Feidhmeannacht na Seirbhíse Sláinte
Health Service Executive

Enhanced Care and Meaningful Activities Policy:

Is this document a:

Policy [√] Procedure [ ] Protocol [ ] Guideline [ ]

Insert Service Name(s), Directorate and applicable Location(s):

The Village Residence

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QUICK REFERENCE GUIDE

This policy must be followed in full when developing or reviewing and amending any procedural documents for The Village Residence.

For quick reference the guide below is a summary of actions required. This does not negate the need for all staff to be involved in the process to be aware of and follow the detail of this policy.

1. To ensure that residents requiring enhanced care observation have the appropriate level of care, supervision and observation available to them.
2. The decision to implement enhanced care observation is made following a holistic risk and multidisciplinary assessment of the resident'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 non-clinical staff identified.
3. The nurse in charge must review on a daily basis every resident receiving enhanced care observation to ensure that the risk identified in the individual risk assessment (appendix 1) still applies and if the enhanced care observation is still required.
4. All residents must be reviewed on an on-going basis and reviewed at the start and finish of each shift by the nurse in charge, and be dependent on the resident's individual needs.
5. Staff providing enhanced care level 4 must only do so for a maximum of two hours.
6. A plan must be put in place at the beginning of every shift as to how this level of enhanced support at Level 4 is to be implemented This applies to both morning and night shifts.
7. Nursing staff must check in regularly on staff providing enhanced care level 4
8. Enhanced care at all levels must be provided with the appropriate activities, recreation and occupation at all times.
9. Staff must not be close to a resident when they are asleep, with family or friends or when they are engaging in private times.
10. Contemporaneous note taking is essential during the provision of enhanced care level 4
11. If staff are providing this level of support at night time, they must not be present in a room with lights switched off.

Enhanced Care Criteria

Level of enhanced care		Inclusion criteria
1	**General Observation (Routine Care)**	Resident identified as: • At low risk of falls; no history of falls. • Occasional episodes of mild confusion. Very occasional restlessness. • No evidence of responsive behaviour. • Low risk of deterioration. • Low risk of self-harm/injury; no history of self-harm/injury.
2	**Intermittent Observation**	Resident identified as being: • At risk of falls; no history of falls. • Mild confusion. Occasional restlessness. • Occasional episodes of agitation, or attempting to leave the facility. • Low risk of deterioration. • At risk (or has had history) of self-harm/injury.
3	**Constant Observation (Whereabouts/Location is always known to staff)**	Resident identified as being: • At risk of falls; history of falls/resident is compulsive • Moderate confusion. Frequently restless, requiring regular reassurance. • Regular episodes of agitation, or frequent attempts to leave the facility. • Resident acutely unwell and at risk of deteriorating. • Identified as being at risk of self-harm/injury; history of self-harm/injury.
4	**Enhanced Observation (Continuous Observation)**	Resident identified as being: • At significant risk to falls; actual fall has occurred. • Severe confusion. Regular and frequent episodes of distress. • Regular and frequent episodes of agitation, violent behaviour, at risk of leaving the facility. • Resident acutely unwell and requiring constant clinical care to maintain safety. • Identified as being at serious risk of self-harm/injury; suicidal intention, serious self-harm/injury incident has occurred.

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1. Introduction

1.1. The Village Residence staff, are committed to delivering safe, high quality and person centred care. This policy provides an evidence based framework which enables staff to be responsive to alterations in risk for the residents requiring enhanced care observation.

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

2. Purpose of this Policy

2.1. The purpose of this policy is to:

• Provide a framework for the delivery of enhanced care which is implemented when residents are considered to be at risk of harm to themselves or others.

• Ensure a safe environment using effective assessment and intervention.

• Support residents to remain independent, empowered and safe.

• Support person centred care planning.

• Support residents who are admitted through the Ward of Court process.

3. Scope

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

3.2. This policy is only applicable to residents over 18 years of age.

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

Clinical Staff:

3.3.1 The Enhanced Care policy will focus collaboratively on the holistic needs of each resident which will include:

- The person: including physical, cognitive, behavioural factors and support the resident with interventions.
- Their environment: including bedrooms and communal areas internally and externally.
- Their activities: the required level and type of assistance to maintain safety, engaging with the resident promoting independence, resilience, choice and wellbeing.

3.3.2 The Nurse in charge of the shift is responsible for monitoring the care

regularly, ensuring that any significant risk is controlled.

3.3.3 Registered Nurses (RNs) are accountable for delegating tasks to others, including health care assistants and Student Nurses. The NMBI Scope of practice (2015) states *"Nurses and midwives are professionally responsible and accountable for their practice, attitudes and actions, including inactions and omissions. The nurse or midwife who is delegating (the delegator) is accountable for the decision to delegate. This means that the delegator is accountable for ensuring that the delegated role or activity is appropriate to the level of competence of the student or the regulated or unregulated HCW to perform".*

3.3.4 The primary accountability for assessing residents for their requirement for enhanced care is a nursing responsibility. This complies with professional standard set out by the NMBI Code of Conduct (2014) in which all nurses must uphold;

- Respect for the dignity of the person.
- Professional responsibility and accountability.
- Quality of practice.
- Trust and confidentiality.
- Collaboration with others.

Medical Officer/General Practitioner/Doctor:

3.3.5 Medical Officer/ Doctor: In adhering to the General Medical Council, medical staff have a responsibility to collaborate with other colleagues to ensure good quality care in order to reduce the requirement for the use of restrictive practice. Considerations should be given to the assessments that are specifically medical including cardiovascular, neurological and cognitive assessment and medication review.

Physiotherapist:

3.3.6 Physiotherapists: Provide evidence-based exercise, education and advice programmes aimed at preventing falls, improving balance, increasing self-confidence, reducing fear of falling and the promotion of active and healthy lifestyles.

Occupational Therapist:

3.3.7 Occupational Therapists: Provide practical support to enable people to overcome barriers that prevent them from doing the activities that matter to them.

Pharmacy:

3.3.8 Pharmacy: Along with the medical officer and the nursing staff, the pharmacist will highlight high risk medications associated with restrictive practice and make recommendations based on current up to date guidance and individual residents preferences.

Risk Officer:

3.3.9 Risk Service: Will give advice on health and safety requirements

regarding the enhanced care criteria.

Management:

3.3.10 Nursing Administration, Person in Charge, Clinical Nurse Managers and Practice Development Facilitator: Through their managerial, leadership duties, accountabilities in the enhanced care criteria will also maintain overview in the following ways;

- Reviewing the appropriateness of the enhanced care process.
- Responsible for the overall safe and supportive care of the residents in DSOP.
- Responsible for the implementation and monitoring of the policy.
- Organising actions responsive to learning from audit, complaints and incident investigations.
- Making the settings for best practice to materialise (through measuring the environment of care and the influence of training provided).

Non-Clinical Staff:

3.3.11 Non-Clinical staff play an important role in the process of information gathering and assessment of resident's enhanced care requirement.

- Non-Clinical staff are to be informed of the level of observation identified, as well as the level of information that will be required for the appropriate staff member to complete the care plan during their period of observation. They must be informed who to report to when concerns arise, when leaving the resident/area, as well as being offered the opportunity to take regularly breaks.
- Non-Clinical staff must hand over information pertaining to the care of residents when one non-clinical staff is replaced with another.
- Non-Clinical staff need to familiarise her/himself with the resident including their history, background, specific risk factors and current care plan.
- Consider approaches/interventions and meaningful activities that have been effective for the resident in similar situations in the past, such as distraction, diversion and de-escalation techniques.

4.0 Objectives:

4.1 Ensure the safety of the resident receiving enhanced care.

4.2 Ensure the safety of others from the resident receiving enhanced care.

5.0 Outcome:

5.1 Each resident within DSOP will receive the correct and appropriate level of care.

6.0 Supporting Evidence:

- Health Act (2007)
- Health Information and Quality Authority 2021, Restrictive practice thematic programme
- Health Act 2007 (Registration of Designated Centres for Older People) Regulations 2009;
- The Assisted Decision Making Capacity Act, 2015
- Health Act 2007 (Registration of Designated Centres for Older People) (Amendment)Regulations 2010;
- Health Act (2007) (Care and Welfare of Residents in Designated Centres for Older People)Regulations 2009;
- Health Act (2007) (Care and Welfare of Residents in Designated Centres for Older People) (Amendment) Regulations 2010.
- Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) (Amendment) Regulations 2012
- Department of Health (2008) Strategy to Prevent Falls and Fractures in Ireland's Ageing Population.
- HSE (2014) Safeguarding Vulnerable persons at risk of abuse.
- HSE (2015) About the Assisted Decision Making (Capacity) Act.
- NICE guideline NG10 (2015) Violence and aggression: short-term management in mental health, health and community settings.
- HSE (2017) Safety Incident Management Policy.
- Health Service Executive (HSE) (2018) Service User Falls: A Practical Guide for Review.
- HSE (2018) Safety, Health and Welfare at Work Act.
- HSE (2018) Manual Handling and People Handling Policy.
- HSE (2018) Incident Management Framework.
- Safety Statements for St Mary's Hospital Drogheda Services for Older People (2023) Falls Prevention and Management Policy.
- Saint Mary's (2019) Restrictive Practice Policy.

7.0 Glossary of Terms:

HSE - Health Service Executive.

PPPG - Policies, Procedures, Protocols and Guidelines.

HIQA - Health Information and Quality Authority.

Observation - A minimally restrictive intervention of varying intensity in which staff observes and maintains contact with a resident to ensure the safety and the safety of others.

Self-harm - is commonly given a broad definition in research studies and includes 'all acts of intentional injury to self, regardless of intent' (James et al., 2012, p. 302). Self-harm has been differentiated from attempted suicide using a variety of criteria including expression of suicidal intent, clinician classification, lethality of the attempt and other rating scales.

Anger – Anger is one of the basic human emotions, as fundamental as happiness, sadness, anxiety, and disgust. These emotions are tied to basic survival. Anger is related to the "fight, flight, or freeze" response of the sympathetic nervous system; it prepares humans to fight. "*At any point in time, a combination of physical, mental and social factors interact to make us feel a certain way. It's different for each of us. Our feelings are influenced by our emotional make-up, how we view the world, what happens around us and our circumstances. Like other emotions, anger rarely acts alone"* https://www.mentalhealthireland.ie/a-to-z/anger/accessed11.07.2019

Agitation - Agitation is a feeling of aggravation, annoyance, or restlessness brought on by provocation or, in some cases, little to no provocation. It can be a sign of an underlying medical or psychiatric condition. It can be defined as "*the act or an instance of agitating something : a moving back and forth or with an irregular, rapid, or violent action, a state of excessive psychomotor activity accompanied by increased tension and irritability"* Merriam-Webster (2008).

Aggression - can be broadly defined as '*hostile, injurious or destructive behavior*' (Merriam-Webster, 2008). Examples of aggressive behaviour in research studies include 'threatening or intimidating behaviour, verbal assault, assault on property, self-injury and physical assault directed at others such as hitting with hand or fist, kicking, scratching, spitting, sexually threatening, throwing objects, pinching, biting, hitting with an object, grabbing clothes, pulling hair, choking or strangling' (Hamrin et al., 2009).

8.0 DEVELOPMENT OF POLICY – Enhanced Care

8.1 Literature review:

The literature related to older people requiring enhanced care in Ireland, residential care and nursing expertise. The search strategy commenced with a review of databases in CINAHL, MEDLINE and PUBMED by cross referencing the terms: nursing homes, enhanced care observation and older people. This search resulted in a huge body of published literature which was initially scanned in

terms of journal article title, and abstracts. There was a vast amount of evidence for clinical observation in psychiatric units however there was limited research published on enhanced care observation in nursing homes.

From the literature there is limited evidence in regards to enhanced care pathways with formal observation representing a balance between keeping people safe and developing therapeutic relationships (Fletcher, 1999, Vråle and Steen, 2005).

Unfortunately, the terminology used to describe formal observation differs widely among researchers (Duffy, 1995, Manna, 2010) and practitioners (Bowers et al., 2000, Jayaram et al., 2010). Even the term formal observation has not been consistently used in the literature. There seem to be two key points on which definitions vary: (1) the frequency and intensity of formal observation (for example, intermittent observation or continuous observation) (2) the purpose of formal observation (for example, surveillance or therapy). From the evidence the closes definition from a study by Kerr, Verner and Traynor (2013) suggested that this "Special observation is delivered following an individual assessment undertaken by nurses with advanced assessment and care planning skills using a nurse-patient ratio of one-to-one to enable person-centred therapeutic practice interventions and promote safety. Best practice special observation is promoted through the delivery of evidence based education and monitoring of adherence".

Observation can be a restrictive intervention; therefore every effort should be made to use the least intrusive level of observation necessary, balancing the resident's safety, dignity and privacy with the need to maintain the safety of those around them. The level of observation and positive engagement must be used to ensure resident safety and can be used for people with issues of dysphagia, falls risk, physical health concerns, amongst others. The level of supportive observation agreed should ensure that the restriction is both appropriate and proportionate to the resident's presentation. In relation to the standards this policy focus is on enhanced care in line with HIQA regulations. Who is responsible for the registration and inspection of all private, voluntary and public nursing homes in Ireland to ensure compliance with 32 national standards (HIQA 2009). The standards are articulated in seven sections (rights, protection, health and social care needs, quality of life, staffing, care environment and governance and management).

In conclusion there is no published research on enhanced care observation in relation to older people and DSOP recognise that the need for admission to residential care occurs in the context of an older person experiencing cognitive and or physical decline which makes independent living challenging. The decision to what level of observation a resident needs will a joint decision between the Nurse In charge/PIC and staff and/or physician and a decrease in monitoring frequency will be based on the progress of the resident, their mental state, and recovery from their illness.

8.2 Conclusion

The Village Residence Staff will implement a new policy, enhanced care pathway flowchart, a risk, dependency and additional support flowchart and enhanced care risk assessment that will:

- Provide guidance on safe care and level of observation.
- Assistance in identifying the risks to residents and the care and treatment put in place to promote independence.

- Residents will receive care and treatment that is tailored to them and which meets their needs and preferences and maintain their dignity and consent.

- All staff will have appropriate skills, competence and experience to promote safety, assess acceptable level of risk and prevent harm.

8.3 Recommendations for Level of Observation

8.3.1 The Village Residence has in place 4 levels of enhanced care, these are defined below;

Level 1 – General Observation

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

Level 2 – Intermittent Observation with Meaningful Activities

For residents who have been assessed as; having a potential risk of falls, a cognitive impairment which results in increased risk, or presents with behaviour that challenge, a history of previous risk but are in the process of recovery.

- Residents assessed to be requiring level 2 enhanced care must have a care supports implemented, ensuring that the frequency (5, 15, 30, 60 minutes etc.) is appropriate to meet individual needs, and this is clearly written in their care plan. Care support is a structured process where staff carry out regular checks with individual residents at set intervals, addressing residents' pain, positioning and toilet needs; assessing and attending to the resident's comfort; and checking the environment for any risks to the resident's comfort or safety. This role can often be delegated by nurses to care assistants.

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

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

- Consider congregation of Level 2 residents – Intermittent Observation with Meaningful Activities.

- Care support is a method for reducing the risk, and congregation (where residents are located in the same area can provide a strategy for effectively managing those residents who require intermittent observation with meaningful activities.

- The Nurse in Charge must ensure that where residents are congregated, staff are appropriately delegated to carry out the required enhanced care. Delegated staff must have a practicable understanding of care support, and must be aware of the frequency of this.

- When residents are presenting with restlessness, walking about, sleep disturbance, behaviours which challenge and/or unpredictable behaviour which puts them at risk of harm, it is important to try and establish the possible cause of such behaviours so these can be appropriately managed; thus preventing a resident requiring enhanced care. Consider using in epicCare ABC tool for assessing responsive behaviour or PINCH ME to look at possible causes (Appendix 2).

- When attempting to manage these, it is important to establish a person-centred approach to care, involving carers and family members where possible; the '***a key to me' or "resident communication passport***" booklet provides a template for health care professionals to build a better understanding of who the resident is.

- For further support techniques to reduce residents' risk of harm refer to appendix 3.

Level 3 – Enhanced Care within Line of Sight

For residents who have been assessed as having an imminent risk of, falling, and/or have a recent history of repeat falling which cannot be managed by techniques described in level 2, for example, residents who have a heightened level of risk linked to increased confusion/disorientation/ agitation, and also have deterioration from their normal level of mobility. At risk of harming themselves or others which is unpredictable in nature. Leaving the building unattended (Absconding, see policy on restricted care practices).

- Residents who are admitted through the Ward of Court have been assessed by an approved Doctor as suffering from a mental disorder of a nature or degree which warrants the admission of the resident in hospital for assessment and/or treatment in the interests of the residents own health, in the interests of the residents own safety or with a view to the protection of others. Therefore all residents who are subject to being a Ward of Court should be placed on line of sight enhanced care. If it is assessed that line of sight is not required the rationale and risk assessment must be clearly recorded in the residents notes including who has been consulted with regards to the decision to reduce or discontinue enhanced care.

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

- They should have a risk assessment form and care plan contained within their nursing notes.

- Any equipment or instruments deemed harmful should be removed if necessary.

- Levels may vary between night and day dependent on the resident's presentation. For example if the resident is known to go to bed and sleep well throughout the night level 3 could be reduced to level 2.

- Congregation of Level 3 residents – within Line of Sight with appropriate activities

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

- The non-clinical staff must have access to call for immediate help (call bell, beds near nurses' station). The Nurse in Charge must be aware of the congregation and make other Allied Health Professionals aware that there is a congregation of level 3 residents on the Unit and that the non-clinical staff may call for immediate help.

- The residents must never be left unobserved, if the non-clinical staff has to assist one level 3 resident, they must call for help from another member of staff to temporary take over the care of the other residents.

Level 4 – Enhanced Care within Arm's Length with appropriate activities

This is the highest level of enhanced care for residents, and should only be implemented in exceptional circumstances where residents are at imminent and significant risk of harm to themselves or others, that may result in death. This may be as a result of suicide, self-harm or interfering with medical devices e.g. the pulling out of tracheostomy tubes.

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

- Residents should have a risk assessment form and care plan contained within their nursing notes.

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

- It will be necessary to use more than one member of staff and or specialist support i.e. Health Care Assistant as enhanced care level 4 provision should only be for a maximum of two hours.

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

- The Implementation of level 4 enhanced care must been overseen by the Nurse in Charge when implemented due to mental health issues; also by the Mental Health Team and the General Practitioner.

- Should never be undertaken by only one staff member. This must always be rotated at least hourly.

8.3.2 Assessment of Level of Enhanced Care

- All residents requiring enhanced care must follow the Enhanced Care Pathway (Appendix 4), considering the risk defined in Appendix 5.

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

- The request for additional staff to manage enhanced care must be authorised by the Director of Nursing or Assistant Director of Nursing, and sanctioned as per the current process. Out of hours, this should be the Person in Charge as per the weekend rota. The decision must be clearly documented in the resident's notes.

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

8.3.3 **Implementing Enhanced Care**

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

- Staff allocated to deliver level 3 and 4 enhanced care must complete the behaviour chart in full (ABC Chart)

- Positive engagement with the resident is essential using the techniques.

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

- It is the responsibility of the Nurse in Charge to consider if the resident is being deprived of their liberty by the safety measures put in place. If there are concerns that the resident is being deprived of their liberty then appropriate action should be taken in accordance with Safeguarding policy and an NIMS Form completed.

- The member of staff allocated to carry out enhanced care should spend time building a therapeutic relationship with the resident. Enhanced care should be a supportive and therapeutic activity. The process of enhanced care calls for empathy, engagement, taking note of the resident's needs, and a readiness to act.

- Residents, and with the residents approval, their carers/relatives are to be informed of the enhanced care procedures. Clear, honest and open dialogue must take place regarding the reasons for a change in the level of enhanced care.

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

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

- Under no circumstances should the member of staff or any staff member delivering the enhanced care reduce the level prescribed for the resident without prior discussion with the

Nurse in Charge. Any attempt not to follow the enhanced care by the Clinical Nurse Manager may result in disciplinary action

- If the resident requires level 3 or 4 enhanced care and this level cannot for whatever reason be provided, an incident report must be completed immediately, and mitigating actions documented

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

- In situations where the resident presents a clear threat to harm themselves or others, staff must complete an incident report and work in accordance with the Risk Management Policy and the Principles as set out in PMAV Training.

- When residents are transferred to in resident care at a mental health unit or in a general hospital, and whose current mental health problems may cause a risk to themselves or others this Centre will not be responsible for providing the observation staff except if transferred to a Casualty Department. All assessments for commencing enhanced care will be made in full consultation with the mental health unit.

- It may be necessary where possible to call on the Mental Health Team to ascertain whether they may be able to provide support to staff in this Centre.

8.3.4 **Reassessment of Enhanced Care**

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

- The need for level 3 and 4 enhanced care must be reviewed at the beginning and end of every shift by the Nurse in Charge, or as defined in the care plan, which may state a specific level of enhanced care for a defined period of time. Where possible this should be done with consultation with members of the multi-disciplinary team; and discussed with the General Practitioner at least daily; and where additional staff is required continued to be authorised by the Person in Charge through the Director of Nursing Office. A decision will be made to subsequently curtail, reduce, maintain or heighten enhanced care based on the information recorded on the behavioural chart (ABC CHART). The decision must be clearly documented in the Resident's notes and handed over to the commencing shift. This assessment must be based on the residents behaviour, physical and mental state.

- Prior to discontinuation, there must be a sufficient period of time between de-escalation from level 3 or 4 to level 2. For residents where it has been assessed that they need to continue to receive level 3 and 4 enhanced care, then a decision may have to be made whether this Centre can continue to meet the needs of that resident.

8.3.5 **Assisted Decision (capacity) Act 2015 Considerations**

- If an individual is assessed as lacking capacity any act done for, or any decision made on behalf of that person, must be done or made in the person's best interest.

- Enhanced care must be set at the least restrictive level for the least amount of time within the least restrictive environment, and proportionate to the risk. General observation will be the presumed level and justification will be required to move up (or down) the levels according to the resident's condition. Raising levels of enhanced care may be required and both staff and resident need to be clear about its purpose. It is essential that communication is effective and the situation managed sensitively.

8.3.**6 SPECIAL NOTE: Role of the Relative / Carer**

- Relatives and carers should be involved with the resident care as much as possible, dependant on their own or the resident wishes. In particular, explanations should be given sensitively about why limits are being set. Relatives and carers can observe the resident without staff present if this is the wish of the relatives or resident; clear instruction must be given to how they are to manage that observation, including how to summon for help and what they do when they are leaving the resident, however they should not be made responsible for the formal documentation of enhanced care, this must be clearly documented in the individual intervention section of the care plan. Please ensure that this is noted within the Care Plan.

9.0 Policy Group:

9.1 Membership of the Policy Development Group (Appendix 6).

2.2 Membership of the Approval Governance Group (Appendix 7).

10.0 Implementation and dissemination

10.1. This policy will be cascaded by the policy lead to the Village Residence Nursing Governance Meeting for communicating and sharing at a local clinical level, making all resources available to all relevant staff.

10.2. This policy's implementation will be led by the Director of Nursing Office through each Person in Charge and Practice Development management team members to Unit teams. Training and support will be made available by the Director of Nursing Office.

10.3 All staff must sign appendix 8 that they have read and understood the policy.

11.0 Monitoring, audit and evaluation

- Audit.
- In conjunction incident management framework - NIMS Incident reporting.
- Examining good practice**.**

12.0 Revision/update

13.1 The procedure for updating the policy will be amended based on best practice guidelines.

13.2 A version control sheet will be updated on POLICY Template cover sheet.

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Appendix 1 – Enhanced Care Risk Assessment

Resident Name:

DOB:

Unit:

Date of Assessment:

Risk Assessment Score:

Cognition			
The resident is not confused	The resident is confused, but not agitated. This resident is not at risk of harming self.	The resident is confused and agitated. The resident requires frequent reassurance and reorientation to the environment Presents with behaviours that challenge. The resident is at risk of self-harming.	The resident is confused and agitated with episodes of violence and aggression directed toward staff/others. The resident has the potential or has displayed sexually disinhibited behaviour. The resident is at risk of life threatening consequences.
0	1	2	3
Risk of Falls			
The resident is at low risk of falls.	The resident is at risk of falling, but is able to summon assistance to mobilise/no history of falls.	The resident is at risk of falling and is unable to understand the need to summon assistance to mobilise. Imminent risk of falling and/or have a recent history of repeat falling.	The resident is at risk of falling and is unable to understand the need to summon help to mobilise. The resident has a history of falling and is at high risk of harm. Imminent and significant risk of harm to themselves or others, that may result in death.
0	1	2	3
Risk of Leaving unattended			
The resident is able to leave the unit/is not attempting to leave the unit.	The resident needs to remain on the unit for their safety, leave the unit accompanied. Is not attempting to leave the unit.		Is attempting to leave the unit unaccompanied/required to stay on the unit for safety.
0	1		2
Residents Condition			
The resident is stable. No evidence of deterioration.	The resident is stable and low risk of deterioration. Enhanced care, known whereabouts.	The resident is at risk of deterioration and requires observation. Enhanced care in line of sight.	The resident is unstable and requires constant observation and support. Enhanced care within arm's length.
0	1	2	3
Total Risk Score:			
Level 1 Observation Score 0 - 3	Level 2 Observation Score 4 -7	Level 3 Observation Score 8 -9	Level 4 Observation Score 10 -11

ABC Tool for Assessing Responsive Behaviour

Resident Details

Name **Date of Birth**

Room Number **Gender**

Assessment Details

Please ☑ the appropriate boxes below

A - Antecedent *This is something that occurs before a behaviour*

Internal Antecedent Conditions

Communication Issues	☐	Pain	☐	Infection	☐	Depression	☐
Hunger	☐	Invasion of personal space	☐	Constipation	☐	Confusion	☐
Fear / Anxiety	☐	Anger	☐	Unintended effects of drug therapy	☐		

External Antecedent Conditions

Unfamiliar Caregivers	☐	Change in Routine	☐	Lack of Activities	☐	Loud Noises	☐
Temperature of Environment	☐	Crowding	☐	Lack of Control	☐		

B - Behaviour

Describe what you see the person doing

C - Consequences

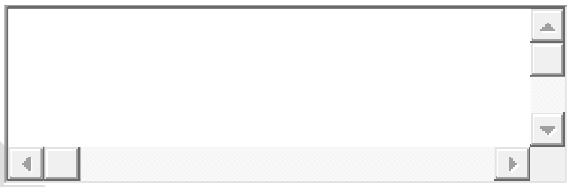
What actions were taken by the caregiver / nurse?

How does the resident react to the action taken?

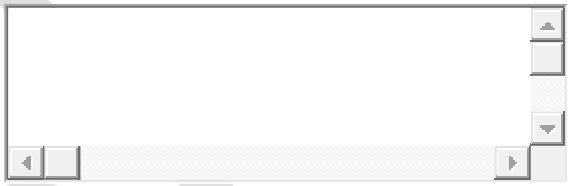
Intervention

• Assess for Pain, constipation, infection, anxiety, or drug interactions
• Speak in short simple statements
• Maintain a calm environment
• Ensure staff safety and other resident's safety
• If resistive to care - withdraw and try later
• Provide meaningful activities and distractions
• Arrange for a GP / Psych review

If psychotropic intervention is suggested document same including associated risks with using Pharmacological intervention



Document potential harm / level of distress without the use of Pharmacological intervention



Assessor: **Assessed Date:**

Change in Behaviour Documentation Tool

Pain/Physical
Infection
Nutrition
Communication/Constipation
Hydration/Haemorrhage
Medications
Environment

Appendix 3 - Techniques that may help to reduce residents' risk of harm include:

• Providing a supportive environment.

• Establishing a daily routine the resident is familiar with.

• Engaging the resident in meaningful activities such as listening to music, reading, chatting.

• Engaging the resident in activities that provide a sense of purpose such as making the bed and tiding the bed space.

• Encouraging the resident in exercise such as daily walks, or seated exercises for those with less mobility.

• Attendance at memory activities.

• Consider issues with continence.

• Providing something to occupy their hands e.g. a 'rummage box'.

• Writing down basic facts e.g. what day or date it is.

• Providing a clock next to the bed which shows whether it is day or night.

• Cutting down on caffeine in the evening.

• Removing any trip hazards e.g. furniture in the way.

• Assessing the resident's mood as this can contribute to poor sleep. If you think the person may be depressed refer to the doctor.

Appendix 4: Enhanced Care Pathway

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

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

Level 2: Intermittent Enhanced Care

For resident who have been assessed as:

• Having a potential risk of falls

• Having a cognitive impairment which results in increased risk, or present with behaviour that challenges

• Having a history of previous risk but are in the process of recovery

Residents must have Care Support implemented, which clearly indicates the intervals.

Consider techniques that may help to reduce residents 'risk of harm thus preventing a resident requiring more heightened level of enhanced care

Consider level 2 cohorting

Manage with agreed staffing levels for the clinical area

The need for Level 3 and 4 enhanced care must be approved by the Nurse in Charge, and the request for additional staff to manage this must be authorised by the Director of Nursing/Person in Charge and sanctioned as per current process. Out of hours, this should be the Assistant Director of Nursing as per the weekend rota or the PIC of centre during normal working week

Level 3 Enhanced Care within Line of Sight For residents who have been assessed as having an imminent risk of:

• Falling, and/or have a recent history of repeat falling which cannot be managed by techniques described in level 2 observations.

• Harming themselves or others which is unpredictable in nature

• Absconding

Consider level 3 cohorting

Complete Risk Assessment and Incident Form

Level 4 Enhanced Care within Arm's Length

This is the highest level of enhanced care for residents, and should only be implemented in exceptional circumstances where residents are at imminent and significant risk of harm to themselves or others, that may result in death.

Level 4 must be overseen by the Mental Health Team and/or General Practitioner, Person in Charge, Mental Health Older People Team dependent on reasons for implementing.

Consideration must be given to:

- The Health Act 2007, Care and Welfare Regulations 2013.
- Safeguarding Vulnerable People at risk of Abuse.
- Assisted Decision Capacity Act, 2015.

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

The level of enhanced care must be reviewed on an on-going basis, and at least reviewed at the start and finish of each shift by the Nurse in Charge, is discussed with the PIC at least daily and discussed with the G/P at each visit, and where additional staff is required is authorised by the Director/Assistant Director of Nursing.

Appendix 5

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

Consider these risks on assessment

Low -Level 1 General Observation

- Additional support not indicated.
- Support to be provided by care rounds if required.
- Existing ward staff.
- General observations and assessments.

Moderate – Level 2

(Intermittent Observation with

Meaningful Activities)

The resident:

- Cannot maintain their dignity.
- Cannot maintain their fluid and nutritional intake.
- Cannot manage independently their toilet needs.
- Cannot communicate there are in pain.
- Has a cognitive impairment which results in increased risk.
- Presents with behaviours that challenge.
- Has a history of previous risk but are in the process of recovery.

Enhanced care level 2 must:

- Have Care support implemented, ensuring that the frequency (5, 15, 30, 60 minutes etc) is appropriate to meet individual needs.
- This is clearly written in the care plan.

High – Level 3

(Enhanced Care within Line of Sight)

The resident:

- Is likely to self-harm.
- Present with destructive behaviour.
- Inappropriate behaviour.
- Is likely to abscond.
- Cannot maintain their safety in the ward environment.
- Is at risk of suicide.
- Imminent risk of falling and/or have a recent history of repeat falling.

Enhanced care in line of sight.

Exceptional – Level 4 (Observation within arm's length)

This is the highest level of observation for residents, and should only be implemented in exceptional circumstances where residents are at imminent and significant risk of harm to themselves or others, that may result in death.

Enhanced care within arm's length

Appendix 6 -Membership of the Policy Development Group.

Please list all members of the development group (and title) involved in the development of the document.

Michael Seamus McCaul Director of Nursing	Signature: _____ Date: _____
Jolly Varghese Assistant Director of Nursing	Signature: _____ Date: _____
Leenamma Varghese Assistant Director of Nursing	Signature: _____ Date: _____
Eimear Hickey Assistant Director of Nursing Practice development Facilitator	Signature: _____ Date: _____
Chairperson: Michael Seamus McCaul Director of Nursing	Signature: _____ Date: _____

Appendix 7 - Membership of the Approval Governance Group.

Membership of the Approval Governance

Please list all members of the relevant approval governance group (and title) who have final approval of the policy document.

Michael Mc Caul Director of Nursing	Signature: _____ Date: _____
Maura Ward Older People Services Manager/Louth & Meath	Signature: _____ Date: _____

Appendix 8

Signature Sheet

I have read, understand and agree to adhere to this Policy, Procedure, Protocol or Guideline:

Print Name	Signature	Area of Work	Date