Care plan

RISK LEVELS	OBS	ACTION PLAN	RATIONALE
Bed 1 Riley	Sec 3 1:15	The risk is reviewed and 1:15 observations are maintained, with attention to agitation and mental state. Fluid and food intake is documented, and continued refusal is escalated to the nurse in charge. Urgent access to Lorazepam is requested, and an update with a physical health review is prepared for the MDT.	The refusal of food and fluids creates a risk of dehydration and physical deterioration, so monitoring and timely escalation are important components of care. Increasing agitation may indicate a deterioration in mental state, which requires continued observation, timely medication and communication with the MDT (NMC, 2018).
Bed 2 Bailey	Sec 3 1:1	Continuous 1:1 observation at arm's length should be continued until handover, and all pens and sharp objects removed. The wrist wound is cleaned, dressed and assessed for infection, and the risk assessment is updated. A verbal and written handover is then provided to the receiving ward before transfer under escort.	The significant self-harm during the night shows an immediate risk of further injury, therefore continuous observation and the removal of accessible means are necessary (Evoy et al., 2023). Prompt treatment of the wrist wound reduces infection risk, while a structured handover supports continuity between the two clinical settings (NICE, 2022).
Bed 3 Ashley	Sec 2 1:60	The discharge concerns are escalated to the MDT and social worker, as discharge should not proceed without accommodation. An urgent housing referral is requested, and the discharge care plan and risk assessment are completed. The Grade 2 pressure ulcer is dressed and repositioning arranged, with follow-up from community nursing services.	Discharge without secure accommodation presents a significant risk to continuity of care and recovery, and may increase the likelihood of relapse, readmission or harm (Russolillo et al., 2023). As Ashley is subject to Section 2, planning is urgent, while the ward acquired ulcer requires active management and reporting (Russolillo et al., 2023).
Bed 4 Ellis	Sec 2 1:1	Continuous 1:1 observation should be maintained in a calm, low stimulation environment, with attention to safety. Therapeutic de-escalation is used and PRN medication offered, while an urgent medical review of mental state is requested. All staff are briefed about the threats made, and environmental hazards are removed or minimised.	The threats, overturned furniture and continuing hallucinations indicate a significant and immediate risk of violence to others. Therefore, early de-escalation and close observation are prioritised to maintain safety, using the least restrictive approach (Hallett & Dickens, 2017). Sleep deprivation and possible drug induced psychosis require assessment to find reversible causes.
Bed 5 Alex	Sec 3 1:15	The unexplained bruising is escalated to the nurse in charge and safeguarding lead, and documented using a body map.	Multiple bruises at different stages, together with self-neglect, financial concerns and recent social withdrawal, raise significant concerns about possible physical or financial abuse.

		Visitors are supervised and Alex is not left alone with them, while 1:15 observations are continued. A mental state and capacity assessment is completed using clear and learning disability friendly communication.	The mild learning disability may increase vulnerability, therefore supervised contact and accessible communication support participation and rights of Alex (Bakkum et al., 2022).
Bed 6 Zain Settled	Sec 2 1:60	Section 17 leave is confirmed as authorised by the responsible clinician, and a pre-leave risk assessment is documented. The escorting staff member is briefed about risks, duration and escalation, and carries a charged mobile telephone. On return to the ward, the outcome is documented and a debrief is completed with Zain.	Section 17 leave requires authorisation by the responsible clinician, and the pre-leave assessment ensures that any change in risk is identified before Zain leaves. As Zain is settled and lower risk, the task can follow immediate safety priorities, although the escort reduces ward staffing (NMC, 2018).

References

Bakkum, L., Schuengel, C., Sterkenburg, P. S., Frielink, N., Embregts, P. J., de Schipper, J. C., ... & Tharner, A. (2022). People with intellectual disabilities living in care facilities engaging in virtual social contact: A systematic review of the feasibility and effects on well-being. *Journal of Applied Research in Intellectual Disabilities*, *35*(1), 60-74. DOI: 10.1111/jar.12926

Evoy, D. M., Clarke, M., & Joyce, M. (2023). Time of self-harm presentations to hospital emergency departments: a scoping review. *Social psychiatry and psychiatric epidemiology*, *58*(3), 335-354. https://doi.org/10.1007/s00127-022-02353-4

Hallett, N. & Dickens, G.L., (2017). De-escalation of aggressive behaviour in healthcare settings: Concept analysis. *International Journal of Nursing Studies*, 75, 10–20. https://doi.org/10.1016/j.ijnurstu.2017.07.003

NICE, (2022). *Self-harm: Assessment, management and preventing recurrence (NG225)*. https://www.nice.org.uk/guidance/ng225

NMC, (2018). *The Code: Professional standards of practice and behaviour for nurses, midwives and nursing associates*. https://www.nmc.org.uk/standards/code/

Norman, I. (Ed.). (2013). *The art and science of mental health nursing: principles and practice*. McGraw-Hill Education (UK).

Russolillo, A., Moniruzzaman, A., Carter, M., Raudzus, J., & Somers, J. M. (2023). Association of homelessness and psychiatric hospital readmission—a retrospective cohort study 2016–2020. *BMC psychiatry*, *23*(1), 459. https://link.springer.com/content/pdf/10.1186/s12888-023-04945-z.pdf