Sherwood Forest Hospitals
NHS Foundation Trust

ENHANCED PATIENT OBSERVATION GUIDELINE (for adult inpatients)

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Evidence Base/ References:	See Section 7

Lead Division:	Corporate
Lead Specialty:	Nursing/ Corporate Team
Lead Author:	[redacted] – Corporate Matron for Enhanced Patient Observation
Sponsor:	Chief Nurse

	Name the documents here or record not applicable
Associated Policy	Not Applicable
Associated Procedure(s)	Not Applicable
Associated Pathway(s)	Not Applicable
Associated Standard Operating Procedure(s)	Not Applicable
Other associated documents e.g. documentation/ forms	**Enhanced Patient Observation Care Plan** – available to order from Clinical Illustrations and includes: • An MCA 2-stage Assessment Tool to facilitate a daily patient review of capacity (page 1) • Risk assessment and suggested level of supervision for specific activities (High/Medium/Low risk) (page 2) • Safeguarding assessment (page 3) • Checklist of actions for daily consideration (page 3) • Increased Supervision Guidance (page 4) • Activity chart (pages 5-8) • Increased Supervision Supplemental Sheet • ABC Chart

Consultation Undertaken:	• Dementia Specialist Nurse • Falls Prevention Practitioner

	• Matrons • Ward Leaders • Restrictive Practitioner • Rapid Response Liaison Psychiatry Team • MCA DoLs LPS Lead Practitioner

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1.0 INTRODUCTION

All patients who are admitted to the hospital require a level of observation to maintain their safety. On occasion patients may need enhanced observation to prevent them harming themselves or others.

The aim of this guideline is:

- To provide a framework for practice to facilitate safe and supportive observations of patients at risk due to their physical or psychological condition
- To support practice with evidenced based research and resources
- To allow all patients admitted to SFHFT to be appropriately assessed and given a category of observation based on their individual care needs
- To give guidance to staff when making decisions on the required level of observation for patients at risk
- To encourage the development of therapeutic interaction/ engagement with patients that keeps a balance between intrusion and safety

The provision of enhanced observation is not a custodial activity. It forms part of the on-going maintenance of positive relationships with patients, their families and carers. It is an opportunity for staff to interact with them in an empathetic, therapeutic way.

The guideline is to assist in decision making; it does not replace clinical judgement. Regardless of the strength of the evidence, it remains the responsibility of the clinician to interpret the application of the clinical guidance to local circumstances and the needs and wishes of the individual patient, ensuring that safe personalised care is delivered consistently.

Where variations of any kind occur, staff must document the variation and the reason for them in the patient's health record using the Enhanced Patient Observation care plan.

2.0 SCOPE (including Related Trust Documents)

Staff groups

- The guideline applies to all clinical staff employed within the Trust.

Clinical areas

- This guideline covers all clinical areas across the Trust that are designated as inpatient areas for adult patients

Patient groups

- The guideline will apply to all adult inpatients and should be applied to those who have confusion, alteration in cognition, alteration in or fluctuating behaviour or mental illness that are identified as potentially requiring a level of supervision outside of those provided by agreed staffing levels.

Related Trust Documents

- Deprivation of Liberty Safeguards Policy (for Adult Patients aged 18 or over)
- Guidance for the Management of Work Related Violence and Aggression
- Incident Reporting Policy
- Management of Children and Young People admitted to Ward 25 with Self- harm - Guideline
- Mental Capacity Act (MCA) Policy
- Consent to Examination, Treatment and Care Policy
- Risk Management and Assurance Policy
- Restraint and Restrictive Practices Policy
- Safeguarding Adults Policy
- Self-Harm - Assessment and Management of Adult Patients at Risk Policy

3.0 DEFINITIONS AND/ OR ABBREVIATIONS

Trust/ SFHFT	Sherwood Forest Hospitals NHS Foundation Trust
Staff:	All employees of the Trust including those managed by a third party on behalf of the Trust (e.g. Agency Workers)
Enhanced patient observation (EPO):	The term identifies the task performed when the 'Enhanced Patient Observation (EPO) care giver' is engaged in delivering enhanced patient support through directly observing the location, mood and activity of specific patient/s at set time intervals and where required from a specified distance (e.g. within eyesight or within arm's length/ close observation). These terminologies and the specific requirements are fully explained within the main section of the guideline. Effective enhanced patient observation is facilitated by engagement. It is not sufficient when undertaking enhanced observations to merely record that an individual is settled/observed. The EPO care giver should satisfy themselves that the individual that they are observing is safe.
EPO care giver:	The EPO care giver is a member of staff who has been identified to undertake the task of observing a specific patient or patients who have been risk assessed and assigned a level of enhanced patient observation.
Nurse in charge:	This phrase refers to the nurse designated as 'in charge' of the ward over a span of duty. It should not be confused with the most senior nurse on the ward, e.g. a ward sister/charge nurse, deputy ward sister/charge nurse or another ward nurse who at the time is the most senior present because the nurse in charge is temporarily away from the ward.
Designated Nurse:	A registered nurse who has been designated the responsibility of the nursing care for a number of patients for a duty period

4.0 ROLES AND RESPONSIBILITIES

4.1 Ward/ Unit Sister/Charge nurse (or deputy)

Is responsible for:

- Ensuring that each member of staff in areas that undertake enhanced patient observations are competent to undertake the task and are familiar with the EPO Guidelines and the EPO care plan.

4.2 Nurse in charge

At any one given time there must be someone who holds responsibility to review the level of EPO daily, in line with the patient's condition. The level of observation should be added to Nervecentre by the nurse in charge. Their responsibility includes; stopping, maintaining, increasing or decreasing the level of observation. Ideally, the staff member will make this decision in consultation with other members of the nursing team and MDT).
It is also the responsibility of the nurse in charge of the clinical area to:

- Ensure that the individual delegated to undertake the EPO has the appropriate skills and understanding. Where the person undertaking EPO is a student nurse, the nurse in charge should liaise with the appropriate mentors to ensure that the student has the skills and understanding to carry out the task safely
- Ensure supervision of non-registered staff designated to provide the EPO
- Establish a rota for the staff that have been identified to carry out the task of EPO duties over the course of a span of duty period, ensure this is communicated to all staff on shift
- Communicate to all staff on duty which patients are subject to EPO and at what level of observation they require
- Ensure that EPO care giver does not engage in 'within arm's length/close observation' for more than **two hours** at a time, unless there are compelling clinical or safety reasons why the EPO care giver should carry on for longer, this should be evidenced in the EPO care plan documentation/nursing evaluation

4.3 Multi-Disciplinary Team members

- Determining EPO levels for patients requiring enhanced support is principally a task which falls to nursing staff. However, good practice dictates that it should involve as many members of the Multi-Disciplinary Team (MDT) as practicable and in many instances joint nursing/medical assessments, decisions can be made
- Where patients are transferred to the care of another provider (e.g. another acute trust) the MDT must clearly communicate the individuals care needs and risks in relation to EPO

4.4 EPO care giver

The EPO care giver is responsible for:

- Ensuring they are competent to undertake the task

- Undertaking the delegated EPO in accordance with this guideline utilising the relevant documentation
- Ensuring there is a clear exchange of information pertaining to the patients care when one EPO care giver is replaced by another
- Ensuring the documentation is completed with relevant information (supported by the Activity Chart)

4.5 Designated Nurse

The designated nurse is responsible for:

- Ensuring that the relevant documentation has been correctly completed by the EPO care giver
- Ensuring that the episode of care has been evaluated in the nursing records per duty period
- Liaising with the nurse in charge regarding the current level of observation being undertaken

5.0 NARRATIVE

5.1 Consent, capacity and deprivation of liberty

All healthcare professionals are required to ensure appropriate lawful authority is in place prior to undertaking any examinations, initiating treatments or implementing care. This lawful authority will normally either take the form of valid, informed consent from the patient or, where a person lacks capacity to give or with-hold consent, making the decision in the patient's interests following the Mental Capacity Act (MCA).

It is assumed that every person has capacity to give their informed consent unless there is evidence to suggest otherwise. Where there are concerns that a patient may lack capacity to give their informed consent, the patient's capacity to make the specific decision regarding the level of observation, should be formally assessed and this should be documented using MCA Form 1.

If a patient lacks capacity the decision regarding their care and treatment is made in their best interests, following the best interests checklist in the Mental Capacity Act Code of Practice, importantly the patient's involvement in the decision making process should be encouraged as much as possible and the patient's family and / or carers should be consulted. This should be documented in the patient's clinical record.

All clinical documents must include information regarding consent/ capacity specifically in relation to the subject matter of the document and associated documentation/ record keeping e.g. use of consent forms, two stage test, best interests checklist and recording when verbal consent has been gained.

Whilst the use of enhanced observations is important to ensure patient safety and to prevent the patient from coming to avoidable harm and is only implemented in the best interests of the

patient; it is important to acknowledge that when a patient lacks capacity to give their informed consent to that care, it is considered a restrictive practice, especially when a patient would not be free to leave the hospital if they chose to.

The Right to Liberty is protected by Article 5 of the ECHR; importantly a deprivation of liberty is unlawful, unless it has been authorised in accordance with a process in law. For patients who lack capacity to consent to enhanced levels of observation the Deprivation of Liberty Safeguards (DoLS) can be used to lawfully authorise a deprivation of liberty, in the patient's best interests.

A person is considered to be deprived of liberty if they are:

- Not free to leave, ***and***
- Under continuous supervision and control, ***and***
- Lack capacity to give their informed consent to the care and treatment that deprive them of liberty

Although each case is different and must be assessed on the unique facts of the situation; if the patient is placed on an enhanced level of observation and lacks capacity to give their informed consent to that, there is a risk that the patient would be deprived of liberty. This is because it is likely that the patient would not be free to leave hospital and would be considered to be subject to continuous supervision and control and therefore, regard should be given as to whether the patient is being deprived of liberty and whether an authorisation for is required.

For a deprivation of liberty to be authorised, this must be in the patient's best interests, and necessary to prevent them from coming to harm. For this to be shown to be in a patient's best interests. there should no lesser restrictive option to keep the patient from coming to harm; and, the level of observation must be a proportionate response to the likelihood of harm and the seriousness of that harm.

The Deprivation of Liberty Safeguards (DoLS) are not divorced from the wider framework of the Mental Capacity Act and therefore staff should follow the best interests checklist in the MCA Code of Practice, importantly the patient's involvement in the decision making process should be encouraged as much as possible and the patient's family and / or carers should be consulted about the decision.

Where required, the following related Trust policies should be referred to:

- Deprivation of Liberty Safeguards Policy (for Adult Patients aged 18 or over)
- Mental Capacity Act (MCA) Policy
- Policy for Consent to Examination, Treatment and Care

Advice can also be sought in office hours from the Trust's MCA / DoLS Lead Practitioner on ext: 3357.

5.2 Safe and Supportive observation guidelines: care planning and delivery

Determining the level of supervision required while caring for a patient that are identified as being at increased risk of harm, considering the patients capacity.

The least restrictive means of observations should be always used to manage risk.

This guideline is based on three levels of observation:

a) Low Risk - Normal level supervision

Staff are expected to be aware of the whereabouts of all patients in their care, whose needs can be met within normal staffing limits. This group of patients can be supported by intentional rounding, the timing determined by the Registered Nurse in charge of the care of that patient.

b) Medium Risk – Continuous Cohort Supervision/within eyesight

The patients' location, activity and any interventions should be checked at regular intervals and the outcomes of these checks should be documented using the **Activity Chart: Increased Supervision** pages 5-8 of the Enhanced Patient Observation care plan. (see Appendix 1 for representational copy) The exact intervals between assessment and what the checking activity and interventions should consist of, should be decided initially and documented. This level of EPO may have an implication for staffing levels. Patients may be safely cohorted after assessment.

c) High Risk* - Constant observation

These patients are at immediate risk of harming themselves or others, due to their clinical or psychological condition, behaviour or lack of awareness. Constant level of observation requires that a member of staff always remain with the patient and should not leave the patient unsupervised and will not undertake any other duties. Those performing the observation should document all activity/interventions and detail the effectiveness of these. **Activities SHOULD be recorded when they occur (not every hour).** Where a patient is isolated due to infection, the allocated EPO care giver should remain with the patient.

It is the responsibility of the nurse in charge to ensure that all staff allocated to perform this level of observation are competent to do so. The nurse in charge must also ensure that there is a sufficient rotation of staff to ensure that no member of staff spends over two hours undertaking the level of observation. The staff member should feel empowered to ask to rotate, if this has not taken place. A member of staff is required to always stay with the patient and the implication for staffing levels must be explored.

* where patients are deemed to require the use of restrictive physical interventions for the safety of themselves and others, staff should refer to the Restraint and Restrictive Practices Policy. (Section 8.0) Advice can also be sought in office hours from the Trust Restrictive Practices Specialist on ext. 4158.

5.3 Result of implementing guideline:

a) Enhanced professional decision making about the need for and the appropriate use of staff for EPO
b) Standard set of observation level/staff required
c) Balance between independence and supervision established
d) Enhanced structured communication of requests for additional staff to supervise patients which must be communicated and approved by the Matron or Divisional Directors of Nursing

6.0 GUIDELINE DETAILS

Pre-printed Enhanced Patient Observation care plans must be ordered via Clinical Illustrations. Supplemental Activity Charts pages may be downloaded and printed from the Sherwood Forest Hospitals content from the Royal Marsden Manual Online (login to the RMM online via the intranet homepage) these are co –located with the Enhanced Patient Observations care plan. See Appendix 1 for a representational copy.

A new care Enhanced Patient Observation care plan is required for every 7 days of increased observation.

6.1 Determining an appropriate level of supervision – the process

All patients identified as potentially requiring an increased level of supervision should be assessed by a registered practitioner using the Risk assessment and suggested level of supervision guidance - found on page 2 of the Enhanced Patient Observation care plan.

The assessment should take in to account the immediate and potential risks of the patient coming to harm and should consider medical and social history, with the emphasis on assessment, care planning and regular evaluation, which should involve the multi-disciplinary team.

These guidelines are not prescriptive as there are many possible situations and factors that may influence the decision to assess for an increased level of observation. Risk level can be identified in relation to safety, communication, cognition and procedural interventions.

Risk assessment should include discussion with the patient and carer, assessment and evaluation of the patient's history, assessment of falls risk, manual handling needs and aggression and should also include a review of medications and current medical plan considering the assessment of other health professionals such as the psychiatric team.

Document if the patient is exhibiting any behaviour that will give cause for concern or potential risk:

- Self-harming and self- injury behaviour
- Marked wandering around which may result in self-injury
- Attempting to remove invasive lines and /or monitoring equipment

- Physical aggression
- Altered mental state

The assessment should be used to help identify the level of risk that the patient presents with.

Once the level of risk has been identified the risks should be documented and any mitigation steps should be documented - these may include:

- Where there are concerns about the patient's capacity to make the specific decision regarding the level of observation, carrying out a formal assessment of the patient's capacity and documenting this; where the patient lacks capacity making the decision in the patient's best interests, following the guidance in the Mental Capacity Act
- Care and comfort rounding
- Use of a 'This is Me' document
- Risk assessments
- Use of a Falls Mitigation care plan
- Moving the patient to an observable position
- Environment
- Cohort supervision
- Side room
- Informing the family of increased observation and the reasoning for this
- Language barriers, including actions needed to resolve
- Increased visiting, consideration of the Carer Passport
- Medicine review
- Multi- Disciplinary Team review
- Monitoring for precipitating factors i.e. noise, constipation, incontinence
- Engaging patient in meaningful activities (reminiscence, therapeutic)
- Considering whether the patient is being deprived of liberty and seeking appropriate authorisation under the Deprivation of Liberty Standards (DoLS)

Staff providing the increased observation should complete the **Activity Chart: Increased Supervision** pages of the EPO care plan. These are helpful if the level of supervision required is unclear for any reason. It is imperative that staff capture any interventions and their level of effectiveness to ensure that forward care planning is optimised for the individual.

It may also be appropriate to use an **ABC chart** (antecedent, behaviour, consequence) (Appendix 2) to determine what triggers any changes in behaviour. Advice regarding this can be sought from the Rapid Response Liaison Psychiatry team.

Staff should not be put at risk when observing and managing very violent or aggressive patients. In these circumstances further help should be sought through security or police, caution should be taken as in some instances the presence of the police or security will further distress the patient which may lead to an escalation in their aggression.

Where possible the level of EPO should be assessed by the Nurse in Charge of the patient's care in conjunction with other members of the healthcare team. Comments from the other staff members and family may be noted in the decision-making process. The level of supervision required should be documented including any variations throughout a 24-hour period. Some

patients may be manageable with normal staffing levels during the day but at higher risk overnight. The observation level should be set on identification of the potential risk and be reassessed every 24 hours or as the risk or patient's condition changes. The level of EPO can be added to Nervecentre and is easily identifiable for staff.

6.2 Documentation and Communication

Any patient requiring additional level of supervision should be commenced on an EPO care plan.

All members of the ward team must be aware of the level of supervision required, which members of staff are providing the supervision and plans for rotation of staff. It is the responsibility of the Nurse in Charge of the ward to ensure that any specific risks are communicated amongst the ward teams.

When initiating the level of observation, every effort should be made to explain the process and why it is necessary to the patient concerned and where appropriate to carers and relatives.

The patient's plan of care should be reflective of their need for EPO and the assessment and evaluation of this care documented within their nursing care evaluation.

6.3 Reviewing the level of observation required

Throughout the patients stay, the level of risk will be determined and the appropriate observation level prescribed accordingly.

Any member of the multidisciplinary team will be able to ask for the level of observation to be reviewed by the nurse in charge if they feel it appropriate.

Where any patient is under continuous observation, the need for this to be continued should be evaluated, every 24 hours or as the patient's condition changes.

6.4 Evaluation

It should be noted that level of supportive observation may differ within a 24-hour period e.g. late evening and early night may be high risk for some patients with delirium or dementia. Therefore, the level of observation may differ throughout a 24-hour period.

- Decisions should be recorded, even if the level of observation is to remain the same
- Other members of the multi-disciplinary team should be consulted, and staff should feel comfortable in seeking advice from senior members of staff and other health professionals so that the correct levels of observation are maintained
- Staff working on the ward must be aware of the level of observation agreed

7.0 EVIDENCE BASE/ REFERENCES

- Alzheimer's Society (2009) Counting the cost: Caring for people with dementia on hospital wards. Alzheimers Society, London.
- Cayton H, Nori G, Warner J (2011) Alzheimer's and other Dementias, London
- Champion E (2014) Person-cented dementia care in acute settings. Nursing Times, Vol 110, No 37 p 23-25
- Department of Health (2009) Living Well with Dementia: A National Dementia Strategy. Department of Health, London
- FONS (2017) Making Additional/Special Observations Meaningful for Patients Living with a Diagnosis of Dementia
- Foster. S, (2016) Good Practice for one-to-one care. British Journal of Nursing, Vol 25, No 14 p 819
- May H, Edwards P, Brooker D (2009) Enriched Care Planning for people with dementia – a good practice guide for delivering person centred care. Jessica Kingsley Publications, London
- Mental Capacity Act 2005. London: HMSO
- National Association for Providers of Activities for older people 'Why activities are important' London: NAPA.
- NHS Confederation (2010) Acute awareness: improving hospital care for people with dementia NHS London
- Nursing and Midwifery Council (2009) Guidance on the Care of Older People, NMC: London.
- Nursing and Midwifery Council (2018) The code: Professional standards of practice and behaviour for nurses, midwives an nursing associates. NMC: London.
- Royal College of Nursing (2011) Dignity in Dementia; transforming general hospital care, RCN: London.
- RCN (2019) Commitment to Care of People with Dementia (SPACE principles) RCN London
- RCN (2010) Improving quality of care for people with dementia in general hospitals, RCN London
- Zeisel, J. (2011) I'm still here: a breakthrough approach to understanding someone living with Alzheimer's', London: Piatku

8.0 EDUCATION AND TRAINING

All staff

The Ward/ Unit Sister/Charge nurse (or deputy) will ensure that each member of staff in areas that undertake EPO, receives an explanation of the different levels of observation and appropriate documentation and how to use them as part of workplace induction. This will also include:

- *Enhanced Patient Observation levels – the level that individuals may be subject to, what they mean and how they are carried out*
- *Duty of care –in particular the responsibility to act to maintain safety*
- *Behaviours and expectations*
- *Record keeping – responsibilities and standards*
- *Accident/Untoward occurrence reporting and procedures – when these should be completed*
- *Engaging with the patient and performing meaningful activities, resources can be found in the library or via the Dementia Team ext. 2705*

Student Nurses

Where the person undertaking EPO duties is a student nurse, they may do so with a level of appropriate supervision and support as with any other nursing role as part of their learning. It is the responsibility of the mentor/practice supervisor/practice assessor to ensure that the student has the skills and understanding to carry out direct observation safely. Competence will vary from individual to individual. Competence in this instance relates to the ability to safely undertake duties in accordance with this guideline and in accordance with any requirements set by individual higher education providers.

The opportunity to care for a patient who requires enhanced observation should be recognised as a valuable learning opportunity and reflected and recorded in the student's record of placement/practice.

9.0 MONITORING COMPLIANCE AND EFFECTIVENESS

The recommendations for EPO will be monitored daily by the Ward/ Unit Sister/Charge nurse (or equivalent). They are responsible for overseeing the processes and documentation surrounding EPO. They will ensure that all relevant documentation has been correctly completed, the care evaluated per duty period by the delegated nurse and that they agree the level of observation required for individual patients. The Ward/ Unit Sister/Charge nurse (or equivalent) will also ensure that a formal review of the patient and their plan of care take place every 72 hours as a minimum.

If any incidents occur, they will be subject to review following the Incident Reporting Policy and acted upon accordingly.

10.0 EQUALITY IMPACT ASSESSMENT

- Guidance on how to complete an Equality Impact Assessment
- Sample completed form

Name of service/policy/procedure being reviewed: Enhanced Patient Observation Guideline (for Adult inpatients)			
New or existing service/policy/procedure: Existing			
Date of Assessment: 12 February 2023			
For the service/policy/procedure and its implementation answer the questions a – c below against each characteristic (if relevant consider breaking the policy or implementation down into areas)			
Protected Characteristic	a) Using data and supporting information, what issues, needs or barriers could the protected characteristic groups' experience? For example, are there any known health inequality or access issues to consider?	b) What is already in place in the policy or its implementation to address any inequalities or barriers to access including under representation at clinics, screening?	c) Please state any barriers that still need to be addressed and any proposed actions to eliminate inequality
The area of policy or its implementation being assessed:			
Race and Ethnicity:	None	Not applicable	None
Gender:	Sensitivity to the needs of patients when undergoing constant supervision	Nurse in charge to delegate appropriately	None
Age:	None	Not applicable	None
Religion:	None	Not applicable	None
Disability:	None	Not applicable	None
Sexuality:	None		
Pregnancy and Maternity:	None	Not applicable	None
Gender Reassignment:	(see gender)		
Marriage and Civil Partnership:	None	Not applicable	None
Socio-Economic Factors	None	Not applicable	None

What consultation with protected characteristic groups including patient groups have you carried out? ➢ None
What data or information did you use in support of this EqIA? ➢ Content of the guideline
As far as you are aware are there any Human Rights issues be taken into account such as arising from surveys, questionnaires, comments, concerns, complaints or compliments? ➢ No

Level of impact
From the information provided above and following EqIA guidance document please indicate the perceived level of impact:

Low Level of Impact

For high or medium levels of impact, please forward a copy of this form to the HR Secretaries for inclusion at the next Diversity and Inclusivity meeting.

Name of Responsible Person undertaking this assessment: [redacted]
Signature: [redacted]
Date: 12th February 2023

11.0 APPENDICES

Appendix 1. Activity Chart : Increased Supervision Supplemental Chart (from EPO care plan) – representational copy not for print/ use in practice

Appendix 2. ABC Chart (antecedent, behaviour, consequence) (hyperlinked to intranet)

Appendix 1. Activity Chart: Increased Supervision Supplemental Chart (from care plan) – representational copy not for printing/ use in practice

Name_____

Date of birth _____

Address _____

_____

_____

District or NHSNumber _____

ACTIVITY CHART: INCREASED SUPERVISION

Please document in detail all patient activity throughout the day and night. Document each activity. If the patient is sleeping document **every 2 hours**				
Date	Time	Activity / intervention and location	Was the activity / intervention effective?	Initial

Page.....

Hourly Rounding Charts do not need to be completed in addition to this document