





Enhanced Care Observations (ECO) Booklet 1

PLEASE RETAIN BOOKLET 1 AT THE BEDSIDE

ECO should never be used in isolation.

ECO should be part of a person centred management plan, to promote safety, while identifying the cause of and relieving distress.

This assessment tool should be commenced for any adult in-patient who requires assessment and monitoring of distressed behaviours, which may increase the risk of harm to themselves or others.

An Enhanced Care Observation Assessment should be considered for any patient with: (This list not exhaustive)

- An identified medical condition which may impair situational and safety awareness, e.g. Dementia, Delirium, Learning Disability, Brain injury, Alcohol/Drug withdrawal.
- Distressed or challenging behaviors which have the potential to become harmful.
- Mental ill health with concerning behaviors that may lead to self-harm or harm to others.
- High risk of falls, likely to cause harm, by attempting to mobilise unaided.
***NB: ECO alone will not prevent falls, consider falls prevention pathway.**
- High risk of absconding from the ward environment with risk of harm to self or others.

Distressed behaviour is often a communication of unmet need.

The first step in easing distress is getting to know the patient.

Complete My Story (page 5) within 24 hours of admission or Purple Heart “This is me” for Patients living with Dementia.

Signature:

Date:

Is the patient distressed and/or displaying behaviours that increase the risk of harm to themselves and/or others ?

YES

Patient...

- May have mild cognitive impairment and/or other medical condition that has reduced their situational awareness.
- Is usually able to co-operate and engage with treatment and is compliant with the use of the call bell.
- Has pulled out an indwelling device such as IVCs
- Has potential falls risk (consider falls prevention strategies (e.g. assistive technology, footwear, mobility assessments).

YES

Green ECO
Level A - No ECO
Do not progress to Page 3.

Core Staff will therapeutically engage with patient during routine care.

NO

OR

Patient...

- Has impaired situational and safety awareness.
- displays episodes of distress, agitation or erratic behaviour, may be walking with purpose
- assessed as requiring assistance and at risk of fall due to attempting to mobilise unaided
- at risk of absconding with potential to cause harm.
- has a change in behaviour or is displaying behaviours that concern.

YES

Amber ECO

Level B - Within eyesight

OR

Patient...

- has frequent episodes of distress +/- agitation
- +/- aggression toward self or others
- is displaying destructive behaviour which could be harmful to recovery e.g. removing essential clinical devices—high flow O2 therapy, central lines
- ILS have recommended constant observation
- remains high risk of falls despite prevention strategies or has already had an in-patient fall resulting in harm.
- requires constant clinical care to maintain safety or
- unable to cooperate with treatment.

YES

Red ECO

Level C - Within arms reach

Issues identified regarding consent/ capacity should be addressed as per Mental Capacity Act (NI) 2016.

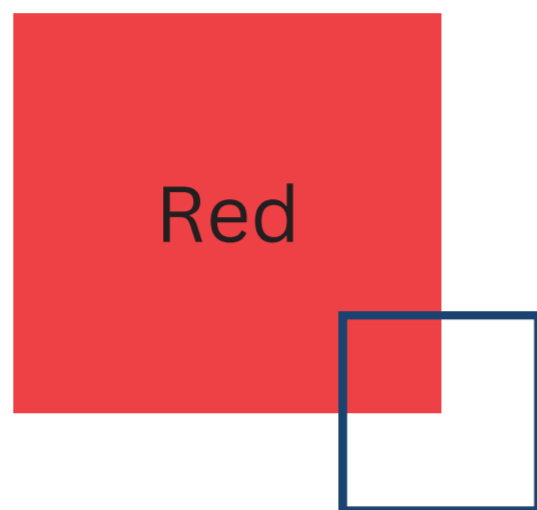
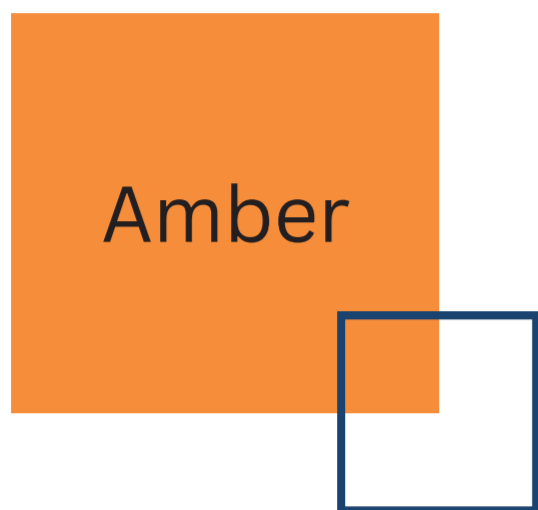
Outcome of Initial Risk Assessment:

Please tick all that apply:

Ward:

Date:

Time:



Alcohol/Drug withdrawal	<input type="checkbox"/>
Dementia	<input type="checkbox"/>
Delirium	<input type="checkbox"/>
Brain Injury (including stroke)	<input type="checkbox"/>
Mental Ill-health	<input type="checkbox"/>
Learning Disability	<input type="checkbox"/>
Other	<input type="checkbox"/>

Reason for ECO:

Staff member allocated to patient (if required):

Document immediate steps to ensure patient safety:

Discussed with Nurse in Charge:

Registered Nurse Signature:

Level of observation and staffing added to safety briefing.

Does the person require a referral to ILS?

MCA implications considered and actioned:

ECO must be at the **LEAST** restrictive level, for the **LEAST** amount of time, within the **LEAST** restrictive environment which promotes patient safety.

<p>Is there reasonable belief that the patient lacks capacity?</p>	<p>No</p> <p>Yes</p>	<p>Does the patient agree to ECO Yes/No</p> <p>Inform Medical Team Consider MCA/STDO/DoLS</p>
<p>Discussed with: Patient Family/Carer</p>	<p>Yes/No</p> <p>Yes/No</p>	<p>If no, please comment:</p> <p>RN Signature:</p>
<p>Information Leaflet given</p>	<p>Yes/No</p>	<p>If no, please comment:</p> <p>RN Signature:</p>
<p>"About me" Completed</p> <p>"This is me" Completed</p>	<p>Yes/No</p> <p>Yes/No</p>	<p>If no, please comment:</p> <p>RN Signature:</p>

My Story

Knowing these things will help you communicate with me.

For Dementia Patients please use "This is me" document within the "Purple Heart" Project

I like to be called:

My home is:

The person who knows me best is?

Contact Details:

How I communicate (include any aids used)

What are my interests?

Personal care/toileting needs:
(Do I require support? Should you approach me in a certain way?)

Sleeping pattern (usual nighttime routine)

My Life Story (including childhood, important life events, things that are important to me.)

What is important to me?

What helps me relax?

Any other important information that will help you support me
Religious/spiritual needs, music likes, culture. interests, sports, things that upset me and things that will help me feel safe.

Signature:

Date:

Nursing Interventions

GREEN NO ECO

- Hello my name is....
- HSC Values
- Update patient and family regularly
- Distraction therapy/music
- Pathways and bundles in place for prevention and treatment
- Delirium bundle/alcohol withdrawal/ GMAWS/ sepsis 6 bundle.
- Consider unmet needs triggers such as thirst / pain / toilet need
- Complete a **full** assessment using PACE.
- Pharmacy/medical staff to review kardex.
- Encourage **collaboration** with family – Care Partner.
- Risk Assessments complete – Falls / bedrails / moving and handling.
- Consider falls assistive technology to reduce falls risk and check equipment working daily
- Utilise dementia companions if appropriate.
- Complete 'My Story : understanding what matters to me
- Learning Disability Passport.

AMBER ECO - Within Eye-sight (cohort)

The patient must be within eyesight of a member of staff at all times – consider cohort.

All green interventions plus:-

- Review ECO observation charts at end of every shift and observe for trends in behaviour.
- Consider environmental factors – noise, light etc.
- Discuss plan of care at all MDT opportunities.
- Review behaviours that challenge checklist particularly the amber actions
- Discuss with appropriate specialist lead for Falls, MHLS, SW, Delirium, Dementia and LD Acute Advisory Service
- Identify any anticipated issues which may delay discharge.
- Medical staff to review prescribed medications.

RED ECO - Within Arms Reach

Patient must be within arm reach of staff designated to this role to provide constant uninterrupted observation.

All green and amber interventions plus:-

- Ensure specialist opinion has been sought.
- Consider impact of acute ward environment on patient's behaviour.
- Refer to Behaviours that challenge checklist particularly the red actions
- Consider rapid tranquillisation protocol when imminent risk of harm to self/others. – last resort.
- **NB- specific protocols for - dementia/delirium/ Alcohol withdrawal.**






Common Triggers	Presentation	Interventions	Outcomes
Hunger/Thirst	<ul style="list-style-type: none"> • Dry lips/mouth. • Weight loss. • Reduced urinary output. • Asking for drinks/food. 	<ul style="list-style-type: none"> • Monitor intake. • Provide drink, snack. • Ensure finger foods are available on the ward. 	<ul style="list-style-type: none"> • Patient is satiated. • Discomfort reduced
Bladder/Bowel	<ul style="list-style-type: none"> • Moving around more. • Squirming • Touching private parts. • Removing clothes. • Appears unsettled or uncomfortable. • Trying to get up. • Calling out. • Distress during personal care 	<ul style="list-style-type: none"> • Assist to toilet • Provide adequate water and fibre. • Mobilise patient. • Support to change position. • Change continence product if appropriate. 	<ul style="list-style-type: none"> • Patient settled as no longer experiencing discomfort.
Pain	<ul style="list-style-type: none"> • Crying out, vocalisations • Pulling away when touched. • Hitting out during interventions. • Pained facial expression. • Refusing food. 	<ul style="list-style-type: none"> • Discuss with Nurse in Charge or medical team to see whether pain relief has been given or should be considered. • *RN to refer to Abbey Pain scale • Consider prophylactic pain relief as appropriate. 	<ul style="list-style-type: none"> • Patient no longer experiencing pain
Medication	<ul style="list-style-type: none"> • Evidence of pain indicators listed above. • More drowsy. • Behavioural changes 	<ul style="list-style-type: none"> • Discuss with Nurse in Charge. Medical Team or Integrated Liaison Service as appropriate 	<ul style="list-style-type: none"> • Pain is managed effectively.
Fear/Environment	<ul style="list-style-type: none"> • Asking for home, their mother or father (This can often mean the person is seeking out safety/solace). • Trying to leave. • Crying out • Distress. • Appears easily startled. 	<ul style="list-style-type: none"> • Provide reassurance • Speak to the person, get to know them and complete “This is me” • Offer engagement: RITA, meaningful activities - music, film, arts/crafts etc • Seek support of family, advise of enhanced visiting arrangements. • Create a visiting schedule. • Offer relaxation activities or sensory activities such as aromatherapy 	<ul style="list-style-type: none"> • Patient feels safer. • Patient is reassured. • Patient is engaged in activities that mean something to them and is distracted from feeling fear/anxiety.
Boredom Including change of routine/normal activities.	<ul style="list-style-type: none"> • Restless. • Trying to leave. • Getting up to move. • Distressed (notice if this happens at certain times, what did they usually do at this time?) 	<ul style="list-style-type: none"> • Get to know the patient and what is important to them. • Provide access to meaningful activities outlined above. • Use “This is me” and mirror usual routine as much as possible. 	<ul style="list-style-type: none"> • Patient is occupied in an activity that is meaningful to them.

Common Triggers	Presentation	Interventions	Outcomes
Particular Staff/visitors	<ul style="list-style-type: none"> • Patient is more settled/unsettled with certain people. • Patient displays signs of distress when a particular visitor is present. 	<ul style="list-style-type: none"> • Monitor which staff members the patient responds well to and where able utilise these staff to support the patient. • Monitor visiting times and whether there is a pattern to their behaviour when receiving certain visitors. • Where appropriate discuss Care Partnership arrangements with supportive family members and involve in Enhanced Care. 	<ul style="list-style-type: none"> • Patient is less distressed. • Supportive carers are involved in providing Enhanced Care. • Patient is protected from potential harm.
Sun-downing or late-day confusion	<p>Definition: Sundowning is a term used for changes in behaviour that occur in the evening, around dusk. Some people who have dementia experience a growing sense of agitation or anxiety at this time. Sundowning often makes the person with dementia feel very strongly that they are in the wrong place.</p>	<ul style="list-style-type: none"> • Use “This is me” to ascertain what patient usually did in the afternoon - are they trying to complete that task? • Offer distraction therapy and engagement with meaningful activities (as above) • Consider use of circadian rhythm/SAD light as appropriate. • Take patient for a walk if safe to do so. • If patient has a typical behaviour pattern speak with ILS/Medical team regarding timing of medication - should it be given before usual episodes of sun-downing? 	<ul style="list-style-type: none"> • Patients distress is recognised and support sought from ILS/Medical team. • Patient if offered distraction therapies and is occupied during usual times of distressed. • Staff are aware of usual pattern of behaviour and supported to minimise distress to patient and reduce the risk of any escalation.
Noise/Environment	<ul style="list-style-type: none"> • Patient is startled • Patient is more confused at busy times or in higher traffic areas. • Patient is more irritated or unsettled. 	<ul style="list-style-type: none"> • Where available provide a quiet space, whether this is a side room or quieter day room. • Soft close bins to reduce noise at night. • Implement a rest period during the day where visitors are reduced. 	<ul style="list-style-type: none"> • Unnecessary distress is reduced. • Patient has some down time from busy ward environment.




Ward:

Date:

PLEASE  level of observation as per assessed risk at each time interval

Time	ECO Level			Behaviour	Intervention	Outcomes	Initials
8:00 - 8:30							
8:30 - 9:30							
9:30 - 10:30							
10:30 - 11:30							
11:30 - 12:30							
12:30 - 13:30							
13:30 - 14:30							
14:30 - 15:30							
15:30 - 16:30							
16:30 - 17:30							
17:30 - 18:30							
18:30 - 19:30							
19:30 - 20:30							
Subtotal Hrs							





























Nurse in Charge: End of Shift Review

Is ECO still required	Yes/No	RN Signature:
Level of ECO required	  	
Family updated if change to ECO level	Yes/No	If no, please comment: RN Signature:
Rationale for recommended ECO level based on observations, interventions and outcomes		

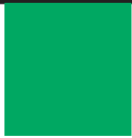


Ward:

Date:

PLEASE  level of observation as per assessed risk at each time interval

Time	ECO Level			Behaviour	Intervention	Outcomes	Initials
20:30 - 21:30							
21:30 - 22:30							
22:30 - 23:30							
23:30 - 00:30							
00:30 - 1:30							
1:30 - 2:30							
2:30 - 3:30							
3:30 - 4:30							
4:30 - 5:30							
5:30 - 6:30							
6:30 - 7:30							
7:30 - 8:00							
Subtotal Hrs							




Nurse in Charge: End of Shift Review

Is ECO still required	Yes/No	RN Signature:
Level of ECO required	  	
Family updated if change to ECO level	Yes/No	If no, please comment: RN Signature:
Rationale for recommended ECO level based on observations, interventions and outcomes		




Ward:

Date:

PLEASE  level of observation as per assessed risk at each time interval

Time	ECO Level			Behaviour	Intervention	Outcomes	Initials
8:00 - 8:30							
8:30 - 9:30							
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10:30 - 11:30							
11:30 - 12:30							
12:30 - 13:30							
13:30 - 14:30							
14:30 - 15:30							
15:30 - 16:30							
16:30 - 17:30							
17:30 - 18:30							
18:30 - 19:30							
19:30 - 20:30							
Subtotal Hrs							

















Nurse in Charge: End of Shift Review

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Level of ECO required	  	
Family updated if change to ECO level	Yes/No	If no, please comment: RN Signature:
Rationale for recommended ECO level based on observations, interventions and outcomes		




Ward:

Date:

PLEASE  level of observation as per assessed risk at each time interval

Time	ECO Level			Behaviour	Intervention	Outcomes	Initials
20:30 - 21:30							
21:30 - 22:30							
22:30 - 23:30							
23:30 - 00:30							
00:30 - 1:30							
1:30 - 2:30							
2:30 - 3:30							
3:30 - 4:30							
4:30 - 5:30							
5:30 - 6:30							
6:30 - 7:30							
7:30 - 8:30							
Subtotal Hrs							


Nurse in Charge: End of Shift Review

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Level of ECO required	  	
Family updated if change to ECO level	Yes/No	If no, please comment: RN Signature:
Rationale for recommended ECO level based on observations, interventions and outcomes		




Ward:

Date:

PLEASE  level of observation as per assessed risk at each time interval

Time	ECO Level			Behaviour	Intervention	Outcomes	Initials
8:00 - 8:30							
8:30 - 9:30							
9:30 - 10:30							
10:30 - 11:30							
11:30 - 12:30							
12:30 - 13:30							
13:30 - 14:30							
14:30 - 15:30							
15:30 - 16:30							
16:30 - 17:30							
17:30 - 18:30							
18:30 - 19:30							
19:30 - 20:30							
Subtotal Hrs							
















Nurse in Charge: End of Shift Review

Is ECO still required	Yes/No	RN Signature:
Level of ECO required	  	
Family updated if change to ECO level	Yes/No	If no, please comment: RN Signature:
Rationale for recommended ECO level based on observations, interventions and outcomes		




Ward:

Date:

PLEASE  level of observation as per assessed risk at each time interval

Time	ECO Level			Behaviour	Intervention	Outcomes	Initials
20:30 - 21:30							
21:30 - 22:30							
22:30 - 23:30							
23:30 - 00:30							
00:30 - 1:30							
1:30 - 2:30							
2:30 - 3:30							
3:30 - 4:30							
4:30 - 5:30							
5:30 - 6:30							
6:30 - 7:30							
7:30 - 8:30							
Subtotal Hrs							

Nurse in Charge: End of Shift Review

Is ECO still required	Yes/No	RN Signature:
Level of ECO required	  	
Family updated if change to ECO level	Yes/No	If no, please comment: RN Signature:
Rationale for recommended ECO level based on observations, interventions and outcomes		

Summary Sheet
Nurse in Charge to complete every 3 days

Date	Hours per day	Hours per day	Hours per day

Is there a specific pattern to the patients distressed behaviours?

Did any specific interventions help?

Management plan moving forward:

