

# Enhanced Supervision Framework Patient record

## Patient Addressograph

Date of Admission \_\_\_\_\_  
Ward \_\_\_\_\_

## Page number

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15-16	Enhanced supervision review

## Instructions

1. This document should be used for all patients requiring enhanced supervision.
2. "Read About Me" **must** be completed in conjunction with use of this document.
3. For **all** patients under enhanced supervision please provide carers/relatives with the information leaflet.



GIG  
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Caerdydd a'r Fro  
Cardiff and Vale  
University Health Board

# Enhanced Supervision Framework Patient record

## Patient Addressograph

Date of Admission \_\_\_\_\_

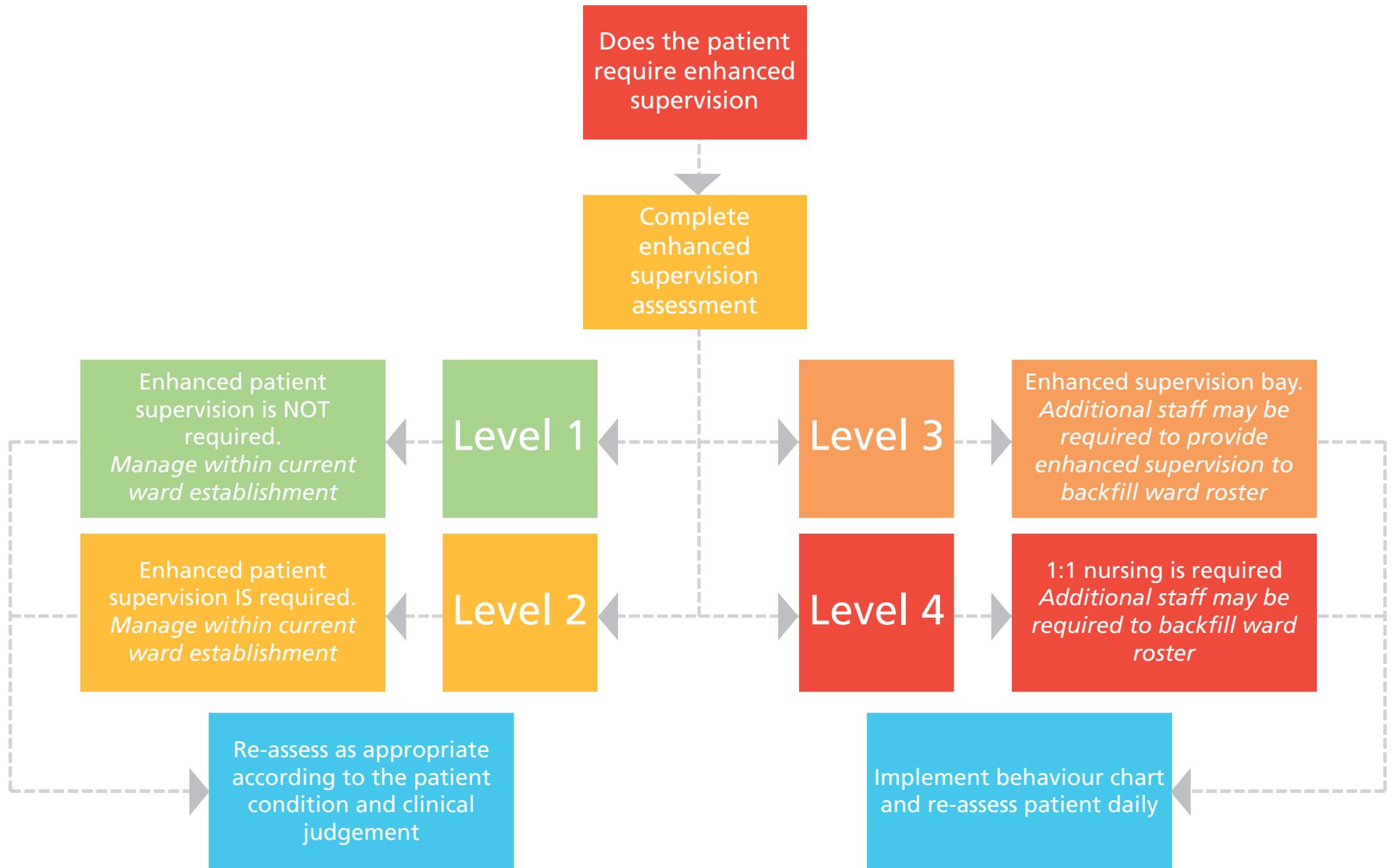
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# Enhanced supervision framework



# Enhanced supervision framework level 1 and 2 (V1.2 Jan 2018)

Level Descriptor	Descriptor of patient's behaviour	Enhanced Patient Support and Supervision Plan
<p><b>LEVEL 1</b>  <b>Enhanced patient SUPERVISION is NOT REQUIRED</b></p> <p><i>Manage with current ward establishment</i></p>	<p>The patient has predictable and safe behaviour towards self, others and environment.</p> <p>No concerns regarding risk to well-being.</p>	<ol style="list-style-type: none"> <li>1. Regular open and informative communication with patient and family/ carers.</li> <li>2. Routine observations and two hourly intentional rounding.</li> <li>3. Routine contact with staff for planned drug rounds, meal times and drinks rounds.</li> </ol>
<p><b>LEVEL 2</b>  <b>Enhanced patient OBSERVATION is REQUIRED</b></p> <p><i>Manage with current ward establishment</i></p> <p>The patient displays mainly predictable behaviour with occasional unsafe behaviour (which is not expected to result in serious harm) or is at avoidable risk of mild levels of ill-being.</p> <p>Unknown behaviour, triggers easily de-escalated.</p>	<p>Occasional unsafe behaviour such as mobilising alone and unsafely.</p> <p>Can slip/fall from bed.</p> <p>Reduced mobility or bedbound and attempting to mobilise</p> <p>Calling out &amp; disturbing other patients.</p> <p>Low risk of pulling out any indwelling devices.</p>	<ol style="list-style-type: none"> <li>1. Regular open and informative communication with patient /family/ carers. Give carer information leaflet. Tick box- <input type="checkbox"/></li> <li>2. Consider moving patient to a more visible area on the ward.</li> <li>3. Consider undertaking a mental capacity assessment/DoLS and document in nursing evaluation.</li> <li>4. Increase intentional rounding and patient contact to 1 hourly.</li> <li>5. Consider pathways such as alcohol detoxification.</li> <li>6. Ensure flexible visiting is encouraged and encourage family to assist with personal care and at meal times as appropriate.</li> <li>7. Consider patient activity where assessed as appropriate and use volunteers to support staff.</li> <li>8. Undertake a multi factorial falls assessment and consider use of falls alarms, high / low beds and crash mats.</li> <li>9. Consider undertaking behaviour monitoring chart to help develop creative solutions for managing behaviour challenges.</li> <li>10. Obtain life history -complete Read about Me. Tick box- <input type="checkbox"/></li> <li>11. Complete pain assessment and administer analgesia if required.</li> <li>12. In conjunction with the medical team review patient to rule out organic cause of confusion and review medication.</li> <li>13. Refer/request support from LPOP HCSW team</li> </ol>

# Enhanced supervision framework level 1 and 2 (V1.2 Jan 2018)

Level Descriptor	Descriptor of patient's behaviour	Enhanced Patient Support and Supervision Plan
<p><b>LEVEL 3</b> <b>Enhanced Supervision bay</b></p> <p><i>Additional staff may be required to provide enhanced supervision; this is observation of patients / engaging in activities, does not include providing personal care as patients cared for in this bay must be observed at all times.</i></p> <p>The patient displays infrequent, unpredictable, (potentially) unsafe behaviour towards self, others and/or the environment although such behaviour is NOT EXPECTED to result in serious harm.</p> <p>Unknown behaviour triggers, but can easily be de-escalated.</p>	<p>Cognitively impaired and unsafe mobilising presenting risks to self and others.</p> <p>High risk of pulling out any indwelling devices</p> <p>Moderate Agitation / Anxiety</p>	<p><b>All interventions for Level 2 Plan. In addition:</b></p> <ol style="list-style-type: none"> <li>1. Complete behaviour monitoring chart.</li> <li>2. Complete supervision risk assessment on Clinical Work Station.</li> <li>3. Consider need for enhanced supervision bay, and whether this is to be conducted utilising the current ward staffing, consideration must be given to the acuity and dependency of the ward.</li> <li>4. Consider whether patient can be moved to appropriate enhanced supervision bay in another ward.</li> <li>5. Consider one to one care (from existing ward skill mix) during periods of unpredictable, unsafe behaviour.</li> <li>6. Consider appropriateness of patient joining activities on adjacent wards or within Day Hospitals.</li> <li>7. Consider referral to relevant specialist service (e.g. Occupational Therapist, Liaison Psychiatry team).</li> <li>8. Request for additional staff must be discussed and approved by Senior Nurse.</li> <li>9. Nurse in charge must review requirement for cohort supervision every 24 hours and discuss with Senior Nurse.</li> <li>10. Lead nurse must review requirement for enhanced supervision bay after 48 hours and frequency of further review will be determined by Lead Nurse.</li> </ol>
<p><b>LEVEL 4</b> <b>1 to 1 Nursing</b></p> <p><i>Additional staff may be required.</i></p> <p>The patient displays:</p> <ol style="list-style-type: none"> <li>1. Frequent, unpredictable, unsafe behaviour towards self, others and /or the environment; or</li> <li>2. Infrequent, unpredictable, actual or potentially unsafe behaviour towards self, others and/or the environment which it is expected may result in serious harm; or</li> <li>3. Is at avoidable risk of significant harm. Can't de-escalate.</li> </ol>	<p>Cognitively impaired and unsafe mobilising presenting risks to self and others.</p> <p>Violent behaviour &amp; aggression to others and self.</p> <p>Immediate risk to self/harm to others. Substantial &amp; immediate risk of absconding.</p> <p>Expressing intent or recently attempted to self-harm/suicidal ideation.</p> <p>Under Mental Health Section</p>	<p><b>All interventions for Level 2/3 Plan. In addition:</b></p> <ol style="list-style-type: none"> <li>1. Reassessment of continued requirement for Level 4 at every shift with medical review as required (at a minimum of 48hrs or more frequently if condition changes).</li> <li>2. Lead nurse must review requirement for enhanced supervision 1:1 Nursing after 48 hours and frequency of further review will be determined by Lead Nurse.</li> <li>3. Consider use of RMN – must be discussed with Lead Nurse before RMN is requested.</li> <li>4. Request for additional staff must be discussed with and approved by Senior Nurse.</li> <li>5. Lead Nurse to escalate concerns relating to patient risk management to Clinical Board Nurse Director.</li> </ol>

# Behaviour Chart (V1.4 May 2018)

**1. Assessment** (please tick and sign)

Level 2

Level 3

Level 4

Signature of registered nurse-

Date/Time-

2. Complete the behaviour chart to reflect patient behaviour and trigger points (this could be as frequent as half hourly depending on the patients' condition)
3. Ensure it is signed and dated.
4. Assess patient daily against the framework, record on the behaviour chart and discuss with the ward sister.
5. Rationale for de- escalation MUST be documented clearly in the patient nursing/medical notes.

Time and date	Describe what the patient is doing	What actions did you take to engage with the patient?	How did the patient respond to you?	Signature of person supervising	Print Name
10:00 11/11/2017 Example	Mrs X is pacing in the corridor and attempting to leave the ward when the doors are opened	Encouraged to come with staff to the day room and Mrs X was assisted to choose a magazine, which she sat and read for half an hour	Pt was calm whilst in the day room with her magazine, but when the member of staff left, she again became wandersome and started pacing in the corridor again		

Time and date	Describe what the patient is doing	What actions did you take to engage with the patient?	How did the patient respond to you?	Signature of person supervising	Print Name

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Specific information to support the plan of care for enhanced supervision (in addition to core care plans)

Care plan number	What is the Identified Problem?	What are the prescribed actions?	Signature
	<p>What is the Identified Problem?</p> <p>Behaviour Falls Risk Pulling at Lines Is increasing risk to the safe delivery of care.</p> <p><b>Desired Outcomes:</b></p> <ul style="list-style-type: none"> <li><input type="checkbox"/> To reduce risk to patient.</li> <li><input type="checkbox"/> Ensure Dignity is maintained at all times.</li> <li><input type="checkbox"/> Ensure Individualised care is provided while under enhanced monitoring.</li> <li><input type="checkbox"/> To meet patient needs using the least restrictive principles</li> </ul>	<p><b>Behaviour (eg: Agitation, Anxiety, Aggression)</b> <i>E.g. Intervention required to manage patient's behaviour. Refer to "Read About Me" for patients' usual routine.</i></p> <p><b>Falls Risk</b> <i>E.g. Interventions required to minimise risk of falls of the patient while under enhanced monitoring</i></p> <p><b>'Pulling at lines'</b> <i>E.g. Interventions required to minimise risk</i></p>	

# Enhanced Supervision Review

Time and date	Designation	Current Level	Reasons for initiation or de-escalation of enhanced supervision	Re-assessed level as...	Sign and Print Name
<b>Example</b> 18/04/2018 @ 0740	Senior Nurse	Lv4	Patient behaviour settling at night, not requiring any further interventions apart from personal care as per intentional rounding. Behaviour not displaying any risky behaviour. On low rise bed, sensor mat now in place. Continue behaviour chart.	Lv3	A. Nother

Time and date	Designation	Current Level	Reasons for initiation or de-escalation of enhanced supervision	Re-assessed level as...	Sign and Print Name