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V4.0	06/03/2020	Scope, terminology and format reviewed. New risk assessment framework and supporting documentation incorporated. HLS checklist reviewed and updated.	HLS Steering Group
V3.0	23/05/2018	Re-formatted, content and risk assessments reviewed and updated.	UHC Medical CNM & HASU
V2.0	04/08/2016	Re-formatted, content and risk assessments reviewed and updated.	UHC Medical CNM & HASU

Approvals: this document was formally approved by:

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Senior Charge Nurse Clinical Meeting	May 2018	V3.0

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NHS A&A Acute and Community Hospitals All nursing staff	Athena		V4.0

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Higher Level Supervision Care Plan	
Higher Level Supervision Checklist	

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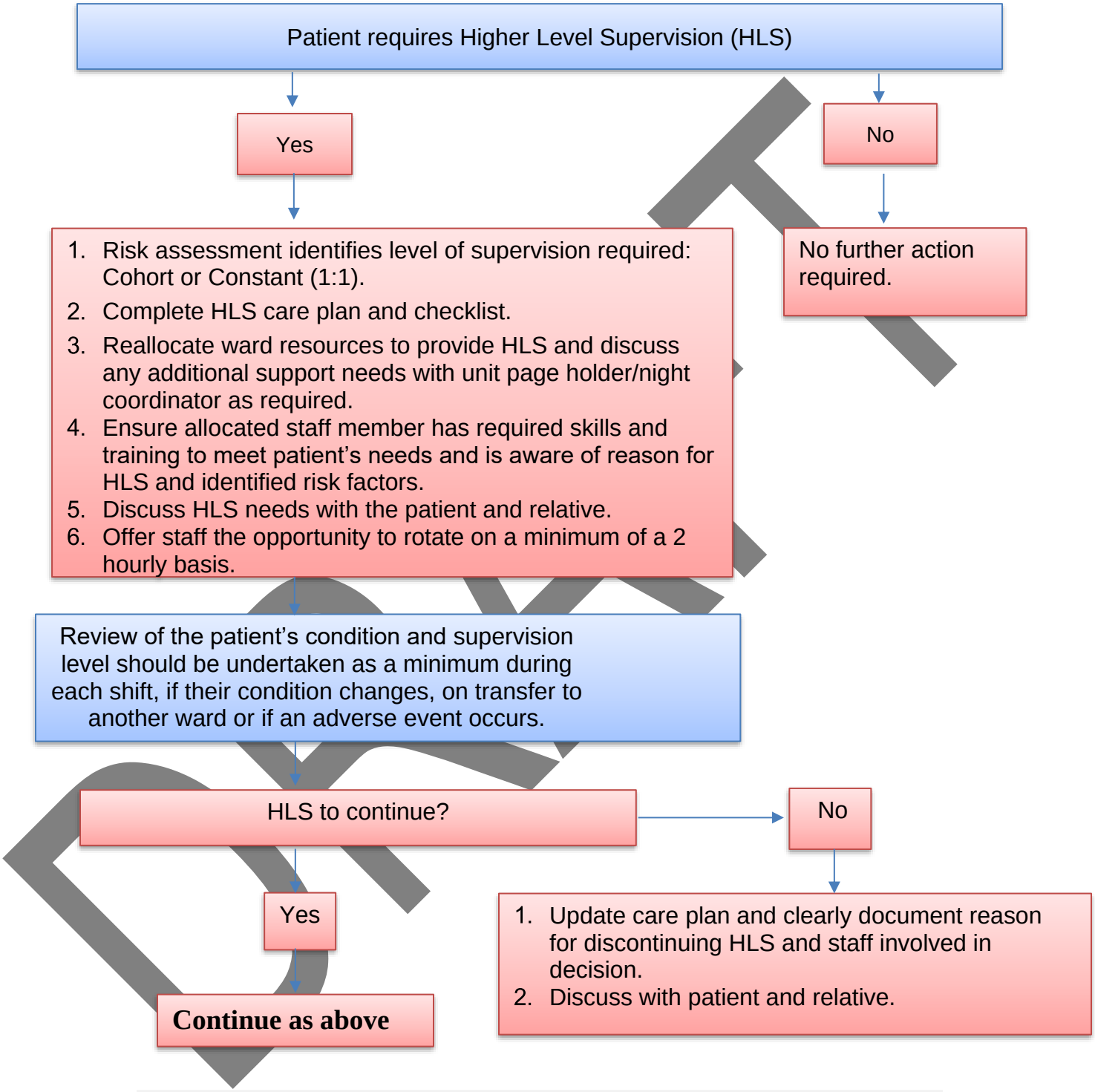
Contents

NHS Ayrshire & Arran – Acute and Community Hospitals
Process for Implementation of Higher Level Supervision



If patient is assessed at significant risk of self-harm or suicide and/or is detained under the Mental Health (Care and Treatment) (Scotland) Act 2003, HLS should not be discontinued without consultation with the Nurse in Charge and Medical Staff and/or Psychiatric Liaison Team.

1. Introduction

Within NHS Ayrshire and Arran general hospitals, constant (1:1) and cohort supervision are terms used to describe “Higher Levels of Supervision” provided by staff to ensure the safety of patients assessed as being at risk of harm to self or others, either within the clinical environment and or/if they were to leave the ward.

This guideline provides a framework for staff who are caring for patients, who require a higher level of supervision. It aims to:

- Ensure safe and supportive supervision practice.
- Clearly articulate roles and responsibilities.
- Provide a clear framework of expectations.
- Ensure a consistent approach to supervision practice.
- Clearly describe approved levels of supervision.

2. Scope

2.1 This guideline applies to patients being cared for within acute and community hospital settings across NHS Ayrshire and Arran.

2.2 It is applicable to all registered nurses, medical staff, healthcare assistants and wider members of the multi-disciplinary team (MDT) working within any acute or community hospital setting within NHS Ayrshire & Arran.

2.3 The care of adults with mental health needs presenting to emergency departments should be supported by the Clinical observation guideline for adults presenting with mental health problems in Emergency Departments

3. Rationale

Although there is a routine level of supervision afforded to anyone in the care of NHS Ayrshire and Arran, some patients will require a higher level of supervision to reduce the harm to self or others.

Patients whose condition may require a higher level of supervision include:

- Patients at risk of falling.
- Patients with dementia and or delirium.
- Patients demonstrating symptoms indicative of stress and distress.
- Patients presenting with violent and aggressive behaviours.
- Patients who are at risk of self-harm or suicide and/or detained under the Mental Health (Scotland) Act.

Supervision should not be viewed as a standalone task but as a therapeutic intervention which is part of a patient's wider care (HIS, 2019). The following core, care principles (Mental Welfare Commission, 2013) must also be assured:

- Care is planned and is person-centred, dignified and responsive in nature.
- Therapeutic interactions and activities are provided.
- Interventions are least restrictive and for the minimum period required.
- As much privacy as is safely achievable is provided.

Referral to relevant specialist for advice and guidance should also be sought as applicable i.e. Liaison Psychiatry, Falls Nurse Specialist, Alcohol Liaison etc.

4. Higher Levels of Supervision

4.1 Cohort Supervision:

A designated member of staff must have continuous awareness of the precise whereabouts of patients through visual observation and must be close enough to respond to any incident immediately. A staff member may observe more than one patient who requires this level of supervision.

4.2 Constant (1:1) Supervision:

Is required for patients who have been clinically/risk assessed as posing a high level of risk to themselves or others. The patient must receive uninterrupted one to one supervision by a designated staff member.

N.B It is recognised that there are rare occasions when a patient may require to be supervised by more than one member of staff e.g. 2:1. If required, this should be detailed in the plan of care.

5 Decision making and allocation of resources

5.1 The nurse in charge should consider:

- The level of supervision required and if this can be safely supported by the existing staffing resources within the clinical setting.

- If the use of existing ward resources is likely to compromise the ability of staff to meet the fundamental care needs of other patients, then the nurse in charge should discuss the requirement for additional support, with the unit page holder/night coordinator.

5.2 The unit page holder/night coordinator:

- Should liaise with other areas to explore the option of reallocation of staff, this may mean several areas assisting for a given period. This is often more manageable than providing a member of staff for a full shift.

- The utilisation of bank/agency staff to provide additional support in line with local escalation processes, if no existing resources can be reallocated.

5.3 The Nurse in Charge must ensure:

- If the need for higher level supervision is identified, it is implemented immediately.
- Decisions regarding the assignment of staff to deliver care is based on the skills and experience of staff available to meet patient needs.
- Whenever possible, staff who know the patient(s) best should provide higher level supervision i.e. ward based staff.
- Staff know what is expected of them and the identified risk/safety issues.
- Staff are provided with relevant information about the patient(s) and use this to engage in meaningful interactions and activities.
- Staff are provided with regular breaks and are offered the opportunity to rotate on a minimum of a 2 hourly basis.
- Staff members are aware of how to seek assistance if required.
- Any incident is reported via the adverse (DATIX) reporting system.

6 Involving Patients, Relatives/Carers

6.1 All staff will work in partnership with patients and relatives/carers regarding assessment, care planning, and care delivery.

6.2 Relatives/carers who wish to assist in providing care, should be made fully aware of the risks involved and support required.

6.3 Relative/carer involvement in the provision of higher level supervision must be fully documented in the patient's care plan.

6.4 The nurse in charge must ensure that relatives/carers are supported, able to call for assistance and given breaks as they request. Staff should ensure that when relatives /carers are having a break that a staff member undertakes the supervision.

7 Risk Assessment and Documentation

7.1 The patient's records must clearly state who was involved in making the decision to implement higher level supervision and the rationale for this decision.

7.2 All records should be clearly written, dated and timed (NMC, 2018) and should be updated at the time or as soon as possible after an event.

7.3 A risk assessment should be undertaken to identify the patient`s individual risk and steps taken to manage and where possible reduce that risk. The below guide is designed to support clinical decision making in relation to the level of supervision required and provide a guide as to risk reduction/management requirements.

Risk Assessment Framework

Level of Supervision		Level of Care	Minimum Risk Reduction/Management Requirements:
1	Consider the following: Routine Supervision	Low risk of falls/ no significant history of falls Episodes of mild confusion. Occasional restlessness No evidence of aggressive behaviour	• Identify and complete relevant risk assessments within Patient Profile and care planning documentation.
2	Consider the following: Cohort Supervision	Routine supervision has not kept the patient safe &/or based on clinical judgement patient is: • At risk of falls with 1 or more of the following: -At risk of falls with a history of falling within the last six months. -An actual fall has occurred during this admission. -Lacks insight into risk by attempting to mobilise unaided. • Moderately confused. Frequently restless requiring regular reassurance. • Frequently agitated and/or making frequent attempts to leave the clinical area. • Acutely unwell and at risk of deteriorating but inhibiting treatment (pulling at IV's etc).	• As above plus: • Complete - Higher Level Supervision Care Plan Higher Level Supervision checklist to reflect the assessed needs of the individual, level of supervision required and risk reduction /management interventions to be implemented.
3	Consider the following: Constant (1:1) Supervision	Routine or cohort supervision has not kept the patient safe &/or based on clinical judgement patient is: • At significant risk of falls &/or falls with harm remains. • Severely confused and is experiencing frequent episodes of agitation and/or distress. • Physically aggressive. • At risk of absconding. • Patient acutely unwell and requiring constant clinical care to maintain safety. • Unstable mental health.	• As above plus: • Please seek advice from psychiatric services if patient is at risk of suicide/self-harm and consider if environmental hazards can be safely managed.

8 Review & Termination of Higher Level Supervision

8.1 The allocated nurse may make the decision to increase a patient's supervision level.

8.2 The allocated nurse may make the decision to reduce a patient's supervision levels **with the following exceptions**:

- Patients who are high risk of suicide or self-harm and/or detained under the Mental Health Scotland Act: Consultation should be undertaken with the nurse in charge and medical staff (FY2 or above) and ANP for mental health and/or the mental health liaison team/duty psychiatrist.

- Patients who are high risk of violence and aggression: Consultation should be undertaken with the nurse in charge, medical staff and MDT as appropriate.

8.3 Review of the patient's condition and supervision level should be undertaken as a minimum during each shift, if their condition changes, on transfer to another ward or if an adverse event occurs.

8.4 All decisions must be recorded within the care plan when a decision is made to increase or decrease supervision levels including full rationale when higher level supervision is discontinued.

8.5 Once it has been identified that a patient's level of supervision requires to be increased or decreased then every effort should be made to implement this immediately.

9 Equality and Diversity Impact Assessment

Employees are reminded that they may have patients/carers who require communication in an alternative format e.g. other languages or signing. Additionally, some patients/carers may have difficulties with written material. At all times, communication and material should be in the patients/carers preferred format. In some circumstances there may be religious and/or cultural issues which may impact on clinical guidelines e.g. choice of gender of health care professional. Consideration should be given to these issues when treating/examining patients.

References:

Health Improvement Scotland (2019) *From Observation to Intervention: A proactive, responsive and personalised care and treatment framework for acutely unwell people in mental health care.* Healthcare Improvement Scotland: Glasgow

Mental Welfare Commission for Scotland (2013) *A Good Practice Guide: Rights, Risks and Limits to Freedom,* Mental Welfare Commission: Edinburgh

Nursing Midwifery Council (NMC) 2019 *The Code: Professional standards of practice and behaviour for nurses, midwives and nursing association.* NMC: London.

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