# MHS 23.1 - Continuous Intervention Guidance

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| Approved by: | Mental Health Policy Steering Group |
| Date approved: | 27/03/2025 |
| Date for Review: | 31/03/2028 |
| Replaces previous version: | MHS 23 Safe and Supportive Observation Policy and Operational Guidance (Revised) 2023 |

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## Practice and Operational Guidance for Continuous Intervention for Inpatient Multidisciplinary Teams

### 1.0 Introduction

The National guidance, From Observation to Intervention spsp-iop-from-observation-to-intervention.pdf (ihub.scot), A Proactive, Responsive and Personalised Care and Treatment Framework for Acutely Unwell People in Mental Health Care proposes that a ***continuum-based approach will utilise specific nursing and multidisciplinary interventions of a nature, frequency and intensity that is tailored to the clinical and personal needs of each patient and is therefore flexible and patient-led, and both proactive and responsive***.

It focuses practice on a culture of inquiry, personalised assessment and proactive, skillful mental health care and treatment interventions for all patients.

In NHSGG&C the current MH23 Safe and Supportive Observation policy has been replaced by a revised policy statement and this practice guidance. The practice guidance has been informed by the national guidance, other associated and relevant NHS GGC local policies and guidance. It has been developed by representatives from nursing, medical, psychology, AHP, operational management, staff partnership and the Mental Health Network and lived experience members.

The practice guidance aims to support Multidisciplinary team practice that will be in line with the seven underpinning national guidance principles as outlined in the policy and the 9 strands outlined below.

Strand 1: Involving carers and families in treatment, wellbeing, and recovery.
Strand 2: Adopting a continuum-based approach to care, treatment, and safety planning. Strand 3: Supporting early recognition of, and response to, deterioration.
Strand 4: Improving communication around clinical needs, deterioration, and risk. Strand 5: Promoting least restrictive practice.
Strand 6: Managing periods of continuous intervention or support Strand 7: Developing a trauma-informed workforce.
Strand 8: Supporting personalised care and treatment.
Strand 9: Creating an infrastructure to support learning and quality improvement.

### 1.1 Professional Lead and Senior Management Infrastructure to Support Staff

Each area has a local senior management structure with designated Professional Leads for Nursing, Medical, AHP, and Psychology and Pharmacy staff. These teams will support staff to implement the

CI policy and practice guidance and will provide Practice Development support and skills enhancement opportunities.

## 2.0 Continuous Intervention – Definition

Continuous Intervention (CI) is an enhanced level of care and is used when a patient presents with persistent elevated levels of risk that cannot be safely managed without CI and requires the continuous, supportive intervention of a member of staff. This intervention should be therapeutic in nature and should focus on supporting and working alongside the patient in their recovery. CI should be specific, therapeutic, and purposeful and informed by the patient's needs, strengths, purpose of admission and best practice.

The need for CI will be subject to ongoing review determined by the needs of the patient. The Continuous Intervention should be described in the CI Person Centred Care Plan (PCCP) (Appendix 1)

## 2.1 What does CI involve?

The continuous intervention descriptor within the CI PCCP needs to include what therapeutic intervention will be taking place, and how this will be delivered.

There is an understanding that having knowledge of the general whereabouts and wellbeing of all patients is necessary within an inpatient environment from a health, safety, and care perspective.

If a patient requires continuous intervention as part of the clinical risk assessment, this may involve a period of increased observation and engagement with staff. The nature, frequency, proximity, and delivery of the continuous intervention should be recorded in detail within the CI PCCP.

The CI will have several elements that include clinical, therapeutic, and enhanced engagement and activity requiring staff to use a range of clinical and practical skills, tools, and techniques. In practice this may be about providing a period of safety for people during temporary periods where they may be at risk to themselves or others.

The proximity of the member of staff to the patient as indicated by the clinical risk assessment framework should be agreed by the MDT and recorded in the CI PCCP with regular review periods outlined. The level of competence and skill required to conduct the CI as well as the duration should be noted in the CI PCCP, staff and patient wellbeing should always be a consideration particularly during an intense period of care delivery. Appendix 2 is the CI Designated Staff and Comments Log template that will be used to record staff allocation and

review of the CI daily. Appendix 3 is the EMIS recording form within the electronic patient record, which must be completed when a CI is commenced, changed, or removed.

### 2.2 When CI does not apply:

CI **will not** apply for patients where there is an ongoing need for increased/episodic support for specific needs such as personal care or where other care interventions exist, for example the falls bundle. In these situations, CI would only apply if there were a deterioration in mental health triggering a review of the risk which may result in CI.

CI **will not** apply for patients where risk can be managed by routine care and treatment.

CI **will not** apply where there is an acute event, and the incident is resolved, and the MDT are satisfied that the clinical risk has been managed.

### 2.3 What are the changes we expect to see in staff practice?

The previous Safe and Supportive Observation Policy focused on describing categories of observation and physical proximity of the person conducting the observation rather than the individualised nature of the care and interventions required.

The Continuous Intervention Policy promotes practice that is person centred and proportionate to presenting risks and engages the person directly. The interventions should always consider how the care will be conducted, the number of staff involved and the proximity of the member of staff to the patient. This must always be assessed, considered, agreed, and recorded in the persons CI PCCP, including the conditions present or absent, and which members of the team are able to alter the CI outlined in the CI PCCP.

CI takes cognisance of the dynamic nature of risk. It is based on an individualised and formulation- driven understanding of a patient's distress and related risk, in which this formulation is used to inform the intervention offered during ongoing care.

We have aligned the following practice guidance to the in-patient pathway and potential experiences that people may have throughout their stay in hospital and some of the critical decision-making points for people, their families, and staff.

## 3.0 Inpatient Pathway

The following sections outlines what should happen at each stage of the in-patient pathway and how it relates/contributes to Continuous Intervention. An Algorithm (Appendix 4) and a Policy Summary flow chart (Appendix 5) highlight key actions and decisions for ease of reference. Case Vignettes are available in (Appendix 6) to help staff to navigate patient interaction and decision-making perspectives and potential outcomes.

### 3.1 Preadmission

This tends to be the period between referral to the ward and admission into the ward. This may be a planned (elective) or unplanned (crisis) process and as such the period of pre-admission will vary from patient to patient.

During pre-admission, the referrer should have completed a robust assessment which they share with the ward and includes reason for admission and level of risk. Referrers should advise the level of input and the support the patient had prior to admission (if known). Level of intervention required within the ward, will be assessed, and determined by admitting ward staff. Relevant others such as families/carers and other services should be aware of the admission and involved if possible and agreed.

Referrers should inform ward staff of any pre-existing admission plans and/or current care guidance (e.g., advanced statement, psychological formulations, community based PCCP) There should be agreement about how the admission will happen and if there is a requirement to use the Mental Health Act (see PEP) 2024 Psychiatric Emergency Plan.pdf (scot.nhs.uk). Identification of the purpose, goals, and therapeutic tasks to be completed during admission must be described.

Ward staff should begin to plan admission to the ward and anticipate likely level of intervention required (e.g., consideration of safe staffing levels and requirements, environmental space). Ward staff should check whether there is a pre-established admission plan to follow (e.g., BPD pathway) MHS 58 - BPD Guidance - Pathway and Stepped Matched care.

## Specific guidance applies to Children, young people and adults with learning disabilities who are being considered for admission to an adult ward.

### CAMHS Consultant RMO Role:

- Involved in the ongoing management of the patient in conjunction with other community CAMHS staff involved in the case working with the inpatient multidisciplinary team.
- Assumes S22 Approved Medical Practitioner duties.
- Conducts weekly clinical reviews and coordinates a management plan. Patient Admission:
- If admitted to a general adult psychiatry ward, the patient is considered boarding from Skye House and should be on the transfer waiting list.

MWC Guidance:

- Recommends using side rooms over dormitories whilst considering the impact of isolation.

Staff Training and Intervention:

- Staff with experience of working with young people should be available to provide direct input to the PCCP, and support and guidance to ward staff.
- Ward managers should access bank staff familiar with young people.
- Joint training sessions and regular meetings with CAMHS are essential.
- Intervention levels are based on a multi-professional assessment of the young person's needs and vulnerabilities in an adult environment.

PEP: - http://www.staffnet.ggc.scot.nhs.uk/Partnerships/MHP/Legislation/PEP/S%20-%20Admission%20of%20under18s%20to%20General%20Adult%20Psychiatry%20Wards%20in%20 Glasgow%20and%20Clyde.pdf

Admission_of_young_people_to_adult_mental_health_wards review_12_june_2020.pdf (mwcscot.org.uk)

A best practice guideline for admission to adult mental health wards for under 18s with mental health problems : Adaption for Scotland. January 2020 (www.gov.scot)

**Learning Disability:**

Expertise and Services:

- Specialist Learning Disability Inpatient Services provide specialist assessment and treatment in relation to the patient's learningdisability.
- Most patients who need specialist input have moderate to profound learningdisabilities.
- Patients with mild learning disability and severe and enduring mental illness may have their needs better met on a General Adult ward.

Referral Process:

- All referrals should come from the sector Learning Disability psychiatrist and are discussed through the weekly bed management group.

Alternative Arrangements:

- If a patient is deemed to require a bed in Specialist Learning Disability Services but a bed is unavailable, patients may be admitted to adult mental health units.
- The receiving mental health service will be the same as for other patients of the same age and address.

Specialist Input:

- Admission and patient transfer should be in line with "MHS 45 Shared Protocol for Learning Disability and Mental Health Interface Working" and the PEP.
- Whether or not a patient with a Learning Disability requires a specialist inpatient service, they should receive support from the community Learning Disability team in line with the guidance "LD support to LD patients on GA wards".

Intervention Levels:

- Determined by a multi-professional assessment of the patient's needs.
- Consider the patient's potential vulnerability in an adult environment.

LD support to LD patients on GA wards.docx

http://www.staffnet.ggc.scot.nhs.uk/Partnerships/MHP/MHP%20Corporate%20Information/Policies/MHS%20Policies/MHS%2045%20-%20Shared%20Protocol%20for%20Learning%20Disability%20and%20Mental%20Health%20Interface%20document.pdf

**Acute Care:**

In the context of Continuous Intervention (CI) within acute hospital care, Mental Health (MH) liaison teams will request acute registered nurse to contact the NHSGGC Nursing and Midwifery Staff Bank to book a registered nurse or HCSW to provide what was previously termed enhanced observations, now referred to as CI. Otherwise, this process remains unchanged from current arrangements.

For MHS staff delivering CI offsite, CI processes and paperwork will follow the individual from MH wards.

### 3.2 Admission (initial assessment at point of admission)

This is the assessment that takes place when the patient enters the ward. This assessment should include risk assessment and identifying initial needs.

Based on rapid initial assessment, there are two potential outcomes:

- **Patient does not require continuous intervention.**
- **Patient requires continuous intervention.**

Staff should consider how admission and context can be traumatic for patients and those close to them. This will include gathering information about the individual's personal history and considering which aspects of inpatient care and treatment could be associated with the risk of re-traumatisation. Staff can then consider strategies to reduce the risk of this as far as possible. As part of the assessment actions should include:

- Check for advance statement and confirm Named Person.
- Collaboration fromcolleagues/collateral information from others e.g., family particularly when patient is acutely unwell.
- Getting to know patient – could be incremental process ("Getting to Know Me," "What Matters to Me" will not be a one-off exercise) – this will aid identification of what CI could entail.
- Getting to know a patient's coping mechanisms – helpful and unhelpful
- Direct intervention with patient and indirect observation of how the patient is, how they are behaving and interacting – incremental building up of assessment information allowingteam to get to know the patient.

- Risk Assessment – CRAFT warning signs, triggers – what helps, consider the requirement for continuous intervention and enhanced level of observation and engagement.
- Ward welcome and orientation should reference and outline therapeutic activity and where a continuous intervention can be utilised.

### 3.3 Assessment Process and Mental Health Risk Assessment and Management for Continuous Intervention

When a person requires inpatient treatment, their needs are unique, and when understood, staff can deliver a safe and effective person-centred Continuous Intervention when indicated. To determine the need for Continuous Intervention, the assessment and risk management process begins on admission.

Risk Management is everyone's business, and a multidisciplinary process conducted in collaboration with patients, families, and carers. A collaborative approach to the completion of CRAFT will enable the MDT to work effectively to assess and respond to changing needs and provide individual centred therapeutic Continuous Intervention MHS 07 - Clinical Risk Screening and Management Policy Welcome | Mental Welfare Commission for Scotland (mwcscot.org.uk)

#### 3.3.1 Admission Assessment will include:

- Referral source.
- Reason for hospital admission/presenting symptoms.
- Chronological account of events/aetiology and onset of current episode
- Precipitating factors observing for exacerbating/ameliorating factors.
- Pre-morbid personality
- If cognitive issues, enquire as to concerns with memory/onset/duration.
- Consideration of any additional requirements to support the admission process e.g. British Sign Language or Interpreter

  Accessing Advocacy Support is crucial for ensuring that individuals' voices are heard, and their rights are protected. By providing independent support to help patients understand their rights, express their views, and make informed decisions about their care and treatment. Advocates can assist with navigating systems, attending meetings, and communicating with professionals involved in providing care. They also offer support in situations where individuals may feel vulnerable or unable to speak up for themselves including the use of Continuous Interventions. By empowering patients, advocacy services play a vital role in promoting autonomy, ensuring fair treatment, and enhancing the overall quality of mental health care.

### 3.3.2 Mental State Examination

Appearance/Behaviour/Speech/Mood/Thoughts/Perceptions/Delusions/Cognition/Insight/ orientation/suicidal ideation/thoughts/acts of deliberate self-harm/previous self-harm history and understanding of reason for and attitude current admission.

### 3.3.3 Developmental History

Reliable indicator of adult self-esteem, interpersonal relationships, coping response developmental milestones, attachments, history of past trauma/neglect/physical/sexual/psychological abuse.

### 3.3.4 Family History

Will give a good indication of family relationships. Ascertain what their birth order was in the family they grew up in, what were the quality of family relationships when growing up; ascertain current family set up including any dependents/quality of relationships/close relationships/role within family/conflicts. Identify if any family psychiatric history, including identifying who they currently living with.

### 3.3.5 Personal History

Important in contextualising patient and builds upon developmental and family history. Helps to gain understanding of what has led the patient to become who they are and how they understand the world the way they do (early experiences/school/forming friendships/qualifications/further or higher educational attainment/employment history/spiritual history/psychosexual history/forensic history/substance use history.

### 3.3.6 Social History

Current social supports/networks/ability to establish and maintain relationships all of which provide an accurate indicator and is directly correlated to incidence of illness.

### 3.3.7 Past Psychiatric History

Contextualises current episode, assists with diagnosis/prognosis, establishes patterns and coping responses etc.

### 3.3.8 Past and Present Medical History

Enquires as to state of general health, physical co-morbidity, vascular – stroke/cardiac/diabetes, history of infection, history of cancer, mobility and pain experience, current medications with attention to any side effects, compliance or prompting required. Also consider lifestyle factors such as alcohol and drug use, smoking, physical activity, diet etc.

### 3.3.9 Functional History

ADLs/managing personal hygiene/self-care/managing medications/keeping safe/transfers/mobility/smoking/fire risk/managing money/mobility and transfers, falls, community alarm/Fire Safety Assessment. Existing Community supports.

### 4.0 Mental Health Risk Assessment and Management – CRAFT completion

CRAFT will be completed within **2 hours** of admission by the practitioner conducting the assessment (i.e., Junior Doctor or admitting Nurse). The assessment process will highlight risks ascertained from history, facilitate comprehensive mental health risk assessment CRAFT completion. The outcome of the assessment/CRAFT will determine if the person requires CI. The Continuous Intervention described within the PCCP requires a dynamic review and update of CRAFT, coordination of which is the responsibility of the person's allocated Named Nurse.

### 4.1 First MDT Meeting Following Admission

As part of the collaborative and proactive assessment process the Named Nurse (refer to Named Nurse Guidance) will coordinate and gather all risk relevant information to present in time for the first MDT meeting immediately following admission. This will inform the ongoing management plan and the development of the CI Person-Centred Care Plan.

Informed by CRAFT the MDT management plan will prescribe safe and effective, person-centred care. Where CRAFT indicates a continuous intervention this will support the MDT to formulate a Continuous Intervention Person Centred Care Plan that is aligned to personal preferences, preserves dignity is proportionate and of therapeutic benefit to the person requiring additional care and support including a description of the continuous intervention and engagement which has been agreed through the MDT processes to ensure that care is safe and effective.

Whilst the Named Nurse has a coordinating function each professional discipline will also have an opportunity to contribute to the MDT discussion and the formulation of CRAFT. This approach supports the development of individualised person-centred care.

**Actions:**

- **T**he MDT will agree who is responsible for updating relevant documentation following the MDT meeting.
- The Named Nurse will update (in the absence of the named nurse this will be completed by the delegated associate nurse or nursing team) the CI Person-Centred Care Plan detailing therapeutic interventions.

### 4.2 Risk increasing/decreasing.

Where any MDT practitioner becomes aware of a change in a person's risk profile, during their own therapeutic interaction or otherwise they would initiate a review of the Mental Health Risk

Assessment and Management Plan, CRAFT. At this point, and/or at any other time that the MDT practitioner senses a 'shift' in the person's presentation, they should also give some consideration to immediately and proactively 'stepping up' their therapeutic interactions by initiating a CI approach. By adopting such an 'early intervention' stance, this might not only prevent any further significant deterioration in the person's mental health from occurring, but it may also serve to strengthen the therapeutic alliance and prevent any risk of disengagement at a particularly vulnerable point in the patient's recovery journey. This earlier intervention may also help reinforce the person's sense of safety, thereby helping them to quickly stabilise the patient from whatever it was that caused the shift in their presentation in the first place.
In the instance of deteriorating mental health and increasing risk the practitioner will respond to ensure all immediate risk is mitigated. This will involve communication of increasing risks observed to the Nurse-in-Charge.

The need for continuous intervention often follows an event such as an act of aggression and or violence, absconding, self-harm, or disclosure of active suicidal ideation and or planning, and or a non-completed suicide. It is important that these events are followed by some degree of post incident analysis with the patient. This allows the care team to understand the drivers and context for the behaviours and attribute a risk value to the likelihood of these reoccurring. This also serves as an informal debrief whereupon the care team and patient can see things from all perspectives and plan and negotiate what care is required moving forward. It also attributes a value to the patient that they are being recognised and listened to, that their safety is being prioritised, and is an opportunity to reconfirm a person-centred therapeutic approach. This post incident review and reflection should use basic behavioural chain analysis techniques to create a sequence, from thoughts or distress to the risky behaviour exhibited. *This should be recorded within the patient's chronological account of care.*

In the event of absconding, it is extremely important to identify if there were any risks attached to the absconding. Issues such as what the patient did when out, how long they were out for and what their general intentions should be considered alongside the review of individual pass plans and joint action forms. This will assist clinical teams in weighting this behaviour in terms of ongoing risk. Aggression/violence can have many causes, some of them relating to active symptomatology, relational/interpersonal tensions, or difficulties and some related to environmental factors which can be impacted by sensitive and patient centred care planning. It is imperative that the clinical team understand in depth, the chronology and sequence which preceded such action.

Self-harm and suicide are linked with ***mental distress*** experienced across a range of mental health problems, such as depression, depression with psychosis, psychosis or schizophrenia, bipolar disorder, post-traumatic stress disorder, or a personality disorder" (NICE, 2024). It is

therefore important to follow and apply the core principles of the Co-ordinated Clinical Care (CCC) from admission to discharge. CCC has many practical tools such as the Crisis Prevention Worksheet which can be used proactively and reactively. In some instances, self-harm for some patients may be predictable. In these situations, the response should be, when practicable, agreed by the MDT in advance of the act of self-harm and be known by the patient, (usually this would be part of an agreed and pre-existing crisis management plan).
Understanding the functions of self-harm and non-suicidal self-injury can be of benefit in reducing risk and in aiding longer-term recovery.

GIPSI Borderline Personality Disorder Page - CCC (scot.nhs.uk)

These practical and considered approaches can be applied to any presenting behaviour which results in continuous intervention and should be incorporated into the patient's Person-Centred Care Plan.

All the above should be captured in an updated CRAFT following any of the clinical events referenced. Continuous intervention following these events should not be viewed as an inevitability.

**Actions**: In all instances where change in risk is observed the practitioner will complete the following:

- Document change in EPR (standards for record keeping GGC 11 - Professional Standards for Record Keeping – board-wide policy reference – applies to all disciplines)
- Update CRAFT based on individual professional observations as far as it may contribute to the ongoing management plan.
- Review and update profession specific plan of care e.g., Nursing PCCP, Psychological Formulation, OT Treatment Plan, Medical Plan
- Confirm and communicate change to safety critical discipline (Nurse-in-Charge/Named Nurse if available at that time)
- Change in risk communicated and updated CRAFT and CI Management Plan as clinically indicated.

## 5.0 CI PCCP

A Person-Centred Care Plan (PCCP) is a requirement within NHS GGC for all who use mental health services, it demonstrates biopsychosocial needs and a person's preferences for care, and it considers and takes into account views of relative's carers and or the person's nominated proxy.

A PCCP sets out broad themes for care within physical health, mental and psychological

health substance / alcohol use, social issues legal aspects of care and spiritual needs. It also is a tool to measure safe effective care delivery.

Continuous intervention signifies a requirement for an enhanced level of care and will be described in a specific CI PCCP. The elements required within a CI PCCP include:

- A record of patient and carer involvement.
- Personal preferences and choices to care, such as advanced statements and what matters to me documents and as expressed by the person or their proxy.
- CI described and aligned to the CRAFT risk assessment outcomes and identified from the mental health assessment and MDT discussion.
- Who will conduct the intervention, describe the nature of the intervention and anticipated duration of the CI.
- The conditions for review, including who needs to be involved in decisions to reduce or alter the CI.

### 5.1 Continuous Interventions and PCCP's In Practice

The CI PCCP can be developed by any member of the MDT however the named nurse will take a lead role in ensuring that a CI PCCP will be commenced that will set out the nature of the continuous intervention and activity that can be undertaken, provision purpose and nature of the continuous intervention will be documented.

If continuous intervention is indicated, by MDT / medical / nursing staff on initial assessment at admission and /or during an episode of increased distress or escalation in risk, the conditions of the continuous intervention should be set out clearly within the CI PCCP. The CI PCCP will be reviewed as agreed by the MDT or if the patient's condition/risk changes.

### 5.2 Daily Continuous Intervention and CI PCCP review

The effectiveness of the continuous interventions should be evaluated daily as a minimum, as risk can change over time and quickly, (this could be throughout the shift or shift to shift). This should be recorded in the chronological account of care, with changes made to the CI PCCP if indicated for the continuous intervention.

The CRAFT should also be updated to reflect progress or changes to the continuous intervention within the risk management plan.
CIs should be discontinued once the goals of the continuous interventions have been met. The continuous interventions should be flexible, evaluated as indicated as above and reviewed at each MDT meeting or as required guided by MDT decision.

## 6.0 Multidisciplinary Team Review - Weekly MDT meeting

The weekly Multidisciplinary Team Meeting is the forum for formal multidisciplinary review of

patient progress, risk, response to interventions and development of management plan. This policy and guidance reflect a change from the traditional model where risk assessment, management and decision making were the realm of psychiatry and nursing alone, to a wholeteam approach.

### 6.1 Patients, Carers and Families

The NHS Greater Glasgow and Clyde (NHSGGC) Pursuit of Healthcare Excellence Quality Strategy (2023), the Excellence in Care Framework (2015) and the Mental Welfare Commission, Human rights in Mental Health services Good Practice Guide (2017), highlight the importance of Person-Centred Care and the requirement for patients and those supporting them, to be fully involved in their care. Patient's preferences should shape their care and treatment, and should include being involved in the review of their care MHS - 06 Confidentiality and Consent Best Practice Guide

### 6.2 What happens/expected/staff roles/ process.

Preparation for MDT (Detail required to inform CI)

Named nurse or Associate Nurse/nursing team prepare in advance. This should include:

- Do carer and patient wish to attend?
- Carer views
- Patient views
- Summary of progress since last MDT
- When patient on CI, summary of progress and engagement in CIs
- Highlight any new identified risks.
- Summary update from members of MDT unable to attend.

### 6.3 During MDT meeting

- The MDT discuss and review information gathered in preparation for the meeting and feedback from members of the team, patient, family, and carers.
- MDT discuss risk which will inform an updated CRAFT.
- MDT discuss need for continuous intervention.
- Where relevant, continuous intervention should be reviewed and adapted to current presentation and identified risk taking into consideration patient and carer views.
- Discuss and agree interventions that would manage patient safety.
- Identify risk reduction and escalation indicators to inform review of CI and to support early recognition and response to changes in patient presentation.
- Discuss and agree conditions/roles for increasing or decreasing CI or changing the CI PCCP out with the MDT meetings and record this information within the CI PCCP
- Consideration should be given at all MDTs to need for individual and/ or team psychological formulation.
- MDT outcome template completed as record of discussion and actions.

### 6.4 MDT Meeting Outcomes

- CRAFT is reviewed and updated.
- Patient centred care plan is reviewed and updated including CI PCCP.
- Allocation of actions to relevant discipline

### 6.5 MDT Meeting Actions

- Person centred care plan should be updated to reflect MDT outcomes and CI (named nurse/ associate/nursing team)
- CRAFT updated by designated person.
- Feedback outcomes to patient and carers by designated person
- Registered nurse updates ward team of any changes utilising huddles, shift handovers and briefings to supplementary/other staff.

### 6.6 Reviews of Continuous Intervention

- Once in place, the Continuous Intervention should be reviewed, at a minimum, once every 24 hours. Out with MDT meeting the Nurse in Charge should ensure the CI is reviewed at least once every 24 hours. The review should take into consideration the conditions of variation documented within the CI PCCP. If the Nurse in Charge has assessed that the conditions are met such that the CI is no longer necessary or should be altered in line with the CI PCCP then this can be actioned following discussion with another senior member of nursing staff (Band 6 or above, this could be the nursing page holder). The reasons for alteration should be clearly documented and updated in the CI PCCP.
- If the CI PCCP has not yet been agreed through the MDT meeting, then change to CI should, where practicable, be discussed with a member of medical staff and, where appropriate, other MDT members of staff.
- Where the MDT meeting does not take place within 24 hours of the CI being put in place, proposed variations to the CI should be discussed with medical staff.
- Staff should reference CI when updating the clinical record.

## 7.0 MDT Members and Functions

### Senior Charge Nurse

The Senior Charge Nurse (SCN) is responsible and accountable for ensuring systems and processes are in place that enable nurses to practice in a safe, effective, and person-centred way (PCCP Guidance, Clinical Supervision Policy, and Clinical Risk). The SCN also ensures that staff members are engaged in person centred care and have the necessary knowledge, skills, and experience.

### Nurse in Charge

The ongoing implementation and monitoring of the application of continuous intervention is

the responsibility of the Nurse in Charge on any given shift. The Nurse in Charge must ensure that prior to undertaking a Continuous Intervention including enhanced observation; staff (including Nurse Bank staff) have the relevant skills and must be fully briefed in relation to the patient's background history, presenting symptoms and the reasons for applying the enhanced levels of care which may include observation, the associated clinical risks and what to do in the event of an untoward occurrence. The Nurse in Charge should also ensure that staff delivering the CI have breaks rostered into the CI allocation schedule.

**Named Nurse**

The Named Nurse is responsible for ensuring the application of the nursing process; assessing; planning; implementing; evaluating and reviewing the impact of the nursing care delivered, including the development of person-centred care plans which would also include contributing to and coordinating the CI PCCP, which will be informed through CRAFT and nursing assessment processes.

**Health Care Support Worker**

The Registered Nurse will delegate duties to the Health Care Support Worker in relation to the delivery of person-centred care. The Health Care Support Worker has a duty to accept the delegated task within their sphere of competence.

**Student Nurse**

The Registered Nurse will delegate duties to the Student Nurse in relation to the delivery of person- centred care The Student Nurse has a duty to accept the delegated task within their sphere of competence and stage of learning.

**Medical**

Medical staff (of all grades) will be involved in initiation, description, and review of CI in conjunction with the wider MDT. However, initiation can be commenced at any time if the person's clinical presentation and risk assessment indicates this. Review should be conducted as part of MDT process as described in section 6.6.

Every patient will have a designated Consultant Psychiatrist responsible for their care. The Consultant Psychiatrist has a lead role in the MDT review process and the formulation of care which will be informed through CRAFT and medical assessment processes.

**Allied Health Professionals**

Allied Health Professionals (AHPs) within inpatient services play a crucial role in assessing and treating patients throughout their continuous intervention journey. The therapeutic input varies based on the patient's needs and the specific AHP profession required. The most frequently accessed AHPs within inpatient services include Occupational Therapy, Physiotherapy, Speech and Language Therapy, and Dietetics.

AHPs contribute to and inform multidisciplinary care planning, offering both direct and indirect therapeutic interventions. These interventions can encompass routine and structure, meaningful activities, functional skills, communication, physical exercise, and dietary requirements.

**Occupational Therapists** help individuals introduce or reintroduce meaningful occupations that provide structure and routine, tailored to their needs, strengths, and protective factors. It is appropriate that OTs are involved with individuals at all stages of continuous intervention, to ensure therapeutic activity is person centred. The CI PCCP should reflect any modification of occupational demands or the individual's environment.

**Physiotherapists** are essential in promoting physical health and mobility. They collaborate with patients to improve movement, strength, and function through tailored exercise programs, manual therapy, and education. This can help improve pain management, prevent physical deterioration, lead in falls prevention strategies, and enhance overall well-being. It is important that Physiotherapists are involved with individuals at all stages of continuous intervention, to ensure physical and mental health outcomes are maximised.

**Speech and Language Therapists, Dietetics** and **Pharmacy staff** will advise and review options and interventions within the CI person-centred care plan. This will be based on their specific knowledge and skills and assessed patient needs. This should be undertaken as part of the MDT process and reviews with the involvement of the patient and family.

**Clinical Psychologists** contribute to the MDT working formulation of a patient's difficulties and associated risks, as required. This formulation will be used to inform risk management, decisions regarding continuous intervention, identify interventions that may reduce a patient's distress and associated risk, and assess and reduce the risk of re-traumatisation association with restrictive interventions.

Clinical psychologists may offer direct psychological interventions during continuous intervention where these are indicated by a patient's formulation but may also offer a range of indirect psychological interventions. Indirect psychological interventions may include supporting the wider MDT to identify and offer psychological interventions (e.g., Emotion regulation interventions, and/or reflective practice groups to examine, recognise and support staff with the demands of providing continuous intervention).
Staff in conjunction with the clinical team will advise and review medication options and interventions as part of the person-centred care plan and MDT reviews.

**On Call Senior Clinical and Operational support are available** and all staff have access to site page holders, consultant psychiatrists and senior operational management on call support.

This is available to staff if advice on clinical decisions is required on any aspect of care or implementation of the CI policy and practice guidance.

**8.0 CI Skills Enhancement**

It is important to consider that within each ward team there will be a skill mix, allowing teams to work at providing a meaningful and therapeutic CI for patients when required. There will be specific skills and training to support this already in place for distinct types of care provided. There are a range of interventions that staff might consider as part of the CI PCCP. What a CI consists of will vary depending on the patient's mental health and risk assessment outcomes, but regardless of age, diagnosis, presenting symptoms the core principles of person-centred care remain.

In providing a Continuous Intervention staff will have the benefit of shared information about the patient assessment, formulation and what the suggested intervention is. Interventions will often be remarkably similar or the same as the person-centred and therapeutic care being provided already. Teamwork and effective use of the Multidisciplinary Team (MDT) meeting will support this work. In addition, all staff are encouraged to access appropriate training/skills enhancement and supervision to ensure consistent ongoing support and professional development.

Teams are encouraged to consider what training/skills enhancement is already in place for staff professional development and how this can be linked to CI work. Local contacts such as Practice.

Development Nurses, Senior Charge Nurses, Lead Psychologist, Lead Occupational Therapist and Consultant Nurse will be key contacts.

Support for CI work via awareness sessions and additional training/skills enhancement will be available for teams also. In addition, vignettes have been developed to support clinicians deliver CI in practice and develop CI PCCPs that promote safe, effective person centred care, (Appendix 6).

***This guidance has been developed to support staff to provide safe, effective, and person-centred care for patients on Continuous Intervention within our inpatient facilities across NHSGGC. The content of the guidance will evolve and develop with staff over time. Skills enhancement, supervision and effective multidisciplinary team working, and risk assessment are critical components to ensuring safe and effective care.***

In this way the combination of current practice with awareness of the Continuous Intervention Policy and upskilling where required it is anticipated that CIs are introduced and developed in a meaningful and therapeutic manner within inpatient care.

Appendix 1

# MDT Continuous Intervention Person Centred Care Plan

NHS Greater Glasgow and Clyde

| Full Name: | | Preferred Name: | | DOB: | | CHI: | |
|---|---|---|---|---|---|---|---|

| Summary of risk findings CRAFT/ Face CARAS (CAMH's only) |
|---|
| |

**Reason For continuous Intervention (please tick all that apply)**

Self-Harm ☐ Aggression ☐ Vulnerable ☐ Disinhibition ☐ Suicidal intent ☐

Unpredictable Behaviour ☐ Accidental Injury ☐ Off Site ☐ Violence ☐

Absconding with Associated risk ☐ Details: .....

Other Reason ☐ Details: .....

| Information/Discussion with: | | | |
|---|---|---|---|
| Patient | Yes ☐ | No ☐ | Reason: |
| Relative or Carer (if appropriate) | Yes ☐ | No ☐ | Reason: |

**Staff matching**

Male ☐ Female ☐ Any ☐

**Continuous intervention proximity**

WS=Within sight AL=Arm's length VP=verbal prompt and check

| Activity | Review date: | Review date: | Review date: |
|---|---|---|---|
| Shower/Toilet | WS / AL / VP | WS / AL / VP | WS / AL / VP |
| Sleeping | WS / AL | WS / AL | WS / AL |
| Own time in room | WS / AL / VP | WS / AL / VP | WS / AL / VP |
| Visiting | WS / AL | WS / AL | WS / AL |
| When in Public areas - in ward, out ward or at school (CAMH'sonly) | WS / AL | WS / AL | WS / AL |
| Interview with visiting Professionals | WS / AL | WS / AL | WS / AL |
| When using phone | WS / AL | WS / AL | WS / AL |
| Other | WS / AL | WS / AL | WS / AL |

**Verbal Prompts and check - frequency**

| | Review date: | Review date: | Review date: |
|---|---|---|---|
| Shower/Toilet | | | |
| Sleeping | | | |

| Prohibited Item | Supervised Item |
|---|---|
| | |

# MDT Continuous Intervention Person Centred Care Plan

| Identified Need | Person Centred Goal/idea of recovery | Family/Carer Views | Review Frequency |
|---|---|---|---|
| | | | 24hr minimum |

| | Person centred interventions | Start Date | End Date |
|---|---|---|---|
| Triggers and warning signs | | | |
| What makes me feel better | | | |
| Wellness Toolkit | | | |
| Conditions for decreasing/Increasing Continuous Intervention | | | |
| Other Interventions | | | |
| | | | |
| | | | |



**Completed By:**

**Print and sign:** .....

**PatientSignature:** .....

**Please retain with Appendix 2 in medical notes. Adult Services DO NOT upload to EMIS. CAMH's please follow local EMIS Guidelines.**

Appendix 2

# Continuous Intervention
## Designated Staff, Comments, and review Log

NHS Greater Glasgow and Clyde

**Ward:** **Patient Name:**

**Date:**

| **Patient CHI:** | **RMO:** | **Intervention:** | |
|---|---|---|---|
| **Delegating Nurse in Charge Early shift/12-hour day shift** | **Signature** | **Night Shift Delegating Nurse in Charge** | **Signature** |
| **Delegating Nurse in Charge Late Shift** | **Signature** | | |

| Time | Designated Responsible Staff Member | Patient location & brief comment on activity, significant changes and or concerns |
|---|---|---|
| 07.00 – 08.00 | | |
| 08.00 – 09.00 | | |
| 09.00 – 10.00 | | |
| 10.00 – 11.00 | | |
| 11.00 – 12.00 | | |
| 12.00 – 13.00 | | |
| 13.00 – 14.00 | | |
| 14.00 – 15.00 | | |
| 15.00 – 16.00 | | |
| 16.00 – 17.00 | | |
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| 18.00 – 19.00 | | |
| 19.00 – 20.00 | | |
| 20.00 – 21.00 | | |
| 21.00 – 22.00 | | |
| 22.00 – 23.00 | | |
| 23.00 – 00.00 | | |
| 00.00 – 01.00 | | |
| 01.00 – 02.00 | | |
| 02.00 – 03.00 | | |
| 03.00 – 04.00 | | |
| 04.00 – 05.00 | | |
| 05.00 – 06.00 | | |
| 06.00 – 07.00 | | |



## Continuous Intervention 24hr review

**Time:** ……..

**Who was involved in review?** .....

**Print name and sign:** .....

**Designation:** .....

**Outcome:** .....

Please retain with Appendix 1 in medical notes. Adult Services **DO NOT** upload to EMIS. CAMH's please follow local EMIS Guidelines.

New !:>ecoon 1

Commenced Continuous 6
Intervention

Staff who commenced the a ()

Reason

Discussed with relativecarer/ 6
patientproxy

Discussed with patient? ()

Staff Allocated 6

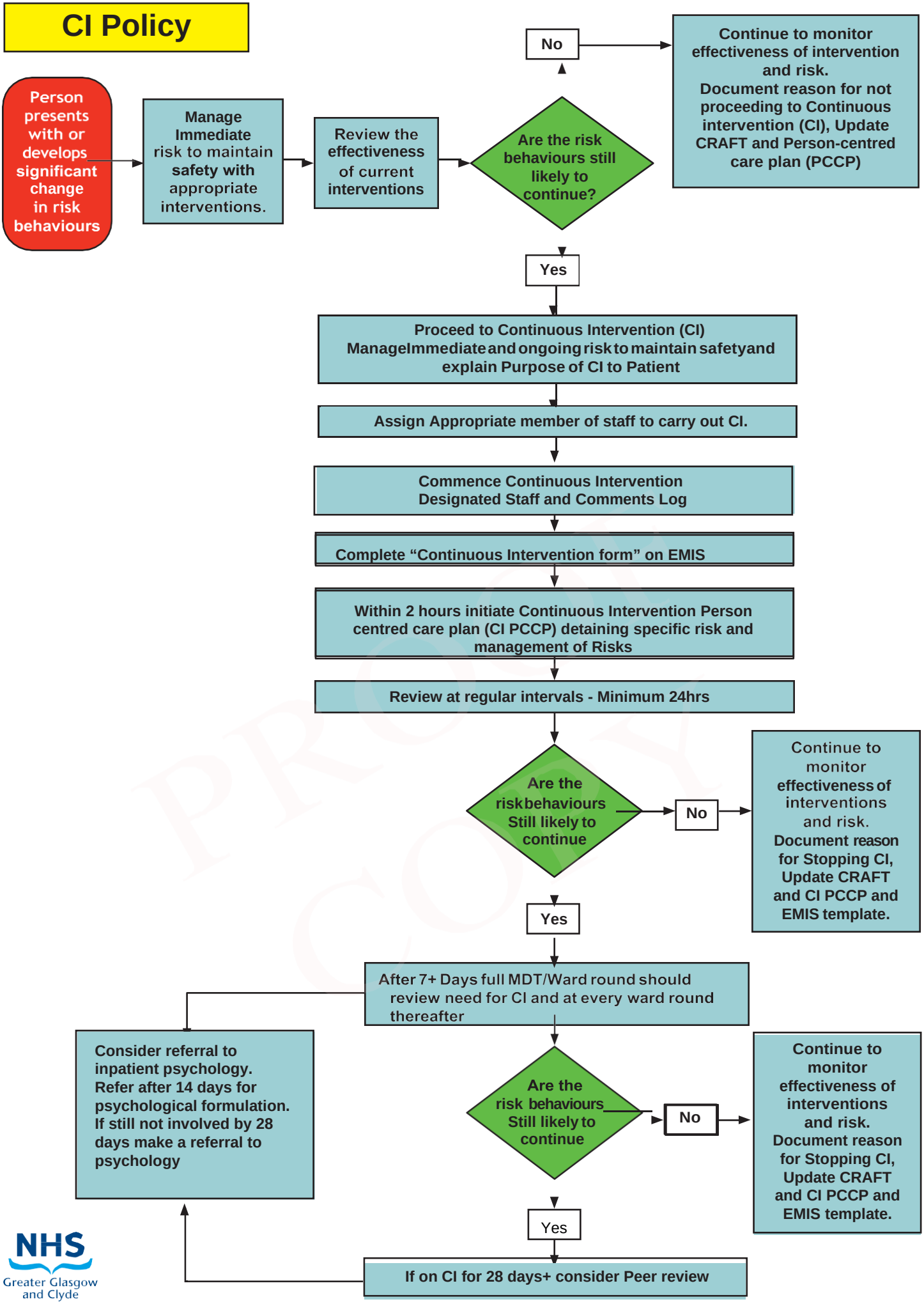
Rdes of staff allocated 6

Continuous intervention stopped
date **and** time

Discussed with relativecarer/
Proxy when continuousintervention
stopped

Discussed with patient?

# CI Policy






NHS Greater Glasgow and Clyde

# Continuous Intervention Process Summary

**Continuous intervention should only be implemented after positive engagement with the patient has been unable to reduce the risk to self or others and for the least amount of time clinically required.**

NHS Greater Glasgow and Clyde

| Process | Clinical Practice | Quick ref policy |
|---|---|---|
| Patients' presentation of risk raises clinical concern: Decision to commence Continuous intervention (CI) Made | - Decision should be made when previous intervention has been unsuccessful and risk level continues.<br>- Decision Should be made by MDT discussion/ assessment or by Nurse in charge (NIC) and discussed with medical staff<br>- Complete CI EMIS recording form within the electronic patient record<br>- CRAFT should be updated<br>**Clinical notes should record:**<br>- reason for continuous Intervention,<br>- decision maker<br>- circumstances for variation and review<br>- Communicate Changes to Staff | See practice guidance Section 4.2 |
| Nurse in Charge (NIC) Assigns Appropriate **members of staff to carry** out CI for the Shift | Commence "designated staff- comments and review log"<br>**Staff must have knowledge of CI policy**<br>They must be made aware of:<br>-patients risk<br>-the patient centred interventions developed with the patient, relative and or carer.<br>**Clinical staff are responsible for:**<br>- maintaining safety and engaging with the patient using CI PCCP/<br>- recording their interaction and observations<br>- record and report any changes to the NIC | See practice guidance Section 2.1 |
| Within 2 hours a Person-Centred Care Plan (PCCP) should be initiated. Detailing risk and management of | Clinical staff should involve and communicate with patients about<br>- The reason for CI<br>- Develop CI PCCP collaboratively, including the use of the wellbeing toolkit.<br>- Where appropriate involve carers<br>- NIC or delegated member of nursing staff should complete PCCP<br>- communicate content to staff | See practice guidance Section 5.0, |
| Review at regular Intervals - Minimum of 24hrs | Designated member of staff to complete continuous intervention review found at bottom of CI designated staff-comments and review log<br>- Record in chronological nursing notes.<br>- Discuss decision with patient and where appropriate/Practicable with carers<br>Any decision to continue or Stop CI should include:<br>- The rationale for decision,<br>- Persons involved in the decision<br>- Circumstances that may require the increase or reduction of CI<br>- CRAFT and PCCP should also be updated when any change occurs<br>- Any changes should be recorded on EMIS CI form<br>- Daily evaluation of CI PCCP documented in Chronological account of care<br>- Communicate any changes to staff | See practice guidance Section 6.6 |
| After 7+ Days full MDT/Ward round should review need for CI and at every ward round thereafter | **MDT reviews should:**<br>- be clearly recorded in the clinical record/MDT template and referred to on the Continuous Intervention Review.<br>- Review all historical and dynamic clinical information and any new risk<br>- be in collaboration with patient, and where appropriate carers and relevant professionals to formulate CI PCCP<br>- Forward plan for conditions where CI potentially could decrease/increase<br>- If not already involved, consider referral to inpatient psychology.<br>- if still on CI after 14 days Refer to psychology for formulation<br>- Roles and responsibilities within CI should be recorded at MDT.<br>- Any change to CI from MDT should also be recorded on **EMIS CI form**<br>- CRAFT should be reviewed and updated | See practice guidance Section 6.0 and 7.0 |
| If on CI for 28 days + consider Peer review | - Repeat the above steps for MDT meeting and consider a peer review<br>- If Psychology Services not involved yet refer at this stage | See practice guidance Section 6.0 and 7.0 |

**See Continuous Intervention flow chart for assistance with decision making**



Published: November 2024

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# CI Policy Awareness Session – Vignettes & CI Person Centred Care Plans

## Mr. Smith – Older Adult Mental Health

Mr. Smith, who has a diagnosis of Dementia, was transferred from an acute ward to a special dementia unit, due to the staff being unable to manage Mr Smith's elevated levels of distressed behaviour.

Mr Smith was initially in the acute ward after a fall where he had a fractured neck of femur and required surgery. Mr Smith can mobilise however, not safely independently and this causes him a lot of frustration. Mr Smith refuses to utilise any walking aids provided to him following physiotherapy assessment which increases his risk of a further fall.

**What Did We Do**
Look at what referral and background information available. What has led to admission? What interventions have been tried to date? Speak to relatives to collate further information about Mr Smith and the issues he is having. Encourage Mr Smith (if he can participate) and his family to fill out the getting to know me documentation.

Completion of CRAFT which indicate risks in terms of Mr Smith's mobility. Complete falls risk assessment/bundles. Consideration of any advance statements. Complete 14-day stress and distress assessment tool. Medication review to ensure prescribed medication is not having an adverse impact on mobility. Involving physio following admission for further advice on mobility

**What Happened**
Staff are concerned that Mr Smith remains a high falls risk and at risk of further significant injury if he were to fall again. Mr Smith's agitation appears to be since he is unable to safely mobilise independently and becomes distressed and, at times aggressive, when staff try to assist him. Mr Smith, despite staff encouragement, refuses to utilise the walking frame provided by Physio, and at times, during periods of agitation, uses this as a weapon.

Following CRAFT risk assessment and information gathered, staff feel like Mr Smith would benefit from CI when he is showing higher levels of distress to minimise the risk of further falls.

**Continuous Intervention**
Through conversations with Mr Smith's relatives and getting to know me documentation, it was identified that Mr Smith enjoys reading the paper, listening to X music and he likes talking to people. Mr Smith is a very sociable man and enjoys company and his family identified that they feel he would become frustrated if he was sat with no one to talk to and unable to mobilise himself to go and speak to someone. They identified that they felt he would benefit from sitting in the main body of the ward where there was 'a lot going on' as he would feel he would have company. Nursing staff spent time with Mr Smith and his relatives to create the CI PCCP to support the times where Mr Smith becomes distressed and becomes a higher risk of a fall.

Mr Smith Continuous Intervention continued….

If staff note Mr Smith is becoming agitated, they should sit with him and engage him in conversation. Distracting Mr Smith with conversation about his family, discussing current news (with a paper if its available) and playing some music has noted to significantly decrease Mr Smith's level of distress and that 1:1 time spent with him by a member of the nursing team can be enough to distract Mr Smith from attempting to mobilise

Mr Smith also requires 1:1 input when mobilising. Mr Smith should be supported to mobilise at X times of the day to reduce his level of distress/relieve pressure and stretch his legs. As he refuses to utilise any walking aids to mobilise, he requires the support of x2 members of nursing staff.

To reduce the level of frustration of being assisted, staff should explain to Mr Smith in full why it is important he is assisted. Relatives feel it would be beneficial for his understanding to remind him of his recent surgery and explain the concern about him falling. Staff should assist Mr Smith from the chair utilising recognised moving and handling guidance. There should then be x1 member of staff on each side of Mr Smith when he is mobilising. It has been recognised that being assisted to mobilise regularly, decreases the risk of agitation and frustration and reduces the likelihood of Mr Smith attempting to walk unaided.

# MDT Continuous Intervention Person Centred Care Plan

| Full Name: | John Smith | Preferred Name: | Mr Smith | DOB: | 10.10.1950 | CHI: | 1010500110 |
|---|---|---|---|---|---|---|---|

**Summary of risk findings CRAFT / Face CARAS (CAMHS's only)**

Stress & Distress behaviour posing high risk of falls – John is unable to safely mobilise independently and refuses to utilise walking aids recommended by physiotherapy. John has had a significant previous fall where he sustained a fracture to the neck of femur and required surgery.

**Reason for continuous intervention (please tick all that apply)**

Self-Harm ☐ Aggression ☐ Vulnerable ☐ Disinhibition ☐ Suicidal Intent ☐
Unpredictable Behaviour ☒ Accidental Injury ☐ Off Site ☐ Violence ☐
Absconding with Associated risk ☐ Details: ……..
Other Reason ☒ Details: When distressed high risk of falls……

| Information/Discussion with: | | | |
|---|---|---|---|
| Patient | Yes ☒ | No ☐ | Reason: |
| Relative or carer (if appropriate) | Yes ☒ | No ☐ | Reason: |

**Staff matching**

**Male** ☐ **Female** ☐ **Any** ☒

**Continuous intervention proximity**

WS = Within Sight AL = Arm's length VP = verbal prompt and check

| Activity | Review date: | Review date: | Review date: |
|---|---|---|---|
| **Shower/Toilet** | WS / AL / (VP) | WS / AL / VP | WS / AL / VP |
| **Sleeping** | WS / AL | WS / AL | WS / AL |
| **Own time in room** | (WS) / AL / VP | WS / AL / VP | WS / AL / VP |
| **Visiting** | WS / AL | WS / AL | WS / AL |
| **When in Public areas –** In ward, our ward or at school (CAMH's only) | WS / AL | WS / AL | WS / AL |
| **Interview with visiting Professionals** | WS / AL | WS / AL | WS / AL |
| **When using phone** | WS / AL | WS / AL | WS / AL |
| **Other** | WS / AL | WS / AL | WS / AL |

**Verbal Prompts and check - frequency**

| | Review date: | Review date: | Review date: |
|---|---|---|---|
| **Shower/Toilet** | | | |
| **Sleeping** | | | |

| Prohibited Item | Supervised Item |
|---|---|
| | |

# MDT Continuous Intervention Person Centred Care Plan

| Identified Need | Person Centred Goal/idea of recovery | Family/Carer Views | Review Frequency |
|---|---|---|---|
| John is at high risk of falls when he becomes distressed and frustrated about being unable to mobilise independently | John was unable to fully articulate how he feels about being unable to mobilise independently or give his thoughts about recovery | Family feel John becomes agitated and distressed if he becomes bored or has been sitting too long. He becomes uncomfortable and its clear he wants to be able to get up and walk around however is unable to do this himself.<br>John's wife feels that any time he has 'hit out' at staff, it is because he has become so frustrated with his situation and is unable to verbalise this, so feel support from staff to mobilise regularly and distraction are important to stop him from getting to this stage | **24hr minimum** |

| | Person centred interventions | Start Date | End Date |
|---|---|---|---|
| **Triggers and warning signs** | If John has been sat in the same position for a period of time, he can become frustrated and attempt to get up and walk – causing him to become a high risk of falls<br>John becomes agitated and frustrated if he is sat on his own/does not like to spend time in his room himself and likes to spend time in the main body of the ward<br>When john becomes frustrated/distressed – this presents as him, in the first instance shouting out for assistance. John can become verbally/physically aggressive towards staff if he feels he has been sitting down for too long | 14/02/25 | |
| **What makes me feel better** | When John first becomes distressed, he may just require a 1:1 chat with a member of staff by way of distraction. This can be about his family, news events about music<br>Johns Family identified John likes to read the newspaper and therefore looking at discussing the new paper articles maybe be beneficial<br>John likes Elton John and so playing some of his music again may settle John<br>John likes to talk about his wife Jane and his 2 daughters Amy and Amanda. Asking John questions about his family and chatting about them often makes John feel at ease<br>Getting up for a walk also makes John feel better. John gets tired quickly and can only mobilise for roughly 10 meters at the one time, however assisting john to mobilise for this distance on a regular basis can help to reduce agitation and distress<br>Mobilising John requires the assistance of x2 members of staff utilising recognised moving and handling techniques. Staff should try and encourage John to utilise the walking aid provided by physiotherapy however if John is refusing, staff should just support John to walk with x1 member of staff on either side<br>Note: Before assisting John to mobilise, staff should ensure John is wearing his glasses and he is wearing his slippers which have support at the back and Velcro across his foot | 14/02/25 | |
| **Wellness Toolkit** | Newspapers – John likes to read & be read to<br>Family photo album/ family tree/ info on family – John likes to see his family<br>Recordings/ notes from family – wife/daughters have provided this<br>Playlist for life – John has specific preferences | 14/02/25 | |

| | | | |
|---|---|---|---|
| **Conditions for decreasing/Increasing Continuous Intervention** | Increasing: When John is shouting out/presenting at distressed/attempting to stand independently – staff should approach John and initiate continuous interventions as above.<br>Decreasing: Often after intervention (having been for a walk/had 1:1 input with member of staff) John will become much more settled and will be able to sit within the body of the ward without support and staff can decrease continuous intervention. If john is spending time with his family, there is no requirement for CI<br>Discontinuing – Should staff feel John no longer requires CI, discussion around this should be brought to the MDT. Johns wife would also like to be involved in the discussion about any discontinuation of John's CI. The MDT discussion and decision should be documented within the MDT template and within the care plan – the rationale and decision should also be documented in the CAC within EMIS. CRAFT should be updated of the changes.<br>If John's CI requires to be discontinued out of hours, the nurse in charge should update the PCCP and CRAFT to reflect the decision and the rationale for this decision. This should also be documented in the CAC and nursing page holder/response nurse should be made aware. This should then be discussed at MDT at the earliest opportunity. | 14/02/25 | |
| **Other Interventions** | Occupational Therapy: If occupational therapy are in the ward to do a group, John is always keen to join any group, even if he isn't particularly interested in the subject – he enjoys the groups for the social aspects and likes to attend. John participates well and in general, is settled throughout the duration of the group | 14/02/25 | |
| | | | |
| | | | |

**Completed By:** A. Nurse Charge Nurse / Named Nurse

**Print and sign:** Mr J. Smith

**Patient Signature:** Mrs F. Smith

**Please retain with Appendix 2 in medical notes. Adult Services DO NOT upload to EMIs. CAMH's please follow local EMIS Guidelines.**

## Ms Jo X – Adult Mental Health

Jo was admitted to the adult acute unit due to concerns in relation to her diagnosis of Bipolar Affective Disorder. Jo was admitted informally and engaged with staff openly.

**What Did We Do**

Referral information was available. Nursing staff encouraged Jo to complete the 'Getting to Know Me' document and had discussion with her family in this also. Jo spoke with staff about her previously completed Advanced Statement which included preferences for inpatient admissions.

**What Happened**

Due to planned changes in Jo's medication, BPAD symptoms increased including experiencing racing thoughts, difficulty concentrating, increased thoughts of leaving the ward and disinhibition among other patients and staff. Due to change in presentation, updated risk assessment/management plan indicated Continuous Intervention in order to offer increased safety and support during this period.

**Continuous Intervention**

From Jo's Advanced Statement and Getting to know me document it was identified that during periods of elation Jo previously found the following helpful- listening to calming music, using grounding exercises, having a clear plan for the day. Jo identified at this time it was helpful to reduce being in busy areas, contact with too many people and time spent online. Nursing staff therefore spent time with Jo to create an activity planner offering some structure to her day and this was detailed in her Continuous Intervention Person Centred Care Plan (CI PCCP). It was important for Jo to be reminded of the ward routine including mealtimes, family visits and any meetings with MDT staff.

Jo was also offered a Wellness Toolkit to utilise in her bedroom area, with support was able to highlight activities to help with racing thoughts including using notepad to write down thoughts and illustrate feelings, using mindful colouring sheets and was able to download an app on her phone to assist with grounding and relaxation. At times Jo required assistance from staff to identify activities and concentrate on the task e.g., steps in downloading app.

**What Happened Next – Recovery Journey**

After 3 days of Continuous Intervention Jo reported to staff within the MDT meeting that she felt "more like myself". After consideration of Jo's current presentation, review of the CI PCCP and risk assessment it was decided that CI was no longer required.

# MDT Continuous Intervention Person Centred Care Plan

| Full Name: | Jo X | Preferred Name: | Jo | DOB: | 01011977 | CHI: | 010119770101 |
|---|---|---|---|---|---|---|---|

**Summary of risk findings CRAFT / Face CARAS (CAMHS's only)**

Risk: Sexually disinhibited behaviours towards Patients & Staff
Riske to self: Sexually disinhibited – vulnerable
Risk from others: Risk of retaliation from other patients
Absconding: Several attempts to leave ward

**Reason for continuous intervention (please tick all that apply)**

Self-Harm ☐ Aggression ☐ Vulnerable [X] Disinhibition [X] Suicidal Intent ☐
Unpredictable Behaviour ☐ Accidental Injury ☐ Off Site ☐ Violence ☐
Absconding with Associated risk [X] Details: Making attempts to leave, disinhibited, vulnerable……..
Other Reason ☐ Details:……

| Information/Discussion with: | | | | |
|---|---|---|---|---|
| Patient | Yes [X] | No ☐ | Reason: | |
| Relative or carer (if appropriate) | Yes [X] | No ☐ | Reason: | |

**Staff matching**

**Male** ☐ **Female** [X] **Any** ☐

**Continuous intervention proximity**

WS = Within Sight AL = Arm's length VP = verbal prompt and check

| Activity | Review date: 14/02/25 | Review date: | Review date: |
|---|---|---|---|
| **Shower/Toilet** | WS / AL / (VP) | WS / AL / VP | WS / AL / VP |
| **Sleeping** | (WS) / AL | WS / AL | WS / AL |
| **Own time in room** | (WS) / AL / VP | WS / AL / VP | WS / AL / VP |
| **Visiting** | (WS) / AL | WS / AL | WS / AL |
| **When in Public areas –** In ward, our ward or at school (CAMH's only) | WS / (AL) | WS / AL | WS / AL |
| **Interview with visiting Professionals** | (WS) / AL | WS / AL | WS / AL |
| **When using phone** | WS / (AL) | WS / AL | WS / AL |
| **Other** | WS / AL | WS / AL | WS / AL |

**Verbal Prompts and check - frequency**

| | Review date: 14/02/25 | Review date: | Review date: |
|---|---|---|---|
| **Shower/Toilet** | 30 seconds | | |
| **Sleeping** | Hourly | | |

| Prohibited Item | Supervised Item |
|---|---|
| | Use of mobile phone – potential to send inappropriate messages etc. on social media |

# MDT Continuous Intervention Person Centred Care Plan

| Identified Need | Person Centred Goal/idea of recovery | Family/Carer Views | Review Frequency |
|---|---|---|---|
| Jo is at risk of absconding and risks associated with same<br>Jo is vulnerable re disinhibited behaviours – potential for retaliation from others or adverse outcome. | Reduced incidents of disinhibition towards staff and patients<br>Nil attempts to leave the ward.<br>Improvement re racing thoughts & poor concentrating<br>Jo currently lacks some insight into their mental health, feels she should be able to leave ward but benefited from intervention and agreeable to CI. | Jos NOK is in agreement with CI due to the current risk to self and others. They visit regularly and are happy to be involved in Jo's care with continued visits to the ward. | **Daily** |

| | Person centred interventions | Start Date | End Date |
|---|---|---|---|
| **Triggers and warning signs** | Lack of concentration & racing thoughts, disturbed sleep pattern are all warning signs that Jo is becoming more elated in presentation.<br>Jo identified at this time it was helpful not to be in busy areas, reduce contact with too many people and not to spend time online/social media | 14/02/25 | |
| **What makes me feel better** | Within Jo's Advanced Statement and 'Getting to Know Me' it was identified that during periods of elation Jo previously found the following helpful:<br>- listening to calming music<br>-using grounding exercises<br>-having a clear plan for the day – structure and routine<br>Jo has daily planner which offers structure to her day | 14/02/25 | |
| **Wellness Toolkit** | Jo was also offered a Wellness Toolkit to utilise in her bedroom area, with staff support was able to highlight activities to help with racing thoughts including using notepad to write down thoughts and illustrate feelings, using mindful colouring sheets.<br>Jo's family often support this on visits<br>Watching a short film on her phone whilst spending quiet time in her room has been helpful for Jon in the past.<br>Use of relaxation aps has also been helpful for Jo. | 14/02/25 | |
| **Conditions for decreasing/Increasing Continuous Intervention** | Increasing - Increased attempts to leave ward & incidents relating to disinhibited behaviours<br>Decreasing – Review daily - Nil attempts to leave ward. Nil incidents related to disinhibited behaviour.<br>If Jo is spending time with her family, there is no requirement for CI. Review for ongoing CI must be undertaken when family leave.<br>Discontinuing – Should staff assess that Jo no longer requires CI, discussion around this should be brought to the MDT. The MDT discussion and decision should be documented within the MDT template and within the care plan – the rationale and decision should also be documented in the CAC within EMIS. CRAFT should be updated of the changes.<br>If Jo's CI requires to be discontinued out of hours, the nurse in charge should update the | 14/02/25 | |

| | | | |
|---|---|---|---|
| **Other Interventions** | Tree for Life Group. This is a small group delivered by Psychology/Nursing which Jo enjoys and regularly presents calm in – Jo would benefit from attendance at this group. | 14/02/25 | |

**Completed By:** A. Nurse Charge Nurse / Named Nurse

**Print and sign:** Mr J. Smith

**Patient Signature:** Mrs F. Smith

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Mr Brown – Adult Mental Health (**Risk Assessment and Management**)

Mr Brown, who has a primary diagnosis of Paranoid Schizophrenia, a secondary diagnosis of Emotionally Unstable Personality Disorder (EuPD), and other co-occurring difficulties including problems with substance misuse, anxiety, and low mood, was recently transferred from an acute admission ward to IPCU. This was due to his extremely high levels of verbal aggression and violence. Mr Brown had already caused significant injury to other patients and staff - as well as to himself - and showed no sign that this dangerous and risky behaviour was in any way lessening…

Mr Brown was initially admitted to the AAU following a deterioration in his mental health. Whilst in the community, and during a lengthy period of relative stability (in terms of his primary diagnosis), he had been attending weekly Mentalisation Based Treatment (MBT) groups where he had been working at addressing long-standing difficulties with "grievance thinking" (frequently perceiving he was somehow being wronged or 'slighted' by others, accompanied by angry, hostile ruminations about revenge, often culminating in him verbally challenging, or, **when significantly emotionally aroused AND when his mental health was less stable,** behaving aggressively and/or violently towards others).

Prior to this admission to AAU, Mr Brown had also started using skunk (super-strength cannabis) on a regular basis. This resulted in a significant increase in his propensity for both paranoid and grievance thinking and a subsequent loss in his (already fragile) ability to regulate his emotions and behaviour. On admission, Mr Brown believed that others were "playing mind games," "gaslighting" and "taking the piss" out of him, which caused him to feel significant anger and distress. It also led to him, at times, challenging others to "tell the fucking truth," and "stop winding me up", about their [*perceived*] negative intentions/threatening behaviours towards him. And then, when others attempted to deny or otherwise clarify their *actual* perceptions about him, Mr Brown would erupt in fits of rage and respond aggressively and/or violently towards them. Mr Brown's behaviour was also noted to deteriorate significantly after visits from his partner who was suspected of supplying further quantities of skunk to him…

**What Did We Do?**

We looked at all relevant referral and background information, including multiple earlier Datix reports about similar incidents. We liaised with Mr Brown's MBT team about his progress within that treatment programme. We spoke with his family/significant others who were able to tell us about recent stresses in his relationship with his partner, who apparently had also returned to using street drugs and had subsequently introduced Mr Brown to this particular brand of cannabis. We supported Mr Brown to complete his *'Getting to know me'* documentation during a calmer point in the admission process. At that point, Mr Brown was also able to help us begin to develop an anticipatory CI PCCP, as this was something that was strongly linked to core aspects of his ongoing MBT sessions (especially the advanced 'crisis management planning' component of it).

A CRAFT was completed which indicated ongoing risks in terms of Mr Brown's ability to maintain his own and others' safety, and to him having suspected ongoing access to illicit substances, which appeared to be implicated in maintaining his still significant paranoid/grievance thinking.

Mr Brown Continuous Intervention continued….

**What Happened?**
Following the above CRAFT risk assessment and management planning meeting, the MDT considered that Mr Brown would benefit from CI to help maximize engagement with him in support of his recovery, whilst minimizing his current experience of crisis and distress. We also conducted a thorough search of Mr Brown's belongings to ensure that he had no further access to illicit substances. Further, the increased levels of security within the IPCU environment also enabled us to better maintain Mr Brown's and others' safety and to more closely monitor his volatile mental state, as well as his interactions with visitors, to ensure that no further substances were being passed onto him.

**Continuous Intervention**
From Mr Brown's '*Getting to know me'* documentation, his advanced MBT 'crisis management plan', his overall PCCP and his emerging anticipatory CI PCCP, it was identified that, during periods of crisis and distress, he found it particularly helpful to engage with staff he knew and trusted, e.g. his key worker, rather than with less familiar staff (e.g. bank or other occasional/visiting staff). Mr Brown also found it helpful for staff to tell him clearly what was in their mind about him when interacting with him, e.g., by saying something like, "It looks like you're upset/struggling at the moment. Is that correct?." Mr Brown said it was also particularly helpful for staff to **ASK ME what's in MY mind at this point**, rather than assuming that they know what I'm thinking and how I'm feeling. (We learned from multiple previous post-incident reviews with Mr Brown, that staff either assuming or mislabeling his emotions was a particular 'red flag' for him, as this had often led to him experiencing increased paranoid/grievance thinking, as well as increasing his sense of threat, resulting in him feeling "cornered" and responding violently). Mr Brown further explained that when staff communicate and attempt to 'reach in' and engage with him in this way, it really helps him to connect with them such that he knows he's not alone with his distress and that staff are explicitly trying to help him.
The IPCU staff therefore adopted this explicit communication approach with Mr Brown. This resulted in him quickly settling, feeing 'connected,' engaged with, and able to trust the staff. He also began making use of a variety of coping strategies from his personal toolkit, e.g., he liked to talk about football and music. He liked to listen to music and share his extensive knowledge about this with others, and he liked a good bit of 'banter' about who won or lost at football in recent days. Mr Brown also played football, enjoyed walking and other physical activity, so spending time in the gym also helped him to significantly de-stress. Within 24-hours of the above CI package being delivered with Mr Brown, together with a review of, and a temporary increase in his antipsychotic medication, he had settled significantly within IPCU. There were no further violent incidents. There were, however, a few further episodes of verbal aggression when Mr Brown perceived others' as being critical towards him. However, with staff continuing to adopt this same open and reflective communication stance, Mr Brown was easily reassured that no hostile intention was being directed at him. Within 48-hours of his admission to IPCU, the need for CI was reviewed and considered no longer necessary. Mr Brown therefore continued to receive ongoing general care within this environment. This included spending time with staff who encouraged him to focus on reflecting about this recent experience, and to incorporate what learning he had taken from this into a future 'Staying Well Plan' ('therapy blueprint'). Mr Brown was then returned to the AAU a week later where he maintained his progress and was discharged back to the community shortly afterwards.

# MDT Continuous Intervention Person Centred Care Plan

| Full Name: | James Brown | Preferred Name: | Jim | DOB: | 12/02/1985 | CHI: | 12028510161 |
|---|---|---|---|---|---|---|---|

**Summary of risk findings CRAFT / Face CARAS (CAMHS's only)**

Risk: Aggression and violence towards patients and staff
Risk to others: Verbal aggression/abuse and/or significant violence/assault
Risk to self: Personal injury when acting violently
Risk from others: Risk of retaliation from other patients

**Reason for continuous intervention (please tick all that apply)**

Self-Harm ☐ Aggression ☒ Vulnerable ☐ Disinhibition ☐ Suicidal Intent ☐
Unpredictable Behaviour ☐ Accidental Injury ☐ Off Site ☐ Violence ☒
Absconding with Associated risk ☐ Details: ……..
Other Reason ☐ Details:……

| Information/Discussion with: | | | |
|---|---|---|---|
| Patient | Yes ☒ | No ☐ | Reason: |
| Relative or carer (if appropriate) | Yes ☒ | No ☐ | Reason: |

**Staff matching**

**Male** ☐ **Female** ☐ **Any** ☒

**Continuous intervention proximity**

WS = Within Sight AL = Arm's length VP = verbal prompt and check

| Activity | Review date: | Review date: | Review date: |
|---|---|---|---|
| **Shower/Toilet** | WS / AL / (VP) | WS / AL / VP | WS / AL / VP |
| **Sleeping** | (WS) / AL | WS / AL | WS / AL |
| **Own time in room** | (WS) / AL / VP | WS / AL / VP | WS / AL / VP |
| **Visiting** | (WS) / AL | WS / AL | WS / AL |
| **When in Public areas –** In ward, our ward or at school (CAMH's only) | WS / (AL) | WS / AL | WS / AL |
| **Interview with visiting Professionals** | (WS) / AL | WS / AL | WS / AL |
| **When using phone** | WS / (AL) | WS / AL | WS / AL |
| **Other** | WS / AL | WS / AL | WS / AL |

**Verbal Prompts and check - frequency**

| | Review date: | Review date: | Review date: |
|---|---|---|---|
| **Shower/Toilet** | | | |
| **Sleeping** | | | |

| Prohibited Item | Supervised Item |
|---|---|

| | |
|---|---|
| | |

# MDT Continuous Intervention Person Centred Care Plan

| Identified Need | Person Centred Goal/idea of recovery | Family/Carer Views | Review Frequency |
|---|---|---|---|
| Jim is at risk of being verbally aggressive/abusive AND/OR significantly violent/assaultive with patients and staff.<br><br>Jim is at risk of sustaining personal injury when acting violently towards others<br><br>Jim is at risk of verbal abuse and/or violent injury/attack from others in retaliation for verbal abuse and/or violence directed at them by him | Cessation of all acts of aggression and/or violence<br><br>Reduce hyper-arousal levels and return to within 'Window of Affective Tolerance' (WoAT)<br><br>Restabilise mental health<br><br>As above<br><br>As Above | | **Daily** |

| | Person centred interventions | Start Date | End Date |
|---|---|---|---|
| **Triggers and warning signs** | When staff want to press me into talking about things straight away, before I'm ready, I sometimes need 20-30 minutes to calm down.<br><br>**Triggers:**<br>• When there's a misunderstanding with someone else<br>• When I feel like I'm being inappropriately 'dug out' about something<br>• When an encounter with someone has left me feeling rejected, embarrassed or disrespected, e.g. **when people tell me how I am feeling, rather than checking this out with me**<br>• When others are being moody and inconsistent with me and with what they're telling me<br>• When I can't handle things and left telling myself "I'm sick of you. You're useless!"<br><br>**Warning Signs:**<br>• Not thinking things through or reflecting, but ruminating and "festering" instead; especially when this lasts for days<br>• "losing the tattie!" i.e. shouting out and confronting people, being verbally aggressive and abusive; talking over people, being violent or assaultive<br>• Not letting other in – i.e. when I'm keeping my anger going<br>• When I'm avoiding talking about it and start isolating myself e.g. missing meals, staying in my room, pacing up and down with my headphones on | 24/02/25 | |

| | | | |
|---|---|---|---|
| **What makes me feel better** | • Engaging with staff that I know and trust, e.g., my key worker.<br>• Staff **telling me clearly** what they're trying to do with me – i.e., **what's in your mind about me** (not just approaching me and putting 'hands on' or whatever and saying nothing). E.g., saying something like, "It looks like you're upset/struggling at the moment. Is that correct? So please, **ASK ME what's in MY mind at that point**. Then you could tell me something like, "Let's try and work through this together and see if we can find out what's behind thisupset…." When you do this, **I'll know I'm not alone** with my distress…<br>• I like a good laugh, so sometimes a bit of banter can jolt me out of a difficult moment | 24/02/25 | |
| **Wellness Toolkit** | • Listening to music on my headphones helps me calm down and manage my emotions better.<br>• Going to the toilet to look in the mirror and talk to myself as this can sometimes help me to think more clearly and rehearse being more assertive and less aggressive.<br>• Use of various relaxation techniques and strategies. I like all forms of relaxation –i.e., breathing, 'tense and relax' exercises and visualisation<br>• Talking about football or music with others is a great form of distraction forme.<br>• Doing practical/physical things like walking, playing football, or going to thegym<br>• Using anything that makes me laugh – e.g., jokes, comedy programmes, character impersonations.<br>• Playing card games and Scrabble | 24/02/25 | |
| **Conditions for decreasing/Increasing Continuous Intervention** | **Increasing** = when my mind's closed, my thinking's rigid, I'm holding onto grudges, refusing to talk and "festering," using illicit substances (e.g. skunk, which has a significant destabilising effect on me), my arousal levels are high, and I'm acting aggressively and/or violently towards others<br><br>**Decreasing** = when my mind's open, my thinking's flexible, I'm curious and wondering about things, I'm actively talking things through and not holding onto grudges, refraining from substance misuse, absence of aggression and/or violence towards others | 24/02/25 | |
| **Other Interventions** | Community based MBT team maintaining contact and continuing to offer treatment during inpatient stay. | 14/02/25 | |

**Completed By:** xxxxxxx Nurse (Charge Nurse/Named Nurse)

**Print and sign:** ..**XXXXXX** Mr Brown……

**Patient Signature:** ..XXXXXX Mrs Brown (mother)……

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