Trust Policy

Plymouth Hospitals NHS
NHS Trust

Enhanced Observation of Patients Policy

Date	Version
24th February 2016	Version 5

Purpose

To provide a robust framework to ensure a consistent approach across the whole organisation, and supports our statutory duties as set out in the NHS Constitution and the Government's requirement that all inpatients are seen regularly and this can be evidenced

Who should read this document?

All Clinical Staff who have direct contact with patients.

Key messages

This operational policy will support clinical staff in their decision making for ensuring that all patients are assessed using a standard criteria for enhanced observation including;

- Definitions of the types of observations required.
- The standard of practice expected for the observation of patients.
- The process for requesting a worker to provide 1:1 support.
- The risk assessment to determine the type of worker required.

Accountabilities

Production	Beverley Allingham, Deputy Director of Nursing Nicola Phillips Matron for Clinical Standards
Review and approval	Deputy Director of Nursing Heads of Nursing Matron Group NMOC
Ratification	Deputy Director of Nursing
Dissemination	Nursing Quality Team
Compliance	Nursing and Midwifery Operational Committee

Links to other policies and procedures and National Drivers

Infection Prevention & Control Operational Policy. Infection Prevention & Control Operational Policy
Tackling Violence and Aggression Policy. Tackling Violence and Aggression Policy
Restraining Therapies within the Acute Hospital setting for Adults Version 2.1 Feb 2016 Restraining Therapies within the Acute Hospital setting for Adults Version 2.1 Feb 2016
Carers Policy Version 1 June 2012 Carers Policy Version 1 June 2012
Intentional Care Rounding SOP 2014 Intentional Care Rounding
Prevention and Management of Patient Falls in Hospitals (Adults) Version 1 August 2012 Prevention and Management of Patient Falls in Hospitals
Consent to Examination or Treatment Version 8 September 2012 Consent to Examination or Treatment
The Safeguarding Adults at Risk Policy Version 4 July 2015 The Safeguarding Adults at Risk Policy
Safe staffing for nursing in adult inpatient wards in acute hospitals NICE guidelines July 2014
Operational Productivity and Performance in English NHS acute hospitals Feb 2016

Version History

26/10/15	**V1**	Draft to pilot wards	Comments and feedback received

31/11/15	**V2**	Draft to DDON and HON	Comments and feedback received
4/12/15	**V3**	Draft to all Matrons	Comments and feedback reviewed

24/2/16	**V4**	Final version for ratification	Bed watch comments and new process added

Last Approval	Due for Review
February 2016	February 2021

The Trust is committed to creating a fully inclusive and accessible service. By making equality and diversity an integral part of the business, it will enable us to enhance the services we deliver and better meet the needs of patients and staff. We will treat people with dignity and respect, promote equality and diversity and eliminate all forms of discrimination, regardless of (but not limited to) age, disability, gender reassignment, race, religion or belief, sex, sexual orientation, marriage/civil partnership and pregnancy/maternity.

An electronic version of this document is available on Trust Documents. Larger text, Braille and Audio versions can be made available upon request.

1 Introduction

This document sets out Plymouth Hospitals Healthcare NHS Trust's system for providing observation of all patients within adult ward settings. It details the different levels of observation a patient should receive. It provides a robust framework to ensure a consistent approach across the whole organisation, and supports our statutory duties and the Government's requirement that all inpatients are seen regularly and this can be evidenced.

The decision for enhanced observation will be supported by using the Risk Assessment in Appendix A.

2 Purpose, including legal or regulatory background

The purpose of this document is to describe the Trust's expected practice related to the observing of patients in the inpatient setting.

Implementation of this policy will ensure that:

- All staff are aware of the different levels of patient observation and how to apply these.
- All staff are aware of the process in which they need to follow to perform a satisfactory risk assessment
- Staff maintain an environment which is safe and reassuring for patients by providing heightened levels of observation for all vulnerable patients who require these

If the patient is suffering from a known infection/infectious condition, Trust policy should be followed for the patient's care. See Infection Prevention & Control Operational Policy.

3 Definitions

3.1 General observation

General observation within the ward environment requires clinical staff to be aware of the whereabouts and condition of all patients, at all times.

3.2 Enhanced observation

Some patients will require enhanced observation if they do not have the capacity to decide on risk or if they are under physiological or psychological risk. There are two types of enhanced observation – intermittent supportive observation and continuous supportive observation.

3.3 Intermittent Supportive observation

This level of observation is appropriate when patients are potentially but not immediately at risk of seriously harming themselves or others, or need specific regular therapeutic/clinical interventions. Intermittent supportive observation must be carried out even when the patient is asleep in bed.

3.4 Continuous Supportive Observations

Continuous observation is required when the patient requires continued regular therapeutic/clinical intervention or if the patient is likely to seriously harm themselves or others. This would include injuring themselves (e.g. falling and sustaining broken hip or sustaining a head injury), absconding from the ward and/or suffering high levels of distress and anxiety that are not alleviated without the physical, ongoing presence of a health care worker/relative/friend etc.

4 Duties

Responsibilities

4.1 Role of the Director of Nursing

The Director of Nursing is responsible for;

- The overall safe and supportive care of patients in this Trust

4.2 Role of the Deputy Director of Nursing

The Deputy Director of Nursing is responsible for;

- The delivery of this policy and have delegated duties for the safety and supportive care of patients from the Director of Nursing

4.3 Role of the Heads of Nursing

The Heads of Nursing are responsible for;

- Acting as a lead in the implementation of the policy across the Trust
- Ensure the Matrons are acting in accordance with the policy
- Review the risk assessments presented at the staffing meetings
- Give authorisation to book an Agency worker if the risk assessment request is supported

4.4 Role of the Matron

The Matron is responsible for;

- Acting as a lead in the implantation of this policy in their areas of responsibility
- Ensuring all staff have the requisite skills and behaviours to undertake this
- Ensuring when additional staffing is required as a result of the risk assessment, this request is supported.

4.5 Role of the Ward Manager (Nurse in Charge out of hours)

The Ward Manager is responsible for;

- Reviewing the daily clinical condition and need for the patient to remain on enhanced observation
- Ensuring staff carry out the risk assessments and they are acted on and escalated as necessary
- Supervising the implementation at ward level
- Monitoring compliance with the process
- Ensuring risk assessments and care plans are up to date
- Coordinating the multidisciplinary team assessment which will decide the level of observation required

4.6 Role of carers and relatives

As part of their role, carers and relatives play an important role in the process of information gathering and assessment. They should be kept informed of changes in observations and be offered explanations about the observation level and the reasons for that level.

Caring for someone who needs enhanced observation is not a process to which only professionals can contribute. Carers with an awareness of the patients risks can, at times help and may, on occasions, are more appropriate than the professional. The risk assessment process and subsequent

multi-disciplinary team discussion must include decision making; agreement should be reached on the appropriate level of observation and who can offer the greatest level of support to the patient.

5 Key Elements

Assessment of the patient and identification of the level of observation required

The level of observation risk assessment (Appendix A) should be completed for all patients where there is a concern about their safety. If a patient's behaviour is at risk of becoming very challenging, please refer to the Trust's Managing Violence and Aggression Policy.

The risk assessment will enable the clinician ti make a considered clinical judgement on the patient's level of risk. The Nurse in Charge will coordinate this assessment.

The decision regarding the level of observation required must be documented in the clinical notes, together with a record of who was involved in the decision making process.

Each patient considered for enhanced observation is assessed on an individual basis. This assessment ensures that issues related to race, gender, disability, age, culture, religion, beliefs and sexual orientation are considered and if relevant incorporated into the development and implementation of the patients care.

5.1 General observation

General supportive observation and overview of care is the minimum acceptable level of observation for all patients. The location of all patients should be known to staff, but not all patients need to be kept within sight. The patient's allocated nurses or team member will communicate or view all patients at hourly intervals to check the patient is comfortable and safe. By documenting in the patients' care plan evaluation, a nurse is confirming that these checks have been undertaken.

The care for those patients who are assessed as a high risk of suffering a harm event will be recorded on the Intentional Care Record (ICR).

If the patient is sleeping, contact would take the form of "seeing instead of speaking to" the patient and a professional judgement is made about how intrusive the nurses overview and assessment should be by the registered nurse responsible for the care.

At the beginning and end of every nursing shift the whereabouts and condition of all patients will form part of the handover.

5.2 Enhanced observation

Some patients will require enhanced observation if they do not have the capacity to keep themselves safe or if they are at physiological or psychological risk. There are two types of enhanced observation – intermittent supportive observation and continuous supportive observation.

Action to be taken prior to beginning enhanced observation/s;

5.2.1 Consent

Assessment must always place the person at the centre of the process, involving them and those who are important to them in their lives. If agreement or consent can be gained without undue pressure from the person, then enhanced observation can be put in place. It must be remembered that the person has the right to withdraw their agreement or consent and they should be informed of this at the start.

If the person withdraws their consent but it is felt that enhanced observation should continue, law will supersede the withdrawal of consent if they are a danger to themselves or others. This can only be achieved if the practice is sanctioned under the Mental Health Act or the

Mental Capacity Act. Documentation is essential to evidence the decision making trail and process.

If the person cannot consent to the enhanced observation due to a lack of capacity, this must be evidenced with the completion of a mental capacity assessment. If it is felt that the enhanced observation is in the person's best interests then this should also be clearly evidenced and documented on the reverse of the mental capacity assessment form.

If high levels of observation are being used e.g. continuous observation and the patient has been assessed as lacking mental capacity in regards to their care and/or treatment, consideration should be given as to whether the restrictions in place amount to a deprivation of liberty. The Deprivation of Liberty Safeguards Risk Assessment Tool should be completed and a subsequent DoLS application made if a possible DoLS is identified.

For further guidance see the Trust's Mental Capacity Policy (Mental Capacity – Deprivation of Liberty Safeguards Policy) and the Consent Policy.

5.2.2 Environment

The environment should be risk assessed for the patient. Consideration should be given to where the patient is located on the ward e.g. a patient at high risk of falls should be in a bed where they can be closely observed. The availability of exits or objects which can be thrown or provide a hazard should be taken into account in this assessment.

5.2.3 Specialist Input

Assistance should be sought from specialist medical teams and specialist nurses as appropriate e.g. Liaison Psychiatry Team or Learning Disability.

5.3. **Intermittent supportive observation**

This level of observation is appropriate when patients are potentially but not immediately at risk of seriously harming themselves or others, or need specific regular therapeutic/clinical interventions. Intermittent supportive observation must be carried out even when the patient is asleep in bed.

All adult patients must be commenced on ICR and have a specific care plan that clearly indicates;

- The intervals at which observations should be carried out
- The nature of the therapeutic activity planned
- The frequency of intentional/comfort rounding
- A record of the discussions with the patient about the supervision being undertaken to reduce any assessed risks
- A record of any untoward incidents

Documentation of the patient's care must be completed in the relevant risk assessment care plans and evaluation sheets.

5.4 **Continuous supportive observation**

Continuous observation is required when the patient requires continued regular therapeutic/clinical intervention or if the patient is likely to seriously harm themselves or others. This would include injuring themselves (e.g. falling and sustaining broken hip or sustaining a head injury), absconding from the ward and/or suffering high levels of distress and anxiety that are not alleviated without the physical, ongoing presence of a health care worker/relative/friend etc.

The patient will be kept within sight at all times, by day and by night. The team at the time will assess the proximity that staff need to be in to keep the patient safe. At no point, should the patient be left unobserved, this includes whilst using the toilet or taking a shower. It may be

necessary to use a “tag” system. This system is when another clinical staff member enters the bay if the allocated nurse is assisting with personal care behind the curtains or needs to leave the bay. This system ensures that the patient is not left unattended.

All patients on continuous supportive observation will have a specific care plan on their ICR that clearly indicates;

- That the patient is on continuous supportive observation
- The nature of the therapeutic activity planned
- A record of the discussions with the patient about the supervision being undertaken to reduce any assessed risks
- A record of any untoward incidents
- Documentation of the patient’s care must be completed in the relevant care plans and evaluation sheets.

Action to be taken prior to beginning Intermittent & Continuous Supportive Observation

Actions to be taken by the nurse in charge:

- Intermittent Supportive Observation and Continuous Supportive Observation
- Inform Ward Manager / Matron
- Inform patient’s consultant, include specialist medical teams (e.g. Liaison Psychiatry Team) if involved and GP’s when in community hospitals. Inform security if at high risk of absconding or aggression.
- Inform patient and family/carers (ensure informed consent).
- Inform relevant specialist Nurses e.g. Mental Health, Learning Disability.
- Ensure all staff are aware of the risk (include in handover/safety briefings).
- Ensure relevant risk assessments are completed and care plans in place e.g. falls and confusion.
- Ensure patient is commenced on intentional/comfort rounding in relation to assessment of risk.
- Ensure dignified care not compromised as this is undertaken

The staff member responsible for carrying out the enhanced observation will normally:

- Be a first level registered nurse or a health care assistant or a final year student nurse who is deemed to be competent by the nurse in charge
- Know the patient, their history, background and risk factors (avoid allocating temporary/agency staff who do not know the patient)
- Be familiar with the ward, the ward policy for emergency procedures and the potential risks within the environment
- Should take an active role in positive engagement with the patient.
- Should be approachable, listen to the patient, know when self-disclosure and the therapeutic use of silence are appropriate and be able to convey to the patient that they are valued

5.4.1 Delegation to Unregistered Staff

The first level Registered Nurse remains accountable for the decision to delegate observation to a Health Care Assistant or student in training and for ensuring that they are sufficiently knowledgeable and competent to undertake the role.

5.4.2 Consideration of individuals who will be providing continuous observation

Although it is important to ensure that staff responsible for carrying out the enhanced observation know the patient, it is best practice is for the nurse in charge to make sure that a rota of different staff are allocated to undertake close observations. This ensures the continued alertness of the whole team over the period of a shift.

It is not recommended that one member of staff carry out the enhanced observation for the whole shift. Cover should be organised for staff breaks as appropriate. The member of staff must use the observation period to talk to the patient and build a therapeutic relationship.

5.4.3 Documentation

The decision regarding the level of observation required must be documented in the clinical (medical) notes, together with a note of who was involved in the decision making process.

There are care plans for dementia, learning disability, patients with a history of wandering and short term memory problems. If required a universal care plan can be used to make an individualised care plan. Comfort rounding must be commenced for all patients on enhanced observation. The additional care plans should be completed as appropriate.

The 'getting to know you' should be used for people with dementia. It provides a 'snapshot' of the person, giving information about them as an individual such as needs, preferences, likes, dislikes and interests.

For patients with a learning disability, there is a Hospital Passport which provides essential information about the individual's specific needs and preferences.

5.5 Bed Watch

If the risk assessment demonstrates a high risk of aggression and Bed watch is required please follow the process in Appendix B. The staff designated to provide Bed watch services can be recognised with the standard uniform of polo shirt and black trousers with the company logo. ID will be worn but will not be visible – so not to cause offence or upset to other patients or carers.

These staff members are not to work in a clinical capacity and as such will not provide any clinical care to patients. They may assist the patient to walk to the bathroom but will need to be escorted by a member of trust clinical staff. However in the event of an emergency situation they will provide/offer any support.

The Bed watch staff are there to provide 1:1 care and therefore cannot provide care to more than 1 patient, however this can be negotiated one a patient by patient basis. In an emergency they will provide help and support with a violent or aggressive patient.

It is important that bed watch staff are offered breaks during their shifts and the Trust Security staff are happy to be called to arrange a convenient time to cover. All Bed Watch staff have access to a hand held radio to use in an emergency to contact the Trust security team.

5.6 Paediatrics

- Staff caring for and observing children must have enhanced DBS clearance.
- There must be a specific enhanced observation care plan, with multi-disciplinary input (where appropriate) and consulting with the child's parents/carers.(please note, that in some instances, parental responsibility may be shared between parents and other agencies such as social services).
- Any child requiring enhanced observations will be identified via the care plan process and the Paediatric Early Warning Signs monitoring tool (PEWS). This will be continually reviewed at each subsequent observation.
- Any child requiring enhanced observations will ideally be situated in a bed space that facilitates optimum visual observations and enhanced clinical observations i.e. the High Dependency Unit
- For any child requiring enhanced observations, nursing and medical assessment will be made to review the additional need for an extra specialist 1 to1 nurse to provide this care.
- For all children requiring enhanced observations or specialist paediatric care, nursing staff will encourage parents NOT to draw the curtains around the bed space other than is absolutely essential for privacy, thus maximising visual observation by nursing and medical staff.
- All in-patient children on the paediatric ward can have their medical/vital signs observations electronically and centrally monitored as appropriate.

- All parents and carers will continue to be actively involved in all consensual issues, care planning and care provision.

5.7 **Reviewing Enhanced Observation**

Patient will be reviewed on a shift by shift basis regarding the need for enhanced observation and at end of each week that the patient is under enhanced observation. The nurse in charge is to ensure an accurate handover is given and received to/from person providing enhanced observation. The staff member must understand the importance and what is required.

The patient's condition must be reviewed formally at every shift, to note any change in behaviour which could lead to a reduction in the level, or discontinuation, of enhanced observation. The review must be carried out by the Nurse in Charge and representative of the medical team as appropriate, with the result recorded in the clinical (medical) notes and in the nursing notes.

Any specialist medical teams (e.g. Liaison Psychiatry Team) involved, if any, will need to be consulted before any change in the level of observation is implemented

The decision to discontinue enhanced observation, and who has contributed to making that decision, needs to be recorded in the patient's notes.

5.8 **Escalation Process where no extra support is provided**

Please refer to Appendix C: the escalation process to be started when extra support is required but none is available.

Office Hours (09:00 – 17:00, Monday to Friday)

Nurse in charge will alert the Ward Manager / Matron to discuss the availability of internal staff.

The Ward Manager / Matron will consider:

- Moving staff internally or across service lines
- Reprioritising so that one nurse provides enhanced observation and the rest of the team look after the remainder of patients.
- Considering temporary staffing.
- Agency should be considered as a last resort when all other options have been explored.

Escalation if required should be to the Head of Nursing, who will decide whether the risk is sufficient to merit further action. If further action is deemed necessary they will decide what action to take and will implement the plan.

5.9 Out of Office Hours

Outside office hours, the escalation process is the same as above, except that the nurse in charge will alert the Senior Nurse, bleep 0355

6 Overall Responsibility for the Document

Nursing and Midwifery Operational Committee (NMOC)

7 Consultation and Ratification

The design and process of review and revision of this policy will comply with The Development and Management of Trust Wide Documents.

The review period for this document is set as default of five years from the date it was last ratified, or earlier if developments within or external to the Trust indicate the need for a significant revision to the procedures described.

This document will be approved by the NMOC and ratified by the Deputy Director of Nursing.

Non-significant amendments to this document may be made, under delegated authority from the Deputy Director of Nursing by the nominated author. These must be ratified by the Deputy Director of Nursing and should be reported, retrospectively, to the approving NMOC committee.

Significant reviews and revisions to this document will include a consultation with named groups, or grades across the Trust. For non-significant amendments, informal consultation will be restricted to named groups, or grades who are directly affected by the proposed changes

8 Dissemination and Implementation

Following approval and ratification, this policy will be published in the Trust's formal documents library and all staff will be notified through the Trust's normal notification process, currently the 'Vital Signs' electronic newsletter.

Document control arrangements will be in accordance with The Development and Management of Trust Wide Documents.

9 Monitoring Compliance and Effectiveness

Compliance with this policy is monitored on a daily basis as part of the Safer Staffing Agenda for Matrons and Senior Nurses.

Significant reviews to this policy will be discussed with all Matrons and Senior Nurses and ratified in accordance with Trust Policy.

This document will be reviewed and monitored through staffing reports at the Nursing and Midwifery Operational Council.

10 References and Associated Documentation

Appendix A Risk Assessment for Level of Observation

Level of Enhanced Observation- Risk Assessment & Decision Algorithm for Acute Adult Inpatient Areas- Version 5			
Section A: IMMEDIATE ACTIONS TO ASSESS AND REDUCE RISK- Please tick YES or NO			
Immediate Actions	**YES**	**NO**	**Subsequent Actions:**
Recent medical/medication review			If NO- request review within 6 hours
Relevant history obtained-carers or NOK/this is me/passport			If no provide "Getting to know you" document and involve patient/family/carers in completion/if not applicable=NA
Referral to the MDT? Is there a clear MDT management plan including risk assessment?			If NO-make referrals and use the behaviour chart &/or night time functional chart to develop plan
Is there a current alcohol misuse problem?			If YES- refer to Alcohol Liaison Practitioner via Salus or bleep 89174) Complete CIWA pathway. (Restraining Therapies within the Acute Hospital setting for Adult Patients Policy - Appendix D)
Have environmental concerns been considered?			If No- reduce environmental stimuli- noise etc./move to more observable position
Have environmental concerns been addressed?			If Yes- document any improvements
Has the falls trigger assessment been completed?			If NO-complete and consider referral to falls team, ultralow bed/sensor alarm, completed falls assessment and refer to falls team
Is a Mental Health Act assessment pending or is the patient detained under the Mental Health Act?			If YES- refer to Psychiatric liaison nurse (PLNs) or Psychiatric SHO or On-call Manager, to determine when MHA assessment is planned to take place. Ensure assessment time is documented.
Does the patient have mental capacity?			If NO-complete Mental Capacity Act assessment
Has Mental Capacity been clearly documented – consider using Record of Capacity and Best Interest (MCA 2005) document.			If Yes-ensure the restraining therapies is in place. Continue to review care plan regularly: review level of restraint and intensity and consider Deprivation of Liberty Safeguards (DoLS) application – refer to DoLS pathway. Consider daily; mental capacity, restraint and need for DoLS application. Safeguarding Adults team can advise.
Has intentional rounding been commenced?			If NO- complete and prescribe an *individual plan* for intentional rounding
Can the patient's care be safely maintained within the usual staffing levels?			If NO – proceed to section B and follow algorithm and clinical judgment to inform your request for a special

Section B: Risk reason and Enhanced Observation recommendation algorithm.			
No.	**Risk/Reason**	**Tick**	**Recommended level of Enhanced Observation: professional/clinical judgement must be used**
	ALL PATIENTS		
1 Low Risk	Can slip/fall from bed Reduced mobility or bedbound and attempting to mobilise Calling out & disturbing other patients Risk of pulling out any indwelling devices. Already detained under the Mental Health Act to another hospital and attending on S17 Leave. Behaviour not causing significant concern. A Deprivation of Liberty Safeguards application has been submitted: behaviour not causing significant concern (patient must be on restraint therapy care plan)		**Manage with current ward establishment** • Consider Memory box/twiddle muff • Consider 1 hourly intentional rounding • Ensure patient has had relevant nursing risk assessments • Use strategies to minimise risk • Use of sensor alarms • Cohort patients where possible/safe • Consider family support when appropriate • Continue to risk assess – consider restraints therapy care plan and need for Deprivation of Liberty Safeguards (DoLS).
2	Confused and wandering Risk of pulling out any indwelling devices		**Use current ward establishment/ may need additional support**

Med Risk	Agitation/Anxiety Impaired cognition/reduced insight Newly detained under the Mental Health Act or already detained and behaviour causing significant concern A Deprivation of Liberty Safeguards application has been submitted: behaviour causing significant concern.		• Consider family support where appropriate • Ensure patient has had relevant nursing risk assessments falls, cot sides assessment and care plan in line with the restraining therapy policy/cohort where possible • Use strategies to minimise risk (bay nursing, reduced noise and light) • Continue to risk assess – consider restraints therapy care plan and need for Deprivation of Liberty Safeguards (DoLS) • Consider booking Registered Mental Nurse (RN03) or Care Support Worker (CSW03) with mental health experience.
3 High Risk	Confused & wandering presenting risks to self and others (patients/staff)		**1:1 HCA or RN**
	Violent behaviour & aggression to others and self, volatile or unpredictable aggression. Immediate risk to self/harm to others. Substantial & immediate risk of absconding to undertake deliberate self harm/harm others		**1:1 Bed watch or if not available Security**. Follow Restraining Therapies Policy: if level of restraint is intensified over a prolonged period during the 72 hour period or restraint is still required after 72 hours and patient is not likely to regain capacity consider a Deprivation of Liberty Safeguards (DoLs) application – Follow the DoLS pathway. Security to be informed of stepped change. If risk of absconding security will special but only where a valid 'lawful authority' to restrain exists (i.e. MHA, DoLS, Court of Protection).
	Expressing intent or recently attempted deliberate self-harm/suicidal ideation		**1:1 HCA**
	Detained under Mental Health Act, expressing deliberate self-harm intent		**1:1 Mental Health experienced HCA or RNM** dependant on patient need. Contact Duty Senior Nurse on Bp 0355 to book, using RN 03 or CSW 03 If not available RN with Bed watch support if patient violent or aggressive

Ward Nurse to review individual patient needs.		*Circle*		*Sign + Print na*
Date	After completing the risk assessment overleaf do you feel in your professional judgement enhanced observation is still required?	Yes	No	
	Are other patients within the clinical area receiving enhanced observation? If YES- consider cohorting patients to enable closer supervision \and interaction. Patients under Bed watch must remain on 1:1	Yes	No	

Shift	Can the patient's care be safely maintained within the usual staffing levels (circle)	If no indicate risk reason (1-3)	Sign + Print name
DAY	YES / NO		
NIGHT	YES / NO		

Matron or Duty Senior Nurse on Bp 0355 to authorise the booking of a special	
Identify what risk reason (1-3)	
If risk level 1-2 in your clinical judgement is an additional special require. Please state reason why you are authorising:	
Recommendation (use Algorithm as stated on the form)	
Authorised by: Print: Date & Time	Sign:

RE-ASSESSMENT of RISK (each shift handover or if patients condition changes). Ward manager to document they have reassessed every 48hrs				
Date	Time	Can the patient's care now be safely maintained within the usual staffing level?	If No indicate Risk Reason 1-3	Print & Sign

Appendix B

Bed Watch Request Form

This request form should only be used after an Enhanced Observation Risk Assessment has been undertaken. This can be found in the Enhanced Observation Policy – see Appendix *

Request received	**Date:** **Time :**
Location	**Ward:** **Bedspace**
Name of Nurse that completed Enhanced Observation Risk Assessment	
Position/Grade	
Bed Watch needed from	**Date:** **Time :**
Anticipated End Date (to be reviewed by DSN every 48 hours)	**Date:**

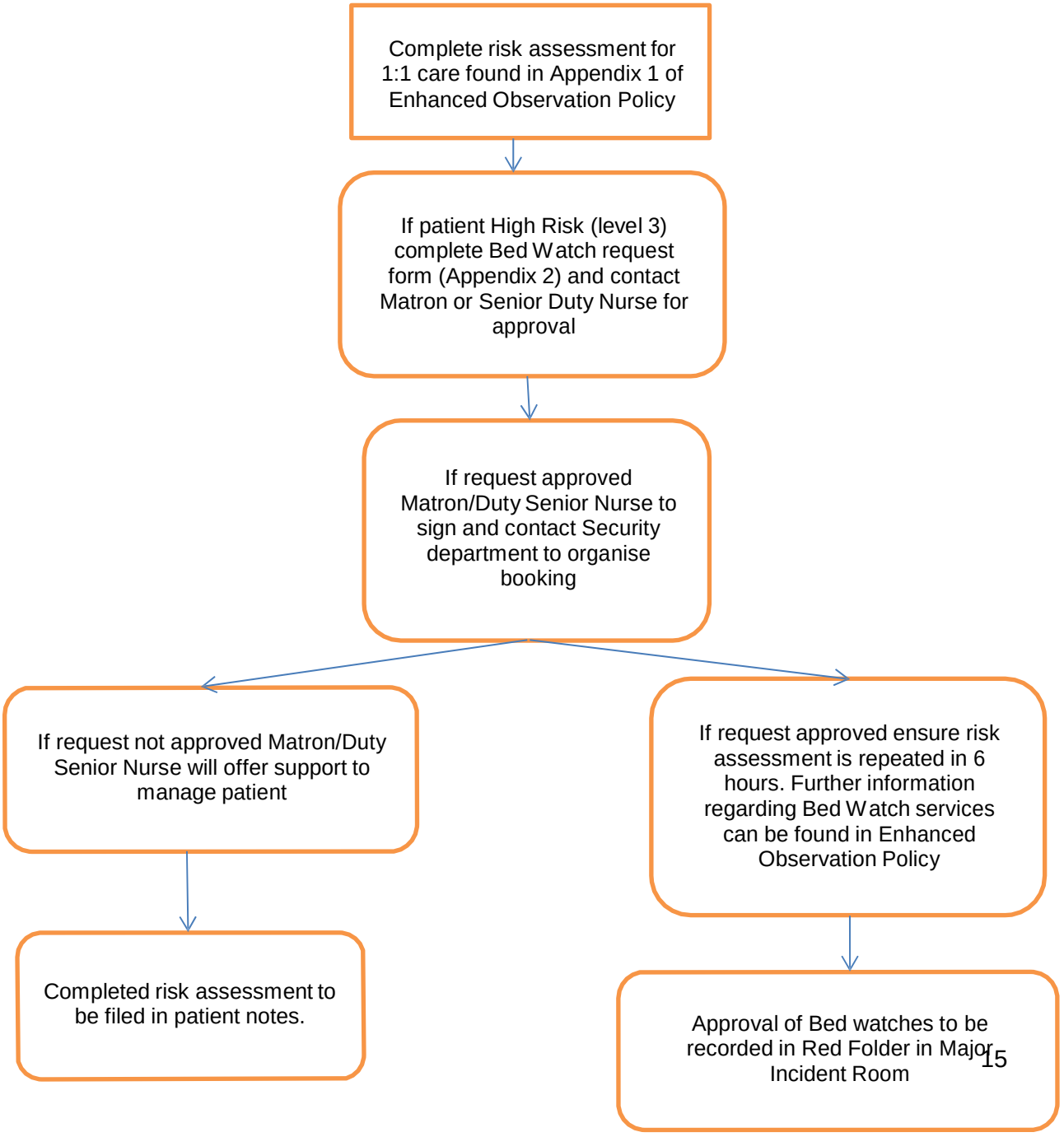
Does the Enhanced Observation Risk Assessment meet the Bed Watch criteria?	❑ **violent/aggressive/volatile/unpredictable** ❑ **substantial risk of absconding, to undertaken deliberate self harm/harm others**
No – alternatives more appropriate: **Detail why Bed Watch not appropriate** **Explain to Nurse in Charge of Ward why Bed Watch not appropriate**	**Yes - authorised:** **Contact Security to book Crown Bed Watch** **Up-date Salus with Bed Watch attribute**

Authorised by (name)	
Position	**Duty Senior Nurse (Bp0355)**

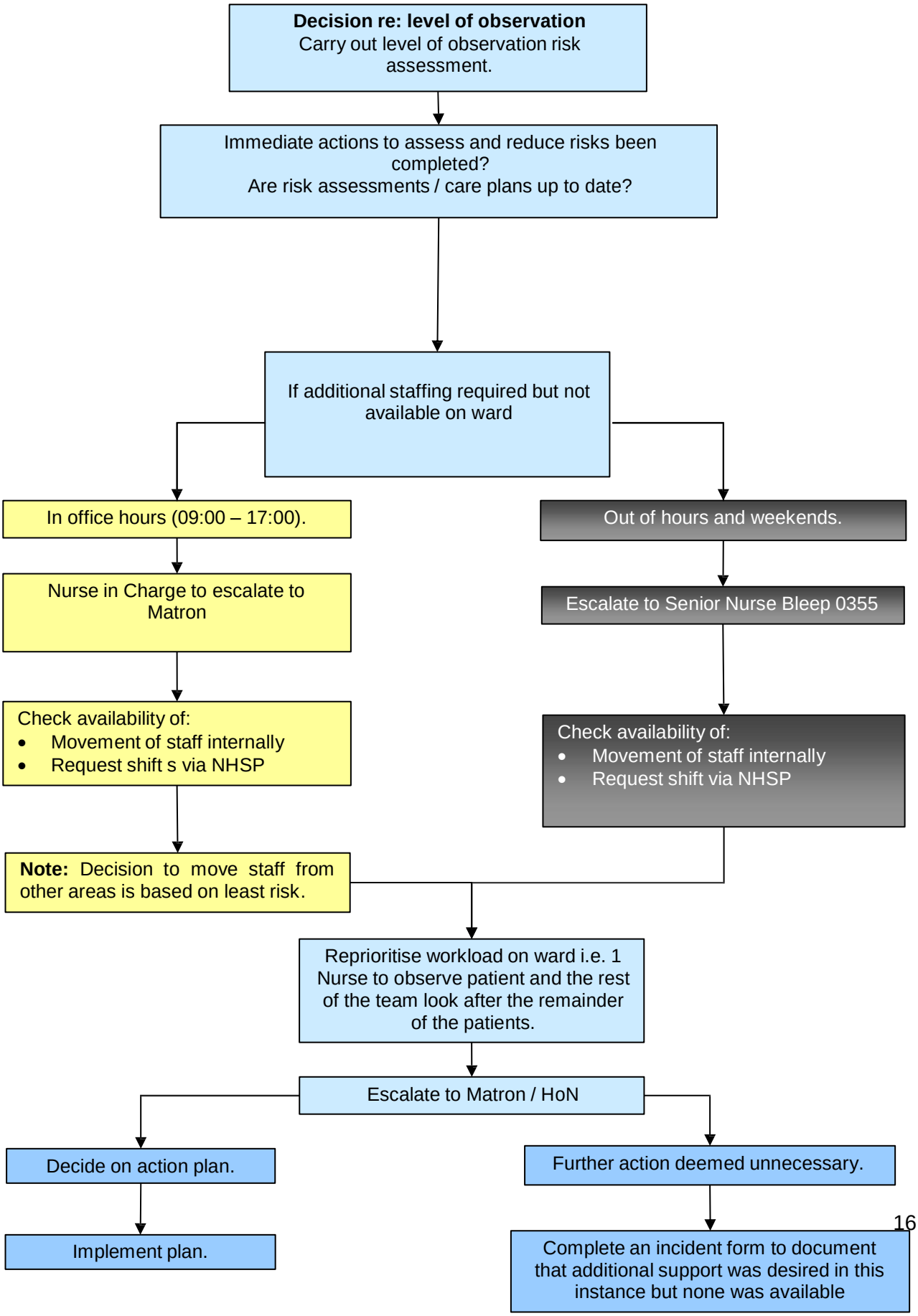
- Bed Watch should be requested by the Nurse in Charge of the ward and can only be authorised by the Heads of Nursing/Duty Senior Nurse (Bp 0355), following receipt and review of an Enhanced Observation Risk Assessment, that meets the criteria for Bed Watch to be authorised.
- If approved, ward staff are to be reminded:
  - Bed Watch staff are non-clinical personnel and will not undertake any clinical duties, this includes feeding or assisting with personal care
  - Bed Watch staff are unable to provide care for more than patient at a time, even if that patient is asleep
  - Ward staff must ensure that Bed Watch staff are given enough information to enable them to support the patient and to stay safe.

This Bed Watch should be attached to the Enhanced Observation Risk Assessment and filed in the Enhanced Observation folder held in the Major Incident Control Centre for audit and governance purposes.

Process for Requesting "Bed watch"



Appendix C Process for escalation when additional staff are required but not available



Appendix D: Guidance for those presenting with confusion and/or behaviours which challenge

Here are some prompts which you could think about when behaviour and confusion is heightened as well as a baseline assessment backdrop as to why someone may be confused.

Intrinsic (influences from within the patient)

What's the issue	Helpful intervention	Hints and Tips	Desired Outcome for patient
Homeostasis (the point at which the cells can cope with change) is less in older age.	Base line observations A good chemical and blood profile , to establish the norm for them	Tolerance rates for some results in older people will be different I.e. CRP in younger adult greater than 5-6 concerning in older adult with renal failure 20 may be ok	Keep them within their norm and functioning parameters
Infections? sub clinical without high temp or more obvious	Identify through blood profile and other diagnostics Blood cultures	Older people may have a normally lower temp on day to day basis, therefore any raise in temp worth noting	Treat infections in a timely manner an d prevent whole system failure and septicaemia
Electrolyte imbalance? and Biochemical balance i.e. endocrine system i.e. Calcium levels	Identify through blood profile and other diagnostics Blood pressure monitoring	Think about Renal failure leading to electrolyte imbalance Think about fluid levels input and output charts needed Or and Daily weighs Low BP may indicate dehydration	Hydration and electrolyte level optimisation for this person
Any Neurological symptoms? Head aches or unexplained pain	CT scan Neuro obs including a good look in the eyes	Think about any recent head injury or unseen fall?	Early diagnosis and treatment of any neurological conditions Including undiagnosed tumours or lesions
Visual disturbance	Ensure they have their glasses, if they wear them A recent eye test may be helpful. Consider a well lit room or are they light sensitive	Think about macular degeneration (wet is progressive , but can often be treated) Seeing little people at the edges of the room is a visual condition? Name, not necessarily a delusion.	Referral to ophthalmic specialists or opticians as required
Constipation or alerted bowel habit	Establish the norm for this person Are they within their norm Send samples as need be Correct constipation Check diet for enough roughage and fluids	Bristol stool chart use good for a standardised approach to describing the bowel actions Consider self administration of laxatives at home they may no longer have Ensure feet on floor when evacuating bowel	Establish a regular bowel habit
Unexplained Anaemia	Blood count Stool and urine specimens	Consider are they pale or symptomatic in any other way , breathless, tired	Correct Anaemia and establish cause

What's the issue	Helpful intervention	Hints and Tips	Desired Outcome for patient
Blood sugar status	Blood glucose monitoring (random)	Consider the times confusion arises in relation to mealtimes. Confusion at night? When do they have food, was 6pm their last meal? how does this differ from their pattern at home	Blood sugars in good range Meals aligned to keep this stable Including late night snack as required
Chronic respiratory disease leading to intermittent hypoxic states	O2 saturation measurements Give prescribed O2 to see if it makes a positive difference Record their respiratory rate	Consider their breathing at times of acute exacerbation of confusion Open windows at times to relax breathing Use a profiling bed and optimise position for good chest expansion Ensure physio assessment and care plan.	Cognitive function not impaired by reduced respiratory function.

Extrinsic (influences from outside the patient)

What's the issue	Helpful intervention	Hints and Tips	Desired Outcome for patient
Polypharmacy	Review of medication by medicines reconciliation Pharmacy and medical review of current meds If possible check with patient if they do take what is prescribed , when at home	Consider previous prescription are they taking over and above what they take at home Once a patient is taking more than four medications the side effects and interactions between them may outweigh the anticipated benefits The aging liver and kidneys are unable to metabolise dugs as effectively as a younger person, therefore half lives etc are affected. This can lead to a build up of toxins which the body cannot excrete quickly The impact of alcohol and recreational drugs can be the same, all can lead to delirium.	Prescribing and what is taken matches need and does not affect patient adversely
Hydration, with more pharmacy more hydration is usually required, same applies for a high temp.	Encourage regular fluids Fluid chart for at least first 24 -48 hrs until this issue is resolved.	Ensure you know what the patient likes	Patient well hydrated
Environment	Place in the place on the ward with the least stimulation and noise	Consider behind the nurses station can be an active and busy place	Patient feels safe and secure in their new surroundings

What's the issue	Helpful intervention	Hints and Tips	Desired Outcome for patient
	Try to see through their eyes. Adjust Lighting Reduce Noise Assess for their understanding of person, place and time. Have visual prompts in prominent places, clock , calendars and newspapers for example Encourage visitors who can help person understand where they are	Consider, what you may see as an easy to clean shower surface may be a reflective surface in which they think they can see people looking at them. Has the patient been moved recently have they had 48 hrs to settle in? Reinforce through conversation who you are, where they are and what time it is. Photos and personal objects in the bed space can help	
Sensory challenges	Can the person see Hear Express themselves	Consider , do they have their glasses (please see above) Consider , do they have their hearing aid Consider the pace at which information is given and the time taken to listen Do they have capacity to make decisions Consider is this a Deprivation of Liberty (DoLS) issue have they had a mental capacity act assessment (MCA)	Person is as fully engaged with their outside world as they can be Communication has been made as accessible as possible
Pain	Pain score and assessment Analgesia offered regularly and before pain felt	Consider , the person may not say they have pain , may massage an area, or appear restless or grimace or be rude about intervention	Pain free or well controlled
Skills level of staff involved	Have all staff with a baseline understanding of all aspects of this assessment Use the This is Me assessment If specialing, do this from an appropriate distance Feel free to use creative solutions	Staff can be afraid of people with behaviours which challenge and should be encouraged to keep seeing the person behind the behaviour and not to serotype or assume. Sometimes a watchful eye is more comfortable and as effective then crowding someone's personal space People when confused can benefit from creative solutions , like Writing your notes whilst	Patient receives person centred , dignified care Person has occupation and the level of tolerance with others in the environment increases of their confusion.

What's the issue	Helpful intervention	Hints and Tips	Desired Outcome for patient
		sitting with them Letting them be close the to the nurses' station Giving them occupation, for example, sorting , line or papers Walking round with the teas trolley taking orders for drinks etc	
Misinterpretation of patients actions and body language	Stop and think what is going on around the person?	Consider are they waving their stick, aggressively or trying to point at something, e.g. as an extension of their arm. Are they pushing past you because they feel hemmed in and frightened, not knowing where they are? Or to be aggressive? (remember flight or fight adrenaline response)	Understand their reactions And respond to them accordingly
Patient choices Are they making choices which are being labelled as non compliance	Explain all procedures fully Respect peoples right to make choices we may not agree with	Consider people can make informed but unwise decisions. Give people time to think about the decision, often people can feel rushed. Think about respectful partnerships as the bedrock of all therapeutic interventions	Care is always developed in a consensual way and in partnership Or A best interest assessment informs all actions the patient doesn't have capacity to consent to.

Appendix E

Guidance terminology for requesting enhanced observation (1:1 enhanced observation)

Patients undergoing detoxing treatment displaying specific behaviours	Requires 1:1 enhanced observation
Patient with anorexia displaying specific behaviours	Requires a Mental Health 1:1 Special
Patient with psychosis following cardiopulmonary bypass displaying specific behaviours	Requires 1:1 enhanced observation
Patient being cared for under a DoLs	Does not automatically require 1:1 enhanced observation. A risk assessment must be completed.
Patients with Dementia	Does not automatically require 1:1 enhanced observation. A risk assessment must be completed.

Dissemination Plan	Appendix 1

Core Information	
Document Title	Enhanced Observation Policy
Date Finalised	March 2016
Dissemination Lead	Nicola Phillips Matron for Clinical Standards
Previous Documents	
Previous document in use?	No
Action to retrieve old copies.	NA

Dissemination Plan

Recipient(s)	When	How	Responsibility	Progress update
All staff		Email	Document Control	

Review		
Title	Is the title clear and unambiguous?	Y
	Is it clear whether the document is a policy, procedure, protocol, framework, APN or SOP?	Y
	Does the style & format comply?	Y
Rationale	Are reasons for development of the document stated?	Y
Development Process	Is the method described in brief?	Y
	Are people involved in the development identified?	Y
	Has a reasonable attempt has been made to ensure relevant expertise has been used?	Y
	Is there evidence of consultation with stakeholders and users?	Y
Content	Is the objective of the document clear?	Y
	Is the target population clear and unambiguous?	Y
	Are the intended outcomes described?	Y
	Are the statements clear and unambiguous?	Y
Evidence Base	Is the type of evidence to support the document identified explicitly?	Y
	Are key references cited and in full?	Y
	Are supporting documents referenced?	Y
Approval	Does the document identify which committee/group will review it?	Y
	If appropriate have the joint Human Resources/staff side committee (or equivalent) approved the document?	Y
	Does the document identify which Executive Director will ratify it?	Y
Dissemination & Implementation	Is there an outline/plan to identify how this will be done?	Y
	Does the plan include the necessary training/support to ensure compliance?	Y
Document Control	Does the document identify where it will be held?	Y
	Have archiving arrangements for superseded documents been addressed?	Y
Monitoring Compliance & Effectiveness	Are there measurable standards or KPIs to support the monitoring of compliance with and effectiveness of the document?	Y
	Is there a plan to review or audit compliance with the document?	Y
Review Date	Is the review date identified?	Y
	Is the frequency of review identified? If so is it acceptable?	Y
Overall Responsibility	Is it clear who will be responsible for co-ordinating the dissemination, implementation and review of the document?	Y

Core Information	
Manager	Nicola PHILLIPS Nicola, Matron for Clinical Standards
Directorate	Nursing Quality
Date	24th February 2016
Title	Enhanced Observation Policy
What are the aims, objectives & projected outcomes?	The aim of the policy is to ensure that all staff are aware of the different levels of patient observation and how they should be applied consistently. All staff will be aware of the process in which they need to follow to undertake a satisfactory risk assessment. Staff will maintain an environment which is safe and reassuring for patients by providing heightened levels of observation for all vulnerable patients who require enhanced observation.

Scope of the assessment

Collecting data	
Race	There is no evidence to suggest that there is a disproportionate impact on race.
Religion	There is no evidence to suggest that there is a disproportionate impact on religion.
Disability	There is no evidence to suggest that there is a disproportionate impact on disability
Sex	There is no evidence to suggest that there is a disproportionate impact on sex.
Gender Identity	There is no evidence to suggest that there is a disproportionate impact on gender identity.
Sexual Orientation	There is no evidence to suggest that there is a disproportionate impact on sexual orientation.
Age	There is no evidence to suggest that there is a disproportionate impact on age.
Socio-Economic	There is currently no data collected on this area.
Human Rights	There is no evidence to suggest that there is a disproportionate impact on human rights.
What are the overall trends/patterns in the above data?	There has been no comparative data used to date which means that there are no patterns or trends to date.
Specific issues and data gaps that may need to be addressed through consultation or further research	

Involving and consulting stakeholders

Internal involvement and consultation	Deputy Director of Nursing Matrons and Ward Managers - Pilot Groups Matrons Nursing and Midwifery Operational Committee Emergency Planning Officer
External involvement and consultation	Security Services Bed Watch service

Impact Assessment

Overall assessment and analysis of the evidence	

Action Plan

Action	Owner	Risks	Completion Date	Progress update
Approval by Director of Nursing	Matron for Clinical Standards			