RCHT Enhanced Care and Meaningful Activities Policy

V4

September 2016
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1. **Introduction**

1.1. Royal Cornwall Hospitals NHS Trust (RCHT) is 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 risk, whilst being cost effective and efficient.

1.2. It outlines the responsibilities of staff at all levels to provide a clear pathway of care and the process by which levels of enhanced care are determined, recorded, and reviewed.

2. **Purpose of this Policy**

2.1. The purpose of this policy is to:-

- Provide a framework for providing enhanced care which is implemented when patients are considered to be at risk of harm to themselves or others
- Ensure a safe environment using effective assessment and intervention
- Support patients to remain independent, empowered and safe
- Support person centred planning

3. **Scope**

3.1. The content of this document is relevant to all clinical staff working in RCHT whose practice brings them into contact with vulnerable patients.

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

3.3. Enhanced care is a shared responsibility between members of the multidisciplinary team.

4. **Definitions / Glossary**

4.1. According to the Standing Nursing & Midwifery Advisory Committee (SNMAC) practice guidance on the safe and supportive observation of patients at risk (SNMAC 1999) observation is defined as “regarding the patient attentively, whilst minimizing the extent to which they feel they are under surveillance.”

5. **Ownership and Responsibilities**

5.1. **Chief Executive**

The Chief Executive has overall responsibility for the strategic direction and operational management, including ensuring that Trust policies comply with all legal, statutory and good practice guidance requirements.

**Trust Board**
The Trust Board has responsibility for setting the strategic context in which this policy will be implemented.

5.2. **Clinical and Associate Directors**

Clinical and Associate Directors are responsible for ensuring that;

- The policy is implemented and adhered to in their services.
- Training or education needs are identified and met.
- Requirements for implementation of the policy are built into the delivery planning process.
- Staff have received, are aware of and comply with all relevant policies and supporting documents.

5.3. **All Clinical Staff**

All Clinical staff, including temporary and agency staff, are responsible for;

- Compliance with the policy.
- Ensuring that knowledge and skills are gained and are maintained.
- Identifying training needs in respect of policies and procedures and bringing them to the attention of their line manager.
- Attending training / awareness sessions.
- Ensuring that; particularly medical and nursing staff; familiarise themselves with the practice and terminology of enhanced care and share in the clinical decision making of this key area of clinical risk.

5.4. **RCHT Safeguarding Adult Operational Group**

This group is responsible for maintaining an up to date policy and monitoring compliance with delivery and impact.

6. **Standards and Practice**

RCHT has in place 4 levels of enhanced care, these are defined below;

6.1. **Level 1 – General Observation**

This level of observation is the minimum acceptable level for all in-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.

6.2. **Level 2 – Intermittent Observation with Meaningful Activities**

For patients who have been assessed as;

- Having a potential risk of falls
- Having a cognitive impairment which results in increased risk, or present with behaviour that challenge.
- Having a history of previous risk but are in the process of recovery.
6.2.1. Patients assessed to be requiring level 2 enhanced care must have a CARE Rounding form (CHA3061) implemented, ensuring that the frequency (5, 15, 30, 60 minutes etc) is appropriate to meet individual needs, and this is clearly written on the form. CARE rounding is a structured process where staff carry out regular checks with individual patients at set intervals, addressing patients’ pain, 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.

6.2.2. High risk activities and times of the day should be planned for, for example, sundowning, 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.

6.2.3. The need and frequency for level 2 enhanced care should be assessed by a Registered Nurse at the beginning and end of every shift. This assessment must be based on the patient’s behaviour, physical and mental state, and the decision must be clearly documented in the nursing notes and handed over to the commencing shift.

6.2.4. Cohorting Level 2 – Intermittent Observation with Meaningful Activities

6.2.4.1. CARE Rounding is a method for reducing the risk, and cohorting (where patients are located in the same area/bay) can provide a strategy for effectively managing those patients who require intermittent observation with meaningful activities.

6.2.4.2. The Nurse in Charge must ensure that where patients are cohorted, staff are appropriately delegated to carry out the required enhanced care. Delegated staff must have a practicable understanding of CARE Rounding, and must be aware of the frequency of each patient’s CARE Rounding.

6.2.5. Techniques for Reducing the Risk of Harm

6.2.5.1. When patients are presenting with restlessness, walking about, sleep disturbance, behaviours which challenge and/or unpredictable behaviour which puts them at risk of harm, it is important to try and establish the possible cause of such behaviours so these can be appropriately managed; thus preventing a patient requiring enhanced care.

6.2.5.2. Possible Causes:

- Pain or discomfort,
- A medical reason, e.g. depression, constipation or the side effects of medication
- A basic need, e.g. hunger, thirst or needing the toilet
- A feeling, e.g. anxiety or boredom
- Communication problems
The environment i.e. too hot or too cold, over-stimulating or under-stimulating.

- Disorientation
- Consider nicotine and alcohol withdrawal

6.2.5.3. When attempting to manage these, it is important establish a person-centred approach to care, involving carers and family members where possible; the ‘This is Me’ booklet provides a template for health care professionals to build a better understanding of who the person really is.

6.2.5.4. Such techniques that may help to reduce patients’ risk of harm include:

- Providing a supportive environment
- Establishing a daily routine the patient is familiar with
- Engaging the patient in meaningful activities such as listening to music, reading, chatting
- Engaging the patient in activities that provide a sense of purpose such as making the bed and tiding the bed space
- Encouraging the patient in exercise such as daily walks, or seated exercises for those with less mobility
- Attendance at the memory cafe
- Consider issues with continence
- Providing something to occupy their hands e.g. a 'rummage box' and Twiddlemuffs
- Writing down basic facts e.g. what day or date it is
- Providing a clock next to the bed which shows whether it is day or night
- Cutting down on caffeine in the evening
- Removing any trip hazards e.g. furniture in the way
- Assessing the patient’s mood as this can contribute to poor sleep. If you think the person may be depressed refer to the doctor

6.3. Level 3 – Enhanced Care within Line of Sight

For patients who have been assessed as having an imminent risk of:

- Falling, and/or have a recent history of repeat falling which cannot be managed by techniques described in level 2, for example, patients who have a heightened level of risk linked to increased confusion/disorientation/agitation, and also have deterioration from their normal level of mobility.
- Harming themselves or others which is unpredictable in nature
- Absconding

6.3.1. These patients should be within line of sight and accessible at all times, this includes at times of toileting and personal care whilst having regard for their privacy and dignity.

6.3.2. They should have a risk assessment form (CHA3717) and care plan (CHA2917) contained within their nursing notes.
6.3.3. Any equipment or instruments deemed harmful should be removed if necessary. 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.

6.3.4. 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 level 3 could be reduced to level 2 CARE rounds.

6.3.5. **Cohorting Level 3 – within Line of Sight**

6.3.5.1. Cohorting can provide a strategy for effectively managing those patients who require enhanced care within line of sight, following appropriate assessment of the individuals and the patients collectively.

6.3.5.2. The observer must have access to call for immediate help (call bell, beds near nurses’ station). The Nurse in Charge must be aware of the cohort and make other Allied Health Professionals aware that there is a cohort of level 3 patients on the ward and that the observer may call for immediate help.

6.3.5.3. The patients must never be left unobserved, if the observer has to assist one level 3 patient, they must call for help from another member of staff to temporary take over the care of the other patients in the cohort.

6.4. **Level 4 – Enhanced Care within Arm’s Length**

6.4.1. 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. This may be as a result of suicide, self-harm or interfering with medical devices e.g. the pulling out of tracheostomy tubes.

6.4.2. They 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.

6.4.3. They should have a risk assessment form (CHA3717) and care plan (CHA2918) contained within their nursing notes.

6.4.4. Level 4 enhanced care is obtrusive and restrictive; therefore a multidisciplinary assessment must be carried out to ensure the benefits outweighs the risk of this level of care.

6.4.5. 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.

6.4.6. 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.
6.4.7. The Implementation of level 4 enhanced care must been overseen by the Mental Health and Wellbeing Nurse when implemented due to mental health issues; by the Psychiatric Complex Care and Dementia Team when implemented due to Dementia; and by the Learning Disability Nurses for ASD & LD (Learning Disability Nurses) when implemented due to learning disabilities.

6.5. Assessment of Level of Enhanced Care

6.5.1. All patients requiring enhanced care must follow the Enhanced Care Pathway (Appendix two), considering the risk defined in Appendix 3.

6.5.2. A Registered Nurse should assess the level of enhanced care required, the need for level 3 and 4 must be approved by the Nurse in Charge and a risk assessment must be completed (CHA3717).

6.5.3. 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, this should be the Clinical Matron as per the weekend rota or the Site Co-ordinator, and sanctioned by the On Call Manager. The decision must be clearly documented in the patient’s notes.

6.5.4. Where enhanced care is implemented due to mental health issues, the Psychiatric Liaison Service should be contacted as soon as possible. The liaison service will provide a mental health risk assessment and advice on the level of enhanced care that may be required. Where enhanced care is implemented due to Dementia, the Psychiatric Complex Care and Dementia Team should be contacted as soon as possible.

6.6. Implementing Enhanced Care

6.6.1. Staff delivering the enhanced care will need to be familiar with the ward, all relevant clinical guidelines and potential risks within the environment. All staff in the ward must receive a thorough handover, including risk factors.

6.6.2. Staff allocated to deliver level 3 and 4 enhanced care must complete the behaviour chart in full (CHA2914)

6.6.3. Positive engagement with the patient is essential using the techniques defined under section 6.2.2.

6.6.4. The Nurse in Charge will ensure that each member of staff does not undertake a period of enhanced care lasting longer than two hours.

6.6.5. It is the responsibility of the Nurse in Charge to consider if the patient is being deprived of their liberty by the safety measures put in place. If there are concerns that the patient is being deprived of their liberty then appropriate action should be taken in accordance with Trust policy.

6.6.6. 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. The process of enhanced care
calls for empathy, engagement, taking note of the patient’s needs, and a readiness to act.

6.6.7. Patients, 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 reasons for a change in the level of enhanced care.

6.6.8. When patients who are being transferred to another ward on level 3 and 4 enhanced care; then the receiving ward must be given sufficient time to make arrangements to cover this level of care. The member of staff assigned to carry out the enhanced care on the transferring ward must escort the patient and remain with them until the receiving ward provides cover for the level of enhanced care required.

6.6.9. Patients will 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.

6.6.10. Under no circumstances should the member of staff delivering the enhanced care reduce the level prescribed for the patient without prior discussion with the Nurse in Charge.

6.6.11. If the patient requires level 3 or 4 enhanced care and this level cannot for whatever reason be provided, a DATIX incident report must be completed immediately, and mitigating actions documented as per the RCHT Incident Reporting and Management Policy and Procedures.

6.6.12. 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.

6.6.13. In situations where the patient presents a clear threat to harm themselves or others, staff must complete a DATIX incident report and work in accordance with the RCHT Management of Violence & Aggression Policy.

6.6.14. When patients receiving inpatient care at a mental health unit are on leave in a general hospital, and whose current mental health problems may cause a risk to themselves or others the mental health unit in which the patient was receiving treatment prior to transfer will be responsible for providing the observation staff. All assessments for commencing enhanced care will be made in full consultation with the mental health unit.

6.6.15. It may be necessary where possible to call on the Mental Health Team to ascertain whether they may be able to provide staff to support the patient in the acute setting. Any support will need to be authorised by senior management. The person observing the patient must receive a thorough handover including risk factors.
6.7. Reassessment of Enhanced Care

6.7.1. The need and frequency for level 2 enhanced care should be reassessed by a Registered Nurse at the beginning and end of every shift.

6.7.2. The need for level 3 and 4 enhanced care must be reviewed at the beginning and end of every shift by the Nurse in Charge, 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 Medic 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 behavioural chart (CHA2914). The decision must be clearly documented in the patient’s notes and handed over to the commencing shift. This assessment must be based on the patient’s behaviour, physical and mental state.

6.7.3. Prior to discharge or transfer, there must be a sufficient period of time between de-escalation from level 3 or 4 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.

6.8. Mental Capacity Act Considerations

6.8.1. If an individual is assessed as lacking capacity any act done for, or any decision made on behalf of that person, must be done or made in the person’s best interest. Please refer to the Trust Policy: Mental Capacity Act Advocacy and Deprivation of Liberty Safeguards Policy. The Mental Capacity Act sets out a checklist of factors to be considered when taking into account the best interests of the person. A mental capacity act (MCA) assessment record and best interest checklist is required: new MCA level 2 ‘stickers’ are available to record actions or if required a MCA Level 3 form (CHA2920) is available. This often requires a best interest decision being recorded and form CHA2912: Best Interest Meeting Checklist and Record should be used.

6.8.2. 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. General observation will be the presumed level and justification will be required to move up (or down) the levels according to the patient’s condition. Raising levels of enhanced care may be required and both staff and patient need to be clear about its purpose. It is essential that communication is effective and the situation managed sensitively.

6.8.3. The Mental Capacity Act 2007 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.
6.8.4. The Deprivation of Liberty Safeguards apply only to those aged 18 and over who lack mental capacity. The urgent and standard authorisation forms are available on the RCHT intranet and Sisters shelf. 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. When a patient is in seclusion the seclusion record should be used, (please refer to the Restrictive Practice Policy), however if seclusion is terminated and enhanced care continues then the enhanced care, care plan and behavioural chart must be used. Please refer to the RCHT Seclusion Guidelines.

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. If the patient makes an attempt to leave and cannot be readily dissuaded from doing so a Section 5(2) of the Mental Health Act 1983 may be required.

7. SPECIAL NOTE: Role of the Relative / Carer

7.1. Relatives and carers should be involved with the patient care as much as possible, dependant on their own or the patient wishes. In particular, explanations should be given sensitively about why limits are being set. 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.

8. Dissemination and Implementation

8.1. This policy will be cascaded by the policy lead to divisional management teams and to the RCHT Senior Nursing and Midwifery team for communicating and sharing at a local clinical level, making all resources available to all relevant staff.

8.2. This policy’s implementation will be lead by divisional management team members to clinical ward teams. Training and support will be made available by the division using resources of the liaison team and the Trust’s mental health and well-being specialist nurse.
9. Monitoring compliance and effectiveness

<table>
<thead>
<tr>
<th>Element to be monitored</th>
<th>Effective implementation of this policy across clinical areas, monitoring of compliance with this policy will be overseen by the RCHT Safeguarding Adult Operational Group</th>
</tr>
</thead>
<tbody>
<tr>
<td>Lead</td>
<td>Divisional Nurses</td>
</tr>
<tr>
<td>Tool</td>
<td>Matron Rounds Safecare</td>
</tr>
<tr>
<td>Frequency</td>
<td>Monthly Matron Rounds Daily Safecare Annual report at divisional level reporting into the RCHT Safeguarding Adult Operational Group</td>
</tr>
<tr>
<td>Reporting arrangements</td>
<td>Reporting into the RCHT Safeguarding Adult Operational Group Evidenced through minutes of meetings</td>
</tr>
<tr>
<td>Acting on recommendations and Lead(s)</td>
<td>Actions will be carried out by Divisional Nurses across each Division</td>
</tr>
<tr>
<td>Change in practice and lessons to be shared</td>
<td>Required changes to practice will be identified and actioned. A lead member of the team will be identified to take each change forward where appropriate. Lessons will be shared with all the relevant stakeholders.</td>
</tr>
</tbody>
</table>

10. Updating and Review

10.1. The document review process is managed via the document library. Document review will be every three years unless best practice dictates otherwise. The author remains responsible for policy document review. Should they no longer work in the organisation or in the relevant practice area then an appropriate practitioner will be nominated to undertake the document review by the designated Director.

10.2. Revision activity will be recorded in the Versions Control Table to ensure robust document control measures are maintained.

10.3. This Policy replaces the V3.2 (May 2016)

11. Equality and Diversity

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

12. Equality Impact Assessment

12.1. The completed Equality Impact Assessment Screening Form is at Appendix One.
### 11. Governance Information

<table>
<thead>
<tr>
<th>Document Title</th>
<th>RCHT Enhanced Care and Meaningful Activities Policy</th>
</tr>
</thead>
<tbody>
<tr>
<td>Date Issued/Approved:</td>
<td>September 2016</td>
</tr>
<tr>
<td>Date Valid From:</td>
<td>September 2016</td>
</tr>
<tr>
<td>Date Valid To:</td>
<td>September 2019</td>
</tr>
<tr>
<td>Directorate / Department responsible (author/owner):</td>
<td>Deputy Director of Nursing, Midwifery and Allied Health Professionals</td>
</tr>
<tr>
<td>Contact details:</td>
<td>(01872) 252267</td>
</tr>
<tr>
<td>Brief summary of contents</td>
<td>This policy provides staff with the organisation’s expectations for the standard of care in delivering enhanced care</td>
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<tr>
<td>Suggested Keywords:</td>
<td>Enhanced care, Safe and supportive observations</td>
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<tr>
<td>Target Audience</td>
<td>RCHT PCH CFT KCCG</td>
</tr>
<tr>
<td>Executive Director responsible for Policy:</td>
<td>Director of Nursing, Midwifery and Allied Health Professionals</td>
</tr>
<tr>
<td>Date revised:</td>
<td>September 2016</td>
</tr>
<tr>
<td>This document replaces (exact title of previous version):</td>
<td>V3.2 (May 2016)</td>
</tr>
<tr>
<td>Approval route (names of committees)/consultation:</td>
<td>Safe and Supportive Observations Task and Finish Group with Divisional Representation, Safeguarding Adults Operational Group, Associate Director and Senior Nurse Meeting, Enhanced Care Success Regime</td>
</tr>
<tr>
<td>Divisional Manager confirming approval processes</td>
<td>Deputy Director of Nursing, Midwifery and Allied Health Professionals</td>
</tr>
<tr>
<td>Name and Post Title of additional signatories</td>
<td>Not Required</td>
</tr>
<tr>
<td>Signature of Executive Director giving approval</td>
<td>{Original Copy Signed}</td>
</tr>
<tr>
<td>Publication Location (refer to Policy on Policies – Approvals and Ratification):</td>
<td>Internet &amp; Intranet Intranet Only</td>
</tr>
<tr>
<td>Document Library Folder/Sub Folder</td>
<td>Clinical / Nursing Generic</td>
</tr>
</tbody>
</table>
Links to key external standards


Related Documents:
- Mental Capacity Act
- Deprivation of Liberty Guidance
- Vulnerable Adult Policy
- Mental Health Act
- CARE round documentation

Training Need Identified? Yes

Version Control Table

<table>
<thead>
<tr>
<th>Date</th>
<th>Version No</th>
<th>Summary of Changes</th>
<th>Changes Made by (Name and Job Title)</th>
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<tbody>
<tr>
<td>07/07/11</td>
<td>v1.0</td>
<td>Final amendment made; document published</td>
<td>Lerryn Hogg, Divisional Quality Facilitator</td>
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<tr>
<td>15/09/11</td>
<td>v1.1</td>
<td>Procedure reviewed in line with the RCHT Policy for Policies Inc. EIA.</td>
<td>Mary Mallet, Safeguarding Adult Named Nurse</td>
</tr>
<tr>
<td>25/09/12</td>
<td>v2.0</td>
<td>Complete revision responding to the implementation of RCHT CARE Rounds and audit results of the previous policy.</td>
<td>Caroline Dunstan, Divisional Nurse; Frazer Underwood, Consultant Nurse; Lerryn Hogg, CNS Mental Health and Well-being</td>
</tr>
<tr>
<td>20/03/12</td>
<td>V3.0</td>
<td>Clarification in the definition of the levels. Examples added</td>
<td>Zoe Mclean, Safeguarding Nurse for Adults; Lerryn Hogg, Mental Health and Well-being Specialist; Frazer Underwood, Consultant Nurse;</td>
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<tr>
<td>Date</td>
<td>Version</td>
<td>Details</td>
<td>Reviewers</td>
</tr>
<tr>
<td>------------</td>
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<td>-------------------------------------------------------------------------</td>
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</tbody>
</table>
| 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) |
| 16/05/16   | V2      | Circulated to Divisional Nurses                                         | Divisional Nurses                                                         |
| 22/05/16   | V2      | Amended to reflect senior nurse comments                                 | Deputy Director of Nursing, Midwifery and Allied Health Professionals     |
| 23/05/16   | V3.2    | Finally approved 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) |
| 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) |
Appendix 1. Initial Equality Impact Assessment Screening Form

| Name of the strategy / policy / proposal / service function to be assessed (hereafter referred to as policy) | Provide brief description: RCHT Enhanced Care and Meaningful Activities |
| Is this a new or existing Policy? | Existing |
| Name of individual completing assessment: | Lerryn Hogg |
| Telephone: | 01872 252630 |

1. Policy Aim*  
Who is the strategy / policy / proposal / service function aimed at?  
This document sets out the best practice guidance for staff working in the Royal Cornwall Hospitals Trust (RCHT). 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 be 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 the outcome?  
Via DATIX reports and audit

5. Who is intended to benefit from the policy?  
All patients who require enhanced care.

6a) Is consultation required with the workforce, equality groups, local interest groups etc. around this policy?  
No

b) If yes, have these *groups been consulted?  
Safe and Supportive Observation Task and Finish Group  
Safeguarding Adults Operational Group  
Associate Director and Senior Nurse Meeting Safeguarding Enhanced Care Success Regime

7. The Impact  
Please complete the following table.

<table>
<thead>
<tr>
<th>Equality Strands:</th>
<th>Yes</th>
<th>No</th>
<th>Rationale for Assessment / Existing Evidence</th>
</tr>
</thead>
<tbody>
<tr>
<td>Age</td>
<td>√</td>
<td></td>
<td>The aim of this policy is to establish a process and offer guidance, which can be implemented in the event of a patient requiring enhanced care. It is intended to ensure a consistent approach in the implementation and management of enhanced care.</td>
</tr>
<tr>
<td>Sex (male, female, transgender / gender reassignment)</td>
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<td>Race / Ethnic communities /groups</td>
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<td>Disability - Learning disability, physical disability, sensory impairment and mental health problems</td>
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<td>Religion / other beliefs</td>
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<td>Marriage and civil partnership</td>
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<td>Pregnancy and maternity</td>
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<tr>
<td>Sexual Orientation, Bisexual, Gay, heterosexual, Lesbian</td>
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You will need to continue to a full Equality Impact Assessment if the following have been highlighted:

- You have ticked “Yes” in any column above and
- No consultation or evidence of there being consultation - this excludes any policies which have been identified as not requiring consultation. or
- Major service redesign or development

8. Please indicate if a full equality analysis is recommended.  
   | Yes | No  √ |

9. If you are not recommending a Full Impact assessment please explain why.

Not required

<table>
<thead>
<tr>
<th>Signature of policy developer / lead manager / director</th>
<th>Date of completion and submission</th>
</tr>
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<tbody>
<tr>
<td>Lerryn Hogg/Lorrie Maltby/Tracey Frowde/Kim O'Keefe/Christine Perry</td>
<td>May 2016</td>
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<tr>
<th>Names and signatures of members carrying out the Screening Assessment</th>
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<td>2.</td>
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Keep one copy and send a copy to the Human Rights, Equality and Inclusion Lead, c/o Royal Cornwall Hospitals NHS Trust, Human Resources Department, Knowledge Spa, Truro, Cornwall, TR1 3HD

A summary of the results will be published on the Trust’s web site.

Signed ____________________

Date ____________________
Appendix 2: Enhanced Care Pathway

Level 1
General Observation
No further action required unless risk levels increase

Patient requiring enhanced care (above Level 1 General Observations) based on increased risk

A Registered Nurse, and where possible with consultation with members of the multi-disciplinary team assess the level of enhanced care required

Level 2
Intermittent Enhanced Care
For patient who have been assessed as:
- Having a potential risk of falls
- Having a cognitive impairment which results in increased risk, or present with behaviour that challenge
- Having a history of previous risk but are in the process of recovery

- Patients must have CARE Rounding implemented, which clearly indicates the intervals
- Consider techniques that may help to reduce patients’ risk of harm thus preventing a patient requiring more heightened level of enhanced care
- Consider level 2 cohorting
  Manage with agreed staffing levels for the clinical area

Consider level 3 cohorting

Level 3
Enhanced Care within Line of Sight
For patients who have been assessed as having an imminent risk of:
- Falling, and/or have a recent history of repeat falling which cannot be managed by techniques described in level 2 observation
- Harming themselves or others which is unpredictable in nature
- Absconding

Complete the Enhanced Care Risk Assessment (CHA3717), Care Plan (Level 3 CHA2917 or Level 4 CHA2918) and a behavioural chart (CHA2914)

Consideration must be given to the Mental Health Act 1983 and the Mental Capacity Act 2005 including the Deprivation of Liberty Safeguards

Level 4
Enhanced Care within Arm’s Length
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.

Level 4 must be overseen by either the Mental Health and Wellbeing Nurse, Psychiatric Complex Care and Dementia Team or the Learning Disability Nurses dependent on reasons for implementing

Document the decision making process, agreed level of enhanced care and subsequent actions

The level of enhanced care must be reviewed on an on-going basis, and at least reviewed at the start and finish of each shift by the Nurse in Charge, and discussed with the Medic at least daily, and where additional staff is required continued to be authorised by the Clinical Matron.
## Appendix 3: Risk, Dependency and Additional Support Flowchart

### Low - Level 1
**General Observation**
- Additional support not indicated.
- Support to be provided by care rounds if required
- Existing ward staff
- General observations and assessments

### Moderate – Level 2
(Intermittent Observation with Meaningful Activities)
**The patient:**
- Cannot maintain their dignity
- Cannot maintain their fluid and nutritional intake
- Cannot manage their own toilet needs
- Cannot communicate there are in pain
- Has a cognitive impairment which results in increased risk
- Presents with behaviours that challenge
- Has a history of previous risk but are in the process of recovery.

Enhanced care level 2 must have a CARE Rounding form (CHA3061) implemented, ensuring that the frequency (5, 15, 30, 60 minutes etc) is appropriate to meet individual needs, and this is clearly written on the form.

### High – Level 3
(Enhanced Care within Line of Sight)
**The patient:**
- Is likely to self-harm
- Present with destructive behaviour
- Inappropriate behaviour
- Is likely to abscond
- Cannot maintain their safety in the ward environment
- Is at risk of suicide
- Imminent risk of falling and/or have a recent history of repeat falling

**Enhanced care in line of sight.**

### Exceptional – Level 4
(Observation within arm’s length)
**This is the highest level of observation 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.**

**Enhanced care within arm’s length**