**Delivering care through collaboration**

**Guideline/Protocol/Procedure**

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| **Name** | **Guidelines for Increased Intervention for patients with Altered Cognition.** |
| **Summary**  | Guidance for all staff providing care to patients with cognitive impairment requiring increased interventions to maintain their safety or the safety of others. |
| **Associated Documents** | Clinical Decision Making Tool. C.E.A.S.E. poster.Personalised Interventions Bundle.  |
| **Target Audience**  | All Nursing, Medical and AHP staff.      |
| **Version number**  | 3 |
| **Date of this version**  | 15th June 2023 |
| **Review Date** | 15th June 2025 |
| **Approving committee/group** |      Senior Nurse Governance and Review Group |
| **Document Lead** | Con Gillespie/Eleanor Lang  |
| **Document Author (if different)** |       |

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| **Have you made any changes as part of your review: Yes**  |
| **If yes, please list any key changes made to this document as part of the review:**Adapted in line with national guidelines “ From Observation to Intervention “ December 2018 [https://ihub.scot/project-toolkits/improving-observation-practice/from-observation-to-intervention**/**](https://ihub.scot/project-toolkits/improving-observation-practice/from-observation-to-intervention/)S.I.G.N. 157 <https://www.sign.ac.uk/sign-157-delirium.html>Adaption of supporting documentation |

(For clinical guidelines only)

A guideline is intended to assist healthcare professionals in patient care.

Clinical judgement should be exercised on the applicability of any guideline, influenced by individual patient characteristics. Clinicians should be mindful of the potential for harmful polypharmacy and increased susceptibility to adverse drug reactions in patients with multiple morbidities or frailty.

If, after discussion with the patient or carer, there are good reasons for not following a guideline, it is good practice to record these and communicate them to others involved in the care of the patient.

1 **Background**

Whilst under our care some patients with reduced cognitive function, due to existing conditions or current illness, may be unable to maintain their own wellbeing or present a risk of harm to themselves and others. These guidelines support staff to risk assess, care plan and provide appropriate interventions to maximise the patient’s safety, comfort, independence and reduce the risk of harm to others. These interventions are intended to support the ongoing care needs of the patient and all planned care should continue where possible.

**2 Appropriate level of Support.**

 **Always consider least restrictive intervention.**

Patient’s level of intervention should be assessed on an individual basis. Where staff have concerns the Clinical Decision Making Tool (Appendix 1) alongside existing risk assessment tools i.e. M.U.S.T., Falls risk and professional judgement should be used to agree a plan of support.

The level of intervention should be assessed regularly and adjusted dependent on patients need. This may fluctuate over the course of the day. Use of the Personalised Interventions Record (Appendix 2) will assist staff to be proactive in increasing or decreasing levels of support.

 Support Levels: Level 1- routine care

 Level 2- Increased frequency of Care Rounding.

 Level 3-Enhanced Interventions

 Level 4-Enhanced Interventions and Escalation

**3 Level 3 and 4 Enhanced Interventions**

Where patient is exhibiting severe stress and distress, interventions should initially be focused on safety of patients and staff. Room should be made safe for patient and staff by removing any furniture, equipment and supplies which are not in use.

Consider the C.E.A.S.E (Appendix 3) approach to identify causes of distress.

Whenever possible the member of staff providing support should engage with the patient to reduce their stress.

If not already completed a “Getting to know me (Appendix 4) “should be started. This can be helpful when identifying possible causes of stress and distress and information to support care planning to provide person centred interventions.

 Family and friends should be asked to provide therapeutic items which may be helpful i.e. CD player, CDs, books or magazines. Photographs can also help.

An activities resource is available in room B5071 in Clinical Education, security will allow access out with office hours. Risk should be added to Safety Brief and reported at Daily Huddle.

Personalised Intervention Bundle should be started for all Level 3 and 4 patients.

**Who should provide support?**

The Nurse in Charge should identify the appropriate grade of staff to support patient. They should then assess if this is possible from ward staffing complement. If not Senior Nurse should consider if staff can be deployed to area. It may be that deployed staff would be used as part of rotation of staff supporting the patient or to assist with staff breaks and would only be required for part of shift. Additional staff from Nurse Bank may be required to support area to implement 2 hourly rotations and existing procedure should be followed.

Where possible all planned nursing, medical and AHP care and treatment should continue for the patient. The member of the MDT providing that care to the patient would also be providing 1-1 support during the period of care. When their input is complete they must ensure that 1-1 care is maintained.

Patient’s family and friends can also provide support unless it is deemed unsafe for them to do so. They should also be reminded to inform staff if leaving patient.

At all other times care can be provided by a Nursing/Rehab assistant.

Where patient is not a risk to others i.e. high falls risk hospital volunteers may be able to support activities with patient.

Providing 1-1 support can be very mentally challenging and tiring. Staff should be rotated at a minimum of 2 hourly intervals. If patient has a special rapport with 1 member of staff and their removal is likely to cause further the distress the staff member should be given a break every 2 hours.

Practice Supervisors/ Practice Assessors might find this a suitable learning opportunity for a student nurse and should plan student nurse involvement appropriately.

It is very important that staff have an appropriate level of guidance and training to provide optimum support to fulfil the Enhanced Interventions role.

**For Level 4 Intervention consideration may be given for support to be provided by a Registered Mental Health Nurse – for patients with specific mental health requirements, discussion and agreement should be sought between the ward clinical team and Mental Health team to ensure the appropriate level of therapeutic support is provided.**

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**Personalised Intervention Record**

**Guidelines for completion of Personalised Interventions Record**

Apply Patient Sticker

* Registered Nurse in charge of patient’s care should commence Bundle once decision to provide interventions has been taken.
* Reason for interventions should be recorded. Further narrative may be required in evaluation.
* Decision should be communicated to all members of MDT, patient and relative. If any potential infection risk Infection Control team should be advised.
* Communication should be recorded. If preferred note can be made of date, time and with whom communication took place with “see medical/AHP/Nursing notes”
* Care Plan. Documentation list are suggestions of documentation which should be considered apart from Getting to know me which should be completed for all patients requiring 1-1 interventions.
* If 1:1 intervention is assessed to be required, the nurse in charge should ensure that member of the team supporting has sufficient skills and level of support to fulfil a therapeutic Enhanced Intervention role (this may require review if patient’s needs change)
* Care planning should reflect patients’ care out with I.C.P. Consideration should be given to interventions which minimise/reduce distress.
* Daily checklist should be completed by Nurse in charge of care. Assessment of need for continued 1-1 should be documented in evaluation.
* Review of Supportive Intervention Record will assist in this assessment and may also identify times when care may be stepped down.
* Timetable should be completed to evidence relief of staff at 2hourly intervals.
* Where it is agreed that a particular member of staff should stay with patient rationale should be documented in evaluation and staff member provided with regular 15 minute breaks.
* Supportive Intervention Record should be completed by person providing support. 9 and 10 are left blank for other identified signs of distress.
* Record should be reviewed by Nurse in charge of care to support care planning. It may provide indication of triggers, patterns of distress or interventions that have reduced distress.



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| **This level of support has been identified as the patient is** | Date  | Sign |
| **at risk of harm to self-due to** |  |  |
| The patient is at a high risk of falls and unable to comply with physiotherapist instructions. |  |  |
| The patient is at risk from disruption of care i.e.: removing medical devices,  unable to comply with prescribed care. |  |  |
| 1. The patient is at risk of absconding
 |  |  |
| other |  |  |
|  |  |  |
| 1. **at risk of harm to others**
 |  |  |
| The person is expressing agitated +/or aggressive behaviour? |  |  |
| The person is indulging in impulsive and dis-inhibited acts that are a danger to the person or others. |  |  |
| Other  |  |  |
|  |  |  |

**IF THIS IS A CHANGE IN BEHAVIOUR ALL OTHER RISK ASSESSMENTS SHOULD BE UPDATED**

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| --- | --- | --- | --- |
|  | **Yes/no** | **Comment** | **Initial** |
| Ward Safety Brief |  |  |  |
| Patient |  |  |  |
| Relative  |  |  |  |
| Consultant |  |  |  |
| RMO |  |  |  |
| Senior Nurse |  |  |  |
| Hospital Huddle |  |  |  |
| Physiotherapist |  |  |  |
| OT |  |  |  |
| Other |  |  |  |
| Other |  |  |  |
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**Communication Record**

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| **Communication Notes.** |
| **Date and time** |  | **sign** |
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| **Communication Notes.** |
| **Date and time** |  | **sign** |
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**Care Plan**

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| **Documentation**  |
|  | **YES/NO/NA** | **Comment** |
| Getting to know me |  |  |
| A.W.I. Section 47 and treatment plan |  |  |
| 4AT/CAM-ICU |  |  |
| T.I.M.E. |  |  |

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| **Relative/carer involvement** |
| Name(s) |  |
| When wanting to be involved |  |
| Planned involvement |  |

**Patient centred interventions.**

Where possible all previous care should continue as per ICPs and Risk Assessments.

Additional care identified from: Discussion with patient and family.

 Getting to know me

 Supportive Intervention Record

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| **Support Need**  | **Planned care** | **initial** |
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**Daily Checklist**

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| **Date** |  |  |  |  |  |  |  |  |  |
|  | **Y/N** | **Y/N** | **Y/N** | **Y/N** | **Y/N** | **Y/N** | **Y/N** | **Y/N** | **Y/N** |
| 1-1 required |  |  |  |  |  |  |  |  |  |
| Risk on Safety Brief |  |  |  |  |  |  |  |  |  |
| Highlighted at Huddle |  |  |  |  |  |  |  |  |  |
| Repeat 4AT if delirium |  |  |  |  |  |  |  |  |  |
| Supportive Intervention Record reviewed |  |  |  |  |  |  |  |  |  |
| Review Care Plan |  |  |  |  |  |  |  |  |  |
| **Initial** |  |  |  |  |  |  |  |  |  |

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| **Date** |  |  |  |  |  |  |  |
| Time | **Unit/ward** | **Unit/ward** | **Unit/ward** | **Unit/ward** | **Unit/ward** | **Unit/ward** | **Unit /ward** |
| 00:00-02:00 |  |  |  |  |  |  |  |
| 02:00-04:00 |  |  |  |  |  |  |  |
| 04:00-06:00 |  |  |  |  |  |  |  |
| 06:00-08:00 |  |  |  |  |  |  |  |
| 08:00-10:00 |  |  |  |  |  |  |  |
| 10:00-12:00 |  |  |  |  |  |  |  |
| 12:00-14:00 |  |  |  |  |  |  |  |
| 14:00-16:00 |  |  |  |  |  |  |  |
| 16:00-18:00 |  |  |  |  |  |  |  |
| 18:00-20:00 |  |  |  |  |  |  |  |
| 20:00-22:00 |  |  |  |  |  |  |  |
| 22:00-24:00 |  |  |  |  |  |  |  |

**Timetable for allocation of staff**

**A verbal handover should be given at each changeover of staff.**

**This should include**

* Introduction to patient and family/carers
* Need for interventions.
* Report of how patient has been over previous period.
* Any identified triggers
* Any planned care.

**Supportive Intervention Record**

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| --- | --- | --- | --- |
| **Time** | **Patient is** | **Comments.** Consider patient activity, ward activity.Record time of changeover of staff | **Initial** |
| 00:00-02:00 |  |  |  |
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| 20:00-22:00 |  |  |  |
| 22:00-24:00 |  |  |  |

Patient is:

 1 Sleeping 2 Awake and settled 3 Crying out

4 Shouting 5 Hallucinating 6 Pulling at devices

7 Restless 8 Aggressive



**Supportive Intervention Record**

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| **Evaluation** |
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