Gateshead Health
NHS Foundation Trust

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Sponsor	Nichola Kenny Associate Director Medicine
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This policy supersedes all previous issues

Version Control

Version	Release	Author/Reviewer	Ratified by/Authorised by	Date	Changes (Please identify page no.)
1.0	14/08/2018	Kelly Chequer & David Gilbert	Mental Health Performance and Quality Committee	01/03/2018	

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Enhanced Care and Supportive Engagement Policy

1 Introduction

Supportive engagement and enhanced observation with patients provides an opportunity to assess and respond to individual needs to aid recovery. Engagement and observation includes the reporting and recording of the patient's location, mental state, wellbeing and behavior, which is central to the role of in patient care. All those receiving inpatient treatment are observed at some level as a necessary part of their care. Where there are specific concerns, the patient may need to be placed on enhanced levels of observation, for the least period of time necessary.

There are many reasons why a patient may require an enhanced level of observation. Within mental health services, the aim of supportive engagement and observation is to prevent potential suicide, violence, or vulnerable patients from coming to harm or from harming themselves or others.

With regards to physical illness/conditions, the need for enhanced observation often relates to those patients at high risk of falls and all cognitive impairment secondary to a delirium and/or alcohol withdrawal.

The aim of enhanced observation in these situations is to reduce risk and maintain the safety of the patient.

The use of supportive engagement and enhanced observation must not breach the European Convention on Human Rights, and in particular the right to have private life respected. No patient should be unnecessarily subjected to an enhanced observation in a way that would breach their human rights.

In order for this policy to comply with the law, it must be justifiable and proportionate, and support the guidance on restrictive practice, ensuring the least restrictive option is always utilised.

Clinicians therefore need to ensure that the use of supportive engagement and enhanced observation is no more intrusive, nor continues longer than is required by the circumstances.

2 Policy scope

This policy applies to:

- All patients over the age of 18 whom have been identified as requiring supportive engagement and enhanced observation.
- All staff involved in engagement and observation of patients during their hospital admission.

Whilst observation and engagement is primarily a nursing function, other health professionals are responsible for the planning and implementation of these, and are required to adhere to this policy.

3 Aim of policy

The aim of this policy is:

- To provide staff with a framework to support the decision making process and determine the type, level and use of supportive engagement and enhanced observation.
- To detail requirements for the recording of interventions, review of supportive engagement procedure within the hospital setting.
- To identify the skills that staff will need to deliver evidence based engagement and observation.
- To ensure supportive and engagement and observations of patients are undertaken appropriately, consistently and responsibly and are integral to the plan of care.

4 Duties (roles and responsibilities)

Trust Board
The Trust Board is responsible for implementing a robust system of corporate governance within the organisation. This includes having a systematic process for the development, management and authorisation of policies.

Chief Executive
The Chief Executive is ultimately responsible for ensuring effective corporate governance within the organisation and therefore supports the Trust-wide implementation of this policy.

Associate Directors/Senior Managers
The Divisional Manager is responsible for ensuring staff are aware of and adhere to this policy

Modern Matron/Senior Nurses/Nurse Consultant
To support clinical staff in receiving appropriate training and to support the audit of use of this policy

Responsible Clinician
To ensure the safe and therapeutic use of supportive engagement and enhanced observation through regular review with the multidisciplinary team, at least every 24 hours.

Ward Sister
To ensure that the correct process is followed, and promote the consistent high standard of care in line with the policy, ensuring a robust quality assurance process.

All Registered Staff
All clinical staff will adhere to this policy when co-ordinating, assessing, planning or providing care and treatment (directly or indirectly) to individuals

All Unregistered Staff
All clinical staff will adhere to this policy when assessing or providing care and treatment (directly or indirectly) to individuals

5 Definitions

Formal Patients: A formal (or detained) patient is one whereby the person is detained under the Mental Health Act and the care and treatment provided for this person has to be in accordance with the parameters of this act. Engagement with the patient and their views and opinions about the care and treatment they receive must always be sought and where possible adhered to.

Informal Patients: An informal (or voluntary) patient is one whereby the person agrees to receive care and treatment in an inpatient setting. As such, engagement with them and having their consent and agreement to receive the care and treatment planned and offered is paramount. At times, whereby the professionals providing this care and treatment feel that that the informal patient no longer has the capacity to consent to this care and treatment, the use of the Mental Health Act must be considered.

Inpatient Ward: The residential environment whereby the patient is admitted to receive care and treatment. For the purposes of this policy, the main inpatient wards that are relevant are within the Older Persons Mental Health (OPMH) and Physical Health Wards.

Multidisciplinary Team (MDT): A group of clinicians from a variety of professional backgrounds who contribute to the care and treatment that a patient receives.

Supportive Engagement A practice of supporting patients in a therapeutic way which encourages the patient to patriciate in their care and recovery.

Mental Health Observations: A routine clinical intervention whereby patients are monitored at regular intervals as per the clinical decision making process. It has two main purposes; firstly to promote therapeutic engagement between staff and patients and secondly, to meet the patients' needs and manage the risks that they pose.

Enhanced Health Care Observations: The requirement for a higher level of observation due to the patient's complexity of condition.

Enhanced Care Observation Levels (for either Physical or Mental Health): 3 predetermined observation levels to ensure that the staff team can meet the needs and minimise the risks posed by patients to either themselves or others. These are described in more detail in point 6.1

6 Enhanced Care and Supportive Engagement

6.1 Engagement and Observation Levels

All patients with mental health or enhanced physical health care needs will be allocated a level of engagement and observation. There are three categories, which have different responsibilities. The multi-disciplinary team has a duty to risk assess and designate a level of observation for every patient within their care. These levels of observation should be assessed against the individual patient needs either relating to their mental health **or** physical care needs (This specifically relates to

'Enhanced Care Observations'). The person carrying out the levels of observation with the patient at any level needs to have the appropriate training, skills, expertise and knowledge.

a) Level 1 - General engagement and observation

- Staff will be aware of the general location of all patients for whom they are responsible.
- The patients allocated nurse to conduct ongoing assessments of the patient's physical and mental wellbeing throughout their span of duty.
- As part of the assessment, the nurse should evaluate the impact of the patient's mental state on the risk of harm and record any risk in the notes.
- Any change in the assessed level of risk should be discussed with the Nurse in charge of the ward area who will then trigger an appropriate review.

b) Level 2 - Intermittent supportive engagement and observation

- This is used if a patient is at risk of harm to self or others but does not represent an immediate risk i.e. extra support is required but the person does not require constant observations to keep them safe. This level can also be applicable to people with vulnerability issues such as the risk of exploitation or high levels of disinhibition that may cause distress to themselves or others.
- The frequency (every 10 minutes is the recommended maximum time and this is specific to mental health areas) and type and frequency of engagement must be recorded in the care plan care.
- Within physical health while supporting patients where enhanced care is required where intermittent observation is identified as being appropriate patients must have a 'rounding form' (see Appendix 1) implemented, ensuring that the frequency (5, 15, 30 minutes etc.) is appropriate to meet individual needs. This must be clearly written in the care record. '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 patients comfort or safety.
- Observing patients at predictable times can provide the opportunity to plan or engage in meaningful activities. This should be considered when determining the use of this observation method.
- The staff member responsible for any period of intermittent supportive engagement & observation must indicate via the records on every occasion they observe the patient (see care plan example, appendix 2). The narrative notes should also indicate information about all contact with the patient during this period. Any concerns or changes in level of risk should be discussed with the Nurse in charge who will trigger an appropriate review.

c) Level 3 - Continuous supportive engagement and observation

- Continuous supportive engagement and observation are used when a patient presents an immediate risk of serious harm to self or others and needs to be kept within eyesight or at arm's length of a designated member of staff, with immediate access to other members of staff if needed.
- The specific level **must always be stipulated**, i.e. "***within eyesight***" or "***within arms' length***".
- Cohorting of patients on enhanced observation: This method can be utilised if there is more than one patient on an enhanced observation level. They may be cohorted into the same area to allow the observation of more than one patient at a time. The appropriateness of this approach would be risk assessed and reviewed by the senior nurse on duty/nurse in charge of the group of patients.
- Some individuals may require the support of more than one member of staff. In this circumstance each member of staff must have clearly defined roles for this period.
- Consideration should be given to whether the person may be alone for short periods (e.g. personal care needs, whilst sleeping or for other reasons of privacy and dignity) which would be detrimental to their mental health and risk of harm is manageable. This should be clearly documented within the multi-disciplinary agreed care plan.
- It may be necessary to search the patient and their belongings, e.g. If genuine concern an item that may cause harm to the individual or others is been deliberately concealed. If it is required, it must be done with due regard for the person's legal rights and conducted in a sensitive way.
- In certain circumstances the patient may need to leave the ward e.g. to any appointments outside their allocated area of care, or short breaks in the grounds or building as part of the patient's therapy/recovery. These decisions must be part of the risk assessment process and be discussed with the multi-disciplinary team. This should only take place in the company of a suitably qualified and experienced practitioner and only when the risks have been assessed. It may be decided that additional members of staff should accompany the person to reduce the risk of harm. Staff should have means of contacting the ward for immediate assistance if required.
- Staff will ensure any pertinent information is handed over verbally when ending a period of continuous supportive engagement and observation. This can, wherever appropriate, be done involving the patient in the dialogue.
- Staff allocated to deliver continuous engagement and observation would be rotated, with each staff member involved with the patient for a maximum of 2 hours in any continuous episode.
- The staff member responsible for any period of continuous supportive engagement and observation must document narrative in the patient's records about their contact during this period. Any

concerns or changes in level of risk should be discussed with the Nurse in charge who will trigger an appropriate review.

6.2 Decision Making Process of utilising Enhanced Care and observation

Multi-disciplinary assessment and collaborative risk formulation with the patient represent best practice in determining the appropriate use of supportive engagement and observation.

Levels of observation should be set in the least restrictive form, within the least restrictive setting to protect the safety of the patient, safety of others and to promote positive engagement. It is necessary to balance the patient's safety, dignity and privacy with the need to maintain the safety of the patient and others. Shared decision making should be utilised whenever possible, leading to a co-produced care plan which will identify:

- Why and what that level is
- How it will be carried out, remembering the importance of positive engagement
- What are the indications in assessing whether the risk of harm has lessened
- How long it is likely to last
- The review process

Where positive risk taking is incorporated into the care plan it should be made explicit within the plan that the actions prescribed can be overridden should the clinical risks and circumstances dictate. All such decisions to clinically override must be fully documented.

Even if the patient has not been involved in the development of the plan, they should be informed of the above, and this be documented. If the patient gives consent an explanation to carers about the aims and level of observation should be undertaken. Involvement of an advocate should always be considered.

6.3 On admission to a ward or clinical area

Upon admission, an appropriate level of engagement and observation will be introduced to reflect the risk of harm as identified following a thorough risk assessment by the admitting team, including the patient whenever possible. The review period will be identified within the initial plan.

a) **When to consider the use of Enhanced Care Observation**

There are a number of circumstances where patients may require additional supervision (Enhanced Care). These include:

- cognitive impairment as a result of substance misuse , intoxication, dementia, delirium, brain injury or exacerbation of a mental health condition
- the patient is likely to abscond from the ward and lacks capacity
- the patient is at risk of falling and cannot be managed without supervision
- the patient is pulling at lines, tubes and devices

- Risk of removing medical devices – e.g. tracheostomies, cannulas, VAC dressings
- Risk of falling
- Non-compliance with bed rest
- High risk of absconding
- High risk of self-harming
- Clinically unstable and requires constant observation for monitoring purposes

b) Enhanced care is used to ensure patient safety is maintained for those that may require close observation or 1:1 supervision. The principles outlined in this policy to support all levels of observation should be considered where a patients' needs require *enhanced care.*

6.4 Initiating supportive engagement and observation levels above general level

A minimum of two practitioners in the clinical area can initiate supportive engagement and observation levels above general. At least one must be a registered nurse who has undertaken a clinical risk assessment review of the patient. The second practitioner may be any member of the multi-disciplinary team that has been involved in the clinical risk assessment. A review with the responsible Consultant/on call mental health doctor (mental health wards) or an urgent referral (or request for urgent review if already referred) to the mental health liaison team should be initiated (Acute hospital wards/departments).

Decisions about supportive engagement and observations should be made as far as possible via multi-disciplinary discussion, based on the on-going assessment of the patient's needs. This process should include the patient wherever possible.

If a patient or patients require enhanced levels of observation the ward sister/charge nurse or their deputy will use their professional judgement in considering the potential impact on staffing levels within the ward. If the ward sister/charge nurse or their deputy has concerns regarding staff levels they would escalate to their Matron/SNOOH or Acute Response team out of hours.

6.5 Increasing and decreasing supportive engagement and observations (Mental health wards)

Registered nursing staff with delegated responsibility for a ward area have the authority to implement an increase in the level, i.e. Intermittent/constant from/to constant/intermittent. Best practice remains that the decision-maker consults as widely as feasible in helping them come to a decision; the patient should, wherever appropriate, be involved. The identified Consultant (or on-call doctor) should be liaised with as part of the decision making process and kept updated with all changes, including evidence from the most up to date risk assessment to support the decision. Assessment and decision making to reduce levels of observation should be made by a senior nurse or doctor.

The rationale supporting the decision to increase or reduce the levels of supportive engagement and observation should be documented in the patient s' health records plus evidence of a review of the risk assessment. The current risks and how the level of observation is being used to manage that risk should also be included in the reviewed care plan. The nurse in charge must ensure the rest of the care team and the patient are informed of all changes and the reasons.

6.6 Increasing and decreasing supportive engagement and observations (Acute Medical/Surgical Wards/A+E

Registered nursing staff with delegated responsibility for a ward area have the authority to implement an increase in the level of observation to above general engagement levels. Any such decision should be made with the senior nurse on duty and/or senior medical staff involved. An urgent referral (if not already made) to Mental Health Liaison services must be initiated, if already known then a request for an urgent review must be requested.

Within acute inpatient areas, decisions about reducing a level of supportive engagement and observations for mental health, should only be made by the Mental Health Liaison team following assessment and collaboration with the care team, with clear documentation in the patients' health care record outlining the risk assessment and triggers that may require an increase in the supportive engagement & observation level.

6.7 Review of engagement and observations

Engagement and observation practice will be reviewed at a minimum once every 24 hours. If intermittent and/or continuous observations continue for 1 week a full review of observation levels must take place (& be comprehensively recorded) by the MDT including the discussion, who was present, the decisions agreed, actions with those responsible named, including the views of the patient.

A review of enhanced care must take place (as a minimum) every 24 hours and will include medical and nursing staff; where other staff groups are involved in the delivery of interventions they should be asked for their views as part of this review.

6.8 Night time observations (All patients will have a minimal level of the following)

- The level of night time observation will be included in the risk assessment, in collaboration with the patient whenever possible. The care plan will clearly state what the risks are and what staff should be mindful of at night when the person is in their bedroom/cubicle/bay. (While in the general ward area the agreed plan should be followed).
- Staff will have discussed, if at all possible, with the person the reason for the level of observation and how this will be undertaken over the 24 hour period.
- The member of staff should be able to clearly see the person's head and that they are breathing, and be assured that there is nothing impeding the person's breathing.

- If the staff member undertaking the observation is unable to see the person clearly they should enter the room/cubicle/bay to ensure there is no risk to the person.
- If there are any concerns about the person's mental state or physical wellbeing a top to toe check may be required to see if the person is moving freely and not restricted in anyway; this would be at the discretion of the nurse carrying at the check.

6.9 Responsibilities for Observation when patients care is being transferred.

When a patient care is being transferred to another hospital area, there is a requirement to review the risk assessment prior to transfer (If urgent then the level of engagement and observation should be maintained by the transferring ward team until a review can take place) and an appropriate level of observation will be determined/agreed based on identified risk. Where the person occupies an acute hospital bed in QEH a referral to the Mental Health Liaison service should be made immediately (by the receiving ward/department). Where the patient is to be admitted to another acute hospital facility then a referral to the on-site (where it exists) Mental Health Liaison service will be made by the transferring ward. The responsibility for supportive engagement & observation is the responsibility of the new care team (unless reasons why this should not occur are explicit within the care plan or risk assessment); a copy of the (reviewed) care plan should be included in the transfer documentation. The Nurse in charge of the transferring ward/department should clearly outline the risks and care plan detail to the Nurse in charge of the receiving ward/department; this should be documented in both health records (if different).

Where this arrangement takes place between acute hospital wards/departments the principles above must be followed.

6.10 Record keeping

Decision making in respect of the authority to change the level of observation should be described within the care plan, so that responsibilities for managing risks are well understood. Decision making is generally delegated to the Nurse in charge of a (mental health) ward unless the care plan specifies. The risk assessment and rationale for all changes must be clearly documented in the care plan/clinical notes.

The care plan or patient record will specify:

- The rationale for supportive engagement and observations, including a consideration of what immediate harms are being addressed and potential harms that the observation may cause.
- Intermittent supportive observations should always specify the type and frequency of engagement.
- Continuous supportive engagement and observations will always specify the number of staff on continuous observation and their position, i.e. within eyesight or at arms-length. If more than one staff is required, this should be made clear and their respective roles should be explicit.
- Specific detail for night time observations.

- Any details on how engagement and observation may vary depending on the patient's presentation and during any periods away from the ward environment.
- Family or other person's involvement in maintaining the supportive engagement and observation.
- Detail of any triggers that may escalate the level of risk plus techniques that may support de-escalation with the named patient. (Historical evidence where known)
- The appropriate document (See **Appendices 2 & 3** for mental health observations and appendix 1 for enhanced care) should be completed covering every 24 hour period.
- The person responsible for the increased level of observation or care must complete a narrative every 1 hour on the appropriate document, and in the care record against the intervention plan after each period of care ends; i.e. Where you have being allocated to carry out an increased level of observation or enhanced care you must add a narrative to the nursing record regarding the patients presentation, risks, any expressed wishes or ideas, issues and activities during this period.
- The registered nurse must review and summarise the risks and complete an evaluation summarising the episode of the duty.
- Any concerns must be brought to the attention of the Nurse in Charge of the Ward and the Medical staff immediately.

7 Training

- All staff that are required to participate in providing supportive engagement and enhanced care needs to receive appropriate training in Conflict Resolution as per the hospital training needs analysis.
- It is the responsibility of the nurse in charge of the patient that requires enhanced care to ensure that the staff supporting the patient is trained to the appropriate level. This should include consideration of level 3 PMVA where there is a risk of violence and aggression and an awareness of Mental Capacity and Mental Health Act.
- Within Mental Health Departments, all staff will receive Mental Capacity, Mental Health Act, Risk Assessment, Level 3 PMVA and Suicide prevention training as per the mental health training needs analysis.
- All staff should be made aware of the principles in participating in Continuous Observation (**Appendix 4**)

All staff have access to falls prevention and supportive engagement and enhance observation is incorporated in the follow training sessions

- Preceptorship
- Care certificate
- Dementia awareness sessions
- Local induction to inpatient area

8 Diversity and Inclusion

The Trust is committed to ensuring that, as far as is reasonably practicable, the way we provide services to the public and the way we treat staff reflects their individual needs and does not unlawfully discriminate against individuals or groups on the grounds of any protected characteristic (Equality Act 2010). This policy aims to uphold the right of all staff to be treated fairly and consistently and adopts a human rights approach. This policy has been appropriately assessed.

9 Monitoring compliance with the policy

Monitoring of this of this policy will be conducted through the health records audit and nursing note audits within the mental health areas.

Standard / process / Issue	Monitoring and audit			
	Method	By	Committee	Frequency
Health record audit	Health care record audit	Nursing Team	Professional Nursing and Midwifery Forum	Monthly
Mental health teams nursing note audit	Audit of nursing notes	Mental Health Team	Mental Health Act Committee	Monthly

10 Consultation and review

This policy have been developed utilising best practice guidelines and in consultation with members of the professional nursing and midwifery forum, strategic falls group and mental health steering group. And will be reviewed on a three yearly basis.

11 Implementation of policy (including raising awareness)

This policy will be circulated by the Trust secretary as detailed in OP27 Policy for the development, management and authorisation of policies.

12 References

This policy will operate in conjunction with the following policy and associate documentation:

- Department of Health Standing Nursing and Midwifery Advisory committee (1999) Practice Guidance Safe and Supportive Observation of Patients at Risk.
- Human Rights Act (1998)
- Mental Capacity Act (2005
- Mental Health Act 1983
- RM01: Risk Management Policy
- RM10: Violence at Work
- MH29: Clinical Risk Management & Suicide Prevention Policy
- MH27: Care Programme Approach (CPA) & Management

Affix Addressograph Label or Complete Box below:
Patients name:
Date of Birth:
Hospital number:
NHS Number:
Ward: **Date:**

QE Gateshead
Quality and excellence in health

Integrated Intentional Rounding Chart

Intentional Rounding

Intentional rounding is a structured process where nurses on the wards carry out regular checks with individual patients at set intervals. During these checks, nursing staff carrying out scheduled tasks or observations with patients; 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.

This form has been devised to incorporate the SSKIN bundle: a five step model to prevent pressure ulcers

S = Support surface S = Skin inspection K = Keep moving I = Incontinence N = Nutrition

and also Incorporates measures staff can take as part of our falls prevention strategy.

F = Footwear O = Observation level C = Call bell U = Understanding patient needs S = Sensors

SSKIN		FOCUS	
Save our Skin (SOS) Stickers	**Action to be Taken**	**Falls**	
Please place a SOS sticker on the patients' white name board at the bedside for those patients who require assistance to change their position. Visual prompt to staff 	Please refer to Care Standard 15 for appropriate action to be taken for the prevention and treatment of pressure ulcers. "Remember react to red skin"	If patient is identified as at risk of falls please place a falling star on the patients white board as a visual prompt for staff. 	Please ensure patient are risk assessed using the falls assessment and intervention pathway. Please be reminded that care standard 21 has been integrated within the pathway and all documentation relating to falls prevention should be written in this document.

Equipment in Place: (Please tick)			
Mattress Support Surface	NP 150 / Thermocontour ☐ Protecta ☐ Primo ☐ Clinactiv ☐ Duo 2 ☐ Dolphin ☐ Other:	Bed and chair sensor (please refer to Bed and chair sensor guidelines prior to use) Please remember disposable pads are for single patient use to be changed after 14 days of first use	Date bed and chair sensor in use Date:
Preventative Products	Gel products: Other:		Date for change of disposable pads
Chair Cushion:	Prima 3 Foam ☐ Primagel ☐ Reflex ☐		
Heel Floor Cushion (not to be used in bed)	Invacare ☐ Other:		Date:

References

Gateshead Health NHS Foundation Trust (2015) Slips, Trips and Falls Policy (RM 50)

Gateshead Health NHS Foundation Trust (2014) In-Patient Falls Assessment and Intervention Pathway

NICE (2015) Falls in Older People Quality Standard 86 National Institute for Health & Care Excellence.

Orsted, H. L. Ohura. T (2010) Pressure, shear, friction and microclimate in Context International Review.

European Pressure Ulcer Advisory Panel (2009)

National Pressure Ulcer Advisory Panel (2009)

www.healthcareimprovementscotland.org (2011)

Gateshead Health NHS Foundation Trust (2014) Pressure Ulcer Prevention and Management Policy

The Royal Marsden Manual of Clinical Nursing Procedures (Ninth edition, 2015)

NICE (2014) Pressure Ulcers: The Management of Pressure Ulcers in Primary and Secondary Care: A Clinical Guideline. National Institute for Health and Clinical Excellence, London

File in section 3 medical notes

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If Pressure area care is not required staff nurse please sign	Signature: Print name:	If Falls Focus is not required staff nurse please sign	Signature: Print name:

Patient Repositioning Chart

Date : Record time of intervention	S	K	I	N	F	O	C	U	S			
	1 **Skin Inspection** Y – Yes N – No Please record any changes in daily care record and report to the nurse in charge	2 **Keep Moving** L – Left side R – Right side B – Back S – Stood C - Chair W – Walked P - Physio O – Other please state	3 **Incontinence** I – Incontinence/skin cleaned barrier product used T – Toilet / Commode/ Bed pan NA – Not applicable C – Catheter Checked S – Stoma Checked	4 **Nutrition** Please complete food chart D – Drink F - Food N – Nil by mouth M – mouth care given	5 **Footwear** Y – Yes N – No R – Patient removing footwear N/A – Please expand in Falls Assessment and Intervention Pathway reason	6 **Observation Level** I – Intentional rounding C – Cohort / Bay / Zone Nursing O – One to One observation	7 **Call Bell** Is call bell within reach of patient Y – Yes N – No N/A - Please expand within Falls Assessment and Intervention Pathway	8 **Understanding patient needs** ask patient if they wish to go to toilet, require a drink, require pain relief Y – Yes needs met N – No needs not met please expand in tFalls Assessment and Intervention Pathway	9 **Sensor:** if patient has bed/chair sensor is it connected and working. Y – Yes N – No N/A - No sensor required	**Non compliance** (Please specify which aspect of care / number)	**Patient not on Ward** - Please State	**Initials**
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Integrated Fluid Chart

Previous 24hr Balance =

If fluid chart is NOT needed RN to sign and print name:

	Offer Oral intake or Mouth care & record	IV	Other Peg / NG	Running Total In	Offer toileting and Record Urine	Record Bowel Activity	NG	Other (drains etc)	Running Total out	Initial
00.00										
01.00										
02.00										
03.00										
04.00										
05.00										
06.00										
07.00										
08.00										
09.00										
10.00										
11.00										
12.00										
			Total in =					Total out =		

Patients with midday totals of Intake of less than 300mls and/or Output less than 300mls

Must have:

- ☐ Accurate fluid balance recorded
- ☐ Red drinking glasses Red jug lids
- ☐ Identified on Handovers that patient requiring encouragement/assistance to drink
- ☐ If safe to do so, relatives should be encouraged to give patient drinks.

Tick and initial when in place

- ☐ Daily target of fluid intake set
- ☐ Information about importance of hydration

If urine output drops to below 30 mls per hour for more than four hours then the patient should be escalated as though they are at medium risk as per NEWS

- if catheterised, please check urinary catheter is patent,
- if not catheterised already, consider if pt is in urinary retention and/ or need for catheter

	Offer Oral intake or Mouth care & record	IV	Other Peg / NG	Running Total In	Offer toileting and Record Urine	Record Bowel Activity	NG	Other (drains etc)	Running Total out	Initial
13.00										
14.00										
15.00										
16.00										
17.00										
18.00										
19.00										
20.00										
21.00										
22.00										
23.00										
			Total in =					Total out =		
					24 Hrs Balance =					

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Any patient NBM must have a plan including reason and review date in medical notes

If Food Chart is Not Applicable; a RN must tick box and Print Name:

Food Chart	All	¾	½	¼	0	record all dietary intake after every meal
Breakfast Record what has been refused by patient						
Lunch Record what has been refused by patient						
Supper Record what has been refused by patient						
Snacks offered						

WHAT assistance/support IS required to eat or drink?

Food Chart Guidance

Tick and initial when in place

Any patient in the red

- ☐ Must be offered alternative meal/Build Ups at every meal that is missed
- ☐ Must have a red placemat
- ☐ Ensure likes and dislikes form is completed
- ☐ Re calculate NRS

Any patient in the yellow

- ☐ Offer alternative meals
- ☐ Ensure likes and dislikes form is completed
- ☐ If in yellow for 3 days consider fortifying food and giving ward snacks / Build Ups

Remember

Nutrition & Hydration is as important as medication

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Appendix 2

INTERMITTENT OBSERVATION CHART - 10 minute observation

Patient name		Date of Birth	
M Number		Legal Status	
Consultant Psychiatrist		Named Nurse	
Ward		Date implemented	
RATIONALE **Risk Behaviours**		RATIONALE **Risk Factors**	

- This record is to work alongside the care plan that outlines needs in relation to being supported with a higher level of engagement.
- You must add a narrative to the patient s care record following every episode you were allocated to support their care with an increased level of observation. See the intervention plan and the Nurse in Charge for guidance.
- This observation record should be completed and signed every 10 minutes below.

Date	Time	Behaviours observed during observations	Signature / designation of member of staff carrying out observations	Signature / designation of member of staff carrying out / receiving handover

Date	Time	Behaviours observed during observations	Signature / designation of member of staff carrying out observations	Signature / designation of member of staff carrying out/receiving handover

Appendix 3

OBSERVATION CHART - Continuous Observations within Eyesight or Arm's

Patient name		Date of Birth	
M Number		Legal Status	
Consultant Psychiatrist		Named Nurse	
Ward		Date implemented	
Exact Level of observation			
RATIONALE **Risk Behaviours**		RATIONALE **Risk Factors**	

- This record is to work alongside the care plan that outlines needs in relation to being supported with a higher level of engagement.
- You must add a narrative to the patient s care record following every episode you were allocated to support their care with an increased level of observation. See the intervention plan and the Nurse in Charge for guidance.
- This observation record should be completed and signed every 30 minutes below.

length

Date	Time	Behaviours observed during observations	Signature/designation of member of staff carrying out observations	Signature/designation of member of staff carrying out/receiving handover

Date	Time	Behaviours observed during observations	Signature/designation of member of staff carrying out observations	Signature/designation of member of staff carrying out/receiving handover

Appendix 4

Continuous Mental Health Observations (Armslength or Eyesight)

- The purpose of supportive observation is to provide a period of safety, during temporary periods of distress with engagement & observation levels set at the least restrictive level, for the least amount of time, in the least restrictive setting.
- It is not just about visual observation but also about engaging with the patient: listening and assessing behaviours and reactions then recording and passing this information to other members of the MDT.
- Every effort should be made to inform the individual to explain the level, the rationale, what it entails for the patient & staff including any restrictions.
- It is the responsibility of the Nurse-in-charge to ensure that observations are carried out and recorded according to the agreed level.
- A minimum of one staff member will be assigned to the patient **at all times**.
- The allocated staff must read the care plan, be appropriately briefed about the patient's history, specific risk factors, the patient s particular needs and their (staff members) explicit responsibilities prior to undertaking the observations.
- The allocated Nurse **must** maintain visual or the agreed level of contact with the patient at all times.
- Care plan including narrative regarding their contact with the patient in the health care record.
- If the allocated nurse cannot continue the observation for any reason, they will be responsible for notifying the Nurse-in-charge, whilst ensuring observations are maintained by another member of staff.
- An uninterrupted record of observation is required, the allocated nurse must sign for each episode of observations in the patients if observations are not carried out as per plan a clear record must be made in the patient s health care notes plus an incident form should be submitted.
- Any concerns about the patients' observations status, risk or deterioration in their mental health should be relayed to the Mental Health Liaison Team as an urgent request.
- Out of *working hours*, the on-call Consultant Psychiatrist can be contacted via switchboard.
- The patient will be assessed on a regular basis by the mental health team and the current care team will be involved in the review of the engagement observation level on each occasion.
- The observations can only be rescinded by the Consultant Psychiatrist.