GUIDELINE

Reference Number	GUID/N&Q/0045
Title	In-Patients at Risk of a Fall
Version Number	2.0
Document Type	Guidance
Original Policy Date	September 2015
Review & Approval Committee	Safety Committee Integrated Quality Assurance Committee
Approval Date	21st February 2017
Next Review Date	21st February 2020
Originating Directorate	Integrated Adult Care Group
Document Owner	Sue Day Clinical Services Manager Durham Dales
Lead Director or Associate Director	David Bruce
Scope	Trust-wide
Equality Impact Assessment (EIA) Completed on	8.7.15
Status	Approved
Confidentiality	Unrestricted
Keywords	Supervision, fall

Ratification

Signature of Chairman of Ratifying Body	
Name / Job Title of Chairman of Ratifying Body:	Prof Chris Gray, Executive Medical Director
Date Ratified	21st February 2017
Signed Copy Held at:	Corporate Records Office, DMH

VERSION CONTROL TABLE

Date of Issue	Version Number	Status
September 2015	1.0	Superseded
February 2017	2.0	Approved

TABLE OF REVISIONS

Date	Section	Revision	Author
January 2017	All	Guidelines reviewed following the introduction of Appendix 7 Patient Information Leaflet	Sue Day

CONTENTS

1 INTRODUCTION

By 2030, one in five people in England will be aged over 65 years. Each year one in every three adults age 65 and older falls. Falls can cause moderate to severe injuries, such as hip fractures and head injuries, and can increase the risk of early death.

Patient falls have both human and financial costs. For individual patients, the consequences can range from distress and loss of confidence, to injuries that cause pain, suffering, loss of independence and delays in discharge.

For NHS organisations patient falls can incur additional costs relating to extra treatment, increased length of stay, complaints and in some cases litigation. The cost for immediate healthcare treatment alone was estimated at £15 million per annum in 2007.

Available evidence suggests that “sitters” contribute little to falls prevention programs. Two studies from Australia had mixed results, however neither of these studies described the training or education provided to paid sitters. Whilst these suggest a questionable effect on falls rates, studies that involve increased observation and surveillance by nursing staff appear to have a more consistent positive effect on falls rates.

2 PURPOSE

The purpose of this guideline is to provide a standardised framework which outlines best practice for the supervision of patients at risk of falling using assessment criteria to ascertain the level of supervision required, clear expectations on the role of the nurse providing the supervision and a de-escalation pathway to reduce or withdraw the supervisory care.

Commonly referred to as “specialling” close observation of patients although widely used nationwide, has very little published within general nursing referring to the criteria and triggers used for its commencement or de-escalation.

This guidance applies to adult patients 18 years and over who are eligible for inpatient hospital care.

3 SCOPE

All nursing and allied health professionals working within County Durham and Darlington NHS Foundation Trust

4 DUTIES

The Trust Board and Chief Executive have ultimate responsibility for overseeing the implementation of this guideline. The Chief Executive has delegated responsibilities to the following:

4.1 Executive Director of Nursing

The Executive Director of Nursing is the Board level Director responsible for Health and Safety in the Trust and for monitoring the implementation of this guideline

4.2 Directors, Heads of Service and Care Group Managers

Directors, Heads of Service, and Care Group Managers are responsible for the implementation and dissemination of this policy in their areas. This involves the following key responsibilities:

- Identify and allocate resources to implement this guideline in their areas of responsibility.
- To monitor and ensure compliance of this policy within their areas of responsibility

4.3 Ward Managers, Matrons and Heads of Departments

Ward Managers, Matrons and Heads of Departments are responsible for implementing and monitoring this policy within their wards/departments. This involves the following key responsibilities:

- Ensure any resource implications are highlighted
- Ensure compliance with this guideline within their areas of responsibility
- Ensure that this guideline is used in conjunction with the trust policy for the management falls involving inpatients.
- Ensuring that appropriate training, support and advice is given.
- Monitoring the application of these guidelines in practice.

- Identifying and communicating when changes to this guideline are needed according to changes in practice, to Trust policy or national recommendations.

4.4 Nursing Staff

Nursing Staff must ensure the safety of patients and self and that appropriate assessments are in place. This involves the following key responsibilities:

- Compliance with this guideline. Failure to comply may result in disciplinary action being taken.
- Co-operating with the development and implementation of policies and procedures as part of their normal duties and responsibilities.
- Identifying the need for a change in policy or procedure as a result of becoming aware of changes in practice, changes to statutory requirements, revised professional or clinical standards and local/national directives, and advising their line manager accordingly.
- Identifying training needs in respect of policies and procedures and bringing them to the attention of their line manager.
- Attending training / awareness sessions when provided.

5 SUPERVISION

Observation of patients is an important part of day to day nursing activity, which enables the multi-disciplinary team to assess patients and their progress. It is recognised that patients require varying degrees of observation and supervision depending upon their identified needs, behaviour and current nursing risk assessments.

Observation is an important skill for all nurses, but skilled supervision calls for empathy and engagement combined with a readiness to act. The following mnemonic underpins compassionate care based on empathy, respect and dignity which links to the trust's aim of providing dignity for all patients.

Staff who are skilled and have time to care: by identifying the training/orientation and requirements of staff whilst performing supervision.

Partnership working with family and carers: by involving and discussing the need for supervision.

Assessment and early identification: by the completion of the relevant supervision level criteria.

Care plans which are person centered and individual: by the use of a 24 hour diary and process with daily review.

Environments that are dementia friendly: by linking to the dementia strategy and ultilisation of the activity/memory box.

Supervision is one tool that can be used to reduce the risk of a patient falling. Others include the use of equipment for example Hi/Lo beds and bed/chair sensors and alarms. Guidance on the use of this equipment is described in the Policy for the Management of Falls Involving Patients. The use of safety huddles also has an important role in preventing falls and assessing why falls occur and prevent them from happening again.

Supervision when implemented correctly enables observation and the ability to learn about the patient(s) being supervised which can be used to inform care planning and de-escalation. In most instances cohort or 1:1 supervision is required for a time limited period. A 24 hour diary (appendix 4) should be used to document observations, behaviour, interactions with others and reactions to situations or activities during supervision.

By its very nature supervision can be deemed as restricting patient(s) movement by preventing patient(s) from leaving a clinical area. Therefore cohort and 1:1 supervision can now be identified as a potential deprivation of liberty (DOL) within the new legislation and whilst patients are at risk and require this level of supervision a DOL application should be made.

These guidelines will describe 3 levels of supervision which will be applicable to all adult in-patients who are deemed to be at risk of a fall. They should be used in conjunction with the trust's policy for the management of falls involving patients.

5.1 Supervision Levels

Level 1: Intermittent Supervision

Definition: Patients who require documented observation, supervision and intervention at pre-determined intervals of time.

This group of patients will be assessed as being at risk of a fall using the trust falls bundle. Intermittent Supervision is carried out using individualised care rounds. Clinical judgement should be used to determine the level of risk and frequency of individualised care rounds required. However patients assessed as being at high risk of a fall should have as a minimum hourly individualised rounds during the day and two hourly overnight utilising the high risk individualised round sheets within the falls bundle. The frequency of rounds required for each patient should be communicated within the ward team at handovers, board rounds and safety huddles.

Intermittent Supervision Criteria

Any patient with a positive trigger on the falls risk assessment which initiates the implementation of the trust falls policy and a falls prevention care plan.

Level 2: Cohort Supervision

Definition: Supervision of a group of patients in a designated room or bay

This group of patients will be clinically assessed as being at high risk of a fall and deemed unsafe to be left unsupervised. These patients should already be on hourly high risk individualised care rounds.

The decision for cohort supervision and the reasons for its application should be clearly identified and documented by 2 Registered Practitioners using the level 2 cohort supervision assessment criteria in appendix 1 which will indicate the criteria used to trigger its commencement. Whenever possible the patient and/or family should be involved in the decision making process and provided with information leaflet.

The requirement to continue or de-escalate cohort supervision should be reviewed at least every 24 hours at handover, board round or safety huddle and clearly documented in the patient's notes the rationale for change.

Cohort supervision may be required throughout the 24 hour period, or during defined times when patients are assessed as being more at risk of a fall due to behaviour, activity or the time of day. The details of this should be clearly indicated in the patients' care plan.

Cohort supervision can be very intense for the person supervising and should therefore be allocated to staff on a rotating hourly basis. Staff should not leave the area until the person relieving them has arrived.

Level 3: 1:1 Supervision

Definition: Constant 1 nurse to 1 patient supervision.

This is the most intense level of supervision and should only be instigated for patients deemed as being at high risk of falls and unsuitable due to the level of risk to have cohort supervision. These patients should already be on hourly high risk individualised care rounds.

The decision for 1:1 supervision and the reasons for its application should be clearly identified and documented by 2 Registered Practitioners using the Level 3: 1:1 supervision assessment criteria in appendix 2 which will indicate the criteria used to trigger its commencement. Whenever possible the patient and/or family should be involved in the decision making process and provided with information leaflet.

The requirement to continue or de-escalate 1:1 supervision should be reviewed at least every 24 hours at handover, board round or safety huddle and clearly documented in the patients notes.

The patient's care plan should detail the interventions required to meet the patients' needs including the times of the day that 1:1 supervision is required. This should be updated as the patient's condition and requirements change.

The nurse in charge of the ward will be responsible for determining the level of nursing skills required and allocation of nurses on a rotating hourly basis to carry this out. Issues of privacy, dignity and consideration of gender in allocating staff may need to be incorporated in the decision making process in some situations.

5.2 Requirements of Registered Nursing Staff When a Decision to Implement Level 2 Cohort or Level 3 1:1 Supervision

When a decision to implement cohort or provide 1:1 supervision the following should be completed and documented:

- Complete appropriate supervision level assessment criteria sheet in appendix 1 or 2 of this guideline. This should then become part of the patients notes.

- Ensure the nurse allocated to complete cohort or 1:1 supervision has the appropriate skills, has received an adequate handover and is made aware of any specific risk factors.

- Ensure copies of the 24 hour diary template (appendix 3), 24 hour diary completion guidance notes (appendix 4), behavioural guidance for 24 hour diary completion (appendix 5) are available at the bedside of each patient receiving cohort/1:1 supervision.

- Highlight the "this is me" document (s) and hospital passport (for learning disabilities if appropriate). Ensure the member of staff

completing cohort or 1:1 supervision has read it to provide background information about the patient(s) being supervised.

- Consider the ultilisation of memory/activity box and ask family/carers to bring in their own.
- Update the patient's care plan detailing the type supervision to be implemented and what times of the day this is required.
- Discuss with the patient's next of kin/family the decision and rationale for implementation and ensure the appropriate patient information leaflets are supplied (appendix 6 and 8).
- Ensure a medication review is carried out.
- Ask the patient's family to complete the "This is me" document (if not already done) and suggest development of the patients own memory box.
- If appropriate refer the patient to the Mental Health Liaison Team (MHLT) if not already completed.
- Complete the AMTS and delirium screen (if not already completed) and ascertain if the patient's behaviour is a temporary delirium or deterioration in cognition.
- Seek a physiotherapy review to assess patient gait and requirement /safety of any assistance aids.
- Ensure a deprivation of liberty application is completed.
- For patient(s) requiring cohort supervision ensure a risk assessment is documented on the suitability of the patient(s) being left in the toilet alone.
- Consider trigger factors which can result in patients wandering (in useful related documents page 22.
- A risk assessment should be completed on whether the patient is deemed safe to be left alone in the toilet area and any specific actions that are required. This should be clearly documented in the patient's care plan.

5.3 Expectations of Staff Whilst Performing Cohort or 1:1 Supervision

Following a decision to implement cohort or 1:1 supervision the following should be completed and documented:

- Provide essential care needs for the assigned patient(s) obtaining assistance when necessary to maintain patient safety.
- Record and document patient observations.

- Observe and engage with patient(s), attempt to orientate them to time and place where appropriate and carry out diversional activities if at all possible using any available appropriate activity equipment for example books, talking books, newspapers, playing cards or games, puzzles or newspaper/magazine. Consider utilisation of memory box/memory box.

- Encourage diet and fluid intake and record appropriately.

- Give any assistance required with diet and fluids ensuring fluid balance and food intake charts are kept up to date and accurate.

- Promote continence and provide any assistance with toileting requirements requesting assistance when necessary to maintain patient safety.

- Complete 24 hour diary (appendix 3) detailing the patient(s) behaviour, interactions with others and reactions to situations or activities. Guidelines for completion are in appendix 4 & 5.

- Ask for assistance as required.

- Complete all required documentation for example: nursing evaluation, individualised care rounds, positional change and pain charts.

- Report any change in condition to the Registered Nurse responsible for the patients care that shift.

- Participate in the 24 hour review, safety huddle or board round.

- Rotate with other staff in the clinical area on at least an hourly basis.

- Keep the bed space(s) clean and clutter free to prevent trip hazards.

- Do not leave the area until the person relieving you has arrived.

- Consider the trigger factors which can result in patients wandering if applicable (appendix 7).

5.4 Assessing Future Needs and De-escalation

Planning and risk assessment is required to de-escalate from increased supervision levels to maintain patient safety, meet patient / family / carers / care home expectations and inform future care needs

De-escalation is an important phase of the patient's care and treatment pathway and carries inherent risks. However documented risk assessments and discussions in the multi-disciplinary arena including families and carers will aid safer decision making.

With some patients and families the consequence of not planning a de-escalation phase may result in increased dependence, loss of confidence, longer length of stays and the inability to plan future care needs.

Two registered practitioners must be in agreement that de-escalation can take place and the rationale for this decision must be documented in the patients notes.

General principles for De-escalation:

- Use the 24 hour diary to review levels of aggression / drowsiness / increased confusion / alertness / lucidness / to ascertain an overview of behaviour, interaction with others and reactions to situations and activities to inform a plan for safe de-escalation of supervision. Consider a reduction in the level of supervision and the time of day required: for example 1:1 to cohort supervision and 24 hour supervision to day or night or other specified times.
- Re -assess the patient's behavior and temperament with the implementation of diversional activities and use of memory/activity box.

- The requirement for continuing 1:1 or cohort supervision should be subject to constant review at least every 24 hours using the safety huddle or board round including the involvement of staff who have/are providing supervision.

- Ensure when possible and practicable that the patient and/or family/carers are involved in the decision making process to de-escalate supervision and explore their participation in the process.

- Discuss in MDT forum with MHLT and family/carers the likelihood of behaviour improvement and aspirations for future care.

- Establish if behaviour is subject to a temporary delirium or decreasing cognitive function.

- Use the assessment outcomes to inform decisions about future care needs and discharge.

- Review patient position within the ward environment when changing supervision level.

- Two registered practitioners will agree and document the de-escalation plan within the patients notes and care plan.

- Ensure appropriate on-going medical and nursing reviews and follow up blood and microbiology results.

5.5 Training Needs of Staff Providing Supervision

It is the responsibility of the allocating nurse to ensure that the staff member providing supervision has the relevant skills and information to safely carry out this activity.

The staff member providing supervision should:

- Have completed local induction and therefore be orientated to the ward area.

- Be familiar with the content and requirements of the CDDFT policy for the management of falls involving patients and principles of the SPACE mnemonic.

- Be familiar with the content of this guideline and its requirements.

- Be able to complete all related documentation including nursing evaluation, patient observation charts, individualised rounding charts, 24 hour diary, fluid balance, food intake and positional change charts.

- Have received a patient handover and be aware of any specific risk factors.

- Be familiar with the content of the CDDFT Moving and handling policy.

- Be familiar with the content of the CDDFT dementia strategy.

- Be aware of any equipment aids needed to safely move the patient(s) and have received training to enable its safe operation.

- Ideally have completed the trust falls e-learning package and dementia awareness booklet. With CDDFT employed staff there is an expectation that these have been completed.

- Have attended conflict resolution training or is aware on how to manage aggressive and/or challenging behaviour and break away techniques.

- Be aware of the safety huddle principles.

6 DEFINITIONS

6.1 Glossary of Terms Used

MDT	Multidisciplinary Team Meeting
MHLT	Mental Health Liaison Team
CDDFT	County Durham and Darlington NHS Foundation Trust
DOL	Deprivation of Liberty

7 DISSEMINATION ARRANGEMENTS

- Discuss and agree at falls group.
- Review at safety committee and quality and healthcare governance meeting.
- Discuss and share at senior nurse, midwifery and AHP meeting
- Discuss and share at sisters meeting and cascade to all areas through team meetings across the organization.
- Agree pilot sites x 6 for 3 months before full trust implementation of the contents of this guideline commencing in September 2015.

8 MONITORING

8.1 Compliance and Effectiveness Monitoring

Monitoring Criterion	
Who will perform the monitoring?	Matrons/Heads of Departments/Ward Managers/Sisters/Charge Nurses
What are you monitoring?	Compliance with this guideline
When will the monitoring be performed?	During observation of patient care Investigation of reported incidents or root cause analysis investigation
How are you going to monitor?	Benchmark patient care against guideline
What will happen if any shortfalls are identified?	Review of care delivery or RCA and development of an action plan

Where will the results of the monitoring be reported?	Ward meetings, Specialty operational meetings
How will the resulting action plan be progressed and monitored?	Through the care group quality and assurance meetings and forums
How will learning take place?	Monitoring completion of actions, supervision of care delivery, ward meetings, incorporation into teaching sessions/training needs analysis

9. REFERENCES

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Giles LC, Bolch D, Rouvray R, et al. (2006) Can volunteer companions prevent falls among inpatients? A feasibility study using a pre-post comparative design. BMC Geriatr 6:11.

Tzeng H-M. (2010) Understanding the prevalence of inpatient falls associated with toileting in adult acute care settings. J Nurs Care Qual 25:22-30.

CG161 Falls: NICE guideline National Institute for Health and Care Excellence (2013) Publisher: NICE - Publication type: NICE GuidanceList any relevant legislation, and other sources referred to.

University Hospitals Birmingham NHS Foundation Trust. (2015) Make specialing special.

10 ASSOCIATED DOCUMENTATION

POL/MH/000: Moving and handling policy

POL/NG/0009: Medical device policy

POL/ICC/0001: Policy for infection control

POL/NQ/0005: Clinical record keeping & healthcare records management policy

SOP Specialling/Cohorting patients at high risk of falls

Safety huddle booklet

Delirium algorithm with MHLT referral

POL/N&Q/0002: Policy for the production of clinical patient information.

POL/NG/0005A: Going home policy

Mental health act 2014

POL/N&Q/0050: Deprivation of liberty safeguards

APPENDICES

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Appendix 1

Level 2: Cohort Supervision Assessment Criteria

Decision for cohort supervision with any one criteria met below with agreement of two registered practitioners

Addressograph

Site……Ward……Date…….

Criteria	**Applicable Y/N**	**Signature/ Designation**	**Signature/ Designation**
Clinically assessed as being at risk of falling and unable/deemed unsafe to nurse with intermediate supervision	Y ☐ N ☐		
Disoriented to person, place and time but will settle with diversional activities or reassurance	Y ☐ N ☐		
Attempts to mobilise unaided although unable and unsafe to do so but will respond to verbal instructions	Y ☐ N ☐		
Potential or previous attempts to leave / wander from the ward	Y ☐ N ☐		
Demonstrates Intrusive behaviour towards other patients and or rummages through other patients belongings	Y ☐ N ☐		
Part of a de-escalation plan to step down from level 3 1:1 supervision	Y ☐ N ☐		
Interfering with medical treatment i.e pulling at IV lines catheters, drains	Y ☐ N ☐		

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Appendix 2

Level 3: 1:1 Supervision Assessment Criteria

Decision for 1:1 supervision with any one criteria met below with agreement of two registered practitioners

Addressograph

Site……Ward……Date……

Criteria	Applicable Y/N	Signature/ Designation	Signature/ Designation
Clinically assessed as being at risk of falling and unable/deemed unsafe to nurse with cohort supervision	Y ☐ N ☐		
High risk of or demonstrates unpredictable or impulsive behaviour that may be harmful to self or others	Y ☐ N ☐		
Mobilizes around the ward frequently with difficulty in sitting still although unsteady with deficit of balance or gait	Y ☐ N ☐		
Assaultive / aggressive behaviour towards staff, visitors and/or other patients	Y ☐ N ☐		
Immediate and high elopement risk from the ward	Y ☐ N ☐		
Actively experiencing visual, auditory and / or command hallucinations which the patient enacts presenting a risk to themselves or other patients and staff	Y ☐ N ☐		
Uncooperative / unwilling or unable to follow instructions	Y ☐ N ☐		
Impaired judgment with an inability to realise their limitations or understand the risks of activities	Y ☐ N ☐		
Patient being nursed on a mattress on the floor	Y ☐ N ☐		
Requires supervision but unable to cohort due to infection status	Y ☐ N ☐		

Appendix 3
Addressograph

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Cohort/1:1 Supervision 24 hour Diary

Site.....**Ward**.....**Date**.....

	Time	Observation (see guidance)	Signature & Designation
08:00-12:00			
12:00-16:00			
16:00-20:00			
20:00-24:00			
24:00-04:00			
24:00-04:00			

Appendix 4

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24 hour Diary Completion Guidance Notes

Providing cohort or 1:1 supervision gives the supervisor the time and opportunity to observe and learn about the patient(s) in their care and is an important way of reviewing how well a person is responding to different situations. It is often difficult to understand why an individual behaves in a given way and with rotation of staff it can be difficult to ensure any identified triggers are handed over to everyone.

The correct use of a 24 hour diary will highlight situations in which behaviours are observed, how they are triggered, record the actual behaviour, how the patient responded to attempts to manage that behaviour. This will also enable specific safety issues to be addressed with understanding.

Daily review of the diary at a safety huddle or board round will help to decide if episodes of aggression and/or safety issues are improving and inform a safe de-escalation plan on when and how to reduce or withdraw increased levels of supervision.

Prolonged unnecessary periods of increased levels of supervision can increase dependence, reduce confidence, delay progression with rehabilitation, increase length of stay in hospital and ultimately affect future care needs.

De-escalation of supervision can be planned using information within the 24 hour diary and this should be discussed, agreed and monitored by the multidisciplinary team in the conjunction with families and carers.

The table below provides some guidance on aspects which can be observed and documented.

Appendix 5

Behaviour Guidance for 24 hour Diary Completion

Mood	Happy, sad, tearful, anxious, worried, frightened, agitated, angry, tense, panicky, irritated, frustrated, restless, bored, distracted, preoccupied,
Appearance/Hygiene	Wearing appropriate clothing for weather, prompts required to bathe/shower
Thought/ speech content	What patient says, makes sense, rational, factual, realistic, fixed ideas/beliefs, receptive/expressive dysphasia
Speech	Rate- normal/slow/pressured/rambling. Train of thought/conversation - disjointed /smooth/spontaneous, able to answer questions
Behaviour:	What the patient does (be specific), verbal/physical aggression, unpredictable, impulsive, hesitant, avoidance of tasks/activities/people
Motivation:	Co-operative, motivated, concentration, participation in and enjoyment of activity, apathetic, general interest levels
Social interactions	Visits by relatives, friends, chaplain. Patient isolating self, withdrawn, selective, over-familiar, disinhibited, friendly, sociable
Cognition:	Orientation, memory problems, understanding of what they are told, confusion, insight into difficulties, any difficulties noted on activities
Physical issues/ abnormalities:	tremor, shaking, dizziness, stiffness, dry mouth, nausea, temperature, pain, mobility, hydration, pale, rash, sweaty
Diet:	Appetite, types of food eaten, consider food record chart
Medication	Compliance
Sleep	Describe pattern, broken, insomnia, Somnambulism (sleep walking) Noctambulism (walking or performing activities whist asleep), Somniloquy (sleep talking)
Mobility	Aids used, prompts to use aids, wandering (see triggers sheet)
Pain	Assessment required?, consider pain chart, effectiveness of analgesia
Challenging behaviour	Time of day, activities that were happening or about to happen. Was anything different to usual? Record the actual behaviour. What happened? How long did it last for? How severe was it? Did anyone present do anything to try and manage it? If so, what? How did the behaviour settle? How did the person respond to attempts to manage the behaviour? Important to include things that didn't work. What worked well? Were there any significant consequences, eg family member now refusing to visit, care staff injured, patient fall or injury? Remember to report any violent or aggressive behaviour on the safeguard system

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Appendix 6

De-escalation Assessment Criteria

The general principles of de-escalation have been considered and if yes stated this reflects an improvement in patient's clinical presentation which is an enabler to consider de-escalation to take place.

Addressograph

Site……Ward……Date……..

Criteria	**Y/N**	**Signature/ Designation**	**Signature/ Designation**
Patients behaviour and temperament has improved	Y ☐ N ☐		
Patient/family/carers understand and accept need for de-escalation	Y ☐ N ☐		
Safety of patient considered and de-escalation can take place	Y ☐ N ☐		
Temporary delirium has improved and referral to MHLT has taken place	Y ☐ N ☐		
Patients medications have been reviewed and documented	Y ☐ N ☐		
Follow up of bloods and microbiology results to eliminate physiological causation has taken place and documented	Y ☐ N ☐		
Risk assessment carried out to identify appropriate care needs following de-escalation e.g. appropriate positioning on ward etc	Y ☐ N ☐		

Date of de-escalation agreed……..

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Appendix 7: Patient information

Increased Levels of Supervision for Patients at Risk of a Fall

What is supervision?

Supervision is observation of a patient or a group of patients.

Why is supervision used?

Supervision is used to prevent patients from falling. Patients are risk assessed on admission in relation to their falls risk and appropriate care is provided according to their individual needs. Specific risk factors should be explained by the nursing staff on the ward.

What are the supervision levels?

Level 1: Intermittent Supervision: Patients who require documented observation, supervision and intervention at pre-determined intervals of time. All patients assessed as being at risk of a fall will receive this level of supervision which is completed using individualised care rounds.

Level 2: Cohort Supervision: Supervision of a group of patients in a designated room or bay.

Level 3: 1:1 Supervision: Constant 1 nurse to 1 patient supervision.

What will happen during supervision?

Staff allocated to this activity will observe behavior and responses to external stimuli and complete a 24 hour diary. Monitoring of behaviours will allow staff to assess if improvements have been made in preparation of de-escalation from level 2 cohort supervision or level 3 1:1 supervision.

Staff will encourage independence, self-care and orientation where appropriate. Patients will be encouraged to participate in appropriate activities of daily living and rehabilitation for example reading newspapers, games, washing, dressing, eating and choosing diet etc.

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How will supervision be de-escalated?

Requirement to continue or de-escalate supervision will be assessed every 24 hours by the multidisciplinary team involving doctors, nurses and therapists. Nursing staff will involve patients and/or family and carers in this decision making process.

Who do I speak to if I want further information?

If you have any further questions please speak to the nurse responsible for your/your relatives care, sister or ward manager.

Publication Date: Jan 2017
Date of review: Jan 2020
Responsibility for review: Falls Lead
Leaflet reference: PIL/CG/0429
Version: 1.0

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Appendix 8

Useful Related Documents

Safety huddle booklet	Safety Huddle Booklet.pptx
This is Me	This_is_me_v2[1].pdf
Delirium algorithm with MHLT referral UHND	Delirium Algorythim + MHSOP Ref UHND.do
Delirium algorithm with MHLT referral DMH	Delirium Algorythim + MHSOP Ref DMH.doc
Trigger factors which can result in patients wandering	Trigger Factors Which Can Result in F
Dementia care pathway	Draft Dementia Care Pathway.doc
Dementia Awareness Workbook	Dementia Delirium and Depression Awar

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Patient information booklets

Delirium: Information for patients, families and carers	Delirium: information for patients, families a
Bedside guide	Bedside Guide.docx

Appendix 9

Equality Analysis / Impact Assessment

EAIA Assessment Form **v3/2013**

Division/Department:	Nursing and Service Transformation
Title of policy, procedure, decision, project, function or service:	Supervision Guidelines for In-Patients at Risk of a Fall
Lead person responsible:	Sue Day
People involved with completing this:	Falls group Senior Nursing and Midwifery Leadership Group

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Type of policy, procedure, decision, project, function or service:

Existing	☐
New/proposed	x☐
Changed	☐

Date Completed: 8.7.15

Step 1 – Scoping your analysis

What is the aim of your policy, procedure, project, decision, function or service and how does it relate to equality?

Provide a standardised framework for supervision in order to provide

- Assessment criteria for triggering its implementation
- Principles of de-escalating supervisory care
- Responsibilities of Nursing Staff following the decision to implement
- Requirements of staff providing supervision
- Training needs of staff providing supervision
-

Who is the policy, procedure, project, decision, function or service going to benefit and how?

Patients and Staff

What barriers are there to achieving these outcomes?

None

How will you put your policy, procedure, project, decision, function or service into practice?

Guideline will be disseminated trust wide and available on the intranet

Does this policy link, align or conflict with any other policy, procedure, project, decision, function or service?

POL/NG/0008:
Policy for the Management of Falls Involving Patients

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Step 2 – Collecting your information

What existing information / data do you have?

Equality data is collected by workforce

Who have you consulted with?

Falls Group
Senior Nursing and Midwifery Leadership Group
Quality and Healthcare Governance Committee

What are the gaps and how do you plan to collect what is missing?

None identified

Step 3 – What is the impact?

Using the information from Step 2 explain if there is an impact or potential for impact on staff or people in the community with characteristics protected under the Equality Act 2010?

Ethnicity or Race

No impact or potential impact

Sex/Gender

No impact or potential impact

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Age

No impact or potential impact

Disability

No impact or potential impact

Religion or Belief

No impact or potential impact

Sexual Orientation

No impact or potential impact

Marriage and Civil Partnership (applies to workforce issues only)

No impact or potential impact

Pregnancy and Maternity

No impact or potential impact

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Gender Reassignment

No impact or potential impact

Other socially excluded groups or communities e.g. rural community, socially excluded, carers, areas of deprivation, low literacy skills etc.

No impact or potential impact

Step 4 – What are the differences?

Are any groups affected in a different way to others as a result of the policy, procedure, project, decision, function or service?

No

Does your policy, procedure, project, decision, function or service discriminate against anyone with characteristics protected under the Equality Act 2010?

Yes ☐ **No** x☐

If yes, explain the justification for this. If it cannot be justified, how are you going to change it to remove or mitigate the affect?

N/A

Step 5 – Make a decision based on steps 2 - 4

If you are in a position to introduce the policy, procedure, project, decision, function or service? Clearly show how this has been decided.

Guideline is required to support the supervision of patients at risk of a fall

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If you are in a position to introduce the policy, procedure, project, decision, function or service, but still have information to collect, changes to make or actions to complete to ensure all people affected have been covered please list:

Following approval of the guideline

How are you going to monitor this policy, procedure, project or service, how often and who will be responsible?

Bi –annual review of guideline in conjunction with the Falls Group and Senior Nurse and Midwifery Leadership Group

Step 6 – Completion and central collation

Once completed this Equality Analysis form must be forwarded to Jillian Wilkins, Equality and Diversity Lead. jillian.wilkins@cddft.nhs.uk **and must be attached to any documentation to which it relates.**

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