**Patient Name: Pt. Number: Ward:**

Assessment to support the prescribing of **Therapeutic Enhanced Supervision** for Patients

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| --- | --- | --- | --- | --- | --- | --- |
| **Risk of Falls** | **At risk of getting up unaided or attempting to leave the ward** | **An episode of increasing confusion/delirium/**  **dementia** | **Other clinical risks** | **Score** | **Level of observation** | **Menu of possible interventions** |
| **Patient not deemed as a Falls risk as per initial falls risk assessment** | **Patient is independently mobile around ward area** | **No identified confusion or delirium** | **Clinically stable** | **No risk** | **Usual ward based observation** | **-No need for further assessment unless condition deteriorates, or any change in clinical treatment plan** |
| **0** | **0** | **0** | **0** |  | **0** |  |
| **Patient identified as being at risk of falls. No history of actual inpatient Falls.** | **Limited risk to patient health / safety if they were to abscond** | **Mild to moderate confusion. Patient requires regular reassurance and reorientation to ward area. Can be agitated or restless.** | **Patient is at low risk of deterioration**  **Patient has a learning disability/autism but able to function independently and verbalise needs** | **GREEN**  **Level 1**  **Some risk** | **Intermittent observation** | **-Additional Family support, open visiting times,**  **This Is Me document/board or Hospital Passport**  **-Consider re-location of patient in area of high visibility and falls toilet**  **Use available equipment to minimise risk**  **-Maintain intentional rounding – hourly day, 30mins at night**  **- Review medications with Doctor and Pharmacist**  **-Communicate and escalate at safety huddle**  **-Nurse in Charge to inform Ward Sister/Charge Nurse**  **Capacity assessment & consider an Urgent DoLS authorisation** |
| **1** | **1** | **1** | **1** |  | **<4** |  |
| **Patient identified as being at risk of falls with one or more of the following:**  **An actual fall has occurred**  **Patient is impulsive and/or non-compliant in using nurse call bell.**  **GREEN level interventions have not made the patient safe.** | **Patient is wandering.**  **Patient with dementia-walking with a purpose.**  **Consider DOLS/MHA assessment and document decision outcome** | **Moderate confusion. Frequently agitated and restless or requires regular reassurance and reorientation to the ward environment**   * **At risk of pulling out an indwelling device** * **Unable to make needs known** * **Expressive dysphagia** | **Patient is acutely unwell with elevated NEWS score and requires additional nursing care to maintain safety.**  **Patient is at risk of deterioration eg seizures, declining medical treatment**  **Patient has a learning disability/autism – needs some support and unable to verbalise needs** | **AMBER**  **Level 2**  **Moderate risk** | **Within eyesight** | **-Relocation of patient in area of high visibility & identified falls toilet**  **-Cohorting of at risk patients-1 staff member per bay using current staffing levels**  **-Confirmation of patient safety at regular 15-30minute intervals**  **-Communicate and escalate at safety huddle**  **-Use available equipment to minimise risk**  **-Refer to action cards**  **-Request additional family support, open visiting times**  **-Commence patient engagement activities**  **-Capacity assessment and Urgent DOLS authorisation +/- Mental Health assessment**  **-Review medications with Doctor and Pharmacist**  **-Refer to management of delirium policy**  **-Ward sister/charge nurse/nurse in charge to inform Matron (in-hours) Site team (out of hours)**  **-Consider referral to Safeguarding/ MCA for advice** |
| **3** | **3** | **3** | **3** |  | **4-12** |  |
| **Patient is identified at significant risk of falls with serious harm and one or more of the following is present.**   * **All amber actions have been attempted but risk remains** * **An actual fall with harm has occurred** | **Patient is wandering and/or standing unaided and attempting to leave the ward.**  **Serious risk to patients health and safety if they were to abscond**  **Consider DOLS/MHA assessement and document decision outcome** | **Severe confusion with regular episodes of agitation, violent behaviour and/or aggression towards staff, other patients or relatives.**  **Psychosis** | **Patient requires 1:1 care to maintain safety e.g. Severe alcohol withdrawal, airway comprised, and risk of self-harm.**  **Unstable mental health**  **Patient needs continuous enhanced observation/intervention**  **Profound learning disability requiring fall nursing support and unable to verbalise needs** | **RED**  **Level 3**  **High risk** | **Continuous observation** | **-Implement 1:1care – consider if this can be managed with current staffing in the first instance. And/or support of family/carers.**  **-If staffing levels cannot be used escalate to matron**  **1:1 security maybe required if violent/highly aggressive or unpredictable aggression. Inform Head of Security and Matron and consider side room**  **Capacity assessment and DOLS authorisation, Mental Health assessment, seek advice from safeguarding lead, mental health liaison**  **-Communicate and escalate all TEC patients at safety huddle/safety brief**  **-Refer to action card for therapeutic care**  **-Assess capacity to self-discharge if no DoLs in place**  **-Refer to management of delirium policy**  **-Ward sister/charge nurse/nurse in charge to inform Matron (in-hours) site co-ordinator (out of hours)**  **-Utilise patient engagement activities**  **-Review medications with Doctor and Pharmacist** |
| **12** | **12** | **12** | **12** |  | **>12** |  |

**Risk Assessment Tool Guidance**

* The assessment tool should be completed on every patient over the age of 16 admitted to SFT on admission and MUST be completed within 12 hours of admission to each ward area the patient is transferred to.
* The assessment tool should be reassessed on change of condition or change of treatment plan for patients deemed at no risk.
* The assessment should be reassessed daily on **Green,** **Amber,** or **Red** or on any change in condition or treatment plan.
* Following calculation of the score all interventions should be documented within the plan of care.
* Use this assessment as a Decision aid if you are requesting an enhanced care special – and reassess and document each shift.
* In some circumstances where a patient scores green or amber, 1:1 care may still be required (such as an isolated patient with a tracheostomy) – discuss with Matron/Head of Nursing for advice.
* Remember this is a decision aid and does not replace professional judgement by a Matron, Sister or Nurse-in-charge (who may decide to escalate or de-escalate). These decisions should be validated by the Matron next working day.
* Out-of-hours – assessment, deployment and de-escalation of a 1:1 is the responsibility of the nurse-in-charge. Clinical site team are available for advice and support.
* Remember capacity assessment for admission, treatment & care and to authorise an urgent DoLS in cases where an individual may be at risk of being deprived of their liberty with the deployment of 1:1.DoLS . The patient may also require a mental health assessment– Contact the Matron or the Adult Safeguarding Nurse or Mental Health Liaison team for advice.