# Action Card 1

The Staff providing Enhanced Supervision:

* You may be expected to stay with the patient or group of patients at all times; you must inform the Nurse In Charge if you intend to leave the patient(s) for any reason, so temporary cover can be provided.
* You will be expected to actively contribute to the patient’s daily needs e.g.: washing, dressing, shaving, combing hair, offering and supervising drinking and eating, toileting and emptying commode or catheters, complete fluid and food charts.
* If you are a RN/RMN/Nursing Associate you will also be expected to carry out medicines management within your competencies along with all aspects of clinical observations and escalation.
* You are expected to:
* Receive an induction to the clinical area including the location of emergency equipment, bleep system and ward escalation process
* Have a hand over of the care required for the patient. This will include the patient’s clinical history, ‘This is Me’ or Learning Difficulty Hospital Passport (if relevant), background, specific risk factors and the patient’s care plan
* Engage and involve the patient in therapeutic activities
* Engage and involve the patient’s next of kin or family as appropriate
* Fully complete all relevant documentation
* Comply with the Trust uniform policy
* You are not expected to:
* Sleep on duty
* Read books/magazines unless this is for the patient benefit
* Eat or drink by the patient’s bedside
* Use a mobile phone or other electronic device not issued by SFT

# Action Card 2

The staff providing Enhanced Supervision should consider the following therapeutic activities

After completing a risk assessment (appendix 1) therapeutic activities must be considered, used alongside the actions outlined in the risk assessment and be tailored to the patient’s clinical condition. This means that some patients might require more passive activities such as reading to the patient, holding a hand or listening to music if the patient is unwell or they may need more stimulating activities if frequently drowsy or physical activity if they have a lot of energy. If a patient is becoming more agitated, suspicious or threatening then they may need moving to a lower level of interaction or stimulation.

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| Cognitive Activity:  Reading a newspaper or book together; completing crossword/quiz/jigsaw/ward activity box  Consider use of RITA system ( Contact Spire and Durrington wards)  Additional family support e.g. relaxed/open visiting times  Magic table (Spire / Farley) | Physical Activities:  Walking around the ward or off ward if safe to do  Moving from bed to chair;  Encouraging patient to eat, dress and wash independently – provide assistance as required  Relocation of patient in area of high visibility & identified falls toilet.  Use exercise programme on the RITA system  Magic table (Spire / Farley) |
| **Social:**  Talk with patients about current affairs, family, pets, hobbies, television programmes.  Encourage patient with hot drinks  Encourage family and friends to visit  This is Me’ document; Hospital Passport | **Calming:**  Music  Reduce the noise levels particularly at nights.  Read to the patient especially their favorite book  Review medications with pharmacist and doctor |

# Action Card 3

Actions for Reducing the Risk of Aggression or Violence

* Have a calm, relaxed and respectful attitude
* Allow the patient to verbalise and express themselves and empathise and demonstrate an understanding of their feelings, don’t be afraid to say sorry. Patients need to be listened to
* Use simple words and short sentences
* Encourage the use of strategies to reduce or channel feelings of irritability (reading, writing, listening to music, etc.)
* Avoid confrontation and arguments
* Move slowly, avoid sudden and spontaneous gestures
* Allow the patient to talk with a friend or family member on the phone.
* Reduce stimulation (lights, noise)
* Make contact with the patient through eye contact, tone of voice and touch (dementia)
* Be mindful of your own non-verbal communication, this can often be a catalyst for behaviours to escalate
* Ensure patient has adequate amount of personal space and inform them of your role and intended action every time you approach them more closely
* Monitor any triggers that cause a change in behaviour, examples include personal care, gender, staff uniforms, entering their personal space – this list is not exhaustive
* Escalate to the nurse in charge at the earliest opportunity as behaviours increase.
* Ensure that the patients clinical records are completed to provide a comprehensive account of the situation in a factual manner
* Encourage open visiting and involvement of family and friends
* Consider use of ABC charts to monitor and evidence challenging behaviours

# Action Card 4

Actions for Reducing Risk of Falls

* Make sure the environment is safe (clutter, trip hazards, non-slippery floor)
* Ensure the patient has had a falls risk assessment completed and risks actioned
* Ensure the patient has appropriate footwear
* Encourage the patient to use any recommended walking aids
* Consider use of hip protectors
* To protect and soften impact to vulnerable body areas, consider carrying a pillow when mobilising with patient to protect head if they fall
* Identify with the patient ways to reduce stress and anxiety
* Accompany the patient in a problem-solving process

# Action Card 5

Actions for Patient at Risk Trying to Leave the Ward

* During care, try to respect the person’s routines and life habits. (Read the patients LD Hospital Passport or This is Me document or encourage patient, family or carer’s to complete these where appropriate)
* Try to understand the reasons behind the patient wanting to leave: anger and frustration, anxiety, pain, looking for something, forgetting where they are or why they are there, etc. validate their feelings, wanting to end their life
* Address identified needs and document the outcome to support other staff in the provision of care
* Ensure you have a good description of the patient and what they are wearing on each shift
* Occupy the patient with activities s/he knows: reading, folding laundry, games, RITA system, TV likes, Magic table (on Spire / Farley) etc
* Encourage independence through this therapy approach using daily skills such as washing, brushing teeth and brushing hair, doing daily activities
* If the patient becomes agitated inform the nurse in charge immediately
* If appropriate consider open visiting for those that would benefit from a friend or family member being with them
* Review medications- are mood stabilisers/ dementia/ mental health medications they being taken regularly? If not, consider Covert Medication utilizing appropriate policy
* If actively trying to leave, remind patient of the reason they are in hospital and our legal duty to keep them safe. If distraction and discussion routes not successful discuss with medical team option to offer medication to reduce arousal and further escalation. Medicines should be last option.
* Consider multiprofessional review & care plan (Nurses, Clinicians, MCA Lead, MHLT, Social Care)

# Action Card 6

Actions for Patient at Risk of Suicide

* Remove unused medical equipment and any ligature risks
* Allow for the open expression of feelings without judgement
* Encourage the patient to contact family and loved ones
* Encourage the patient to call for help if suicidal thoughts intensify
* Identify with the patient ways to reduce stress and anxiety
* Accompany the patient in a problem-solving process
* Encourage the patient to contact family and loved ones if appropriate
* Ensure a referral is made to Mental Health Liaison team
* Ensure medicines are locked away
* Ensure any administered medicines are swallowed
* Be aware of items that could be used as a ligature
* Notice and document any signs of increasing risk or distress, for example more agitated, more withdrawn, more occupied
* Escalate to Nurse in Charge if suicidal thoughts intensify or if you are concerned that the risk is increasing

**Action Card 7**

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