FALLS: SAFE AND SUPPORTIVE OBSERVATION GUIDELINES

<table>
<thead>
<tr>
<th>APPENDIX REFERENCE NUMBER</th>
<th>CG58, Appendix 11</th>
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<td>VERSION NUMBER</td>
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<tr>
<td>AUTHOR</td>
<td>Falls Lead; Tower Ward Manager; Operational Services Manager</td>
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<tr>
<td>CONSULTATION GROUPS</td>
<td>ADs/Heads of Service, Falls Group, Head of Risk and Compliance, Head of Workforce, Head of Serious Incidents and Quality</td>
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<td>MAY 2019 (date added to CG58)</td>
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<td>PROCEDURE SUMMARY</td>
<td>The purpose of this guideline is to provide information and guidance to ensure that adult inpatients assessed as at risk of harm from falling have the appropriate level of care, supervision and observation available to them. It will also raise awareness of how to ensure all patients are observed in the most appropriate way to prevent harm.</td>
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The Trust monitors the implementation of and compliance with this procedure in the following ways:

The monitoring of compliance will this procedure will through audit and review of incidents.

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<tr>
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The Director responsible for monitoring and reviewing this procedure is Executive Nurse
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APPENDICES

Appendix 1 - Falls Supportive Observation Pathway
Appendix 2 - Risk Assessment, Dependency & Additional Support Flow Chart
Appendix 3 - Falls Observation/Care Rounding Chart
Appendix 4 - Prompts for a patient safety huddle meeting
1. **Operational Summary**

**Guideline Aims:**

This guideline describes the process for managing the safe and supportive observations of adult in-patients, assessed as at risk of harm from falling and or other medical conditions, within all acute and community hospital premises. It will also raise awareness of how to ensure all patients are observed in the most appropriate way to prevent harm and should be read in conjunction with the associated documentation section 10 and appendices in section 11.

**Guideline Summary:**

By using the associated documentation and appendices, the Trust will be able to operationalize the overall strategy as recommended within this policy. This embraces guidance from The Standing Nursing & Midwifery Advisory Committee (SNMAC) practice guidance on the safe and supportive observation of patients at risk (SNMAC 1999) where observation is defined as “regarding the patient attentively, whilst minimizing the extent to which they feel they are under surveillance.” Ownership and Responsibilities. NICE (guidance 2013) and HSE (2010).

What it means to staff:

**Guideline Authors** – Ensure that the guideline is regularly reviewed and updated in accordance with EPUT governance frameworks, using the latest national and professional body recommendations, legislation and evidence based practice.

**General and Operational Service Managers** - are responsible for ensuring that all relevant nursing staff have the facilities to operate this guideline for the over-all benefit of patient safety.

**All Trust Employees** – Are responsible for reading the new guideline to maintain current awareness of changes in their roles and that they receive the required knowledge on Supportive Observation's and all the processes required to ensure adult patient safety by closely following this guideline in full and completing relevant training as stated in Section 7. All relevant employees will ensure the appendices in this guideline are used appropriately and evaluated fully to ensure adult in-patient safety.

2. **Introduction**

Essex Partnership University NHS Foundation Trust is committed to delivering safe, high quality and patient centered care. This guideline provides an evidence based framework which enables staff to be responsive to alterations in risk, whilst being caring, cost effective and efficient.

It outlines the responsibilities of staff at all levels to provide a clear pathway of care and the process by which levels of observation are determined, recorded, and reviewed.

The content of this document is relevant to all clinical staff working in Essex Partnership University NHS Foundation Trust whose practice brings them into contact with patients who are assessed at risk of harm.

This guideline is only applicable to patients over 16 years of age.
3. Purpose

The purpose of this guideline is to:-

- Provide a framework for heightened levels of safe and supportive observations which are implemented when patients are considered to be at increased risk of falls.
- Ensure a safe environment using effective assessment and intervention
- Support patients to remain independent, empowered and safe
- Support person centred care planning
- Ensure supportive observation is a shared responsibility between members of the multi-disciplinary team

4. Duties

The Trust Board has overall responsibility for ensuring:

- That the principles of this guideline and other associated procedures are implemented across the organisation
- The availability for any necessary financial resources and ensure staff are appropriately trained and have access to appropriate equipment.

The Executive Nurse has lead responsibility to ensure:

- Clinical Guidelines are embedded into clinical practice and in ensuring these are updated regularly.
- That any clinical risk issues identified are addressed with relevant line managers

Directors and Senior Management are responsible for:

- Disseminating, implementing and monitoring this guideline within their services via clinical audit and supervision
- Ensuring that EPUT policies and procedures are followed

Managers and other Persons in Charge will ensure that:

- The procedures and principles detailed within this guideline are followed, to ensure best practice and that national guidelines are met
- Staff receive appropriate and correct training
- The monitoring the implementation of this guideline via clinical audit and supervision

Individuals will ensure:

- Any difficulties relating to carrying out the care of patients who are reported to their line manager;
- That they adhere to all EPUT policies and guidelines;
- That they are familiar with these guidelines and associated documents and know where to locate them i.e. on the Trust intranet (InPut).
5. Definitions

Standing Nursing & Midwifery Advisory Committee (SNMAC) practice guidance on the safe and supportive observation of patients at risk (SNMAC 1999) observation is defined as “regarding the patient attentively, whilst minimizing the extent to which they feel they are under surveillance.” Ownership and Responsibilities

Care Rounding: Is a structured process where staff carry out checks with individual patients at set intervals, addressing patients’ pain, positioning and toilet needs; assessing and attending to the patient’s comfort; checking the environment for any risks to the patient’s comfort or safety.

Cohorting/“Baywatch”: A term used in older peoples’ community health services where the nurse in charge designates a nursing bay on the ward and patients at high risk of falls are then nursed in this bay. A nurse is allocated to observe day and night with a two hourly changeover.

Zonal observations: used in older peoples mental health settings and is a process where patients are located in the same area i.e. lounge or dining room, and a minimum of two staff nurses are allocated to that area delivering the nursing care required at the timeframe documented on the rounding chart and fall’s care plan.

Line of sight: Where the assigned nurse for this level of observation, uses their peripheral vision to observe the patient / s at risk of falling at all times.

Safety Huddle: This is a 5-10 minute additional multi-disciplinary team meeting led by a senior nurse which occurs daily and is a review of patients considered at very high risk of falls. The aim of the safety huddle is to discuss fall prevention strategies and to review supportive observations. Please see an example of prompts for a patient safety huddle meeting (Appendix 4)

6. Process

The Trust has in place 4 levels of observations, these are defined below; Appendix 1 & 2 must be used to assess the level of observation required for each individual patient

6.1 Level 1 - Routine Care Rounding

This level of observation is carried out every hour in mental health settings and two hourly in community health services (CHS) and is then documented on the care rounding chart. This is the minimum acceptable level of observation for all adult in-patients. The location of all patients should be known to staff at all times, but they are not necessarily within sight of the staff. At the beginning and end of every nursing shift the whereabouts and general condition of all patients should be part of the handover and nursing documentation.

6.2. Level 2 – Increased Care rounding

For a patient who has been assessed as:-

- Having the potential risk of falling
- Having a cognitive impairment / delirium which results in increased risk, or presents with behaviour that is complex and at times can be challenging.
- History of recent falls and/or on admission is disorientated to the ward, increasing their falls risk.
6.2.1. - Patients assessed to be requiring **level 2** (4-6 checks per hour) or increased to hourly in (CHS) must have a **falls observation/Care Rounding chart**. (Appendix 3) which clearly indicates the intervals at which the increased observations should be carried. This type of observation and the required timeframe to be used is part of the professional nursing judgement and should be put into all handover sheets too.

6.2.2. - High risk activities and times of the day these activities occur should be planned for, e.g. sun-downing, going to the toilet when at risk of falling and the needs of patients at night when lighting is subdued and staff numbers are possibly decreased.

6.2.3. - Increased Care Rounding should be managed with the staffing levels agreed for that clinical area. In circumstances where additional staffing is required for this level of observation this must be agreed and authorised by both the Nurse in Charge and the Matron.

6.2.4. - The frequency for the **level 2 observations** should be assessed by a Registered Nurse at the daily huddle. This assessment must be based on the patient’s behaviour, physical and mental state, and the decision must be clearly documented in the nursing notes and put into the handover sheet, then this must be verbally handed over to the commencing shift.

6.2.5. **Techniques for Reducing the Risk of Harm for level 2**

When patients are presenting with restlessness, walking about, sleep disturbance, behaviours which challenge and/or unpredictable behaviour which puts them at risk of harm, it is important to try and establish the possible cause of such behaviours so these can be appropriately managed; thus preventing a patient requiring more heightened level of observation.

**Possible Causes:**
- Pain or discomfort,
- A medical reason, e.g. depression, constipation, effects of medication
- A basic need, e.g. hunger, thirst or needing the toilet
- A feeling, e.g. anxiety or boredom
- Communication problems
- The environment i.e. too hot or too cold, over-stimulating or under-stimulating.
- Disorientation
- Consider nicotine and alcohol withdrawal

When attempting to manage these, it is important to establish a person-centred approach to care, involving carers and family members where possible; the Trust booklet: My care, my support, my care my recovery. This provides a template for health care professionals to build a better understanding of who the person really is.
Such techniques that may help to reduce patients’ risk of harm include:

- Establishing a daily routine the patient is familiar with refer to my care, my recovery/support.
- Engaging the patient in meaningful activities such as listening to music, Reading, talking
- Engaging the patient in activities that provide a sense of purpose e.g. making their bed and tiding the bed space
- Encouraging the patient in exercise such as accompanied daily walks
- Exercises for those with less mobility
- Reminiscence tools
- Consider issues with continence
- Providing something to occupy their hands e.g. a ‘rummage box’ and Twiddle muffs
- Writing down basic facts e.g. what day or date it is
- Providing a clock next to the bed to orientate them to the time of day
- Cutting down on caffeine in the evening
- Removing any trip hazards e.g. furniture in the way
- Assessing the patients mood as this can contribute to poor sleep
- If you think the person may be depressed refer to the doctor

6.3 Level 3 – Observation within Line of Sight or 1:1 nursing

For patients who have been assessed as having an imminent risk of:

- Falling, and/or have a recent history of repeat falling which cannot be managed by techniques described in level 2 observation, for example, patients who have a heightened level of risk linked to increased confusion/delirium/dementia / agitation, and also have significant deterioration from their former level of mobility.
- Harming themselves or others which is unpredictable in nature

6.3.1. - Any additional staffing required for this level of observation must be agreed and authorised in the absence of ward manager/matron by the Nurse in Charge and the Matron, discussed in the safety huddle using the falls care plan and appendix 1 of this guideline. For CHS, the matron will have to authorise and contact the CCG for additional funding.

6.3.2. - Levels of risk may vary between night and day dependent on the patient’s presentation. For example if the patient is known to go to bed and sleep well throughout the night level 3 observation could be reduced to level 2 increased care rounding during that timeframe. Level 3 observations may also be reduced at night if other falls prevention strategies are in place i.e. The patient has a high/low bed with a falls sensor alarm and a crashmat placed at the side of the bed(where appropriate consider trip hazard. The
level of observation must be recorded on the care rounding chart, in the medical notes and on handover sheets.

Level 3 – within Line of Sight using Cohorting/zonal observations

6.3.3. - Cohorting/zonal observations can provide an alternative strategy for effectively managing those patients who require close and continuous observation within line of sight, but is less intrusive and allows greater privacy for the patient, reducing the risk of the patient becoming agitated.

6.3.4. - The cohorting/Zonal observation approach aims to ensure appropriate observation of individual patients without the need to assign a particular nurse to be in close proximity to the patient for long periods and this decision will always be based on clinical need and not be financially driven.

6.3.5 - For zonal observations used in mental health settings - Identified staff (always minimum of two staff members) will be responsible for observing and engaging with all service users within a particular zone (area) of the ward, lounge or dining area. The zone area could change during the course of the day, but the nurse in charge is responsible for identifying the specified zone. Staff members will be involved with assisting a person to find their way about within the zone, intervening when necessary to maintain safety of those in the zone, but staff will also need to consider restrictive practice guidelines. There may be specific times in the day that there is a higher risk of falls for particular patients and they need closer observation i.e. during visiting, handover and at meal times e.g.

A zonal area could be 4 level 3 patients seated around a dining table which are observed by two staff members.

6.3.6. - The Nurse in Charge must be aware of level 3 patients that have been placed on zonal observations and make other members of the multidisciplinary team aware on the ward that day. The observer may call for immediate help using pin point alarm, which must be given. The Nurse in charge will always be accessible during the nursing shift to review the zonal observations and make changes if needed.

6.3.7. - The patients must never be left unobserved, if the observer has to assist one level 3 patient, they must call for help from another member of staff to temporarily take over the observation of the other patients in the zone.

6.3.8. - Zones should have explicitly defined rooms, corridors and spaces within them. The zone should be described clearly with defined boundaries as to where the zone starts and ends i.e.

Zonal areas i.e. Large lounge, small lounge, area of dining room or corridor

6.4.  Level 4 – Observation within arm’s length

6.4.1. - Level 4 observations can be obtrusive and restrictive for the patient, it is the highest level of observations and should only be implemented in exceptional circumstances for patients that are at imminent and significant risk of harm from falls and must be reviewed at the next care review meeting.

6.4.2. - They should be supervised continuously within close proximity (arm’s length), with due regard for safety, privacy, dignity, gender and environmental dangers, these should be discussed as a multidisciplinary team. They should have an observation record / falls care plan and for special observations these should be contained within their nursing notes and must be recorded on the intentional care rounding chart too.
6.4.3. - It may be necessary on rare occasions to use more than one member of staff and or specialist support for this level of observation.

6.4.4. - A regular summary of the patient's condition, care and treatment must be entered into the falls risk assessment/care plan. This must include changes in mental state, physical, psychological and social behaviour, pertinent developments and significant events.

6.5. Assessment Process for all the required Levels of Observation

6.5.1. - All patients requiring supportive observation must follow the Supportive Observation Pathway (Appendix one) including the risk assessment defined in Appendix two.

6.5.2. - A Registered Nurse should assess the level of observation required, the need for level 3 and 4 observations must be approved by the Nurse in Charge and or Matron, and a care plan must be completed clearly stating the risk.

6.6. Implementing Safe and Supportive Observation

6.6.1. - Observing staff will need to be familiar with the ward, all relevant clinical guidelines and potential risks within the environment. All staff in the ward must receive a thorough handover, including assessed risk factors.

6.6.2. - Positive engagement with the patient is essential using the techniques defined under section 6.2.6

6.6.3. - The Nurse in Charge of the shift will allocate and identify staff to undertake observation levels during their shift periods including zonal observations. Staff should be rotated every hour.

6.6.4. - It is the responsibility of the Nurse in Charge to consider less restrictive practice when managing patients on observations levels for falls risk.

6.6.5. - The member of staff allocated to carry out supportive observations should spend time building a therapeutic relationship with the patient. Observation should always be a supportive and therapeutic activity. The process of observation calls for empathy, engagement, taking note of the patient's needs, and a readiness to act.

6.6.6. - Clear, honest and open dialogue must take place at the earliest opportunity with the patient, family and carers regarding the implementation of increased levels of observations for falls and that these observations are reviewed regularly and may not be a permanent.

6.6.7. - For patients who are being transferred to another ward on level 3 and 4 observation; then the receiving ward must be given sufficient time to make arrangements to cover this level of observation. The member of staff assigned to carry out that observation on the transferring ward must escort the patient and remain with them until the receiving ward provides cover for the level of observation required.

6.6.8. - When a patient is transferred from ward to ward within the Trust they are at increased risk of falls due to unfamiliar surroundings and therefore need to be on a minimum period for 24 hours on level 2 observations.

6.6.9. - Patients will be offered an opportunity to formally or informally discuss their views and/or their concerns on this process with the Nurse in Charge or a senior member of staff.
and have the right to involve someone (an advocate or friend/relative) in these discussions if they wish.

6.6.10. - Under no circumstances should the observing staff reduce the level of observation prescribed for the patient without prior discussion with the Nurse in Charge.

6.6.11. - If the patient requires level 3 or 4 observations and this level cannot for whatever reason be provided, a DATIX incident report must be completed immediately, and mitigating actions documented as per the Trust’s Incident Reporting and Management Policy and Procedures.

6.6.12. - Staff must try to ensure that the patient’s privacy and dignity, cultural, religious beliefs and gender specific needs are maintained. However, at times where the level of risk supersedes these issues this must be clearly explained to the patient.

6.7. Reassessment of safe and supportive observations

6.7.1. - The need and frequency for level 2 observations should be reassessed by the Registered Nurse in the daily safety huddle and handover.

6.7.2. - The need for level 3 and 4 observations must be reviewed at the beginning and end of every shift by the Nurse in Charge, or as defined in the Falls / nursing care plan, which may state a specific level of observations for a defined period of time. Where possible this should be done with consultation with members of the multi-disciplinary team; and discussed with the Medical staff at least daily: Handover, safety huddle; and where additional staff is required continued to be authorised by the ward manager/matron or on-call manager. A decision will be made to subsequently curtail, reduce, maintain or heighten supportive observation based on the information recorded. The decision must be clearly documented in the patient’s notes and handed over to the commencing shift. This assessment must be based on the patient’s behaviour, physical and mental state.

6.7.3. - Prior to discharge or transfer, there must be a sufficient period of time between de-escalation from level 3 or 4 and the planned discharge date. For patients where it has been assessed that they need to continue to receive level 3 and 4 observations on discharge, then the discharge destination needs to agree to support this level of observation for a specified time period.

6.8. Mental Capacity Considerations

6.8.1. - Supportive observation must be set at the less restrictive level for the least amount of time within the least restrictive environment, and proportionate to the risk. Routine Care Rounding will be the presumed level and justification will be required to move up (or down) the levels according to the patient’s condition. Raising levels of supportive observation may be required and both staff and patient need to be clear about its purpose. It is essential that communication is effective and the situation managed sensitively.

6.8.2. - The Mental Capacity Act 2007 places a responsibility on organisations to protect an Individual’s right to liberty and to undertake certain procedures where they are or need to be deprived of that liberty; these procedures are known as Deprivation of Liberty Safeguards (DOLS). It may be necessary to place a number of restrictions on the patient and as a result the Deprivation of Liberty Safeguards may need to be considered.

6.8.3. - The Deprivation of Liberty Safeguards applies only to those aged 18 and over who lack mental capacity. The urgent and standard authorisation forms are available on the Trust intranet site. All Registered Staff and Doctors involved in the persons care can
complete this application form. The Safeguarding team are available should you need advice or guidance on the application process.

6.9. Role of the Relative / Carer

Relatives and carers should be involved and understand the patient falls care plan as much as possible, seeking the views of the patient views dependent on their own or the patient wishes. Refer to my care my support, my care, my recovery

In particular, explanations should be given sensitively about why limits are being set. Relatives and carers can observe the patient without staff present where appropriate if this is the wish of the relatives or patient; clear instructions must be given on how they are to manage that observation, including how to summon for help and what they do when leaving the patient, however they should not be made responsible for the formal documentation of observations, this must be clearly documented in the individual section of the care plan.

7 Training & Awareness

7.1 It is the responsibility of the individual staff member as overseen by your line manager to ensure that they are aware of the contents of these guidelines. It is the responsibility of senior clinical staff to identify and respond to any identified training needs.

7.2 To provide care for patients requiring enhanced observation, registered nursing staff are equipped via their pre-registration training. Unregistered staff will be supported by induction and the generic competency framework.

7.3 Specific training for engagement and supportive observation to manage patients that are at risk to themselves or others due to acute mental health issues will be provided annually via e-learning- OLM programme.

8 Monitoring compliance with this guideline

The nurse in charge/senior sister will routinely monitor implementation and compliance with this guideline and to ensure that there is accurate documentation relating to safe and supportive observation for falls prevention.

9 References:

Patient safety First “How to Reduce Harm From deterioration” Patient safety First website

Standard Nursing and Midwifery Advisory Committee (1999) Practice Guidance, Safe and supportive Observations of Patients at Risk

National Institute for Clinical Excellence (NICE) Clinical Guidance 161 Falls: The assessment and prevention of falls in older people, June 2013

Healey F., Oliver D (20060 Preventing Falls and Injury in Hospital HealthCare Risk report. P127 15 – 17

10  **Associated Documentation:**

RM05 – Restrictive Practice Policy
CLP39 Safeguarding Adults Policy
MCP2 Mental Capacity Act and DOLS Policy
CLP8 Engagement and Supportive Observation Policy
FALLS SUPPORTIVE OBSERVATION PATHWAY:

**Routine Care Rounding:** No further action required unless falls risk level increases

**Patient requiring a more heightened level of observation from routine care rounding based on increased falls risk**

**A registered Nurse and where possible with consultation with members of the multidisciplinary team assess the level of enhanced falls observation required**

**Increased Care Rounding:**
For a patient who has been assessed as:
- Having a potential falls risk
- Having a cognitive impairment which results in increased falls risk
- Having a history of previous falls risks, but is in the process of recovery.

The need for line of sight/ arm’s length observation must be approved by the nurse in charge, and the request for additional staff to manage this falls risk must be authorised by the ward manager/matron and out of hours, the nurse practitioner/site officer.

**Line of Sight:**
For patients assessed as having imminent risk of:
- Falling and/or have a recent history of repeat falling which cannot be managed by increased care rounding
- Causing harm to themselves or others

**Within Arm’s Length:**
This is the highest level of observation and should only be used in exceptional circumstances:
- Patients are at imminent and significant risk of harm to themselves or to others
- A serious fall could be fatal for the patient resulting in death.

**Consider increased cohorting/zonal obs.**

**Review and evaluate the falls care plan in place to indicate the type of falls observation to be used**

**Document the decision making process, agreed observation and subsequent actions in the patient’s notes**

The observation **must be** reviewed on an on-going basis, at least reviewed at the start and finish of a shift or safety huddle by the Nurse in Charge, discussed with medical staff at least daily. Where additional staff is required it must be authorised by the ward manager/matron.
# Risk Assessment, Dependency and Additional Support Flowchart

**ALWAYS COMPLETE A FALLS RISK ASSESSMENT ON ADMISSION**
**CONSIDER THESE RISKS ON ASSESSMENT**

## Low – Routine care rounding
- Additional support not indicated
- Support to be provided by care rounds if required
- Existing ward staff
- General observations and assessments

## Moderate – Increased Care rounding
**The Patient:**
- Cannot maintain their dignity
- Cannot maintain their fluid and nutritional intake
- Cannot manage their own toilet needs
- Cannot communicate when they are in pain
- Their cognitive impairment significantly increases the risk of them falling i.e. Lack of safety awareness
- Presents with behaviours that challenge
- A recent history (last 12/12) of previous falls risk

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<th>Level 2 observations should be managed with the staffing levels agreed for the clinical area</th>
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## High – (Observation within line of sight)
**The Patient:**
- Is agitated/aggressive
- Presents with destructive behaviour
- Cannot maintain their safety in the ward environment
- Imminent risk of falling and/or have a recent history of repeat falling

**Additional support or cohort following appropriate assessment of the individuals and the patients collectively**

### Key to Risk Assessment

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<th>Likelihood</th>
<th>Insignificant 1</th>
<th>Minor 2</th>
<th>Moderate 3</th>
<th>Major 4</th>
<th>Catastrophic/Tragic 5</th>
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<td>Low risk (yellow)</td>
<td>Moderate risk (orange)</td>
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<td>2 Unlikely</td>
<td>Very low risk (green)</td>
<td>Very low risk (green)</td>
<td>Low risk (yellow)</td>
<td>Moderate risk (orange)</td>
<td>Moderate risk (orange)</td>
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<tr>
<td>3 Possible</td>
<td>Very low risk (green)</td>
<td>Low risk (yellow)</td>
<td>Low risk (yellow)</td>
<td>Moderate risk (orange)</td>
<td>High risk (brown)</td>
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<tr>
<td>4 Likely</td>
<td>Very low risk (green)</td>
<td>Low risk (yellow)</td>
<td>Moderate risk (orange)</td>
<td>High risk (brown)</td>
<td>Very high risk (red)</td>
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<tr>
<td>5 Certain/almost certain</td>
<td>Very low risk (green)</td>
<td>Low risk (yellow)</td>
<td>Moderate risk (orange)</td>
<td>Very high risk (red)</td>
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### Exceptional – (Observation within arm’s length)
**This is the highest level of observation for patients, and should only be implemented in exceptional circumstances where patients are at imminent and significant risk of harm to themselves or others, or a serious fall could be fatal for the patient resulting in death.**

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**CG58 Appendix 11 Appendix 2**

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**SAMPLE – DO NOT USE**
### INCREASED OBSERVATION CHART (Falls)

<table>
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<tr>
<th>Time and initials</th>
<th>Is the patient steady when mobilising? What is their speed when mobilising, slow, normal, fast, shuffling?</th>
<th>Does the patient use a walking aid and do they use it appropriately?</th>
<th>Distracted by noise/presence of others or reacting to seen or unseen stimuli?</th>
<th>Does the patient show spatial awareness?</th>
<th>Physical changes including incontinence, pain, increased fatigue/side effects of medication</th>
<th>Signature and designation of staff member observing</th>
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Nurse in Charge Long Day checked & signed .............................................
Nurse in Charge Long Night checked & signed .............................................
<table>
<thead>
<tr>
<th>SAFETY HUDDLE</th>
<th>DATE</th>
</tr>
</thead>
<tbody>
<tr>
<td>Which patient has the most needs?</td>
<td></td>
</tr>
<tr>
<td>Any patients had a recent fall or at a Very high risk of falls?</td>
<td></td>
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<tr>
<td>Falls care plan implemented?</td>
<td></td>
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<tr>
<td>MEWS scores – above 3 – action taken</td>
<td></td>
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<tr>
<td>Any concerns regarding patient’s physical health?</td>
<td></td>
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<tr>
<td>Upcoming appointments, transfers</td>
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<tr>
<td>Is transport booked?</td>
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<tr>
<td>Is Section 17 completed?</td>
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<tr>
<td>Is risk assessment completed?</td>
<td></td>
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<tr>
<td>Are all observations and engagement forms up to date and signed?</td>
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<tr>
<td>Any level of observations reviewed?</td>
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<tr>
<td>Medication compliance</td>
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<td>Any PRN medication given?</td>
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<tr>
<td>Are all medication charts signed?</td>
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<tr>
<td>Food and fluid intake / All up to date?</td>
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<tr>
<td>Low fluid intake (less than 1000 ml) at 1800</td>
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<tr>
<td>Any concerns?</td>
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<tr>
<td>Bowel – Check bowel charts</td>
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<tr>
<td>Any concerns?</td>
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<tr>
<td>Any other business?</td>
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<tr>
<td>Any incidents?</td>
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</tbody>
</table>