Healthier Lancashire & South Cumbria

Enhanced Observations Request Form ***Please complete all fields***	
1 Type of Request	
Is this a new referral or a request to renew existing approved enhanced observations? *(Please check one box)*	☐ New referral ☐ Renewal ☐ Amendment
2 Sharing of Information	
Is the client and/or representative aware of the request for enhanced observation?	☐Yes ☐No
Is an advocate required?	☐Yes ☐No
3 Client Details	*Clients should be aware personal and sensitive details will only be shared when necessary. Demographics are required to administer requests and supply funding (if approved).*
NHS Number	
Date of Birth	
Current address & telephone number	
Client's GP, surgery address & telephone number	
Does this person have mental capacity regarding this request?	☐Yes ☐ No Date: ______________________
Date best interest process completed.	Date: ______________________
Details of any Deprivation of Liberty Safeguards/Court of Protection in place	☐Yes ☐ No Date: ______________________

Have you informed statutory bodies of enhanced observation changes?	☐Yes ☐ No Date: ______________________

How is the patient/service user currently being funded?	☐CHC ☐ LA ☐ Self-Funded ☐ Joint funded ☐ FNC and LA ☐ Section117 ☐ Family, Friend or Carer
What type of placement is it?	☐ Residential ☐ Nursing ☐ Dementia nursing ☐ Challenging behaviour/Specialist unit ☐ Own home with package of care ☐ Supported living
4 Referrer details	
Name: Designation: Address: Telephone: Email:	
5 Client's Diagnosis	
Unmet health needs/risks that the resource will support (Reason for request)	
6 Tried Therapeutic interventions	
Has there been any environmental triggers or change in patient/staffing which could explain a change in patient presentation?	

Has the GP or appropriate Clinician been contacted regarding the change in need?	☐Yes ☐ No Date of contact ______________________.

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Are there any actions from the GP referral? (e.g., Mental Health Services/OT and Falls Team)	☐Yes ☐ No Date of contact ____________________
Is there an outcome from the above secondary referral?	☐Yes ☐ No If yes, date of referral ____________________
And has this referral been triaged and actioned? Provide details of services currently involved.	☐Yes ☐ No Date: ____________________
Which assessments are still pending an outcome?	
Is there a date planned for any outstanding assessments to take place?	☐Yes ☐ No If yes, date of this ____________________
Has telecare / remote monitoring been considered to alert risk and reduce restrictions before this request?	☐Yes ☐ No If yes, date: _________________
Is the 1:1 being requested as part of a safeguarding concern or a DoLs condition?	☐Yes ☐ No If yes, referral source and date of request (please attach for evidence): _________________
Is 1:1 being requested as the person is awaiting detention under the Mental Health Act awaiting a Psychiatric bed?	☐Yes ☐ No If yes, date of Psychiatric assessment for recommendation _________________
Hospital discharge recommendation for 1:1?	☐Yes ☐ No

What risk is the 1:1 being requested to mitigate? How long is the request for 1:1 for? What is the onward plan following discharge? Please attach relevant evidence	
What support is currently involved (please provide details of this support and advice given if applicable) E.g. Community Health Teams Private care agency Voluntary services Family and friends	
Does the individual have regularly scheduled activity/visits/support? Is the individual cared for in a visible area? Is there a carer/staff member present in the communal areas if the individual accesses this area? Are any other individuals in receipt of 1:1 care? Has sharing this resource been considered? If not, why? Rationale required.	
Is there an immediate risk of harm to self/others? Does the person require admission to Hospital? (for either physical or mental health needs ?)	
8 Outcomes	
If approved, how will the outcomes be measured?	
What is the plan to reduce the 1:1? Please provide this detail and how this is proposed to be implemented.	
9 Proposed providers of enhanced observations	
○ Own staff ○ Care agency (Please identify the agency to be used)	

10 Request Details:	
Anticipated length of time enhanced observations required	
Anticipated skill required to provide observations	○ RMN/RGN ○ Care support worker ○ Senior carers ○ Other (please specify)
11 Cost:	
Number of initial hours of enhanced observations covered by provider	
Anticipated hourly rate for enhanced observations	

Prior to submission, please ensure that the following evidence is included with this referral:

- **48-hour activity log**
- **Enhanced Observation care plan**
- **Current risk assessment**
- **Any referenced professional reports**

Name of referrer:		
Signature of referrer:		
Date submitted:		
Please return this form to: **(Note to practitioner**: Please ensure the provider knows the appropriate Health or social care commissioner for the services in place.)		
Funding approved – yes/no		
Reason(s) for non-approval		
Further action/information required		
Authorising Signature	*Print Name*	*Date*