| **Standard Operating Procedure: The Practice of Continuous interventions in Mental Health Wards in NHS Lothian** | | |
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| **Date Approved: 9/7/20** | | **Review Date: Feb/2022** |
| **Approved by** | REAS SMT / SJH MT | |
| **Authors** | Continuous Intervention Working Group | |
| **Scope** | To describe the procedures for supporting people who are in-patients in Lothian Mental Health Wards when Continuous Intervention may be required. | |

## 1.0 Introduction and Background

This paper outlines procedures to be carried out and offers guidance for staff to consider when a person may require a higher level of intervention and engagement due to risky behaviour within inpatient wards in NHS Lothian.

The procedures have been influenced by the guidance from Healthcare Improvement Scotland (HIS) '*From Observation to Intervention: A proactive, responsive and personalised care and treatment framework for acutely unwell people in mental health care'*.

This procedure is applicable across all inpatient areas of mental health services. Decisions made underpinned by this policy should be values and rights based, taking the Millan principles of the Mental Health (Care and Treatment) (Scotland) Act 2003, the Rights in Mind pathway and the *From Observation to Intervention* guidance as the foundation of care provision.

*From Observation to Intervention* aims to focus practice towards a culture of inquiry, personalised assessment and proactive, skilful mental health care and treatment

interventions for all patients. This is particularly important during periods which can be challenging, dangerous and immediate. As part of this cultural shift the intention is to end the use of the historical language (general, constant or special observations) associated with enhanced observation practice, whilst continuing to effectively review and manage risk to the patient and others.

Whilst this procedure does not make specific reference to observation levels, it does suggest two distinct levels of care and treatment:

a) **General care** – this is the expected level of care all patients should receive General care is a continuum-based approach which allows multidisciplinary teams to focus on personalising interventions and meaningful activities (engagement) to a patient's overall needs and purpose of admission rather than determining interventions solely on the presence or absence of risk.

   The critical factor in general care is that **all** patients have access to therapeutic and meaningful interventions on a flexible continuum that is influenced by their clinical needs, clinical formulation, deterioration factors and risks. This must include care planned individualised periods of 1:1 intervention, with attention paid to specific times or places that people may need enhanced support, as their presentation may fluctuate throughout the day.

**b) Continuous intervention** – when a patient requires the continuous presence of a member of staff to support them manage their distress and their interactions with other people safely. This period of intervention will be triggered after a risk assessment that highlights a deterioration and increased risky behaviours that can only be supported safely by 1:1 input.

   This period of intervention should be therapeutic **in nature and should focus on supporting and working alongside the patient in** their recovery.

Continuous intervention should be as least restrictive as possible. It should be

specific, therapeutic and purposeful, in line with the patient's needs, strengths, purpose of admission and evidence-based practice.

A personalised care, treatment and safety plan generated by the clinical team, patient themselves and/or carers should be generated and reviewed regularly. 1:1 care offers a huge range of opportunities to support a person to recover whilst maintaining safety. The plan should set out the provision, purpose and nature of the continuous intervention, and demonstrate how it relates to the patient's existing care, treatment and safety plan. It should be flexible and reviewed regularly with clear criteria agreed for ending the period of continuous intervention documented at every MDT review.

**Clinical Pause**

Decisions about instigating a period of continuous intervention should made in a reflective and thoughtful way that engages as many important people as possible.

Prior to the multi-disciplinary decision being made to commence continuous intervention, a period of up to 2 hours should be used to facilitate an assessment of the need for full 1:1 support. This period will allow the team, including the person affected and their supporters and carers, to evaluate the current safety issues and co-produce a plan of intervention to address the issues identified.

| 2.0 | Scope and competencies |
|---|---|

The policy and practice guidance apply to all NHS Lothian Mental Health staff at the Royal Edinburgh Hospital and St John's Hospital. Where required clinically, supplementary guidance will be developed and applied by specialist areas such as Forensic Mental Health Services, Children & Adolescent Mental Health Services; Perinatal Mental Health Services and Learning Disability Services

This SOP pertains to all members of the multidisciplinary team (MDT) and all staff should also be familiar with the following SOPs and guidelines:

- Keyworkers on inpatient wards
- Individual patient care plans
- Individual patient risk assessments
- Environmental ligature policy
- From observation to intervention framework

| 3.0 | Purpose |
|---|---|

This procedure is to ensure that patients receive the appropriate level of intervention and therapeutic engagement with staff by:

- involving patients, carers and families in treatment, wellbeing and recovery adopting a continuum-based approach to care, treatment and safety planning
- supporting early recognition of, and response to, deterioration
- improving communication around clinical needs, deterioration and risk
- promoting least restrictive practice
- managing periods of continuous intervention or support

- developing a trauma-informed workforce
- supporting personalised care and treatment
- creating an infrastructure to support learning and quality improvement, and
- to define roles and responsibilities of the clinical team (see appendix 2 for a detailed breakdown).

| | |
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| **4.0** | **Ward Environment**<br>**Relational, procedural and structural security**<br>**Risk assessment** |

The specific environment where a person is being supported will be key in understanding the level of intervention required. For example a single room that has known ligature points may require a different level of intervention to a communal ward area where there is always staff and fellow patients present.

All ward areas should be subject to an **environmental risk assessment** to identify any specific risks in particular those associated with use of ligature. This risk assessment should be available to all staff working on the ward.

It is expected that an initial, personalised risk assessment is completed within 2 hours of admission to hospital for all patients. This is completed by updating the **Mental Health Risk Assessment** in the questionnaire section of TRAK.

Both the environmental risk and the individual risk should be considered when deciding the level of intervention required. This should be kept under constant review, in case either of these risks changes. Risk assessment is a dynamic process that includes historical, clinical and environment aspects and continues throughout an inpatient stay.

The floor nurse should have knowledge of **all** the patients general whereabouts at all times and this will be marked on the environmental check sheet. The

environmental check should be completed hourly by core, familiar, competent staff. The staff should have a brief interaction with the patient, adopting the approach "How are you?" rather than "Where are you?" allowing for a brief assessment of the patient's wellbeing. Where concerns are identified these should be escalated to the shift co-ordinator.

All wards use the safe care assessment matrix to evaluate the level of intervention a patient requires for a specific shift (see figure below). These scores are aggregated for a ward and allows for the flexible allocation of staff to a specific ward based on patient need. Staffing allocations to a ward should not be based on the number of patients requiring continuous interventions, but instead on clinical need as assessed by the safe care tool. This allows for an increase in staffing to provide a higher level of input to a ward that is supporting people manage a high level of a distress and/or risky behaviour, without the need for a patient to placed on full continuous interventions.

Continuous Interventions Safecare Dependency Levels

| Safe Care Level | | Descriptors | Interventions | Consider? |
|---|---|---|---|---|
| 1,2 | Low Dependency | Self caring<br>Unescorted pass/standard pass<br>Low risk<br>Engaging in therapeutic activities<br>Engaging in care planning and risk assessment process | Encourage continued engagement with therapeutic interventions | Remember physical health |
| 3,4a | High Dependency | May require some support with regards safety and management<br>↑agitation ↑distress<br>↑unpredictability<br>Mental state may pose risk to safety of others<br><br>Has escorted passes | Complete plan your day<br>↑therapeutic interventions<br>As required medication<br>Review and update care plans<br>Update MDT and CCN (if OOH)if behaviour is escalating | Does patient require increased interventions<br>Consider Clinical Pause<br>Is an advance statement in place<br>Remember physical health |
| 4b,4b+ | Continuous intervention | Requiring continuous interventions<br>High risk to safety self or others<br>4b, requires 1:1<br>4b+, requires 2:1 or Seclusion | Ensure continuous Intervention care plans are up to date and goals completed<br>Review every.....hours<br>Plan your day has been completed<br>CCN aware | Does patient ligature risk assessment need carried out?<br>Family and/or carers have been informed<br>Remember physical health |

A full review of the personalised risk assessment should be triggered if:

1. There is any sign of clinical deterioration of the patient's mental state
2. There is any change to the person's personal situation such as interpersonal conflict or break-up, receiving bad news, deterioration in physical health
3. Further risk information comes to light which was not previously considered

If any member of staff observes these or other triggers that may indicate a potential need for Continuous Interventions they should initiate an immediate review of by the nurse-in charge and/or MDT.

| 6.0 | Clinical Pause |
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The Clinical Pause lasts up to 2 hours during which patients who have experienced an increase in distress or risky behaviour are given the opportunity to respond to de-escalation, other psychosocial interventions or medication prior to moving immediately to continuous interventions.

It is expected that during this period of assessment the patient will have a very high level of input to facilitate the assessment and maintain safety through this period. To facilitate this the nurse in charge of the shift **will allocate one member of staff** to lead the assessment. It is vital that this member of staff co-ordinates the team in a way as to be **aware of the patient's mental state and location continuously throughout this period**.

During the clinical pause, a number of information sources could be considered to inform decision-making:

- patient's views
- carers' views
- aggression rating scale, for example DASA
- risk assessment
- use and response to medications
- recent substance use or withdrawal
- care plans
- formulation, and
- the patient's advance statement.

During the clinical pause, staff should support a person to use personalised strategies and interventions. For people who are already inpatients care plans that have developed during their stay should be used to inform strategies to safely development therapeutic relationships e.g. for example playing cards, or watching

TV.

Once the clinical pause begins the staff member allocated to the lead the person's care will need to coordinate wider members of the multi-disciplinary team to contribute to a review of the level of intervention being offered. This review meeting must occur within 2 hours of the onset of the clinical pause. This meeting should take place 24/7 on any ward and at a minimum should have the participation of the doctor on call and the relevant senior nurse. In hours it is expected a wider range of the MDT will be involved. This meeting gives the MDT the opportunity to consider what input each discipline can offer for the benefit of the patient and detail the multidisciplinary interventions tried and care plans developed to support the person and is required to document a specific and personalised patient safety plan. A 'canned text' structure for documenting this review is found in appendix 1.

| 7.0 | Continuous Intervention |
|---|---|

If after the Clinical Pause the MDT agree that a period of continuous intervention is required, a personalised safety plan must be developed. This will include details of the interventions being agreed. The goals of the continuous intervention must clearly identify a criteria for ending the Continuous Interventions and be developed at the onset. These should be updated as the formulation of the interventions develops.

**Therapeutic Relationships**

These interventions are based on the relationships developed and it is these relationships that provide the primary component of all healthcare interactions and facilitate the development of positive clinician–patient experiences. Therapeutic interpersonal relationships have the capacity to transform and enrich the patient's experiences. Consequently, with an increasing necessity to focus on patient-centred care, it is imperative for the healthcare professional to therapeutically engage with patients to improve health-related outcomes. All interventions should be therapeutic in nature and should focus on supporting and working alongside the patients in their recovery. This is associated with improvement with patient satisfaction and adherence to treatment. Any intervention can be defined as one which is viewed by the patient to encompass care, is supportive and non-judgemental and embedded in a safe environment.

There are a wide range of interpersonal skills to alleviate deterioration and distress and support recovery. These range from one-to-one or group activities, talking therapies and physical/social activities. Staff supporting patients within the inpatient setting should have a wide range of therapeutic assessment skills such as being able to:

- engage and establish trust and rapport with patients

- develop personalised risk assessment, safety planning and clinical formulation
- recognise triggers and early warning signs of deterioration
- develop personalised care, treatment and safety plans. This may include activities and support off the ward.
- demonstrate expertise and capabilities in trauma-informed care, suicide awareness and psychological interventions
- communicate changes rapidly and consistently and to forward plan for patients
- consider a range of approaches and interventions beneficial, for example mindfulness, goal setting, distress tolerance and mentalisation
- recognise and harness patients' strengths, talents and experiences in order to promote self-management, and
- ensure that clinical activity, and the nature and frequency of intervention, are all tailored to a patient's care, treatment and safety plan.

**Care Planning**

Once it has been decided that continuous interventions are required then the following actions should be implemented:

- generating a multidisciplinary care plan using a formulation approach
- assessing the need for continuous visual assessment
- putting the continuous intervention guidance into practice, and
- proactive reviewing of continuous intervention and support as part of the patient care, treatment and safety plan.

Continuous intervention should be as least restrictive as possible. It should be specific, psychotherapeutic and purposeful, aligned with the patient's needs, strengths, purpose of admission and evidence-based practice. A care, treatment and safety plan, generated by the patient's named nurse, senior charge nurse,

psychiatrist, the patient themselves and/or their carer, therapist, as well as any other relevant parties (such as third sector care providers), should set out the provision, purpose and nature of the continuous intervention and demonstrate how it relates to the patient's reason for admission and their existing care, treatment and safety plan.

Depending on the reasons for, and nature of, the continuous intervention, as well as the associated risk assessment and existing care, treatment and safety plan, there may or may not be a need for continuous visual assessment of the patient's activity, for example when in the bathroom or asleep. However, as continuous visual assessment helps to measure engagement with, and impact of, psychotherapeutic interventions during continuous intervention, it would be expected as the norm here, as the focus is on being with the patient. The guidance for continuous visual assessment, along with the rationale for decision making, should be detailed in the continuous intervention care, plan.

Specific services have developed clear checklists for how intense 1:1 interventions are e.g. level of monitoring in the toilet. Consistency between staff is vital in helping patients to understand the level of intervention. **The range of environments across NHS Lothian mean that these must be developed for each service by each service**. As part of the local sign off the competency framework these should be available for all staff to discuss and use.

Clinical teams must ensure that any periods of continuous intervention or support are evidenced by the following factors.

- They are **purposeful** – clearly planned with specific psychotherapeutic interventions and/or activities, related to the patient's clinical needs and strengths.
- They are **goal directed** – aiming to return to a frequency of interventions that is less intrusive, as quickly as possible.

**Role of professional carrying out continuous intervention**

This intervention can be carried out by a number of different professionals (nursing, medical, AHPs, clinical psychology) as long as their competencies have been completed. It is important to take into consideration the preferences of the patient especially regarding their history.

- Where possible the staff carrying out the intervention should be known to the patient and the allocation of bank staff to this role should be avoided. Only staff who have completed the competencies should be involved in carrying out this intervention
- Prior to carrying out the intervention staff should be aware of the care plans relating to the patient
- There is no minimum or maximum time for staff to spend on continuous intervention, as this is dependent on the engagement and activities being carried out, however, 1 hour may be a reasonable time frame.
- The named nurse responsible for the patient that day will meet at their earliest opportunity to make a plan for the day and discuss with the patient any appointments they may have.
- The changeover of staff should happen with the patient present. Staff should handover how the patient has been, and the patient should also be asked for their input. Rarely this will not be possible and the reasons for not handing over with the patient should be clearly documented every day.
- Should the patient's behaviour cause concern to the staff who are carrying out the intervention then help should be summoned via the assist button on the pinpoint alarm.
- Staff should clearly document the patient's presentation and engagement during their period of continuous intervention.

**Review**

All reviews should clearly document criteria for ending the period of continuous

intervention. This should include which staff members can decide that the criteria have been met. Continuous interventions should not be maintained solely to facilitate a review, although in complex situations it may be appropriate for senior staff to be available to decide on whether the criteria to end have been met.

Initially a MDT review should take place every day, including weekends and bank holidays. This review should include as a minimum a doctor and a nurse, but it is expected that it would include all relevant members of the MDT when available. Reviews that take place on a normal working day would be expected to have wider participation. The canned text for a structured progress note in TRAK is found in appendix 1.

Embedding a formulation approach to the level of intervention is vital. Work is ongoing to agree on staffing for a full MDT formulation within 3 working days of starting continuous interventions. This working formulation will be regularly updated as engagement with the patient and understanding of their background develops. It is expected that approaches to embed this practice will be piloted in 2020 and this procedure will be updated by 2021 with a full account of this.

After 2 weeks of continuous intervention a wider review of the ongoing goals is required. The clinical nurse manager for the ward will co-ordinate a case discussion that may include the relevant Consultant Psychiatrist, clinical director, consultant clinical psychologist and Lead AHP. At this wider review meeting a care plan must be developed that focuses on the interventions required to support the person use their own skills to manage safely. Clear criteria and process must be documented for deciding on the ending of continuous intervention. Within the scope of this detailed personalised care plan a decision may be taken to reduce the frequency of MDT reviews, but only with the agreement of the service manager, clinical director and clinical nurse manager.

| 8.0 | Staff Education and Supervision |
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Each senior charge nurse will be responsible for ensuring all staff who are expected to undertake engagement and continuous interventions have the knowledge, skills and abilities to implement this procedure. A competency framework is found at appendix 3 and this should be used all for all staff performing continuous intervention

Support for providing intense relationship based continuous interventions should be available for all staff expected to participate in this procedure. A range of supports should be available ranging from access to training relevant to the patient group, presenting difficulty or specialty area, 1:1 supervision to ward based reflective practice groups. It should be recognised that less experienced or skilled staff will require more support to ensure therapeutic engagement and interventions.

Many people who require continuous interventions to maintain their safety have an experience of trauma. Training and support for practitioners to develop a trauma informed workforce will be vital in maintaining reliable and high-quality continuous interventions. All staff involved in continuous intervention should have a minimum of level 2 training.

Each period of continuous intervention will be monitored by the relevant service management team. This will provide the opportunity for supportive learning to take place and themes to inform ongoing training and development opportunities for staff and teams.

| Appendix 1 | Canned text for Clinical Entries in TRAK |
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**In any free text box in TRAK a short code followed by 'space' inserts a structured entry into the box. It is expected that these structured entries will be used at key review points in this procedure/**

### 6.1 Clinical Pause canned text

**\cpc**

Time CP Commenced:

Staff Member leading care:

Reasons for clinical pause:

Interventions offered during clinical pause:

Patient's views:

Time of MDT discussion:
Staff Present:
MDT discussion:

Plan of care:

Period of Continuous intervention instigated?
If yes, Criteria for ending 1:1 care:

### 6.2 Review meeting canned text

**\cireview**

Time receiving continuous intervention:
Doctor involved:
Nurse involved:
MDT members involved:

Mental state since last review:

Engagement with staff:

Interventions used:

Medication effectiveness:

Goal for further period of continuous intervention:

Criteria for ending:

**6.3 Continuous Intervention update**

**\cirecord**

Length of time spend with patient:

Presentation during intervention:

Support strategies tried?  What worked, what did not?:

| Appendix 2 | Roles and Responsibilities |
|---|---|

It is the responsibility of all staff and all disciplines to ensure that this policy is central to the care and treatment of **all** patients in their care.

The following people have specific responsibilities.

## 2.1 Patients, carers and families

The patient must be provided with an initial verbal explanation about the aim and purpose of the continuous intervention they require. Staff should make every effort to engage and involve the patient and carers in ongoing care decisions as far as it is reasonably practical. MDT reviews of continuous intervention must include the patient. If is not practicable for the patient to attend/contribute a formal meeting, alternative strategies must be used to gather views. If the patient has an advance statement this should be considered in regards to level of care and treatment. If present Crisis care plans should be examined for previous coping strategies that the patient may use while under periods of distress. Carers and supporters are vital partners in developing personalised care plans and it is expected that specific information would be sought regarding the effect and range of interventions that may be effective during a period of continuous intervention.

**Note:** If an advanced statement exists and the service does not follow the statement, the reason for doing so must be clearly documented in the clinical record. Consideration should be given to engage and involve carers, relatives and the named person when it is reasonable and practicable to do so.

## 2.2 Chief Executive/Board/Associate Directors (Executive Sponsors)

The Royal Edinburgh and Associated Services Senior Management Team, chaired by the Site Director, are responsible for the implementation, monitoring and review of

this procedure.

### 2.3 Medical/Associate Medical Director

The Medical/Associate Medical Director is responsible for supporting senior medical staff and doctors in training involved in caring for patients requiring continuous interventions to have the necessary supervisions, skills and experience to undertake the role in a way that supports the patient and the multi-professional team.

### 2.4 Clinical Nurse Managers

The Clinical Nurse Managers plan workforces in terms of the resources, staffing, activities and skills required to deliver preventative, early intervention-focused care, treatment and safety to a patient group. They are supported by Clinical Services Managers.

### 2.5 Senior Charge Nurse

The Senior Charge Nurse is responsible for ensuring that any named member of staff, including students, involved in supporting a patient requiring continuous intervention has the necessary experience, skills and support to undertake the role in a way that engages with and supports the patient whilst acknowledging the clinical risks. Particular note should be made at induction when there is new staff, bank staff or staff that are unfamiliar with the clinical area. It remains the responsibility of the Senior Charge Nurse or their deputy to ensure that other staff undertaking periods of continuous intervention are prepared, supported and supervised for this role. Staff competencies to participate in continuous intervention should be included in the relevant health and safety return.

The Senior Charge Nurse must assure the Clinical Nurse Managers that this is in place and seek support where it is not. The Senior Charge nurse must role model the skills and behaviours necessary to truly deliver the positive and proactive culture

required.

## 2.6 Key/Coworker

The Key worker should ensure that care plans are written collaboratively with the patient and their families or carers. Any continuous intervention must be rights based and consider least restrictive alternatives at frequent intervals. The key worker is responsible for identifying any knowledge and training required. And they also have a duty to be a positive role model to peers and students in engaging with the patient.

## 2.7 Healthcare Support Workers

Healthcare Support Workers (HSWs) are expected to be involved in all aspects of general care and for periods of continuous interventions.

Prior to the commencement of the continuous intervention, the HSW must ensure that they are fully briefed in relation to the patient's background history, presenting symptoms and the reasons for the intervention or interventions, the associated clinical risks and what to do in the event of further deterioration.

## 2.8 The role of Allied Health Professionals

The assessment and treatment skills of Allied Health Professionals (AHPs) working within mental health care services provide key interventions throughout a patient's recovery journey. Therapeutic interventions may vary depending on the specific profession and experience of an AHP and should both contribute to and inform the multidisciplinary care planning that supports services to provide a range of interventions. Including AHPs in this planning provides an opportunity to look at increasing engagement wherever possible.

All therapeutic interventions delivered by AHPs should be risk assessed based on a patient's individual needs, the skill set of the AHP and the environment in which the intervention is to take place. In addition, all AHPs should be trained in line with local or national requirements in risk assessment relevant to their area of practice and should work within their level of competence. Supervision should be routine to practice.

For example Occupational Therapists can offer a vital advisory and support role to other disciplines in relation to appropriate grading and adapting of therapeutic activities. Specific Occupational Therapy 1:1 and/or group sessions will be risk assessed and included within the patient's continuous intervention plan where appropriate. Art Therapist can engage with patients using interventions that promote interactions using different media. These skills can both inform assessment and formulation, alongside being key providers of periods of continuous interventions.

### 2.9 Clinical Psychologists

Clinical Psychologists will take the lead in generating formulations to inform care planning, and in facilitating formulation meetings with MDT staff.

Psychologists can contribute to the development of appropriate assessment and monitoring measures and tools that support clinical assessment, formulation, intervention and evaluation process. Dependent on need, psychologists may further contribute by direct or indirect psychological assessment with patients, carers and/or staff, in addition to providing direct psychological therapy or interventions within the context of the patient's care plan, as appropriate to the formulation and care plan.

### 2.10 Student Mental Health Nurses

Supported by their mentors, Student Mental Health Nurses may provide day-to-day, proactive, planned interventions as part of their patients' care, treatment and safety

plans. In situations where students are expected to develop specific therapeutic nursing skills as part of their set learning objectives, these should be tailored and specific to the needs of the patients, and should reflect the goals and interventions set out in patient care, treatment and safety plans.

The extent to which student nurses can deliver interventions independently should be decided in agreement with their mentor or the nurse in charge of the ward and should be based on the student's stage of education, the associated expectations of the learning objective with regard to independent practice, and the clinical needs and risks associated with the patient and the environment.

- Year 1 (PLE 1 and PLE 2): student mental health nurses participate in provision of general care but not in continuous interventions.

- Year 2 (PLE 3 and PLE 4): student mental health nurses actively participate in continuous interventions but only with direct guidance and support from a designated registered professional.

- Year 3 (PLE 5 and PLE 6): student mental health nurses participate in continuous interventions, with indirect supervision from a designated registered professional. This indirect supervision must include:
  - establishing that the student understands both the risk assessment and the specific psychotherapeutic intervention required
  - ensuring that participation in the continuous intervention is appropriate to the student's learning,
  - maintaining patient safety.

Consent must always be obtained from the patient before the intervention takes place.

## 2.11 Patients Council and Advocacy Services

The Patients Council provides a vital role in monitoring the implementation of this procedure, and a key role in discussing further version / developments of the procedures. Representatives will continue to be members of the steering group.

Advocacy services support patients in understanding and practically using their rights. All patients who are working with 1:1 continuous interventions will have the opportunity to engage with advocacy facilitated by the ward MDT. The team will be expected to support ongoing contact with advocacy throughout the period of continuous interventions.

| Appendix 3 | Competency framework |
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# Pan Lothian Continuous Intervention Competency Framework Guidance Notes

All staff who will be undertaking any aspect of care within Continuous Interventions must have completed competencies beforehand. The level of competencies completed will be dependent on the level of intervention that may be given and the level of responsibility of the professional providing the intervention.

| Nursing | Level 1 | Level 2 | Assessed by |
|---|---|---|---|
| CNM | | ✓ | Deputy Chief Nurse |
| Band 7 | | ✓ | CNM |
| Band 6 | | ✓ | Band 7 |
| Band 5 | | ✓ | Band 7/6 |
| Band 4 Nursery Nurse | | | Band 7/6/5 |
| Band 3 | ✓ | | Band 7/6/5 |
| Band 2 | ✓ | | Band 7/6/5 |
| Student Nurse | ✓ | | Band 7/6/5 |
| Medical Staff | | | |
| Consultant | | ✓ | PEER:PEER |
| Specialist trainees | | ✓ | Consultant |
| Junior Doctors | | ✓ | Consultant |
| Medical Student | ✓ | | Consultant |
| AHP's | | | |
| Occupational Therapists (Band 7/6) | | ✓ | Band 7 SCN |
| OT Band 5 | | ✓ | Band 7/6 OT |
| OT Band 3 | ✓ | | Band 6/5 OT |
| Music/Art therapy | ✓ | | Band 6/5 OT |
| Psychology<br>Consultant<br>Psychologists Band 7 – 8b<br>Psychology Bands 4-6 | | ✓ | PEER:PEER<br>PEER:PEER (Consultant)<br>Consultant Psychologist<br>Psychology Supervisor (Band 8a or above) |
| Self-harm service | | ✓ | QI Nurse |
| Band 7 Dietician | | | Band 7 SCN |

# Pan Lothian
# Continuous Intervention Competency Framework

| | |
|---|---|
| Name: | |
| Ward: | |
| Position: | |

| Has been able to demonstrate that they have achieved the following competencies in carrying out the NHS Lothian Continuous Intervention Policy. | |
|---|---|
| Level 1 | |
| Level 2 (all registered practitioners) | |

| | |
|---|---|
| Assessor / Date | |
| Staff Member / Date | |

# Level 1 competency

The Healthcare practitioner can demonstrate a clear understanding of the Continuous Intervention policy and how it can relate to the delivery of person-centred care to inpatients within mental health services.

| | Achieved | Y | N |
|---|---|---|---|
| Knowledge | • Staff can outline the principles of the Continuous Intervention Framework.<br>• Staff can describe situations where continuous Interventions may be considered.<br>• Can describe a range of interventions that may be considered as an alternative to Continuous Interventions<br>• Is aware of and can comment on the 'From Observation to Intervention Framework' document | | |
| Skills | • Can describe a range of interventions that may be appropriate to put in place for patient on continuous interventions<br>• Can demonstrate accurate recording of patient's presentation during period of continuous intervention | | |
| Attitudes | • Can discuss the importance of the involvement of patients and carers in the Continuous Intervention Process<br>• Shows through discussion that the patient is at the centre of all decisions and their safety and dignity is always considered. | | |

Competency achieved Yes/No

**If No**

| Action Plan: | |
|---|---|

| Review Date | |
|---|---|

**NB Level 1 competencies must be achieved before staff can take part in Continuous Intervention**

| Assessor | Name | Position | Date | Staff member | Name | Position | Date |
|---|---|---|---|---|---|---|---|

# Level 2 competency

The Healthcare practitioner can demonstrate a clear understanding of the Continuous Intervention policy and how it can relate to the delivery of person-centred care to inpatients within mental health services.

| | | Achieved | Y | N |
|---|---|---|---|---|
| Knowledge | | • Can discuss the decision-making process when continuous interventions are being considered and can identify alternatives to such an intervention<br>• Can describe the roles and responsibilities of different members of the MDT regarding Continuous Intervention<br>• Can discuss a range of different therapeutic interventions that may be considered for use with a patient on continuous interventions<br>• Is aware of and can comment on the 'From Observation to Intervention Framework' document<br>• Shows a knowledge and understanding of Trauma Informed Care<br>• Can identify different risk assessment tools that may be used when considering continuous interventions | | |
| Skills | | • Can describe through discussion the initiation and process of the 'Clinical Pause'<br>• Can discuss the escalation and review process regarding continuous interventions both in and out of office hours<br>• Can demonstrate accurate recording of patient's presentation during period of continuous intervention<br>• Can accurately use the related canned text relevant to Continuous intervention<br>• Always manage ward resources to ensure safety of patient<br>• Ensure that a person-centred care plan related to continuous intervention is developed and reviewed regularly | | |
| Attitudes | | • Can describe a range of issues for consideration when Continuous Interventions are being considered.<br>  ○ Advance statement<br>  ○ Patients safety and dignity<br>  ○ Role of advocacy | | |

| | | | | |
|---|---|---|---|---|
| | | • Can discuss the importance of the role of the carer and identify any carer needs<br>• Demonstrate the ability to challenge and voice constructive opinions about planned care. | | |

Competency achieved Yes/No

**If No**

| | |
|---|---|
| Action Plan: | |

| | |
|---|---|
| Review Date | |

**NB Level 1 competencies must be achieved before staff can take part in Continuous Intervention**

| Assessor | Name | Position | Date | Staff member | Name | Position | Date |
|---|---|---|---|---|---|---|---|

| Appendix 4 | Flowchart for Clinical Pause and Continuous Intervention |
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# Continuous Intervention, 3 Step Clinical Pause Flowchart

MDT identifies need for further risk assessment due to
1. Clinical deterioration of the patient's mental state
2. A change to the person's personal situation such as interpersonal conflict or break-up, receiving bad news, deterioration in physical health
3. Further risk information comes to light which was not previously considered

1

**Clinical pause**

Up to 2 hours – The MDT use this time to assist the patient to de-escalate by use of engagement or medication instead of resorting immediately to continuous interventions. The Patient will have a high level of input from MDT to facilitate the assessment and maintain safety.
Assessment should include patient's views, carers' views, risk assessment, use and response to medications, recent substance use or withdrawal, care plans, formulation and the patient's advance statement.
Patient should be supported to use personalised strategies and interventions. MDT to contribute to a review of the level of intervention being offered

- Clinical Pause TRAK entry \cpc

2

Are continuous Interventions required?

Yes

At the earliest opportunity initiate a multidisciplinary discussion and agree care plan using a formulation approach
Assessment of the need for continuous Intervention e.g. do we need continuous sight of patient, where are they allowed to go? etc.
Follow guidance in SOP
Proactively review continuous intervention and support required as part of the patient care, treatment and safety plan

No

End Process
Capture learning from clinical pause

**Review**

All reviews should clearly document criteria for ending the period of continuous intervention.
A full review should take place every day including weekends and bank holidays (can be via telephone/TEAMS). This review should include as a minimum Approved Medical Practitioner, the relevant charge nurse (or CCN) and ward staff but it is expected that all relevant members of the MDT will be invited to participate (during office hours).

- Review TRAK entry \clreview

3

Clinical teams must ensure that any periods of continuous intervention or support are evidenced by the following factors.

- They are **purposeful** – clearly planned with specific psychotherapeutic interventions and/or activities, related to the patient's clinical needs and strengths.
- They are **goal directed** – aiming to return to a frequency of interventions that is less intrusive, as quickly as possible