SOP: Interventions in General Adult Inpatient Settings across NHS Lothian

NHS Lothian

Contents

1.0 Purpose

The purpose of this procedure is to provide clinical staff with direction and guidance about maintaining safety using intervention levels for an individual or others, during periods of distress or when a patient is assessed at being at risk of harm to themselves or others within adult inpatient wards in NHS Lothian including:

- Responsibilities of all staff involved in interventions.
- Risk assessments and documentation.
- Decision making on the appropriate level of intervention required.
- Patient and carer involvement/information required.
- Staffing, including escalation procedure.
- Reviewing levels of interventions.
- Providing interventions in practice.
- Education and training required.

2.0 Scope

The guidance contained within this document applies to all adult general inpatient areas, including acute hospitals and community hospitals/inpatient facilities, and would be applied in situations where the risk assessment identifies and/or professional judgement of the clinical staff considers the need for intervention.

This procedure must be applied by all clinical staff working in these settings, including those working with Staffbank, and on temporary, locum, honorary, agency or fixed term basis, and students, within NHS Lothian.

The general principles can be applied to all clinical areas and clinical staff within NHS Lothian but may be particularly applicable to nurses, medical staff, and allied health professionals, working in collaboration with the patient.

Staff working in Mental Health services should refer to the Standard Operating Procedure for the Practice of Interventions in Mental Health Services

3.0 Definitions of intervention levels

To ensure standardised and consistent terminology across all NHS Lothian inpatient settings, the term ‘intervention’ replaces the terms; observation, supportive observation, close/constant supervision, 1:1 care among others. This is in line with Healthcare Improvement Scotland’s (2019) Framework and acknowledges the need for safe and therapeutic engagement with patients to form part of the care provision.

Interventions are a continuum-based approach which allows staff to focus on personalising meaningful interventions to a patient’s overall needs and purpose of admission, rather than determining interventions solely on the presence or absence of risk.

Level of risk should be determined following full assessment of patient using appropriate risk assessments and the least intrusive and restrictive level of intervention that is appropriate to the situation should always be adopted so that due sensitivity is given to a patient's dignity and privacy whilst maintaining the safety of the patient and/or those around them. The practice of intervention within inpatient care settings must above all be a process of personalised safe and therapeutic engagement.

Decisions about intervention levels should made in a reflective and thoughtful way that engages as many important people as possible, including the patient, and the patient's carers/relatives where appropriate, the Senior Charge Nurse or Nurse- in-Charge and the multidisciplinary team.

There are three levels of intervention used within NHS Lothian inpatient settings, with increasing intensity:

Intervention Level	Definition
General	This is the minimum level for all patients. It will therefore apply to most patients who are assessed to be at **low risk** of vulnerability, suicide, self-harm, or harm of others. Patients' needs are met by provision of usual ward care. The nurse in charge of the patient's care should always have knowledge of the patients' whereabouts, such as whether they are on or off the ward. Access to therapeutic interventions should be available regularly throughout the day.
Increased	This level is appropriate for patients who are assessed as potentially, but not immediately, at **medium risk** of vulnerability, suicide, self-harm, or harm of others during periods of distress. A designated staff member must be aware at all times of the precise whereabouts of the patient through visual observation or hearing at prescribed time intervals over 24 hours. The primary purpose of increased interventions is to keep the patient safe by increasing engagement, with the aim of developing a supportive relationship with the patient, engaging in action or activity that may help to calm the patient.
Continuous	This level is appropriate for patients who are assessed as being at the **highest level of risk** of vulnerability, suicide, self-harm, or harm of others during periods of distress. The patient will require the continuous presence of a member of staff to support them to manage their distress and their interactions with other people safely. A designated staff member should always be within an appropriate

	level of proximity to the patient to carry out the continuous intervention and always be able to see and hear the patient. Periods of continuous interventions should be therapeutic in nature and should focus on supporting and working alongside the patient in their recovery.

Increased or continuous interventions cannot be reduced or stopped unless discussed with the Senior Charge Nurse or the Nurse in Change of the ward.

See Appendix 1 - Intervention Levels and Therapeutic Engagement for General Adult Inpatients for detailed information on actions to take and consider for each level, and Appendix 2 - Common triggers and interventions to be consider.

4.0 Capacity

In Scotland, all adults are presumed to have the capacity to make decisions about their medical care. However, there are circumstances where an adult might permanently or temporarily lose the capacity to make specific decisions. The Adults with Incapacity Act (AWIA) can be used in these cases. The AWIA defines incapacity, in adults aged 16 or over, as when an adult is incapable of:

- Acting on decisions; or
- Making decisions; or
- Communicating decisions; or
- Understanding decisions; or
- Retaining the memory of decisions; or
- Because affected by mental disorder or inability to communicate because of physical disability (this physical disability incapable of being made good through human or mechanical aid).

Of note, this capacity relates to a specific decision, and is not "all or nothing". It is possible for an adult to retain the capacity to make decisions about some aspects of their care, but not others.

The clinical judgement as to whether a patient retains the capacity to make decisions regarding treatment or welfare should be made by an experienced doctor from the team providing their care in most circumstances. These decisions do not typically require the specific expertise of a psychiatrist.

If the patient is assessed as lacking capacity, an AWI Section 47 certificate and AWI Annex 5 (available on the NHS Lothian intranet) must be completed. The Annex 5 treatment plan is an essential stage in the placement of a Section 47 certificate. It allows a clear documentation of the patient's capacity and what the certificate will and will not cover.

Section 47 certificates should be reassessed regularly and with any change in the patient's condition. They can be revoked and can also be replaced later.

It is key that capacity assessments are conducted and recorded accurately in the patient's notes on MedTRAK (TRAK). To assist clinicians with this with TRAK there is a canned text Capacity Assessment Guidance Tool. **To access; type \capacity and then press the space bar in the clinical notes.**

For more information please refer to Capacity & Consent intranet page on the NHS Lothian intranet.

4.1 The Mental Health (Care and Treatment) (Scotland) Act 2003

Usually when people become unwell, they understand that they need treatment. Sometimes, because of a mental disorder, people are unable or unwilling to agree to treatment. In certain circumstances, The Mental Health Act allows doctors to take people to hospital, or keep them in hospital, against their will.

4.2 Emergency Detention

An Emergency Detention Certificate (EDC) (section 36) allows a person to be held in hospital for up to 72 hours while their condition is assessed. Any fully registered doctor can complete this part of the Mental Health Act. If possible, it should be completed with the consent of a Mental Health Officer (MHO). For more information, please see the Procedure for patients detained under The Mental Health Act (Care and Treatment) Scotland 2003 (available on the NHS Lothian intranet)

4.3 Suicide Prevention

If staff assessing the patient are concerned about a patient's self-harm or suicide risk, they should **always** ask them directly if they are thinking of harming themselves. This will not increase their risk. Some ways to phrase these sensitive questions are:

"Sometimes when people feel this low it seems that life is not worth living. Have you had thoughts about ending your life?"

"Have you thought about how you would do it?"

"What has been keeping you going so far?"

If a patient is identified as being at risk of suicide, Liaison Psychiatry should be contacted in working hours, or the Psychiatry SpR on-call out of hours.

All staff must be aware of environmental risks (including ligature risks). See section 6.1.

5.0 Assessment

Nurses must use their clinical judgement to ascertain what risk assessments are required for each individual person admitted to their area, and this must be reviewed frequently. TRAK will display icons for each risk assessments review date:

Icon	Description
⧗	Risk assessment is required to be completed for the first time
⧗	Risk assessment is due on the day
⧗	Risk assessment review timescale is overdue
⧗	Risk assessment is up to date

If the nurse considers a risk not to be relevant at the time of assessment, they must tick the checkbox within the relevant assessment and provide rationale:

Full information on the risk assessment icons can be read in the TRAK Person-Centred Care Plan and Risk Assessment Status Icons document, available on the NHS Lothian intranet.

Risk assessments on TRAK relevant to this procedure include:

5.1 Falls Risk Assessment

This should be commenced as soon as possible for all adult patients who are admitted to hospital and completed within 24 hours of admission. This is especially important for those aged over 65, those with a history of falls or admitted due to a fall. This is a simple five-question assessment with any answer YES identifying the patient as more vulnerable to falls.

Review of Falls Risk Assessment

High risk of falls – Review daily

Low risk of falls – Review every 3 days

The falls risk assessment should also be reviewed if the patient falls or if their condition deteriorates.

5.2 4AT

Use to assess for delirium within 24 hours of admission:

- If patient is age 65 years or older
- Has cognitive impairment (past or present) and/or dementia

- Has a current hip fracture
- Has severe illness (a clinical condition that is deteriorating or is at risk of deterioration)

If a diagnosis of delirium is made and documented, use the Time Bundle (Part 2) Delirium Screening Tool (available on the NHS Lothian intranet/TRAK) to identify triggers, investigate cause, create a management plan, and engage with patient and families.

See Appendix 4 - Delirium Flowchart

Review of 4AT:

Risk Score 0 – Review weekly unless condition changes.

Risk Score 1-3 – Review every 3 days.

Risk Score 4 or above – Review a minimum of daily

5.3 Rationale for the Use of Bed Rails

Complete within 6 hours of admission.

The use of bedrails must be considered as part of the patient's individual care plan.

Refer to the Bedrail Protocol for full information

Review of Rationale for the Use of Bed Rails:

Yes, bed rails in use with clear rationale – every 3 days

No, bed rails not in use – weekly

5.4 Mobility Assessment

Complete within 6 hours of admission.

For patients that require manual handling assistance or present a manual handling risk the mobility assessment must be completed.

Review of Mobility Assessment:

A review should take place every 3 days unless condition changes.

5.5 Mental Health Risk Assessment

Completing the Mental Health risk assessments is a multi-factorial process and is a tool to assist in information gathering as part of an overall assessment. Information should be gathered on the current situation, history, and social factors to inform a collaborative approach to care planning and assess level of risk to the patient and others. This should be reviewed weekly or if there is a change in presentation, circumstances, or environment.

For further information and training on the TRAK Mental Health Risk Assessment is available on the NHS Lothian intranet.

6.0 Decision Making

Following full assessment using appropriate risk assessments and based on clinical judgement, the level of risk should be determined. Patients assessed as being at medium or high risk of harm to self or others should be discussed with the Doctor and Nurse in Charge as soon as possible and the most appropriate intervention level agreed upon. Actions and considerations should be discussed at this time including capacity, investigations and treatment and referral to specialist services. The least intrusive and restrictive level of intervention that is appropriate to the situation should always be adopted so that due sensitivity is given to a patient's dignity and privacy whilst maintaining the safety of the patient and/or those around them.

Any periods of intervention must be evidenced by the following factors:

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

Different levels of interventions may be required throughout the day and night dependant on the individual's needs. They should be agreed with the patient where possible and the multidisciplinary team and clearly documented in the person-centred care plan.

For further guidance please refer to Appendix 3 –Decision Making Flowchart.

6.1 Ward Environment and Patient Placement

6.1.1 Ward environment

All ward areas must undertake a Health & Safety Workplace Assessment on an annual basis, including an Ligature Point Inspection and Risk Assessment (available on the NHS Lothian intranet) to identify any specific risks associated with use of ligature (Refer to the Environmental Ligature Point Procedure) (available on the NHS Lothian intranet). Once completed, this risk assessment should be accessible to all staff working on the ward. All staff should be aware of ligature point risks within their ward/area, including those in bathroom areas, e.g. hooks on the back of toilet cubicle doors.

Staff must give consideration of the ward environment, particularly for patients assessed as requiring increased or continuous interventions, paying particular attention to hazards which may cause slips trips or falls. Objects, or other means, of harming self or others should be removed into safekeeping.

- Windows should be secured or, if they are opened, should only be opened to a maximum of 100mm (10cm)
- Staff should maintain constant awareness of hazards that may result in slips, trips and falls
- Items such as clinical sharps, and other items which may cause harm, must be cleared away
- Patients should be encouraged to keep their area and belongings tidy. Maintaining a tidy area will help to alert staff to any new risks in the environment.

Further information and guidance is contained in:

Ligature Point Inspection and Risk Assessment (available on the NHS Lothian intranet)

Model Risk Assessment, Slips Trips and Falls

Model Risk Assessment, Windows and Balconies

Clinical Sharps Procedure

6.1.2 Patient Placement

Patient placement in the ward must considered in as person-centred a way as possible. 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 are always staff and fellow patients present.

Staff should also consider how, for example, issues such as noise levels, lighting, and other patients, may impact on the patient.

Where a patient is on 'increased interventions', the designated staff member must be aware at all times of the precise whereabouts of the patient through visual observation or hearing and know where the patient is and/or if they are moving around, but does not have 'eyes on' the patient constantly.

Cohorting (looking after 2 or more patients) may only be carried out with permission from the Senior Charge Nurse and is only appropriate if a specific activity is being pursued for part of the day with two or more patients for example an art therapy session or game of dominoes. The description of a continuum is to allow for these therapeutic activities to be managed, assessed, and amended as appropriate to the individual's needs. Where the designated member of staff, responsible for engagement activities, is looking after two or more patients (i.e. cohorting) that will only be at the increased intervention level, and not at continuous intervention level.

6.2 Inpatient Searches

A priority of NHS Lothian is to ensure the safety and security of all patients, staff and others.

Where there are any immediate and significant concerns about the safety or security of any individual, the police should be called immediately by dialling 999.

It is not routine practice to carry out a search upon a patient's property or the environment in which they are being cared for. Exceptions exist in the following circumstances:

- Patients are at risk of suicide
- Patients have a history of violence involving weapons
- Patients have a history of illicit substance misuse
- Patients have a forensic history i.e. arson
- Patients are suspected of concealing a weapon or a dangerous item/substance
- A vulnerable patient is suspected of being coerced or manipulated by another patient into concealing items such as weapons or drugs

NHS Lothian authorises medical staff and nursing staff to undertake searches in the circumstances described. Searches of a patient or their property must only take place if there has been a risk assessment and a risk identified or valid concerns have been expressed by staff, relatives and carers or other patients.

Consent **must** be sought before searching a patient's belongings or property. If the patient refuses, consent it is the responsibility of the responsible medical officer (RMO) to reassess the risk and record this in the patient's record.

To assist the consent process, information leaflets are available for patients and visitors:

- Why am I being searched? Information for patients [under development]
- Searches for restricted and prohibited items, Information for visitors [under development]

Further guidance is available in the Procedure for Searching Patient's Personal Property within NHS Lothian (available on the NHS Lothian intranet).

6.3 Who can carry out increased and continuous interventions?

Interventions will usually be carried out by a nurse or student nurse (but not limited to nursing) and can include non-permanent staff such as bank and agency. These staff must have completed the necessary training and complete the Patient Engagement Policy and SOP for Interventions in General Adult Inpatient Settings - Competency Assessment following the Patient Engagement (Foundation) LearnPro Module and, where possible, the staff carrying out the intervention should be known to the patient.

It is the responsibility of the Senior Charge Nurse, or Nurse-in-charge of the ward, to ensure that staff are appropriately allocated to increased and continuous intervention duties. Consideration must be given to the patient's cultural, religious beliefs and gender specific needs before allocating a staff member. If this is not possible an explanation should be offered to the patient and their family where appropriate.

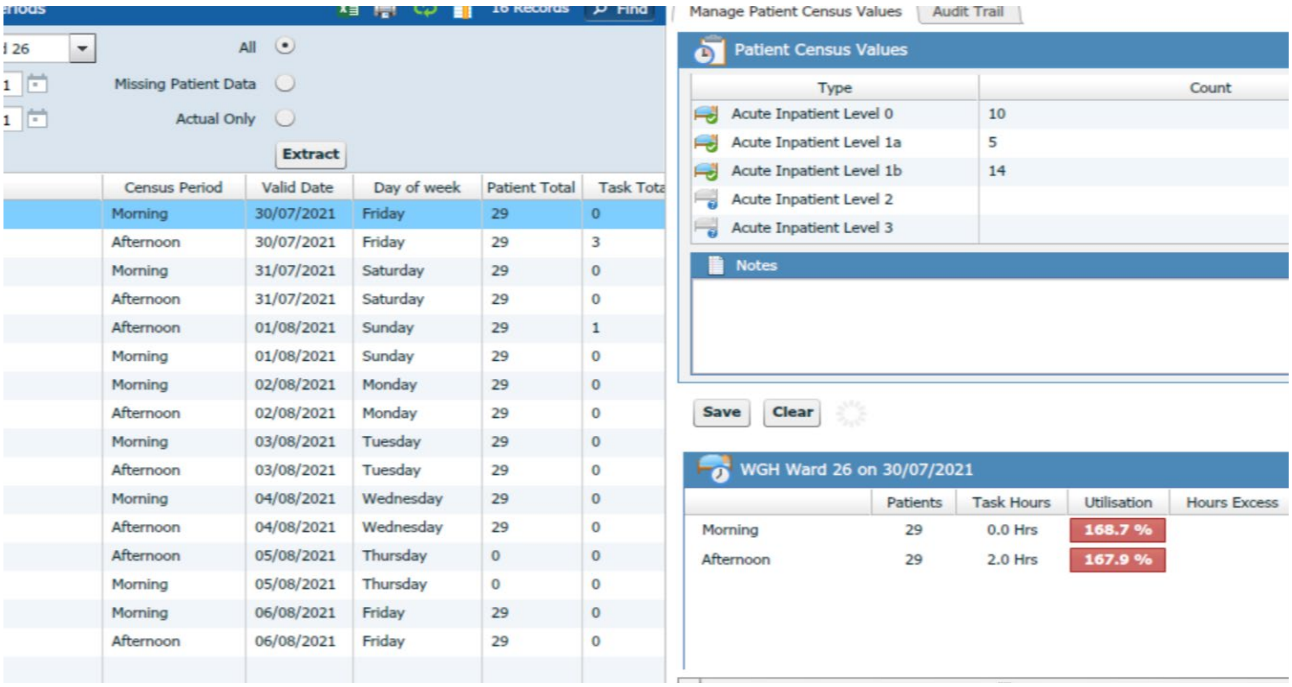
The period during which staff undertake increased and continuous intervention duties should not exceed a continuous period of 2 hours. Therefore, a clear plan for who will provide support to the patient for the 24-hour period should be available at the start of each shift that all staff involved are aware of. There should be a clear plan agreed for staff changeover after each 2-hour period, including time to ensure a verbal handover.

6.4 Staffing Levels/Rostering

The Clinical Nurse Manager must always be informed of patients who are assessed as requiring increased or continuous interventions and this information shared at site/service safety huddles.

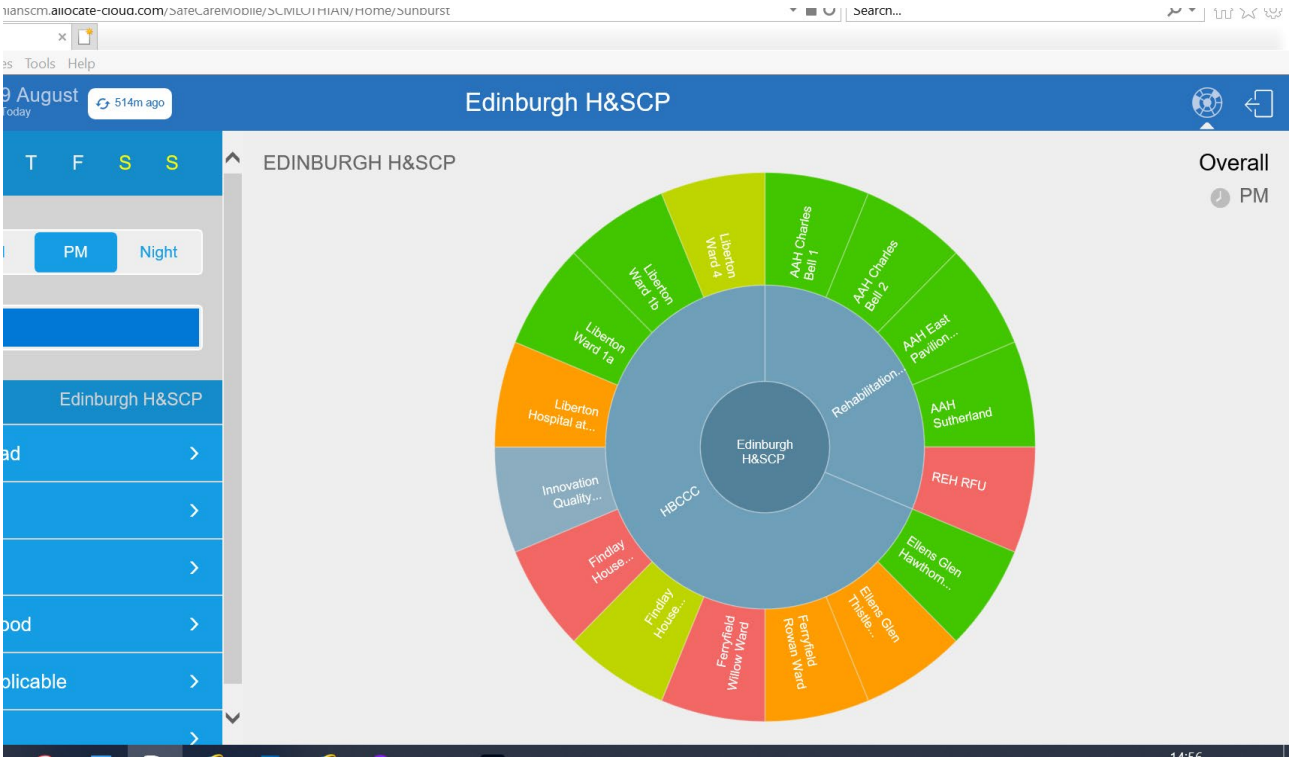
All adult in-patient wards have access to SafeCare - within the electronic rostering system - to identify and record every patient's level of acuity and dependency twice daily. This identifies in real time if the number of staff available is adequate to provide safe staffing. It is the responsibility of the nurse-in-charge to complete SafeCare and identify the risk of harm to patients and/or staff. If appropriate the nurse in charge must escalate any identified staffing risk as soon as possible, using local procedure to inform site and senior staff.

SAFECARE



Mitigation using SafeCare Live should be used in the first instance to identify any area that could release staff to provide assistance, even in the short term, and supplementary staffing should be sourced as soon as possible.

SAFECARE LIVE



Before delegating intervention duties to any staff, the nurse-in-charge must ensure that the staff member:

- Is clear about the reasons why the patient is on their level of interventions
- Has been briefed about the patients' history, specific risk factors and particular needs of the patient's person-centred care plan
- Is familiar with the ward and potential risks in the environment, and how to gain rapid access to assistance if required

6.5 Responsibilities of Designated Staff Member

The aim of providing interventions is to develop a supportive relationship and keep the patient safe through engaging in therapeutic engagement. Prior to carrying out interventions, the designated staff member must:

- Familiarise themselves with the specifics of the care plan including what matters to the patient and clarify anything not understood with the nurse-in-charge.
- Always introduce themselves to the patient as the designated support nurse at the beginning of each session.
- Consideration should be given to how an individual's dignity could be maximised without compromising safety when individuals are in a state of undress, such as when using the toilet, bathing, showering, dressing, etc and clarity should be sought from nurse in charge if unsure.
- When interacting with patients' staff should get to know them as individuals and what and who matters to them; this will provide an understanding of the most appropriate interventions such as engaging in an action or activity that may help to calm a stressed/distressed patient and what the stressors are that could create an escalation of the risk and should be avoided.
- The opportunity should be taken to assess/monitor specific issues noted within the care plan and other changes that may include the following:
  - General behaviour
  - Movement
  - Speech
  - Appearance
  - Expression of ideas
  - Orientation
  - Food and fluid intake
  - Mental Health
  - Physical Health
  - Mood and attitude
  - Interaction with others
  - Reaction to medication
  - Level of consciousness
  - Cognition

Any concerns must be immediately communicated to the nurse in charge.

- Complete any required documentation at the frequency stipulated in the individualised care plan. This may include Care Rounding, Behaviour Charts, Food, Fluid and Nutrition Charts and others.

- The staff member must provide a verbal handover to the nurse that is taking over the intervention, encouraging patient participation in the handover when possible.
- If the designated staff member cannot continue the intervention for any reason, they will be responsible for notifying the nurse-in-charge, whilst maintaining the patient's safety, who will ensure that another member of staff carries takes over the intervention period.

6.6 Visitors and Increased/Continuous Interventions

Staff should always welcome the support and company of a patient's relatives and/or friends to assist with interventions and well-being. Depending on the risk identified the patient may prefer the company of a relative/carer or friend. With the patients consent, relatives/carers and visitors should be provided with information regarding the rationale for the patient requiring increased or continuous interventions.

For patients on increased interventions, it may be appropriate for the relative/carer to provide a period of intervention and the designated staff member to reduce their level of intervention (with permission of the nurse-in-charge). Relatives/ carers and visitors must be made aware that they are to inform staff when they are leaving the patient, and this must be clearly recorded and documented.

For patients on continuous interventions, the designated member of staff should continue to be within an appropriate level of proximity to the patient to carry out the continuous intervention and be able to see and hear the patient while relatives/carers and visitors are with the patient. At the discretion of the nurse-in-charge and based on the clinical and risk assessment at the time, this may be reduced to maintaining a visual observation only to allow periods of privacy for the patient and their loved ones. This decision and the rationale including agreed timeframe must be documented in the patient's progress notes.

6.7 Reviewing Levels

Periods of intervention should be as least restrictive as possible, should be therapeutic in nature and should focus on supporting and working alongside the patient in their recovery.

Proactive review of the level of intervention a patient requires should be, as a minimum, every 24 hours, including weekends and bank holidays.

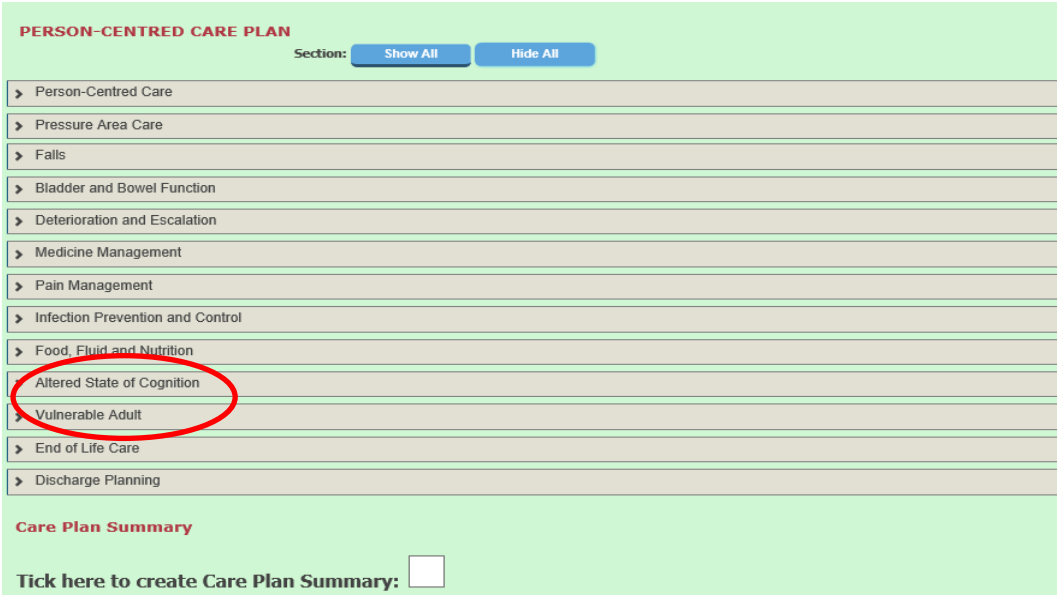
All reviews should clearly document the criteria for increasing or decreasing the level of intervention a patient requires.

The level of intervention cannot be reduced or stopped unless discussed with and agreed by the Senior Charge Nurse or the nurse-in-charge of the ward and ideally the multidisciplinary team. This must also be discussed with the patient and their carer/family where appropriate. The full reason for the change, the names of all staff involved in the decision and criteria for reinstating the level must be documented in the patient's progress notes and care plan. The decision must also be communicated to the multidisciplinary team via shift handovers and safety brief/huddles.

6.8 Documentation

The risk assessments highlighted in Section 5.0 of this procedure should be completed on TRAK, following which a person-centred care plan should be created.

All patients should have their intervention level recorded in the Person-Centred Care Plan on TRAK under either the 'Vulnerable Person' section or the 'Altered State of Cognition' section, depending on which the nurse feels most appropriate. Please refer to the SOP, Model Ward – Person-Centred Care Plans for detailed information on where to access the care plan on TRAK and how to complete:



The care plan should be subject to ongoing review; as a minimum, every 24 hours and must include the following:

- The person's goal of care and nursing aims/personalised aims of care.
- Information from the nurse's observations on assessment.
- Intervention level
- Specific personalised interventions
- Daily update of care given and outcomes.

Considerations for the person-centred care plan include:

- Special requirements, e.g. dignity, culture, religious beliefs, gender specific needs.
- Decisions regarding visitors (See section 6.6)
- Specific interventions known to calm patient when stressed/distressed.
- Mealtimes.
- Bathroom access and privacy.
- Medicine administration.
- Sleep and frequency/level of interventions overnight. It is important that the arrangements maintain the patients' dignity and promote a healthy sleep environment whilst also managing the identified risk.
- Any specific issues to be monitored during periods of intervention.
- Off ward arrangements (e.g. actions should patient require to go for a procedure, or family wish to take out with/without staff).
- Action to take if patient goes missing (whom to notify).
- Additional documentation required may include the Getting to Know Me Document, Care Rounding, NEWS2, Pain Assessment, Food/Fluid Diaries.

7.0 Communication and Engagement

7.1 Patients, Families and Carers

Levels of interventions should be discussed and/or negotiated with the patient and (whilst taking into consideration patient consent, confidentiality, and capacity issues) their carer/family wherever possible. With some patients it may be necessary to use a range of mechanisms to explain this. Patients should be offered the opportunity to talk to a member of the Multi-Disciplinary Team regarding any concerns or questions they have with regards to the level of intervention. The patient should be encouraged and supported to co-produce their person-centred care plan to include what and who matters to them, and this may also include family or carers as appropriate.

Staff must clearly explain the reasons for the level of intervention decided. If the patient lacks capacity to have these discussions, then the intervention level and care plan must be discussed with their Welfare Guardian/next of kin. The opportunity to gain information from the patient's relatives and carers as to the patient's likes and dislikes and history can assist with specific intervention options for staff when the relatives are unable to be present.

Patients/carers should be provided with a copy of Patient Engagement and Interventions - Information for Patients and Carers.

7.2 Between Staff

Increased and continuous interventions will involve several nurses or other staff members, with care being handed over at regular intervals. Excellent communication among staff must be maintained and staff involved in interventions must be involved in the team handover at the

beginning of each shift where intervention levels must be clearly stated including a clear plan of who will be undertaking the interventions throughout the shift and any specific person-centred information regarding the patient's care plan.

A verbal handover will be given at each change of staff member delegated intervention duties, involving the patient in this wherever possible. An entry must be made in the patient's 24-hour Interventions Record for General Inpatients detailing any significant events which occurred during the period.

At the end of each shift the Daily Progress section of the care plan will be updated using the information from the Interventions Record which will be used to automatically generate the care plan summary within the progress notes on TRAK.

The nurse-in-charge should give an update on each patient requiring increased or continuous interventions to the CNM at each site safety huddle/brief.

Wards may choose to use their own method for the ongoing highlighting of patients on increased/continuous interventions, such as using the ward whiteboard for example. However, these methods must ensure patient confidentiality, dignity and respect and the Senior Charge Nurse must ensure that all staff working in the ward are aware of the local process.

8.0 Missing Persons and Absent Patients

It is the responsibility of clinical staff, as part of ongoing assessment, to identify and initiate action for those patients who may be potentially at risk of becoming a missing person. Clinical staff must set up local systems to ensure that they are aware of patients' whereabouts on a regular basis.

8.1 Missing Persons

- Patients who are HIGH risk and disappear from an in-patient area, treatment area or hospital grounds and whose condition and/or devices give cause for concern (e.g. venflon in situ)
- Patient at immediate risk to themselves or others:
- Patients who wander or are disorientated are at HIGH risk because of factors in their clinical or mental presentation or who have shown a propensity to stray beyond the view or control of staff and who lack capacity to make informed decisions should they leave the site.

8.2 Absent Patients

- Patients who are considered LOW risk and leave the in-patient area, treatment area or hospital grounds without informing staff. An absent patient will have been deemed to have capacity to make informed decisions should they leave the site.
- A person who is discovered not to be in the hospital/care setting or has failed to attend/return to the hospital/care setting, who is identified as being not at risk of harm to themselves, or any other person.

The NHS will not report this matter to the police and will retain ownership and responsibility for contacting that person.

If this is not possible, or the person needs to be physically traced, then the police can be called on 101 and a 'cause for concern' incident raised.

This person is not a "missing person" (unless new circumstances or evidence around risk and vulnerability are known or become known).

Owing to the changing nature of health, and associated risk, the level of risk is dynamic, and individuals can move between these levels of risk and robust and timely communication between agencies is required to react in a proportionate and appropriate manner.

All these risks are subject to clinical judgement.

8.3 Missing Persons and Absent Patients Search

Guidance on searching for a Missing Person or Absent Patient is contained within:

Patients who absent themselves from Adult Inpatient Services, Royal Edinburgh Hospital

Standard Operating Procedures for Reporting Missing Persons from Adult & Older People's Mental Health In-patient Services, Royal Edinburgh Hospital

RIE Missing Person Procedure

Adult Missing Patient Policy, Acute Hospitals

9.0 Transfer from Mental Health Services

Many patients who have been transferred to acute hospitals from Mental Health areas are detained under the Mental Health (Care and Treatment) Scotland Act 2003, and some will require an escort (accompanying nurse) with knowledge of the patient and mental disorder. For further information refer to SOP for Transfer and Escorting Inpatients to and from Acute Medical Hospitals (REAS) (available on the NHS Lothian intranet).

10.0 Staff Education and Training

Each Senior Charge Nurse or Nurse in Charge will be responsible for ensuring all staff who are expected to undertake interventions receive training and education appropriate to their roles and responsibilities, to ensure that they have they are competent to implement the Patient Engagement Policy and this procedure into practice.

A competency framework should be used all for all staff performing interventions and therapeutic engagement with patients.

All staff must complete the Patient Engagement (Foundation) LearnPro module and complete the Patient Engagement Policy and SOP for Interventions in General Adult Inpatient Settings - Competency Assessment with an identified mentor in their clinical area.

Each member of staff undergoes an annual Performance and Development Plan Review (PDPR), highlighting their on-going performance and their learning and development needs. The Senior Charge Nurse/Line Manager is responsible for ensuring that the staff members competence regarding the safe supportive care of patients that pose a risk to themselves, or others, is achieved and up to date.

Training in person-centred care planning is also essential to this SOP and should be achieved through completion of the Introduction to Person-Centred Care Planning Workbook (available on the NHS Lothian intranet).

11.0 Monitoring and Review

- Each Ward / area should undertake monthly PCAT-4 audits reviewing five patients per month which includes review of the quality of the person-centred care plans including those for patients who require increased or continuous interventions.
- Results of PCAT-4 data should form part of the monthly one to one conversation between the Clinical Nurse Manager and the Senior Charge Nurse triangulated with any Significant Adverse Event reports and Datix investigations where Care Planning has been identified on the report.
- Evaluation of the person-centred care plans will be collated through the wards quarterly Lothian Accreditation and Care Assurance Standards (LACAS) (available on the NHS Lothian intranet) report.
- As part of the LACAS reviews, the Clinical Nurse Manager will undertake ward observations of person-centred care delivery, including patients undergoing continuous or increased observations.
- The Senior Charge Nurse should collect feedback from patients and their families/carers on their experience of this procedure using the Care Experience Improvement Model (CEIM)
- The Senior Charge Nurse should collect feedback from staff, allowing them an opportunity to voice areas of concern, the need for more training or suggestions to improve this procedure.
- The LACAS Site / Area report will provide a structure to inform areas for improvement.
- Each Ward's Quality Improvement Plan will be displayed locally, and at Site / Area level.
- Each ward will follow the LACAS Submission & Report process to give ward to board level assurance.
- All breaches of this SOP or incidents involving patients receiving increased or continuous interventions must be reported on the DATIX system.

12.0 Associated materials

Patient Engagement Policy

Procedure for patients detained under The Mental Health Act (Care and Treatment) Scotland 2003 (available on the NHS Lothian intranet)

Patients who absent themselves from Adult Inpatient Services, Royal Edinburgh Hospital

Standard Operating Procedures for Reporting Missing Persons from Adult & Older People's Mental Health In-patient Services, Royal Edinburgh Hospital

RIE Missing Person Procedure

Adult Missing Patient Policy, Acute Hospitals

SOP for Transfer and Escorting Inpatients to and from Acute Medical Hospitals (REAS) (available on the NHS Lothian intranet).

Patient Engagement Policy and SOP for Interventions in General Adult Inpatient Settings - Competency Assessment

Patient Engagement and Interventions - Information for Patients and Carers

Model Ward SOP (available on the NHS Lothian intranet)

Person Centred Care Planning Workbook (available on the NHS Lothian intranet)

Risk Assessments on TRAK:

- Mental Health Risk Assessment
- 4AT Delirium Screening Tool
- Falls Risk Assessment
- Mobility Assessment
- Bed Rails Assessment
- TIME Bundle

eHealth Training Document: TRAK Person-Centred Care Plan and Risk Assessment Status Icons (available on the NHS Lothian intranet)

Forms/Charts

Interventions Record for General Inpatients

Care Rounding Chart

Rostering

SafeCare Process – Using SafeCare Live (available on the NHS Lothian intranet)

eRostering User Guide (available on the NHS Lothian intranet)

Environmental Risk:

Health & Safety Workplace Assessment

Environmental Ligature Point Procedure (available on the NHS Lothian intranet)

Quality Assurance

Lothian Accreditation and Care Assurance Standards Framework (available on the NHS Lothian intranet)

LACAS Review Timetable (available on the NHS Lothian intranet)

Intervention Levels and Therapeutic Engagement for General Adult Inpatients

The primary purpose of increased/continuous interventions is to maintain patient safety.

Staff should get to know the patient and what matters to them; this will provide an understanding of the most appropriate interventions such as engaging in an action or activity that may help to calm a stressed/distressed patient and what the stressors are that will create an escalation of the risk and should be avoided. Level of risk should be determined following full assessment of patient using appropriate risk assessments.

Risk	Intervention Level	Definition	Actions	Considerations
Low	**General**	Patients' needs are met by provision of usual ward care. Allocated member of staff should always have knowledge of the patients' whereabouts, such as whether they are on or off the ward. Access to therapeutic interventions should be available regularly throughout the day.	– Ask patient 'what matters to you and who matters to you and record in Person-Centred Care Plan on TRAK – Evaluate and update care plan daily.	– Environmental Risk Assessment – Therapeutic Intervention boxes
Medium	**Increased**	A designated staff member must be aware at all times of the precise whereabouts of the patient through visual observation or hearing at prescribed time frequencies. Patient may require regular therapeutic engagement. This level of intervention cannot be reduced or stopped unless discussed with the Senior Charge Nurse or the Nurse in Change of the ward.	– Inform SCN/CNM – Discuss with patient/family and create personalised plan of care to include most appropriate interventions over a 24-hour period and communicate at handovers. – Medication review with Doctor/Pharmacist – Review response to interventions and review plan of care regularly. – Communicate and escalate at safety huddle – Plan of care reviewed minimum every 24	– Workforce requirements/experience, skills, and competencies of staff on duty to provide interventions. – Environmental Risk Assessment – 4AT Assessment/TIME Bundle – Adults with Incapacity (AWI) Section 47 with ANNEX 5 Treatment Plan – Getting to Know Me Document – Relocation of patient to area of higher visibility. – Additional family/carer support – Referral to specialists

			hours	(Dementia/Mental Health/Falls) – Therapeutic Intervention boxes
High	**Continuous**	Designated staff member* should always be able to see and hear patient and patient should always be within an appropriate level of proximity to carry out required interventions, e.g. at arm's length. This level of intervention cannot be reduced or stopped unless discussed with the Senior Charge Nurse or the Nurse in Change of the ward.	– Inform SCN/CNM – Rule out/ identify and treat potential causes of delirium. – Medication review with Doctor/Pharmacist – Discuss with patient/family and agree plan of care to include most appropriate interventions over a 24-hour period and communicate at handovers. – Environmental Risk Assessment – Communicate & escalate at safety huddle. – Plan of care reviewed minimum every 24 hours.	– Workforce requirements/experience, skills, and competencies of staff on duty to provide interventions. – Adults with Incapacity (AWI) Section 47 with ANNEX 5 Treatment Plan – Relocation of patient to area of high visibility. – Additional family/carer support – Referral to specialists (Dementia/Mental Health/Falls) – Getting to Know Me Document – Therapeutic Intervention boxes

Common triggers and interventions to be considered

Interventions used to de-escalate and calm episodes of stress and distress and to engage patients will be individual to the patient's specific needs. Staff should get to know the patient as an individual and establish what and who matters to them; this will provide an understanding of the most appropriate interventions activity that may help them remain calm.

The following table offers some ideas of common triggers which if identified can be addressed early or prevented where possible and interventions to be considered to assist in de-escalation and engagement of patients who require increased or continuous intervention. This is not an exhaustive list:

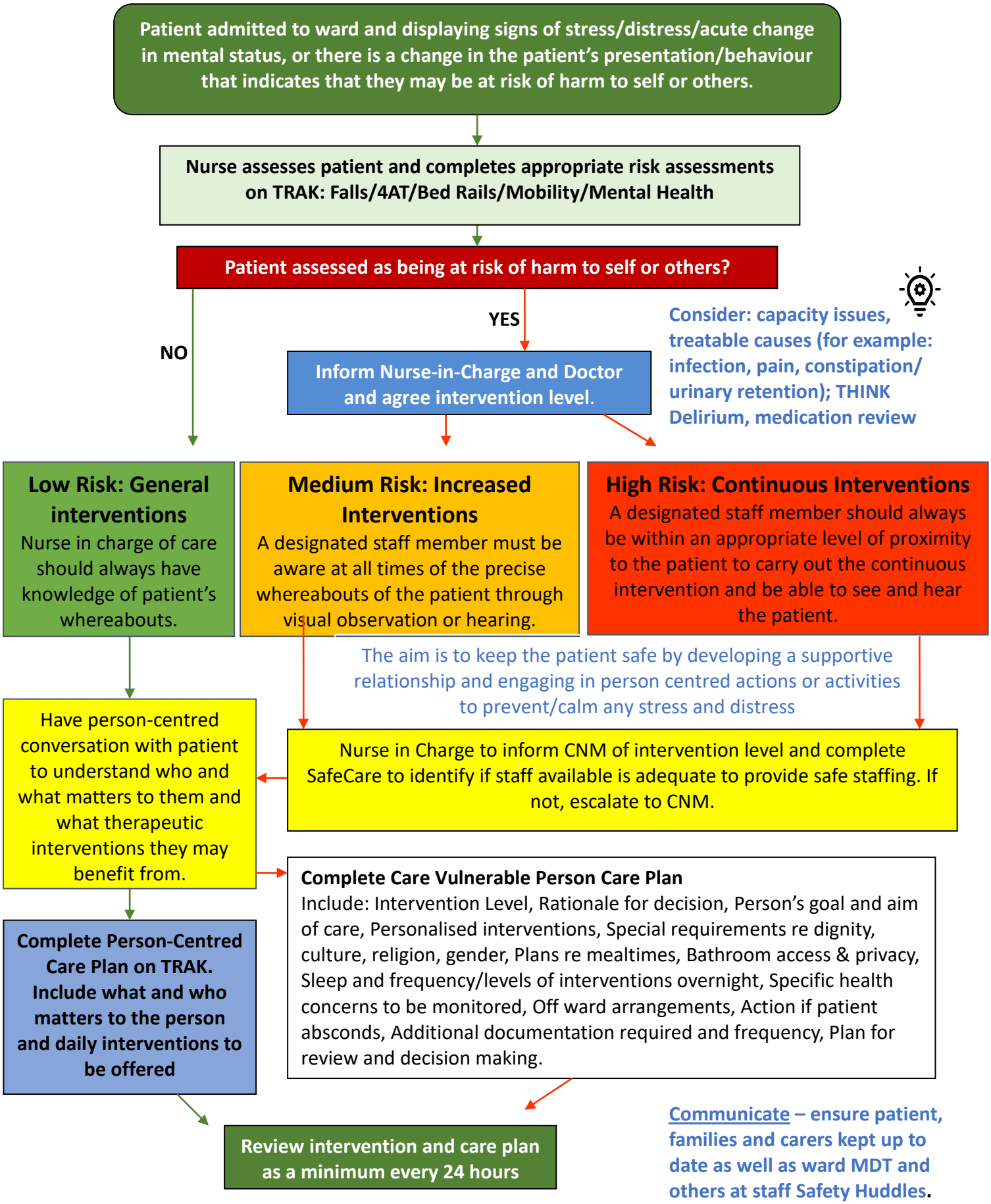
Common Triggers

- Hunger
- Thirst
- Depression
- Fear
- Noise
- Environment
- Certain Staff
- Times of Day
- Medication times
- Full Bladder
- Certain Medications
- Constipation
- Tiredness
- Anxiety
- Sun Downing
- Disorientation
- Pain
- Certain Visitors/Relatives/Carers

Interventions to be Considered

- Ward Interventions Box: e.g. jigsaws, games, playing cards, picture books etc
- Looking at reminiscence materials
- Calm/Quiet environment or room
- Music/radio
- Conversation about family, hobbies, and interests (use Getting to Know Me document/WMTY info)
- Engagement with certain staff (encourage consistency)
- Visitors/Relatives/Carers
- Walk with patient (check care plan before going off ward)
- Rest/Sleep
- Reading
- Appropriate management of
- Bladder & Bowels/Scheduled Toileting
- Orientation to ward/toilets/bed area
- Washing and dressing practice/Brushing/styling hair/manicures

Decision Making Flowchart



Delirium Flowchart