Welsh Levels of Care Edition 1

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Contents

Document Information

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Summary:

This document has been produced by the All Wales Nurse Staffing Programme to assist local nursing teams participating in the national acuity audit for adult acute medical and surgical wards. For further information please contact:

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Foreword

We are the first country in Europe to write into law an obligation for Health Boards to calculate and take steps to maintain nurse staffing levels. The evidence unequivocally tells us that having the right number of registered nurses and the right skill mix reduces patient mortality and improves patient outcomes. Ensuring patients have a safe, high quality standard of care was at the heart of why we supported the introduction of the Act.

The Welsh Levels of Care is a key component to implementing the Act in practice, forming one third of the triangulation method that Health Boards are required to use when calculating their nurse staffing levels. The Act makes it clear that any workforce planning tools to be used must be evidence-based and specific to the Welsh context. Given the iterative testing and refinement that has been done over the past two years, I am confident that the Welsh Levels of Care meets those criteria and will give a consistent, standardised approach to nurses in Wales when establishing the acuity of their patients on adult medical and surgical wards.

I would like to thank the All Wales Nurse Staffing Group and the large number of nurses across the country who are responsible for developing this document. Their hard work has laid the groundwork for producing similar evidenced-based tools which will allow the Act to be extended to other care settings in the future and empower an even greater number of Welsh nurses, ensuring the resources are there to care sensitively for patients.

Professor Jean White CBE
Chief Nursing Officer (Wales)/
Nurse Director NHS Wales

Executive Summary

This is the first edition of the Welsh Levels of Care, and constitutes a key component of the operational guidance being developed for national implementation of the Nurse Staffing Levels (Wales) Act 2016.

The Welsh Levels of Care have been developed and tested over the past two years, through widespread engagement with participating adult acute medical and surgical wards throughout Wales. Set out below are descriptions of patients across five archetypal levels of care, from routine and simple to critical and unpredictable. These descriptions are broken down into typical patient needs, conditions and situations and the corresponding clinical assessments, interventions and tasks undertaken by nurses.

The purpose of this document is to provide nursing teams with the advice, guidance and definitions required to consistently assign individual patients to a level of care. The level of care is the principle data of the national acuity audits that take place every six months, in January and June. This data is collated and analysed to provide comparative information on the range of nurse staffing levels deployed on every participating ward in Wales.

Together with information on workload and the current deployment of staff this data is provided in feedback to operational staff on a tool known as the Visualiser.

The data on the acuity audits is then considered alongside comparative data related to the quality of care. Also considered is a professional narrative on the operational pressures that have influenced the care of patients and deployment of nursing staff during the audit period.

This evaluation is mandated in the Statutory Guidance 2017, referred to as the Triangulation, and is the method by which Nurse Staffing Levels are to be calculated.
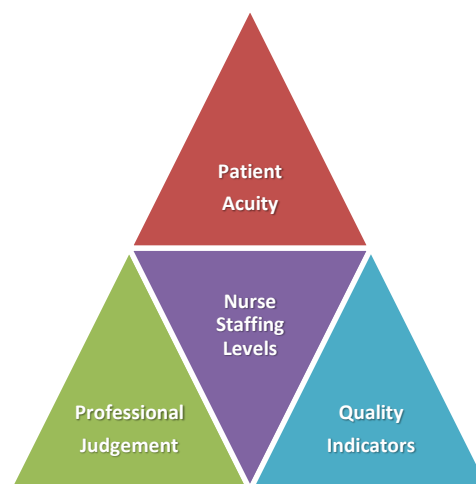
This is entitled the 'first edition' as the document will continue to develop and evolve. Further learning from the audit results and the operational process will be evaluated and incorporated into the concepts, methods and tools designed and developed through the Nurse Staffing Programme. For example, it may prove necessary to include additional descriptors for particular clinical specialities.

At present there are six working groups at different stages of development, each focussed on different areas of nursing. It is intended for each work stream to produce its own Welsh Levels of Care, based on the same underpinning model of patient need. As those tools are developed and tested they will be published as additional chapters in future editions.

To support adoption of the Welsh Levels of Care, the Nurse Staffing Programme is providing workshops and master classes in each Health Board. These sessions are designed to assist local leads in their preparations for implementation of the Act. They provide opportunities for nursing staff to share learning, become confident in using the Welsh Levels of Care, be able to understand and interpret the data and participate in the required triangulation.

Ruth Walker
Executive Nurse Director
Cardiff and Vale University Health Board

Introduction

This document describes the Welsh Levels of Care, developed for use within adult inpatient areas in NHS Wales to assist nursing staff in measuring levels of patient acuity. This should be read in conjunction with the guidance on participating in the national acuity audits.

The Welsh Levels of Care consists of 5 levels of acuity ranging from; level 5 where the patient is highly unstable and at risk, requiring an intense level of continuous nursing care on a 1:1 basis, down to level 1 where the patient's condition is stable and predictable, requiring routine nursing care.

This document explains how nurses can use the Welsh Levels of Care to assign their patients into the right level of care, by providing descriptions of the types of typical patient at each level of care. These descriptions are broken down into categories with increasing specificity:

Lay Descriptors – describe in simple terms the typical condition of the patient and types of care
Clinical Descriptors – more detail including professional considerations at each level
Nursing Themes – technical detail about the condition and interventions required at each level

These descriptors were developed through detailed examination and iteration with a wide range of nursing staff from a number of disciplines. They are designed in such a way that the categories are coherent across the 5 levels of care, leading to a more consistent scoring of the right patient into the right level of care.

How to choose the right level of care

It is expected that for most patients, most of the time, the Lay Descriptors will be sufficient to assign an accurate Level of Care. The Lay Descriptors are given in detail on page 10, but are summarised as follows:

Level 5	**One to One Care** - the patient requires at least one to one continuous nursing supervision and observation for 24 hours a day
Level 4	**Urgent Care** - The patient is in a highly unstable and unpredictable condition either related to their primary problem or an exacerbation of other related factors.
Level 3	**Complex Care** - The patient may have a number of identified problems, some of which interact, making it more difficult to predict the outcome of any individual treatment
Level 2	**Care Pathways** - The patient has a clearly defined problem but there may be a small number of additional factors that affect how treatment is provided.
Level 1	**Routine Care** - The patient has a clearly identified problem, with minimal other complicating factors.

If the Lay Descriptors are insufficient, the nurse completing the acuity audit can refer to the Clinical Descriptors to assign the right level of care. If this once more proves insufficient, they can then refer to the Nursing Themes Descriptors: Assessment & Observation; Respiration; Personal Care, Nutrition & Hydration; Cognition & Communication; and Medication.

It is possible for a patient to have needs in different Levels of care in the Nursing Themes. These descriptors are meant as a guide and ultimately the nurse completing the score will need to aggregate this information and make a reasonable professional judgement, as to the level of care that best describes the patient in line with the requirements of the acuity audit. Clearly the patients' level of care will change and the score will need to be regularly reviewed.

Frequently asked questions

What is acuity?

Acuity can be defined as the measurement of the intensity of nursing care required by a patient. For the purpose of this work we use the term 'acuity' as an umbrella term which encompasses other terms such as dependency, intensity, unpredictability and complexity to describe the amount of care that a patient requires based on their holistic nursing needs.

When considering acuity, there are two principle attributes: 'severity' which indicates the physical and psychological status of the patient, and 'intensity' which indicates the nursing needs, complexity of care and the corresponding workload required to care for a patient, or group of patients.

Why does the document include so many descriptors?

The Welsh Levels of Care document is a reference guide and it is not an operational process to be followed from beginning to end each time a patient is assessed. Nurses are required to make a professional judgement about their patients' levels of acuity and this document is simply to provide nurses with sufficient information to validate that judgement.

Staff feedback has shown that the Lay Descriptors can be used to consistently categorise the patients and the Clinical Descriptors and Nursing Themes will be used to provide additional guidance to assist staff in categorising their patients.

Is there training to support staff in using the Welsh Levels of Care?

A handbook is being devised to assist staff in using the Welsh Levels of Care. Health boards are holding local sessions with ward managers and staff to explore the practical application of the Welsh Levels of Care and discuss how their 'typical' patients are categorised.

Why are the levels listed from 1-5?

The levels have been listed from the lowest level, which is level 1 at the bottom, to the highest level, which is level 5 at the top. This is because the format of the levels was designed to match the intuitive method of decision making in practice and mimic directional cues in devices such as a thermometer ie: cold at the bottom of the range and hot at the top. We also use this cue in the production of the Visualiser that replicates the pattern of 1 at the bottom and 5 at the top and serves as a powerful sense checking device.

Why have Lay Descriptors?

A requirement of the Act is to communicate information to the public using language that can be easily understood. The Lay Descriptors use clear, simple, ordinary language without the use of technical terms to describe the patients' needs at each level of care. These descriptions will continue to be developed and refined to produce a variety of accessible versions of this narrative for sharing with a variety of audiences.

I am concerned that the time the data is collected does not accurately reflect the typical acuity of the ward?

The data collection method is referred to as a spot audit that is designed to capture patient acuity at a specific point in time during the middle of the day. It is likely that there will be occasions when a higher acuity patient will be replaced by a lower acuity patient just before the audit is conducted and vice versa and therefore will

not always provide a true reflection of the patients' acuity on the ward. However in choosing a specific time during the day the probability of either scenario is evened out and so should not significantly affect the results for analysis. In other words, capturing data at set times compensates for unpredictable changes in acuity. For example, the bed may have been occupied by a person awaiting discharge or by a patient who is at the height of acuity during their period of admission.

The ideal would be to capture data more frequently and there are plans in the future to move towards to continuous capture of acuity scores related to individual patients. As the technological enhancements planned with the programme are rolled out, it is likely that the audit will move from capturing once a day towards capturing patient specific acuity scores as the patients' level of acuity changes. At present this is not mandated within the programme.

What should I do if the bed is empty or recently empty at the time of data capture?

To complete the acuity audit you score every patient who is under the care of the ward at the time of the audit. Do not look back and estimate a score for the preceding 12 hours, this invalidates the method and the analysis, as the score is related to a patient not a bed. An empty bed, is an empty bed. It is acknowledged it will not be possible to conduct the audit on every patient at exactly 3pm.

The additional information on ward attenders and escorts can be aggregated over the preceding 12 hours and passed on to complete the audit. In essence for one 24 hour period, we need to capture: a sample of the levels of care of the patients; the amount of nursing time actually deployed by the ward during that 24 hours; and a small amount of additional indicators as defined on the audit tool.

How do I score a patient who requires 1:1 care due to their level of need, however due to availability of resources patients are cohorted?

There will inevitably be patients at the higher levels of acuity (level 4 patients requiring 1:1 care for the majority of the day and level 5 patients who require 1:1 care for 24 hours per day). The purpose of the tool is to measure the level of care patients require. If patients require 1:1 care and they do not receive this level of care eg: to mitigate the risk these patients are cohorted, these patients should be recorded as level 5 patients. This should be reflected within the operational narrative and the reasons for this should be explored, because the data recorded may result in the staffing levels being seen as inadequate given the acuity of these patients.

It is important to acknowledge that in cases where patients are assessed as requiring 1:1 care and this cannot be provided due to lack of staff resource this situation should be escalated through the health boards local reporting and escalation procedures.

How do I classify patients that are being cohorted?

By 'cohorting' we mean forming a professional judgement that a patient or group of patients require a similar level of supervision. Professional judgement must be used when determining the patients' levels of acuity, bearing in mind that the nursing care they receive will need to be shared between the patients within that bay.

Example 1: In a 2 bedded bay where 2 patients are cohorted and cared for by 1 member of staff for 24 hours this would equate to each patient receiving 1:1 care for the majority of care, so each patient would be categorised as a level 4.

Example 2: when cohorting several patients together in a nursing bay to enhance the level of supervision available to them, this doesn't mean that they all need the same level of supervision. Cohorted patients may also have different levels of acuity and so it would be appropriate for those patients to be categorised at

different levels. When cohorting professional judgement must be used to determine the patients' level of care.

Why have the levels been renamed and will the link with the critical care levels be lost?

One of the problems in the measurement of acuity is the misinterpretation of the nomenclature used by intensive care units who classify HDU and ICU as levels 2 and 3, leaving only level 1 to describe all other patients. This historical reference to intensity is no longer relevant.

In early stages of development the original classification set the precedent that staff could not allocate their patients to levels 4 or 5 as these were reserved for patients requiring critical care.

The Welsh Levels of Care is based on a underpinning model of patient demand verses capacity to respond. The Welsh Levels of Care has been created for general use and we have changed the levels to 1-5, which simplifies the coding process and allows staff to aggregate patient acuity scores to provide a measure of the total acuity of the caseload.

Does changing some of the descriptors mean that the tool is no longer accurate?

Work has been undertaken during national workshops where the descriptors have been revised and additions made. The work is in the process of being validated by testing the Welsh Levels of Care (version 1) through the bi annual audits and staff feedback. The Welsh Levels of Care is designed to enable staff to drill down into the detail to describe patients' needs and identify their level of acuity. Analysis will continue to take place as the Welsh Levels of Care continues to be tested through bi annual audits and further revisions will be made as required.

Are we using multipliers to determine the number of staff required?

The Act in Wales follows a clearly defined approach using a triangulated methodology to estimate the amount of nursing time required. We are implementing a much more rigorous process of monitoring staffing levels on a continuous basis rather than relying upon a set of theoretical multipliers. The focus of the work is to calculate the nurse staffing level by using the triangulated approach, which gives the ability to flex the number and skill mix of staff based on the needs of the patient at the time.

How can we capture the time spent on ward attenders/ escorts?

So far all the work has focused on traditional inpatients, based on feedback ward teams are undertaking a much wider range of activity, interrogating traditionally inpatient activity with day cases and ward attenders. We are working with health boards to identify and define this additional acuity and the impact upon on nursing time, as this develops in sophistication this information will be included within the activity and the deployed staffing levels for each ward.

There are plans to create a bed equivalency for the number of ward attenders and how that equates in staffing terms may equate to an inpatient bed and this work will be undertaken alongside other activity that is known to affect the number of staff a ward requires.

How is the data analysed?

The programme receives support from analysts based within Public Health Wales (PHW). They extract the data from the Health Care Monitoring System (HCMS), collate it into a database and produce charts for each participating ward in a tool called the Visualiser. This data is then provided to local leads for interpretation.

There is no centralised interpretation or reporting or aggregation of the data to any person or organisation beyond the participating sites and wards. PHW has no role in providing information or reporting to the Welsh Assembly for the data gathered within the All Wales Nurse Staffing Programme, that is the responsibility of participating health boards. The Visualiser and analytical tools and techniques are also shared to inform discussions and decisions at the adult work stream group.

Why take a snapshot of audit data?

None of the existing tools are currently capable of describing all the demands placed upon nursing time. The only way to do that will be to capture timings and scores for every patient every time their acuity changes and based on the acuity, mathematically weight the proportion of dedicated time in each hour that each patient sits at each level of acuity, add up the aggregate time, divide by the number of hours which should equate to an average level of care.

This is very complicated, we neither have the time nor the technology to enable it and as yet we don't know the correct mathematical weighting for each level. Therefore, we are using a number of statistical techniques to view patterns of activity (including patient acuity, patient flow and deployed staffing) over time. The fixed time of the audit each day, helps to facilitate this analysis and through bi annual audits we are continuing to develop a robust evidence base to support the effectiveness of a real-time decision making.

How can we capture acuity in high throughput areas?

There is recognition that the methods currently used to complete the acuity audit are best suited to a fairly traditional model of inpatient activity. This means that activity within the ward that has a much faster turn-around or turn-over rate is not accurately captured.

A slightly different audit technique is being tested in a few places within the adult work stream, such as assessment and day-case units, to design a meaningful process of capturing this type of demand.

Lay Descriptors

The Lay Descriptors provide information on the general characteristics of a patient at each level of care

Level 5 **One to One Care**	The patient requires at least one to one continuous nursing supervision and observation for 24 hours a day. The patient is highly unstable, unpredictable, in immediate risk of harm or in serious clinical deterioration. There may not be a clearly identified primary problem and the patient's condition, the care plan, observations, clinical review, decision making and the work to deliver care, may include a combination of any or all of the factors described in the lower levels of care.
Level 4 **Urgent Care**	The patient is in a highly unstable and unpredictable condition either related to their primary problem or an exacerbation of other related factors. The existing or longer term plan of care may be postponed, while alternate urgent treatments and interventions are put in place to avoid any further deterioration, or protect the patient. The patient's condition may change rapidly and therefore high levels of observation and supervision are in place, or provided on a continuous basis for the majority of the day. There is regular senior clinical review. The work to deliver care is multifaceted with a number of highly skilled interventions and technical procedures interspersed with numerous tasks to provide full personal care. The patient's ability to participate in the ongoing care, and maintain their own safety and that of others, may be the primary factor in their ongoing instability and therefore, require actions and interventions beyond the normal routines of the nursing team.
Level 3 **Complex Care**	The patient may have a number of identified problems, some of which interact with one and other making it more difficult to predict the outcome of any individual treatment. The care plan is often multidisciplinary and broken up into smaller goals or steps with ongoing observation and regular review by the multidisciplinary team. The patient may have a combination of treatments from more than one traditional pathway, or have phased treatment to overcome short term problems, while planning out care aimed at ongoing rehabilitation or long term support. The work to deliver care will have a number of skilled interventions and many tasks including close personal care for ordinary day to day activities and there is a risk of harm without this intimate support. The outcome of treatment could vary considerably and the patient may need close supervision and ongoing assessment from a range of staff to deal with problems as they arise and adapt the plan of care.
Level 2 **Care Pathway**	The patient has a clearly defined problem but there may be a small number of additional factors that affect how treatment is provided. The care is fully planned out but there is a need for regular observation to look out for any variations or unplanned changes in the patient's condition. The work to deliver care may be described on a detailed pathway designed to deliver a specific treatment, for a common problem. The work to deliver care will include several routine tasks planned together, some skilled interventions and ongoing clinical decision making, but remains within the normal routines of the nursing team.
Level 1	The patient has a clearly identified problem, with minimal other complicating factors. The care plan is straight forward and ongoing observations may be scheduled but the outcome is predictable with very little variation from what is

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Routine Care	expected. The work to deliver care is routine and there will be a number of tasks, including skilled interventions and are completely within the normal routines of the nursing team.

Clinical Descriptors

The Clinical Descriptions provide an overview of the type of patient and the nursing interventions that are required to meet the needs at each level of care.

Level 5 One to One Care	• Requiring a similar level of nursing care as a patient within a typical intensive care environment as the patient's condition highly unpredictable. • Rapid or irreversible deterioration from an unknown cause. • Requiring emergency intervention and highly intensive levels of nursing care on at least one to one for 24 hours a day • Patient at imminent risk of harm requiring constant monitoring, for example: awaiting transfer to Intensive care unit
Level 4 Urgent Care	• Requiring a similar level of nursing care as a patient within a typical high dependency environment, for example, a bed dedicated to high risk patients. • Patients requiring 2:1 care for 24 hours or 1:1 care for the majority of the day • Requires highly skilled, proactive intervention to prevent the patient deteriorating or requires urgent intervention due to a rapidly changing condition or ongoing instability • Deteriorating or compromised single organ system • Maintain and stabilise prior to urgent transfer • Pre operative invasive monitoring and extended post operative optimisation • Severe infection or sepsis
Level 3 Complex Care	• Patient's condition may be stable but has the propensity to change quickly. • Multiple co-morbidities requiring frequent interventions or close observation • Complex needs, requiring varying degrees of support with majority of activities of daily living • Patients who are in a stable condition but are dependent on nursing care to meet most or all of their activities of daily living. • Facilitating a complex discharge where it is the responsibility of the ward nurse
Level 2 Care Pathway	• Patient's condition is predictable but with some variation. • Patient's conditions are managed via care pathways. • Patient requires additional support on discharge eg: a package of care or referral to District Nursing • Acutely Ill patients requiring ongoing intervention or with the potential to deteriorate • Post-operative care with complications.
Level 1 Routine Care	• Patient stable and the care is routine with little variation. • Routine post-operative care • May require therapy input prior to discharge • Patient has a small number of clearly defined needs • The care required is obvious and task oriented • All activities within the normal routines of the ward, eg: elective medical or surgical admission

Nursing Theme 1

Assessment and observation

Level 5 One to One Care	• 1:1 nursing care constantly over a 24 hour period • Monitoring and supportive therapy for compromised or collapse of two or more organs or systems • Requires close and constant monitoring for a life threatening condition or an immediate risk to life • Requires constant observations due to highly unstable and unpredictable condition.
Level 4 Urgent Care	• Instability requiring continuous observation , for example cardiac monitoring, invasive pressure monitoring, invasive neurological monitoring • Patient receiving interventions for high NEWS (National Early Warning Score) • Emergency admissions requiring immediate therapeutic intervention. • Patients requiring 2:1 care for 24 hours or 1:1 care for the majority of the day • Requires ongoing monitoring and observations 1-2 hourly due to unstable and unpredictable condition. • Cord compression with unstable spine, for example requires log roll.
Level 3 Complex Care	• Neurological observations 2-4 hourly • Fluctuating levels of consciousness • Ongoing management of escalating NEWS score • Risk of falls requires close supervision.
Level 2 Care Pathway	• Intermittent arterial blood gas analysis • Increased level of observation and therapeutic interventions • NEWS score trigger point reached and requiring escalation. • Patient stable but requires monitoring and regular interventions. • Post operative care with complications • Care determined by established care pathway
Level 1 Routine Care	• Ongoing treatment for an underlying medical condition • Routine post-operative or post-procedural care, for example requiring observations half hourly initially then 4-hourly. • Routine observations 2 - 4 hourly • NEWS is within normal parameters • ECG (Electrocardiogram) monitoring • Assessment of bloods

Nursing Theme 2

Respiration

Level 5 **One to One Care**	• Respiratory or CNS (Central Nervous System) depression or compromise requiring mechanical or invasive ventilation • Emergency or temporary tracheostomy requiring constant monitoring and 1:1 care • Complicated airway requiring constant monitoring and frequent intervention • Monitoring and interventions in immediate post cardiac or respiratory arrest • Patients needing advanced respiratory and therapeutic support of multiple organs.
Level 4 **Urgent Care**	• First 24 hours following tracheostomy insertion or ongoing care of an unstable tracheostomy • Patients in acute respiratory failure, requiring non-invasive ventilation or respiratory support using CPAP (continuous positive airway pressure) or BiPAP (Bilevel positive airway pressure) • Greater than 50% oxygen continuously • CNS depression of airway and reflective reflexes • Frequent de-saturations on high flow oxygen • High risk of aspiration or requires oral pharyngeal suction
Level 3 **Complex Care**	• Post 24 hrs following insertion of tracheostomy central lines, epidural, multiple chest drains or extra ventricular drains • New or increased requirement for less than 50% oxygen • Complex management of chest drain • Patient requiring non invasive ventilation or respiratory support requiring close observation for complications • Frequent changes to BIPAP or CPAP
Level 2 **Care Pathway**	• Oxygen therapy greater than 35%. • Regular chest physiotherapy, for example 2-6 hourly • Ongoing care of BIPAP or CPAP • Ongoing care of chest drain with complications • Ongoing care of established or stable tracheostomy
Level 1 **Routine Care**	• Oxygen therapy less than 35% • Routine care of a single chest drain • Long term oxygen • Stable, long term non invasive ventilation.

Nursing Theme 3

Personal Care, Nutrition & Hydration

Level 5 **One to One Care**	• Totally dependent for all activities of daily living as unable to participate in own care and requires constant intervention at 1:1 care.
Level 4 **Urgent Care**	• Patients requiring 1:1 care for the majority of the day and also requires 2 or more staff for most activities of daily living. • Fungating or constant bleeding wound requiring interventions more than three times a day • High risk and history of falls requiring close supervision.
Level 3 **Complex Care**	• Complex wound management requiring more than one nurse, or takes more than one hour to complete or chronic wound management at least once a day, or requires pressure area care 2 hourly • Mobility or repositioning difficulties requiring the assistance of two people and, or the use of aids • Requires assistance with most or all activities of daily living, or requires personal care lasting more than an hour. • Patients with spinal instability, spinal cord Injury and/ or cord compression • TPN (Total parenteral nutrition) or requires enteral feeding up to 4 hourly • Naso-gastric tube (NGT) aspiration
Level 2 **Care Pathway**	• Enabling, assistance or prompting with varying degrees of support for some activities of daily living. • Pressure area care 4 hourly, including skin bundle • Assistance with feeding or routine PEG (percutaneous endoscopic gastrostomy) / NGT (Nasogastric Tube) • Daily wound dressings taking up to 20 minutes to complete • Catheter care and monitoring fluid balance
Level 1 **Routine Care**	• Routine management of nutrition and hydration. • Patients requiring occasional assistance with some activities of daily living, for example the assistance of one person to mobilise, or experiences occasional incontinence. • Self caring and independent • Mobile, with or without use of aids • Simple wound management • Routine pressure area care

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Cognition & Communication

Level 5 One to One Care	• Violent and aggressive patient at immediate and significant risk of serious harm to self and or others requiring constant supervision from 1 or more staff for 24 hours a day • Continuous monitoring of neurological deficit due to risk of rapid deterioration • Patient at significant risk which is further compromised by their inability to initiate any communication • Patient has significant mental health problems, is highly unpredictable and so requires constant supervision on a 1:1 basis.
Level 4 Urgent Care	• Patients with mental health or learning disabilities requiring supervision, support and frequent intervention for the majority of the day. • Risk of harm to self and others which could result in injury • Patients maybe cohorted to provide continuous supervision at a ratio of 2:1 for the majority of the day. • Patient with enduring mental health problems and requiring enhanced supervision
Level 3 Complex Care	• Patient or carers requiring enhanced psychological support owing to poor disease diagnosis or clinical outcome • Confused patients who are at risk and may be cohorted in small groups to provide close supervision • Patient with an enduring mental health problem requiring intervention from members of the multi-disciplinary team • Patient with cognition and communication difficulties experiencing increased anxiety and so requires additional support and reassurance • Limited cognition and level of understanding or participation • Difficulty with communication. • Anxious patient requiring support & reassurance. • Potential for accidental harm • Patient requires enhanced support during nursing interventions
Level 2 Care Pathway	• Presence of cognitive impairment and reduced level of understanding that requires ongoing support, reassurance or intervention • Patient with compromised cognition and communication, maybe allocated to a specific bed to aid supervision • Patient exhibits periods of confusion or mild challenging behaviour
Level 1 Routine Care	• Confused patient not at risk • Patient compliant or has full capacity • Requires minimal psychological input • Patient has mental health issues which do not impact on their acute care • Able to communicate needs

Nursing Theme 5

Medication

Level 5 **One to One Care**	• Invasive monitoring, vasoactive drugs, treatment of hypovolaemia, haemorrhage, sepsis or neuro protection in a patient receiving constant intervention
Level 4 **Urgent Care**	• Pain management- intrathecal analgesia • Drug infusions that require continuous intensive monitoring, for example vasoactive drugs (amiodarone, inotropes, GTN) or potassium, magnesium • Unstable patient requiring medication regime requiring frequent changes
Level 3 **Complex Care**	• Complex intravenous drug regimes (including those requiring prolonged preparatory administration or post administration care • VAC therapy where ward based nurses undertakes treatment • Complex medication or IVI (Intravenous Infusion) regime • Patient requires support to take medication lasting more than 30 minutes • Blood transfusion • New insertion of central line or Portacath
Level 2 **Care Pathway**	• Patient controlled analgesia requiring monitoring under supervision, for example when initially established or patients condition fluctuating • Syringe driver • Peritoneal dialysis • Assistance taking medication • Multiple intravenous anti-biotics • Sub cutaneous medication • Nerve block with possible complications • Administration of standard blood products • Established central line or Portacath
Level 1 **Routine Care**	• Established patient controlled analgesia • Routine nerve block • Self medicating for symptom control

Additional technical and speciality themes

It is envisaged that as the Welsh Levels of Care are further refined and embedded, that other descriptors, compatible with the 5 levels of care may be developed.

For example, in areas with particular cohorts of patients or where specific interventions are undertaken; such as cardiology or stroke there could be further work done to describe typical patients compatible with the overarching levels of are. Whereas this may eventually extend beyond the current remit of adult acute medical & surgical wards, any further development would need to maintain the integrity of the underpinning structure and be compatible with the Welsh Levels of Care.