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Trustwide Provision of ‘Close Support’ for Adult Patients Clinical Guideline

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| Implementation Lead | | Divisional Matron | |
| If developed in partnership with another agency, ratification details of the relevant agency | | Acute Mental Health Liaison Service GWH | |

**Equality Impact**

Great Western Hospitals NHS Foundation Trust strives to ensure equality of opportunity for all service users, local people and the workforce. As an employer and a provider of health care, the Trust aims to ensure that none are placed at a disadvantage as a result of its policies and procedures. This document has therefore been equality impact assessed in line with current legislation to ensure fairness and consistency for all those covered by it regardless of their individuality. This means all our services are accessible, appropriate and sensitive to the needs of the individual.

**Special Cases**

This document does not apply to those under the age of 18.

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# Document Details

## Introduction and Purpose of the Document

In patient groups such as the vulnerable older person (especially those with dementia, people with mental health needs, people with acquired brain injury, those with Learning Disabilities and for patients lacking the mental capacity to make decisions relating to their care), further levels of observation and ‘close support’ may be required to ensure the patients safety, meet the needs of the individual and other patients around them

This document provides the framework of support to deliver additional levels of observation and support.

‘Close Support’ is defined as support and monitoring provided to a patient on a one to one basis (Appendix G- Close Support Care Plan provides full details of what is expected in providing close support).

Ward establishments may not always have sufficient flexibility to provide close support for patients who need it. Observation levels above the standard within the hospital may have impact on the establishment employee/skill mix numbers and additional employees may be required to maintain the safety of some patients.

Close support ensures the safe and sensitive monitoring of the patients physical, psychological and emotional well-being. Through this monitoring employees will quickly identify changes in the patient’s condition and well-being and enable them to facilitate a rapid and appropriate response.

Senior Sisters/Senior Charge Nurses must first look at the current employee and skill mix on the ward, and/or seek support from other wards before requesting the provision of additional employees.

**Examples of when close support may be needed include the following:**

* Patient at high risk of falls/high risk of harm from falls.
* Acute delirium/confusion.
* Violent or challenging behaviour.
* Risk to self or others.
* Risk of absconding.
* Under the Deprivation of Liberty Safeguards (DoLS).
* Detained under the Mental Health Act (2007) (MHA).
* Due to mental health needs.
* Has a learning disability and requires additional support to maintain safety.

The over-all aim is that the close support will be therapeutic and engaging for the patient, will be compassionate in approach and that the patient’s safety, privacy and dignity are respected at all times.

This guideline is applicable to patients over 18 years of age.

This policy has been created to assist the Trust to meet observations and support of patients who have been assessed as lacking capacity to make decisions about their own care or treatment as per the Mental Capacity Act 2003 (MCA) and DoLS .The patient safety observatory has published evidence that good close support can prevent death or serious harm.

**This guideline aims to**

* Outline the responsibilities of the employees at all levels to provide a clear pathway of care.
* Clearly document why close support is needed and promotes a person centred approach to determining observation levels.
* Ensure that patients are provided with close support under the relevant legislative framework.
* Ensure that the patient’s capacity (or lack of) is established and documented in the patients care records and appropriate risk assessments, and forms. .
* Ensures that the patients ‘best interests’ are served at all times.
* Identify which employee group is best suited to support the patient.
* Clearly stipulate expectations of employees and workers (Bank and Agency) that may provide close support in augmenting safe, effective and dignified care.
* Ensure the need for close support is reviewed at least every 24 hours.

## Glossary/Definitions

The following terms and acronyms are used within the document:

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| **Allocated employee** | Members of the nursing team who is identified and allocated to the specific task of observing the patient for a defined and agreed period of time. This person may be required to be a registered or care staff |
| **AWP** | Avon and Wiltshire Mental Health Partnership NHS Trust |
| **Care staff** | Employees without a professional registration but who may possess a recognised health and social care related qualification (e.g. such as a Health Care Assistant) |
| **Close Support** | The process of identifying and assigning an employee to supervise and monitor a patient who has been assessed as being at potential risk. The intensity and duration of the close support has to be appropriate to the patients’ needs and the principle of ‘least restrictive option’ must be applied at all times. Therapeutic engagement is a fundamental and important part of this process/intervention. |
| **Detained** | Refers to a patient subject to a formal detention under the provision of the Mental Health Act (1983) (MHA) |
| **DH** | Department of Health |
| **DoLS** | **Deprivation of Liberty Safeguards**  Part of the Mental Capacity Act (2005). They aim to protect people in hospitals from being inappropriately deprived of their liberty. The safeguards have been put in place to make sure that a hospital only restricts someone’s liberty when the patient is at risk and lacks capacity to decide for themselves what is in their ‘best interests’.  A Deprivation of Liberty (DoLS) is when an individual is subject to a continuous form of supervision provided by the state. Any DoLS that has not been prescribed or supported by a legal framework is an interference with the individuals Article 5 Human Rights. The DoLS were introduced as an amendment to the MCA in 2009 to bridge a gap in legislation and provide safeguards for people who lack capacity to consent to care and treatment in either a hospital or care home that, in their own best interests can only be provided in circumstances that amount to a deprivation of their liberty. |
| **Engagement** | Combines ‘being attentive’ to the patient alongside the use of advanced observation, active listening, fostering and encouraging interaction, rapport building and collaboration with the patient and their family to convey the message that they are valued and cared for |
| **Flexible Work Force Team (FWT)/Nurse Bank** | The team based at the hospital who co-ordinate and book temporary employees (Including bank and agency) |
| **GWH** | Great Western Hospital |
| **IR1** | Electronic Incident Reporting Form |
| **Learning Disability** | A significantly reduced ability to understand new or complex information, to learn new skills, with a reduced ability to cope independently, which started before adulthood and has a lasting effect on development (DH, 2009) |
| **Level of Support** | The framework from which the level of support is assessed and recommended |
| **IP&C** | Infection Prevention and Control |
| **D&V** | Diarrhoea and vomiting |
| **MCA`** | Mental Capacity Act 2005 |
| **MDT** | The multi-disciplinary care team |
| **Mental Capacity Act (2005)** | The Mental Capacity Act 2005 The MCA provided the legal framework for decision making. The Act is empowering and enshrines principles and guidance that upholds people’s rights when significant decisions need to be made.  The MCA places a responsibility on organisations to protect an Individual’s right to liberty. Where they are or need to be deprived of that liberty; these procedures are known as Deprivation of Liberty Safeguards (DOLS- see above) |
| **Mental Health Act (2007)** | Provides legislation for the compulsory assessment and treatment of people with a mental disorder |
| **MHA** | Mental Health Act 2007 |
| **NHS** | National Health Service |
| **NMC** | Nursing and Midwifery Council |
| **Nurse-in-charge** | Registered nurse who is responsible for co-ordinating and managing the ward on a shift-by-shift basis |
| **OOH** | Out of hours . this refers to the period of time between 17:00 and 09:00 the following day. |
| **PIN** | Personal Identification number when a person becomes a Registered Nurse or other Health Care Professional. |
| **PQC** | Patient Quality Committee |
| **RCA** | Royal College of Nursing |
| **RMHN** | Registered Mental Health Nurse  Heath or Social Care practitioner who is registered with Nursing and Midwifery Council as a RMHN |
| **RN** | Registered Nurse  Heath or Social Care practitioner who is registered with one of the recognised Professional Bodies: e.g. Nursing and Midwifery Council, General Medical Council |
| **SOP** | Standard Operating Procedure  This document aims to provide a framework to ensure that all patients being provided with ‘close support’ (1-1) have their care needs met  The document lists the key elements of care that must be provided alongside some suggestions in relation to ensuring the patient engages in ‘meaningful’ activity to prevent boredom and/or agitation/challenging behaviour sets |

# Main Guideline Content Details

This process applies when an identified individual patient has been assessed as needing ‘Close Support’. It does not apply when the dependency on the ward has increased.

## Who Provides Close Support

Dependent on the risks and the clinical situation it may be appropriate that employees can be provided from the existing ward team to provide the required level of support.

As part of learning and development it may be appropriate, under appropriate supervision, for supernumerary employees to provide the required level of support (i.e. Employees being inducted into the workplace, nursing students and new employees awaiting confirmation of Nursing and Midwifery Council (NMC) Registration)

Additional ward support could be provided by additional care staff.

At times members of the patient’s family or their carer/s may volunteer to provide some aspects of the patients care. In circumstances such as these appropriate support must be provided for the family member or carer and the arrangement must be reviewed by the nurse looking after the patient on a regular basis. This informal agreement should be documented in the patient’s notes.

At times where it proves difficult to access specialist support (i.e. Registered Mental Health Nurse (RMHN)) a registered adult nurse may be an appropriate person to support. If there is a clear need for specialist support an RMHN or care staff with mental health competencies must be sought.

Employees wishing to ascertain the level of support that is required should complete the ‘Close Support Risk Assessment’ (Appendix E) available on the safeguarding pages of the intranet on the under ‘Close Support’.

## Levels of Observation 1 to 3

Levels of observation above level 1 may have an impact on standard employee/skill mix numbers and may necessitate the requirement for extra controls and/or additional employees.

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| **Level 1:** ***General Observation*** | | This is the minimum acceptable level of observation for all in-patients. The location of all patients should be known to employees but not all patients would need to be kept in line of sight at all times. At least once a shift the nurse looking after the patient should evaluate the patient in relation to health and well-being and record the outcome in the patients care record. These patients would be risk assessed as ‘Green’. |
| **Level 2: *Intermittent observation.*** | | This is appropriate when patients are potentially at risk. Care rounds would be deemed to be intermittent observations. The regular care round is to ensure that patients who need regular help and/or support are routinely provided with that care. ‘Care rounds provide assurance, prompt the initiation of essential care ensures an early response to any change in condition and promotes independence and autonomy whilst trying to ensure patient safety. These patients would be risk assessed as ‘Green’. |
| **Level 3: *In line of sight.*** | | This is required when the patient could, at any time make an attempt to harm themselves or others. The patient should be kept within sight at all times of the day and night and any items that could be used to harm self or others must be removed. These patients would be risk assessed as ‘Amber’ or ‘Red’. |
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**For all patients assed as a levels 1 to 3, =the following must be undertaken:**

**Assessments must be undertaken by a registered nurse, a RMHN or a doctor.**

* If there is evidence that the patient has an impairment of the mind/brain that may disrupt decision making complete Appendix C -Mental Capacity Assessment (Two Stage Test).
* If the patient lacks capacity complete Appendix D - Best Interest Decision Record.
* Complete ‘Appendix E -Close Support’ (1-1) Risk Assessment and calculate level of risk.
* Request the level of support as identified by completing the risk assessment Proforma by completing an agency request form and forwarding to the divisional Matron. If out of ‘normal working’ Hours (OOH) request support from the duty Matron or the Great Western Hospital (GWH) Site Management Team.
* If level 3 or 4 observation is required the ‘Appendix F -Close Support’ Observation Proforma must be activated and used to record all interventions and actions of those providing close support (Appendix F).
* The ‘Appendix G - Close Support Care Plan must be completed and individualised for each patient.
* The Appendix H -Standard Operating Procedure Close Support (1-1) must be read and understood by the person providing support.
* If the patient has dementia ensure the ‘This is me’ document is completed and used to provide individualised care ( Alzheimer’s Society- Ref 16 ))
* If the patient has a learning disability ensure the ‘My Health in Hospital’ Booklet is completed and used to provide individualised care (Learning Disabilities intranet pages (Ref 17).

## Levels of Observation – Level 4

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| **Level 4:**  **Within arm’s length** | Patients at the highest risk of harming themselves or others may need to be nursed in close proximity. Consideration must be given to employee safety and each individual case risk assessed in relation to protecting the health and well-being of employee.  These patients would be risk assessed as ‘Red’ |

**For these patients the following must be undertaken:**

**Assessments must be undertaken by a registered nurse, a RMHN or a doctor.**

* If there is evidence that the patient has an impairment of the mind/brain that may disrupt decision making complete Appendix C -Mental Capacity Assessment (Two Stage Test).
* If the patient lacks capacity complete the ‘Appendix D - Best Interest Decision Record.
* Complete Appendix E -Close Support’ (1-1) Risk Assessment and calculate level of risk.
* Request the level of support as identified by completing the risk assessment Proforma by completing an agency request form and forwarding to the divisional Matron. If OOH request support from the duty Matron or the GWH Site Management Team.
* If level 3 or 4 observations are required the ‘Appendix F -Close Support’ Observation Proforma must be activated and used to record all interventions and actions of those providing close support.
* The Appendix G - Close Support Care Plan must be read and understood by the person providing support.
* The Appendix H -Standard Operating Procedure Close Support (1-1) must be read and understood by the person providing support.
* If the patient has dementia, ensure the ‘This is me’ document is completed and used to provide individualised care (Ref 16).
* If the patient has a learning disability ensure the ‘My Health in Hospital’ Booklet is completed and used to provide individualised care (Ref 17).
* The patients should be issued with a close support information leaflet.

The Appendix E -Close Support’ (1-1) Risk Assessment will be used to highlight risks and give guidance to observation level and/or employee group who may be best placed to provide additional support

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| RED -will indicate a **need to consider** requirement of: | RMHN for patients who may be sectioned for which require specialist advice relating to intervention, sedation and restraint. Patients who are violent and aggressive may fall into this category.  For sectioned patients or those who require specialist support in relation to violence and aggression to self or others. |
| AMBER -indicate a **need to consider** requirement of | Observation by care staff for reduction of risk by managing behaviour and risk i.e. falls.  Observation by a Band 3 where expertise is required in mental health presentations where specialist intervention is required. |
| GREEN -will indicate a **possible** requirement of: | Observations by existing ward employee. |

This risk assessment is designed to indicate the level of support needed to maintain patient safety and to ensure the patient is looked after under the relevant legislative framework. The final agreement as to the level of support required must be agreed by the Matron or Senior Sister/Charge Nurse for the clinical area. If OOH the level of support must be agreed by the late matron or the on-call manager. The nurse requesting the close support must ring switchboard (‘0’) to access a member of the OOH team.

## Securing Close Support Employee

**Securing close support employees. Guidance for the nurse in charge.**

**Workforce:**

1. How many supernumerary employees are available? Do they have the skills to provide close support?
2. Number of nurses awaiting a Personal Identification number (PIN) from the Nursing and Midwifery Council – Do they have the skills to provide close support?
3. Student nurses on placement – As part of their learning and development can they (with appropriate supervision) provide close support?
4. Employee on phased return – Can they provide close support within their plan?
5. Does the current acuity allow for the patient to be supported by the team currently on duty?
6. **If appropriate** have family members or carers been invited to be included in the care planning?

Please note that none of the above would be suitable for any patient requiring specialist mental health intervention. To be considered very carefully and risk assessed: employees also need to feel comfortable if they decline (with good reason).

**Next steps:**

1. Discuss need for an employee to provide close support with the Senior Sister/Charge Nurse or Matron (in their absence) for the clinical area. If OoH discuss with the Late Matron or site management team.
2. Close support is to be requested via the e-roster system.(see Electronic Rostering Policy Ref 19).
3. **Options for booking support employee are as follows**

* Close support – Care staff Band 2.
* Close support – Dementia - Band 2.
* Close support – Acuity Mental Health – RMHN.

1. **Use the 24h ‘**Appendix F -Close Support’ Observation Proforma **to monitor behaviour and support decision making in relation to what level of support is required.**
2. Senior Sister/Senior Charge Nurse or Matron to review need for close support every 24h and sign the close support Observation proforma. On the rare occasion that at the weekends or at times Senior Sister/Charge Nurses or the matron is unavailable the most senior person on the ward can make this assessment. Place the signed close support Observation proforma in the bedside nursing notes for records.

**Information for Senior Sister/Charge nurse/Matron:**

Please ensure the need for close support’ is reviewed at least every 24 hours and the ‘Close Support Observation’ proforma is signed to evidence this has been done.

Record close support usage (retrospectively and on a weekly basis) on the template on the T Drive in the folder labelled ‘Close Support Acute Trust’.

**For all levels of close support issues of privacy, dignity and consideration of gender in allocating employee, and environmental dangers need to be discussed and incorporated into individual care plans. In all instances the principle of ‘least restrictive option’ must be applied and adhered to.**

## Implementation of Close Support

The decision to implement supportive observation i.e close support, 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 any given time. The rationale for the implementation of close support must be clearly documented in the patients care record.

The employee allocated to provide close support should spend time building a therapeutic relationship with the patient. Booking the same employee where ever possible for a series of shifts will facilitate this. Observation should be a supportive and ***therapeutic*** activity. The process of observation calls for empathy, engagement, taking note of the patient’s needs, and a readiness to act, at all times, in the best interests of the patient.

All patients requiring close support” must have their behaviour documented through the use of the Appendix F -Close Support’ Observation Proforma and have an Appendix G - Close Support Care Plan completed. The pathway begins following the holistic risk assessment and continues until their needs / risks can be provided for / mitigated through alternative interventions or care pathways.

The decision to provide close support should be made by the Multidisciplinary Team (MDT). However, in situations where prompt action is required the Nurse in Charge can implement a heightened level of observation independently, ideally in discussion with another registered nurse such as the Senior Sister/Senior Charge Nurse or the Divisional Matron. If OOH discuss with the duty Matron, Clinical Site Manager or on the community with the community on-call manager.

If the holistic risk assessment by the MDT and/or the Nurse in Charge concludes that the patient requires Level 3 or 4 close support, under normal circumstances the Nurse in Charge must request additional employees via the e-roistering system and seek authorisation from the departments Divisional Matron. The ward/department Divisional Matron will then authorise the request. If OOH the most senior Nurse available should authorise the provision of close support by an additional employee.

The Nurse in Charge must then liaise directly with the Acute and/or Community Nurse Bank to request the provision of additional employees. If the required employee cannot be allocated an incident report form (IR1) must be completed as per the Incident Management Policy (Ref 18)

The Nurse-in-Charge must contact the patients’ senior clinician informing them of the decision to provide close support as soon as possible.

It may be that the patient has different levels of observation for day and night. Requests can be made for ‘day only’, ‘night only’ or ‘day and night’ observation.

If close support is required overnight or at times when the patient is sleeping, the employee must demonstrate at each observation interval that all clinical findings support that the patient is alive, breathing and not showing signs of clinical deterioration. The employee can do this by completing the ‘Close Support Observation Proforma’ (Appendix F). In addition the registered nurse or the RMHN must complete baseline observations using the ‘National Early Warning’ Scoring tool (NEW’s)

**The decision to implement close support must be reviewed at least every 24 hours**. At any point the MDT can decide to curtail, reduce, maintain or increase close support” plans dependent on the needs of the patient. All relevant decision making must be clearly documented in the patients care record and be underpinned by the appropriate legal framework.

## Payment Arrangements for Patients who have Private Care Providers Outside of the Acute Setting

There may be times when for continuity of care and patient safety the use of private providers would be endorsed (i.e. For a patient with a Learning Disability who was used to having 1-1 care provision in their own community setting) This would need to be agreed by all parties. This arrangement may incur a financial charge and Senior Sisters/Senior Charge Nurses would be invoiced to pay outstanding costs.

## Arrangements for Patients Transferred to the GWH acute site from a Mental Health Unit

When a patient is admitted to GWH from a mental health unit the escort/1-1 care is provided for 24 hours (For further information please access the ‘Multi-Agency Protocol for the Internal and External Transfer of Patients to and from Care Settings’ available on the Intranet under ‘Safeguarding’)

Such a transfer does NOT automatically mean that the patient has been discharged from Avon and Wiltshire Mental Health Partnership NHS Trust (AWP) care.

If the patient is to remain at the acute Trust for longer than 24 hours, responsibility for their day to day care (Including the provision and associated costs of additional or specialist nursing employee) becomes the responsibility of the acute Trust. However the named nurse/shift co-ordinator from the transferring AWP team must ensure that all practical help, support and advice is provided to the receiving acute trust/ward team in relation to planning the patients care. In particular, any need for enhanced observation or supervision, and any associated risks must be communicated to the Trusts acute team in order that they can plan for appropriate levels of nursing care and any other appropriate support.

The nurse-in-charge will delegate employees, which have been deemed competent by means of current competency, to be responsible for carrying out close support’.

The identified employee will need to be orientated to the ward and have read Appendix H - Standard Operating Procedure Close Support (1-1) and the patients care plan. The employee providing close support must have a clear understanding of why the close support is being provided and their role in mitigating risk to the patient.

All employees in the ward providing close support must receive a safety briefing and a thorough handover from the previous nurse, including previous clinical history, risk factors, plan of care and reasons for close support. This handover must include verbal and written information. The patient must have the opportunity to contribute to this handover (If appropriate).

The Nurse in Charge will ensure that the employee providing close support is provided with relevant break periods and that their position is backfilled when breaks are being taken.

All patients must have a care plan which is up-to-date and accurate in relation to levels 3 or 4 observations.

Discussions, reviews or alterations to the level of observations must be documented in the patients’ notes.

Inadequate employee cover challenges to support the right level of close support must be immediately reported up through the Division. The Divisional Management team must be made aware if inadequate numbers and grades of employees are available for future shifts. A plan to mitigate the risk must be agreed, implemented and documented in the patients care records. If the GWH Nurse Bank Service cannot allocate appropriate employees to provide close support then the Nurse in Charge must complete an IR1 incident form. The MDT will need to discuss what action they need to take to minimise risk to the patient with the employee level/ skill mix they have.

Patients, and with the patient’s approval, their carers/relatives are to be informed of the provision of close support observation. Clear, honest and open dialogue must take place regarding the reasons for an increased level of observation.

The patient being observed may welcome the company of a relative or friend, and depending on the level of risk and the level of close support this arrangement may or may not be appropriate by use of clinical judgement.

The completion of the Appendix F -Close Support’ Observation Proforma must continue as implemented during visits from carers, relatives and friends.

Under no circumstances should the observing employee reduce the level of observation prescribed for the patient without prior discussion with the Nurse-in Charge.

Employees must try to ensure that the patient’s privacy and dignity, cultural, religious beliefs and gender specific needs are maintained as far as reasonable and practical when implementing close support.

Compassionate care must be provided at all times.

When a patient has close support by care staff or a Bank or Agency RMHN they are to provide this support for the whole shift (with allocated breaks).

Ensure all risks are documented and formally handed over. The reason for the close support must be clearly documented on the risk assessment form.

Named Nurse – must check that the patient has a completed ‘This is me’ (for patients with dementia) (Ref 16), or the ‘My Health in Hospital’ booklet (Ref 17) (for patients with a learning disability).

The Named Nurse will delegate care of the patient/s to the employee supporting them. Both employees are to sign the 1-1 care handover form to document the formal handover of care.

When the shift ends each employee must complete the care handover form to formally handover the care of the patient. A record of care given, patients presentation, risks, needs, areas of concern must be documented within the nursing care records.

Additional specific duties when close support is used for patient with mental health needs that is carried out by an RNMH.

**Please note – if a RNMH is requested then the nurse in charge of the ward MUST also inform the Mental Health Liaison Team of the request to enable the ward to be provided with the appropriate support .** For clinical support between 0800 and 1600 telephone (01793) 327907. Out of Hours (OOH) contact the intensive team on (01793) 836820

The Trust Mental Health Liaison Service may undertake a mental health risk assessment and advice on the level of supportive observations that may be required.

The nurse in charge will provide the RNMH with the " Appendix F -Close Support’ Observation Proforma they need to complete hourly, the completed risk assessment, the Appendix H -Standard Operating Procedure Close Support (1-1) and the patients risk assessment.

The patient’s thoughts, feelings and wishes with regard to self-harm or harm to others must be approached using direct and respectful questions.

The duty Matron or GWH Site / community on-call Manager (out of office hours) will be informed immediately if close support is required from a RMHN. The Duty Matron or Site Manager will need to authorise the request for an RMHN.

When a patient has a RNMH present for safe and supportive observations they are to provide this support for the whole shift (with allocated breaks that are covered by appropriately trained Ward employees).

## Special Considerations: Patients who require Close Support and need Isolating for Infection Control (IP& C) Reasons/Outbreaks of Diarrhoea and Vomiting (D& V)

An individual risk assessment must be undertaken in relation to protecting employees who are providing close support for patients who have a transferable/communicable infections. The risk assessment template can be found on the Health and Safety website on the Trust Intranet. This rule applies to both Trust and temporary (agency) employees.. For guidance in relation to specific infection control issues please refer to the relevant IP& C Policy or contact the IP and C team (Contact details on the IP&C intranet pages)

If patients isolated due to an outbreak of diarrhoea and vomiting require close support this must form part of the multi-disciplinary risk assessment framework and management plans agreed at the outbreak meeting with reference to the Management of Diarrhoea and Vomiting (D& V) including he Norovirus Policy (Ref 20). It is important that temporary (agency) workers have access to the relevant policies so that they can provide practice that adheres to Trust policy.

If the employment of Bank and Agency workers is considered necessary, they must be advised not to work in other clinical areas for at least 48 hours after they worked on the affected ward.  If there is more than one ward affected with the same virus, they can work between these areas without any restrictions see Ref 20.

## Support for Employees who have undertaken Close Support

It is recognised that employees who provide close support for patients can be at increased risk of harm should the patient’s behaviour be unpredictable. It is very important that employees minimise risk to their self as much as possible by completing the ‘Close Support risk assessment’ (Appendix E) . Should an employee suffer physical harm whilst undertaking the role they should seek appropriate help and support from the senior nurse on duty and complete an IR1. Emotional and psychological support can also be provided by the Occupational Health department and Staff Support Services. (Details of how to access these services can be found on the Intranet)

## Mental Capacity Act (2005) (MCA) Considerations

## Principles of the MCA

1. Presumption of capacity.
2. Take all practicable steps to help someone make his/her decision.
3. A person is ***not*** incapable merely because they make unwise decisions.
4. Acts or decisions on behalf of a person lacking capacity must be in their best interests.
5. Regard must be had as to whether a less restrictive alternative (re freedoms and rights) is available.

Close support **must** be set at the ***least restrictive*** level for the ***least amount of time*** within the ***least restrictive environment***. General observation will be the presumed level and justification will be required to move up the levels according to the patient’s condition. Raising levels of supportive observation may be required and both the employee and patient need to be clear about its purpose as far as they are able to understand. It is essential that communication is effective and the situation managed sensitively.

The MCA places a responsibility on organisations to protect an individual’s Article 5 Human Rights to liberty. Where they are or need to be deprived of that liberty to maintain safety in their best interests this must be undertaken by a procedure prescribed by law; In relation to Patients who lack capacity to make decisions about their admission to hospital and accommodation there for the purpose of receiving care and treatment these procedures are known as Deprivation of Liberty Safeguards (DoLS).

### The ‘Acid Test’ for Deprivation of Liberty

The Supreme Court has clarified that there is a deprivation of liberty for the purposes of Article 5 of the European Convention on Human Rights in the following circumstances:

**The person is under continuous supervision and control and is not free to leave, and the person lacks capacity to consent to these arrangements.**

Therefore any patient who is having close support’ and lacks capacity to consent to the care and treatment may be being deprived of their liberty. Please refer to the mental health and safeguarding intranet page for guidance and relevant forms.

**3.1.2 Two Stage Test of Capacity:**

If it is believed the person has a temporary or longer term condition that is affecting their capacity to make a decision for themselves, employees must use the following test to assess if the person has capacity to make decisions re their admission to hospital for the purpose of receiving care and treatment and to make decisions re consenting to that care and treatment:

1. **Stage One: Diagnostic Test**

* Is there an impairment of, or disturbance in, the functioning of mind or brain?
* Is the impairment sufficient to disrupt decision making?
* Capacity must be decision and time specific.
* Don’t make unjustified assumptions, e.g. on the basis of age or appearance.

1. **Stage Two: Functional Test**

Ask the question: Is the impairment or disturbance sufficient that the person is unable to make that particular decision/action when he/she needs to?

**If the patient is able to make a decision and therefore DOES have capacity if he/she can do ALL of the following:**

* Understand the information relevant to the decision (as presented appropriately and with assistance).
* Retain that information (long enough to make an effective decision).
* Use or weigh up that information as part of the process of making the decision.
* Communicate the decision (after all practical and appropriate efforts have been made).

**3.1.3 ‘Best Interests’**

This links with Principle 4 of the MCA and is only to be applied once it has been established the person lacks capacity. A record of the Best Interest decision must be clearly documented in the patients notes.

**Best Interest ‘Checklist’**

* Involve the person who lacks capacity.
* Consider their beliefs and values together with past and present wishes and feelings.
* Consult with others who are involved in their care.
* Do not make assumptions based solely on the person’s age, appearance, condition or behaviour.
* Is the person likely to regain capacity to make the decision in the future so could the decision wait?
* Is this the least restrictive option?

## Deprivation of Liberty Safeguards (2009)

DoLS was an amendment to the Mental Capacity Act (2005) and has been a legal requirement since October 2009.

These safeguards provide a legal framework to protect uphold the Human Rights of adults who lack capacity to consent to their admission and accommodation in hospital for the purpose of receiving their care and/or treatment.

### Who does a DoLS apply to?

* A person that are aged 18 and over that lacks capacity to consent to care/treatment they receive
* A person receiving care in a hospital, a care home setting or an adult placement scheme and the care they receive deprives them of their liberty.
* A person that is not detained under the MHA.

### Why Might Someone need a DoLS?

Sometimes it is necessary to restrict or restrain a person in order to provide care and treatment or protect them from harm.

Principles 4 and 5 of the MCA Act should always apply and any restraint or restriction MUST be in their best interests and of the least restrictive nature.

### When Should a DoLS Application be considered?

On 19th March 2014 the Supreme Court revised the DoLS threshold to the following set of criteria:

* Is the person subject to continuous supervision and control? (Note: This has not been clearly defined by the Supreme Court and could be as low as the care and support required to meet the needs of the patient to meet their needs and keep them safe whilst in our care. This could include hourly checks, 1:1 support on a continuous or intermittent basis and the supervision of mobility/care tasks?
* Is the person free to leave?
* This should not be assessed solely by whether a patient maybe actively seeking to leave or objecting to the stay but applies equally if the patient id fully compliant with care, treatment and restrictions. The test of whether an application should be considered should be based on the action the staff would need to take in order to prevent harm toward the patient should try to leave.

### What is a DoLS Authorisation?

Where the two conditions are met (See 3.2.3) a DoLS authorisation should be requested from the relevant supervisory body. Contact and referral details of the supervisory bodies can be found on the MCA checklist (Appendix H)

DoLS is a statutory process which involves a number of assessments carried out by the Supervisory body to consider if a person has been deprived of their liberty. A process flow chart and documentation is available on the Safeguarding section of the intranet.

If the supervisory body agrees that the person is being deprived in their best interests they will grant an authorisation to the hospital which legally allows the hospital to detain the person for a specified time.

Supervisory body powers are devolved from central courts/government to local government.

## Restraint

**The decision to restrain must be made by a Registered Nurse, RMHN or doctor.**

Section 6 of the MCA (2005) states that someone is using restraint if they:

* Use force or threaten to use force to make someone do something they are resisting **or**
* Restrict a person’s freedom of movement, whether they are resisting or not.

The MCA Act stipulates that any action to restrain a person who lacks capacity will NOT attract protection from liability unless the following two conditions are met:

* The person taking action must reasonably believe that restraint is necessary to prevent harm to the person who lacks capacity **and.**
* The amount or type of restraint used and the amount of time it lasts must be proportionate response to the likelihood and seriousness of harm.

Any physical intervention should be informed by and comply with professional and regulatory guidance. Any consideration of the use of restraint must have objective reasons to justify if that restraint is necessary. It must be clearly documented that the person being cared for is likely to suffer harm unless proportionate restraint is used.

Employees must not use restraint just so that they can perform a task more easily. If restraint is necessary to prevent harm to the person who lacks capacity, it must be the minimum amount of force of the shortest time possible. For further information refer to Royal College of Nursing RCN guidance ‘Let’s talk about restraint’. (Ref 15).

**Employee MUST NOT physically restrain a patient unless they have been provided with the appropriate training.**

## Medication as a ‘Chemical Restraint’

Where a patient lacks capacity medication should only be given under ‘restraint’ if assessment has been completed under ‘best interests’.

A record of the Best Interests decision must be clearly documented in the patients’ medical notes:

* Involve the person who lacks capacity.
* Consider the beliefs and values together with past and present wishes and feelings (If known).
* Consult with others who are involved in their care.
* **Ask: ‘Is this the least restrictive option’?**

For advice and/or guidance for practice in relation to the MCA (2005) refer to the Mental Capacity Act Policy and Procedures (Ref 3) document available on the Intranet or contact the Safeguarding leads (Contact details available on the Safeguarding section of the intranet).

## Mental Health Act (2007) (MHA) Considerations

In most cases, when people are treated in hospital or another mental health facility they have agreed or volunteered to be there. They are referred to as a "voluntary patient".

However, there are cases when a person can be detained (also known as sectioned) under the Mental Health Act (2007) (MHA) and treated without their agreement. The MHA is the main piece of legislation that covers the assessment, treatment and rights of people with a mental health disorder.

People detained under the MHA need urgent treatment for a mental health disorder and are at risk of harm to themselves or others.

MHA, assessment and treatment are covered under the act, and this would be inclusive of the need for supervision. It is important to note, patients who are subject to provisions of the MHA are exempt from Depravation of Liberty Orders (DoL’s). However, should there be mental health need identified and the patient requires assessment under the MHA, the most ethical way forward would be assessment in a timely and coordinated manner.

If the patient is suffering from mental disorder to such a degree that it is necessary for the patient to be immediately prevented from leaving the hospital either for the patient’s health or safety or for the protection of other people apply the following principle of the MHA;

## Section 5 (2) of the MHA

Section 5(2) is the power under the MHA that allows the responsible consultant or their nominated deputy to detain an existing in-patient for a maximum period of up to 72 hours in order to make arrangements for their assessment for detention under Section 2 or Section 3 of the MHA..

Close support can be applied in the above situation, although treatment cannot be enforced.

Those patients subject to Section 2 and 3 of the MHA can be closely supervised as part of the assessment process to ensure safety. Any risk must be explained to the patient and the need for close support incorporated into the care plan, risk assessment and management plan. Assessment and treatment can be provided under both these provisions of the Act.

Section 5(2) gives doctors the ability to detain someone in hospital for up to 72 hours, during which time the patient will receive an assessment that decides if further detention under the MHA is necessary.

For advice and guidance to practice in relation to the MHA refer to the Mental Health Act Policy and Procedures (Ref 5) document available on the Intranet or contact the Safeguarding leads (Contact details available on the safeguarding intranet pages).

## Expectations of all Employees (including RMHN)

### Expectation of Nursing Employees (inclusive of care staff)

**All nursing employees are expected to:**

* Introduce themselves to the patient (‘Hello my name is’).
* Read medical notes and relevant additional information (such as ‘This is me’ or ‘My Health in Hospital’ passports).
* Read the Appendix H -Standard Operating Procedure Close Support (1-1).
* Use a range of therapeutic activities to engage with the patient such as puzzles/ cards/ reminiscence/ reading the paper together/ time off ward for coffee or a walk.
* Complete entry in the medical notes paying particular attention to areas that have caused distress/ agitation or behaviour that has been challenging- think- what were there triggers that caused this behaviour.
* **Meet the overall needs of the patient**. Essential care is particularly important to avoid exacerbating delirium: focus on nutrition and hydration needs, management of pain and constipation maintain and encourage mobility and personal care, independence and privacy and dignity. Ensure the patient has clean bedding and a clean environment/bed space.
* Provide reassurance if the patient is confused or frightened- orientate the patient as necessary, utilise engaging activities such as those listed above.
* Handover the care of the patient using the Appendix F -Close Support’ Observation Proforma.

### Expectation of Registered Nurse Mental Health (RNMH)

If a patient is being supported by an RNMH from their mental health unit for the first 24 hours, it is expected that the RNMH and the patients RN will work together in meeting the needs of the patient. The GWH has overall duty of care to the patient.

**The RNMH must:**

* Be orientated to the ward by the Nurse in Charge.
* Receive a handover from the previous member of employee providing extra support AND the registered nurse in charge of the patients care.
* Introduce themselves to the patient explaining their role.
* Communicate any concerns relating to physical health care needs to the registered general nurse. It is expected that the RNMH will provide the patient with personal care, nutrition and hydration needs, medication and mobility needs. If the RNMH has any concerns relating to undertaking any of the above tasks then they should raise them to the Nurse in Charge immediately.
* Respect privacy and dignity and personal and cultural sensitivities and ensure they are addressed as needed
* Familiarise themselves with documents such as ‘This is me’ and ‘My Health in Hospital’ and to use ward resources such as reminiscence tools, newspapers or books to develop a rapport and to engage therapeutically with the patient
* Read Appendix H -Standard Operating Procedure Close Support (1-1).
* Liaise with Nurse in Charge if there is any change in the patients mental health needs, especially risks, ensure this information is handed over to Nurse in Charge and the RNMH that is taking over the care once the shift is finished.
* Report any adverse effects from medications prescribed, in particular effects from psychiatric medications and if rapid tranquilisation is used.
* Complete ALL appropriate documentation. This will include completing the observation tools documentation, risk screen and care plan (found within appendices) and make a clear record within the patients’ medical records identifying risks, behaviour, triggers, de-escalation techniques that have/ have not worked, compliance with medication, engagement with RNMH and other patients and any other details that the RNMH feels is beneficial.
* Request assistance when breaks are needed and inform the Nurse in Charge if there is an increasing threat of aggression and/or violence.

### Co-horting Patients

Co-horting (Grouping ‘at risk’ patients together) is not appropriate for close support’ patients unless the need for close support is ‘risk of falls’. The decision to co-hort patients must be taken on a case-by-case basis. If co-horting is being considered a risk assessment must be undertaken by the nurse in charge and the decision discussed with the department Divisional Matron or if OOH the duty Matron/Site Management team.

### Appropriate Bed Space

Consider all patients when considering where would be the most appropriate bed space for the patient (s) being provided with close support.

It is unlikely that an ‘extra’ bed space would be appropriate for a patient requiring close support. A risk assessment would be required if consideration was being given to put a close support patient into one of these bed spaces.

# Duties and Responsibilities of Individuals and Groups

## Chief Executive

The Chief Executive is ultimately responsible for the implementation of this document.

## Deputy Divisional Directors

All Deputy Divisional Directors and Heads of Locality are to ensure that the list of new or revised policies, competencies, clinical guidelines, strategies, plans, protocols or procedural documents published each month is on the agenda at Divisional meetings to ensure that the documents are drawn to the attention of managers and general users. All Deputy Divisional Directors must ensure that employees within their area are aware of the document; able to implement the document and that any superseded documents are destroyed.

## Clinical Leads

Clinical Leads are responsible for ensuring that all clinical employee within their departments are aware of the ‘Close Support’ Protocol and that it is used to ensure that the ‘best interests’ of the patient is served at all times. Clinical leads must support the use of the ‘two stage Mental Capacity’ checklist to ensure the patient is provided with close support in line with MHA/MCA legislation.

## Divisional Matron/Senior Sister/Senior Charge Nurse

Divisional Matron/Senior Sister/Senior Charge Nurse are responsible for ensuring that:

1. The employee within the individual clinical areas are aware of this document and have read and understood it.
2. That employees are given support to familiarise themselves with the document and can implement the document appropriately .
3. That the close support paperwork is readily available in the clinical areas. Due to the legal context of the process photocopying the forms is not recommended. The paperwork can be ordered using the following codes:

* GWH 0668 Close Support Risk Assessment.
* GWH 0669 Close Support Mental Capacity Assessment.
* GWH 0670 Close Support Best Interest Decision Record.
* GWH 0671 Close Support Care Plan.
* GWH 0672 Close Support Observation.

1. That training needs are identified and met in order for employee to adhere to this document
2. That appropriate steps are taken to secure additional employees should the patient be assessed as needing such.
3. That the need for close support’ is reviewed at least every 24 hours.
4. That close support’ usage is recorded within the Close Support Folder on the T Drive to enable monitoring of usage/spend.

## Named Nurse

The Named Nurse is responsible for ensuring the completion of the following:

* The ‘2 stage Mental Capacity Checklist’.
* The ‘Best interest’ checklist (If required).
* The Close Support Risk assessment.
* The Close Support Care plan.
* Ensuring the nurse providing close support has seen and read the Close Support SOP.
* Ensuring the nurse providing close support has seen and read the Close Support Care plan.

## The Nurse in Charge (Co-ordinating Nurse)

The Nurse in Charge (Co-ordinating Nurse) is responsible for:

* Ensuring the policy has been adhered to.
* Ensuring any relevant legislative (Safeguarding) documentation is completed and sent to the relevant agencies.
* That the need for close support is escalated to the appropriate senior nurse.
* If an RMHN is required that a referral is sent to the Mental Health Liaison Team and support requested.
* That the named nurse is supported to achieve the elements of this document they are responsible for.
* Welcome and orientate extra employees to the ward.
* Hand out the Close Support Observation Performa and ensure the nurse has read the SOP and the patients risk assessment and care plan.
* Give a clear concise handover of the patient’s current situation and highlight any risks / concerns to the extra employee and if there is any other specific expectations for the employee.
* Highlight other professionals involved in the persons care.
* That the nurse providing close support has the relevant number of breaks and that the role is backfilled when the break is being taken.
* **Review the observation levels at least every 24 hours, in liaison with Senior Sister/Divisional Matron**

## Document Author and Document Implementation Lead

The document Author and the document Implementation Lead are responsible for identifying the need for a change in this document as a result of becoming aware of changes in practice, changes to statutory requirements, revised professional or clinical standards and local/national directives, and resubmitting the document for approval and republication if changes are required.

## Target Audience – As indicated on the Cover Page of this Document

The target audience has the responsibility to ensure their compliance with this document by:

* Ensuring any training required is attended and kept up to date.
* Ensuring any competencies required are maintained.
* Co-operating with the development and implementation of policies as part of their normal duties and responsibilities.

## Mental Health Liaison Team (Acute based care only)

The Mental Health Liaison Team is responsible for supporting the use of this document, and to provide specific guidance on its application to clinical situations where there is a clear mental health need.

## Agency and Bank Employees (Nursing)

Agency and Bank Employee (Nursing) are responsible for:

* Reading, understanding and complying with the SOP.
* Completing the Close Support Observation Proforma on an hourly basis.
* Providing high quality care.

# Monitoring Compliance and Effectiveness of Implementation

The arrangements for monitoring compliance are outlined in the table below: -

| **Measurable policy objectives** | **Monitoring / audit method** | **Monitoring responsibility** (individual / group /committee) | **Frequency of monitoring** | **Reporting arrangements** (committee / group to which monitoring results are presented) | **What action will be taken if gaps are identified?** |
| --- | --- | --- | --- | --- | --- |
| 100% of patients with close support provision have a 2 stage mental capacity assessment undertaken | Patient records | Safeguarding leads audit programme | As per agreed programme | Safeguarding forum/Patient Quality Committee (PQC) | Action plan |
| 100% of patients with close support provision have a ‘Best Interest’ checklist completed | Patient records | Safeguarding leads audit programme | As per agreed programme | Safeguarding forum/PQC | Action plan |
| 100% of patients being provided with close support have a care plan completed that demonstrates that ‘least restrictive’ and ‘best interest’ measures were in place | Patient records | Safeguarding leads audit programme | As per agreed programme | Safeguarding forum/PQC | Action plan |
| 100% compliance of patients receiving close support having primary and continued assessment for capacity against the mental capacity act. | Patient records | Senior Sister/ Senior Charge Nurse | As and when a pt. is identified as requiring Close Support | Where any exceptions to this is found the Senior Sister/ Senior Charge Nurse must inform the Safeguarding Adults/MCA Committee and an IR1 must be completed. | Provide an action plan. |
| 100% compliance with ‘This is me’/ my health in hospital is completed for each patient under close support | Patient records | Senior Sister/ Senior Charge Nurse | As and when a pt. is identified as requiring close support | Formal discussion with named nurse. | Where any exceptions to this is found the Senior Sister/ Senior Charge Nurse must inform the names nurse and ensure that it is completed as soon as possible |

# Review Date, Arrangements and Other Document Details

## Review Date

This document will be fully reviewed initially one year after ratification and then every three years in accordance with the Trust’s agreed process for reviewing Trust -wide documents. Changes in practice, to statutory requirements, revised professional or clinical standards and/or local/national directives are to be made as and when the change is identified.

## Regulatory Position

Close support process is underpinned by both the Mental *Health Act 2005* and the *Mental Capacity Act (2005)* *designative frameworks*

## References, Further Reading and Links to Other Policies

The following is a list of other policies, procedural documents or guidance documents (internal or external) which employees should refer to for further details:

| **Ref. No.** | **Document Title** | **Document Location** |
| --- | --- | --- |
| 1 | Safeguarding Adults At Risk Policy | Intranet |
| 2 | Deprivation of Liberty Safeguards (DoLS) | Intranet |
| 3 | Mental Capacity Act 2005 Policy and Procedures | Intranet |
| 4 | Safeguarding Adults at Risk Policy | Intranet |
| 5 | Mental Health Act Policy and Procedures | Intranet |
| 6 | AWP Transfer Policy **Multi-Agency Protocol for the Internal and External Transfer of Patients to and from Care Settings’** | Intranet - |
| 7 | Ashaye, O., Ikkos, G., Rigby, E (1997) Study of effects of constant observation of psychiatric in-patients. *Psychiatric Bulletin*, 21:145-147 | *Psychiatric Bulletin*, 21:145-147 |
| 8 | Barker, P., Cutliffe, J. (1999) Clinical risk: a need for engagement not observation. *Mental Health Practice*, 2 (8): 8-12. | *Mental Health Practice*, 2 (8): 8-12. |
| 9 | Barker, P., Cutliffe, J. (2000) Creating a hopeline for suicidal people: a new model for acute sector mental health nursing. *Mental Health Care*, 3 (6): 190-193. | *Mental Health Care*, 3 (6): 190-193. |
| 10 | Department of health (2012) Mental Health Act: Code of Practice (online) available from | <http://www.dh.gov.uk> |
| 11 | Department for Constitutional Affairs (2007) *Mental Capacity Act 2005 Code of Practice*. London: TSE - | http://webarchive.nationalarchives.gov.uk |
| 12 | Deprivation of Liberty Safeguards (2008) | http://webarchive.nationalarchives.gov.uk |
| 13 | Duffy, D (1995) Out of the shadows: a study of the special observation of suicidal psychiatric in-patients. *Journal of Advanced Nursing*, 21: 944-950. | *Journal of Advanced Nursing*, 21: 944-950. |
| 12 | Ministry of Justice (2009) *MAPPA Guidance*. London: MoJ - | http://www.lbhf.gov.uk |
| 13 | National Institute of Clinical Excellence (2005) *Clinical Guideline 25. Violence: The Short-Term Management of Disturbed/Violent Behaviour in In-Patient Psychiatric Settings and Emergency Departments*. London. NICE. | <http://www.dh.gov.uk> |
| 14 | National Institute of Clinical Excellence | <http://www.dh.gov.uk> |
| 15 | RCN Guidance ‘Let’s talk about restraint’ | http://www.rcn.org.uk |
| 16 | Alzheimer Society | www.alzheimers.org.uk |
| 17 | My Health in Hospital’ | Intranet |
| 18 | Incident Management Policy | Intranet |
| 19 | Electronic Rostering Policy | Intranet |
| 20 | Management of Diarrhoea and Vomiting (D&V) Including Norovirus Policy | Intranet |

## Consultation Process

The following is a list of consultees in formulating this document and the date that they approved the document:

| **Job Title / Department** | **Date Consultee Agreed Document Contents** |
| --- | --- |
| Chief Nurse | 18 02 2016 |
| Divisional Head of Nursing (Acute) | 11/02 2016 |
| Divisional Matron (Acute) | 19/08/2015 |
| GWH Nurse Bank Manager |  |
| Infection Prevention and Control | 19 02 2016 |
| Lead for Quality and Patient Experience | 25/01/2016 |
| Mental Health Liaison | 12/02/2016 |
| Parent/Carer | 15/02/2016 |
| Safeguarding lead Acute Trust | 28/01/2016 |
| Safeguarding lead Community | 28/01/2016 |
| Deputy head of community Inpatients | 26/09/2015 |
| Head of Locality (Sarum) | 24/08/2015 |

# Appendix A – Equality Impact Assessment

**Equality Impact Assessment**

**Our Vision**

Great Western Hospitals NHS Foundation Trust wants its services and opportunities to be as accessible as possible, to as many people as possible, at the first attempt.

**Are we Treating Everyone Equally?**

Define the document. What is the document about? What outcomes are expected?

Consider if your document/proposal affects any persons (Patients, Employees, Carers, Visitors, Volunteers and Members) with protected characteristics? Back up your considerations by local or national data, service information, audits, complaints and compliments, Friends & Family Test results, Employee Survey, etc.

If an adverse impact is identified what can be done to change this? Are there any barriers? Focus on outcomes and improvements. Plan and create actions that will mitigate against any identified inequalities.

If the document upon assessment is identified as having a positive impact, how can this be shared to maximise the benefits universally?

# Appendix B – Quality Impact Assessment Tool

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
| **Purpose** To assess the impact of individual policies and procedural documents on the quality of care provided to patients by the Trust both in acute settings and in the community. | | | | | | |
| **Process** The impact assessment is to be completed by the document author. In the case of clinical policies and documents, this should be in consultation with Clinical Leads and other relevant clinician representatives.  Risks identified from the quality impact assessment must be specified on this form and the reasons for acceptance of those risks or mitigation measures explained. | | | | | | |
| **Monitoring the Level of Risk** The mitigating actions and level of risk should be monitored by the author of the policy or procedural document or such other specified person.  High Risks must be reported to the relevant Executive Lead. | | | | | | |
| Impact AssessmentPlease explain or describe as applicable. | | | | | | |
| 1. | Consider the impact that your document will have on our ability to deliver high quality care. | | | This policy will ensure that patients requiring heightened levels of support will be supported using the appropriate legislative framework and by the most appropriately qualified member of employee. | | |
| 2. | The impact might be positive (an improvement) or negative (a risk to our ability to deliver high quality care). | | The policy will have a positive impact on the Trusts ability to provide high quality care to vulnerable adults. This risk will be where a need for close support has been identified but due to lack of employing availability is not achievable. | | | |
| 3. | Consider the overall service - for example: compromise in one area may be mitigated by higher standard of care overall. | | | | Following this policy will not compromise care for other patients. | |
| 4. | Where you identify a risk, you must include identify the mitigating actions you will put in place. Specify who the lead for this risk is. | Mitigating actions to reduce risk if ‘Close Support’ employee are not available:   * Consider cohorting patients (ONLY appropriate for patients at risk of falls) * Move patient nearer the nurses’ station/into line of sight * Consider reconfiguring current workforce | | | | |
| **Impact on Clinical Effectiveness & Patient Safety** | | | | | | |
| 5. | Describe the impact of the document on clinical effectiveness. Consider issues such as our ability to deliver safe care; our ability to deliver effective care; and our ability to prevent avoidable harm. | | | | |  |
| **Impact on Patient & Carer Experience** | | | | | | |
| 6. | Describe the impact of the policy or procedural document on patient / carer experience. Consider issues such as our ability to treat patients with dignity and respect; our ability to deliver an efficient service; our ability to deliver personalised care; and our ability to care for patients in an appropriate physical environment. | | | | |  |
| **Impact on Inequalities** | | | | | | |
| 7. | Describe the impact of the document on inequalities in our community. Consider whether the document will have a differential impact on certain groups of patients (such as those with a hearing impairment or those where English is not their first language). | | | | |  |

# Appendix C -Mental Capacity Assessment (Two Stage Test)



Addressograph

**Mental Capacity Act 2005**

This assessment is designed to record the process followed when assessing a person’s consent to (or refusal of) a proposed treatment or management plan and should be used to record the assessment of any specific decisions required.

|  |
| --- |
| Patient Name: (please print)  Unit No: Ward  Name of Assessor Role/Title |

What prompted this capacity assessment (Brief summary of relevant history)

|  |
| --- |
| **This patient being assessed may require close support due to the following issues (insert details below)** |

What is the specific decision to be taken?

|  |
| --- |
| **There are 2 specific decisions being assessed**:   1. **Can the person consent to being accommodated at GWH for the purpose of receiving care and treatment** 2. **Can the Patient consent to the proposed Close Support Care Plan** |

**STAGE ONE**

Is there an impairment of, or disturbance in the functioning of the person’s mind or brain? Yes  No

Is this of a nature or degree which might be sufficient to affect their capacity for   
this decision?

Please give details

|  |
| --- |
|  |

***NB: IF THERE IS A NO ANSWER DO NOT PROCEED TO STAGE 2, RECORD SUMMARY, SIGN, DATE AND PLACE ON PATIENT’S FILE.***

**STAGE TWO**

Is the person able to understand the information relevant to the decision? Yes No

Please record details (Ensure you have provided the person with sufficient relevant information and that this is included in your consideration of the person’s understanding. Ensure you have presented the information in ways which can enhance the person’s likelihood of understanding)

|  |
| --- |
| **Decision 1- The Patient’s close support risk assessment outcome was discussed with them, including the level of observation and care plan required to meet this.**  The Patient demonstrated the ability to understand this information  The Patient did not understand this information  **Decision 2- The Patient’s current Treatment and Care Plan was discussed with them.**  The Patient demonstrated the ability to understand this information  The Patient did not understand this information  **Please add any additional comments re the Patient’s understanding of the information about the decisions being assessed** |

Can the person retain the information for long enough to reach a decision? Yes No

(Ensure you have presented the information in ways which can enhance the person’s

likelihood of retaining the information)

Please record details

|  |
| --- |
| **Decision 1- The Patient’s close support risk assessment outcome was discussed with them, including the level of observation and care plan required to meet this.**  The Patient demonstrated the ability to retain this information for a sufficient period  The Patient was not able to retain this information for a sufficient period  **Decision 2- The Patient’s current Treatment and Care Plan was discussed with them.**  The Patient demonstrated the ability to retain this information for a sufficient period  The Patient was not able to retain this information for a sufficient period  **Please add any additional comments re the Patient’s understanding of the information about the decisions being assessed** |

Can the person use or weigh the information as part of the process of reaching   
a decision? Yes No

Please record details

|  |
| --- |
| **Decision 1- The Patient’s close support risk assessment outcome was discussed with them, including the level of**  **Observation and care plan required to meet this. This should detail the advantages and disadvantages of the required**  **care**  The Patient demonstrated the ability to use and weigh this information to enable decision making  The Patient was not able to use and weigh this information to enable decision making  **Decision 2- The Patient’s current Treatment and Care Plan was discussed with them. This should detail the advantages**  **And disadvantages of the proposed care and treatment plan.**  The Patient demonstrated the ability to use and weigh this information to enable decision making  The Patient was not able to use and weigh this information to enable decision making  **Please add any additional comments re the Patient’s understanding of the information about the decisions being**  **assessed** |

Can the person communicate their decision by any means? Yes No

Please record details

|  |
| --- |
| **The Patient was able to communicate their decision re decision 1**  **The Patient was not able to communicate their decision re decision 1 by any means**  **The Patient was able to communicate their decision re decision 2**  **The Patient was not able to communicate their decision re decision 2 by any means**  **Please add any additional comments re the Patient’s communication** |

***NB IF THE PERSON IS ASSESSED AS ‘NO’ FOR ANY OF THE SECOND STAGE DOMAINS THEY WILL LACK CAPACITY FOR THE SPECIFIC DECISION AND THE BEST INTEREST DECISION RECORD SHOULD BE COMPLETED. IF ALL THE DOMAINS ARE ASSESSED AS YES THE PERSON IS CAPACITATED RE THE DECISION AND THE ASSESSOR SHOULD COMPLETE THE ASSESSMENT SUMMARY ONLY, SIGN AND DATE AND PLACE ON PATIENT’S FILE.***

**Capacity assessment summary**

|  |
| --- |
| **It is the reasonable belief of the assessor that the Patient has capacity to consent to be accommodated**  **at the Great Western Hospital for the purpose of receiving care and treatment including close support.**  **It is the reasonable belief of the assessor that the Patient lacks the mental capacity to consent**  **to be accommodated at the Great Western Hospital for the purpose of receiving care and treatment**  **Including close support.**  **Please add any additional comments re the Patient’s communication** |

|  |
| --- |
| Signature: ....................................................................... Date: ..............................................  Name: (Please print).......................................................  Role/Title: (please print).................................................... |

# Appendix D - Best Interest Decision Record



Addressograph

**BEST INTEREST DECISION RECORD**

In making a best interest decision you **must not** be influenced **merely** by the person’s age, appearance, any condition of the person or by any aspect of the person’s behaviour which might lead to unjustified assumptions about the person’s best interests.

|  |
| --- |
| Patient name (please print)  Unit No  Ward |

What is the specific decision to be made?

|  |
| --- |
| **The specific decisions to be made;**;  **Should the Patient be accommodated at Great Western Hospital for the purpose of receiving care and treatment, including Close Support Care.** |

Will the person regain the capacity to make this decision? Yes No

If so when (approx. date)

Will this be soon enough to wait for their decision? Yes No

**Decision delayed as Capacity to be reassessed within 24 hours**

**Decision delayed as Capacity to be reassessed within 48 hours**

**Decision delayed as Capacity to be reassessed within 72 hours**

**Decision not delayed**

Has everything “reasonably practicable” been done to encourage the person’s Yes No  
participation?

Has everything “reasonably practicable” been done to improve his/her ability to

Participate as fully as possible? Yes No

Do any of the elements of this decision relate to life sustaining treatment Yes No

***So far as is reasonably practicable has consideration been given to:***

the person’s past and present wishes and feelings (including any written Yes No

statement   
given by the person)?

The beliefs and values that would have influenced his/her decision if he/she had capacity? Yes No

Other factors that he/she would be likely to consider if able to do so? Yes No

What is known to be the most important to the person regarding this decision?

Record relevant Details here

|  |
| --- |
|  |

***Have the views of the following, if it is practicable and appropriate to consult them, been taken into account as to what would be in the person’s best interests:***

Anyone named by the person as someone to be consulted on the matter in question  
or of that kind? Yes No

Please record name, role and details of their views (if no document why)

|  |
| --- |
|  |

Anyone engaged in caring for the person or interested in his welfare? Yes No

Please record name, role and details of their views (if no document why)

|  |
| --- |
|  |

Does the Patient have a Lasting Power of Attorney for Health and Welfare Yes No

decisions? Yes No

Ensure this document has been seen and verified as being registered.

|  |
| --- |
| Please record name, role and details of their views (NB any registered Attorney will become the decision maker) |

Any deputy appointed for the person by the Court of Protection? Yes No

Ensure this document has been seen and verified as being registered

Please record name, role and details of their views NB any registered deputy will become the decision maker)

|  |
| --- |
|  |

Any Advocate/IMCA? Yes No

Please record name and details of their views

|  |
| --- |
|  |

Any professionals involved or consulted? Yes No

Please records name/s, role/s and details of their views

|  |
| --- |
|  |

Does an advance refusal of treatment exist? Yes No

Is it relevant to this decision? Yes No

Can the care be done in a less restrictive way? Yes No

Have all other relevant circumstances been considered? Yes No

Considering all relevant factors what is the Best Interest Decision reached by the Decision Maker

|  |
| --- |
| **I am the decision maker and have considered all the above relevant factors and conclude that the current care and treatment plan for this patient is of the least restrictive nature and it is in their Best Interests to be accommodated at Great Western Hospital in order to receive this.** |

|  |
| --- |
| Signature of Decision Maker  Date  Name (Please print)    Job Title |

Please ensure copy is placed on patient’s file.

# Appendix E -Close Support’ (1-1) Risk Assessment

**‘Close Support’ (1-1) Risk Assessment**

**To be completed by RN or RMHN**

**Demographic Label**

**Name**

**Hospital Number**

**DOB**

**Person completing assessment:**

**Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Designation: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

This assessment will be used to highlight risks and give guidance to observation level and/or staff group who may be best placed to provide additional support

**Red** will indicate a **need to consider** requirement of:

RMN for patients who may be sectioned for which you require specialist advice relating to intervention, sedation and restraint. Patients who are violent and aggressive may fall into this category.

Band 3 unregistered nurse (UR) (With mental health) to provide support and intervention.

For sectioned patients or those who require specialist support in relation to violence and aggression to self or others

**Amber** will indicate a **need to consider** requirement of:

Observation by Band 2 for reduction of risk by managing behaviour and risk i.e. falls

Observation by a Band 3 where expertise is required in mental health presentations where specialist intervention is required.

**Green** will indicate a **possible** requirement of:

Observations by existing ward staff

This risk assessment is designed to indicate the level of support needed to maintain patient safety and to ensure the patient is looked after under the relevant legislative framework. The final agreement as to the level of support required must be agreed by the Matron or Senior Sister/Charge Nurse for the clinical area. If out of hours (OOH) the level of support must be agreed by the late matron or the on-call manager. Ring switchboard to access a member of the OOH team (See ‘Step 5’)

Addressograph Label

Name

Hospital Number

DOB

**Step 1**:

**Complete Mental Capacity Assessment (2 stage test)**

**Patient has capacity to consent to Close support**

**Patient Lacks capacity to consent to close support**

**Step 2: Complete ‘Close Support’ Assessment**

**Key:**

**MCA** Type of behaviour identified is likely to come under the framework of the **Mental Capacity Act. NB the MCA should always be considered in the first instance in relation to patients who are assessed as lacking capacity to consent to close support arrangements.**

**MHA** There may be Patients who require close support due to issues related to a Mental Health disorder that require assessment and/or action under the **Mental Health Act**.

Please tick (as many as applicable) the indicators which demonstrate why the patient is in a specific zone

|  |  |  |
| --- | --- | --- |
| **RED** | **AMBER** | **GREEN** |
| **MCA**  Current history of high risk behaviours – e.g.: self-harming and/or has been assessed as lacking capacity to manage risk taking behaviours.  Applicable Y N | **MCA**  Previous history of high risk behaviours – e.g. self-harming  And/or has been assessed as lacking capacity to manage risk taking behaviours.  Applicable Y N | **MCA**  No known or recent history of high risk behaviours. Patient demonstrates insight into any potential risks and has reasonable risk management strategies/skills. Patient should be worked with under Principle 1 of MCA (2005) and consent to close support should be obtained.  Applicable Y N |
| **MHA**  At risk of suicide or self-harm and assessed by mental health liaison as needing close support care  Applicable Y N | **MHA**  Potential risk of self-harm and assessed by mental health liaison as needing close support care  Applicable Y N | **No requirement for legislative framework**  No evidence of risk of suicide or self-harm.  Applicable Y N |
| **MHA**  Current risk indicators demonstrate a serious risk to staff or patients– e.g. violence, aggression, intimidation or disinhibition.  Applicable Y N | **MHA**  Previous risk indicators identified which are deemed to be possible but not to the degree of serious concern.  Applicable Y N | **No requirement for legislative framework**  Previous risk indicators identified but no longer considered to be an active risk. No evidence of risk indicators.  Applicable Y N |
| **MHA**  Patient exhibits symptoms of acute mental health disorder and is strongly objecting to being accommodated for the purposes of care and treatment with clear statement of intent to harm self on discharge from hospital care.  Patient may be a high absconding risk  Applicable Y N | **MCA**  Patient lacks capacity to consent to be accommodated in GWH NHS FTs’ care and treatment purposes; the patient is medically unfit and has physically attempted to leave/has left the hospital which is considered not to be in their best interests.  **MCA**  Patient lacks capacity to consent to be accommodated in GWH NHS FTs’ for care and treatment purposes, the patient has verbalised a wish to leave the hospital/is at risk of absconding.  Applicable Y N | **MCA**  **No evidence of absconding risk as;**  Patient is capacitated to consent to be accommodated for the purposes of care and treatment.  Patient should be worked with under Principle 1 of MCA (2005) and Consent to Close support should be obtained  **No evidence of absconding risk BUT;**  Patient lacks capacity to consent to be accommodated for care and treatment and is compliant with care regime **(DoLS should still be considered)**  Applicable Y N |
|  | **MCA**  Disorientation or delirium associated with an unsteady gait to a degree that the patient is at very high risk of falls    Applicable Y N | **No requirement for legislative framework**  At risk of falls, has capacity and can be negotiated with to comply with care.  Applicable Y N |
| **MCA**  Non-communicative or minimal communication/inability to anticipate/undertake own essential care needs to a point where physical health would be endangered  Applicable Y N | **MCA**  Communicative and able to anticipate some care needs but self neglects to the point where physical health is at risk      Applicable Y N | **MCA**  Communicative and able to anticipate own care needs/ask for help when appropriate. Patient should be worked with under Principle 1 of MCA (2005) and consent to care plan should be obtained  Applicable Y N |
| **MHA**  Has been administered rapid tranquilisation medication without their consent in the previous 24 hours (including rapid tranquilisation orally or intramuscular)  Applicable Y N | **MHA**  Has been administered rapid tranquilisation medication without their consent in the previous 14 days (including rapid tranquilisation orally or intramuscular)  Applicable Y N | **No requirement for legislative framework**  Rapid tranquilisation medication has never been administered without their consent  Applicable Y N |
|  | **MHA or MCA**  Sudden change in behaviour or presentation with increased risk.  Applicable Y N | **No requirement for legislative framework**  No change in behaviour, no apparent risk behaviours.  Applicable Y N |
|  | **MHA or MCA**  Suspected use of, or appears to be under the influence of alcohol/illicit drugs.  Applicable Y N | **No requirement for legislative framework**  No risk of alcohol or drug use    Applicable Y N |
| **Number of Reds** | **Numbers of Ambers** | **Number of Greens** |

**Step 3: Decide what level of support is required**

|  |  |  |
| --- | --- | --- |
| **HIGH NUMBER OF RED’s**  **RMHN** | **HIGH NUMBER OF AMBER**  **Band 2 RMHN (Dependent on risk)** | **GREEN**  **Own establishment numbers** |
| Patient presenting as add potentially eligible for assessment under Mental Health Act [refer to flowchart; referral to Mental Health Liaison Team for assessment and guidance] | Patient lacks capacity to consent to be accommodated at GWH NHS FT for the purposes of receiving care and treatment [refer to flowchart; completion of 2 stage Mental Capacity Assessment and Best Interest Decision Record, DoLS process] | Patient demonstrates capacity (Principle 1 Mental Capacity Act, 2005) to consent to be accommodated at GWH NHS FT for the purposes of receiving care and treatment [refer to flowchart ] |

If your level of support is ‘Green’ you can **STOP** the assessment here (See flow chart below)

Step 4: **Decision Flowchar**t

**1. MHA: Patient may have capacity to consent to care and treatment but is non-compliant due to acute mental health disorder and poses a risk of significant risk of harm to self and/or others**

**2. MCA: Patient has capacity to consent to care and treatment**

**3. MCA: Patient lacks capacity to consent to care and treatment**

And treatment

And treatment

Contact friends and family/NOK for information and consultation

Complete ‘Best Interests’ Decision form

If declines care and treatment document consequences and risks in the nursing notes

If consents to care and treatment gain consent and document in the medical notes

Patient is eligible for assessment and detention under MHA. Make contact with the relevant Mental Health Team (or OOH the site team) for advice and assessment

Complete DoL’s and fax to relevant Safeguarding MCA/DoLS Team. **Do this even if patient does not need close support**

**Contact safeguarding Adults Lead on 7345 if advice or support is required**

Close support staff required (RMHN)

No close support staff required.

Complete risk assessment/Care plan

Review decisions for the DoL’s AT LEAST every 72h and ensure close support measures are the ‘least restrictive’ option

Request close support if mostly red or mostly amber and clinically indicated.

Refer to front of assessment form for level of support required

**Thinking about grouping your ‘close support’ patients together?**

**This practice should only be considered for patients requiring ‘close support’ for falls risk. Your care must be person centred, least restrictive and in patients best interests**

**Step 5:**

**Securing Close Support Employees. Guidance for ward co-ordinator**

**Workforce:**

1. How many supernumary staff do you have? **Do they have the skills to provide close support?**
2. Number of nurses awaiting a PIN number – **do they have the skills to provide close support?**
3. Staff on phased return – **can they within their plan provide close support?**
4. Does the current acuity allow for the patient to be supported by the team currently on duty?
5. **If appropriate** have you invited family members to be included in the care planning?

Please note that none of the above would be suitable for any patient requiring specialist mental health intervention. To be considered very carefully and risk assessed: staff also need to feel comfortable if they decline (with good reason).

**Next steps (If none of the the above is appropriate):**

1. Discuss need for close support staff with the Senior Sister/Charge Nurse or Matron for the clinical area. If Out of Hours discuss with the Late Matron or site management team.
2. Once authorised Close support to be requested via the e-roster system.
3. **Options for booking support staff are as follows**

* Close Support – HCA Band 2
* Close Support – Dementia - Band 2
* Close Support – Acuity Mental Health – RMHN

1. **Use the 24h ‘Close Support Observation’ proforma to monitor behaviour and support decision making in relation to what level of support is required**
2. Senior Sister/Senior Charge Nurse or Matron to review need for close support every 24h and sign the close support Observation proforma. On the rare occasion that at the weekends or at times Senior Sister/Charge Nurses or the matron is unavailable the most senior person on the ward can make this assessment. Place this form in the nursing notes for records.

**Information for Senior Sister/Charge nurse/Matron:**

Please ensure you review the need for ‘closes support’ at least every 24 and sign the ‘Close support Observation’ proforma to say you have done this.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Appendix F - Close Support’ Observation Proforma (to be used by RN/RMHN or UR Nurse Band 2/3)**

**Observing Patients- 24 Hour Proforma**

|  |  |  |
| --- | --- | --- |
| Patients name/Demographic Label | | Consultant: |
| Name: | | Legislative Framework:  MHA MCA No framework needed |
| Hospital Number | **DOB** | **Nurse Completing Assessment**  **Signature PRINT**   |  |  |  | | --- | --- | --- | | **Early** |  |  | | **Late** |  |  | | **Night** |  |  | |
| NHS Number | | **Date of assessment:** |

**General instructions**

Record your impression of the patient on an hourly basis by ticking the box that most accurately reflects their presentation. If patient is asleep for an hour, and you are unable to determine their red, amber or green status, simply write ‘asleep’

For each hour count up the number of green amber or red boxes and record in the totals section

|  |  |  |  |
| --- | --- | --- | --- |
| **Night Time Sleep Pattern** | | **07.00** | ***Instruction for ‘Night Time Sleep Pattern’***  *This section is completed only once each day i.e. at the end of the night shift by the ‘Nurse-in-Charge’ at night.*  *Mark the box that most accurately reflects the service users sleep pattern for the preceding night* |
| **G** | **Satisfactory night’s sleep reflecting normal sleep pattern** |  |
| **A1** | **An acceptable night’s sleep but altered from normal pattern** |  |
| **A2** | **Disturbed and inadequate night’s sleep** |  |
| **R** | **Unable to sleep at all throughout the night** |  |

Demographic Label

Name

DOB

Hospital number

|  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **1** | **WELLBEING** | **07**  **00** | **08**  **00** | **09**  **00** | **10**  **00** | **11**  **00** | **12**  **MD** | **13**  **00** | **14**  **00** | **15**  **00** | **16**  **00** | **17**  **00** | **18**  **00** | **19**  **00** | **20**  **00** | **21**  **00** | **22**  **00** | **23**  **00** | **12 MN** | **01**  **00** | **02**  **00** | **03**  **00** | **04**  **00** | **05**  **00** | **06**  **00** |
| G | Condition appears unchanged or improved |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| A | Condition appears to have worsened |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| R |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |

|  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **2** | **VERBAL COMMUNICATION** | **07**  **00** | **08**  **00** | **09**  **00** | **10**  **00** | **11**  **00** | **12**  **00** | **13**  **00** | **14**  **00** | **15**  **00** | **16**  **00** | **17**  **00** | **18**  **00** | **19**  **00** | **20**  **00** | **21**  **00** | **22**  **00** | **23**  **00** | **12 MN** | **01**  **00** | **02**  **00** | **03**  **00** | **04**  **00** | **05**  **00** | **06**  **00** |
| G | Communicates needs verbally/non verbally |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| A1 | Difficulty with memory, making choices, informed decisions |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| A2 | Increased rate/some inappropriateness |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| R | At risk due to inability to communicate and physical health endangered |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |

|  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **3** | **CONFUSION/DISORIENTATION/AGITATION** | **07**  **00** | **08**  **00** | **09**  **00** | **10**  **00** | **11**  **00** | **12**  **00** | **13**  **00** | **14**  **00** | **15**  **00** | **16**  **00** | **17**  **00** | **18**  **00** | **19**  **00** | **20**  **00** | **21**  **00** | **22**  **00** | **23**  **00** | **12 MN** | **01**  **00** | **02**  **00** | **03**  **00** | **04**  **00** | **05**  **00** | **06**  **00** |
| G | Alert and orientated |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| A | Mildly confused &disorientated/agitated |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| R | Very confused and/or disorientated to the point of harm to self and/or others |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |

|  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **4** | **AGRESION AND VIOLENCE** | **07**  **00** | **08**  **00** | **09**  **00** | **10**  **00** | **11**  **00** | **12**  **00** | **13**  **00** | **14**  **00** | **15**  **00** | **16**  **00** | **17**  **00** | **18**  **00** | **19**  **00** | **20**  **00** | **21**  **00** | **22**  **00** | **23**  **00** | **12 MN** | **01**  **00** | **02**  **00** | **03**  **00** | **04**  **00** | **05**  **00** | **06**  **00** |
| G | No hostility, aggression or violence |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| A | Irritable/hostile/aggressive manner |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| R | Aggression and violent assault |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |

Demographic Label

Name

DOB

Hospital number

|  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **5** | **SOCIAL INTERACTION** | **07**  **00** | **08**  **00** | **09**  **00** | **10**  **00** | **11**  **00** | **12**  **00** | **13**  **00** | **14**  **00** | **15**  **00** | **16**  **00** | **17**  **00** | **18**  **00** | **19**  **00** | **20**  **00** | **21**  **00** | **22**  **00** | **23**  **00** | **12 MN** | **01**  **00** | **02**  **00** | **03**  **00** | **04**  **00** | **05**  **00** | **06**  **00** |
| G | Socializes well with individuals/groups |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| A1 | Mixes with certain individuals only |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| A2 | Interacts only when necessary |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| R | Withdrawn, isolated & no social contact |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |

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| **6** | **OBSERVABLE BEHAVIOURS** | **07**  **00** | **08**  **00** | **09**  **00** | **10**  **00** | **11**  **00** | **12**  **00** | **13**  **00** | **14**  **00** | **15**  **00** | **16**  **00** | **17**  **00** | **18**  **00** | **19**  **00** | **20**  **00** | **21**  **00** | **22**  **00** | **23**  **00** | **12 MN** | **01**  **00** | **02**  **00** | **03**  **00** | **04**  **00** | **05**  **00** | **06**  **00** |
| G | No apparent behavioural abnormalities |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| A1 | Restless, agitated, overactive or inappropriate sexualised behaviour |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| A2 | Lethargic, loss of drive or slowed down |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| R | Hyperactive, uninhibited or strange |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |

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| **7** | **RISK OF SELF HARM** | **07**  **00** | **08**  **00** | **09**  **00** | **10**  **00** | **11**  **00** | **12**  **00** | **13**  **00** | **14**  **00** | **15**  **00** | **16**  **00** | **17**  **00** | **18**  **00** | **19**  **00** | **20**  **00** | **21**  **00** | **22**  **00** | **23**  **00** | **12 MN** | **01**  **00** | **02**  **00** | **03**  **00** | **04**  **00** | **05**  **00** | **06**  **00** |
| G | No self harm (Thoughts or behaviours) |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| A | Ideas of self harm but NOT acted upon |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| R | Actively self harming |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |

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| **8** | **RISK OF ABSCODING** | **07**  **00** | **08**  **00** | **09**  **00** | **10**  **00** | **11**  **00** | **12**  **00** | **13**  **00** | **14**  **00** | **15**  **00** | **16**  **00** | **17**  **00** | **18**  **00** | **19**  **00** | **20**  **00** | **21**  **00** | **22**  **00** | **23**  **00** | **12 MN** | **01**  **00** | **02**  **00** | **03**  **00** | **04**  **00** | **05**  **00** | **06**  **00** |
| G | No Obvious risk |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| A | Has verbalised intent to leave the ward and lacks capacity |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| R | Actively attempting to leave the ward and lacks capacity |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |

Demographic Label

Name

DOB

Hospital number

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| **9** | **CONCENTRATION AND ATTENTION** | **07**  **00** | **08**  **00** | **09**  **00** | **10**  **00** | **11**  **00** | **12**  **00** | **13**  **00** | **14**  **00** | **15**  **00** | **16**  **00** | **17**  **00** | **18**  **00** | **19**  **00** | **20**  **00** | **21**  **00** | **22**  **00** | **23**  **00** | **12 MN** | **01**  **00** | **02**  **00** | **03**  **00** | **04**  **00** | **05**  **00** | **06**  **00** |
| G | Able to concentrated |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| A1 | Easily distracted or diverted |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| A2 | Unable to concentrated/stay focussed |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| R |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |

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| **10** | **APPETITE – DIET AND FLUIDS** | **07**  **00** | **08**  **00** | **09**  **00** | **10**  **00** | **11**  **00** | **12**  **00** | **13**  **00** | **14**  **00** | **15**  **00** | **16**  **00** | **17**  **00** | **18**  **00** | **19**  **00** | **20**  **00** | **21**  **00** | **22**  **00** | **23**  **00** | **12 MN** | **01**  **00** | **02**  **00** | **03**  **00** | **04**  **00** | **05**  **00** | **06**  **00** |
| G | Normal diet and dietary/fluid intake |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| A | Poor appetite and reduced diet/fluid intake |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| R | Deliberately not eating or drinking due to mental health issues |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |

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| **11** | **DEMEANOUR (i.e. MOOD)** | **07**  **00** | **08**  **00** | **09**  **00** | **10**  **00** | **11**  **00** | **12**  **00** | **13**  **00** | **14**  **00** | **15**  **00** | **16**  **00** | **17**  **00** | **18**  **00** | **19**  **00** | **20**  **00** | **21**  **00** | **22**  **00** | **23**  **00** | **12 MN** | **01**  **00** | **02**  **00** | **03**  **00** | **04**  **00** | **05**  **00** | **06**  **00** |
| G | Stable and ‘normal’ for the individual |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| A1 | Frequently apprehensive or anxious |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| A2 | Labile (Quick changes of mood) |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| R | Persistently depressed or elevated due to mental health issues |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |

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| **12** | **PHYSICAL HEALTH NEEDS** | **07**  **00** | **08**  **00** | **09**  **00** | **10**  **00** | **11**  **00** | **12**  **00** | **13**  **00** | **14**  **00** | **15**  **00** | **16**  **00** | **17**  **00** | **18**  **00** | **19**  **00** | **20**  **00** | **21**  **00** | **22**  **00** | **23**  **00** | **12 MN** | **01**  **00** | **02**  **00** | **03**  **00** | **04**  **00** | **05**  **00** | **06**  **00** |
| G | Minimal assistance with essential care needs |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| A | No ability to help self eat, drink or paralyzed |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| R | Significant risk of choking/dysphasia |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |

Demographic Label

Name

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| **13** | **PERCEPTION (I.e. Hallucinations)** | **07**  **00** | **08**  **00** | **09**  **00** | **10**  **00** | **11**  **00** | **12**  **00** | **13**  **00** | **14**  **00** | **15**  **00** | **16**  **00** | **17**  **00** | **18**  **00** | **19**  **00** | **20**  **00** | **21**  **00** | **22**  **00** | **23**  **00** | **12 MN** | **01**  **00** | **02**  **00** | **03**  **00** | **04**  **00** | **05**  **00** | **06**  **00** |
| G | No altered perceptions identified |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| A | Mild altered perceptions |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| R | Moderate altered perceptions |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| R | Disturbing altered perceptions |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |

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| **14** | **MOBILIZATION AND RISK OF FALLS** | **07**  **00** | **08**  **00** | **09**  **00** | **10**  **00** | **11**  **00** | **12**  **00** | **13**  **00** | **14**  **00** | **15**  **00** | **16**  **00** | **17**  **00** | **18**  **00** | **19**  **00** | **20**  **00** | **21**  **00** | **22**  **00** | **23**  **00** | **12 MN** | **01**  **00** | **02**  **00** | **03**  **00** | **04**  **00** | **05**  **00** | **06**  **00** |
| G | Steady/hesitant/No or low risk of falls |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| A | Very high risk of falls/fallen in the past 24h |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| R |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |

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|  | **Count up the number of observations in each category** | **07**  **00** | **08**  **00** | **09**  **00** | **10**  **00** | **11**  **00** | **12**  **00** | **13**  **00** | **14**  **00** | **15**  **00** | **16**  **00** | **17**  **00** | **18**  **00** | **19**  **00** | **20**  **00** | **21**  **00** | **22**  **00** | **23**  **00** | **12 MN** | **01**  **00** | **02**  **00** | **03**  **00** | **04**  **00** | **05**  **00** | **06**  **00** |
| G | GREEN |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
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|  | **Count up the number of observations in each category** | **07**  **00** | **08**  **00** | **09**  **00** | **10**  **00** | **11**  **00** | **12**  **00** | **13**  **00** | **14**  **00** | **15**  **00** | **16**  **00** | **17**  **00** | **18**  **00** | **19**  **00** | **20**  **00** | **21**  **00** | **22**  **00** | **23**  **00** | **12 MN** | **01**  **00** | **02**  **00** | **03**  **00** | **04**  **00** | **05**  **00** | **06**  **00** |
| A1 or A2 | AMBER |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
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|  | **Count up the number of observations in each category** | **07**  **00** | **08**  **00** | **09**  **00** | **10**  **00** | **11**  **00** | **12**  **00** | **13**  **00** | **14**  **00** | **15**  **00** | **16**  **00** | **17**  **00** | **18**  **00** | **19**  **00** | **20**  **00** | **21**  **00** | **22**  **00** | **23**  **00** | **12 MN** | **01**  **00** | **02**  **00** | **03**  **00** | **04**  **00** | **05**  **00** | **06**  **00** |
| R | RED |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
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Demographic Label

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|  | **SIGN TO DOCUMENT YOU HAVE REVIEWED YOUR PATIENT HOURLY** | **07**  **00** | **08**  **00** | **09**  **00** | **10**  **00** | **11**  **00** | **12**  **00** | **13**  **00** | **14**  **00** | **15**  **00** | **16**  **00** | **17**  **00** | **18**  **00** | **19**  **00** | **20**  **00** | **21**  **00** | **22**  **00** | **23**  **00** | **12 MN** | **01**  **00** | **02**  **00** | **03**  **00** | **04**  **00** | **05**  **00** | **06**  **00** |
|  | **EARLY SHIFT** |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
|  | **LATE SHIFT** |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
|  | **NIGHT SHIFT** |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |

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| **Narrative/Comments Box** | |
| **Early** |  |
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| **Late** |  |
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| **Night** |  |
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Once completed for the 24h period please get your need for ‘Close Support’ reviewed by your Senior Sister/Charge Nurse or Matron.

If it is the weekend and there are no senior staff available your patients need for ‘Close Support’ can be reviewed and agreed by the

most senior Nurse on shift. Remember this decision can be reviewed at any time should your patients’ needs change.

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| **Close Support Nursing is still required for at least the next 24h period** | **Yes** | **No** | **Name (Print):**  **Signature:** | **Designation:** | **Date:** |

# Appendix G - Close Support Care Plan

(To be completed by RN1/RMHN)

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| --- | --- |
| Demographic Label  Patient name:  DOB  Hospital Number: | Name of Nurse completing the Care Plan:  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |

Completion of this care plan is the responsibility of a registered nurse or registered mental health nurse. Please complete each section of this care plan, and record the outcomes in the appropriate section(s) of the patient’s clinical record. Indicate which problem(s) apply to your patient and complete the relevant sections. **Please note this is NOT an exhaustive care plan. There is space provided within the proforma to add additional interventions relevant to an individual care needs.**

| **Problem/need**  **(Please add initials)** | **Interventions to be provided, or actions taken**  **(Please add initials)** | | | | **When** | | **Who by** | | |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **A: CONCORDANCE WITH TREATMENT PLAN** | | | | | | | | | |
| **A1. Mental Health Act status (inform site if detained)**  **Applicable (Circle) Y N**  **A1. Mental Health Act status continued** | **Complete Close support risk assessment proforma Inc. Mental Capacity Assessment**  Seek senior assistance to get relevant paperwork completed and submitted to appropriate agency (Doctor or Site team)  Review appropriateness of environment (i.e. Consider Side room)  Provide close support as recommended by the Close Support Assessment Proforma  Complete Close Support Observation proforma to track behaviour trends/inform re treatment plan  Close support Observation proforma to be completed and reviewed every 24h  Refer to relevant mental health support services if appropriate/applicable  **Distraction or de-escalation techniques should be employed to gently guide away from potentially harmful situations**  **Close support to consider employing purposeful activities that might stimulate and occupy to reduce episodes of frustration and anxiety**  **Additional interventions/Actions:** | | | | At all times | | | Named Nurse/Close support | |
| **Mental Capacity and DoL’s**  **This patient has been assessed as lacking capacity to consent to the following close support care plan. This care plan has been agreed in accordance with Principle 4 of the Mental Capacity Act (2005) as in the best interests of the patient and in accordance with principle 5 of the Mental Capacity Act (2005) will be regularly reviewed to ensure it remains the least restrictive means of meeting their needs**  **Applicable (Circle) Y N** | | | | | | | | | |
| **A2. Mental Capacity and DoLS**  **Applicable (Circle) Y N**  **\_\_\_\_ lacks insight into their current behaviours. This has placed them at risk of harm.**  **A2. Mental Capacity and DoLS continued** | **Complete Close support risk assessment proforma Inc. Mental Capacity Assessment and Best Interest checklist**  Review appropriateness of environment  Provide close support as recommended by the Close Support Assessment Proforma  Complete behaviour chart to track behaviour trends/inform re treatment plan  Close support Observation proforma to be completed and reviewed every 24h  Refer to relevant mental health support services if appropriate/applicable  **Additional interventions/Actions:** | | | | At all times | | | Named Nurse/Close support | |
| **A3. Participation in the processes of care**  **Applicable (Circle) Y N** | Ensure all opportunities are afforded to \_\_\_\_to participate in all aspects of care and care planning  If applicable complete ‘Best Interest’ checklist  Any support should be as unobtrusive as possible to maintain the dignity and safety of \_\_\_\_  Personal space and the right to privacy must be respected at all times and \_\_\_\_ if possible must have an element of choice and control over their day  **Additional Interventions/Actions:** | | | | At all times | | | Named Nurse/Close support | |
| **B: RISK MANAGEMENT** | | | | | | | | | |
| **B1. Risk of absconding**  **Applicable (Circle) Y N**  **\_\_\_\_ lacks insight into their current behaviours. This has placed them at risk of harm.**  **\_\_\_\_ is prone to wandering/risk of absconding. They pose a risk to self**  **\_\_\_\_ may become more agitated if attempts are made to confine them to their bed space.**  **\_\_\_\_ has a DOL order OR is under a section 5:2 (denote as appropriate) and through this is not allowed to leave the ward environment** | Complete behaviour chart to track behaviour trends/inform re treatment plan  Provide close support as recommended by the Close Support assessment proforma  **Complete appropriate paperwork and fax to relevant agency**  **Review orders at least every 72 hours**  Allow \_\_\_\_ to mobilise around the ward with visual ‘line of sight’ supervision  Any support should be as unobtrusive as possible to maintain the dignity and safety of  \_\_\_\_  **Distraction or de-escalation techniques should be employed to gently guide away from potentially harmful situations**  **Close support to consider employing purposeful activities that might stimulate and occupy to reduce episodes of frustration and anxiety**  Personal space and the right to privacy must be respected at all times and \_\_\_\_ if possible must have an element of choice and control over their day **(Whilst maintaining ‘line of sight’ observation)**  **Additional Interventions/Actions:** | | | | At all times | | | Named Nurse/Close support | |
| **B2. Risk of deliberate self-harm/suicide**  **Applicable (Circle) Y N**  **\_\_\_\_ lacks insight into their current behaviours. This has placed them at risk of harm.** | Review appropriateness of environment  Provide close support as recommended by the Close Support Assessment Proforma  Complete behaviour chart to track behaviour trends/inform re treatment plan  Close support Observation proforma to be completed and reviewed every 24h  Refer to relevant mental health support services if appropriate/applicable  **Distraction or de-escalation techniques should be employed to gently guide away from potentially harmful situations**  **Close support to consider employing purposeful activities that might stimulate and occupy to reduce episodes of frustration and anxiety**  Personal space and the right to privacy must be respected at all times and \_\_\_\_ if possible must have an element of choice and control over their day **(Whilst maintaining ‘line of sight’ observation)**  **Additional interventions/Actions:** | | | | At all times | | | Named Nurse/Close support | |
| **B3. Risk of accidental self-harm or injury/High risk of falls**  **Applicable (Circle) Y N**  \_\_\_\_could become more agitated if attempts are made to confine them to their bed space.  \_\_\_\_may be prone to agitation and has the potential to harm self  \_\_\_\_may be prone to boredom and therefore agitation borne of frustration and boredom.  **\_\_\_\_ lacks insight into their current behaviours. This has placed them at risk of harm.** | Complete S.A.F E falls assessment and undertake relevant actions to reduce risk  Complete Close Support Observation chart to track behaviour trends/inform re treatment plan  Provide close support as recommended by the Close Support Assessment Proforma  Review medication  Allow \_\_\_\_ to mobilise around the ward with visual supervision  Any support should be as unobtrusive as possible to maintain the dignity and safety of  \_\_\_\_  **Distraction or de-escalation techniques should be employed to gently guide away from potentially harmful situations**  **Close support to consider employing purposeful activities that might stimulate and occupy to reduce episodes of frustration and anxiety**  Personal space and the right to privacy must be respected at all times and \_\_\_\_ if possible must have an element of choice and control over their day  **Additional interventions/Actions:** | | | | At all times  At all times | | | Named Nurse/Close support  Named Nurse/Close Support | |
| **B4. Risk of harm to others – i.e. inappropriate sexualised behaviour/invading personal space/violent outbursts**  **Applicable (Circle) Y N**  **\_\_\_\_ lacks insight into their current behaviours. This has placed them at risk of harm.**  **B4. Risk of harm to others continued** | Review appropriateness of environment  Provide close support as recommended by the Close Support Assessment Proforma  Complete behaviour chart to track behaviour trends/inform re treatment plan  Close support Observation proforma to be completed and reviewed every 24h  Refer to relevant mental health support services if appropriate/applicable  **Distraction or de-escalation techniques should be employed to gently guide away from potentially harmful situations**  **Close support to consider employing purposeful activities that might stimulate and occupy to reduce episodes of frustration and anxiety**  Personal space and the right to privacy must be respected at all times and \_\_\_\_ if possible must have an element of choice and control over their day **(Whilst maintaining ‘line of sight’ observation)**  Be aware of and sensitive to cultural concerns  Same sex nurse may be appropriate  **Additional interventions/Actions:** | | | | At all times | | | Named Nurse/Close Support | |
| **C: MONITORING OF MENTAL STATE** | | | | | | | | | |
| **C1. Minimum of hourly review**  **Applicable (Circle) Y N** | | | Use ‘Close Support observation proforma’ to track improvement and/or deterioration in behaviour  Personal space and the right to privacy must be respected at all times and \_\_\_\_ if possible must have an element of choice and control over their day  Seek a medical review if concerned  **Additional Interventions/Actions:** | At all times | | | | | Named Nurse/Close support |
| **D: ADMINISTRATION OF PSYCHOTROPIC MEDICATION** | | | | | | | | | |
| **D1. Minimum of daily review of administration and hourly responses to psychotropic medication – including any side effects if applicable**  **Applicable (Circle) Y N** | Use ‘Close Support observation proforma’ to track improvement and/or deterioration in behaviour  Seek a medical review if concerned  **Additional Interventions/Actions:** | | | | At all times | | | | Named Nurse/Close support |
| **E: EATING AND DRINKING** | | | | | | | | | |
| **E1. Impact of mood/behaviour/medical condition on dietary intake**  **Applicable (Circle) Y N** | | Use ‘Close Support observation proforma’ to track improvement and/or deterioration in behaviour  Complete oral assessment; ensure teeth are well fitting and clean.  Assess for oral thrush and act on findings  Complete food chart  Encourage oral intake if appropriate  Offer snacks/build ups between meals as appropriate  Monitor bowel habits/Act to avoid constipation  Refer to dietician  Seek a medical review if concerned  Seek mental health liaison advice/refer to mental health liaison if concerned  **Additional interventions/Actions:** | | | | At all times | | Named Nurse/Close support | |
| **E2. Assistance required with eating and drinking**  **Applicable (Circle) Y N**  **E2. Assistance required with eating and drinking continued** | | Use ‘Close Support observation proforma’ to track improvement and/or deterioration in behaviour  Complete oral assessment/ensure teeth are clean and well fitting  Assess for oral thrush and act on findings  Complete food /fluid chart  Encourage oral intake if appropriate  Offer snacks/build ups between meals as appropriate  Refer to dietician  Monitor bowel habits/Act to prevent constipation  Seek a medical review if concerned  Seek mental health liaison advice/refer to mental health liaison if concerned  **Additional interventions/Actions:** | | | | As behaviour chart indicates | | Named Nurse/Close support | |