



An Roinn Sláinte
Department of Health

Enhanced Care Model Final Report 2019

Taskforce on Staffing and Skill Mix



CONTENTS

Table of Figures	4
Table of Tables	4
1.0 Foreword by the Minister for Health	5
2.0 Foreword by the Chief Nursing Officer	6
3.0 Introduction	8
4.0 Taskforce on Safe Staffing and Skill Mix	12
5.0 Literature and Evidence	14
5.1 Enhanced Care Model	14
5.1.1 Education and Training	14
5.1.2 Specific Initiatives	15
5.1.3 Availability of the right resource	15
5.1.4 An organised approach	16
6.0 The Actions for Organising and Delivering Enhanced Care Model	18
6.1 Aims and Objectives of the Enhanced Care Pilot	22
7.0 Overview of Pilot Testing	24
7.1 Rationale for Pilot Project	24
7.2 Pilot Project Testing	26
7.2.1 Stabilisation of the Nursing and HCA Workforce	26
7.2.2 Organisational monitoring of data regarding demand and supply of nurses and HCAs	28
7.2.3 Develop Bespoke Documentation	30
7.2.4 Develop a Tailored Education Package	32
7.2.5 Governance	35
8.0 Further outcomes of the Pilot	38
8.1 Patient and Staff Outcomes	38
8.1.1 Family Satisfaction:	38
8.1.3 Health Care Associated Infections	41
8.1.4 Care Missed / Delayed Events	42
9.0 Recommendations	44
10.0 Conclusion	46
11.0 All Ireland Enhanced Care Report	48
References	50
Glossary of Terms	52
Appendices	53
Appendix I Enhanced Care Leaflet	54
Appendix II Patient Passport	55
Appendix III Patient Behavioural Chart	57
Appendix IV Referral Pathway	58
Appendix V Risk Assessment	59
Appendix VI ECT Observation Assessment	59
Appendix VII Governance Structure	60
Appendix VIII All Island Collaborative for Enhanced Care	61

Table of Figures

Fig. 1	The Enhanced Care Model	14
Fig. 2	Action Areas for the Organisation and Delivery of Enhanced Care	18
Fig 3	Action of Pilot Project	26
Fig 4	Demand vs Agency Supply 2017 - 2018	28
Fig 5	Demand vs Agency Supply 2018- 2019	29
Fig 6	Projected Savings	30
Fig 7	Patient Passport	31
Fig 8	Patient Outcomes - Documentation	32
Fig 9	Results from Questionnaire 1	33
Fig 10	Results from Questionnaire 2	33
Fig 11	Results from Questionnaire 3	34
Fig 12	Results from Questionnaire 4	34
Fig 13	Satisfaction Response 1	38
Fig 14	Satisfaction Response 2	39
Fig 15	Satisfaction Response 3	39
Fig 16	Satisfaction Response 4	40
Fig 17	Satisfaction Response 5	40
Fig 18	Care Left Undone Events as Reported	42
Fig 19	All Island Collaborative Approach Quadruple Aim	48

Table of Tables

Table 1.0	Organisations Gather Intelligence on Enhanced Care Demand and Supply	19
Table 2.0	The Development of Enhanced Care Guideline	19
Table 3.0	Education & development of Staff Involved in the Delivery of Enhanced Care	21
Table 4.0	Governance of Enhanced Care	21
Table 5.0	HCAIs 2017 and 2018	41
Table 6.0	Recommendations from the Pilot on Enhanced Care	44

1.0 Foreword by the Minister for Health

It has been a year since I published the 'Framework for Safe Nurse Staffing and Skill Mix in General and Specialist Medical and Surgical Care Settings in Adult Hospitals in Ireland' and I am delighted to progress this important work and publish this report on the 'Enhanced Care Model'.

This is a critical milestone in the history of our health service. Sláintecare provides us with a solid framework and guidance for the development of health services over the next decade. There is no doubt that considerable change and transformation is required, and I believe this Enhanced Care Model is a key part of that journey.

As we reform, it is essential our health service anticipates, responds and consistently improves the care we deliver. I strongly believe the 'Enhanced Care Model' goes a long way to achieving our aims of improving staffing conditions and reforming patient care. It is an evidence-based, structured approach that was tested in Our Lady of Lourdes Hospital, Drogheda. The pilot was underpinned by the programme of research for the 'Framework for Safe Nurse Staffing and Skill Mix' that has provided a significant body of evidence for the Irish care context and demonstrated a sustained number of positive patient, staff and cost impacts.

We are now seeking to advance this pilot to a nationwide model. I strongly believe this will improve working conditions for our staff and significantly benefit the care of our patients.

I wish to thank the Chief Nurse, Dr Siobhan O'Halloran, her team and all the members of the taskforce steering committee for producing such innovative, high-quality evidence-based and evaluated policy initiatives. I have no doubt that their work and this Framework will continue to demonstrate the many positive benefits that can be achieved for both patients and staff through the development and implementation of innovative approaches to care delivery.

I would like to pay particular tribute to the Director of Nursing, Mr Adrian Cleary, Assistant Director of Nursing, Ms. Edel Kirwan, Ms Fiona Monaghan-Tyer and their team here in Our Lady of Lourdes Hospital without whose commitment, leadership and vision this pilot would not have been possible. The development of this Report through consultation, testing and evidence, is a great example of successful policy development.

In striving to continuously provide safe, high quality care for the patients in our services, I look forward to further roll-out of the Enhanced Care Model in line with the Framework on a nationwide basis. This project has been a positive partnership between the hospital and the Department of Health and provides a template for an approach that could be used across many areas of the health service for the delivery of the Sláintecare strategy.

I am also pleased that this project is part of an All-Island collaboration between the offices of the Chief Nursing Officer in my Department and the Chief Nursing Officer in Northern Ireland. The work of this collaboration aims to produce key principles for an All-Island approach to Enhanced Care.

Simon Harris T.D. Minister for Health




2.0 Foreword by the Chief Nursing Officer

I am delighted to present this Report on the 'Enhanced Care Model' as part of the ongoing work on the Framework for Safe Nurse Staffing and Skill Mix. The extensive demands placed on the health services in Ireland and throughout the world are constantly changing, increasing and becoming more challenging. In this context, our goal to provide high quality patient care and improved patient outcomes requires innovative patient centred solutions such as the Enhanced Care Model.

The development of the Framework on Safe Staffing and Skill Mix was an innovative approach to addressing workforce planning requirements and commenced in medical and surgical areas in acute hospitals in Ireland. This approach to determining nurse staffing and skill mix is underpinned by evidence-based assessment of individual patient need while also monitoring patient outcomes and measuring staff experience to determine the required nursing hours per patient day. The Framework implementation drew attention to the significant challenge of providing enhanced care or 1:1 specialising. This demand on nursing time arising from the need for Enhanced Care which was regularly supplemented by agency staff was driving an unstable workforce.

Enhanced Care refers to the need for additional or extraordinary care, beyond what is provided for within average daily staffing level. The evidence demonstrates a specific requirement for this type of care for older persons in the acute hospital setting and the need to develop a distinct model for delivering this type of care that supports recovery or healing based on individual patient need.

Incorporating evidenced based key assumptions, the model includes the themes of education and training, the use of specific initiatives, using the right resources and an organised approach. The implementation and testing of the model through a structured, hospital-staffed Enhanced Care Team pilot has demonstrated that it is an effective and sustainable approach to meeting the additional care requirements. The pilot project has demonstrated some initial indicators of positive outcomes including evidence of a stabilised and sustainable workforce, an increase

in delivering a person-centred approach to care, an increase in the involvement of families in Enhanced Care and a reduction in agency costs over time. It is important to me to see policy made real and achieving the intended outcomes.

The development of this model would not have happened without the expertise, dedication and vision of the national taskforce steering committee and the research team led by Professor J. Drennan. A special word of thanks to Dr. Phillippa Ryan - Withero, Deputy Chief Nursing Officer Ms Rachel Kenna and Mr Ray Healy in my office whose commitment and expertise continues to drive the development of the Framework for Safe Nurse Staffing and Skill Mix. I would particularly like to thank Mr Adrian Cleary Director of Nursing, Ms Edel Kirwan Assistant Director of Nursing, Ms Fiona Monaghan - Tyer, the Enhanced Care Team and all the staff involved in the pilot of the model in Our Lady of Lourdes Hospital Drogheda. The leadership and dedication of the whole team was a key success factor in developing and testing the model for this Report.

The values of care, compassion and commitment are reflected throughout this report which has patient safety and quality care at its core. I look forward to working with all our partners and stakeholders including the Chief Nursing Officer in Northern Ireland to further roll - out this model of care.

Dr. Siobhan O Halloran, Chief Nursing Officer.

Siobhán O'Halloran





3

Introduction

3.0 Introduction

Enhanced Care refers to the need for additional or extraordinary care, beyond what is provided for within average daily staffing levels. Enhanced Care is provided for patients who are disorientated, have altered cognition or behaviour or a non-acute mental illness. The Enhanced Care Model includes various levels of care that a patient may require to support recovery or healing. Enhanced Care involves allocating a specific member of staff to a patient or group of patients with responsibility for continuous awareness of the whereabouts and care needs the patient (s) through ongoing observation (Dewing, 2013). This can vary from one-to-one care to general or cohort observation. A variety of titles are used interchangeably to describe Enhanced Care including: constant care; specialising; one-to-one care; and direct patient monitoring (Kerr *et al.*, 2013; Wilkes *et al.*, 2010).

The reasons patients require Enhanced Care are quite similar throughout the system with falls and confusion/agitation being the most frequent determinants. Nursing staff can struggle to manage unpredictable behaviours where there are limited specialist resources and a lack of time to supervise patients exhibiting behaviours, which are seen as challenging (McDonald *et al.*, 2012).

Although nurses are skilled in meeting the acute health needs of most patients they may not have the expertise required to manage or supervise expressions of challenging behaviour (Borbasi *et al.*, 2006; McCloskey, 2004). While Enhanced Care can be of benefit to both patient and staff involved it can also incur significant financial costs. The data collected in the development of this report showed that there is a high reliance in the system on agency staff to deliver Enhanced

Care. It also illustrated that the current system for allocating Enhanced Care lacks uniformity and as such has implications for continuity, quality of care and cost.

The findings from the Framework on Safe Staffing and Skill Mix (*henceforth referred to as the Framework*), (Department of Health, 2018) showed that the requirement for Enhanced Care is presenting a significant challenge for services. The objective of this *Framework* was to develop a robust mechanism to determine safe nurse staffing and skill mix levels in a range of care settings and to stabilise the nursing resource through, in part, reducing reliance on the use of agency staff. The *Framework* drew attention to the demand on nursing time arising from the need for Enhanced Care which was regularly supplemented through the use of agency staff. It also pointed to a specific requirement for Enhanced Care for older persons in the acute hospital setting. While the *Framework* was piloted in three hospitals the evidence is sufficiently robust to infer national scalability.

In summary the evidence from piloting the *Framework* demonstrated the need develop a distinct model to underpin the provision of Enhanced Care. A set of key assumptions upon which to build a model of Enhanced Care were developed from the literature. These assumptions include:

- ensuring patient safety;
- providing a safe, effective and efficient level of care;
- ensuring care compliments any planned treatment or therapy; and
- delivering care based on guidelines supported by clinical judgement.

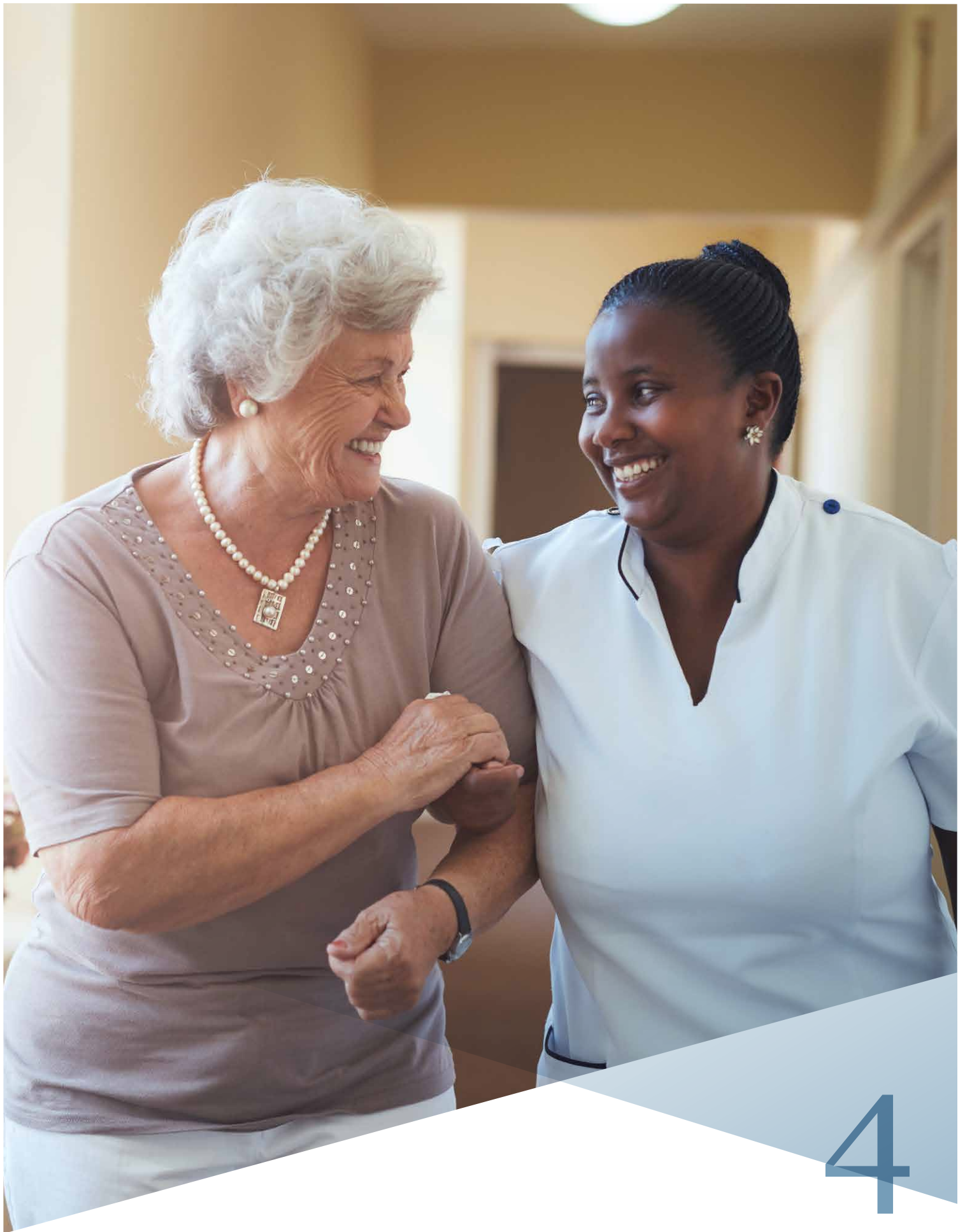
This report sets out to:

- review the available evidence and current practice in the provision of Enhanced Care;
- describe a model and outline actions for organising and delivering Enhanced Care;
- outline and evaluate the implementation of the Enhanced Care model in a pilot site;
- make recommendations for the implementation of the model of Enhanced Care on a national basis; and
- collaborate on an All-Ireland approach to Enhanced Care.

Incorporating an approach that includes leadership, governance, training, and streamlined guidance has the potential to provide the basis for delivering Enhanced Care in a cost effective and safe manner.







4

Taskforce on Safe Staffing and Skill Mix

4.0 Taskforce on Safe Staffing and Skill Mix

In April 2014, the then Minister for Health established a Taskforce on Safe Staffing and Skill Mix under the auspices of the Office of the Chief Nurse (see <https://health.gov.ie/office-of-the-chief-nursing-officer/our-policies/taskforce-on-staffing-and-skill-mix-for-nursing/>). The core objective of the Taskforce was to develop a *framework* to support the determination of safe nurse staffing and skill mix in a range of care settings. Internationally, there are a large number of nurse staffing decision support tools. The challenge with these tools is the variability of validation and applicability, especially in the Irish healthcare context. The development of the *Framework* was based on an extensive body of literature on safe nurse staffing, evidence reviews, national and international consultation and baseline staffing assessment (Drennan et al., 2018). Once this initial work was complete, the *Framework* was tested in three pilot sites underpinned by a programme of research. Data (patient, staff and organisational outcomes) from three pilot sites were continuously monitored by local implementation groups and a research team from University College Cork (UCC). In February 2016, an Interim Report was published which contained a number of preliminary findings from the implementation of the recommendations in the pilot testing of the *Framework* as well as recommendations for further roll-out of the *Framework* (Department of Health, 2016).

Two subsequent research impact evaluation reports have been published which demonstrate the outcome and impact of implementing the *Framework* including a:

- substantial reduction in RN and HCA agency usage ranging from 30% to 100%;
- stabilisation or reduction in the proportion of nursing hours provided for one-to-one “specialling”;
- demand for one-to-one care was identified across all pilot sites;
- general reduction in staff sick-leave;
- significant decline in nurse sensitive outcome indicators;
- perception that the working environment had become less complex;
- perception of that quality of care delivered as good or excellent increased; and
- reduction in the proportion of care left undone and delayed events.

The final report and recommendations by the Taskforce on Safe Staffing and Skill Mix for Nursing was published in 2018. (Department of Health, 2018). The national implementation began in 2019 and is ongoing.



5

Literature and Evidence

5.0 Literature and Evidence

A literature review showed a lack of relevant evidence in relation to Enhanced Care provision in acute care setting. The evidence that is available in the acute setting predominantly refers specifically to the older person care area; there are also several studies available in relation to mental health settings. This is explained by the fact that much of the evidence in this setting revolves around challenging behaviours. The evidence suggests that a deliberate approach is needed when caring for patient with behavioural or cognitive challenges (Chrzescijanski *et al.*, 2007; Kolanowski *et al.*, 2014; Wilkes *et al.*, 2010).

Dewing *et al.* (2010) noted that there is a lack of structure and no clinical or care centred *frameworks* for what should happen during a period of Enhanced Care. People aged 65 years or over are at increased risk of poor outcomes when admitted to the acute care setting as a result of comorbidity and mismanagement of their chronic confusion (Moyle *et al.*, 2011).

It is crucial that through this model therapeutic activities appropriate to the patient are undertaken. The activities which the patient enjoys should be identified either by the patient themselves or a family member; for example, playing cards, arts and crafts, knitting, reading newspapers and exercise. Skills are needed in enabling and assisting the patient in maintaining their safety while promoting independence (Dewing, 2013); this could indeed be applied to all patients requiring Enhanced Care.

The model developed below was created using the evidence and learning arising following implementation of the Framework for Safe Staffing and Skill Mix.

The model is built around the following themes:

- education and training;
- specific initiatives;
- using the right resource; and
- taking an organised approach.

5.1 Enhanced Care Model



Figure 1 - The Enhanced Care Model

5.1.1 Education and Training

The importance and requirement of specific training and education are prevalent throughout much of the evidence that was reviewed (Borbasi *et al.*, 2006; McCloskey, 2004; Rowling, 2012; Yevchak *et al.*, 2012). The evidence demonstrates the need for specific education for health care professionals and health care workers on caring for patients with dementia and/or delirium, the identification of falls' risk and reasons for behavioural disturbances, along with the

management of challenging behaviour (Levy et al., 1999; Mentès et al., 1999). Common to all the evidence, is the approach to education that provides the health care professional/health care worker with the skills and knowledge to manage patients with these care needs more effectively and safely. Enhanced Care should involve the practitioner in some sort of active engagement with the person they are assigned to observe (Dewing, 2013). Education includes the skills to engage the patients in therapeutic interventions, to de-escalate challenging behaviours and to contribute to patient centred care. Moyle et al. (2008) also recognised the prime importance of the development of staff expertise and education in relation to the care of the older person with chronic confusion. Dick et al. (2009) found that staff education had a positive impact on the incidence and duration of “specialling”.

5.1.2 Specific Initiatives

Whilst each of the initiatives differ, having patient specific initiatives as part of an Enhanced Care delivery is a common theme throughout the literature. The available evidence demonstrated the positive effects of initiatives that were tailored to meet the needs of patients requiring Enhanced Care. Environmental and social care strategies work well with older persons with dementia and/or delirium and as a first-line option non-pharmacological initiatives should be introduced (Moyle et al., 2008; O'Brien, 2008; Alzheimer's Society, 2009; Department of Health (UK), 2009; Dewing, 2009). A number of these initiatives have been described by NHS Improvement (2016) as ‘activity’ boxes (East Sussex Healthcare NHS Trust, 2014), falls bundles (NHS East Kent Hospitals University NHS Foundation Trust), close observation units (Eeles et al., 2013), specific assessment tools such as Patient Attendant Assessment Education Tool (PAAT), Agitated Behaviour Scale (ABS), and the ‘What Matters to Me’ initiative (Barry and Edgman-Levitan, 2012). Observation and assessment tools need to be designed and structured efficiently so that they accurately reflect the patient’s condition,

behavioural challenges observed, measures taken to control challenging behaviours and patient outcomes subsequent to the measures being implemented (Wilkes et al., 2010). It is recommended that there is:

- a complete and individual evidence-based assessment of needs to tailor care to each patient;
- a care planning approach focussed on patient-centred methods and includes de-escalation and diversional therapies;
- a dedicated and specifically educated and trained resource to manage the care of patients requiring Enhanced Care.

5.1.3 Availability of the right resource

Availability of the right resource is essential for the implementation of any improvement initiative and in relation to the specific care needs of this patient cohort. Resources in this instance include materials for example equipment related to diversional therapies. However, the evidence also points to the availability of dedicated support care staff who are specifically educated and trained to deliver Enhanced Care. Initiatives such as the Enhanced Care Team (NHS Improvement, 2016), education/training sessions (Kolanowski et al., 2014; Yevchak et al., 2012) and Close Observation Units require staff with a variety of skill sets. Prior to the introduction of these initiatives in the UK there was the reliance on agency staff to meet the needs of these patients. The purpose of introducing these initiatives was to move away from this over reliance on agency staff to a system focussed on ensuring that the right health care worker, with the right skills and education, and from within the organisation’s own workforce, was deployed to deliver this care. Notably, improvement in care quality and reductions in cost were some of the outcomes from the introduction of the initiatives outlined above (NHS Improvement 2016). It is acknowledged that initiatives related

to the introduction of Enhanced Care require adequate resources and funding (Bradley, 2005) with research suggesting that nursing staff often struggle to manage patients with unpredictable and challenging behaviours when there are limited resources and lack of time (Borbasi et al., 2006).

5.1.4 An organised approach

The evidence frequently refers to the necessity for assessment tools to be used to assess the requirement for Enhanced Care and, in some cases, to identify the level of Enhanced Care that is required (Houghton et al., 2016; Ross Baker, 2017; Wilkes et al., 2010). A study undertaken by Dick et al. (2009) found that when a patient required close observation, the most common response and strategy taken by nurses was to request a “special” without having undertaken an

appropriate assessment of the patient’s actual needs (for example: RN, diversion therapy, use of alternative strategies, close observation rather than 1:1 specialling). The importance of developing specific policies and guidelines is considered in the literature as necessary to support the delivery of safe, quality care (Yevchak et al., 2012). It was notable that in some instances, the application of these policies was inconsistent due to a lack of education/training on the approach used. Risk assessment was highly recommended as a way of prioritising the needs of both the patient and the ward. It is important that the approach to risk assessment is robust and can support the decision to allocate resources (Dewing, 2013). In summary the evidence suggests that ensuring consistency in application, developing a supportive structure combined with education and training are key to organising the delivery of Enhanced Care.





6

The Actions for Organising and Delivering Enhanced Care Model

6.0 The Actions for Organising and Delivering Enhanced Care Model

Four action areas emerged from the evidence review and the recommendations from the implementation of the *Framework (Fig 2 - Action Areas for the Organisation and Delivery of Enhanced Care)*. Each action has a number of steps, as described in Tables 1-4 - Steps in each Action Area for the Organisation and Delivery of Enhanced Care.

Enhanced Care does not apply to Registered Nurses providing one-to-one care or close observation to the acutely ill patient; for example, those patients with a raised Early Warning Score (EWS) or who are clinically unstable.

The model for the organisation and delivery of Enhanced Care applies to:

- all patients who are disorientated, have alteration in cognition, altered behaviour or acute mental illness while an inpatient in an acute care setting.
- Health Care Assistants (HCAs) delivering Enhanced Care; and
- the lead nurse or nurse in charge of the patient's care.

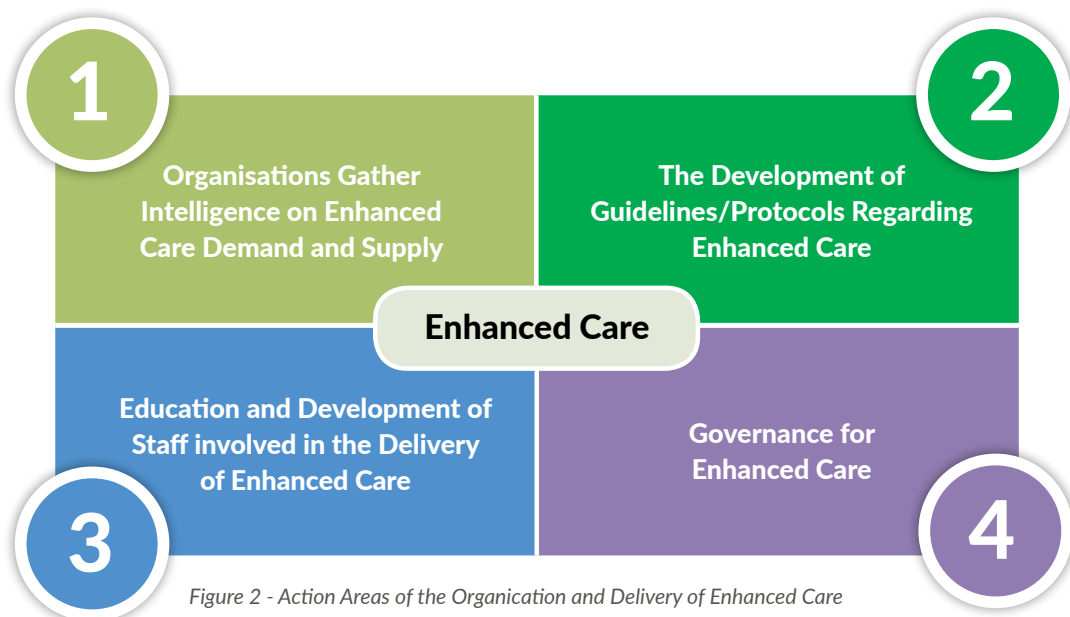


Figure 2 - Action Areas of the Organisation and Delivery of Enhanced Care

Table 1.0 Organisations Gather Intelligence on Enhanced Care Demand and Supply	
1.1	Each site will undertake an assessment of the demand and supply of Enhanced Care.
1.2	Data collected will include the: <ul style="list-style-type: none"> • demand for Enhanced Care (i.e. hours required); • supply for Enhanced Care (i.e. hours available, grade supplied, supply source – ward staff/agency/overtime/bank); and • reasons for Enhanced Care.
1.3	This data will be used to identify trends and patterns of Enhanced Care demand and supply
1.4	Additional risk management data will be incorporated with the above data sources to identify the need for Enhanced Care.
1.5	The data will be used to identify the current cost of Enhanced Care.
1.6	Collectively the data will be used to inform the safest, most effective and efficient approach to the organisation and delivery of Enhanced Care on a site-specific basis. Such methods can include or be a combination of: <ol style="list-style-type: none"> 1. Enhanced Care Teams; 2. Close Observations Units; 3. Video monitoring – similar to telemetry approaches; 4. Therapeutic Activities – e.g. activity boxes, arts and crafts; 5. Involvement of Family – structured approach; and 6. Specific training and education programmes.

Table 2.0 The Development of Enhanced Care Guideline	
2.1	Each organisation will develop a Guideline to support the decision-making process to determine Enhanced Care requirements. It should be noted that this guideline should work in conjunction with and complement other initiatives such as: <i>'what matters to me'</i> as an example (HSE, 2018).
2.2	The guideline will outline the categories of patients that can be safely cared for by a Health Care Assistant who is specifically trained for the role of Enhanced Care.
2.3	The guideline will outline the key steps to be undertaken to both assess and deliver Enhanced Care.

<p>2.4</p>	<p>The steps will include;</p> <ol style="list-style-type: none"> 1. Patient assessment by a Registered Nurse to determine the need for Enhanced Care – this step will identify the reason for Enhanced Care based on a comprehensive clinical evaluation of the patient, inclusive of tailored tools and risk assessments to take account of the risk level in relation to safety, communication and cognition. In this step, referral to other Healthcare Professionals/teams may be identified; for example: Falls team, Mental Health team. The advice of these teams will be used to inform the need and level of Enhanced Care. Additionally, underlying causes, such as infection, pain and dehydration as examples, will be identified and their treatment included in the patient’s overall plan of care. 2. Enhanced Care will be an integral part of the overall therapeutic care plan; this is to ensure the sensitive monitoring of the patient’s behaviour and mental wellbeing and identify factors that may exacerbate or inhibit challenging responses whilst at the same time fostering a positive therapeutic relationship and using the least restrictive means to maintain safety. 3. Continuous reassessment of patient’s Enhanced Care need is required; mainly where underlying causes are being treated. This step will also include an appropriate assessment by other healthcare professionals/teams. 4. Integral to the initial and on-going assessment, is the need to identify and recommend the level and type of Enhanced Care; e.g. close observation; constant observation; cohort Enhanced Care. The guideline will specify the broad levels of Enhanced Care with the option to tailor Enhanced Care to individual patients.
<p>2.4.1</p>	<p>The Enhanced Care guideline will clearly identify the role and responsibilities of all staff engaged in the care of the patient. The role of the HCA in Enhanced Care is one that must be incorporated into the wider health team on the ward.</p>
<p>2.5</p>	<p>At a minimum, the guideline will outline all necessary documentation to be completed both in the assessment/reassessment phases and for on-going monitoring. It is also recommended that organisations develop patient, family, and staff information leaflets on Enhanced Care. In the case of staff, this information should be particularly tailored for temporary staff providing Enhanced Care.</p>
<p>2.6</p>	<p>The guideline will clearly outline the request process for Enhanced Care which must include an on-going review in tandem with patient reassessment as described above.</p>
<p>2.7</p>	<p>Data on patient outcomes and staff experience of the approaches to organisation and delivery of Enhanced Care will be gathered in addition to the data collection processes in section 1.0.</p>

Table 3.0 Education & development of staff Involved in the delivery of Enhanced Care

3.1	Using data intelligence, as outlined in section 1, each site will identify their training needs based on their specific reasons for needing Enhanced Care. It is recommended that training programmes will include for example falls assessment and management, dementia training, delirium management, managing behaviours that challenge and managing violence and aggression. Specific training and education will be provided to enable Health Care Assistants manage these patients safely under supervision of a Registered Nurse.
3.2	Training programmes will incorporate input from the wider healthcare team to ensure a comprehensive approach to education.
3.3	Training programmes will be reviewed and amended where demand for the service alters e.g. reasons for requiring Enhanced Care may change.
3.4	A database of training and education completed by staff will be developed by the organisation to ensure appropriate organisational capability.

Table 4.0 Governance of Enhanced Care

4.1	The governance arrangements for Enhanced Care, taking into consideration local processes, will be specified in the guideline.
4.2	Overarching governance, in the context of safe nurse staffing, falls under the Local Implementation Group which reports to the Hospital Management Team or Board of Management. Reports will include all levels of data to assure patient, staff and organisational outcomes are monitored and maintained.

6.1 Aims and Objectives of the Enhanced Care Pilot

As part of the Phase I pilot a collaborative review of all the evidence took place between the research team, the local implementation group and the Department of Health to identify the aims and objectives of the Enhanced Care Pilot. Enhanced Care aims to prevent patients from coming to harm by ensuring the appropriate level of observation is in place to help safeguard this vulnerable cohort. The overall aim of the pilot is to implement the Enhanced Care Model in a test site.

The objectives of the Enhanced Care Pilot are:

- To improve Enhanced Care specific initiatives.
- Initiate and implement staff education and practice development initiatives.
- Standardise approach to the assessment and delivery of Enhanced Care to the appropriate patients.
- Develop specific and standardised guidelines, policies and procedure to assure the delivery of high-quality Enhanced Care.





7

Overview of Pilot Testing

7.0 Overview of Pilot Testing

Our Lady of Lourdes Hospital Drogheda (OLOL) was included in the original pilot sites in Phase 1 for the *Safe Staffing and Skill Mix Framework*. Through this process, it was identified that the hospital had an over-reliance of agency use to address a high demand for Enhanced Care. In 2017 it was decided to test the new model of Enhanced Care delivery as a pilot project in OLOL. This Pilot adhered to the aims and objectives as set out in Section 4.1 above.

7.1 Rationale for Pilot Project:

Prior to the pilot project commencing, OLOL identified the rationale for why an Enhanced Care model was needed:

- **Demographic Ageing:** Nationally, the over 65-year age group has increased by 13% over the last 5 years. This is expected to rise by a further 3.4% in the next year; in addition, there will be a 3.6% increase in the population of 85 years and older age group. A retrospective review was undertaken across the organisation between January 2018 – June 2018 and this identified that 90% of patients requiring Enhanced Care were over the age of 65 years of age.
- **Dementia Diagnosis:** The National Dementia Strategy outlines that 29% of all patients currently admitted to an acute care setting have a diagnosis of dementia. Many require Enhanced Care due to their specific care needs. The strategy predicts an increase of 24% of people diagnosed with dementia by the year 2021. Currently, within the organisation, 76% of patients requiring Enhanced Care have a diagnosis of a dementia.
- **Department of Health Safe Staffing and Skill Mix Framework:** OLOL was one of three hospitals which were part of a

pilot programme led by the Department of Health to review safe staffing levels across the acute care setting from 2016 – 2018 (Department of Health, 2018). Part of the research identified that there was an over-reliance of agency staffing required to deliver Enhanced Care to patients. It also demonstrated that ward staff felt there was additional time spent orientating agency staff to the ward / patient every shift reducing the amount of time they could contribute to direct patient care.

- **Care events missed or delayed:** The research also identified a relatively high level of care events delayed and missed events which could be associated with the numbers and skill-mix of staff providing care. The baseline data from the research in OLOL identified:
 - Care Undone: The mean number of tasks reported by nurses as undone due to lack of time on their last shift was 2.75 during Phase One. This reduced to 2.13 in phase Two (*following the introduction of the recommendations in the Framework*).
 - Care Missed: The mean number of tasks delayed as reported by nursing staff was 5.83 in Phase One. This reduced to 4.69 in phase Two (*following the introduction of the recommendations in the Framework*).

Care Left Undone Events			
	Ward D	Ward E	Total
Number of activities undone, mean (SD)			
Phase I	3.50 (2.50)	2.00 (2.22)	2.75 (2.44)
Phase II	1.88 (2.30)	2.38 (1.92)	2.13 (2.06)
Shifts where at least one item of missed care was observed, n (%)			
Phase I	11 (91.7)	6 (50.0)	17 (70.8)
Phase 2	4 (50.0)	6 (75.0)	10 (62.5)

Care Delayed as Reported			
	Ward D	Ward E	Total
Number of activities undone, mean (SD)			
Phase I	6.92 (3.70)	4.91 (3.45)	5.83 (3.19)
Phase II	5.63 (2.92)	3.75 (2.87)	4.69 (2.96)
Shifts where at least one item of delayed care was observed, n (%)			
Phase I	11 (91.7)	12 (100.0)	23 (95.8)
Phase 2	8 (100.0)	7 (87.5)	15 (93.8)

- Efficiency Measures:** The provision of Enhanced Care frequently presents a challenge to an already overstretched budget, yet many deem it essential for the provision of safe patient care (Worley et al., 2000) (Rausch and Bjorklund, 2010). The cost of this service is often unpredictable and frequently not estimated within any forecasted budget plan (Laws and Crawford, 2013). It was part of the organisation's Value For Money plan to make cost savings across the use of agency staff providing care. The difference between the agency demand and agency supplied is managed locally, most usually absorbed by the ward's care capacity. The purpose of the Enhanced Care pilot project is not to address the gap between care demanded and supplied but rather to focus on reducing agency care used overall.
- Organisational Context:** Patients who require Enhanced Care, often due to the nature of their condition (e.g. confusion, agitation, etc.), frequently exhibit challenging behaviour that can be distressing for the patient. OLOL allocated external agency Health Care Assistants (HCAs), many of them have received little training in providing care to this cohort of patients. Traditionally, HCAs are deployed to look after one patient or a group of patients as a cohort to provide close monitoring and reduce the risk of incidents. There is research to suggest that their role tends to be as a passive sitter as opposed to one which is participative, therapeutic, active, and caring. This, together with the lack of continuity, leads to difficulty ensuring person-centred care is delivered (Small & Small, 2011).

In OLOL the additional time and cost of Enhanced Care had previously been identified as a challenge and steps had been taken locally to address this; for example, the introduction of new patient behavioural assessments.

However, following the evidence from implementing the Framework, an opportunity was identified to build on the initiatives already in place and implement the model for Enhanced Care.

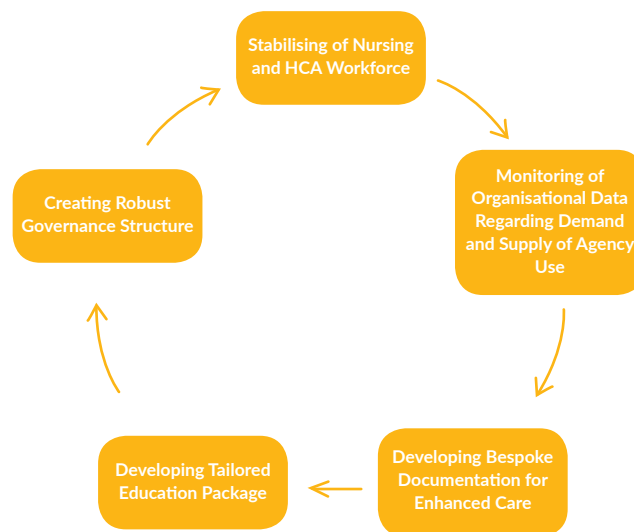


Figure 3 - Action of Pilot Project

7.2 Pilot Project Testing

Based on the actions for organising and delivering the Enhanced Care Model (Section 4.0), OLOL summarised the steps they required into Fig. 3 below. Each action was then assessed through a suite of outcome and impact measures. These included: Each step was assessed through action, outcome and impact measure to assure sustainable success.

7.2.1 Stabilisation of the Nursing and HCA Workforce

ACTION

A centralised and dedicated Enhanced Care team was set up. The calculation method incorporated in the Safe Staffing and Skill Mix Framework was used determine the number of whole-time

equivalent (WTE) HCAs needed to deliver the quantum of Enhanced Care required. This resulted in a requirement for 16 HCAs and one CNM3. An Enhanced Care Coordinator was appointed at CNM3 grade to oversee and manage the day-to-day operations of the Enhanced Care team.

OUTCOME

A stabilised and managed workforce was in place to deliver Enhanced Care as evidenced by the reduction in the use of agency staff to provide this care.

IMPACT

The role of the Enhanced Care Coordinator was fundamental to the roll-out and measurement of the impact of the pilot project. The Enhanced Care Coordinator described the impact of the putting in place the model for delivery of Enhanced Care.:

"The main role and responsibilities of the CNM3 Enhanced Care is to support the ward staff to ensure that the appropriate level of observation and support is in place to manage the patients deemed to require an increased level of observation to maintain patient safety. I meet with patients, families and nursing staff to assess and determine how best to meet the patients' needs using the Enhanced Care team. The introduction of the Enhanced Care team has improved the delivery of patient centred care. The stability of the team ensures that there is continuity of care for the patient. The Enhanced Care team can identify changes in the patient's condition and report this to relevant nursing staff. The introduction of the Enhanced Care team also decreases the amount of time required to orient agency HCA's

The most common reason for patients requiring Enhanced Care is because of the risk of falls. Many of the referrals come after the patient has had an in-hospital fall. To date, there has only been one occasion when a patient had an assisted fall, with no injury, while the Enhanced Care team was in place.

The feedback from the staff to date is very positive in relation to how the Enhanced Care team has led to better patient interaction, the staff acknowledge that the traditional 12-hour shifts sitting beside a patient may not be the best way to care for patients. Also, the rotation of the HCAs is beneficial ensuring positive therapeutic interaction. The Enhanced Care team has stated that they feel like part of the team even though they rotate to different wards. This suggests that they are now merging into the ward culture and are accepted as part of the team.

On reflection I feel that this is a very positive change in how we care for our patients and feeds into our ethos of care, compassion and commitment to delivering quality care to the patients."



Members of the Enhanced Care Team in OLOL – L-R Petra Weldon, Fiona Monaghan-Tyer, Ken Obama, Edel Kirwan, Sharon Burns, Michelle Reilly and Sabu Matthews

7.2.2 Organisational monitoring of data regarding demand and supply of nurses and HCAs

As part of the Safe Staffing and Skill Mix Framework, OLOL had begun streamlining their data collection process to provide accurate monitoring of patient and staff outcomes.

ACTION

Pre-Pilot:

A retrospective review was undertaken to analyse demand and agency supply for Enhanced Care. The demand was extrapolated from the safe staffing taskforce software (Trendcare©)

between August 2017 and May 2018 across all eleven-general medical/surgical wards. On average, there was a requirement for 188 HCAs per month to meet the demand for Enhanced Care. The average agency HCA supply was 124 HCAs per month. While the demand for agency was not always met, other measures were put in place to provide the patients requiring Enhanced Care with safe environment. These measures included, cohorting of patients who required Enhanced Care together in one ward, with one HCA to supervise or placing patients in a high observation area on the ward. Additionally, the wards had access to special assistive devices such as motion/bed leaving alarms that would alert the staff should a selected patient attempt to mobilise without supervision.

Demand vs Agency Supply Aug 2017 - May 2018

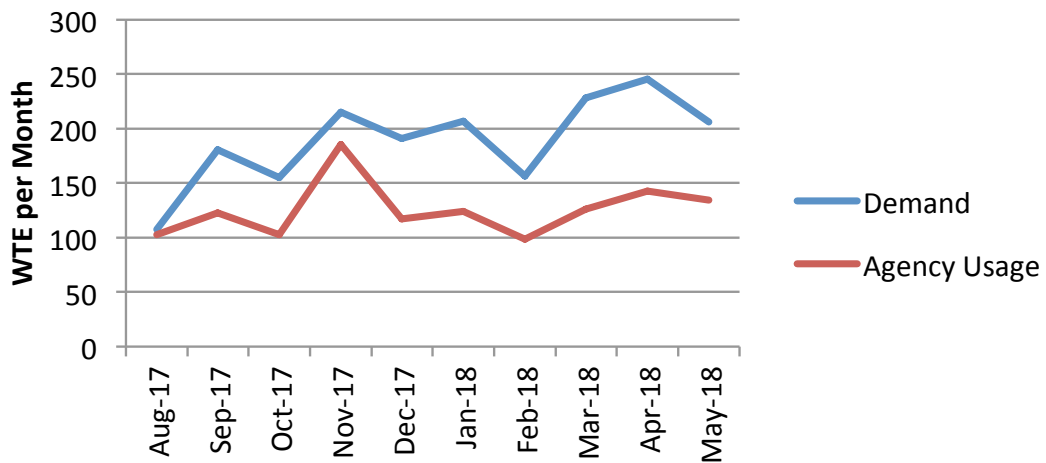


Figure 4 - Demand vs Agency Supply 2017 - 2018

Post-implementation:

A seven-month evaluation following the introduction of the Enhanced Care pilot was undertaken. The date ranges were September 2017 to April 2018 and September 2018 to April 2019. The evaluation showed the demand for Enhanced Care increased by 20.4% post implementation of the Enhanced Care pilot. On average, there was a requirement for 236 HCAs required per month to meet the demand for Enhanced Care post-

implementation. The average number of agency HCAs supplied dropped to 88 WTE per month. This reduction in agency use demonstrates that OLOL is achieving stabilisation of the nursing and HCA workforce over time; this stabilisation is associated with lower organisational costs and better patient outcomes (Department of Health, 2018)

Demand vs Agency Supply 2018 - 2019

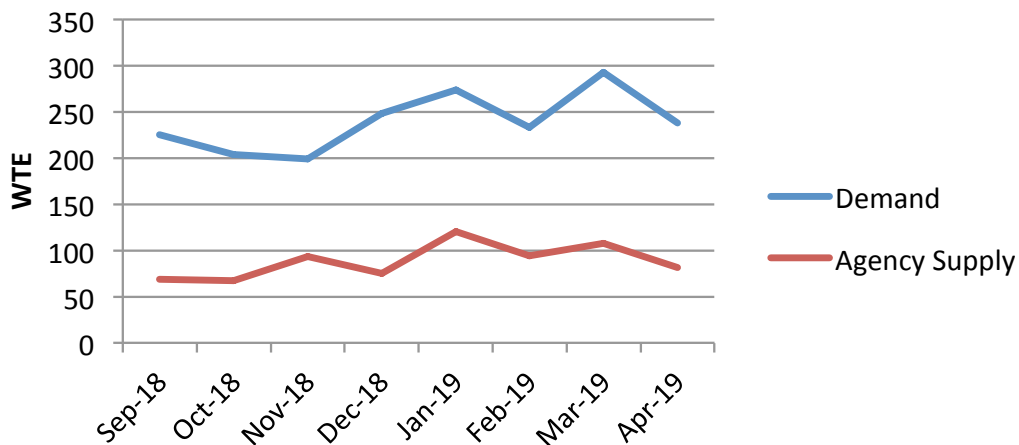


Figure 5 - Demand vs Agency Supply 2018 - 2019

OUTCOME

The reduction in agency usage and spending over the period of the pilot demonstrates the transition to a more stabilised workforce. This in turn indicates that care is being provided more consistently to those with additional care needs. The introduction of the dedicated Enhanced Care team has demonstrated a change in the way that agency use is being deployed, leading

to a sustainable and consistent workforce caring for patients requiring additional care.

There has also been a reduced number of agency staff delivering Enhanced Care, despite the increase in demand over the time of the pilot period.

IMPACT

The estimated overall savings of €400k is based on the costs including the projected increase of demand (estimated at 24% year-on-year) combined with the costs of the Enhanced Care recruitment and ongoing minimal agency required to supplement vacancies.

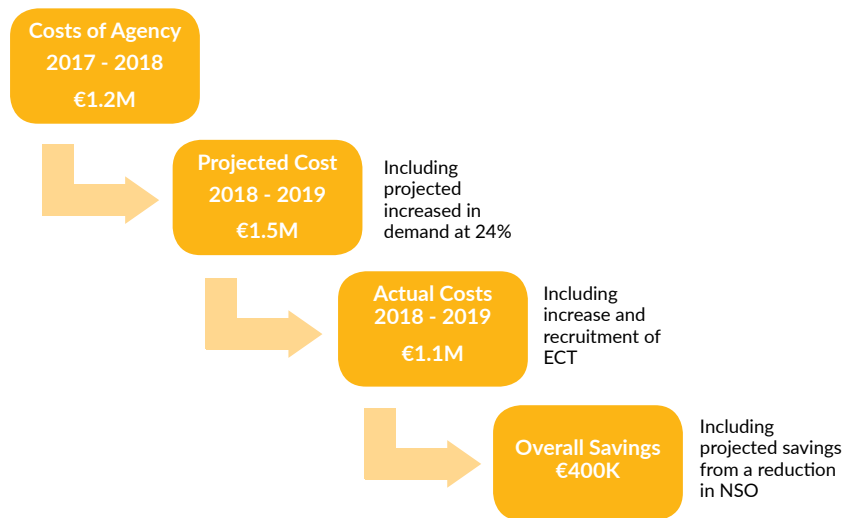


Figure 6 - Projected Savings

7.2.3 Develop Bespoke Documentation

ACTION

Working groups were established to design and develop documentation to support the implementation of the Enhanced Care process. The documentation was created using a co-design approach and reviewed using multiple Plan Do Study Act (PDSA) change cycles and a project process. A suite of documents required to implement Enhanced Care was developed. Under the first assumption of the Framework for Safe Staffing and Skill Mix, each patient's care needs are unique, it can be assumed that not every patient will require each document to record or support the necessary level of care. Each patient should be assessed individually and continuously; these documents will assist in the assessment, care planning and communication of Enhanced Care. The documents developed include:

- Enhanced Care Leaflet (appendix I)
- Patient Passport (appendix II)
- Patient Behavioural Chart (appendix III)
- Referral SOP (appendix IV)
- Risk Assessment (appendix V)
- Enhanced Care Team Observation Assessment (appendix VI)

OUTCOME

Patient Passport

Patient passports were developed to aid the implementation of person-centred care, by providing staff with ready access to clinical and non-clinical information that is important to the patient. This includes information such as; preferred name, name of carer, likes and dislikes. The staff caring for this patient can use this information to tailor intervention to be more person-centred. A spot audit was undertaken to assure the use of the patient passport. A total of 30 of 62 patients were audited February 2019 with a further 30 of 62 patients reviewed March 2019.

Pre-Implementation Audit

	Audit Date Range	No. of Patients Audited	Total Number of patients receiving Enhanced Care
Spot Audit One	11th - 17th February 201	30	62
Spot Audit Two	18th - 24th March 2019	30	61

Table 3 - Pre- Implementation Audit

100% of patients verified in Feb and March had a patient passport by their bed-side with their name above their bed reflective of the name they wanted to be known by. However, following the audit in February, only 46% of passports had evidence that there was family engagement

during its development. Following a PDSA cycle review, it was decided to add a family signature on the form to note their involvement in the development of the passport. During the repeat spot audit in March, this compliance increased from 46 % to 93%.

Post-Implementation Audit

	Audit Date Range	No. of Patients Audited	Total Number of patients receiving Enhanced Care
Spot Audit One	11th - 17th February 201	30	62
Spot Audit Two	18th - 24th March 2019	30	61

Table 4 - Post- Implementation Audit

Patient Passport

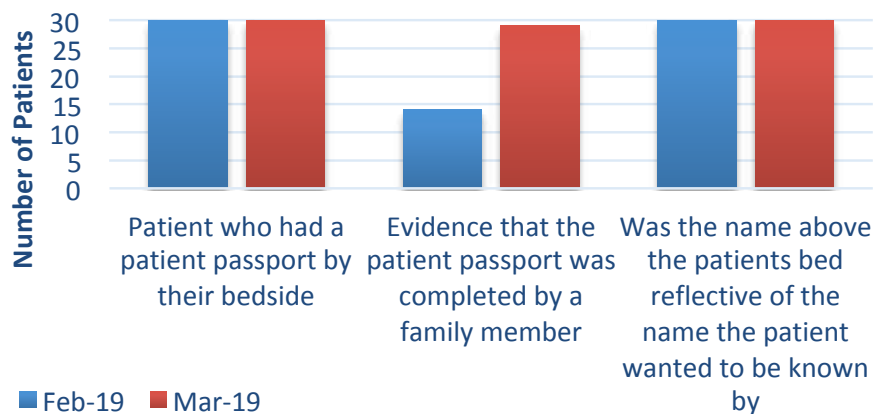


Figure 7 - Patient Passport

Behavioural Chart

A spot audit was also undertaken to examine the compliance of the behavioural and risk assessment. A total of 30 patients were audited on February 2019 with a further 30 patients audited on March 2019. All of patients audited (100%) had a patient passport fully completed; a risk assessment fully completed with a risk rating scoring identified. The majority (90%) of patients in February had an identifying patient sticker on the patient passport. This increased to 93% in the

following audit in March. It is recommended that the audits are continued on a regular basis and findings reported to the local implementation group.

IMPACT

Acknowledging the increase in use and awareness of the bespoke documents demonstrates early sign of the model of care becoming embedded within the organisation's practices.

Behavioural Chart

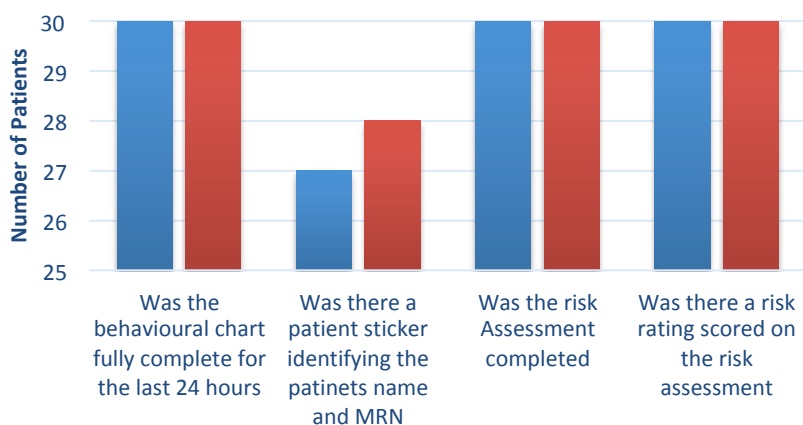


Figure 8 - Patient Outcomes - Documentation

■ Feb-19 ■ Mar-19

7.2.4 Develop a Tailored Education Package

ACTION

A bespoke specialist training programme was developed for all members of the Enhanced Care team. The research reviewed demonstrated the importance of matching education to the patient and staff needs (Schoenfisch et al., 2015; Evans, 2008).

Initially, a retrospective review was undertaken over a six-week period in April and May 2018 to analyse why patients required Enhanced Care. A four-day education programme was then developed around the care needs identified

from this review. Various members of the multi-disciplinary team together with specialist external speakers were involved in the delivery of the programme. All 16 Enhanced Care team members attended the training in December 2018.

OUTCOME

In total over 200 staff, from both the Enhanced Care team and ward staff, enrolled on the specialist training programme.

A questionnaire was circulated to all 16 staff on the Enhanced Care team at the commencement and again upon completion of the bespoke training programme. A 100% response rate was achieved.

Question One:

31.5% of the participants felt they had sufficient skills to complete and use the patient passport pre-training in comparison to 100% of staff post training

Question One: Do you have sufficient skills to complete and use a patient passport

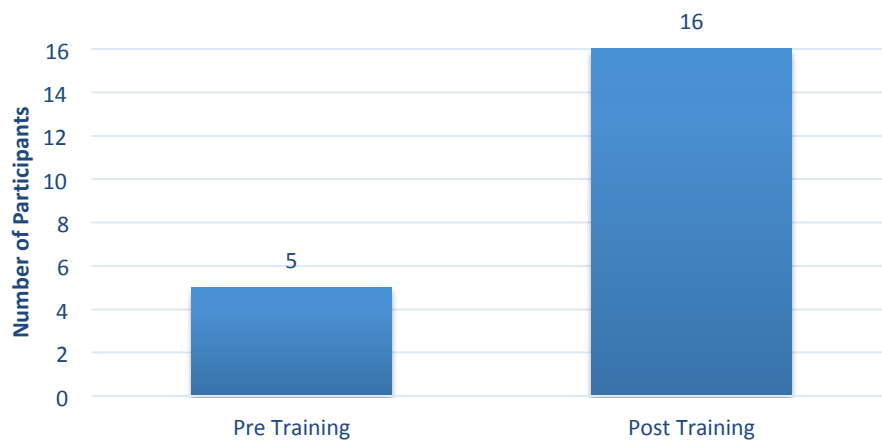


Figure 9 - Results from Questionnaire 1

Question Two:

31.5% of the participants felt they had sufficient skills to manage a patient with dementia prior to this education programme. However, 100% of participants felt that after the training they felt they had enough skills to care for a patient with a dementia.

Question Two: Do you have sufficient skills to manage patients with Dementia

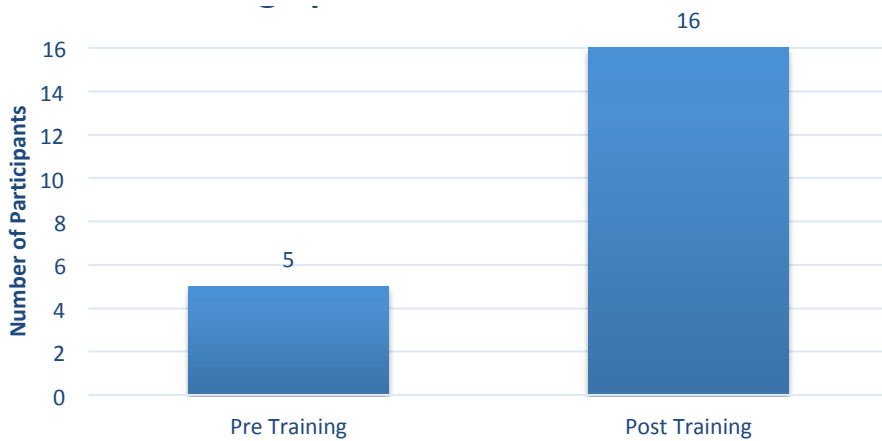


Figure 10 - Results from Questionnaire 2

Question Three:

31.5% of the participants felt they had enough skills to manage a patient with a high risk of falls prior to this education programme in comparison to 100% of participants post training.

Question 3: Do you have sufficient skills to manage patients with high risk of falls

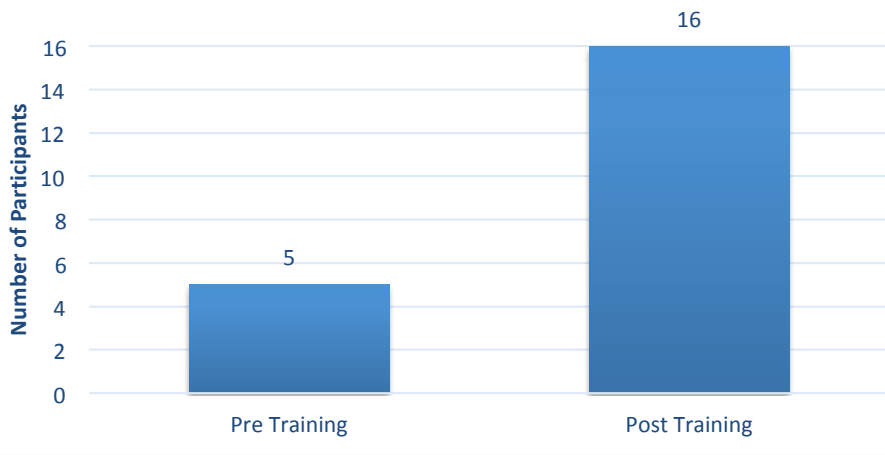


Figure 11 - Results from Questionnaire 3

Question Four:

The literature review strongly supported the importance of including violence and aggression training for Enhanced Care staff (Wilkes et al., 2010). This was in the pilot education curriculum but not delivered because of the unavailability of specialist facilitators in the short time period. Despite not receiving training, the staff became more aware to their own skills deficit and identified this is an area they would seek assistance from nursing staff if required. Whilst 25% of participants felt they had sufficient skills or training surrounding management of violence and aggression pre-training, 50% of participants noted they did not have adequate training or skills in the management of violence and aggression post training.

Question 4: Do you have sufficient skills to manage patients with high risk of violence and /or aggression

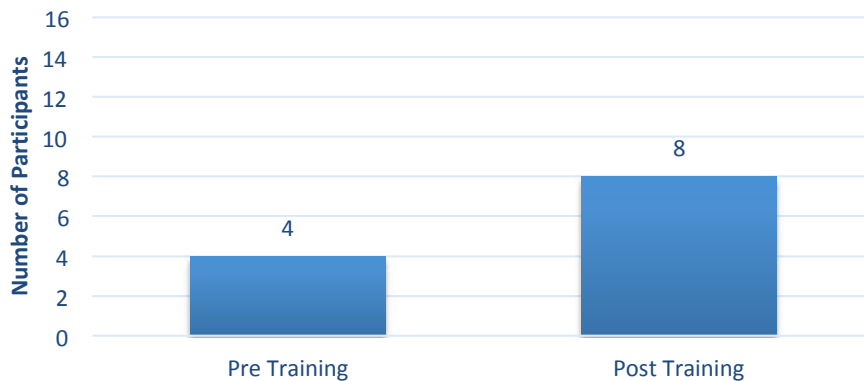


Figure 12 - Results from Questionnaire 4

IMPACT

Overall the results show the participants have a marked increase in knowledge and skills required surrounding the use of patient passports, dementia care, and falls awareness and therefore are equipped to deliver Enhanced Care. Ward Staff were also provided with training regarding Enhanced Care to support the implementation. The test of change will be in the sustained improvement of patient outcomes over time.

7.2.5 Governance**ACTION**

The CNM 3 facilitated the operational management surrounding the implementation and piloting of the project. This role was supported by the Assistant Director of Nursing with responsibility for resourcing and project management. The existing governance structure from phase 1 of the Framework for Safe Nurse Staffing and Skill Mix was expanded to include the Enhanced Care project (Appendix VII).

OUTCOME

Two separate but parallel governance structures were put in place to ensure the implementation of the recommendations in the Framework and the Enhanced Care pilot; these are the Local Implementation Group and Enhanced Care Operational Group. Representatives of key roles or departments throughout OLOL were members of the LIG so that oversight was conclusive and all-encompassing of the various factors

affecting patients and the organisation. The Local Implementation Group (LIG) is chaired by the Director of Nursing and supported by direct reports of the information as set out in Phase 1 of the Framework (Appendix VII) i.e. patient outcomes, staff measure and organisation measures. This information is used to oversee both the Framework and the Enhanced Care pilot. The Enhanced Care Operational Group reports into the Local Implementation Group by providing systematic and triangulated reports of activity and outcomes to inform the LIG's oversight.

The reason two parallel structures exist was due the Framework implementation structure was already in place in OLOL. Once the Framework implementation is complete the LIG will be maintained as the Safe Staffing Oversight Group. This structure will still reflect the governance and oversight as outlined in Appendix VII.

IMPACT

The governance framework oversaw the implementation of the Enhanced Care model across OLOL and sought assurances of effectiveness and efficiency improvements without compromising any patient outcome. The LIG reports regularly to the Hospital Executive Management Group through the Director of Nursing. As a pilot site, the LIG also furnished the Department of Health with regular updates and reports.





8

Further outcomes of the Pilot

8.0 Further outcomes of the Pilot

8.1 Patient and Staff Outcomes

8.1.1 Family Satisfaction:

A family questionnaire was designed and delivered to all family members in March 2018 (prior to the implementation of the Enhanced Care project) and March 2019 (following the implementation of the Enhanced Care project) to assess the effectiveness of the implementation

of Enhanced Care. The family questionnaire was distributed to 35 families: 29 questionnaires were returned from March 2018 survey (82% response rate) with 31 returned in March 2019 survey (88.5% response rate).

Question One:

In March 2018, 40% of families reported that had been engaged with in the development of a one-to-one care plan for their relatives; following implementation of the Enhanced Care initiative, 100% of families questioned in March 2019 reported that they were involved in the development of a one-to-one care plan.

Were you included in the development of your family members 1:1 plan

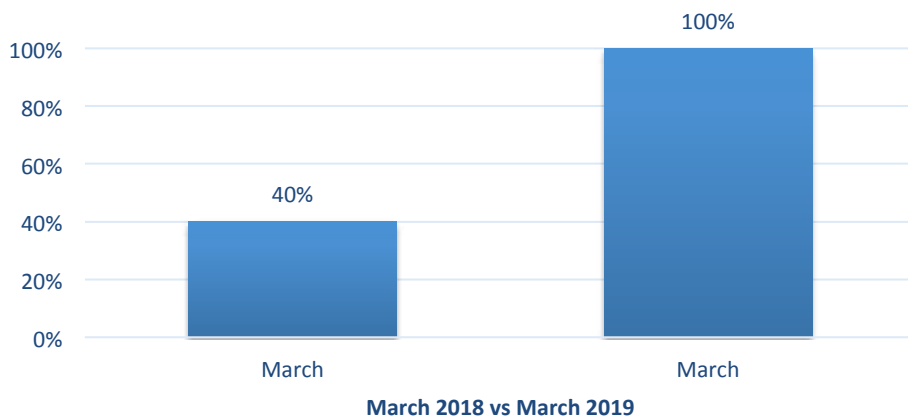


Figure 13 - Satisfaction Response 1

Question Two:

Prior to the implementation of the Enhanced Care initiative, 9% of family respondents reported that they were aware of the availability of activity equipment their relative; following implementation, 75% of families reported awareness. This is a critical indicator of the increased awareness of alternative therapies and activities available to patients that require Enhanced Care.

Is there any activity equipment in use

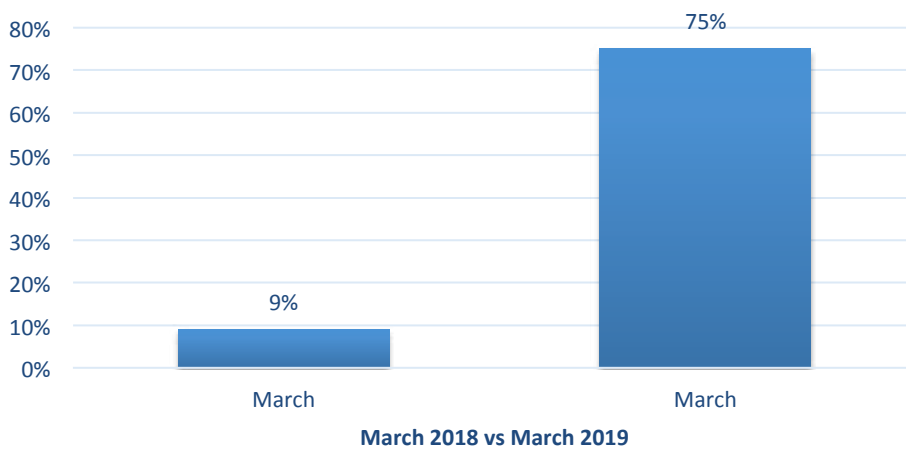


Figure 14 - Satisfaction Response 2

Question Three and Question Four:

All families who had a family member supported by the Enhanced Care team were fully aware of what a patient passport was in comparison to 52% prior to its introduction, with 90% of respondents stating the family passport was in use during this admission. This demonstrates the increased provision on individualised care which is core to both the Enhanced Care model and the Framework for Safe Nurse Staffing and Skill Mix.

Are you familiar with the term Patient Passport?

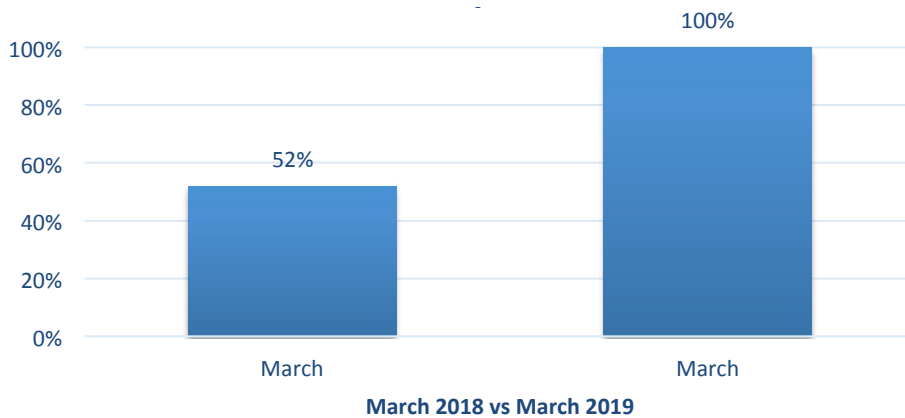


Figure 15 - Satisfaction Response 3

If 'Yes' is it being used during this admission?

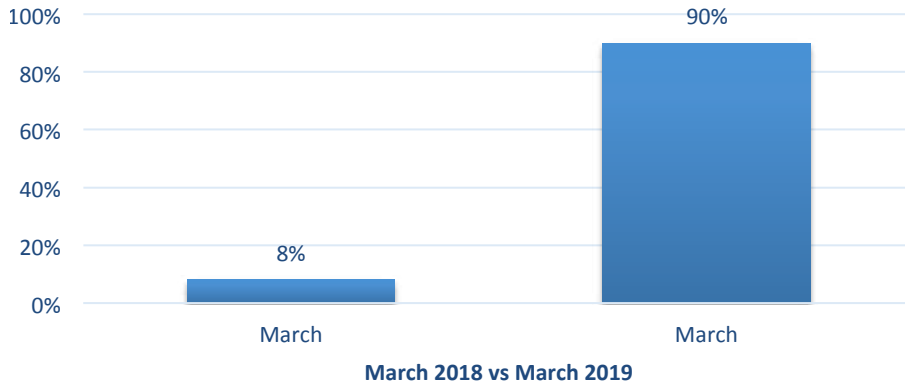


Figure 16 - Satisfaction Response 4

Question Five:

Prior to the implementation of the Enhanced Care team, 31% of respondents reported that the Enhanced Care service was either helpful or very helpful; this is compared to 87% of respondents, who following the implementation of the Enhanced Care team found the service helpful or very helpful.

Family Satisfaction Survey

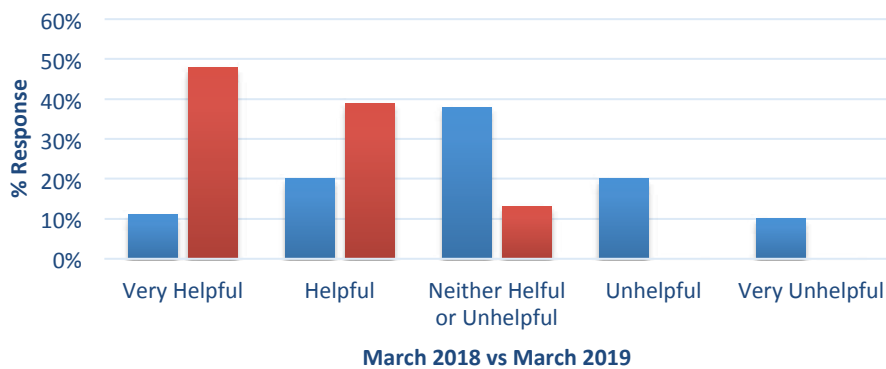


Figure 17 - Satisfaction Response 5

■ Mar-18 ■ Mar-19

Family Testimonial:

An example of a positive experience of Enhanced Care from a family member is outlined in the quotation below:

“The difference in the care with Mam when your team are with her, they don’t just sit there. It is lovely to see her enjoying herself and having her hair done & nails painted and looking so well. We can’t thank you enough for the care you have given Mam.

We couldn’t have done it without you. It means so much to us as a family. Thank you”

8.1.2 Falls

Data from the hospital database was collected between January 2017 and December 2018 and analysed to review falls per 1000 bed days. This information must be taken in context with the implementation of the Framework, and the outcomes cannot be based solely on the implementation of the Enhanced Care pilot project.

- **2017:** 421 falls occurred
(rate: 3.53 falls / 1000 bed days)
- **2018:** 493 falls occurred
(rate: 3.57 falls / 1000 bed days)

These falls rates are well below the NHSI (NHS Improvement, 2017) benchmark for acute hospitals: (6.1 falls/1000 bed days). International research would suggest fall rates may increase with the development of an Enhanced Care process, noting a rise in falls is generally associated with assisted falls (Tzeng & Yin, 2007); in addition, there may be an increase in the

reporting of falls. Yet Spiva et al (2012) & Laws & Crawford (2013) both suggest falls may reduce if members of a specialist team are present and appropriate guidelines and assessments are in use.

In line with the above, only one patient who received care from the Enhanced Care team during the eight-month trial sustained a fall; this fall was classified as an assisted fall with no reported injury.

8.1.3 Health Care Associated Infections

Data from the hospital database was collected and analysed to review Healthcare Associated Infections (HCAIs) in relation to hospital acquired Staph. Aureus and hospital acquired C.Difficile. HCAIs reduced per 1,000 bed day from 2017 to 2018. This information must be taken in context with the implementation of the Framework and should not be based solely on the Enhanced Care pilot project.

5.0 HCAIs 2017 and 2018

	Number of Cases 2017	Number of Cases 2018	Rate per 1000 bed days 2017	Rate per 1000 bed days 2018
Hospital Acquired Staph. Aureus Bloodstream Infection	5	3	0.04	0.02
Hospital Acquired New Cases C.Difficile	19	17	0.15	0.12

Table 5 - HCAIs 2017 and 2018

8.1.4 Care Missed / Delayed Events

Data to measure care events delayed or care left undone were captured across two date ranges: September 2017 to April 2018 (prior to the implementation of Enhanced Care) and September 2018 to April 2019 (following the implementation of Enhanced Care).

Care Missed Events: There was a 79% reduction noted in care missed events with the mean reducing from 1.88% to 0.44% across the two date ranges. This information must be taken in context with the implementation of the Framework, not based solely on the Enhanced Care pilot project.

Care Left Undone Events

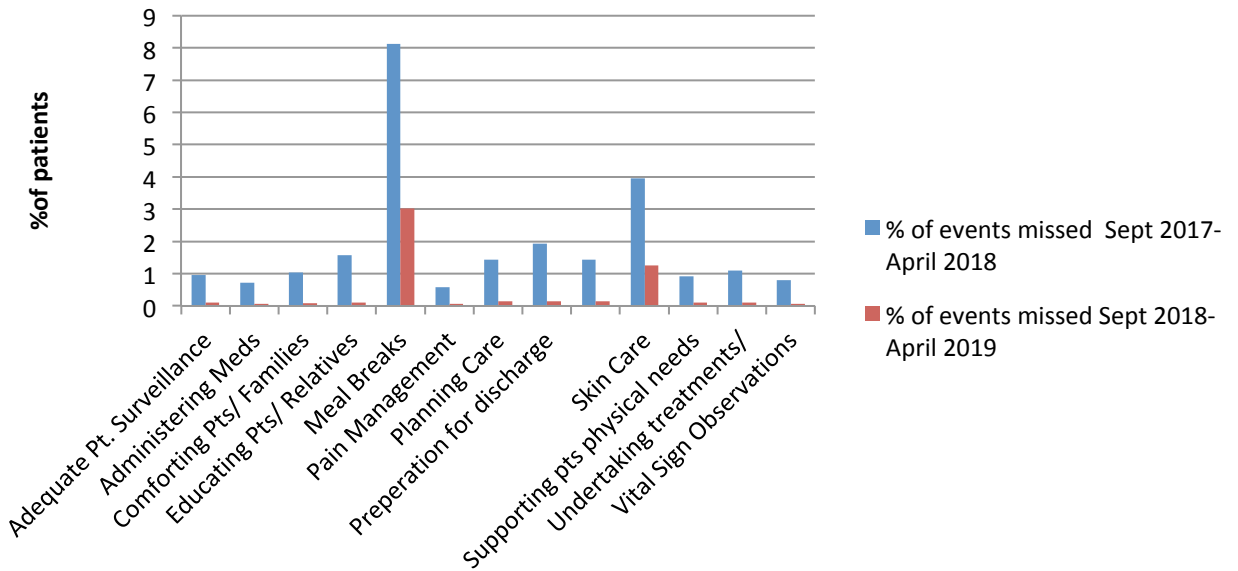


Figure 18 - Care Left Undone Events as Reported



9

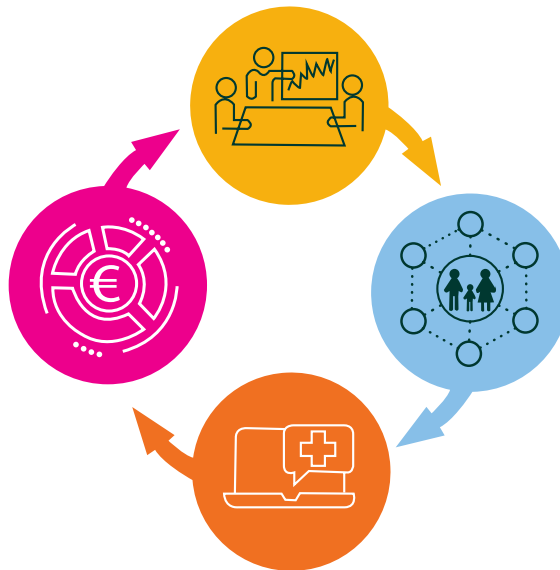
Recommendations

9.0 Recommendations

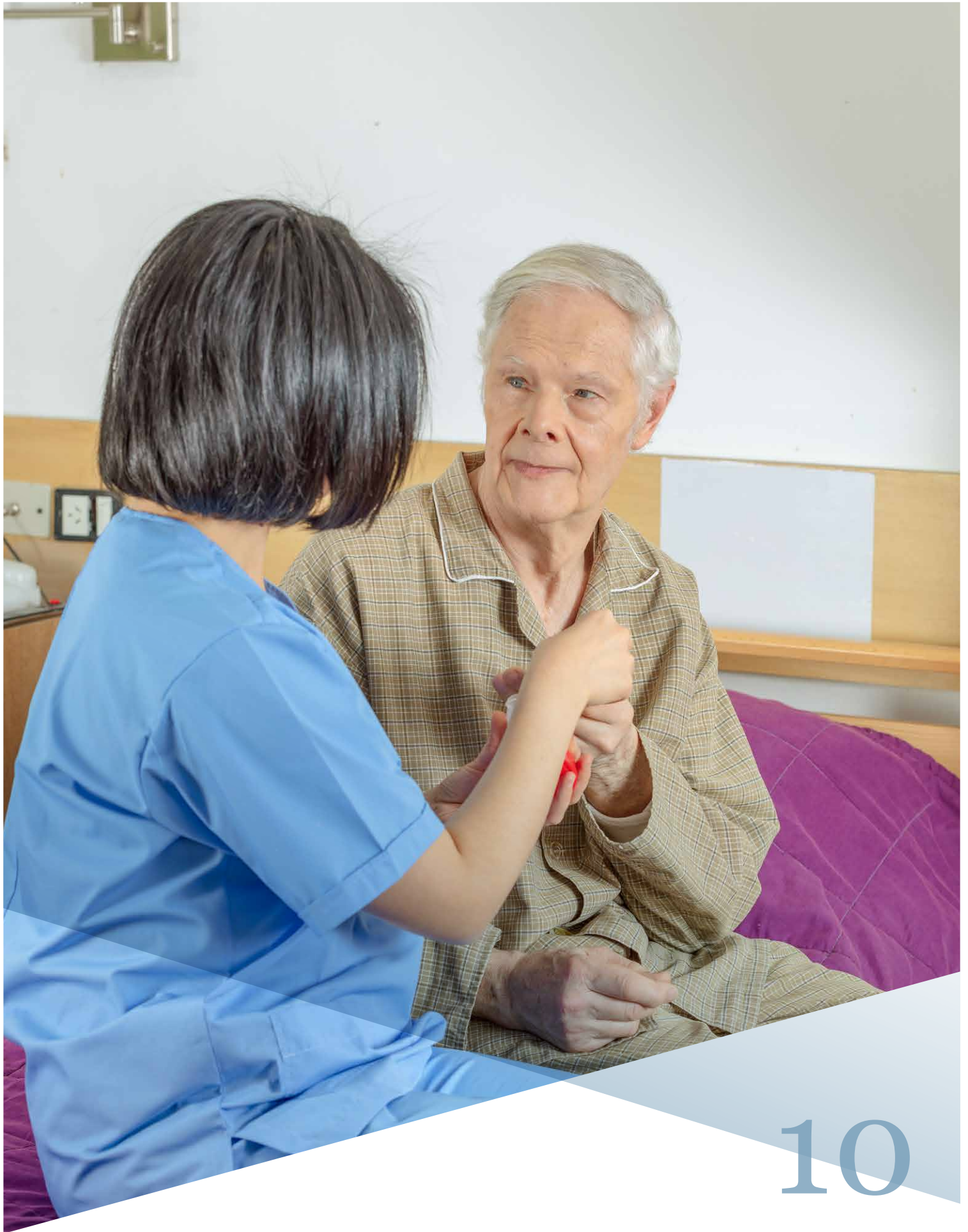
Learnings from the pilot site have provided several recommendations for any organisation undertaking the implementation of the Enhanced Care model.

Table 6.0 Recommendations from the Pilot on Enhanced Care

<p>Recommendation 1</p>	<p>Before implementation, baseline data on patient, staff and organisational outcomes are identified and collected. This allows the organisation to identify the challenges that may impact upon the implementation of Enhanced Care.</p>
<p>Recommendation 2</p>	<p>Provide documentation relevant to the provision of Enhanced Care. Continuously review and assess the data being collected. Ongoing audits of data, documents and patient outcomes are essential to ensuring the success of the project but also the safety of the patients involved.</p>
<p>Recommendation 3</p>	<p>Include violence and aggression management in bespoke education for the Enhanced Care team. The curriculum should be reviewed annually and updated based on the feedback from the patients, families and staff involved. This training should be updated every two years, in line with other mandatory training.</p>
<p>Recommendation 4</p>	<p>Adopt a robust governance structure before commencing implementation. This structure can provide operational and strategic oversight while also assisting with any decisions in the delivery of Enhanced Care</p>



the above recommendations for local development of change to deliver care differently are in line with the Sláintecare vision to change how we deliver care, provide innovative, effective, efficient and patient centred solutions.



10

Conclusion

10.0 Conclusion

A key priority for the HSE is to ensure the care provided anticipates, responds and consistently seeks to improve how patient care is delivered (HSE, 2018). This is taken in the context of increasing demands on the health service not least the growing complexity in patient presentations and the need to provide safe quality care to older people presenting to the acute care setting. To meet the priority of enhancing the care delivered to patients, especially those with complex needs, there is a need to develop and implement innovative approaches to care delivery. One innovative approach, as outlined in this report, is the implementation of an evidence-based initiative to provide safe and effective care to patients who require interventions above and beyond routine care. The implementation of a structured, hospital-staffed Enhanced Care team has demonstrated in this pilot that it can be an effective and sustainable approach to providing safe care to a vulnerable cohort of patient

Acknowledging that further research is needed, the pilot project has demonstrated some initial indicators of positive outcomes:

- A more stabilised and sustainable workforce
- Increased individualised and person-centred approach to care
- Increased involvement of families in Enhanced Care
- Indication of the model becoming embedded in routine practice
- Reduction in agency costs over time

The development of a bespoke education programme helped to deliver appropriate training to staff, ensuring the care needs of the patients could be met. The use of multiple strategies, including referral pathways, risk assessments, behavioural charts, and patient passports provided the staff with the necessary tools required for the successful implementation of this initiative. On-going measurement, evaluation, and dissemination of findings have facilitated staff engagement, whereby staff feel they have been collectively involved throughout the process. This pilot project has improved the way Enhanced Care is provided to patients throughout the organisation.





11.0 All Ireland Enhanced Care Report

An All Island Collaborative Task Group has been set up between the offices of the Chief Nursing Officer (CNO) in Northern Ireland (NI) and Republic of Ireland (ROI), to develop key principles for Enhanced Care that will be applied in both jurisdictions.

This work has been developed in line with the principles of Quadruple Aim (Figure 15). Initially a triple Aim was developed in 2008 to guide the design of healthcare systems within a population health patient experience of care and reducing costs. In recognition that the backbone of any effective healthcare system is engaged and productive in terms of workforce, a fourth (quadruple) aim was introduced improving the experience of providing care. The fourth aim holds particular importance within nursing workforce planning arrangements. Nurses are often central to the teams of health and social care professionals charged with delivering health and service improvements. Effective workforce planning is vital, not only in ensuring the availability of enough number of skilled staff are available but also in providing structures and support so that each member of the nursing workforce team can realise a sense of accomplishment and success that results from meaningful work. A Quadruple Aim approach will be applied to the delivery of this project.

This collaboration aims to:

- Ensure that there is guidance and a framework to support decisions for the requirements for nurse staffing for Enhanced Care in hospital settings.
- Review the available evidence and current practice in each area.
- Propose a set of key principles regarding Enhanced Care taking into account the appropriate professional / skill set to deliver care to the patient.

- Test the experience of the application of a set of principles for Enhanced Care provision in each area through the initiation of test pilot sites in NI and ROI.
- Produce an all-island recommendation and guiding principles for Enhanced Care for the nursing workforce in acute hospital settings.
- Ensure the development of guidance and standardisation of assessment of the requirements of Enhanced Care and implement a process for monitoring and review in each area.

The driver diagram (Appendix VIII) describes the key aims and objectives and change ideas that need to be considered as part of this project. Due consideration will be given to the ongoing work progressing through workforce policy frameworks in each area.

The learning from this pilot project has been shared with the NI approach to their provision of Enhanced Care. The NI group are trialling a different adaptation of Enhanced Care, using the same principles. This trial is ongoing and a report is due to be published in September 2019.



Figure 19 - All Island Collaborative Approach - Quadruple Aim



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Glossary of Terms

Bed Occupancy	The number of beds that are occupied over a 24-hour period
Enhanced Care	The allocating of a dedicated member of the healthcare team to a patient who requires additional care or supervision beyond the usual ward complement.
HCA (Health Care Assistant)	Health Care Assistant is an unregistered healthcare worker, providing patient care under the direct guidance and supervision of a registered nurse.
Skill Mix	The mix of education, training, skills and experience within the nursing care team that includes both registered nurses and health care assistants.
Person Centred Care	Person Centred Care supports people to make an informed decision about, and successfully manage, their health and care (The Health Foundation, 2014)
Registered Nurse	A Registered Nurse is a nurse whose name is entered in the nurse division of the register of Nurse and Midwives by the Nursing and Midwifery Board of Ireland (NMBI, 2014)
WTE	Whole Time Equivalent – calculation of a member of staff delivering 39hrs per week.



Appendices

Appendix I Enhanced Care Leaflet

Appendix I: Information Leaflet

Useful contacts:

- **Your Local GP**
- **Your Local Public Health Nurse**
- **Alzheimer’s Society Ireland**
- **Age Action,**
- **SAGE**



*Enhanced Care:
Patient /Relative
Next of Kin
Information Leaflet*

Please give feedback to The Enhanced Care Team as how we did. You can do this by speaking to or writing to our team.

Version 5 Fiona Monaghan Tyer



Why do I or my relative need enhanced care?

A person who is admitted to hospital who may need additional support because of feeling disorientated or deemed at risk for example of falls.

Following the assessment by the nurse the person may require an enhanced level of observation /care.

What does Enhanced care mean?

Enhanced care refers to the person who may be experiencing problems/ difficulties while in hospital

Who will provide this care?

This care will be provided through partnership with the person’s relatives, the ward staff and the Enhanced care team.



For how long will this care be provided?

The support and care will be provided as long as it is needed.

How can you help?

If you or your relative has a “personnel passport” or a “this is me booklet” please bring this into the hospital with you for your relative or friend.

Members of the Enhanced care team would welcome the opportunity to meet with you to discuss how best we can get to know your relative while in our care. This will help us develop a person centred approach as to what your relatives’ likes and dislikes are, so together we can help to meet their care needs.

Appendix II Patient Passport

This is my Personal Passport

For people coming into hospital who are referred to the Enhanced Care Team

My name is:

. It gives hospital staff important information about me.
It needs to hang on the end of my bed and a copy should be put in my notes.



This passport belongs to me. Please return it when I am discharged.

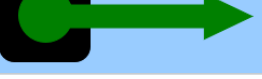
Nursing and medical staff please look at my passport before you do any interventions with me.



Things you must know about me



Things that are important to me



My likes and dislikes

Medical card number:

Date of Birth:

Address:

Tel No:

How I communicate/What language I speak:

Family contact person, carer or other support:

Relationship e.g. Mum, Dad, Home Manager, Support Worker:

Address:

Tel No:

My support needs and who gives me the most support:

My carer speaks:

Ethnicity:

GP: see medical/nursing notes

Address: see medical/nursing notes

Tel No:

Other services professionals involved with me:

Allergies:

Medical Interventions – how to take my blood, give injections, BP etc.

Heart

Breathing problems:

Risk of choking, Dysphagia (eating, drinking and swallowing):

My medical history and treatment plan: see medical/nursing notes

What to do if I am anxious:

Date completed by

 How I eat: (Food cut up, pureed, risk of choking, help with eating)

 How I drink: (Drink small amounts, thickened fluids)

 How I keep safe: (Bed rails, how I behave when I am distressed)

 How I use the toilet: (Continence aids, help to get to toilet)

 Sleeping: (Sleep pattern/routine)



Date completed _____ by _____ 5

 How I take medication: (whole tablets, crushed tablets, injections, syrup)

 How you know I am in pain:

 Moving around: (Posture in bed, walking aids)

 Personal care: (Dressing, washing, etc)



Date completed _____ by _____ 4

Things I like Things I don't like

Please do this: Don't do this:

Date completed _____ by _____ 6

Appendix III Patient Behavioural Chart

Appendix III: Behavioural Chart

Name MRN DATE WARD


Time	Patient has ECT/yes/no	In bed	Sitting in chair	Asleep	Avoids & calm	Avoids & restless	Agitated	Verbally upset	Walking about	Need for safe guarding	Requires ECT/medication	Participate in recreational activity	Relatives / Friends Present	EGS/ HCA Present	Details of any restless, agitated or distresses behaviour-details of circumstances and consequences and how resolved. Eg use of relatives , distraction techniques or sedation
08:00															
09:00															
10:00															
11:00															
12:00															
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05:00															
06:00															
07:00															

This form is to be completed for each patient requiring Enhanced care or who has behavioural issues of concern

Nurse in charge of patients care signature that behavioural chart is reviewed at end of each shift:

DAY Signature: _____ NIGHT Signature PM: _____

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Forfeirneacht na hÉireann
Health Service Executive

Patient Behavioural Chart

Patient addressograph

WARD:

DATE:

Reason for Enhance Care:

Circle the type of enhanced care required:

RED	Requires Continuous observation of the patient within eyesight or at arm's length 1:1
AMBER	Requires Intermittent observation with 15 minute checks and interaction, consider cohort
GREEN	Patient does not need designated HCA for enhanced care observation BUT is at increased risk and must be continued to monitor for changes in behaviour/risks

Any communication issues:

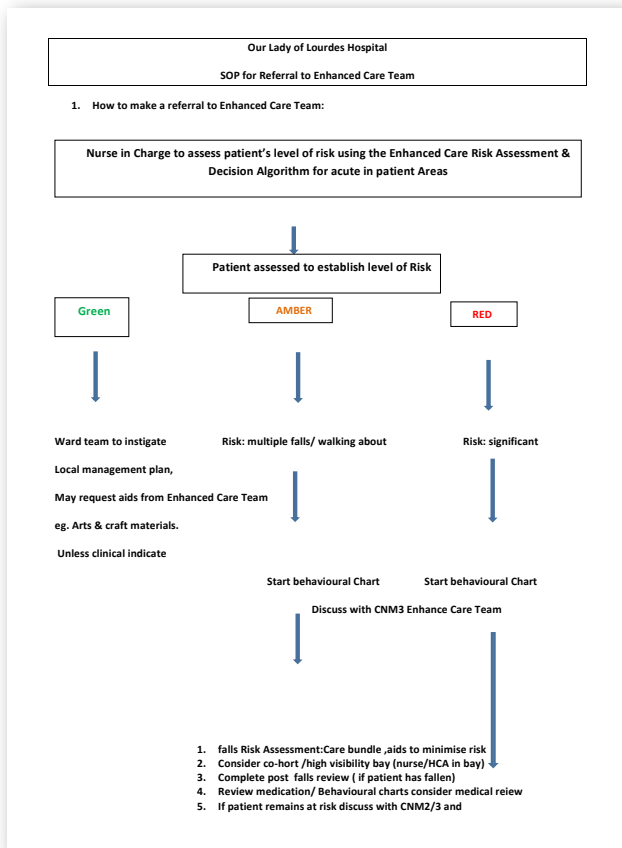
YES: NO:

If Yes -refer to care plan

Nurse assessors' signature:

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Appendix IV Referral Pathway



Reassess. Consider escalation to HIGH RISK RED

Contact Enhance care CNM3 /or out of hours ADON to review patient, actions:

- Review Risk Assessment
- Check Plan in place to investigate cause of distress
- Look to deploy staff from ward/Enhanced Care Team to provide observation

Patient requires Enhanced Care,
CNM3 / Out of hours ADON- patient will be allocated appropriate resources
Where Enhanced Care Team can't provide resource CNM3 will review with ADON RE: need for agency

(Patients who have a diagnosis of dementia do not de-escalate after 72hrs will be referred to the care of the older person CNS team for expert support)

- Out of Hours –Enhance Care Team** members are allocated to patients requiring close observation. All requests for assessment should be completed with CNM3 Enhanced Care Team (i.e. 8am-4pm, Mon-Fri). Outside of these hours/weekends/bank holidays, any requests should be discussed with the ADON out of hours (Bleep 157).

2. Roles and Responsibilities when a patient is receiving Care from Enhanced Care Team
2.1 CNM3 ECT is responsible for:

- Adhering to and implementing the Safe and Supportive Observation Guidance
- Overseeing the management and co-ordination of care plans of patients within their areas who require Enhanced Care on a daily basis.
- Assess and review daily with CNM3/Nurse in charge, the need for Enhance Care Team and the use of additional resources to support enhanced observation e.g. aids, staff to ensure efficient utilisation of Enhanced Care Team.
- Ensuring appropriate escalation of patients who require mental health assessment- were patients are displaying behaviours which cannot be determined by a clinical cause, then ward teams should consider the need to refer to mental health services. Where these behaviours are assessed and are considered to be putting the patients/staff at high risk of harm – this should be escalated and consideration should be given for the need to deploy a registered psychiatric nurse and expedite urgent referral to psychiatric team. This risk is flagged to the divisional CNM3/ADON/ Consultant, so that a safe environment can be maintained for patients and staff.

2.2 Ward teams are responsible for:

- The implementation of the Special Observation Risk assessment
- Reviewing and agreeing risk assessments for enhanced observation and ensuring de-escalation management plans in place

- Ensuring appropriate care management and treatment plans are in place and progressed in a timely manner
- Work in **partnership** with the Enhanced Care Team to ensure appropriate level of care/observation and support is provided throughout the shift
- Responsible for ensuring staff are aware and can adhere to the process when a patient requires a safeguarding assessment.
- Actions for de-escalation of distress should be documented and reviewed as part of the nursing/clinical treatment plan.
- Undertake a review of "Special Observation risk Assessment" within a max. 72 hours and daily thereafter.
- Any patient requiring Enhanced Care Team input for longer than a 21 day period must be referred to the Director of Nursing for discussion relating to the continuation of care.
- Ongoing need for supportive or reduced/de-escalation should be documented in the patient's nursing/medical notes.
- Ensure Enhanced Care Team members are allocated breaks, and provided with rest and changing facilities in line with those provided for the ward team
- Where Ward team/Enhanced Care Team with-draw observation from a patient any ongoing/further concerns regarding risk to the patient should be immediately escalated to the CNM for review. De-escalation by Enhanced Care Team/ward team should be documented in the patient's record and counter-signed by a registered nurse caring for the patient following discussion with CNM/Nurse in charge.

The patient remains the responsibility of the ward team therefore if a patient's behaviour escalates to a level where the safety of the individual patient, staff members or other patient's/visitors is compromised then the nurse in charge of the ward must ensure that appropriate actions are undertaken and ward staff are deployed to support Enhanced Care Team staff members until a time where the situation can be de-escalated or contained.

Working in Partnership:

- Registered Nurses are accountable for maintaining the patient's safety; they retain responsibility for any activities they delegate to the Enhanced Care Team Health Care Assistant including undertaking enhanced observation.
- Registered Nurses must ensure any patient that requires enhanced observations have all their nursing care needs met and that all staff involved in the process receive sufficient handover (ISBAR) to deliver care.
- Enhanced Care Team Health Care Assistant will actively participate in providing care and engage in therapeutic interactions with the patient / document interactions and interventions/ escalate concerns or changes in behaviour to the registered nurse.
- Enhanced Health Care Assistant will work with ward staff to ensure the patient's care needs are appropriately assessed, planned, implemented and evaluated.
- Enhanced Care Team will not provide 2 HCA: 1 patient care; however where patients level of risk is felt to exceed the 1:1 observation this will be escalated to the appropriate nurse manager.
- Enhanced Care Team will not provide care to children or adolescents under the care of children adolescents mental services
- Where a patient requires a Security Officer for reasons of patient/staff safety, local policy to apply.

Appendix V Risk Assessment

Enhanced Care- Risk Assessment & Decision Algorithm for Acute Inpatient Areas			
Section A: IMMEDIATE ACTIONS TO ASSESS AND REDUCE RISK- Please tick YES, NO or N/A			
Immediate Actions	YES	NO	Subsequent Actions:
Recent medical/medication review?			If NO- request review within 6 hours
Has the patient had a pain Assessment?			If NO- complete assessment if exhibiting signs of restlessness/agitation
Has the patient had a Delirium assessment?			If No complete 4AT Delirium screen.
Behaviour chart commenced/completed			If NO - commence chart and record any triggers immediately
Life history taken-careers or Next of Kin/ "personnel passport" "booklet"/ care plan if applicable			If NO - provide "personnel passport" document and involve patient /family/carers in completion
Have appropriate referrals been made to the MDT e.g. physio, OT, Geriatrician			If NO-make referral and use the behaviour chart to advise on plan and need to trigger enhance care response
Has the falls risk assessment been carried out?			If NO complete risk assessment and initiate care bundle if indicated
Has the patient had a fall in the past 12months			If yes:what preventive measures are in place to prevent re-occurrence
Is the patient at risk of walking around?			If yes: consider transferring patient to high visible/ restricted access area
Have environmental concerns been considered or addressed?			If NO - reduce environmental stimuli- noise etc., consider moving to more observable position
Is there a current substance misuse problem?			If YES- inform consultant and refer to appropriate services
Is a mental health assessment required?			If YES- inform consultant and contact: Psychiatry; EXT: 2168. Ensure response time. and advice is documented in nursing notes
Is the patient able to consent to the 'Enhance care team' ?			If NO-Discuss with consultant, CNM2&3 and ADON and inform family or carers
Can family members be utilised to assist with supervision? (within limitations)			If YES consider times available and document- review how risk is to be managed outside of this time
With the above interventions is the patient safe with the current level of supervision?			If NO complete section B and identify level of supervision required and contact CNM3 Enhance Care Team/ ADON / CNM3 / Out of hours ADON for support and intervention.

Section B Risk reason and Enhanced Care recommendation algorithm			
No.	Risk/Reason	Tick	Recommended level of Enhanced Care
1	For all patients		Minimum hourly comfort rounds
	Can slip/fall from bed		Manage with current ward establishment.
2	Reduced mobility or bedbound and attempting to mobilise		<ul style="list-style-type: none"> Ensure patient has had relevant nursing risk assessments Use strategies to minimise risk
Low Risk	Calling out & disturbing other patients		<ul style="list-style-type: none"> Use of assertive technology (low rise bed, alarm system etc.)
	Risk of pulling out any indwelling devices		<ul style="list-style-type: none"> Cohort patients where possible/safe to have therapeutic benefits Risk assess and complete the relevant documentation
3	Confused and walking around		Manage with current ward establishment- may need additional support.
	Risk of pulling out any indwelling devices with mitts		<ul style="list-style-type: none"> Ensure patient has had relevant nursing risk assessments
Med Risk	Agitation/Anxiety		<ul style="list-style-type: none"> Use strategies to minimise risk
	Impaired cognition/reduced insight		<ul style="list-style-type: none"> Cohort patients where possible Consider if family or ward carers can be utilised- discuss with ECT CNM3.
4	Confused & walking around presenting risks to self and others (patients/staff)		1:1 RN required
High Risk	Violent behaviour & aggression to others and self. Immediate risk to self/harm to others. Substantial & immediate risk of absconding		1:1 HCA or may require RPN (to assess, plan, deliver and evaluate mental health care) dependent on patient need HCA may be suitable or utilised if RPN unavailable- discuss with ECT CNM3.
	Expressing intent or recently attempted to self-harm/suicidal ideation		1:1 HCA or may require RPN (to assess, plan, deliver and evaluate mental health care) dependent on patient need HCA may be suitable or utilised if RPN unavailable- discuss with ECT CNM3.
	Under mental health section		1:1 RPN is required - discuss with divisional CNM3/ADON.

To be completed by CNM/ Nurse in charge if referral to ECT is required

Identify risk: Green Amber RED

If risk level 1-2 in your clinical judgement is an additional enhanced care required. Please state reason why you are requesting

Does the person have a diagnosis of Dementia? YES NO

Recommendation (use Algorithm as stated on the form:)

Authorised by: Print: _____ Sign: _____
Date & Time

Enhance care team Lead Review:	Circle Y/N	Rationale
Date: CNM/Nurse In-Charge- After completing the risk assessment overleaf do you feel in your professional judgement Enhanced Care is still required?	Yes No	
Date: Nurse In-Charge -Are other patients within the clinical area receiving Enhanced Care?	Yes No	
Date: IF YES can this patient be co-horted	Yes No	
Date: IF NO, should this patient be considered a 1:1 enhanced care.	Yes No	
Date: If Enhanced Care cannot provide please highlight reason		
Date: How will the risk be managed? (e.g. manage within ward establishment, overtime, agency booking, cohort etc.)		
Date: Anticipated length of Enhanced Care team required		
Date: If referred to Enhanced Care team did patient /family get information leaflet	Yes No	

Risk review/comments:

AUTHORISED BY CNM3/ ADON or ADON OUT OF HOURS (Bleep 157 out of hours) Signature: _____

DECLINED BY CNM3/ ADON or ADON OUT OF HOURS (Bleep 157 out of hours) Signature: _____

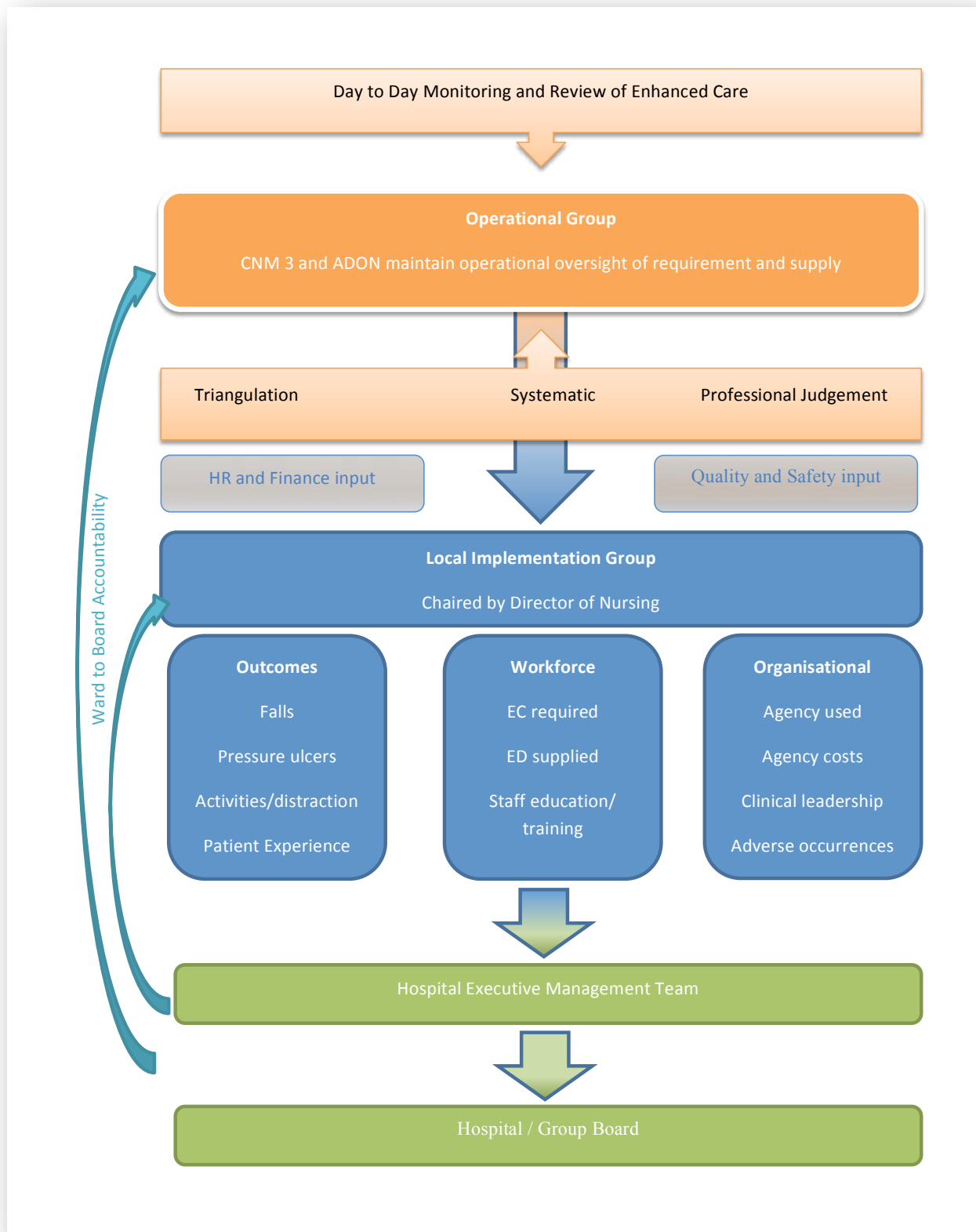
If approved level of risk to be reviewed each day or as condition changes. Behaviour chart must be completed whilst patient is considered to be at risk. Approval and allocation of ECT is only for a maximum period of 72 hours by the Enhanced Care Team CNM3 or ADON. Please contact CNM3 0876240458 or ADON out of hours: bleep 157/mobile:0864141621. If the Enhanced Care Team cannot provide cover approval to be sought from ADON/DON to request overtime/agency.

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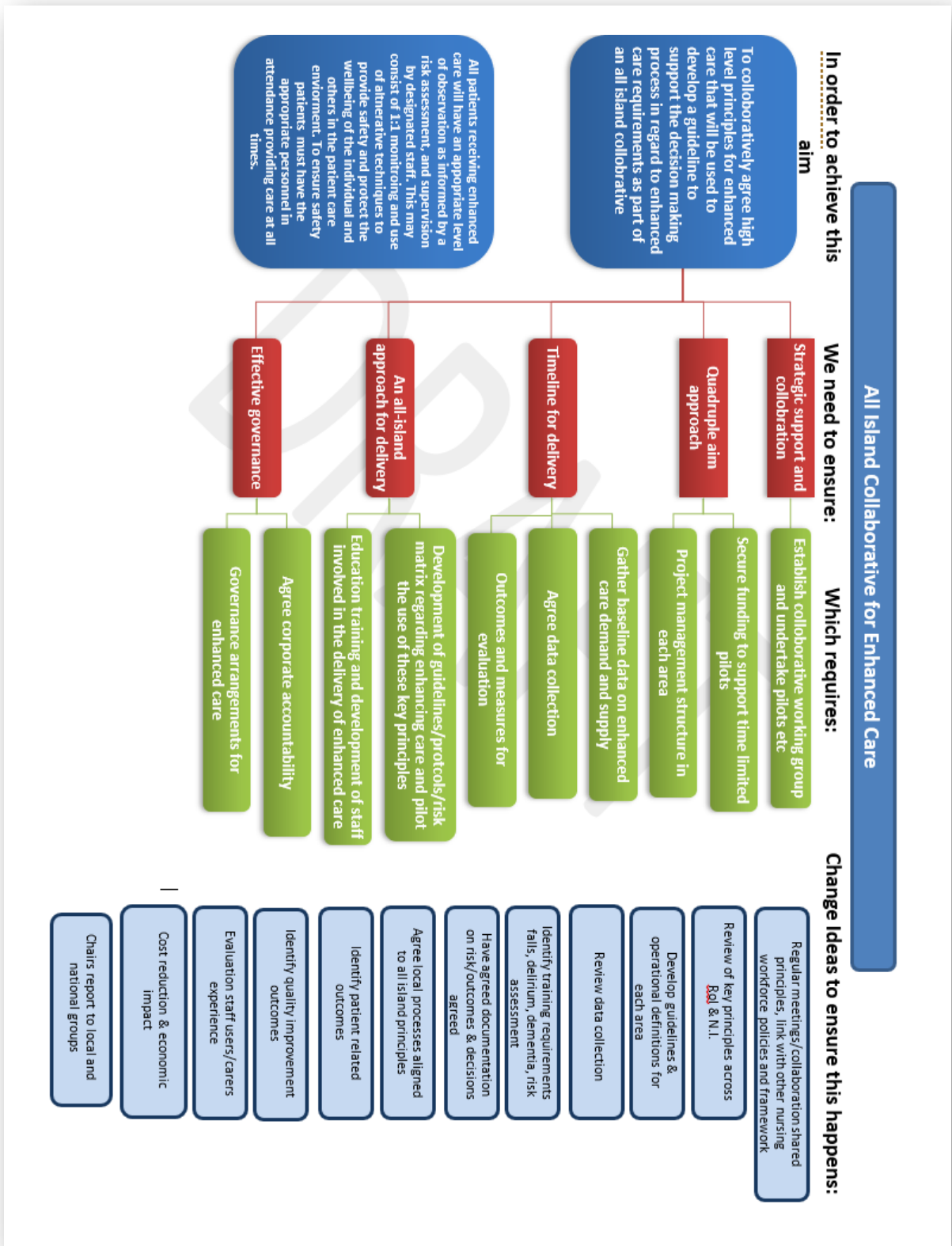
Appendix VI ECT Observation Assessment

Enhance Care Team Level observation assessment		
Consider the Risk		
LOW	MODERATE	HIGH
<p>Safety: Can Mobilise unaided. Can use call bell. May require assistance with personal care</p>	<p>Safety: Can Mobilise with aids or supervision. Can use call bell intermittently. May require assistance with personal care but may show reluctance</p>	<p>Safety: May attempt to mobilise Unaided but unable to do so. Unable/ won't use call bell. Refuses to accept assistance with personal care. Has a history of falls, Altered sleep pattern. Risk of self harm</p>
<p>Communication: Ensure the if the patient wears glasses or a hearing aid has same. No communication issues</p>	<p>Communication: Ensure the if the patient wears glasses or a hearing aid has same Can communicate needs. Has some evidence of expressive and receptive dysphasia</p>	<p>Communication: Ensure the if the patient wears glasses or a hearing aid has same Limited or no effective communication. Confused and or agitated. Constant reassurance & reiteration required. May or may not be de-escalated</p>
<p>Cognition: Comprehends, Aware of limitations/ has insight</p>	<p>Cognition: Has limited comprehension Poor safety awareness</p>	<p>Cognition: No safety awareness. Unable to maintain their own dignity Demonstrates levels of anxiety, aggression. No safety awareness. Display of socially inappropriate behaviour</p>
<p>Procedural: Compliant with treatments and therapy</p>	<p>Procedural: Some compliance with treatments and therapy</p>	<p>Procedural: Non-compliant with treatments and therapy.</p>

Appendix VII Governance Structure



Appendix VIII All Island Collaborative for Enhanced Care







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