Document Reference Code: (to be added by the Policy Coordinator)

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Royal Cornwall Hospitals NHS Trust

Cornwall Partnership NHS Foundation Trust

Enhanced Care for Adults Policy

V6.0

November 2022

CFT Governance Information

Title:	Enhanced Care for Adults Policy V6.0
Purpose:	This policy sets out the best practice guidance for staff working in the Royal Cornwall Hospitals Trust (RCHT) and Cornwall Partnership Foundation Trust (CFT). It provides a framework for enhanced care which are implemented when patients are considered to be at risk of harm to themselves or others.
Applicable to:	This policy is relevant to all staff working in RCHT and CFT whose practice brings them into contact with vulnerable patients at high-risk of harm to themselves or others in the setting identified above.
Document Definition:	Policy
Document Author:	Lorraine Maltby – RCHT Lead Nurse for Quality Safety and Innovation Sarah Washer – CFT Clinical Matron
Supporting Committee Name and Chair:	Chief Nursing Officer and Professional Lead for Midwives and Allied Health Professionals Clinical Cabinet
Freedom of Information:	This document can be released
Key Words: ***(to assist search engine)***	Safe and supportive observation, care rounding, one to one supervision, specialing
Ratified by and Date:	Louise Dickinson - Deputy Director of Nursing, Midwifery and Allied Health 10/09/2022
Review Date:	May 2025
Expiry Date:	November 2025
Document library location:	Corporate
Related legislation and national guidance:	National Institute for Health and Clinical Excellence (NICE) (2005). Violence: The short-term management of disturbed/violent behaviour in in-patient psychiatric settings and emergency departments. London: Royal College of Nursing.

Title:	Enhanced Care for Adults Policy V6.0
Associated Trust Policies and Documents:	CFT Therapeutic observation and engagement of inpatients policy CFT Guidance for the Management of Patients who Lack Capacity (Including Deprivation of Liberty Safeguards) CFT Seclusion Policy CFT Consent Policy RCHT Mental Health Act 1983 & Mental Health Amendment Act 2077 policy RCHT Restrictive Practice Policy RCHT Mental Capacity Act Policy RCHT Adult Discharge and Transfer Policy RCHT Prevention and Management of Falls and a safe use of bedrails in Hospital Policy
Equality Impact Assessment:	The Equality Impact Assessment Form was completed on October 2022
Training Requirements:	The Trust will deliver a programme of training and awareness. Staff will be requested to attend a training session on the subject matter – this currently is not statutory or essential training
Monitoring Arrangements:	Effective implementation of this policy across relevant clinical areas will be monitored through the ward accreditation programme, frequency for each ward is defined by the outcome of their assessment. Compliance is monitored by the DNMAHP Clinical Cabinet. Required changes to practice will be identified and actioned as part of the ward plans following a ward accreditation assessment. Lessons will be shared via relevant work streams.
Implementation:	Actions for implementation will be defined in the trust fall prevention and management work programme.

Version Control – Author to complete the table below with all changes made

Version	Date	Author	Page No.	Changes
V6	November 2022`	Lorrie Maltby - RCHT Lead Nurse for Quality Safety and Innovation Sarah Washer - CFT Clinical Matron	All pages	Section 1 to 4 - reference to both CFT and RCHT Trusts included Section 5 – roles updated to current job titles and to also include CFT roles and responsibilities Section 6 – terminology and practice delivery updated Section 7 – a new section which defines practice in relation to escalation and de-escalation Section 8 to 10 -updated to reflect changes in practice delivery Section 11 - a new section which defines practice in relation to transferring patients who are receiving enhanced care Section 12 – updated to reflect changes to local and national policy in relation to Mental Capacity Act and Deprivation of Liberty. Section 13 – updated to include practices for both CFT and RCHT

This document Replaces:
Royal Cornwall Hospitals Trust Enhanced Care for Adults Policy V5 August 2019

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Data Protection Act 2018 (General Data Protection Regulation – GDPR) Legislation

The Trust has a duty under the Data Protection Act 2018 and General Data Protection Regulations 2016/679 to ensure that there is a valid legal basis to process personal and sensitive data. The legal basis for processing must be identified and documented before the processing begins. In many cases we may need consent; this must be explicit, informed, and documented. We cannot rely on opt out, it must be opt in.

Data Protection Act 2018 and General Data Protection Regulations 2016/679 is applicable to all staff; this includes those working as contractors and providers of services.

For more information about your obligations under the Data Protection Act 2018 and General Data Protection Regulations 2016/679 please see the *Information Use Framework Policy* or contact the Information Governance Team

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1. Introduction

1.1. Both the Royal Cornwall Hospitals NHS Trust (RCHT) and Cornwall Partnership NHS Foundation Trust (CFT) are committed to delivering safe, high quality and patient-centred care. This policy provides an evidence-based framework which enables staff to be responsive to alterations in care risks, whilst being cost-effective and efficient.

1.2. Wood *et al*.'s (2018) evidence review of enhanced care (described in their study as specialling and one to one care) found a wide variation in what enhanced care entails, which they found can in turn lead to the provision of poor quality care. They suggest that high quality care could be achieved through the development of guidelines, training and standardised decision-making tools. This policy sets out a framework for both RCHT and CFT to deliver and monitor enhanced care.

1.3. This version supersedes any previous versions of this document.

2. Purpose of this Policy/Procedure

2.1. The aim of this policy to is to prevent potentially suicidal, violent or vulnerable patients from harming themselves or others through increasing levels of *observation.*

2.2. Observation is not a custodial activity. It is also an opportunity for the multidisciplinary team to interact in a supportive and therapeutic way with the patient.

2.3. This policy will provide:

- A framework for providing enhanced care for patients considered to be at high-risk of harm to themselves or others across both RCHT and CFT Trusts.
- Ensure consistent application of standardised decision-making tools to promote patient safety across both RCHT and CFT Trusts.
- Support for person-centred personalised care planning.

3. Scope

3.1. This policy is applicable to RCHT patients presenting in both admitting and inpatient areas and is applicable to CFT community hospitals inpatients.

3.2. The content of this document is relevant to all staff working in RCHT and CFT whose practice brings them into contact with vulnerable patients at high-risk of harm to themselves or others in the setting identified above.

3.3. This policy is only applicable to patients over 16 years of age.

3.4. Enhanced care is a shared responsibility between all members of the multidisciplinary health and social care team.

4. Definitions / Glossary

4.1. **Enhanced care** definitions come largely from mental health nursing, with different levels of observation defined by the proximity of staff to the patient needing enhanced care.

4.2. **Observation** is *regarding observing the patient attentively, whilst minimizing the extent to which they feel they are under surveillance* (Standing Nursing & Midwifery Advisory Committee (SNMAC) practice guidance on the safe and supportive observation of patients at risk (SNMAC 1999).

4.3. **Care Rounding** is a structured process where staff carry out regular checks with individual patients at set intervals, addressing patients' pain, nutritional, positioning and toilet needs; assessing and attending to the patient's comfort; and checking the environment for any risks to the patient's comfort or safety.

5. Ownership and Responsibilities

5.1. The Chief Executive Officer and wider Trust Board

The Chief Executive Officer and wider Trust Board have key roles and responsibilities to ensure the Trust meets requirements set out by statutory and regulatory authorities. These responsibilities are delegated to an Executive Lead with supportive structure to ensure and assure standards and expectations are met. These are described below.

5.2. The Role of the Executive Lead

Dual Chief Nursing Officer and Professional Lead for Midwives and Allied Health Professionals is the nominated Executive Lead and will be responsible for ensuring structures and processes are in place to assure delivery of this policy. The Executive Lead will report to Trust Board on progress as required.

5.3. The Role of Deputy Director of Nursing, Midwifery and Allied Health Professionals

The Deputy Director of Nursing, Midwifery and Allied Health is the policy holder reporting to the Clinical Cabinet.

5.4. The Role of the Clinical Cabinet

Dual Chief Nursing Officer and Professional Lead for Midwives and Allied Health Professionals Clinical Cabinet will oversee the wider workforce agenda and the delivery of this policy.

5.5. The role of Care Group Triumvirates/Care Directorate

Care Group Triumvirates/Care Directorates (Clinical Directors, General Managers and Heads of Nursing/Midwifery/AHPs) are responsible for ensuring their Care Group/Directorate have effective mechanism for communication and dissemination of this policy and associated information to all clinical teams.

5.6. Role of Ward and Departmental Leaders

Line-managers are responsible for identifying and supporting implementation of this policy, ensuring effective communication channels exist to the Care Group/Directorate representative, encouraging dissemination of information and actions across the wider health and care team.

5.7. Role of Individual Staff

All staff members are responsible to ensure they comply with Trust policy regarding the support patient at high-risk to themselves and/or others. These responsibilities include training and education in policy application.

5.8. Role of Relative

Relatives and carers can observe the patient without staff present if this is the wish of the relatives or patient; clear instruction must be given to how they are to manage that observation, including how to summon for help and what they do when they are leaving the patient, however they should not be made responsible for the formal documentation of enhanced care, this must be clearly documented in the individual intervention section of the care plan. **Please ensure that this is noted within the Carer Passport when appropriate.**

6. Standards and Practice

6.1. Levels of enhanced care

There are 4 levels of patient observation provided, with level 2, 3 and 4 being defined as enhanced care which means the patient has been assessed to require more than the minimum level of observation provided in a hospital environment. What each level means is defined below.

6.1.1. Level 1 Care – General observation

This level of observation is the minimum acceptable level for all patients. The location of all patients should be known to staff at all times, but they are not necessarily within sight. At the beginning and end of every nursing shift the whereabouts and general condition of all patients should be part of the handover and nursing documentation.

6.1.2. Level 2 Enhanced care – frequent intermittent observation

6.1.2.1. This level of enhanced care is for patients who have been assessed as requiring frequent intermittent observation. This level is appropriate when patients are **potentially**, but not immediately at risk of harm to themselves or others.

6.1.2.2. For example, patients who:

- Have a potential risk of falls
- Have a cognitive impairment which may result in an increased risk of harm to themselves or others
- Present with behaviours that challenge

- Are de-escalating from a previous higher level of support

6.1.2.3. Patients assessed to be requiring level 2 enhanced care must have a care rounding form (CHA3061) implemented to document that the frequent intermittent observation has taken place, ensuring that the frequency (15, 30, 60 minutes, 120 minutes) is appropriate to meet individual needs, and that this is clearly written on the form.

6.1.2.4. Care rounding frequency must be no more than every 120 minutes (2 hours) for those who have been identified as requiring level 2 enhanced care. Patients who are not requiring level 2 enhanced care but still have a need for care rounding to be in place based on an assessment of their care needs i.e. pressure ulcer risk, pain management; then these patients can be managed as level 1 and may have a less frequent care rounding in place i.e. every 4 hours.

6.1.2.5. High risk activities and times of the day should be planned for, for example, sun downing, going to the toilet when at risk of falls, and the needs of patients at night when lighting is subdued and staff numbers are decreased.

6.1.3. Level 3 Enhanced care - line of sight

6.1.3.1. Patients assessed as requiring level 3 enhanced care must be within line of sight of a staff member and accessible at all times, this includes at times of toileting and personal care whilst having regard for their privacy and dignity. It is important to note that this does not refer to a bed within line of sight of the nursing station.

6.1.3.2. This level is appropriate when patients are at imminent risk of harm to themselves or others.

6.1.3.3. For example, patients who:

- Are at imminent risk of falling (where a person's risk of falling cannot be managed by techniques described in level 2 enhanced care)
- Have a heightened level of risk harm to themselves or others that is linked to delirium
- Are at imminent risk of harming themselves or others which is unpredictable in nature
- Are at imminent risk of absconding
- Are de-escalating from a previous higher level of enhanced care

6.1.3.4. Observers **are not** required to be at arm's length from the patient when providing level 3 enhanced care. The observer

must position themselves near the patient so they are able to observe them at all times, and provide verbal instructions and/or reassurance when required, and to attend to the patient efficiently if they need assistance.

6.1.4. **A Level 3 and Level 4 Enhanced Care Risk Assessment and** Care Plan form (CHA3717) must be completed for all patients who are being escalated to level 3 enhanced care.

6.1.4.1. An Enhanced Care Level 3 and 4 Behaviour and Psychological Symptoms Observation Chart (CHA2918) must be maintained for all patients receiving level 3 enhanced care.

6.1.4.2. Any equipment or instruments deemed harmful should be removed if necessary and consider any ligature risks, if appropriate. This may warrant searching of the patient and their belongings. This should be done with the patient's consent or consideration of their best interests if they lack the mental capacity to consent.

6.1.4.3. Levels may vary between night and day dependent on the patient's presentation. For example, if the patient is known to go to bed and sleep well throughout the night then level 3 enhanced care could be reduced to level 2 enhanced care. Entries recorded on the Enhanced Care Level 3 and 4 Behaviour and Psychological Symptoms Observation Chart (CHA2918) over a period of time will help to inform this decision.

6.1.5. **Cohorting (cohorted bays)**

6.1.5.1. Cohorting can provide a strategy for effectively managing those patients who require level 3 enhanced care within line of sight, but careful consideration must be given to the assessment of the individuals, the patients collectively, the environment in which the cohort is provided, and the level of staffing required to support the cohort of patients safely.

6.1.5.2. It is important to note that not all patients requiring level 3 enhanced care can be safely observed in a cohorted bay, this will include, although not exclusive to, patients that are active walkers (wandering), patients who are frequently attempting to mobilise from the bed/chair independently and do not respond to verbal instruction, and patients who are at risk of harming themselves or others which is unpredictable in nature.

6.1.5.3. If at any time that the member of staff providing observation feels that a patient cannot be observed safely as part of the cohort then this must be escalated to the Nurse-In-Charge as soon as possible so they can reassess the cohort and make arrangements to support the level 3 observation outside of the cohort if necessary. Staff providing observation and the Nurse-In-Charge must ensure all enhanced care paperwork and the patient's medical record is updated accordingly when a decision

is made to change the patient's plan of care in relation to enhanced care.

6.1.5.4. When there is a need for a bay to become a 'cohorted bay', the Nurse-In-Charge must assess if the location and set up of the bay allows for safe observation of the patients. This will be reviewed at least daily as part of the ward safety huddle to best identify which patients would benefit, based on of their enhanced care risk assessments.

6.1.5.5. To provide a cohorted bay, the Nurse-in-Charge must ensure the following is in place;

- No more than four patients are included in a cohort
- Members of staff providing observation must position themselves in the bay to ensure maximum observation of all patients.
- The bay/s where cohorting is taking place, will be identifiable using a sign on the entrance to the bay (see appendix 4).
- Members of staff providing observation must always by identifiable by wearing a badge (available to order via unit 4). The member of staff wearing the badge is responsible for observation within the bay at all times until the badge is handed over to a colleague.
- The observer must have access to call for immediate help (call bell, beds near nurses' station).
- Personal hygiene products, PPE, patient medical records and other regularly used equipment must be kept within the bay.
- All patients who live with dementia or have a diagnosed or suspected delirium, and are part of the cohort, must have a 'This is Me' completed and made easily accessible to all staff.
- Made arrangements for the meaningful activity coordinator (MAC) service to attend the cohorted bay.
- All patients living with dementia or those diagnosed or suspected to have delirium receiving enhanced care should have access to Meaningful Activities Co-ordinators who will establish a 'Work, Rest and Play Care Plan' to assist with the de-escalation from enhanced care.
- All members of staff providing enhanced care should read the 'This is Me' and 'Work, Rest and Play Care Plan' for each patient within the cohort.

- Instigate a staff rota to ensure no member of staff undertakes a period of enhanced care **lasting longer than two hours.** A tool to support the allocation of staff completing enhanced care is available in appendix 5.

6.1.5.6. In a cohorted bay, the patients must never be left unobserved, if the observer has to assist another patient which takes their attention away from the rest of the cohort i.e., assisting a patient behind the curtain, then they must call for help from another member of staff to temporarily take over the care of the other patients in the cohort. The Nurse-in-Charge can allocate staff to be responsible for temporarily taking over the cohort when help is asked for, this is so staff are aware of their responsibility to assist.

6.1.5.7. When completing the rota, the Nurse-in-Charge must take into account times of high activity such as patient's being supported with personal hygiene in the mornings and mealtimes, and at these times of day, the cohorted bay may need to be supported by extra members of staff to ensure constant observation of all patients in the cohort.

6.1.5.8. Allied Health Professionals must make themselves aware that there is a cohort of level 3 patients on the ward and that the observer may call for immediate help.

6.1.6. Level 4 – Enhanced care within arm's length

6.1.6.1. This is the highest level of enhanced care for patients and should only be implemented in exceptional circumstances where patients are at **imminent and significant risk** of harm to themselves or others, that may result in death. For example, this may be as a result of a suicide attempt, or deliberate or unintended interfering with their own or others medical devices e.g. the pulling out of tracheostomy tubes.

6.1.6.2. This level of observation is not always appropriate in an Adult Community Setting, and if a patient is assessed as requiring this level of observation whilst in this setting, then it should be maintained as per this policy and consideration given to transferring the patient to a more appropriate environment to maintain the patient needs.

6.1.6.3. The patient should be supervised continuously within close proximity (arm's length), with due regard for safety, privacy, dignity, gender and environmental dangers, these should be discussed as a multidisciplinary team.

6.1.6.4. A Level 3 and Level 4 Enhanced Care Risk Assessment and Care Plan form (CHA3717) must be completed for all patients who are being escalated to level 4 enhanced care.

6.1.6.5. An Enhanced Care Level 3 and 4 Behaviour and Psychological Symptoms Observation Chart (CHA2918) must be maintained for all patients receiving level 4 enhanced care.

6.1.6.6. Level 4 enhanced care is obtrusive and restrictive; therefore a multidisciplinary assessment by all appropriate specialists must be carried out to ensure the benefits outweighs the risk of this level of care. This decision must be documented on the A Level 3 and Level 4 Enhanced Care Risk Assessment and Care Plan form (CHA3717) (CHA3717), and as necessary, further detail to be documented in the patient's medical record.

6.1.6.7. It may be necessary on rare occasions to use more than one member of staff and or specialist support i.e. Registered Mental Health Nurse.

6.1.6.8. A regular summary of the patient's condition, care and treatment must be entered into the care plan. This must include changes in mental state, physical, psychological and social behaviour, pertinent developments and significant events.

6.1.6.9. The Implementation of level 4 enhanced care must be overseen by area's Clinical Matron, and the Head of Nursing, Midwifery and Allied Health Professionals.

6.2. Bedwatch

In situations where the patient has actually harmed themselves or others when in the care of RCHT or CFT, or have caused damage to Trust property, then enhanced care may no longer be appropriate. Please refer to the Trust procedure in relation to instigating 'Bed Watch.'

6.3. Escalation and de-escalation of enhanced care

6.3.1. Escalation of enhanced care may need to occur if staff are unable to maintain the patient's safety on the current plan of care. Consideration of the following may help staff decide if they need to complete the Level 3 and Level 4 Enhanced Care Risk Assessment and Care Plan form (CHA3717) to potentially escalate the level of enhanced care:

- Escalation of harm related behaviours
- Escalation of behaviours that challenge
- Escalation in behaviours that increase risk of absconding
- Escalation in behaviour that exacerbate known history of previous risk concerns

6.3.2. De-escalation of the level of enhanced care should be triggered as a result of regular assessment of the impact of the patient's current plan of care. Consideration of the following may help staff decide when to de-escalate the level of enhanced care:

- Evidence of the patient entering a phase of recovery
- Successful trial of frequent care rounds for maintaining safety

6.3.3. It is important to recognise that the transferring of a patient from one location to another (bay, ward or hospital etc) may escalate a patient's behaviour, therefore careful consideration must be given to whether a decision to de-escalate is appropriate prior to the transfer of a patient. Please see section 11 in relation to transferring patients who are receiving enhanced care.

6.4. Assessment of enhanced care

6.4.1. A Registered Nurse must assess the level of observation that the patient requires to maintain their safety throughout their stay in hospital.

6.4.2. The need and frequency for level 2 enhanced care (frequent intermittent observation) must be determined at the beginning and end of every shift and discussed as part of the daily safety huddle, this must be completed by the Registered Nurse using their clinical judgement and following discussion with the wider multidisciplinary team. The assessment must be based on the patient's behaviour, physical and mental state, and the decision must be clearly documented in the patient's medical record and handed over to the commencing shift.

6.4.3. A Level 3 and Level 4 Enhanced Care Risk Assessment and Care Plan form (CHA3717) must be completed for those patients where their enhanced care is being escalated. This must be completed by a Registered Nurse and then approved by the Nurse-in-Charge of the shift for a patient requiring level 3 enhanced care, or the Clinical Matron for a patient requiring level 4 enhanced care.

6.5. Reassessment of enhanced care

6.5.1. The need and frequency for level 2 enhanced care should be reassessed by a registered nurse at the beginning and end of every shift and discussed as part of the daily safety huddle, or when there is a change in patient's condition or circumstances.

6.5.2. The need for level 3 and 4 enhanced care must be reviewed every shift by the Nurse-in-Charge of that shift, or as defined in the care plan, which may state a specific level of enhanced care for a defined period of time. Where possible this should be done with consultation with members of the multi-disciplinary team; and discussed with the medical team at least daily; and where additional staff is required continued to be authorised by the Clinical Matron. A decision will be made to subsequently curtail, reduce, maintain or heighten enhanced care based on the information recorded on the Enhanced Care Level 3 and 4 Behaviour and Psychological Symptoms Observation Chart (CHA2914). The decision must be clearly documented on the chart (CHA2914) and on other sections of the enhanced care paperwork where necessary, with any supporting information to this decision being detailed in the patient's medical record, this must then be handed over to the commencing shift.

6.6. Implementing enhanced care

6.6.1. The patient, and with the patient's approval, their carers/relatives are to be informed of the enhanced care procedures. Clear, honest and open dialogue must take place regarding the plan of care associated with enhanced care.

6.6.2. Where there is doubt over the patient's mental capacity to consent, mental capacity assessment must be carried out in line with the Mental Capacity Act 2005 and its associated Code of Practice. Staff should refer to the RCHT 'Mental Capacity Act *Policy', or the CFT 'Consent Policy' and the 'Guidance for the Management of Patients who Lack Capacity' for further guidance.*

6.6.3. Enhanced care must be set at the least restrictive level for the least amount of time within the least restrictive environment, and proportionate to the risk.

6.6.4. Staff delivering enhanced care will need to ensure that they have received the appropriate enhanced care training provided by the Trust.

6.6.5. Staff delivering enhanced care need to be familiar with the ward, all relevant clinical guidelines and potential risks within the environment. All staff on the ward must receive a thorough handover, including risk factors, associated with those patients receiving enhanced care.

6.6.6. Patients must be offered an opportunity to formally or informally discuss their views and/or their concerns with the Nurse-in-Charge or a senior member of staff and have the right to involve someone (an advocate or friend/relative) in these discussions if they wish.

6.6.7. Under no circumstances should the member of staff delivering the enhanced care reduce the level prescribed for the patient without prior discussion with a registered nurse (level 2) of the Nurse-in-Charge (level 3 and 4).

6.6.8. Staff must try to ensure that the patient's privacy and dignity, cultural, religious beliefs and gender specific needs are maintained. However, at times where the level of risk supersedes these issues this must be clearly explained to the patient and documented.

6.6.9. All the relevant enhanced care paperwork must be implemented as advised throughout this policy.

6.6.10. All patients receiving level 2, 3 and 4 enhanced care must have care rounding implemented, with the frequency being appropriate to meet the patient's individual needs. This provides documented evidence of staff frequently attending to the patient's comfort and safety.

6.6.11. The Nurse-in-Charge for the shift is responsible for instigating a staff rota to ensure no member of staff undertakes a period of enhanced care **lasting longer than two hours.** A tool to support the allocation of staff completing enhanced care is available in appendix 5.

6.6.12. The member of staff allocated to carry out enhanced care should spend time building a therapeutic relationship with the patient. Enhanced care should be a supportive and therapeutic activity. Please refer to the Trust's Meaningful Activities Standard Operating Procedure.

6.6.13. If the patient requires level 3 or 4 enhanced care and this level cannot for whatever reason be provided, an incident report must be completed immediately, and submitted on the Trust incident reporting system.

6.6.14. The request for additional staff to manage enhanced care must be authorised by the Clinical Matron, and sanctioned as per the current Trust process. Out of hours, for RCHT this should be the Clinical Matron as per the weekend rota or the Site Co-ordinator, sanctioned by the On-Call Manager, and for CFT this should be authorised the on-call manager. The decision must be clearly documented in the patient's medical record.

6.6.15. Staff should refer to appendix 6 for a quick reference for the assessment and implementation of enhanced care.

6.7. Transferring patients on enhanced care

6.7.1. When a patient is being transferred to another ward on enhanced care; then the transferring ward must provide clear communication with regards to the level of enhanced care the patient is receiving and plan of care for delivering the enhanced care.

6.7.2. Prior to discharge or transfer, there must be a sufficient period of time between de-escalation from level 3 or 4 enhanced care and their planned discharge date. For patients where it has been assessed that they need to continue to receive level 3 and 4 enhanced care on discharge, then the discharge destination needs to agree to support this level of enhanced care.

6.7.3. It is important to recognise that the transferring of a patient from one location to another (bay, ward or hospital etc) may escalate a patient's behaviour, therefore careful consideration must be given to whether a decision to de-escalate enhanced care is appropriate prior to the transfer of a patient.

6.7.4. If a patient has recently had their enhanced care de-escalated, then the receiving ward must be informed of that, including the reason and plan around de-escalation. This should take into account whether the patient had received enhanced care in the last 4 weeks prior to transfer, or more if deemed appropriate by the nurse handing over the patient's care. The receiving ward must then use this information to decide if the patient would benefit from a period of level 3 enhanced care or frequent intermittent observation (level 2 enhanced care) when transferred, to maintain the patient's wellbeing and safety.

6.7.5. When transferring a patient who is receiving enhanced care, ensure all the appropriate up to date information is included on the transfer form (CHA4158).

6.7.6. Avoid out-of-hours transfers of patients receiving enhanced care - restricted between 8pm and 8am.

6.7.7. When patients are transferred from a mental health unit, the unit is responsible for assessing and communicating the level of enhanced care required on transfer to the general hospital ward, the patient may not always require level 3 or 4 enhanced care.

6.7.8. If a patient requires level 3 or level 4 enhanced care on transfer from a mental health unit, then the unit will provide a member of staff who will support the provision of observation. The member of staff is still required to adhere to a two-hour rota of observation, so the Nurse-In-Charge must still put in place a rota of observation which also includes ward staff. The member of staff attending from the mental health unit can assist with other duties on the ward as their skills allow.

6.7.9. RCHT staff should refer to the RCHT 'Adult Discharge and Transfer Policy' to support best practice when discharge planning. At the time of writing this policy the CFT discharge and transfer policy is under review, therefore staff should seek support from their Clinical Matron with queries regarding safe discharge and transfers.

6.8. Mental Capacity Act Considerations and Deprivation of Liberty Safeguards (DOLS)

6.8.1. If a patient is assessed as lacking capacity, then any act carried out, or any decision made on behalf of that person must be done or made in the person's best interest. Staff should refer to the RCHT 'Mental Capacity Act Policy' and the CFT 'Consent Policy' and 'Guidance for the Management of Patients who Lack Capacity' for further guidance. The Mental Capacity Act sets out a checklist of factors to be considered when taking into account the best interests of the person.

6.8.2. The Mental Capacity Act places a responsibility on organisations to protect an Individual's right to liberty and to undertake certain procedures where they are or need to be deprived of that liberty; these procedures are known as Deprivation of Liberty Safeguards (DOLS). It may be necessary to place a number of restrictions on the patient and as a result the Deprivation of Liberty Safeguards may need to be considered.

6.8.3. It is the responsibility of the Nurse-in-Charge of the shift to consider if the patient is being deprived of their liberty and take appropriate action in accordance with Trust policy.

6.8.4. The Deprivation of Liberty Safeguards apply only to those who lack mental capacity. The urgent and standard authorisation forms are available on the intranet. All Registered Staff and Doctors involved in the persons care can complete this application form. The DOLS team are available should you need advice or guidance on the application process.

6.8.5. In situations where a patient without capacity is supervised in the confinement of a room or separated from all people other than members of staff, it may be interpreted as seclusion. Mental Health Act Code of Practice 1983 states that;

'Seclusion refers to the supervised confinement and isolation of a patient, away from other patients, in an area from which the patient is prevented from leaving, where it is of immediate necessity for the purpose of the containment of severe behavioural disturbance which is likely to cause harm to others.'

6.8.6. When a patient is in seclusion, staff should refer to the RCHT 'Restrictive Practice Policy' and the CFT 'Seclusion Policy' for further guidance. If seclusion is terminated and enhanced care continues then the 'Enhanced Care for Adults policy' must be followed.

6.9. Mental Health Act considerations

6.9.1. If, as a result of mental illness and the symptoms often involved in such diagnoses, the patient is believed to be a risk to themselves or others, it can be necessary to enforce treatment and admission to hospital. This must be done in accordance with the Mental Health Act 1983.

6.9.2. For further guidance, RCHT staff please refer to the 'The Practical Application of the Mental Health Act 1983 and Mental Health Amendment Act 2007 within the Royal Cornwall Hospital Clinical Guideline', and CFT staff please contact the Mental Health Act Office**,** Bellingham House, Bodmin Hospital, Tel: 01208 834270, email: cpn-tr.mhacornwall@nhs.net

7. Dissemination and Implementation

7.1. This policy will be cascaded by the policy leads to RCHT care groups and CFT areas management teams for communicating and sharing at a local clinical level.

7.2. This policy's implementation will be led by the management team to clinical ward teams.

7.3. This document will be available on the Trust Intranet site.

8. Monitoring compliance and effectiveness

Information Category	Detail of process and methodology for monitoring compliance
Element to be monitored	Effective implementation of this policy across relevant clinical areas.
Lead	Joint Deputy Director of Nursing with Heads of NMAHPs
Tool	Ward Accreditation
Frequency	Defined by the Ward Accreditation programme of assessment
Reporting arrangements	Monitoring of compliance with this policy will be overseen by the DNMAHP Clinical Cabinet.
Acting on recommendations and Lead(s)	Clinical Cabinet Members/ Heads of Nursing / Clinical Matrons / Ward leaders
Change in practice and lessons to be shared	Required changes to practice will be identified and actioned as part of the ward plans following a Ward Accreditation assessment. Lessons will be shared via relevant work streams.

9. Updating and Review

This policy will be reviewed in 3 years unless changes are required to data collection and reporting in advance of this date.

10. Equality and Diversity

10.1. This document complies with the Royal Cornwall Hospitals NHS Trust service Equality and Diversity statement which can be found in the 'Equality, Inclusion and Human Rights Policy' or the Equality and Diversity website.

10.2. Equality Impact Assessment

The Initial Equality Impact Assessment Screening Form is at Appendix 2.

Appendix 1. RCHT Governance Information

Information Category	Detailed Information
Document Title:	Enhanced Care for Adults Policy V6.0
This document replaces (exact title of previous version):	RCHT only policy - Enhanced Care for Adults Policy V5.0
Date Issued/Approved:	14th September 2022
Date Valid From:	November 2022
Date Valid To:	November 2025
Directorate / Department responsible (author/owner):	RCHT Lead Nurse for Quality, Safety and Innovation Deputy Director of Nursing, Midwifery and Allied Health Professionals
Contact details:	(01872) 252267
Brief summary of contents:	This policy provides staff with the organisation's expectations for the standard of care in delivering enhanced care
Suggested Keywords:	Safe and supportive observation, care rounding, one to one supervision, specialling
Target Audience:	RCHT: Yes CFT: Yes CIOS ICB: No
Executive Director responsible for Policy:	Joint Director of Nursing, Midwifery and Allied Health Professionals
Approval route for consultation and ratification:	Dual Chief Nursing Officer and Professional Lead for Midwives and Allied Health Professionals Clinical Cabinet
General Manager confirming approval processes:	Dual Chief Nursing Officer and Professional Lead for Midwives and Allied Health Professionals
Name of Governance Lead confirming approval by specialty and care group management meetings:	Dual Chief Nursing Officer and Professional Lead for Midwives and Allied Health Professionals

Information Category	Detailed Information
Links to key external standards:	National Institute for Health and Clinical Excellence (NICE) (2005). Violence: The short-term management of disturbed/violent behaviour in in-patient psychiatric settings and emergency departments. London: Royal College of Nursing.
Related Documents:	CFT Therapeutic observation and engagement of inpatients policy CFT Guidance for the Management of Patients who Lack Capacity (Including Deprivation of Liberty Safeguards) CFT Seclusion Policy CFT Consent Policy RCHT Mental Health Act 1983 & Mental Health Amendment Act 2077 policy RCHT Restrictive Practice Policy RCHT Mental Capacity Act Policy RCHT Adult Discharge and Transfer Policy RCHT Prevention and Management of Falls and a safe use of bedrails in Hospital Policy
Training Need Identified?	Yes – facilitated by the Corporate Nursing Department
Publication Location (refer to Policy on Policies – Approvals and Ratification):	Internet and Intranet
Document Library Folder/Sub Folder:	Clinical / Corporate Clinical

Version Control Table

Date	Version Number	Summary of Changes	Changes Made by
07/07/11	V1.0	Final amendment made; document published	Lerryn Hogg, Divisional Quality Facilitator
15/09/11	V1.1	Procedure reviewed in line with the RCHT Policy for Policies Inc. EIA.	Mary Mallet, Safeguarding Adult Named Nurse

Date	Version Number	Summary of Changes	Changes Made by
25/09/12	V2.0	Complete revision responding to the implementation of RCHT CARE Rounds and audit results of the previous policy.	Caroline Dunstan, Divisional Nurse; Frazer Underwood, Consultant Nurse; Lerryn Hogg, CNS Mental Health and Well-being
20/03/12 11/07/14	V3.0	Clarification in the definition of the levels. Examples added	Zoe Mclean, Safeguarding Nurse for Adults; Lerryn Hogg, Mental Health and Well-being Specialist Nurse; Frazer Underwood, Consultant Nurse.
12/05/16	V1	Reviewed by Safe and Supportive Observation Task and Finish Group	Shirley Harris, Matron. Lorraine Sole, Matron Lerryn Hogg,Specialist Nurse for Mental Health and Wellbeing; Lorrie Maltby, Lead Nurse Q,S&I; Esther Penrose,Matron; Wendy Burnett, Older Persons Clinical Nurse Specialist; Tracey Frowde, Admiral Nurse; Clare Swettenham, L&D Facilitator

Date	Version Number	Summary of Changes	Changes Made by
16/05/16	V2	Circulated to Divisional Nurses	Divisional Nurses
05/16	V2	Amended to reflect senior nurse comments	Deputy Director of Nursing, Midwifery and Allied Health Professionals
08/09/16	V4	Change required to terminology; Safe and Supportive Observation has become Enhanced Care with Meaningful Activities	Kim O'Keefe, Deputy Director of Nursing, Midwifery and Allied Health Professionals; Tracey Frowde, Admiral Nurse; Lerryn Hogg, Specialist Nurse for Mental Health and Wellbeing; Lorrie Maltby Lead Nurse Q,S&I
April 2019	V5	Change to workforce policy. Meaningful activities details removed. Revision to ownership, processes and reporting.	Frazer Underwood Consultant Nurse / Associate Nurse Director – as Chair of Task and Finish Group
May 2022	V6.0	Section 1 to 4 - reference to both CFT and RCHT Trusts included Section 5 – roles updated to current job titles and to also include CFT roles and responsibilities Section 6 – terminology and practice delivery updated Section 7 – a new section which defines practice in relation to escalation and de-escalation Section 8 to 10 -updated to reflect changes in practice delivery Section 11 - a new section which defines practice in relation to transferring patients who are receiving enhanced care	Lorrie Maltby, Lead Nurse for Quality, Safety and Innovation - as Chair of Task and Finish Group Members of the task and finish group;

Date	Version Number	Summary of Changes	Changes Made by
		Section 12 – updated to reflect changes to local and national policy in relation to Mental Capacity Act and Deprivation of Liberty. Section 13 – updated to include practices for both CFT and RCHT	Magda Morgan - Clinical Specialist-CFT Inpatient Falls Lead Sarah Washer – Modern Matron CFT Emma Bellamy – Clinical Matron RCHT Paul Cadger - Improvement Practitioner Falls, Delirium and Dementia RCHT Esther Penrose – Interim Head of Learning and Development RCHT Suzanne Lugg – Frailty Nurse Specialist RCHT Hayley Townsend – Ward Sister RCHT Lerryn Udy – Advanced Nurse for Mental Health and Complex Cases RCHT Shirley Harris – Clinical Matron RCHT Cerian Margetts – Adult Safeguarding Officer CFT

Date	Version Number	Summary of Changes	Changes Made by
			Liz Bray – Staff Nurse CFT Tina Bray – Physiotherapist CFT Wendy Burnett – Older Persons Clinical Nurse Specialist RCHT Jodie Ley – Adanced Clinical Practitioner CFT Kathy Smith – Interim Clinical Matron CFT Contributions to the policy; Philip Belcher – Mental health Act Advisor CFT Colin Peat – AMHP Senior Practitioner CFT

Appendix 2. Equality Impact Assessment

Section 1: Equality Impact Assessment (EIA) Form

The EIA process allows the Trust to identify where a policy or service may have a negative impact on an individual or particular group of people.
For guidance please refer to the Equality Impact Assessment Policy (available from the document library) or contact the Equality, Diversity and Inclusion Team rcht.inclusion@nhs.net

Information Category	Detailed Information
Name of the strategy / policy / proposal / service function to be assessed:	Enhanced Care for Adults Policy V6.0
Directorate and service area:	Corporate Nursing
Is this a new or existing Policy?	Existing
Name of individual completing EIA (Should be completed by an individual with a good understanding of the Service/Policy):	Lorraine Maltby – Lead Nurse for Quality, Safety and Innovation
Contact details:	Lorraine.maltby@nhs.net

Information Category	Detailed Information
1. Policy Aim - Who is the Policy aimed at? (The Policy is the Strategy, Policy, Proposal or Service Change to be assessed)	This document sets out the best practice guidance for staff working in the Royal Cornwall Hospitals Trust (RCHT) and Cornwall Partnership Foundation Trust (CFT). It provides a framework for enhanced care which are implemented when patients are considered to be at risk of harm to themselves or others.
2. Policy Objectives	To provide clear instructions on how enhanced care must bb implemented.
3. Policy Intended Outcomes	To ensure the safety of patients and provide tools and guidance on the implementation of enhanced care.
4. How will you measure each outcome?	Via DATIX reports and Ward Accreditation
5. Who is intended to benefit from the policy?	All patients who require enhanced care.
6a. Who did you consult with? (Please select Yes or No for each category)	• Workforce: Yes • Patients/ visitors: No • Local groups/ system partners: Yes • External organisations: No • Other: No

Information Category	Detailed Information
6b. Please list the individuals/groups who have been consulted about this policy.	Clinical Cabinet
6c. What was the outcome of the consultation?	Approved Policy
6d. Have you used any of the following to assist your assessment?	**National or local statistics, audits, activity reports, process maps, complaints, staff or patient surveys:** Incidents reports

7. The Impact
Following consultation with key groups, has a negative impact been identified for any protected characteristic? Please note that a rationale is required for each one.

Where a negative impact is identified without rationale, the key groups will need to be consulted again.

Protected Characteristic	(Yes or No)	Rationale
Age	No	
Sex (male or female)	No	
Gender reassignment (Transgender, non-binary, gender fluid etc.)	No	
Race	No	
Disability (e.g. physical or cognitive impairment, mental health, long term conditions etc.)	No	
Religion or belief	No	
Marriage and civil partnership	No	
Pregnancy and maternity	No	
Sexual orientation (e.g. gay, straight, bisexual, lesbian etc.)	No	

A robust rationale must be in place for all protected characteristics. If a negative impact has been identified, please complete section 2. If no negative impact has been identified and if this is not a major service change, you can end the assessment here.

I am confident that section 2 of this EIA does not need completing as there are no highlighted risks of negative impact occurring because of this policy.

Name of person confirming result of initial impact assessment: Lorraine Maltby

If a negative impact has been identified above OR this is a major service change, you will need to complete section 2 of the EIA form available here:
Section 2. Full Equality Analysis

Appendix 3. CFT Equality Impact Assessment Form

Policy Overview	Details
Title of Policy / Document for assessment:	Enhanced Care for Adults Policy V6.0
Document Library Section:	
Is this a new or existing document?	Existing
Date of assessment:	10th November 2022
What is the main purpose of the document?	To ensure the safety of patients and provide tools and guidance on the implementation of enhanced care.
Who is affected by the Document?	• Staff: Yes • Patients: Yes • Visitors: No • Carers: No • Other: No • All: No
Who implements the document, and who is responsible?	All staff who come into contact with patients that require enhanced care

The document aims to improve access, experience and outcomes for all groups protected by the Equality Act 2010.

Are there concerns that the procedural document could have a differential impact on:	(Yes, No, Unsure)	What existing evidence (either presumed or otherwise) do you have for this?
• Age	No	
• Disability	No	
• Sex	No	
• Gender reassignment	No	
• Pregnancy and maternity	No	
• Race	No	
• Religion and belief	No	

Are there concerns that the procedural document could have a differential impact on:	(Yes, No, Unsure)	What existing evidence (either presumed or otherwise) do you have for this?
• Sexual orientation	No	
• Marriage and civil partnership	No	
• Groups at risk of stigma or social exclusion (e.g., offenders / homeless)	No	
• Human Rights	No	
• Are there any associated objectives of the document?	No	

Signature of person completing the Equality Impact Assessment:

Name: Lorraine Maltby

Date: 10th November 2022

Appendix 4. Cohorted bay sign

Appendix 5. Enhanced care staff rota

No member of staff undertakes a period of enhanced care **lasting longer than two hours**
There should be no more than 4 patients allocated to a member of staff when observing patients as a cohort

Time		**Bed Space**	**Level of enhanced care provided**	**Staff Member**	**Cohorted bays only– member of staff/s allocated to assist** if the observer is required to assist another patient which takes their attention away from the rest of the cohort
Start	Finish	(If observing a cohort provide each bed space)	L3 – Line of Sight L4 – Within Arms Length		

Appendix 6. Delivery of enhanced care flowchart