The Newcastle upon Tyne Hospitals NHS Foundation Trust

Enhanced Care Observation (ECO) Policy for Adult Inpatients

<table>
<thead>
<tr>
<th>Version No.</th>
<th>3.0</th>
</tr>
</thead>
<tbody>
<tr>
<td>Effective From</td>
<td>28 November 2018</td>
</tr>
<tr>
<td>Expiry Date</td>
<td>28 November 2021</td>
</tr>
<tr>
<td>Date Ratified</td>
<td>23 October 2018</td>
</tr>
<tr>
<td>Ratified By</td>
<td>Clinical Policy Group</td>
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</table>

1 Introduction

1.1 The Newcastle upon Tyne Hospitals NHS Foundation Trust (the Trust) has a duty of care to ensure the safety of patients in its care and takes all possible steps to do so. The purpose of this policy is to ensure that all in-patients' level of observation within the Trust be allocated appropriate to their needs. There may be times during their admission when patients may pose a risk to themselves or others. An ongoing clinical risk assessment is best practice and is the basis for determining levels of observation. This policy applies to all patients, including patients who may be detained under the Mental Health Act or have their liberty restricted under the Mental Capacity Act.

1.2 This policy provides a framework for all patients, either on admission or during admission, in accordance with their assessed level of risk and identified needs. All categories of observation set out in the policy must be adhered to fully. The staff member responsible for carrying out the observations must assure themselves at every observation interval that the patient (and other patients and staff) is safe and that all identified risks are minimised.

1.3 This policy incorporates recommendations from the National Institute for Health and Care Excellence (NICE) Guideline 10 (2015) and is intended to address the short-term management of violence and aggression in adult patients. It is relevant for all adult inpatients. The guideline aims to safeguard both staff and people who use services by helping to prevent and manage situations where patients may present as confused, aggressive and/or violent or present a risk to self or others and provide guidance for safe management.

The Trust is committed to providing a safe and supportive environment to all patients, visitors and staff. It is recognised that patients may have changing clinical, behavioural and social needs and may require varying degrees of support (including observation) to be offered during these phases.

2 Scope

2.1 Some patients require more than a general level of observation, often with the primary aim of reducing risk and protecting the patient (e.g. they have increased confusion or are at risk of falling and sustaining injury). There are many reasons why a patient may require enhanced care observation. The most common factors are high risk of falls and/or cognitive impairment secondary to delirium and/or dementia, as well as where patients present a
risk to self or others. There are separate examples policies for patients at risk of acute physiological conditions and these policies should be referenced in this case.

3 Aim

3.1 This policy sets out the process and procedures for guiding practitioners in making decisions to ensure a safe and therapeutic environment, to facilitate the assessment and management of in-patients level of observation and the rationale for supporting those decisions.

4 Categories of enhanced care observation

4.1 The decision to implement enhanced care observation is made following a holistic risk and multidisciplinary assessment of the patient’s physical and psychological state as well as social and environmental factors at that moment in time. This needs to be clearly documented with the rationale for the level of observations clearly stated and an appropriate observer identified.

4.2 NICE Guideline 10 (2015) ‘Violence and aggression: short-term management in mental health, health and community settings’ makes recommendations regarding terminology and the following has been adopted by the Trust;

<table>
<thead>
<tr>
<th>Level of enhanced care observation</th>
<th>Inclusion criteria</th>
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<tbody>
<tr>
<td>A General Observation (routine care)</td>
<td>Patient identified as:</td>
</tr>
<tr>
<td></td>
<td>• Posing no risk of harm to self or others</td>
</tr>
<tr>
<td></td>
<td>• No behavioural disturbances</td>
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<tr>
<td></td>
<td>• Do not require additional observation above routine physiological observation</td>
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<tr>
<td>B Intermittent observation:</td>
<td></td>
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<tr>
<td>the baseline level of observation whose frequency is every 30-60 minutes.</td>
<td>Patient has one or more of the following:</td>
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<tr>
<td></td>
<td>• Risk of falls; but no history of falls and no condition affecting balance, dizziness or cognitive ability</td>
</tr>
<tr>
<td></td>
<td>• Occasional episodes of confusion.</td>
</tr>
<tr>
<td></td>
<td>• Occasional restlessness or agitation e.g. attempting to leave clinical area</td>
</tr>
<tr>
<td></td>
<td>• Behaviour that may be perceived as challenging</td>
</tr>
<tr>
<td></td>
<td>• Low risk of deterioration</td>
</tr>
<tr>
<td></td>
<td>• Low risk of self-harm</td>
</tr>
<tr>
<td>C Continuous observation:</td>
<td></td>
</tr>
<tr>
<td>e.g. Cohort Bay - used when a patient presents an immediate risk of harm to self or others and needs to be kept within eyesight of a designated nurse.</td>
<td>Patient has one or more of the following:</td>
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<tr>
<td></td>
<td>• Risk of falls; history of falls and has a condition affecting balance, dizziness or cognitive ability</td>
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<tr>
<td></td>
<td>• Moderate confusion. Frequently restless, requiring regular reassurance</td>
</tr>
<tr>
<td></td>
<td>• Regular episodes of agitation, or</td>
</tr>
</tbody>
</table>
D

High Level/Multiprofessional continuous observation:
used when a patient is at the highest risk of harming themselves or others and needs to be kept within arm’s length of at least 1 member of staff.

<table>
<thead>
<tr>
<th>Patient has one or more of the following:</th>
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<tbody>
<tr>
<td>• in need of continuous monitoring for any clinical indication e.g. video telemetry</td>
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<tr>
<td>• at significant risk of falls and harm; actual fall has occurred</td>
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<tr>
<td>• severe confusion. Regular and frequent episodes of distress</td>
</tr>
<tr>
<td>• regular and frequent episodes of agitation, violent behaviour, at risk of absconding</td>
</tr>
<tr>
<td>• identified as being at serious risk of self-harm; suicidal intention, serious self-harm incident has occurred</td>
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</tbody>
</table>

4.3 Both of the levels of observation described in C and D above, should be considered to mean that patients are within eye sight or arm’s length of staff at all times. Where curtains are required for privacy, this must not prevent staff from being able to see the patient. Consideration should be given to the gender of the member of staff since this level of observation will occur within bathrooms/toilets.

4.4 **Level A: General Observation**
This is the minimum acceptable level of observation for all inpatients. The location of all patients should be known to staff, but not all patients need to be kept within sight. At least once a shift a nurse should sit down and talk to each patient to assess their health and wellbeing. This should always be documented in the health care record. At the beginning and end of every nursing shift, the whereabouts and general condition of all patients should be part of the handover.

4.5 **Level B: Intermittent observation** (close observation and intentional rounding)
This means that the patient must be observed at specific intervals agreed by the Nurse-in-charge and where possible agreed in collaboration with the patient/careers/family as appropriate. This level of support is indicated where the risk level is higher than level A (but there is not an acute or overt risk of harm to self or others) and the patient is deemed safe between checks or has capacity to summon support where necessary.

4.6 **Level C: Continuous observation** (within eye sight)
The patient must be visible and under constant, uninterrupted supervision of the observer. Within line of sight should place staff close enough to respond immediately should an incident occur or be likely to occur. Any intervention which results in this level of observation being reduced e.g. toileting a patient,
in a cohort bay would require an additional member of staff. There may be occasions for some degree of privacy (e.g. when visitors present), though this must be carefully considered, agreed and communicated.

A regular summary of the patient’s condition, care and treatment must be entered on the care plan. This must include changes in mental health, physical, psychological and social behaviour, pertinent development and significant events. This level may include cohorting of patients. Methods of interaction and engagement should also be considered. Cohorting patients with dementia and or delirium may not be appropriate due to increased levels of agitation. Staff should contact the Dementia Care Team for advice.

Environmental factors should be considered to maintain patient safety, (e.g. including removing equipment/instruments that may be used to cause harm to self or others, positioning of furniture to reduce falls, consideration of noise/lighting levels.

4.7 Level D: High Level/Multiprofessional continuous observation
The patient must be subject to close proximity (arm’s length), constant, uninterrupted observation. If arm’s length is determined as being not required, the actual distance or proximity must be documented and based on an assessment of the patient’s condition. This level of enhanced care observation is a minimum of one to one care and may require additional staff. This number must be specified.

Staff must ensure their own safety as well as the patient’s at all times.

5 Duties, Roles and responsibilities:

5.1 The Chief Executive is responsible for:

Ensuring that appropriate and adequate infrastructure exists to support the observation and engagement of patients.

5.2 The Directors, Clinical Directors and Directorate Managers are responsible for:

The strategic and operational management of the observation and engagement of patients within the Trust.

5.3 Head of Department/Managers, Matrons, Sisters and Charge Nurses have a responsibility to:

- Ensure that all staff are made aware of policies and receive appropriate training in their application
- Ensure that policies are implemented and evaluated appropriately
- Ensure that periods of observation are viewed as opportunities for therapeutic engagement and relationship building
- Identify/manage and deploy resources to meet service requirement.
5.4 Registered staff have a responsibility to:

- Initiate the care plan if a patient needs continuous monitoring for any clinical condition
- If an enhanced care observation care plan is instigated because of concerns about possible psychiatric illness and/or risk of violence, self-harm or harm to others secondary to this, then the Mental Health team can be contacted for advice and/or intervention and the Patient Services Co-ordinator must be informed. Contact details are as follows;
  - Psychiatric Liaison Team via NUTH switchboard
  - On call Psychiatrist out of hours via St Nicholas Hospital switchboard
  - Patient Services Co-ordinator via switchboard
- Ensure that all patients have an appropriate assessment of risk on admission, at shift handover and if their condition changes (refer to relevant policy e.g. the management of patient slips, trips and falls).
- Provide communication support if this is required
- Complete observation record for their named patient
- Inform each patient of the level of observation they have been assessed to require and the reasons for this
- Provide support and where appropriate information to relatives/carers present
- Ensure that the observation record is completed
- Ensure that periods of observation are viewed as opportunities for therapeutic engagement and relationship building
- Review the plan of care on a regular basis, this may be in discussion with the Psychiatric Liaison Team or other clinical experts such as the Dementia Care Team
- Complete documentation as specified.

5.5 Non-professionally registered staff have a responsibility to:

- Ensure that periods of observation are viewed as opportunities for therapeutic engagement and relationship building
- Be familiar with and implement the observation care plan for each individual in their care
- Complete documentation contemporaneously as specified
- Report any relevant information to assist the effective review of patient’s level of observation.

6 General Principles

6.1 The key to all levels of enhanced care observation is safety and protection from harm and maintenance of well-being. Within the Trust, this policy should be utilised across all clinical settings to support the delivery of effective patient care.
6.2 Enhanced care observation is an intervention that is used both for the short-term management of disturbed/violent behaviour and to prevent self-harm (NICE Guideline 10 2015).

6.3 Levels of enhanced care observation should be discussed and/or negotiated with the patient and (whilst taking into consideration patient confidentiality and capacity issues) their family/partner/carer wherever possible. Staff must clearly explain the reasons for the level of enhanced care observation. This will be based on a sound ongoing risk assessment, which is reactive to dynamic risk factors. As well as any other situations where risk is identified to the patient or others.

6.4 Levels of enhanced care observation should be based on patient need not driven by financial constraints. Where there is a requirement for Enhanced Care Observation but there is a staffing shortfall to be able to provide this level of observation, this should be escalated through the existing mechanisms as highlighted in Appendix 5 of the Nursing and Midwifery Staffing guidelines.

6.5 In most cases the Trust will be responsible for sourcing and providing appropriate staff to provide Enhanced Care Observation. The exception to this is for patients who have been transferred under a section of the Mental Health Act from an inpatient ward of Northumberland Tyne and Wear NHS Foundation Trust (NTW) for physical health treatment and are expected to be transferred back. In this exceptional case, staff from the relevant NTW ward will be responsible for the provision of appropriate support staff to meet the individual’s mental health needs. In the case where the risk is purely related to physical health e.g. falls, telemetry etc, staff would be expected to be provided by the Trust as per any other patient. Where there is any doubt the decision should be taken within the wider MDT involving relevant NTW staff as required.

6.6 Consideration should be given to ensuring a safe environment for patients and staff and the need to be responsive should the patients’ needs or behaviours change.

6.7 Intensive engagement and observation of patients may be seen as intrusive, particularly where it is prolonged for many hours. It is important therefore that staff balance the potentially distressing effect against the risk of harm and justify its use by continually assessing the effectiveness of enhanced care observation in minimising the risk of harm. This should also apply if the patient does not consent to the enhanced care observations. If there is a question about the patient’s ability to consent to the observations, an assessment of capacity should be documented and a decision made in best interests if lacking capacity. This should be regularly reviewed if the patient regains capacity and/or the levels of observations are no longer appropriate to the situation.

6.8 The least intrusive level of enhanced care observation that is appropriate to the situation should always be adopted so that due sensitivity is given to a
patient’s dignity and privacy whilst maintaining the safety of the patient and/or those around them.

6.9 It may be necessary to search the patient and their belongings, while having due regard for patient legal rights and conducting the search in a sensitive way in order to remove any materials that might escalate risk. Consent should be sought and searches should be undertaken by two members of staff, at least one of whom should be the same sex as the person being searched.

6.10 A specific enhanced care observation care record is required (appendix 1). Issues of privacy, dignity and the consideration of gender in allocating staff, and environmental risks need to be discussed and incorporated into the care plan on an individual case by case basis including toileting and personal care. The staff member responsible for carrying out the prescribed observations over the period must document a brief summary of the patient behaviour.

6.11 Careful consideration should be given to patients with Learning Disability or Autism. Previous research has shown that when suffering physical pain and distress some patients with LD present with behaviour which may be perceived by care givers as challenging. Always listen to the patient and family or carers and consider contacting the Learning Disability Liaison Nurse if you are working with a patient who is on an enhanced care observation care plan.

6.12 Providing communication support for those who need it will be critical in assessing and understanding the behaviour of patients who need communication support. This may involve professional Spoken Language Interpreters, British Sign Language Interpreters, Deaf Blind Guides, Learning Disability Advocates or a relative/partner who is familiar with the patient’s communication – such as stroke and ‘neck breathing’ patients.

6.13 Staff members providing level C: Continuous observation should be rotated every 2 hours (as a minimum). Staff providing level D: high level continuous observation on a 1:1 basis should be rotated one to two hourly (as a minimum). If providing level D: Multiprofessional continuous observation with more than one member of staff at least one member of staff should be rotated every hour (as a minimum).

7 Who should set the levels of observation?

7.1 The prescribing of enhanced care observation levels should, wherever possible, be the result of a joint medical/nursing assessment, though nursing staff may need to initiate a level of observation above general level on admission or following a rapid change in the patient circumstances before discussion with medical staff can take place.

8 When should observation levels be set?
8.1 If at any time during or following admission a patient is considered to be at risk either to themselves or others an assessment should be made regarding enhanced levels of observations.

8.2 Consideration should be given to periods of identified increased risk such as evenings and night; nursing handover periods; following a reduction in the levels of observation; improvement in mood etc. and document how specified actions can be taken.

9 **Informing the patient**

Every effort should be made to inform patients about the purpose of any intervention and consent gained where possible. Explain the level and procedure of observations and any restrictions.

Where the patient lacks capacity to consent, consider the use of the Mental Capacity Act/Deprivation of Liberty Safeguards or the Mental Health Act, and involve carers in assessing best interests.

10 **Record Keeping**

10.1 The observation levels prescribed must be recorded into the patient record. An individualised observation record and plan of care should also be drawn up with the involvement of the patient where appropriate.

10.2 The care record should include:

- Level of observation and exact intervals at which the observation should be carried out
- The reason for observation and any specific times or environments as outlined in this policy
- Identification of risks
- Stipulations of what the observing nurses are required to do and frequency thereof, in order to support the patient
- Any changes to the level of observation should be amended on the plan of care
- Whether gender-specific staffing is required and rationale (e.g. bathroom supervision needed)

10.3 The level of observation, including the risk behaviours and factors identified should also be recorded and signed. Records of observation should always accurately reflect prescribed levels of observation.

10.4 Participating staff will make a brief summary of the patient’s behaviour and mental state in accordance with the plan of care.
11 Who should carry out observation?

It is the responsibility of the nurse-in-charge to ensure that observations are carried out according to the agreed level. The staff member responsible for carrying out within arm’s length or eyesight observation will usually:

- Be a registered nurse, nursing healthcare assistant with appropriate training or on rare occasions a member of the hospital security staff
- The patient’s views and needs should be taken into account when allocating staff to undertake observations

The multidisciplinary team (MDT) will review levels of observations at each shift change.

12 Carrying out observation

12.1 Observation usually involves a number of nurses, with care being handed over at intervals. Excellent communication amongst staff must be maintained.

- At the beginning of each shift, as part of the Safety Huddle, the nurse-in-charge shall inform and ensure that all members of the ward team, who are involved in observations with a patient, understand the procedure, in terms of who is being observed at what level, and why.
- Before taking over the patient’s observation, each nurse will have familiarised themselves with the patient plan of care, current risks and individual needs.

The member of staff undertaking observation:

- Should take an active role in providing a stable, safe and therapeutic care environment with meaningful engagement
- Should be appropriately briefed about the patient’s history, background, specific risk factors and particular needs, likes, dislikes.
- Should be familiar with the ward, the ward policy for emergency procedures and potential risk in the environment.
- Should be approachable, listen to the patient, know when self-disclosure and the therapeutic use of silence are appropriate and be able to convey to the patient that they are valued.

12.2 If the nominated staff member cannot continue the observation for any reason, he/she will be responsible for notifying the nurse-in-charge, whilst ensuring that observations are maintained by another member of staff (e.g. staff toilet and/or meal breaks).

12.3 When observing patients staff should be assessing changes in the patient hourly or at any significant change in behaviour or incident:
- General behaviour
- Movement
- Posture
12.4 The purpose is not just visual observation but also about listening and assessing behaviours and reactions and passing this information to other members of the multi-disciplinary team to ensure a dynamic process.

12.5 Staff should also be aware of the other team members’ current duties/locations and how to gain rapid access for assistance if required.

12.6 All staff should be aware that the person carrying out the observations should offer therapeutic engagement and interventions. Staff should also aim to empower the patient and not restrict their movement unnecessarily.

13 Reviewing levels of enhanced observation

13.1 Throughout a patient’s stay, the level of enhanced care observation will be reviewed in discussion with the wider MDT; this may include the Psychiatric Liaison Team.

13.2 Any decision to increase levels of observation should be made by the MDT wherever possible; however, qualified nursing staff have the authority (and professional duty) to change the level of observations in response to urgent changes in need, state, or condition. The change in the level of observation should be communicated to the patient and may need to be discussed with the Psychiatric Liaison Team.

13.3 If a decision is made to reduce levels of observation in patients who are at risk of self-harm, this should be done in conjunction with the Psychiatric Liaison Team.

13.4 Whenever the level of observation has been reviewed a rationale should be recorded in the patient’s record.

13.5 When making or reviewing a decision about enhanced care observation for a patient who lacks capacity, the principles of the Mental Capacity Act should be applied and a Deprivation of Liberty Safeguards (DoLS) authorisation should be considered. The Mental Capacity / DoLS Lead or the Adult Safeguarding Team can be contacted for advice.

A DoLS application should be made whenever any patient has the following:

- Speech
- Expression of unusual ideas
- Appearance
- Orientation
- Mood and attitude
- Interaction with others
- Reaction to medication
- Level of consciousness
- Cognition/thoughts.
i) Lacks capacity to consent to being in hospital for care or treatment therein AND
ii) Is under continuous supervision and control of those caring for them AND
iii) Is not free to leave (irrespective of whether the patient is expressing a desire to leave or not)

Any decision made under the MCA Policy in the patient’s best interests should be regularly reviewed in line with the MCA and this Policy.

13.6 If a patient with capacity is subject to enhanced care observation, consider application of the Mental Health Act (see section 20) and seek further advice from the Psychiatric Liaison Team.

14 Training

Education will be supported by Clinical Educators within the Trust and provided for new staff where appropriate during local induction.

15 Equality and diversity

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 our staff reflects their individual needs and does not discriminate against individuals or groups on any grounds. This document has been appropriately assessed with the Equality and Diversity lead.

16 Monitoring compliance with the policy

<table>
<thead>
<tr>
<th>Standard/ process /issue</th>
<th>Monitoring and audit</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Method</strong></td>
<td><strong>By</strong></td>
</tr>
<tr>
<td>Patients will be appropriately assessed and their level of observation will be determined per policy.</td>
<td>Audit of the patient record</td>
</tr>
<tr>
<td>Documentation of patients who have been under enhanced care observation (Level D) will be completed per policy.</td>
<td>Audit of the patient record</td>
</tr>
<tr>
<td>Patients and their Carers will be involved in decisions about the level of observation implemented</td>
<td>Audit of the patient record</td>
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</tbody>
</table>
17 Consultation and review

This policy was developed in consultation with colleagues from Northumberland, Tyne and Wear NHS Foundation Trust, senior medical and nursing colleagues within the Trust and the Safeguarding Team.

18 Implementation

This policy will be placed on the intranet and listed as ‘New’. It will be circulated through the policy update newsletter.

19 References


20 Associated Trust Policies and Guidelines

Clinical Handover Policy
Clinical Record Keeping Policy
Clinical Records Management Policy
Induction Policy
Missing Adult Patients Procedure
Restraint Policy (Adults)
Nursing and Midwifery Staffing Guidelines
Mental Capacity Act (2005) policy and procedure
Patients Detained under the Mental Health Act
National Early Warning Score (NEWS) Policy
Safeguarding Adults Policy and Guidelines
Deprivation of Liberty Safeguards Policy
Managing Behavioural Disturbances Guidelines
Delirium assessment and management guideline
Care Plan for Adult Enhanced Care Observation (ECO) Level D

Guidance for completion

- This care plan should only be used when the Guidance in the Enhanced Care Observation Policy has been followed and Level D has been selected as the required level of observation and documented on the FOCUS chart.
- The authorisation to provide 1:1 Care (or above) is the responsibility of the Nurse in Charge after discussion with Matron, or out of hours, the Senior Directorate Nurse or Patient Services Coordinator.
- At the beginning of each period of 1:1 observation the staff member providing the 1:1 observation should read the plan of care in Section 2.
- A review of the level of observation required should take place at each change of shift and be documented on the FOCUS chart and ECO record of care if level D.
- The ECO record of care level D is to be completed on an hourly basis.
- The staff member providing 1:1 observation should be rotated regularly (recommended a minimum of every 1 - 2 hours).
- The nature of ECO is very dynamic therefore requires daily review and should be recorded in Section 1 below.

Section 1 – Initial agreement and assessment of the need for ECO at each shift handover

<table>
<thead>
<tr>
<th>Nurse in Charge – Initial decision for ECO and daily review</th>
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<tbody>
<tr>
<td>Date / Time</td>
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Risks identified (leading to level D ECO) please tick all that apply

- In need of continuous monitoring for any clinical indication e.g. video telemetry
- At significant risk of falls and harm; actual fall has occurred
- Severe confusion. Regular and frequent episodes of distress
- Regular and frequent episodes of agitation, violent behaviour, at risk of absconding
- Identified as being at serious risk of self-harm; suicidal intention, serious self-harm incident has occurred
- Other (please state):
Appendix 1

Section 2.

Plan of care – Enhanced Care Observation (ECO) - Adult

Goals – for all

- For the member of staff providing ECO to understand all risks and care required for the patient during this time
- To maintain the safety of the patient and others through safe and sensitive monitoring of their behaviour and mental well-being whilst engaging in a positive therapeutic relationship

Patient Centred Goals

1)  
2)  
3)  

Interventions required

Member of staff providing ECO are expected to adhere to the following:

A. All staff involved in ECO will participate in handover where the individuals’ risk, physical and psychological care needs* will be addressed. Physical needs include washing, toileting, nutrition, mobility and hydration. Psychological care needs include: previous history or current risk of suicide, self-harm or violence and aggression. Paranoid ideas, thoughts or ideas about harming themselves or others. Hallucinations particularly voices suggesting that they harm themselves or others. Recent significant life events or life changes for example bereavement or illness.

B. All staff to be made aware of Named Nurse for the patient and the Nurse in Charge of the shift.

C. All staff to introduce themselves to the patient, family/carers keeping them up to date with current plans and care

D. All staff to utilise the Forget–me–not card and other therapeutic interventions such as reading newspaper, playing cards, My Life software, etc.

E. All staff to be aware of all documentation that needs to be completed; this will include NEWS, FOCUS, Fluid Balance charts etc. It is their responsibility to support all care.

F. To liaise with the Named Nurse to ensure all documentation complete.

G. To provide reassurance if the patient is confused or frightened, orientating them to time and place as required, sharing activities.

H. To liaise with the Named Nurse to reassess level of care required at each change of shift.

I. Staff to handover their observations, care and concerns at end of each shift in relation to the patient on ECO Level D. This may include comments on the patient’s general behaviour, expression of unusual ideas, mood and attitude or interactions with others and reactions to medications.

J. To report any concerns about the patient to the Named Nurse or the Nurse in Charge.

K. All staff to regularly review and determine when ECO level D can be stepped down or altered including planning for discharge. Examples of this include an observed reduction/or increase in agitation/confusion, verbal aggression towards staff/ visitors. This should be discussed as part of the MDT and documented appropriately

L. Please liaise with the Trust Learning Disabilities nurse if required

M. Please liaise with the Trust Dementia Nurse Specialist team if required

N. Advice and support available from Trust Safeguarding Team

O. For further information refer to the Enhanced Care Observation Policy for Adult Inpatients.

P. Further advice can be sought from:
- Newcastle Psychiatric Liaison Team
- On call Psychiatrist out of hours via St. Nicholas’ Hospital switch board
- Patients Services Co-ordinator

<table>
<thead>
<tr>
<th>Care plan developed with</th>
<th>Patient</th>
<th>Carer / family member</th>
</tr>
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<tbody>
<tr>
<td></td>
<td>Insert name</td>
<td>Insert name and relationship to patient</td>
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Enhanced Care Observation (ECO) Level D Record of Care

To be completed hourly by the member of staff undertaking ECO level D to aid with on-going assessment of risk.

**Unsettled**, e.g. pacing, restless, trying to get out of bed, possibly hallucinating or paranoid, showing verbal and or physical hostility. **Remember think HINTS** - Hunger, In pain, Needs toilet, Thirst, Sleep deprived (If patient has a diagnosis of dementia or delirium they are more likely to be restless and disorientated in an unfamiliar environment).

**Settled** e.g. listening to radio or engaging in personalised conversation, remember you need to know your patients history, likes/dislikes.

Make a note of any risk behaviour(s) factors identified during observations in the comments box.

<table>
<thead>
<tr>
<th>Date</th>
<th>Unsettled</th>
<th>Settled</th>
<th>Asleep</th>
<th>Attempts to get up per hour</th>
<th>Visits to the toilet per hour</th>
<th>How much assistance provided</th>
<th>Any other comments (e.g. has there been a change in mental state?)</th>
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Handover: Reassess and document ECO level:

**Print Name and Sign**

Named Nurse (providing handover):

Designation:

Named Nurse (accepting handover):

Designation:
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<tr>
<th>Time</th>
<th>Date</th>
<th>Unsettled</th>
<th>Settled</th>
<th>Asleep</th>
<th>Attempts to get up per hour</th>
<th>Visits to the toilet per hour</th>
<th>How much assistance provided</th>
<th>Any other comments (e.g. has there been a change in mental state?)</th>
<th>ECO level D provider</th>
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*Print Name and Sign*

Named Nurse (providing handover):
Designation:

Named Nurse (accepting handover):
Designation:
## Guidance for agreeing level of Enhanced Care Observation (ECO)

<table>
<thead>
<tr>
<th>Level of enhanced care observation</th>
<th>Inclusion criteria</th>
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</table>
| **A** General Observation (routine care) | Patient identified as:  
- Posing no risk of harm to self or others  
- No behavioural disturbances  
- Do not require additional observation above routine physiological observation |
| **B** Intermittent observation: the baseline level of observation whose frequency is every 30-60 minutes. | Patient has one or more of the following:  
- Risk of falls; but no history of falls and no condition affecting balance, dizziness or cognitive ability  
- Occasional episodes of confusion.  
- Occasional restlessness or agitation e.g. attempting to leave clinical area  
- Behaviour that may be perceived as challenging  
- Low risk of deterioration  
- Low risk of self-harm |
| **C** Continuous observation: e.g. Cohort Bay - used when a patient presents an immediate risk of harm to self or others and needs to be kept within eyesight of a designated nurse. | Patient has one or more of the following:  
- Risk of falls; history of falls and has a condition affecting balance, dizziness or cognitive ability  
- Moderate confusion. Frequently restless, requiring regular reassurance  
- Regular episodes of agitation, or frequent attempts to leave clinical area  
- Identified as being at current risk of self-harm |
| **D** High Level/Multiprofessional continuous observation: used when a patient is at the highest risk of harming themselves or others and needs to be kept within arm's length of at least 1 member of staff. | Patient has one or more of the following:  
- In need of continuous monitoring for any clinical indication e.g. video telemetry  
- At significant risk of falls and harm; actual fall has occurred  
- Severe confusion. Regular and frequent episodes of distress  
- Regular and frequent episodes of agitation, violent behaviour, at risk of absconding  
- Identified as being at serious risk of self-harm; suicidal intention, serious self-harm incident has occurred |
The Newcastle upon Tyne Hospitals NHS Foundation Trust
Equality Analysis  Form A

This form must be completed and attached to any procedural document when submitted to the appropriate committee for consideration and approval.

PART 1

1. **Assessment Date:**

2. **Name of policy / strategy / service:**
   Enhanced Care Observation (ECO) Policy for Adult Inpatients

3. **Name and designation of Author:**
   Suzanne Medows, Senior Nurse (Practice Development Corporate), Ian Joy, Senior Nurse (Nursing & Midwifery Staffing), Rachel Carter, Clinical Improvement Lead (Falls and Pressure Ulcers).

4. **Names & Designations of those involved in the impact analysis screening process:**
   Suzanne Medows Senior Nurse (Practice Development Corporate), Lucy Hall Equality and Diversity Lead

5. **Is this:**
   Policy [x]  Strategy [ ]  Service [ ]
   New [ ]  Revised [x]

   **Who is affected:**
   Employees [x]  Service Users [x]  Wider Community [ ]

6. **What are the main aims, objectives of the policy, strategy, or service and the intended outcomes?** *(These can be cut and pasted from your policy)*
   This policy sets out the process and procedures for guiding practitioners in making decisions to ensure a safe and therapeutic environment, to facilitate the assessment and management of in-patients level of observation and the rationale for supporting those decisions.

7. **Does this policy, strategy, or service have any equality implications? Yes [x]  No [ ]**

   If No, state reasons and the information used to make this decision, please refer to paragraph 2.3 of the Equality Analysis Guidance before providing reasons:
8. Summary of evidence related to protected characteristics

<table>
<thead>
<tr>
<th>Protected Characteristic</th>
<th>Evidence i.e. What evidence do you have that the Trust is meeting the needs of people in various protected Groups related to this policy/service/strategy – please refer to the Equality fact files available via the link below</th>
<th>Does evidence/engagement highlight areas of direct or indirect discrimination? If yes describe steps to be taken to address (by whom, completion date and review date)</th>
<th>Does the evidence highlight any areas to advance opportunities or foster good relations. If yes what steps will be taken? (by whom, completion date and review date)</th>
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<tr>
<td>Race / Ethnic origin (including gypsies and travellers)</td>
<td>Providing communication support for those who need it is incorporated into the policy Provision of Interpreting service Mental Health Community Development Worker post for BME communities E&amp;D Training</td>
<td>People from minority ethnic communities are more likely than the general population to be detained under the Mental Health Act. Lack of communication and cultural understanding contribute to this. <strong>Action</strong> Communication support is available and referred to in this policy (sections 5.4 and 6.11)</td>
<td>Staff undertaking these assessments should be aware of how protected characteristics can impact on behavior</td>
</tr>
<tr>
<td>Sex (male/ female)</td>
<td>Male and female practitioners are available and the policy states that there may be occasions when a practitioner of the same sex is required to promote the dignity of patients</td>
<td>Male suicide rates are on average 3-5 times higher than female rates. <strong>Action</strong> Any training associated with this policy should highlight how protected characteristics can impact on behavior <strong>SM</strong></td>
<td>As above</td>
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<tr>
<td>Religion and Belief</td>
<td>Chaplaincy service provided with links to leaders of major faiths</td>
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<td>As above</td>
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<tr>
<td>Sexual orientation including lesbian, gay and bisexual people</td>
<td>Evidence files used to raise awareness of the impact of discrimination on the mental health of LGB people.</td>
<td>In the 2011, three per cent of gay men and five per cent of bisexual men have attempted to take their own life compared to 0.4% of the general population <strong>Action</strong> Any training associated</td>
<td>As above</td>
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<tr>
<td>Age</td>
<td>The policy includes reference to bereavement and the impact of this on self harm. Dementia Specialist Team</td>
<td>Men aged 30-44 are the group with the highest rate of suicide. <strong>Action</strong> Any training associated with this policy should highlight how protected characteristics can impact on behavior- <strong>SM</strong></td>
<td>As Above</td>
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**Disability – learning difficulties, physical disability, sensory impairment and mental health. Consider the needs of carers in this section**

| Disability – learning difficulties, physical disability, sensory impairment and mental health. Consider the needs of carers in this section | The policy states that careful consideration should be given to patients with Learning Disability.  
Consideration of people with previous mental health needs is incorporated into the policy  
Consideration of carers is incorporated into the policy  
Provision of BSL Signers and Deaf Blind Guides  
LD Liaison Nurse  
Links to Psychological and Mental Health Services | The behavior of LD patients related to pain and distress has been misinterpreted as mental health problems.  
Lack of communication support for deaf and Deaf blind people can lead to misinterpretation of behavior  
Over half of all carers have physical and mental health problems of their own. Carers often feel excluded  
**Action** Add Make reasonable adjustments for people with physical disabilities to 5.4  
Communication support and liaison with the LD nurse if required and family/partner/cares included in associated Care Plan.  
Any training associated with this policy should highlight how protected characteristics can impact on behavior- **SM** | As above |
<table>
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<tr>
<th>Gender Re-assignment</th>
<th>Gender Identity sub group to identify and address needs in relation to Gender Identity</th>
<th>Some evidence suggests that lesbian, gay and bisexual and transgender people, who are perhaps more likely than other groups to face hostility and misunderstanding, are all more likely to experience poor mental health <strong>Action</strong> Any training associated with this policy should highlight how protected characteristics can impact on behavior - <strong>SM</strong></th>
<th>As above</th>
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<tr>
<td>Marriage and Civil Partnership</td>
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<td>Maternity / Pregnancy</td>
<td>Women’s Health and Maternity Services provided by the Trust</td>
<td>Post Natal depression may be a risk factor <strong>Action</strong> Any training associated with this policy should highlight how protected characteristics can impact on behavior - <strong>SM</strong></td>
<td>As above</td>
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9. **Are there any gaps in the evidence outlined above. If ‘yes’ how will these be rectified ?**

   | No |

10. **Engagement has taken place with people who have protected characteristics and will continue through the Equality Delivery System and the Equality Diversity and Human Rights Group. Please note you may require further engagement in respect of any significant changes to policies, new developments and or changes to service delivery. In such circumstances please contact the Equality and Diversity Lead or the Involvement and Equalities Officer.**

   **Do you require further engagement**
   | No |
11. Could the policy, strategy or service have a negative impact on human rights? (E.g. the right to respect for private and family life, the right to a fair hearing and the right to education?)

Rights in relation to dignity and respect are incorporated.

PART 2

Signature of Author

Print name
Suzanne Medows

Date of completion
1st October 2018

(If any reader of this procedural document identifies a potential discriminatory impact that has not been identified, please refer to the Policy Author identified above, together with any suggestions for action required to avoid/reduce the impact.)