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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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1. Introduction

The NHS Greater Glasgow and Clyde (NHSGG&C) Continuous Intervention Implementation and Monitoring Group have developed this policy and practice guidance to ensure that inpatients receive the highest quality care and most appropriate level of supportive engagement and intervention.

Healthcare Improvement Scotland (HIS) developed national guidance in 2019 ['From Observation to Intervention: A proactive, responsive and personalised care and treatment framework for acutely unwell people in mental health care'](#). The national guidance was developed following shared learning from quality improvement projects from across NHS Scotland, along with an emerging evidence base, discussion, consultation and engagement with various groups and organisations and has informed the content of this policy and practice guidance.

Continuous Intervention – Definition

Continuous Intervention (CI) is an enhanced level of care and is used when a patient requires the continuous, supportive intervention of a member of staff. This intervention should be therapeutic in nature and should focus on supporting and collaborating with 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 determined by the presence of persistent elevated levels of risk that cannot be safely managed without CI and should 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)

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 term used in this document to refer to people who use services is patient, agreed with the relevant service user representative groups.

2. Scope

This policy and practice guidance is applicable to all NHS Greater Glasgow and Clyde Inpatient Mental Health Services, Alcohol and Drug Recovery Services (ADRS), Child and Adolescent Mental Health Services (CAMHs), Specialist Learning Disability Inpatient settings and Forensic Regional Services.

3. Purpose

The purpose of this policy is to:

- To take cognisance of current evidence and national guidance.
- Set out aims, principles and standards for Continuous Intervention practice and training.
- Confirm roles and responsibilities within the organisation and Multidisciplinary Teams.
- Identify other policies and guidance that interface with this Continuous Intervention policy (appendix 1).

4. Aims

- To promote a proactive, collaborative, formulation-based approach to person centred care and the management of clinical risk.
- Focus on prevention and early identification of deteriorating mental health.
- Improve individual's experience of inpatient care and involvement in their care.
- Ensure that all patients have a dynamic, readily accessible Clinical Risk Assessment Framework for Teams (CRAFT) and risk management plan that informs a Person-Centred Care Plan (PCCP).
- Promote safe, effective and recovery focused practice.

5. Responsibilities, Accountabilities and Duties for Maintaining Continuous Interventions

All staff and disciplines are responsible for ensuring this policy is central to the care and treatment of all patients in their care.

a. The Associate Medical Director for Mental Health and Addictions and Chief Nurse for Adult Services are responsible for:

- The development, dissemination, and review of this policy
- Ensuring appropriate training and skills enhancement is available and implemented for staff.
- The commissioning of audit and research activity associated with the practice impact of the policy.

b. Heads of Mental Health Service and Clinical Directors are responsible for ensuring:

- The implementation of this policy and practice guidance which has been developed to support safe and effective care for patients, staff, and the public.
- Staff attendance at training and skills enhancement that supports effective continuous intervention practice.
- The monitoring of adherence to this policy and associated mandatory training.
- The identification and commissioning of any specialist training needs for staff

c. Clinical staff working within inpatient wards (including bank staff) are responsible for:

- Completing the recommended LearnPro training on Continuous Intervention on induction and annually thereafter
- Being aware of the policy principles and aims of the Continuous Intervention policy set out below.
- Adhering to the Greater Glasgow and Clyde Continuous Intervention Standards as set out below.
- Maintaining their level of competence in relation to identifying and managing Continuous Intervention in line with the continuous professional development requirements for their discipline will include the requirements for clinical supervision.
- Using the CI Practice Guidance document to inform and support their practice and ensure compliance with the contents of this policy.

d. Multidisciplinary Teams within the inpatient settings are responsible for:

Ensuring a collaborative approach to assessment, clinical risk management and person-centred care planning,

This should be conducted collaboratively with patients and their carers. Each discipline within the MDT has specific professional roles and responsibilities to ensure effective, safe, person-centred care:

Medical Staff

Medical staff (of all grades) will be involved in initiation, description, and review of CI in conjunction with the wider MDT in accordance with policy standards.

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.

Nursing Staff

Registered Nursing staff, with the patient, carers, medical staff, and the wider multidisciplinary team, are responsible for initiating and reviewing continuous interventions in accordance with policy standards.

Registered nursing staff are responsible for providing nursing care and interventions

to support the delivery of safe, effective, person centred care over the 24-hour period and facilitate and coordinate multidisciplinary input to patient care and person centred care plan.

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.

Allied Health Professionals (AHPs)

Allied Health Professionals working within inpatient services provide key assessment and treatment throughout a patient's continuous intervention journey. Therapeutic input will vary depending on the patient's needs and the requirement of the specific input of the AHP profession. Within inpatient mental Health services, the most accessed AHP's are Occupational Therapy, Physiotherapy, Speech and Language Therapy and Dietetics. AHPs will contribute to and inform multidisciplinary care planning. This could include direct and indirect therapeutic interventions such as routine and structure, meaningful activity, functional skills, communication, physical exercise, and dietary requirements.

Psychology

All qualified psychology staff will take a lead role in ensuring a psychological perspective is embedded throughout the continuous intervention process.

Pharmacy

Pharmacy 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.

6.1 Policy Principle

This Policy and Practice Guidance has been informed by the 7 underpinning principles of the National Guidance (appendix 2). Continuous interventions must adhere to Millan Principles¹, deliver recovery focused, trauma informed care based on current evidence. Delivery of Continuous Interventions will be a dynamic, therapeutic, responsive process minimising risk to achieve safe, effective and person centred care.

6.2 Policy Standards

The following standards have been developed using the 9 strands described within the national guidance document:

- Every patient will have a PCCP that describes the interventions relating to patient's clinical needs, signs of deterioration, recovery, and risk as part of a multidisciplinary coordinated and planned approach.
- Where consent has been obtained, carers and families will be included in the person-centered care plan development and review of the clinical risk management plan when the patient has not given consent, this must be reviewed regularly.
- Required level of care and intervention will be described following the completion of CRAFT
- The care and intervention within the person centred care plan must detail strategies that would manage patient safety and promote recovery focused outcomes that would indicate risk reduction and escalation indicators based upon an individualised, person-centred, and formulation-driven understanding of the patient's distress and associated risks.
- Staff will be provided with the opportunity to enhance their skills and learning in relation to providing effective, safe, person centred CI Practice.

7. Review

This policy will be reviewed in line with the current policy management process and standards. Changes in legislation or good practice guidance would trigger an earlier review. The Clinical Governance and Policy Management Steering Group would be responsible for initiating this. Compliance with the Policy standards will be measured through an agreed evaluation framework.

a. Communication and Implementation Plan

The Continuous Intervention implementation and Monitoring Group will ensure there is a communication and implementation plan in place within each local area, overseen by the Heads of Service.

b. Monitoring

Monitoring and reporting of policy implementation and compliance will be to the Core leadership and management group. Clinical Governance and Policy Management Steering Groups will be informed as part the existing policy management process.

c. Impact Assessment

Details of the implication of the policy including EQIA, Policy Risk Assessment Tool and other impacts as set out in the Assurance Checklist 1 in the Policy Development Framework.

APPENDIX 1

The following policies and guidance should be read alongside this policy statement as they relate or align with this policy, the list is not exhaustive.

[MHS 07 - Clinical Risk Screening and Management Policy](#)

[MHS 06 - Confidentiality and Consent Best Practice Guide](#)

[MHS 15 - Management of Non-Clinical Sharps](#)

[MHS 18 - Missing Persons Policy](#)

[MHS 19 - Personal and Environmental Search](#)

[Policy MHS 20 - Physical Healthcare Policy](#)

[MHS 22 - Policy for Locking Locked Doors on Open Wards.](#)

[MHS 26 - The Co-ordination, Planning, Monitoring of Patient](#)

[Passes MHS 24 - Specified Person Policy and Procedures](#)

[MHS 41 - Suicide Reduction Guidance](#)

[MHS 42 - GGC Guidance on Ligatures and the use of the Big Fish Safety Knife Cutters](#)

[GGC 10 - Policy for the Management of Violence and Aggression](#)

[GGC 11 - Professional Standards for Record Keeping](#)

APPENDIX 2

The Underpinning Principles of the National Guidance – *From Observation to Intervention* *January 2019*

- Understanding the lived experience of patients and their families and engaging their participation, consent and choice about treatment and care.
- Creating physical environments that are fit for purpose, therapeutic and, as far as possible, hazard-free. This should be supported by regular audits that take account of any recent safety notices.
- Developing a model of care based on emerging evidence about trauma- informed care environments and the treatment of complex mental health issues and behaviors such as personality disorder, self-harm and violence.
- Creating ward systems that value anticipation, early recognition of deterioration and triggers for harm, as well as personalised early response mechanisms and support for all patients.
- Introducing education, training and clinical supervision or action learning for staff to ensure they have the competencies and capabilities to respond to the demands of contemporary, complex, mental health care delivery.
- Supporting a relational-based approach to care and treatment in order to foster engagement with patients.
- Embedding a human rights-based approach and engaging with the [Rights in Mind](#) pathway to support patients' rights in all mental health settings.