University Hospitals of Derby and Burton
NHS Foundation Trust

ENHANCED NURSING CARE POLICY

Reference Number	**Version:** V2		**Status** Final	**Author: Jane O'Daly** **Job Title**: Head of Safeguarding & Vulnerable People Team
Version / Amendment History	**Version**	**Date**	**Author**	**Reason**
	V1	Aug 2020	J O'Daly-Miller	Original Version
	V2	June 2023	J O'Daly-Miller	Enhance care bundle edit & policy update
Intended Recipients: All ward managers, Matrons & Nursing Staff, Divisional Nurse Directors, Operational Managers and Senior Nurse on Call				
Training and Dissemination: Via the Intranet, Vulnerable People Training				
To be read in conjunction with: Falls guidance, Treatment with Lawful Consent, Safeguarding Policy, Policy for Restraint and Restrictive Practices and Missing Patients Policy				
In consultation with and Date: Safeguarding Group - June 2023				
EIRA stage One Completed: Yes Stage Two Completed				
Approving Body and Date Approved	Trust Delivery Group			
Date of Issue	October 2023			
Review Date and Frequency	August 2026 (then every 3 years)			
Contact for Review	Head of Safeguarding & Vulnerable People Team			
Executive Lead Signature	 Executive Chief Nurse			

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1. Introduction

1.1 All patients receiving care and treatment on Trust premises are assessed with a view to monitoring their general safety and well-being. However, due to the disease process, unfamiliar surroundings, current medication therapy or the patient's mental health needs etc. patients may require a temporary period of enhanced level of observation following a behaviour assessment, to maintain patient safety while the level of risk is managed.

1.2 Enhanced observation is an integral part of a therapeutic plan. The purpose of observation is to ensure the sensitive monitoring of the patient's behaviour and mental state, enabling a rapid response to any change, whilst at the same time fostering positive therapeutic relationships. This may be achieved by establishing a good rapport with patients, promoting their coping skills and being aware of their individual needs. One-to-one support is obtainable via Bank.

1.3 Enhanced nursing should never interfere with, or compromise, any planned treatment or therapy for a patient.

1.4 Any patient under the care of University Hospitals of Derby and Burton NHS Foundation Trust who is detained under any aspect of the Mental Health Act (2007) must be notified to the Trust Mental Health Act Coordinator Safeguarding Team and be reviewed by the appropriate Mental Health Practitioner / Mental Health Liaison Team.

2. Scope

This guidance document is applicable to Inpatient settings only and applies to all clinical staff including all internal "bank" employees and those employed on a temporary / locum / honorary, agency or fixed term basis.

3. Purpose of Policy

The purpose of this policy is to provide a framework for all staff to follow a consistent approach for the planning and implementation of enhanced nursing observation to maintain patient's safety and reduce the risk of harm through enhanced nursing.

The policy provides instructions on how enhanced supervision should be implemented. An assessment guide to identify the level of supervision required and effective care planning is included.

This document is relevant to all clinical staff working in the Trust whose practice brings them in contact with any patient who may be a risk to themselves, their health and safety, if unsupervised. The clinical objective is to provide the least restrictive, safe, and effective care for all patients who are considered a risk to themselves or others. This will be achieved by implementation of the advised level of enhanced supervision.

4. Levels of Observation

- For the purpose of this guidance there are **three** levels of observation to be followed. All patients on admission will have a **Behaviour Risk Assessment** undertaken to obtain a behaviour score which indicates the level of observation, when to commence the Enhanced Care Bundle and corresponding care plan **(Appendix 1, p.12)** See table below.

Table 1: Score outcome

Level 1 Observation Intentional Rounding	Level 2 Observation Continuous Cohort/Bay Nursing	Level 3 Observation Continuous 1:1 Enhanced Care Supervision
Score 0-1 Follow Level 1 Care Plan	Score 2-4 **Commence Enhanced Care Bundle** Follow Level 2 Care Plan	Score 5-7 **Commence Enhanced Care Bundle** Follow Level 3 Care Plan

- Level 1 Routine Care - General Observation
  Nursing staff will make a minimum of hourly checks on the whereabouts and wellbeing of all patients on their wards which will be recorded on the nursing care/intentional rounding charts. If any concerns are raised regarding specific patients during these care rounds the patient will be escalated to level 2, commence the Enhanced Care Bundle, and inform the Nurse in Charge. The need for level 1 observation will be assessed on admission and reviewed on transfer, if patients condition changes, post fall or weekly and documented within Patient Assessment and Care Record/ V6 nursing notes and communicated to the team during nursing hand over. Nursing staff to follow corresponding care plan, (care plan 1 **(Appendix 1, p.16)).**

- Level 2 - Observation of Cohorted Patients– Enhanced Care
  Patients assessed at this level may not display any physically challenging behaviour patterns either to staff or other patients at this stage. However, they need to be within **continuous eyesight** of the nursing staff. Patients identified as having a high risk of falling should have the Falls Prevention Care plan implemented. Patients assessed as requiring level 2 observation trigger the commencement of the Enhanced Care Bundle to be used in conjunction with nursing care/intentional rounding charts. The need for level 2 observation will be reviewed and documented within Enhanced Care Bundle daily and communicated to the team during nursing hand over. Nursing staff to follow corresponding care plan, (care plan 2 **(Appendix 1, p.16)).**

- Level 3 - Observation continuous 1:1 supervision – Enhanced Care
  Patients assessed at this level require supervision within arm's length. This group of patients will be displaying distressed behaviours and be at high risk of harm and require 1:1 nursing. Any patient requiring continuous observation at night or level 3 should have sleep hygiene implemented. Patients assessed as requiring level 3 observation trigger the commencement of the Enhanced Care Bundle to be used in conjunction with nursing care/intentional rounding charts. The need for level 3 observation will be reviewed and documented within Enhanced Care Bundle daily

and communicated to the team during nursing hand over. Nursing staff to follow corresponding care plan, (care plan 3 **(Appendix 1, p.16)).**

- Other responsibilities of the nurse during continuous observation (Following the Enhanced Care Bundle): -

  a) The nurse must be able to always see the patient.
  b) The nurse must complete the Mental Capacity Assessment and Best Interests checklist. **(Appendix 1, p.13-14)**
  c) The nurse must provide positive interaction in conjunction with therapeutic interventions as highlighted in Enhanced Care Guidance. **(Appendix 1, p.27)**
  d) The ABC Record Chart recording patient's behaviours and triggers **(Appendix 1, p.18)** must be completed depending on the patient's needs for all observation level 2 and 3 patients to establish any change to their dependency/risk level and behavioural patterns.
  e) The Enhanced Care Bundle **(Appendix 1)** should be completed and signed by the registered nurse daily and if the patient's condition changes.
  f) The nurse must complete a Deprivation of Liberty Safeguard form (DoLs) for patients requiring Level 3 Observation continuous 1:1 Enhanced Care Supervision.
  g) The nurse must complete a Datix if a Patient requires Level 3 Observation continuous 1:1 Enhanced Care Supervision and additional staff cannot be secured.
  h) The Enhanced Care Bundle document should be filed within the patient notes.
  i) The **need for level 2 and 3 observations will be reviewed daily** during the nursing handover.

5. Patients at risk of Going Missing

- Staff must prevent patients who lack capacity, or those patients subject to a section of the Mental Health Act from leaving hospital in accordance with the Trust Least Restrictive Practice Policy, The MCA policy, and The Mental Health Policy (as appropriate).

- Staff must follow the Trust Policy for Missing Patients when patients have left the ward and have not returned. For patients without capacity please follow the missing person policy and complete missing patient checklist and action plan within policy. A patient who has capacity and can make decisions about their care and treatment and understand the consequences if they leave hospital against medical advice can leave unless they are detained under the Mental health Act 2007, follow link: opac-retrieve-file.pl (koha-ptfs.co.uk)

- If the patient has capacity and has left the ward/department with a Peripheral Venous Catheter (PVC) in place do not call the police but attempt to contact the patient where possible, advise them to either return to ward/department or alternatively contact a healthcare practitioner for removal (e.g., GP Practice, Walk in Centre).

- If any concerns have been identified for the safety and welfare of family members, please inform police.
- Patients without capacity please follow the missing person policy and complete missing patient checklist and action plan within policy.
- Report all absconded patient incidents via Trusts reporting system (Datix).

6. Visitors & Observation

- Once the level of enhanced care has been decided by using the **Behaviour Assessment (Appendix 1, p.12)** to obtain the behaviour score which indicates the level of observation required, patients and their relatives should be involved in the planning of the delivery of care wherever possible.
- While family / carers and visitors are with the patient observation may move to within eyesight observation. Relatives/ carers and visitors should be provided with information regarding the rationale for their loved one requiring enhanced care. This will ensure clear communication and sharing of treatment and care requirements.
- Staff must not coerce relatives to participate in Enhanced Care.
- Where patients have paid carers with them from other sources, the Nurse in Charge must discuss the care they are to provide and ensure that the care is not providing care outside their level of competence. All care must be documented withing patients Nursing records.

7. Authorisation

- All nursing requests and behaviour assessments completed by the ward staff between the hours of 9am - 5pm for Level 3 observation require authorisation from a Matron or nominated deputy in their absence.
- All nursing requests and behaviour assessments are completed by ward staff during out of hours; A Level 3 observation must be authorised by the Clinical Site Practitioner / Patient Flow / Senior Nurse on Call and On- Call Manager or nominated deputy.
- The person who gives the authorisation will also decide the review date and document this on the Enhanced Care Bundle. The behaviour risk assessment review will then be carried out and, if required, authorised.
- A decision will then be made based on the behaviour assessment of any additional staff, dependent upon the level of risk.
- The nursing bank will only supply the ward to increase the ward's staffing levels if all the documentation has been completed and authorised.
- A reassessment of the patient's needs to be completed by the Ward Sister, Matron or equivalent in their absence at the start of normal hours, daily Monday to Friday and out of hours by the Clinical Site Practitioners.
- The patient must be reviewed daily by the Nurse in Charge and escalate to the Matron for the area if patient is receiving a Level 3 observation more than 72 hours.
- If enhanced nursing care has been authorised and the shift has not been covered then an incident form (Datix) must be completed and sent to the relevant Matron/ Head Nurse.

8. Delegation To Unregistered Staff

- The first level Registered Nurse remains accountable for the decision to delegate observation to a Carer / NA / AP or student in training, ensuring that they are sufficiently knowledgeable and competent to undertake the role.

9. Prolonged Use of High Observation Levels

- If a patient remains on the prolonged observation level 3 for a period of 3 days, then a Multi-Disciplinary Team review **MUST** take place, organised by the Senior Sister. The Matron for Vulnerable People should also be invited to attend this meeting. The review panel will discuss the circumstances for the prolonged period of observation and the reasons for the continuation or if there are any alternative approaches. A defined plan of care needs to be identified. The outcome of the review will be documented in the patient's clinical record.
- The Enhanced Care Bundle needs to be completed accurately and a detailed ABC Record Chart recording patient's behaviours and triggers (**Appendix 1, p.18)** must be completed for each patient during a 1-1 observation.

10. Deprivation Of Liberty Safeguard (Dols)

Deprivation of liberty can occur in as little as 20 minutes according to case law. However, in practice it is generally sensible to wait for a reasonable length of time to allow care and treatment such as fluids, antibiotics, and pain relief for example to take effect and thereby hopefully remedy the lack of capacity. A deprivation of liberty safeguard authorization should be completed in the following circumstances:

- When the patient does not, or is no longer requiring, care and treatment that "can only be provided in an acute Trust" and / or the care provided has moved into care that could be provided in their usual "ordinary living circumstances" (as above, generally it is reasonable to allow 3 days as noted above to see if there is improvement) or
- the one to one would not be provided for someone with capacity (and therefore we are treating the patient who lacks capacity differently from a capacious patient) or
- where the patient was subject to a DoLs in their usual residence, or
- where the plan for patient discharge does not include discharge to their usual address or ordinary residence, or
- where the family are not in agreement with the treatment plan and there is the risk of unsafe removal of the patient, or
- where the restrictions and restraints permissible under the MCA cause frequent and intense distress to the patient

- **Application**

To apply an urgent authorization of deprivation of liberty the ward manager can complete the form by following the link below:

Mental Capacity Act (MCA) and DoLS | z UHDB Intranet

11. De-Escalation of any patient requiring constant observation at night or Level 3

- It is important to remember this is a temporary measure and has implications for discharge and the patient's privacy and dignity. Therefore, the following steps should

be taken daily:

- Review of previous 24-hour recorded activity.
- Has the risk you are trying to prevent changed?
- Has the patient's behaviour changed?
- Does the patient require less supervision?
- Has the patient's independence been promoted?
- Is the enhanced care still required? If it is currently 24/7 can this be reduced?
- Is the impact of 1:1 nursing impacting on the patient's discharge plan?
- Has an MDT meeting taken place?
- Has the nurse providing 1:1 care stepped back assessing from a safe distance to begin withdrawal of 1:1.

12. Monitoring Compliance and Policy Effectiveness

Criterion	Lead	Monitoring method	Frequency	Committee / Group
Compliance with MCA Compliance with Datix recording if no 1:1 allocated. Compliance with DOLS	Safeguarding Vulnerable People Matron	Case file audit	Quarterly	Trust Vulnerable People Group

13. Dissemination And Implementation

This Guidance will be made available on the UHDB Intranet site. Matrons and Senior Sisters will disseminate the guidance to all nursing staff and other healthcare professionals.

14. Training And Support

Matrons and Senior Sisters will ensure that nursing staff are aware of this guidance and understand how to use it and will support staff as necessary within their clinical supervisory time and during quality rounds.

15. Equality And Diversity

The Trust recognises the diversity of the local community and those in its employ. Our aim is, therefore, to provide a safe and secure environment free from discrimination and a place where all individuals are treated fairly, with dignity and appropriately to their needs. The Trust recognises that equality impacts on all aspects of its day-to-day operations and has produced an Equality Policy Statement to reflect this. All policies are assessed in accordance with the Equality initial screening tool kit, the results for which are monitored centrally.

16. Definitions

UHDB	University Hospitals of Derby and Burton NHS Foundation Trust
DOLS	Deprivation of Liberty Safeguards
HCA	Healthcare Assistant
NHS	National Health Service
NICE	National Institute for Clinical Excellence
1:1	One to One (One member of staff to one patient)
Challenging behaviour	Can include aggression, self-harm, destructiveness, or disruptiveness A person's behaviour can be defined as "challenging" if it puts them or those around them (such as their carer) at risk or leads to a poorer quality of life. It can also impact on their ability to join in everyday activities. Challenging behaviour can include aggression)
TVPG	Trust Vulnerable People Group

17. References

Safeguarding Policy (see KOHA)

Department of Health (2004) Standards for Better Health fifth domain: Accessible and responsive care London: DoH

Mental Capacity Act 2005 Code of Practice, TSO 2007

Mental Capacity Act 2005 Deprivation of Liberty Safeguards Code of Practice; TSO 2008

Mental Health Act (2007) www.legislation.gov.uk/ukpga/2007
http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicy And Guidance/DH_4005756

Practice Guidance Safe and Supportive Observation of Patients at Risk
Mental Health Nursing "Addressing Acute Concerns" *Standing Nursing and Midwifery Committee (1999)*

The Human Rights Act www.legislation.gov.uk/ukpga/**1998**/42/contents

University Hospitals of Derby and Burton NHS Foundation Trust

Enhanced Care Bundle

Surname:

First Name:

ADDRESSOGRAPH

DoB:

Hospital Number:

Ward _____

This booklet is to be used if patients behaviour risk assessment score is between 2-7 indicating that patient is requiring increased observation

PCC

Please Specify Site QHB ( ) SJH ( ) SRP ( ) RDH ( ) FNCH ( )

All staff that write in this care record must complete this section					
Name	**Designation**	**Initials**	**Signature**	**Date**	**Ward**

Behaviour Risk Assessment

Complete Assessment Daily

Category			
Falls	No falls associated with cognitive impairment.	History of falls within the last 12 months associated with cognitive impairment. A fall more that 48Hrs ago/ Experiencing dizziness or provided with yellow socks.	Fall associated with cognitive impairment within 48hrs prior to admission or during admission. **(Deescalate to amber after 48 hours)**
	0	**1**	**2**
Cognitive Impairment Confusion/ Delirium or Dementia	No evidence of confusion / delirium or Cognitive impairment without signs of distress.	Distressed behaviours that can be managed with distraction and diversion interactions.	Displaying distressed behaviours despite medical management and distraction and diversion interventions. Hallucinations, agitation, physical aggression or Mental health diagnosis concerns.
	0	**1**	**2**
Medical Devices	No attempt to remove or not in use.	Infrequent attempts to remove medical devices that can be mitigated.	Frequent or continuous attempts to remove medical devices.
	0	**1**	**1**
Mobility	Mobilises independently with a purpose without assistance.	Infrequent attempts to mobilise without the assistance required that can be mitigated.	Frequent attempts to mobilise without the assistance required and requires frequent intervention to prevent a likely fall. Attempting to leave ward/ Imposing self on others/ Interfering with patient's medical devices.
	0	**1**	**2**

Level 1 Observation Intentional Rounding	Level 2 Observation Continuous Cohort/Bay Nursing	Level 3 Observation Continuous 1:1 Enhanced Care Supervision
Score 0-1 Follow Level 1 Care Plan Discontinue Enhanced Care Bundle	Score 2-4 Follow Level 2 Care Plan	Score 5-7 Follow Level 3 Care Plan

Ensure that staff providing Cohorted and continuous 1:1 Enhanced Care Supervision rotate on a 2 hourly basis

Please ensure that all behaviours are documented at time of presentation

Mental Capacity and Enhanced Care Assessment (To be completed by a registered practitioner)										
Decision prompting this assessment:										
Complete Daily	Date									
	Time									
MCA Stage 1	Does the person **understand** the information given to them?									
	Can the person **retain** information?									
	Can the person **weigh up** information?									
	Can the person **communicate** their views?									
MCA Stage 2	Does the person have an impairment / disturbance of the function of the mind or brain?	**Y/N**								
If the answer is <u>No</u> to any one of the above, complete **Best Interest** process below in discussion with family / carers.										
Best Interests checklist										
Is there an advance decision to refuse treatment?										
Is there anyone holding a valid Power of Attorney (ask them to provide their certificate and contact safeguarding team if so)										
Is there an appointed court of protection deputy?										
If the answer to the above is No – you are the lawful decision maker as to the care to be delivered										
Past and present wishes: Have steps been taken to consider, as far as is practicable, the patient's past and										

present wishes about the matter, e.g., discussion with family, friends or carers? **Please record names of person the proposed care has been discussed with:**								
Involvement in decision: Have steps been taken to encourage and involve, as far as possible, the patient's involvement in the decision and actions being considered on their behalf?								
Best Interests checklist continued								
Beliefs and values: Have you considered the beliefs and values likely to influence the patient's attitude to the decision, i.e. religious, cultural, lifestyle choices								
Are all elements of basic care to be provided in the best interest of the patient? If some elements of basic care have been identified as **not** in their best interest to be provided, please record which elements they are and why they are not considered to be in the patient's best interest and contact the safeguarding team								
Registered Staff initial								
Enhanced care Assessment total score								
Care plan- Level 1 Observation Intentional Rounding Score (0-1) Discontinue if score 0 – 1 for 72hrs								
Care Plan- Level 2 Observation Continuous Cohort/Bay Nursing (Score 2-4)								
Care Plan- Level 3 Observation Continuous 1:1 Supervision (Score 5-7)								
Additional staff required	Yes							
	No							
Additional staff secured? If not please comment in supervision variance section how was the increased supervision managed	Yes							
	No							
Registered Staff initial								
Senior Staff initial to approve additional staff if required								
Please complete an Datix form if a Patient requires 1:1 continuous supervision and additional staff cannot be secured								

Required for all patients requiring Level 3 Observation continuous 1:1 Enhanced Care Supervision	Date	Time	Initials
Complete a **Deprivation of Liberty**			
Contact Safeguarding Team			

Date	Time	Supervision variance. Please document decisions that do not match the indications of the assessment that still ensure the safety of the patient.	Initial

Date	Time	**Continuous 2:1 Supervision for patients posing risk to themselves, staff or others due to violent behaviour.** Please escalate this to the Matron or Senior Nurse out of hours and refer to the Psychiatrist for Psychiatric Assessment and document interactions here	Initial

Care Plans

Level 1
Intentional Rounding
(Score 0-1)

Re-evaluate daily or as behaviours changes.

- Complete **'Getting to Know me'** or refer to equivalent existing person-centred document.
- Ensure sensory aids are in use, glasses/hearing aids.
- Provide activities and distraction where appropriate (consider distraction products in library)
- Refer to Falls Care Plan e.g., appropriate footwear which includes yellow socks.
- Refer to Continence Care Plan
- Consider location of allocated bed
- Ensure essential possessions are within reach.
- Ensure call bell is within reach.
- Ensure mobility aids are within reach.
- Engage family and carers in care and encourage open visiting. (**John's campaign**)
- Continue intentional rounding.

Discontinue Enhanced Care Bundle if Behaviour Risk Assessment score = 0-1 for 72hrs

Level 2
Continuous Cohort/Bay Nursing
(Score 2-4)

Re-evaluate daily or as the behaviour changes.

- Complete **'Getting to Know me'** or refer to equivalent existing person-centred document.
- Ensure sensory aids are in use, glasses/hearing aids.
- Provide activities and distraction where appropriate (consider distraction products in library)
- Refer to Falls Care Plan e.g., appropriate footwear which includes yellow socks.
- Refer to Continence Care Plan
- Consider location of allocated bed
- Ensure essential possessions are within reach.
- Ensure call bell is within reach.
- Ensure mobility aids are within reach.
- Engage family and carers in care and encourage open visiting. (**John's campaign**)
- **Commence Enhanced Care Bundle**
- **Think Delirium, complete Dementia/Delirium screening.**
- **Assess pain- provide analgesia.**
- **Cohort patients – A member of staff should be always present.**
- **Confirmed/suspected Dementia refer to Dementia Team**

Level 3
Continuous 1:1 Supervision
(Score 5-7)

Re-evaluate daily or as the behaviour changes.

- Complete **'Getting to Know me'** or refer to equivalent existing person-centred document.
- Ensure sensory aids are in use, glasses/hearing aids.
- Provide activities and distraction where appropriate (consider distraction products in library)
- Refer to Falls Care Plan e.g., appropriate footwear which includes yellow socks.
- Refer to Continence Care Plan
- Consider location of allocated bed
- Ensure essential possessions are within reach.
- Ensure call bell is within reach.
- Ensure mobility aids are within reach.
- Engage family and carers in care and encourage open visiting. (**John's campaign**)
- Commence Enhanced Care Bundle
- **Think Delirium,** complete Dementia/Delirium screening.
- Assess pain- provide analgesia.
- Cohort patients – A member of staff should be always present.
- Confirmed/suspected Dementia refer to Dementia Team
- **Full medical and medication review**
- **Provide continuous 1:1 Enhanced Care Supervision (Approved by the Matron/ CSP/SNOC out of hrs)**
- **Complete DoLS and send to Safeguarding**

Patients Preferred Name _____

ABC Record Chart – Guidance			
Date & Time (Minimum 1 hrly intervals)	A—What happened before or during the behaviour was witnessed? ***A**ntecedents*	B—What behaviour was witnessed? Refer to "Definition of Behaviours" ***B**ehaviour*	C—What happened after the behaviour? ***C**onsequent events*
	In this row, with the following questions in mind, provide a step-by-step description of exactly what you observed prior to the behaviour, or at the same time as the behaviour occurred. 1. Where was the person, and exactly what were they doing? 2. Was anyone else around, or had anyone just left? 3. Had a request been made of the person? 4. Had the person asked for, or did they want something to eat or drink? 5. Had the person asked for, or did they want a specific object or activity? 6. Had an activity just ended, or been cancelled? 7. Where were you and what were you doing? 8. How did the person's mood appear, e.g., happy, sad, angry, withdrawn or	In this row, provide a step-by-step description of exactly what the person did, e.g. he ran out of the ward bay, stood in the kitchen doorway and punched his head with his right hand for approximately 1 minute.	In this row, with the following questions in mind, provide a step-by-step description of the exact events that occurred immediately after the behaviour. 1. Exactly how did you respond to the behaviour? Give a step-by-step description. 2. How did the person respond to your reaction to the behaviour? 3. Was there anyone else around who responded to, or showed a reaction to the behaviour? 4. Did the person's behaviour result in them gaining anything they did not have before the behaviour was exhibited, e.g., attention from somebody (positive or negative); an object, food or drink; or escape from an activity or situation?

	distressed? 9. Did the person seem to be communicating anything through their behaviour, e.g. I don't want…; I want…?		

Patients Preferred Name _____

ABC Record Chart			
Date & Time Initials	A—What happened before or during the behaviour was witnessed? ***A**ntecedents*	B—What behaviour was witnessed? Refer to "Definition of Behaviours" ***B**ehaviour*	C—What happened after the behaviour? ***C**onsequent events*

Patients Preferred Name _____

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Do not use this document for those who have self -harmed or expressed the intent to self- harm
For self-harm complete Visa assessment and activity log. Contact Mental Health Liaison (RDH) Liaison Psychiatry (QHB) Psychiatric Team (FNCH) or Child and Adolescent Mental Health Services if required.

This document does not automatically approve requests for additional staffing

This document is designed to support decision making and documentation of care for those patients that may require enhanced care, not just for the occasions when we require additional staff. Many areas find that they can provide increased supervision safely within the numbers of staff they have on duty. Working differently and sharing roles as a team can be sufficient to provide the care required. If this is not possible **then and only then** will additional duties be approved by the Matron, Divisional Nurse Director, or Site practitioner (out of hours).

Undertake your other duties in supervised areas whenever possible

Many wards have found that bay nursing reduces the amount of resources required to provide supervised care. Completing documentation in bays and other regular duties increases the levels of interaction between staff and patients and reduces the need to allocate additional staff to supervision.

Enhanced Care must be continuous

If it has been identified that a patient must be supervised at all times, this supervision must not be interrupted. If those supervising patients need to do other things (away from the bay, behind a curtain or in a bathroom) then support must be found to maintain line of sight as a minimum. Supporting patients that require supervision can be rewarding but should not be provided by one person without a break. If the patient has challenging behaviours, then the enhanced care provider can be rotated to other patients by request.

Not all supervision needs to be within arm's length of the patient.

Establish if the patient is reassured or agitated by staff being close to them. Some patients may respond positively to company and appropriate physical contact and some may become frustrated by constant observation and repeated reminders to remain seated or to remain within a certain area. Assess each person as an individual and remember that staff should not put themselves at risk of injury during physical outbursts or in the event of a fall.

Involve Family/carer/next in the planning and delivery of care

Patients may be calmer and happier when care is personalised and delivered in partnership with those who know them best. If family/carers wish to remain with the patient outside of normal visiting hours, this should be encouraged. Be sure that all those involved in supervision know what is expected of them. When family/carers leave the patient, they should be advised to let you know. This is to avoid gaps in supervision.

Find out what the patient likes and does not like and share this information with your team
Think about what makes you happy and sad and what you would need in hospital. Think about how you can find these things out about your patient. The **Getting to Know Me** or equivalent person-

centred document can help to facilitate conversations with family / carer to improve both experience and safety.

Patients who have been engaged and entertained often require less supervision over time

There are a range of resources and tools available to support you.
There are a range of resources and tools available to support you located in library such as Memory Boxes and Twiddle Mitts which can be effective for many patients.

In addition to central resources these are some other things that teams have found effective:

Books	Socialisation	Exercise
Photographs	Music	Bingo
Movie Nights	Tea Parties	Radios
Computer/ Tablets	Puzzles	Playing Cards
Folding Linen	Handling /Cleaning brass	Creative Writing
Arts and Crafts	Singing	Nostalgia

The patient's perception is important and may help you to manage their care

Try exploring the patient's perspective and see if they respond positively to this. If it is their perception that they are at work, talk about work before you decide if they need to know they are in hospital.

If the person wishes to walk around to find something or someone and they can do so safely, walk with them until they have satisfied their needs. Be sure to protect and respect the dignity of others and follow safe moving and handling principles at all times.

Promotion of continence may reduce the risk of falls

A high proportion of falls are preceded by an attempt to gain access to a toilet or standing to use a toilet or bottle. Promote continence within supervision wherever possible.

Be aware of the risks associated with side rooms, bathrooms and bedrails

Side rooms limit visibility and reduce sound. Staff may not be able to see or hear the early signs of distress or unaided movement and an incident can occur in seconds. Supervision in a bay with others can be more effective and easier to resource within teams. **Care of supervised patients in side rooms should only be provided with continuous 1:1 enhanced care.**

The need for privacy in bathrooms will vary with the individual. For those at risk of falls be sure to manage this risk balanced against what they request. Many of our bathrooms have sufficient space to remain present and discrete so staff may not need to leave the room entirely.

Bed rails can provide comfort and stability for some patients, however for those without capacity they can become a hazard of their own. **Confused and mobile patients must not have bed rails in use.**

General observation must be undertaken for all patients

As a minimum requirement for all inpatients the Nurse in Charge should be aware of the whereabouts of every patient on an hourly basis throughout the 24-hour period. General observation is the minimal acceptable level of observation for all inpatients. Within this, at least once per shift allocated nurses should sit down and talk to their allocated patients.

Managing pain is the right thing to do and can reduce agitation

For patients that can't vocalise pain the following may indicate pain or discomfort

Sounds	crying, groaning, gasps, sighs, grunting, whimpering
Facial expression	wincing, tension, frowning, narrowed eyes, tight lips, teeth clenched, distorted expressions, looking frightened
Body language	guarding part of the body, withdrawn, clutching, or holding tight to things, rocking
Behaviour	Restlessness, refusing food or fluids, irritability, agitation, withdrawal, increased confusion
Physiology	Perspiring, flushing, pallor, cold & clammy, altered temperature or BP outside usual pattern
Causes	pressure ulcers, arthritis, contractures, skin tears, bruising, other injuries

Use the Painad chart if you suspect the patient may be in pain

Use of physical restraint devices is an ethically sensitive issue for the patient, their family and for staff

Decisions for use of physical restraint devices must ensure that such use protects the patient from a greater harm. For this reason, they must only be considered for critical interventions such as airway management, enteral / parenteral feeding / medication and temporary pacing wires.

Delirium is a state of confusion normally short in duration and as the result of a specific cause such as injury, illness or substances including medications. People without a diagnosis or dementia can experience delirium and someone with dementia can experience increased confusion due to delirium. Be sure to work with the medical teams to identify the type of confusion and any possible causes.

All those who lack capacity must have a Best Interest checklist and Deprivation of Liberty (DoLS) checklist and this must be sent to the Safeguarding team.

These processes will support best practice and also document the fact that we have taken all reasonable steps to include the person in all decisions and the delivery of care. It also gives hospitals the

right to detain patients against their wishes for 7 days while the application to deprive liberty is considered by the authority.

Those people who don't have family or friends have a right to the support of an Independent Mental Capacity Advocate (IMCA).

While healthcare teams must always work within the patient's best interest, some people may also need someone to ensure that their rights and wishes are protected.

If you have assessed that the patient has capacity and still requires supervision, please refer to guidance on the care of patients under section 5(2) of the mental health act.

Capacity must always be assumed and for those who have it we must respect their wishes even if we think their choices are unwise by our evaluation. Should it appear that a patient requires detention under the Mental Health Act, this matter should be raised immediately with the patient's Consultant or in their absence, his nominated deputy. This would normally happen when it appears to staff that the patient may be suffering from a mental illness and that they are not prepared to stay in hospital long enough to have the issue formally assessed by a Specialist Psychiatrist and Approved Mental Health Professional. If the patient were to leave hospital, there would need to be concerns that this might pose a risk to the patient, to others or to the patient's health. The Consultant or their nominated deputy should attend urgently as soon as possible in order to determine whether or not a Section 5(2) should be implemented.

The term '1:1' should not be confused with other levels of increased supervision

Different patients may require different levels of supervision at different times. It is possible that up to 4 patients can be supervised by 1 member of staff if the patients are visible within the same clinical area. When this has been decided upon as the most effective way of providing safe, high-quality care it should be referred to as 'cohorting'. Wards may be able to provide cohorted supervision within the normal staffing numbers or staff may be required by request. There may also be patients that require 2 staff to maintain the safety of all parties. This is normally in response to concerns that staff may be at risk of harm if alone with the patient. The distance between the staff and patient will require consideration in this and all cases