Plymouth Hospitals NHS
NHS Trust

Surname:
First Name:
Hospital Number:
NHS Number:

Level of Enhanced Observation- Risk Assessment & Decision Algorithm for Acute Adult Inpatient Areas- Version 5			
Section A: IMMEDIATE ACTIONS TO ASSESS AND REDUCE RISK- Please tick YES or NO			
Immediate Actions	**YES**	**NO**	**Subsequent Actions:**
Recent medical/medication review			If NO- request review within 6 hours
Relevant history obtained-carers or NOK/this is me/passport			If no provide "Getting to know you" document and involve patient/family/carers in completion/if not applicable=NA
Referral to the MDT? Is there a clear MDT management plan including risk assessment?			If NO-make referrals and use the behaviour chart &/or night time functional chart to develop plan
Is there a current alcohol misuse problem?			If YES- refer to Alcohol Liaison Practitioner via Salus or bleep 89174) Complete CIWA pathway.
Have environmental concerns been considered?			If No- reduce environmental stimuli- noise etc./move to more observable position
Have environmental concerns been addressed?			If Yes- document any improvements
Has the falls trigger assessment been completed?			If NO-complete and consider referral to falls team, ultralow bed/sensor alarm, completed falls assessment and refer to falls team
Is a Mental Health Act assessment pending or is the patient detained under the Mental Health Act?			If YES- refer to Psychiatric liaison nurse (PLNs) or Psychiatric SHO or On-call Manager, to determine when MHA assessment is planned to take place. Ensure assessment time is documented.
Does the patient have mental capacity?			If NO-complete Mental Capacity Act assessment
Has Mental Capacity been clearly documented – consider using Record of Capacity and Best Interest (MCA 2005) document.			If Yes-ensure the restraining therapies is in place. Continue to review care plan regularly: review level of restraint and intensity and consider Deprivation of Liberty Safeguards (DoLS) application – refer to DoLS pathway. Consider daily; mental capacity, restraint and need for DoLS application. Safeguarding Adults team can advise.
Has intentional rounding been commenced?			If NO- complete and prescribe an *individual plan* for intentional rounding
Can the patient's care be safely maintained within the usual staffing levels?			If NO – proceed to section B and follow algorithm and clinical judgment to inform your request for a special

Section B: Risk reason and Enhanced Observation recommendation algorithm.			
No.	**Risk/Reason**	**Tick**	**Recommended level of Enhanced Observation: professional/clinical judgement must be used**
	ALL PATIENTS		
1 Low Risk	Can slip/fall from bed		**Manage with current ward establishment** • Consider Memory box/twiddle muff • Consider 1 hourly intentional rounding • Ensure patient has had relevant nursing risk assessments • Use strategies to minimise risk • Use of sensor alarms • Cohort patients where possible/safe • Consider family support when appropriate • Continue to risk assess – consider restraints therapy care plan and need for Deprivation of Liberty Safeguards (DoLS).
	Reduced mobility or bedbound and attempting to mobilise		
	Calling out & disturbing other patients		
	Risk of pulling out any indwelling devices. Already detained under the Mental Health Act to another hospital and attending on S17 Leave. Behaviour not causing significant concern. A Deprivation of Liberty Safeguards application has been submitted: behaviour not causing significant concern (patient must be on restraint therapy care plan)		
2	Confused and wandering		**Use current ward establishment/ may need additional support**
	Risk of pulling out any indwelling devices		

Assessor Print Name: Designation: HRSG: 0799/1
Sign: Date: NH/TRP/15FinalV4a

Med Risk	Agitation/Anxiety Impaired cognition/reduced insight Newly detained under the Mental Health Act or already detained and behaviour causing significant concern A Deprivation of Liberty Safeguards application has been submitted: behaviour causing significant concern.		• Consider family support where appropriate • Ensure patient has had relevant nursing risk assessments falls, cot sides assessment and care plan in line with the restraining therapy policy/cohort where possible • Use strategies to minimise risk (bay nursing, reduced noise and light) • Continue to risk assess – consider restraints therapy care plan and need for Deprivation of Liberty Safeguards (DoLS) • Consider booking Registered Mental Nurse (RN03) or Care Support Worker (CSW03) with mental health experience.
3 High Risk	Confused & wandering presenting risks to self and others (patients/staff)		**1:1 HCA or RN**
	Violent behaviour & aggression to others and self, volatile or unpredictable aggression. Immediate risk to self/harm to others. Substantial & immediate risk of absconding to undertake deliberate self harm/harm others		**1:1 Bed watch or if not available Security**. Follow Restraining Therapies Policy: if level of restraint is intensified over a prolonged period during the 72 hour period or restraint is still required after 72 hours and patient is not likely to regain capacity consider a Deprivation of Liberty Safeguards (DoLs) application – Follow the DoLS pathway. Security to be informed of stepped change. If risk of absconding security will special but only where a valid 'lawful authority' to restrain exists (i.e. MHA, DoLS, Court of Protection).
	Expressing intent or recently attempted deliberate self-harm/suicidal ideation		**1:1 HCA**
	Detained under Mental Health Act, expressing deliberate self-harm intent		**1:1 Mental Health experienced HCA or RNM** dependant on patient need. Contact Duty Senior Nurse on Bp 0355 to book, using RN 03 or CSW 03 If not available RN with Bed watch support if patient violent or aggressive

Ward Nurse to review individual patient needs.		*Circle*		*Sign + Print name*
Date	After completing the risk assessment overleaf do you feel in your professional judgement enhanced observation is still required?	Yes	No	
	Are other patients within the clinical area receiving enhanced observation? If YES- consider cohorting patients to enable closer supervision \and interaction. Patients under Bed watch must remain on 1:1	Yes	No	

Shift	Can the patient's care be safely maintained within the usual staffing levels (circle)	If no indicate risk reason (1-3)	Sign + Print name
DAY	YES / NO		
NIGHT	YES / NO		

Matron or Duty Senior Nurse on Bp 0355 to authorise the booking of a special	
Identify what risk reason (1-3)	
If risk level 1-2 in your clinical judgement is an additional special require. Please state reason why you are authorising:	
Recommendation (use Algorithm as stated on the form)	
Authorised by: Print: Date & Time	Sign:

RE-ASSESSMENT of RISK (each shift handover or if patients condition changes). Ward manager to document they have reassessed every 48hrs				
Date	Time	Can the patient's care now be safely maintained within the usual staffing level?	If No indicate Risk Reason 1-3	Print & Sign

Please file in Nursing Care Plan

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