communicated, with the patient's approval,
  to the nearest relative, friend or carer.

4.0 Policy Detail

- An individual risk assessment must be completed using the Enhanced Care Scoring Tool considering the staffing skill mix and current patient acuity on the ward.
- Any level of enhanced care must be reviewed by the Nurse in Charge or the ward at least daily (including weekends).
- It is acceptable to ask volunteers or a carer *or* relative to be with the patient if this is appropriate and in the best interest of the patient.
- Consider the Deprivation of Liberty Safeguards (DoLS) for all patients identified Amber and Red as they would be continuously supervised and controlled. They must fulfil the criteria, which are that the patient must be 18 years or over, lacks mental capacity for care and treatment, is continuously supervised, continuously controlled, and not free to leave.
- If a patient has capacity, it will be professional judgement to provide enhanced care observation for patients identified as Amber or Red.
- If the patient's circumstances change (i.e., regains mental capacity) then the safeguarding team and supervisory body (Local Authority) must be informed as DoLS would no longer apply.
- If mittens or nasal bridles are used, separate care plans and risk assessments must be used in conjunction with any other monitoring documentation used.
- Records of enhanced care must be kept by staff responsible for carrying out enhanced care, see Appendix 3.
- All decisions regarding observation are recorded by the registered nurse in the patient's main medical or clinical notes. Records should include:
  - Enhanced Care Screening Score and actions taken,

- mental capacity assessment is recorded and reassessed as planned,
- current assessment of risk of falls, and
- Clear directions regarding therapeutic approach i.e., occupation therapy sessions.

Review or Termination of Enhanced Care

- The full rationale for discontinuing close observation must be fully documented in the care record including the names of those involved in making the decision. A relative or carer must be notified of the decision and its rationale, and this must be documented.
- If the patient was at risk of self-harm, a psychiatric assessment must be performed before enhanced care is discontinued.
- If an application has been submitted for a DOLs, assessment this must be reassessed before enhanced care is discontinued.
- Consideration must be given to the patient's previous assessment and the time of day it is required e.g., does the patient require enhanced care for any particular part of the 24 hours such as night-time or twilight shift? If so, consider continuing at these times rather than the close observation being stopped completely.

5.0 Risk Management

Details of how to manage risks can be found in the following associated Royal Wolverhampton NHS Trust policies:

CP42a and b-Falls; OP52-Safe Hands; Chaperone CP36; CP53-Safeguarding; OP26-Security; Safer Nurse Staffing OP 107; Risk management and patient safety reporting-OP10; Temporary Staffing Bank-Managers Guidelines; Visiting Policy CP43; Mental Health CBP webpage, including patient process maps; LD Strategy; Dementia Strategy; Delirium Protocol; OP96-Tissue Viability; CP56-Restraint and Sedation; and Management of deliberate self-harm on hospital premises of young person's up to the age of 18-CP63.

6.0 Process for Monitoring Effective Implementation

The use of all temporary staff and associated costs will be monitored monthly using information collected by the Ward Manager and monitored by Matron and the Divisional Head of Nursing or Midwifery. This must demonstrate that the correct escalation procedures were in place for those patients who needed enhanced care

and to confirm the procedure for approving temporary staff was followed.

This policy will also be monitored in Directorate governance for incident trends where patients have sustained an injury due to any of the reasons for a patient requiring enhanced care that are outlined in section 1.0 of the policy.

7.0 Financial Risk Assessment

1	Does the implementation of this policy require any additional Capital resources	No
2	Does the implementation revenue resources of this policy require additional	No
3	Does the implementation of this policy require additional manpower	No
4	Does the implementation of this policy release any manpower costs through a change in practice	No
5	Are there additional staff training costs associated with implementing this policy which cannot be delivered through current training programmes or allocated training times for staff	No
	Other comments	

If the response to any of the above is **'Yes'** please complete a standard business case report and which is signed by your Divisional Accountant and Directorate Manager for consideration by the Divisional Management Team before progressing to your specialist committee for approval. **Please retain all yes content in the final policy.**

8.0 Equality Impact Assessment

Trust has a statutory obligation to assess the potential for policies to discriminate on the grounds of race, disability, gender (including transgender), sexual orientation, religion and age.

An equality analysis has been carried out and it indicates that:

Tick	Options
x	A. There is no impact in relation to Personal Protected Characteristics as defined by the Equality Act 2010.
	B. There is some likely impact as identified in the equality analysis. Examples of issues identified, and the proposed actions include: • • •

9.0 Maintenance

The Deputy Chief Nurse is responsible for recommending any changes or amendments to the policy and is responsible for ensuring the policy is kept up to date.

10.0 Communication and Training

Wards will have a training pack for cascading to the teams; this includes examples of the enhanced care risk assessment and care record charts. Both have MI number for department ordering.

The VERA communication poster and staff leaflet have MI numbers for department ordering.

Policy communication will be varied including the following:

- Professional Nursing Forum,
- Senior Sister meeting, and
- presentation at key Department Governance meetings such as Gastro, ED, Neuro and OAM.

11.0 Audit Process

Criterion	Lead	Monitoring method	Frequency	Committee/ Group
• Duties (Accountabilities)	Author of Policy	Policy Review	1 year	PSIG
• Audit of enhanced care assessment and resources	Divisional Heads of Nursing	NAAR peer review	Annual	QSAG
• Incidence of falls and trends for patients requiring enhanced care.	Chair of Falls Group	Incidents	Quarterly	Falls Group

12.0 References - Legal, professional, or national guidelines

Official guidance

- Department of Health Guidance on reducing the use of restrictive practices inter alia in health care settings issued by Department of Health (April 2014)
- CQC briefing for providers in health and social care settings (updated late April 2014).

Other policy references

- CP42 Prevention of Adult and Paediatric Inpatient Falls Policy.
- OP52-Patient Identification Policy.
- CP36-Chaperone.
- CP53-Safeguarding.
- OP26-Security Policy.
- HR31 Safe Staffing Policy
- OP10-Risk management and patient safety reporting.
- Temporary Staffing Bank-Managers Guidelines.
- Hospital Visiting Standard Operating
- Mental Health CBP webpage, including patient process maps.
- Learning Disability Strategy.
- OP96-Tissue Viability.
- CP56-Procedural Sedation Policy
- CP63 – Management of Self Harm on Presentation to RWT of Young People up to 18th Birthday - Wolverhampton
- Delirium Protocol

Part A - Document Control

Policy number and Policy version: CP66 Version 3.0	**Policy Title** Policy For Care of Patients Requiring Enhanced Care	**Status:** Final		**Author:** Matron Rehabilitation and Ambulatory Care **Chief Officer Sponsor: Chief Nurse**
Version / Amendment History	Version	Date	Author	Reason
	1.0	January 2017	Matron Rehabilitation and Ambulatory Care	Introduction of policy
	2.0	January 2020	Matron Rehabilitation and Ambulatory Care	Revision of policy
	2.1	October 2020	Matron Rehabilitation and Ambulatory Care	Minor amendment to Appendix 2. Links to appendices 7 & 8 updated.
	2.2	December 2022	Matron Rehabilitation and Ambulatory Care	Review of policy
Intended Recipients: All Trust employees				
Consultation Group / Role Titles and Date: Falls Group, Safeguarding Group and Senior Nurse Group, Quality Team				
Name and date of Trust level group where reviewed	Trust Policy Group – December 2022			
Name and date of final approval committee	Trust Management Committee – January 2023			
Date of Policy issue	January 2023			
Review Date and Frequency (standard review frequency is 3 yearly unless otherwise indicated – see section 3.8.1 of Attachment 1)	December 2025 (every three years)			
Training and Dissemination: Matron Group, Band 7 Professional nurse forum, launch at key directorate governance meetings and intranet				
Publishing Requirements: Can this document be published on the Trust's public page: **Yes**				

If yes you must ensure that you have read and have fully considered it meets the requirements outlined in sections 1.9, 3.7 and 3.9 of OP01, Governance of Trust-wide Strategy/Policy/Procedure/Guidelines and Local Procedure and Guidelines, as well as considering any redactions that will be required prior to publication.

To be read in conjunction with: The following policies CP42a and b-Falls; OP52-Safe hands; Chaperone CP36; CP53-Safeguarding; OP26-Security; Safer Nurse Staffing OP 107; Risk management and patient safety reporting-OP10; Temporary Staffing Bank-Managers Guidelines; Visiting Policy CP43; Mental Health CBP webpage, including patient process maps; LD Strategy; Dementia Strategy; Delirium Protocol; OP96-Tissue Viability; CP56-Restraint and Sedation; Management of deliberate self-harm on hospital premises of young person's up to the age of 18-CP63;

Initial Equality Impact Assessment (all policies): Completed Yes
Full Equality Impact assessment (as required): Completed NA
If you require this document in an alternative format e.g., larger print please contact Policy Administrator 8904

Monitoring arrangements and Committee	Compliance monitored using NAAR peer review reporting to QSAG

Document summary/key issues covered.

Key messages

- Applies to vulnerable patients who need extra observation.
- Vulnerable means: confused, at risk of harm to themselves/ others, or physically frail with the potential for injury.
- Close links to safeguarding and inpatient falls management policies

Enhanced Care Levels

- **Score 0-3 Blue**: general observation is the minimum acceptable level of observation for all in-patients.
- **Score 4-7 Green:** intermittent observation when patients are potentially, but not immediately, at risk.
- **Score 8-11 Amber:** the patient should be kept within sight of member of staff allocated to closely always observe the patient.
- **Score 12-15 Red: patients** at the highest levels of risk of harming themselves (or others), nursed within arm's length.

Designated member of staff is required for compliance at **red and amber**.

Key words for intranet searching purposes	Enhanced Care Score, observation, falls risk
High Risk Policy? **Definition:** • Contains information in the public domain that may present additional risk to the public e.g., contains detailed images of means of strangulation. • References to individually identifiable cases.	**No (delete as appropriate)**

• References to commercially sensitive or confidential systems. If a policy is considered to be high risk, it will be the responsibility of the author and chief officer sponsor to ensure it is redacted to the requestee.	

Part B **Ratification Assurance Statement**

Name of document: Policy for the care of patients requiring enhanced care

Name of author: Matron for Rehabilitation Job Title: Matron

I, the above-named author confirms that:

- The Strategy/Policy/Procedure/Guidelines (please delete) presented for ratification meet all legislative, best practice and other guidance issued and known to me at the time of development of the said document.
- I am not aware of any omissions to the said document, and I will bring to the attention of the Executive Director any information which may affect the validity of the document presented as soon as this becomes known.
- The document meets the requirements as outlined in the document entitled Governance of Trust-wide Strategy/Policy/Procedure/Guidelines and Local Procedure and Guidelines (OP01).
- The document meets the requirements of the NHSLA Risk Management Standards to achieve as a minimum level 2 compliance, where applicable.
- I have undertaken appropriate and thorough consultation on this document, and I have detailed the names of those individuals who responded as part of the consultation within the document. I have also fed back to responders to the consultation on the changes made to the document following consultation.
- I will send the document and signed ratification checklist to the Policy Administrator for publication at my earliest opportunity following ratification.
- I will keep this document under review and ensure that it is reviewed prior to the review date.

Signature of Author: *C.Banks*

Date: 19/10/22

Name of Person Ratifying this document (Chief Officer or Nominee):
Job Title:
Signature:

- I, the named Chief Officer (or their nominee) am responsible for the overall good governance and management of this document including its timely review and updates and confirming a new author should the current post-holder/author change.

To the person approving this document:

Please ensure this page has been completed correctly, then print, sign and email this page only to: The Policy Administrator

IMPLEMENTATION PLAN
To be completed when submitted to the appropriate committee for consideration/approval

Policy number and policy version CP66	**Policy Title** Policy For Care of Patients Requiring Enhanced Care	
Reviewing Group		**Date reviewed:**
Implementation lead: Print name and contact details		
Implementation Issue to be considered (add additional issues where necessary)	**Action Summary**	**Action lead / s (Timescale for completion)**
Strategy; **Consider** (if appropriate) 1. Development of a pocket guide of strategy aims for staff 2. Include responsibilities of staff in relation to strategy in pocket guide.		
Training; Consider 1. Mandatory training approval process 2. Completion of mandatory training form		
Development of Forms, leaflets etc; Consider 1. Any forms developed for use and retention within the clinical record **MUST** be approved by Health Records Group prior to roll out. 2. Type, quantity required, where they will be kept / accessed/stored when completed		
Strategy / Policy / Procedure communication; Consider 1. Key communication messages from the policy / procedure, who to and how?		
Financial cost implementation Consider Business case development		
Other specific Policy issues / actions as required e.g., Risks of failure to implement, gaps or barriers to implementation		

CP66 Appendix 1

Patients Likely to Need Enhanced Care

Violent and aggressive patient (Rule out psychiatric /physical cause)

Consider security presence/ Mental health staff presence

Ensure Patients Who Pose a Risk to Themselves or Others assessment is completed

Band HCA not suitable

Dementia patients/ cognitively impaired patients

Consider distraction therapy

Consider cohorting with others

Increase frequency of intentional rounding

Planned activities during the day

Working with friends/family

1:1 last resort if the above are ineffective – may not need 1:1 24/7

HCA suitable but may need dementia training

Falls Risks (with or without dementia)

Use of alarms

Consider environment

Consider placement on ward

Increased intentional rounding

Work with therapists

Plan activities with patient 1:1 last resort if above are ineffective – again may not be needed 24/7

HCA suitable but may need dementia training

Patients needing DoLS ie with delirium/HI/alcohol withdrawal

Consider placement position on the ward

Increased intentional rounding

Distraction therapy –
Work with therapists
Work with friends/family

May need trained 1:1 depending on issues ie trained in breakaway/ de-escalation techniques

HCA unlikely to be suitable

Patients with a clinical risk ie CPAP/tracheostomy patients especially if isolated in side room

Clinical expertise required so a qualified nurse is required 24/7

HCA unsuitable
RN with specialist skills required

Patients at risk of self-harm

Ensure risk assessment has been undertaken using Self Harm pathway

Consider where patient is placed on the ward

May need MH section

Consider 1:1 if high risk of self-harm

HCA unlikely to be suitable

NHS
The Royal Wolverhampton
NHS Trust

Enhanced Care Scoring Tool

Surname	Unit No
Forename	NHS No
Address	DOB
Postcode	(or affix patient label)

To be completed for any patient who you feel is at risk of harming themselves or others, is confused or is physically frail and at risk of harm.

Instructions for assessing the patient using the ECST: Score each element separately – take the highest score from each element and total all five scores up to identify the enhanced care scoring tool total. **Example:** Psychological factors (e.g. removing critical physiological support) = 3; Cognitive Impairment (patient is wandering) = 2; Distressed Behaviour (trying to get out of bed) = 2; Environment (behaviour requires patient to be isolated) = 3; fall (none) = 0. **ECST score = 10**.

Using the patient ECST score, refer to the guidelines (overleaf) to determine the level of support required.

Element	Score 3	Score 2	Score 1	Score 0
Psychological Factors e.g.	• Patient is a current risk to self • Admission because of self-harm / suicide risk • Irrational behaviour • Attempted to harm others • Patient is removing critical physiological support • Public health issues involved	• Poor compliance with medications and or treatment • Previous suicide attempts • Patient expressing harmful behaviours to self or others. • Patient expressing hopelessness	• Previous self-harm generating on-going concern • Low mood • Background history of mental health issues	• Previous self-harm and not currently generating concern • None this episode
Cognitive Impairment e.g.	• Loss of time, place, person & investigation • Behavioural changes • Inability to rationalise leading to aggression • Carers are expressing concern • Patient is attempting to harm others • Patient has impaired ability to communicate / follow commands or instructions	• Absconding / wandering outside or in the clinical area which impacts on others • Patient has short term memory loss • Removing essential / physiological support lines • Non responsive to distractions such as VERA (Validate, Emotion, Reassure, Activity)	• Low in mood • Withdrawn • Confused but responds to VERA (Validate, Emotion, Reassure, Activity) / distraction.	• Calm • Passively confused
Distressed Behaviour e.g.	• Episodes of physical aggression / agitation in the last 24 hours • Threatening self and / or others • Has bizarre behaviour impacting on self or others • Heavy smoker or uncontrolled withdrawal from alcohol • Uninhibited sexual or physical behaviour, causing concern to self and others	• Symptoms of alcohol or drug withdrawal • Verbally aggressive / agitated • Smoker • Withdrawn / uncommunicative • Inappropriately trying to get out of bed • Restlessness compromising safety	• Alcohol / substance abuse not on withdrawal protocol • History of aggression / agitation	• No signs of agitation or aggression
Environment e.g.	• Unable to call for help or use buzzer and isolation necessary • Behaviour requires patient to be isolated	• Distressed at isolation but able to rationalise and be distracted • Not isolated but cannot communicate needs	• Isolated but no risk to self or others • Can communicate and rationalise	• No isolation
Falls e.g.	• Patient has had a fall with moderate to severe harm associated with an on-going risk (e.g. lack of insight / understanding by patient)	• History of falls in the last month • X1 fall as an inpatient with no harm or low harm	• High risk of falling • Admitted following a fall • Falls equipment not effective	• No / low risk of falls

Note: If, in your professional judgement, you feel that a patient requires enhanced observations, then please provide enhanced care. Please follow specialist advice.

Dementia Specialist Nurse - ext. 8454
Penn Hospital - tel. 01902 444141
Safeguarding - ext. 5163
Psychiatry Liaison - bleep 3933
CAMHS - tel. 01902 444021
Learning Disability Specialist Team - ext. 5228
Security - ext. 8222
CERL - bleep 7394
Drug & Alcohol Liaison - ext. 4079

Guidelines

Please use these guidelines to determine the level of support / observation required based on your enhanced care scoring tool. Please review score every 24 hours.

ECST SCORE	Level of observations and actions to be considered: Blue - General Observation Green - 15-30 minute intervals Amber - Within eyesight Red - Within arms length	*Example*																	
		Date: 13.01.19		Date:		Date:		Date:		Date:		Date:		Date:		Date:		Date:	
0-3	• Patient safe – review daily or if condition deteriorates	Time: 09:00		Time:		Time:		Time:		Time:		Time:		Time:		Time:		Time:	
4-7 Green	• Is the patient clinically well? Exclude physical causes for restlessness. • Consider an appropriate environment – side room if necessary, low lights, reduce noise • Consider cohorting patients in a bay • Escalate to nurse in charge and / or bleep holder of clinical area • Review patient at every shift using the ESCT (and more frequently if indicated) • Appropriate specialist referral (see contact details overleaf) document in Health Records • Try to establish and treat underlying cause / un-met needs where possible • Be fully aware of any care management plan / behavioural guidelines • Communicate clearly with the patient and be sensitive to their needs • Utilise distraction strategies / activities • Ensure next of kin are kept fully informed • Review medication	Signature and designation **A. Nurse** **Staff Nurse**		Signature and designation		Signature and designation		Signature and designation		Signature and designation		Signature and designation		Signature and designation		Signature and designation		Signature and designation	
8-11 Amber	• Consider enhanced care observations • **Implement all of the above actions** • Consider restrictive physical intervention • Consider tag nursing, following assessment of mental capacity • Escalate to nurse in charge and / or bleep holder / matron of clinical area • Consider psychiatric review • Document in patient notes the actions you have taken including any referrals and commence any relevant care plans	Stamp: **A. Nurse** **00AB00Z**		Stamp:		Stamp:		Stamp:		Stamp:		Stamp:		Stamp:		Stamp:		Stamp:	
12-15 Red	• Needs enhanced care observations • **Implement all of the above actions** • Consider security involvement for support and advice • Escalate to nurse in charge / ward manager / bleep holder / Matron / Head of nursing • Consider / consult experts group (see contact details overleaf)	Score: **9**	Level of Observation: **Amber**	Score:	Level of Observation:	Score:	Level of Observation:	Score:	Level of Observation:	Score:	Level of Observation:	Score:	Level of Observation:	Score:	Level of Observation:	Score:	Level of Observation:

CP66 Appendix 3

1:1 Nursing Care Plan/Record Chart for a 24hr period

Nursing Care Plan/Record Chart

Patients Name…… **Unit no**…… **Ward**…… Date……

Risk Assessment Score…….. **Date Level 4 observations commenced** …… **DOLs Referral Required? (Please tick) YES** □ **NO** □

Time	Record patient behaviour/ activities on a minimum of 2 hourly basis or depending on the patient's needs	Identifying what harm you are trying to prevent and the assessed risks	Actions taken to minimise harm to patient and identified risks. i.e. Nursing interventions to determine the least restrictive care possible	Staff or relative responsible for the observation period. Job Title/Relationship	Staff/Visitor Signature
e.g.	*Patient persistently attempting to leave the ward and unsteady on their feet.*	*Falling and sustaining an injury, leaving the ward unaccompanied*	*(depending on the individual patient) talking, reassurance, mobilising the patient, reading to the patient*		

CP66 Appendix 4

The **VERA** framework describes a stage by stage process of communication that guides health care professionals towards providing compassionate and caring responses to patients with dementia.

V	**Validate** Accept and empathise with what the patient is saying, take it at face value and develop an understanding of her perceived situation. “You sound concerned about your husband. May I ask why?”
E	**Emotion** Acknowledgement of her feelings provides a ‘Kind’ and empathic understanding of the patient’s frame of mind. “I would be concerned too if I didn’t know where my loved one was.”
R	**Reassure** Simply stating that the patient is ‘Safe’ communicates to the patient that no harm, real or imagined, will come to him. “We’re in a safe place, may we sit together and work things out.”
A	**Activity** An activity is constructed that fits with the patient’s perceived situation. ‘Excellent’ care incorporates her behaviour rather than invalidates it. “Your ‘This is Me’ says you have a photo album, may we look through it?”

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CP66 Appendix 5
BAY TAGGING OBJECTIVES

Bay Tagging is a method for ensuring that a bay of high falls risk patients has continuous nursing presence to try to reduce the risk of patients falling due to lack of supervision. The main point of Bay Tagging is that the nurse appointed to work in the bay cannot leave until he or she has "tagged" another staff member to take over. If a person in a bay has to go behind the curtains with a patient, wherever possible they should ask for another person to tag them and oversee the bay.
Below is the methodology used on one ward to achieve this:

- ASSIGNMENT OF COLOURED BAY WILL BE GIVEN AT SAFETY BRIEF – EACH 5 BEDDED BAY IS ALLOCATED A DIFFERENT COLOUR
- YOU WILL THEN WEAR THE APPROPRIATE COLOURED BADGE TO MATCH YOUR BAY
- STAFF ASSIGNED TO THEIR APPROPRIATE COLOURED BAY MUST NOT LEAVE THE BAY UNTIL THEY HAVE TAGGED ANOTHER MEMBER OF STAFF
- TO TAG ANOTHER MEMBER OF STAFF YOU MUST GIVE THEM YOUR COLOURED BADGE AND THEY ARE THEN RESPONSIBLE FOR THAT BAY OF PATIENTS

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CP66 Appendix 6

Enhanced Care

A guide for staff on close observation

Safe & Effective | Kind & Caring | Exceeding Expectation

What is Close observation?

Close observation is defined as one-to-one care provided to a patient who may pose a particular safety risk to themselves or others possibly due to physical and/or psychological distress, or frailty. There are two types of close observation

- **Red** – Continuous one-to-one observation at arm's length.
- **Amber** – the patient is in eyesight at all times.

Why do we do it?

If a patient is particularly vulnerable and at risk and we need to help to protect their safety or the safety of other patients and visitors.

When do we do it?

The Nurse In Charge (NIC) will identify patients whom they deem as vulnerable for whatever reason (e.g. falls risk, absconding risk) and require close observation. Some patients may only need close observation for part of the day/night – the NIC will clarify this on the assessment document. The enhanced care assessment will also identify whether close observation needs to continue when the relatives are present. The NIC allocates a rota at beginning of each shift identifying who is responsible for closely observing the patient.

Interaction with the patient is key!

Where do we do it?

A patient on any ward may require close observations. The enhanced care assessment will identify if there are any environmental boundaries, for instance if the patient needs to remain in the ward area, or can only leave the ward with supervision.

Who does it?

Healthcare assistants will normally be delegated to deliver the close observation. However, a Registered Nurse is required to review the enhanced care paperwork and reassess the patient on a daily basis. If you are allocated to closely observe a patient you must ensure you complete the enhanced care record during your time closely observing the patient.

How do I know who needs close observation?

Patients who need close observation will be identified during shift handover. This is followed by a patient specific handover where you will be given information relating to that patient. It is important that you, in turn, give a full handover to the person taking over from you, giving details of what has happened during your time providing the close observation (e.g. pad changed, refused lunch, would like a shower) – this will help your colleague on taking over and ensure consistency of care.

What do I do when I'm closely observing a patient?

Close observation is in place to help ensure the patient's safety. It is not acceptable to sit with a patient and not interact with them. If the patient has dementia you can fill out an 'About Me' booklet find out more about the patient and discuss it with them. You can watch television with them, listen to music, play games or participate in other care activities such cleaning nails and washing hair. Patients will respond more readily if you interact with them than you simply telling them to sit down!

Close observation is an opportunity to enhance patient care and confidence – make sure you use it in this way.

Responsibility of NIC

- Identify patients who require enhanced care observation
- Allocate close observation rota (ideally a maximum 2 hours slot)
- Confirm with person undertaking close observation how to attract attention if it is required for patient such as more than one staff to stand a patient or member of staff e.g. for break
- Communicate the needs of those patients identified to Specialist teams as required i.e. Safeguarding, dementia or LD
- Request additional shifts are put to cover close observation
- Liaise with medical staff about patient condition

Responsibility of staff assigned to closely observe a patient:

- Inform NIC if you have any restrictions on ability to special e.g. pregnancy, muscular-skeletal injuries
- Complete enhanced care observation and interaction document
- Focus on main priority – the patient you are closely observing
- Ask for help if unsure about any aspect of close observation
- Interact with patient and gain their confidence

What do you do if:

Another patient asks for help?

Do not leave the patient you are closely observing. Ask the patient needing help to press their call bell, or ask someone e.g. housekeeper/volunteers to get the nurses attention if you cannot if the other patient is in extreme danger – pull the emergency call buzzer and press the safe hands alert button on your badge.

Emergency Buzzer goes off?

If the emergency buzzer goes off whilst you are allocated to closely observe a patient don't leave the patient unless you are advised by the NIC.

A colleague asks you to help them with a task while you are allocated to close observation of a patient?

If the task doesn't require you to lose direct eye contact with the patient then you can quickly assess the request according to how the patient is at the time – for instance, if they are settled in their chair having lunch. However, do not be afraid to ask your colleague to find someone else to help.

Your main priority is to closely observe the patient you have been allocated to.

You have been closely observing a patient for longer than two hours?

There may be occasions when the patient will benefit from being closely observed by someone they have become accustomed to. However, short periods of close observation may be better for both patient and staff. The NIC will confirm in handover what length of time you can expect to be engaged in close observation.
Unfortunately, there may be rare occasions when the nurse due to take over from you is busy with another patient. If this happens, alert the NIC so that they can manage the rota accordingly and allocate someone to take over.

The patient you are closely observing is asleep?

You can ensure that paperwork for your patient, and the rest of the patients in the bays, are up to date. Do not assume that you can leave the patient if they are asleep unless you have spoken to the NIC , who may wish you to stay with that patient, they may de-escalate them to an amber special during their sleep, or they may ask you to perform other tasks in the bay i.e. vital signs recording, food charts, etc.

The patient you are closely observing is aggressive towards you?

Please use de-escalation techniques – your Team Leader or Staff bank are responsible to ensure you have received conflict resolution training. Security may need to be called if the patient is not readily responding to reassurance.

If a junior colleague tells you the patient doesn't need close observation?

Seek advice from the NIC. Do not assume you can leave your patient – the NIC the NIC is the only one who can alter the level of close observation.

Items that may be useful during close observation:

- Newspaper or magazine
- Memory and Activity Box please ask NIC for this
- Nail Care Kit
- About Me document
- Patient items – photos etc.

People who can support you:

- Relatives – they know the patient best and may know how to reassure them
- Volunteers – a lot of them have dementia awareness, involve them in conversation, but do not leave them to closely observe the patient – we have volunteers at meal times to assist you
- Chaplaincy – the patient may benefit from a religious or pastoral presence.
- Dementia Specialist Nurse – will give advice on techniques/ methods to be used.
- LD specialist nurse – will give advice on techniques/methods to be used.
- Medical Team – they can adjust medication, make referrals etc.

Items to read:

- Enhanced Care Policy
- Prevention, diagnosis and management of delirium and dementia in older patients
- VERA framework communicating with people who have dementia

Nursingstandard.rchpublishing.co.uk/…/article-vera-framework-communicating-with-people-who-have-dementia

The Royal Wolverhampton NHS
NHS Trust

If you require this document in an alternative format e.g., larger print, different language etc., please inform one of the healthcare staff.

Punjabi

ਜੇ ਤੁਹਾਨੂੰ ਇਹ ਦਸਤਾਵੇਜ਼ ਹੋਰ ਰੂਪ ਉਦਾਹਰਨ ਵੱਜੋਂ ਵੱਡੀ ਛਪਾਈ, ਵੱਖਰੀ ਭਾਸ਼ਾ ਆਇਦ ਵਿੱਚ ਚਾਹੀਦਾ ਹੋਵੇ, ਤਾਂ ਕਿਰਪਾ ਕਰਕੇ ਕਿਸੇ ਸਿਹਤਸੰਭਾਲ ਕਰਮਚਾਰੀ ਨੂੰ ਬੇਨਤੀ ਕਰੋ।

Polish

Aby uzyskać niniejszy dokument w innym języku lub formacie, np. pisany dużą czcionką, itp., prosimy skontaktować się z przedstawicielem personelu medycznego.

Russian

Если данный документ требуется Вам в альтернативном формате, например крупным шрифтом, на другом языке и т.п., просьба сообщить об этом одному из сотрудников здравоохранения.

Lithuanian

Jei pageidaujate šį dokumentą gauti kitu formatu, pvz., padidintu šriftu, išverstą į kitą kalbą ir t. t., praneškite apie tai sveikatos priežiūros darbuotojui.

Kurdish

ئەگەر ئەم بەڵگەنامەیە بە شێوازێکی دیکە دەخوازیت بۆ نموونە چاپی گەورەتر، زمانێکی دیکە هتد. تکایە پەیوەندی بە کارمەندانی سەرپەرشتی تەندروستی ناگادار بکەرەوە.

The prevention of infection is a major priority in all healthcare and everyone has a part to play.

- **Wash your hands with soap and warm water and dry thoroughly. Use hand gel, if provided, in care facilities.**
- **If you have symptoms of diarrhoea and vomiting stay at home and do not visit relatives that are vulnerable in hospital or in residential care. You will spread the illness.**
- **Keep the environment clean and safe. Let's work together to keep it that way. Prevention is better than cure.**

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