From Observation to Intervention

A proactive, responsive and personalised care and treatment framework for acutely unwell people in mental health care

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Healthcare Improvement Scotland

Scottish Patient Safety Programme
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Introduction | Mark Gillespie, National Clinical Lead

In 2015, the Scottish Government committed to developing new observation practice guidance for mental health care in response to concerns about the effectiveness of observation policy and practice following incidences of harm and suicide during enhanced and general observations in Scotland. Visits by the Mental Welfare Commission for Scotland[1] raised similar concerns and it became clear – from initial scoping with boards and service users alike – that a radical change to the wider culture and practice linked to observation was needed.

With the support of 12 health boards, we have tested and developed new, ambitious and innovative ways of working. We are engaging more directly with service users to help inform the way we respond to their care, treatment and safety needs when they are acutely unwell and need mental health inpatient care.

Observation is just one part of mental health care and I firmly believe it should not be viewed or undertaken as a standalone task or at a distance from the wider clinical care a patient receives in hospital. Importantly, observation status should not be used in isolation as an indicator of patient need. Our challenge is to develop a more holistic and personalised approach to each and every patient, based on the purpose of their admission, what is happening to them at that time and their clinical need, as well as their risks, strengths and experiences.

Innovative changes that have taken place in mental health practice to reduce restrictive practice and improve risk assessment and safety planning since the launch of the Scottish Patient Safety Programme for Mental Health in 2012 will naturally support this new guidance. However, we acknowledge that some degree of education and training, as well as consideration of workforce planning and duty of care, may be required in the lead-up to full implementation of this guidance by March 2019.

From Observation to Intervention therefore focuses practice towards a culture of inquiry, personalised assessment and proactive, skilful mental health care and treatment interventions for all patients. It is our intention to end the use of enhanced observation practice (also referred to as constant or special observation) in its current format by March 2019.

This guidance supports and challenges mental health care professionals to reframe traditional assumptions about observation practice and work towards a framework of proactive, responsive, personalised care and treatment with the patient at its centre.

Insight

Graham Morgan
Engagement and Participation Officer (Lived Experience)
for the Mental Welfare Commission for Scotland

I remember just how lonely I felt, so many times, when I was on enhanced observation and the person assigned to follow me around, or sit beside me to protect me from myself, had nothing to say. Sometimes they just seemed to be uncomfortable to share space with me. There's something terribly sad about that. When you're at your most distressed and confused, communication can seem impossible.

Yet I've also experienced the most valuable conversations with my key nurse when tenderness, and a message of hope and compassion, reached through what seemed like a never-ending desire to harm myself, making me feel less isolated and less abandoned by the world. There is something very liberating when, late at night, after walking round and round the ward in erratic, upset circles, the nurse providing enhanced observation talks you through a guided relaxation session. The soft music may not send you to sleep, but you do feel treasured and cared for.

In recent months, I have been speaking to other people across the country with lived experience of enhanced observation. We've found many common themes. We agree that enhanced observation can be humiliating and isolating, it can and sometimes does keep us safe, but may not always prevent us from harming ourselves. Conversely, we've discussed the challenge of being on general observation – getting used to the lack of attention and trying to work out the purpose of being in hospital when, day after day, nothing seems to happen.

When we talk about observation, we always seem to move rapidly to a wider discussion. As soon as we talk about someone outside our door, we talk about relationships, about how we need to be listened to, how we need to have some warmth and respect from the people looking after us. We talk about the need to celebrate our common humanity and the connections we can make with each other despite our very different roles. And we talk about what we can offer, formally or informally, because sometimes we have a much clearer idea than staff as to how distressed or not a fellow patient is. Having been there, we can often support each other in hospital in a very different way from people who don't share our lived experience.

It gets a bit basic, the stuff we talk about. Fundamentally, if you take the time to get to know us then you're bound to understand the degree of distress we're in, know the sorts of things we need, and then act accordingly and sensitively to our situation.

Simple things – activity on the ward, pets to stroke, friends and family to hug and talk to – are important. They allow us to feel we are all engaged in a mutual effort to create a place of care and support so that we look forward to seeing our nurses and doctors and feel comfortable with our fellow patients. If these things are made possible then it might mean that the overwhelming need to harm ourselves, or to run away, becomes less overpowering and less necessary to our lives, helping to bring our recovery that much closer.

I do hope this guidance goes some way to bringing these simple wishes to reality. It's all too easy to say how things like a good relationship with staff can help in hospital, but it's crucial to our recovery and eventual discharge to a better and more positive life.

In order to support patients, we need to manage the frequency of contact and observation.

The culture of inpatient mental health services has changed and is still changing; we are embracing recovery and multidisciplinary working, as well as trying to provide proactive support as opposed to simply reacting to crises. The focus on patient-led observation and a continuum approach is welcomed. I have heard positive feedback from colleagues at demonstrator sites who have told me that providing proactive support has enhanced the working of teams and seen the need for observations reduce.

We strive to provide the best possible mental health care in Scotland and innovative changes like these help inpatient care become more patient-centred. I endorse these changes and look forward to their wider adoption across Scotland.

The main aim of *From Observation to Intervention* is to end the use of enhanced observation in its current format by March 2019, replacing this practice with a framework of proactive, responsive and personalised care and treatment which focuses on prevention and early intervention in the context of a deterioration in patients' mental health.

This guidance proposes a continuum-based approach that utilises specific nursing or 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.

From Observation to Intervention replaces the 2002 Clinical Resource and Audit Group (CRAG) observation guidance document *Engaging People: Observation of People with Acute Mental Health Problems*[2]. As observation practice and experience may also be indicative of wider mental health care practice and experience, this guidance also contributes to a refocusing and refreshing of mental health care practice as a whole.

The underpinning principles of this guidance

- Understanding the lived experience of patients and their families and engaging their participation, consent and choice about treatment and care.

- Creating physical environments which are fit for purpose, therapeutic and as far as possible hazardous free. This should be supported by regular audits which takes 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 behaviours 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.

Context

From Observation to Intervention recognises that the needs of today's mental health care service users are increasingly complex and require a more personalised approach to care, treatment and safety planning to enable recovery from, and self-management of, periods of ill health. Such an approach is in line with emerging evidence on new areas of practice – such as trauma-based care and high and low intensity psychological therapies – that may be effective with individuals experiencing complex mental health issues.

This guidance views observation practice as one small part of mental health care practice and recommends that it cannot be undertaken as a standalone task, at a distance from a patient's wider clinical needs. Concerns regarding existing observation practice are outlined in Appendix 1 and the guidance emphasises that observation status should not be used to determine the extent of interaction, care and treatment that a patient receives. This is informed by evidence[3] that most inpatient suicides occur with patients who are on general observation. As such, it can no longer be assumed that general observation equates to low risk or less complexity and it should be accepted that the clinical needs of patients on general observation can still be significant and complex.

This guidance is therefore aimed at mental health care practice as a whole and recommends that personalised care, treatment and safety planning should be determined and informed by each patient's clinical needs, strengths, and indicators of deterioration and harm, alongside their advance statement, carer's views and the purpose of their admission to hospital.

Approach

Many services report that when they ask "What is happening?" rather than "What is the observation status?" or "What is the diagnosis?" they open up the opportunity for personalised care that is tailored to the patient's life, experiences and purpose of admission to hospital. This opens the door to a whole-person approach, a personalised care, treatment and safety plan and the ability to respond early and proactively to any potential deterioration triggers based on a greater understanding of the patient as an individual. As such, this guidance has implications for nursing practice but also for the wider disciplinary team with whom nurses work and coordinate care, treatment and safety plans.

Key factors

Current observation practice is often justified on the basis that a patient is 'too unwell' to engage in intervention at any level and requires 'reduced stimulation'. However, based on test site activity and scoping with service users, this guidance challenges that view and incorporates a number of statements from service users and staff alike which highlight observation experience, negative and positive. *From Observation to Intervention* also recognises that current observation practice can lead to disengagement by patients, thereby increasing the risk of psychological and social isolation, and further increasing the risk of harm to themselves and others.

A growing evidence base comprising literature (cited throughout this guidance document) and current and emerging good practice within mental health inpatient culture and practice informs this changing mindset. We know that violence, self-harm and the restrictive practices of seclusion and restraint can be reduced by using the safety principles tested by the Scottish Patient Safety Programme for Mental Health. Some of these, including improved staff communication through safety huddles, can be used to proactively highlight and action plan for patients at risk of deterioration or harm.

System features

This guidance puts forward the case for a continuum-based approach which relies on a combination of system features as a foundation for good practice – for example, structuring ward activity, multidisciplinary team working to develop personalised approaches, staff training and education. These system features will help to embed this guidance in practice and are outlined below:

- leadership for change and improvement within teams

- skilful, visible, core workforce

- personalised and aligned care, treatment and safety planning

- early recognition of, and response to, deterioration

- safe and therapeutic environments

- psychotherapeutic interventions and approaches

- rights-based, trauma-informed and recovery-focused culture

- flexible, collaborative care, involving patients' carers

- evidencing the impact of changes on patients' and carers' experiences and outcomes

Strand 1 | Involving carers and families in treatment, wellbeing and recovery

Coming into hospital can be particularly distressing for some individuals – and for their carers – especially if admission is made under the Mental Health (Care and Treatment) (Scotland) Act 2003. As carers are usually involved in the day-to-day life of the person they care for, it's very important that this involvement does not stop when that person has been admitted to hospital – indeed, a carer's knowledge and insight will often be a valuable resource for the ward team.

Carers play a critical role in ensuring that the person they care for can look after themselves safely at home and often the carer will be the first to notice signs of deterioration, even before the person they care for. This insight can be extremely helpful during hospital admission, as carers can provide a rich source of information about what does and does not help that individual.

Involving carers can go some way to helping services protect an individual's rights to a personal and family life[4] and, by seeking a carer's advice about the specific needs of the person they look after, services may be better able to engage both patients and carers in treatment plans as well as future discharge arrangements.

"I feel included and welcome."

Carer

Understanding how to uphold carers' rights

It is important to remember that carers have the right to be consulted and have their views taken into account in the care, treatment and safety plan of the individual they care for[5]. However, it's equally important to remember that a carer can only be involved with that individual's consent (unless the individual is lacking capacity) in both community and hospital settings. Services should use the Triangle of Care (Carers Trust Scotland)[6] to find out how to promote carer involvement, and also as a tool to engage individuals in a dialogue about the benefits of having their carer involved. Many of the treatment interventions detailed in this guidance may also be effective in reducing carers' stress or distress.

Maintaining family contact to improve wellbeing

Maintaining family contact, especially with children, is often an essential factor in supporting the improvement of a patient's wellbeing in hospital. Where appropriate, clinical teams should support individuals to maintain contact with their children and family, providing suitable areas in the ward, hospital or treatment setting. Maintaining friendships and social or community connections should also be encouraged, particularly where this contact will be important to the patient, their treatment and their recovery.

Putting guidance into practice

Carers have the potential to be vital partners in the provision of modern mental health care[4] and clinical teams must be able to demonstrate that initial and ongoing contact with both carers and patients' families is established and maintained.

As carers are usually the first to be aware of a developing crisis – often when professional help has not yet been established or is unavailable – they are best placed to notice subtle changes in the person they care for and usually the first to notice early warning signs of a relapse. Carers want to see a collaborative approach to care and be seen as partners who are kept involved and receive information throughout the assessment, treatment and aftercare planning of the patient. This is particularly true in periods of crisis or during the need for acute care when carers will be understandably concerned about the person they care for and keen to ensure that the best care possible is given.

"At the time when my relative was admitted, I felt completely lost. Here was a set of new experiences I could not have imagined. I needed to know the ropes, who was there to help and what was going on. I especially needed to believe in the professionals – that they understood my connection to this precious person now in their care. I needed to have confidence they knew how to help him recover and that they saw me as part of that recovery."

Carer

Ward teams should:

identify carers and acknowledge the essential role they play at first contact with the patient or as soon as possible afterwards

be 'carer aware' and be trained in carer engagement strategies

ensure that policy and practice protocols are in place for both confidentiality and sharing information

ensure that defined posts are in place for members of the ward team with responsibility for carer liaison

make a 'carer introduction to service and staff' available with a relevant range of information across the care pathway

provide a range of carer support services

"I saw it [enhanced observation] purely as a way of keeping me safe and saw any involvement in care planning as separate to that – most patients have no idea what a care plan is and many are very shaky on what a risk assessment is."

Service user

A continuum-based approach is one that supports and reflects a natural flow of interactions or interventions, in response to a patient's wider clinical and wellbeing needs. In other words, it puts the focus back on the patient, not on their observation status (see Diagram 1).

Currently, patients are allocated an observation status (also referred to as a level or category), which should reflect the nature and severity of their risk and need. Patients requiring intensive support and observation can often have aspects of their freedom and movement restricted. As risk assessment and management has increasingly become a central focus of mental health care, observation has evolved as a central task to deliver this. However, in allocating observation tasks to staff as a way of monitoring a patient's whereabouts and safety, a wider understanding of their clinical, treatment and wellbeing needs can often be overlooked. This can lead to observations becoming standalone tasks, unrelated to the patient's overall needs.

This new guidance proposes that patients should no longer be given an observation status and that a continuum-based approach should be adopted instead. This allows risk management to become more closely related to a patient's clinical needs by shifting the focus away from observation and observation status, and concentrating instead on the nature and frequency of interventions, interactions and meaningful activities to support them. Staff can scale the nature, frequency and intensity of such interventions up or down based on a fuller understanding of the patient's needs, their purpose of admission and what is known to help them, without being restricted by their observation status and the assumptions that surround it – for example, their ability to engage in treatment.

Diagram 1: Continuum-based approach to care, treatment and safety planning

Communication and leadership

Early recognition and response

Continuum-based approach

Core, familiar staff

Personalised, aligned interventions
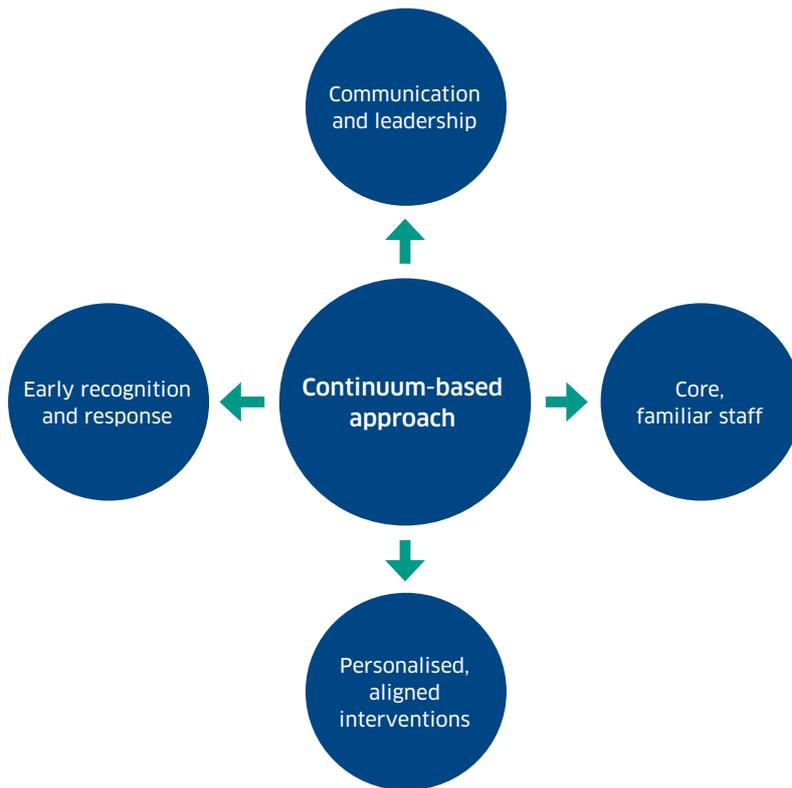
Personalised intervention and activity in collaboration with the patient

In a continuum-based approach, personalised intervention and activity can and should vary in frequency, in response to each patient's clinical needs, clinical formulation, deterioration factors and known risks. Interventions and activities may include talking therapies, physical activities and self-help activities (as well as medication) and can be delivered by various team members, including nurses, psychologists, medical staff and occupational therapists, all working in collaboration with the patient. Such an approach ensures that care and treatment, movement out of the ward, and access to families and children can be flexible and based on what is happening for the patient and their clinical needs and risks *at the time*, rather than being constrained by their observation status.

Scaling interventions up and down, based on patient need

This new guidance moves away from observation status; however, the continuum-based approach does recognise that scaling up care interventions will sometimes be required when a patient does need to have a staff member with them all of the time, for brief periods. However, by providing *meaningful* interventions and interactions, tailored to the patient's needs and strengths, this should help to provide the patient with the support they need to carry out activities either with a staff member on a regular basis (in line with their original care, treatment and safety plan) or on their own for periods of time. A range of low to high interventions and activities is outlined in Appendix 2.

Case study

Scaling interventions up and down in response to Julie's thoughts of self-harming

Julie is 27 years old and was admitted to hospital following a suicide attempt. Although her original care, treatment and safety plan delivered specific and frequent support during the day to help Julie cope with distressing flashbacks, she was becoming increasingly distressed during time spent alone and this was making her think about harming herself. Following a multidisciplinary team discussion at the safety huddle, a plan was made to engage Julie in a period of continuous intervention – initially for one or two days – to support her to manage her flashbacks and, ultimately, to enable her to feel safe on her own.

Together, the ward team and Julie looked at the structure of her day and Julie was offered both group and individual mindfulness and distress tolerance sessions at the times she would ordinarily be on her own. In addition, Julie was allocated time with her healthcare support worker and one or two other patients to plan the evening supper group activities. Afterwards, her healthcare support worker sat with her to carry out a relaxation exercise, so that Julie would be calm enough to read quietly before going to sleep. This scaling up of intervention meant that Julie would only be on her own while sleeping.

A personalised action plan was made with Julie and the ward team to consider her progress every 8-12 hours with a view to scaling back the level of support when Julie was feeling better able to cope with her flashbacks, without feeling the need to self-harm or self-isolate. Importantly, Julie's husband was involved with this new plan.

Supporting Joe's recovery through structured intervention and support

When Joe, a 27 year-old painter, was admitted to hospital, he had already received a diagnosis of personality disorder on a previous admission. He was offered a STORM (Skill Training On Risk Management) suicide prevention assessment. Joe's care, treatment and safety plan included specific nursing interventions around distress tolerance and coping strategy development, which were related to his thoughts of self-harm and the potential risk of his leaving the ward to follow these thoughts through.

One-to-one sessions were introduced to deliver interventions, initially twice during each nursing shift, and Joe was also supported to attend a social group activity that interested him. His progress and presentation were discussed during the safety huddles on each shift but it was noticed that after several days Joe started to self-isolate, although he would still engage briefly in his one-to-one interventions.

Following discussions between Joe and his multidisciplinary team, it was agreed that he would receive additional and structured support during each nursing shift, with a healthcare support worker helping him to organise his day.

Case study

Removing enhanced observation in response to Marjory's wider clinical needs

Marjory, a 65 year-old woman, was admitted to an acute psychiatric ward with a diagnosis of schizoaffective disorder. Her key problems on admission included delusional ideation, increased agitation, vulnerability and aggression and she was placed on enhanced observation by her consultant based on these factors, along with the associated risk of unplanned absences. This level of observation lasted for the duration of her 10-week admission. During this period there were documented incidents of aggression, as well as repeated attempts to leave the ward. Although Marjory was discharged, she was re-admitted a week later.

On her second admission, Marjory was again placed on enhanced observation and remained at this level for five months. However, ward staff recognised that Marjory did not seem to need to be on enhanced observation continuously and had regular periods where she appeared less troubled by her symptoms. Following discussion with Marjory, she was taken off enhanced observation and a structured plan was put in place for frequent sessions of one-to-one nursing care and meaningful activities. This was documented in her care, treatment and safety plan and adopted by the ward team. An activity plan was discussed and drawn up with Marjory and the multidisciplinary team that focused on activities Marjory enjoyed – going for walks in the hospital grounds, hand massages and reminiscing with the use of photographs. The timetabled one-to-one sessions included time for Marjory to spend with her key nurse to discuss her care, treatment and underlying issues, enabling assessments such as STORM to be carried out. The amount of one-to-one time was assessed by the ward team throughout the day and was increased or decreased as necessary in response to Marjory's wider clinical needs.

Putting guidance into practice

Adopting a continuum-based approach allows ward teams to focus on personalising interventions and meaningful activities *specific* to a patient's overall needs, rather than determining interventions solely on the presence or absence of risk.

The environmental, therapeutic and relational context in which these interventions take place is crucial to their success, and in Appendix 2 we highlight emerging practice that is currently being tested in Scotland. As we further test this guidance in other care settings (such as older adult wards, A&E, crisis teams, and medical and surgical wards) where patients have significant mental health needs or would traditionally experience enhanced observation to reduce harm, other appropriate interventions may be developed and shared.

Therapeutic intervention in its widest sense (from low to high intensity psychological interventions) to support meaningful independent or social activity (from gardening to goal setting) is most effective when it is both proactive and scaled in its frequency, according to individual clinical needs and risk assessment. This could range from one or two interventions or activities per nursing shift to a temporary period of continuous intervention. The critical factor is that all patients have access to therapeutic and meaningful intervention on a continuum that is informed by their needs, deterioration factors and risk – not solely on their observation status.

"Some of the nurses and nursing assistants were very humane and compassionate, both able to help me talk with them when I wished and also to give me enough privacy. One in particular seemed warm and kind and was able to speak to me even when I was at my saddest – she was someone I began to look forward to seeing each shift. Another was really good when I was crying about not seeing my child – he helped me cry without feeling shame and helped me not be embarrassed about other patients hearing me."

Service user

Ward staff should:

forward plan the scaling up or down of interventions with the patient and clinical team, ensuring that the right care and treatment is provided at the right time by the most appropriate person, avoiding any unreasonable delays and clearly documenting changes to interventions in the patient's care, treatment and safety plan

ensure that the patient is supported to address the issues that led to their admission – this may require access to other parties, including family and allied health professionals such as psychologists or occupational therapists

ensure that patients are offered a range of activities for therapy and recreation early in the admission process and that these are based on a multidisciplinary assessment of each patient's individual needs and strengths

adopt an inclusive and participative approach with patients, their carers and their relatives

Deterioration in a patient's mental health may be defined as 'changes in a person's mental state that indicate the need for more frequent review and for the introduction, change or up-scaling of therapeutic interventions'[7].

In mental health inpatient settings, a range of social and relational factors can contribute to deterioration and must be taken into account to develop an effective response. These include:

- the patient's circumstances and the experiences that surround their hospital admission

- the patient's environment – the design, nature and focus of ward structure and routines

- the therapeutic milieu of the ward and its ethos, such as trauma-informed as opposed to custodial care, and the use of restrictive practices

- the presence of familiar, skilled, competent and caring staff

- the ward team's workload, communication skills and approach to teamwork

- the degree of anticipatory care planning and personalised assessment that have been addressed to enable early recognition, intervention, support and treatment

Diagram 2: Factors involved in deterioration and the features of a systematic approach to prevent, recognise and respond to deterioration
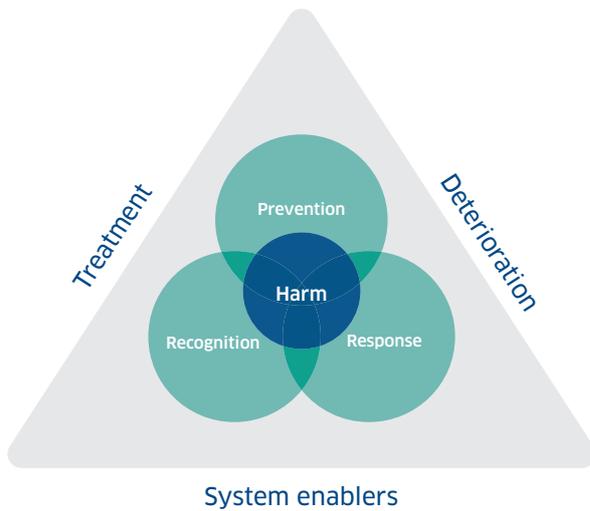
Treatment

- therapeutic interventions or activity, such as psychotherapeutic and interpersonal interventions
- physical activity and exercise
- engagement and follow-up with service users about effects of medicines
- safe prescribing and administration of as required and high-risk medicines
- consideration of impact of physical health issues

System enablers

- SBAR, safety briefings, safety huddles, team briefings, debriefing, flexibility in ward rules with focus on personalisation
- risk assessment linked to goal setting; daily goal setting
- carer engagement and involvement; peer workers
- education and training and agreed competencies, such as distress tolerance, mindfulness and other psychotherapeutic and interpersonal interventions, trauma-informed care – and embedding developed skills in practice
- evidence – and values-based practice
- effective multidisciplinary team working
- sharing learning from adverse events, and from patients' and families' experiences; tools/approaches to support review and upscaling of support
- safety walkrounds; clinical supervision
- ward procedures and routines that build in time for patient–staff contact

Deterioration

- environment – design, sense of space or confinement
- therapeutic milieu – quality of engagement, rapport, therapeutic intervention, empowerment, collaboration
- quality of assessment – indirect or direct
- ethics and human rights
- personal, social and interpersonal factors
- communication and consistency of staff and patient understanding of care planning and intervention
- care and support at critical points – early admission and preparation for discharge

The importance of a multidisciplinary, coordinated and planned approach

Ward systems and activities that are structured to facilitate early recognition and response to a patient's clinical needs are critical to the effective delivery of mental health care that improves patient safety, experience and outcomes. A multidisciplinary, coordinated and planned approach is essential for the delivery of safe, efficient and effective care, support and treatment so multidisciplinary knowledge, combined with effective communication about a patient's clinical needs and reason for admission (and alignment of these factors within care, treatment and safety plans) will ultimately make it easier to recognise when progress against the care plan is not developing as expected.

Putting guidance into practice

Clinical teams must be able to demonstrate evidence of planned and purposeful intentions which are aligned to a patient's assessed clinical needs and must report on the patient's progress against these intentions through effective communication with nursing staff and other members of the multidisciplinary team. When a patient is identified as potentially deteriorating or at risk of harm, their care, treatment and safety plan should evidence details of personalised forward planning, aligned to their wider clinical needs. This may involved increasing nursing or allied healthcare professional contact – such as occupational therapy, physiotherapy or activity coordination – to support the patient engage in new activities which may be inspired by information provided by the patient themselves (see Diagram 3).

"Patients can usually tell when other patients, their peers, are not well or becoming worse. We are usually really good at helping each other, we rely on each other to help."

Service provider

"Getting to know patients makes a huge difference – not using bank nurses."

Service provider

Managing patient engagement

For some patients, engagement in new activities may be in the form of facilitated self-help activities undertaken alongside a member of staff but without direct engagement if the patient finds this too difficult or distressing. Such activities could include personal goal setting, reading, occupational activities (such as sensory modulation) or helping staff on ward routines.

Ward staff should:

record an early intervention personalised action plan during the ward safety huddle or safety briefing discussion, for patients with signs of deterioration or at risk of harm

temporarily increase the frequency of interventions or meaningful activity (or forward plan to do so imminently) where potential or actual deterioration is apparent, to enhance patient engagement and benefit – this may mean prescribing a deteriorating patient a number of specific interventions, contacts or activities per day within their care, treatment and safety plan and following up or reviewing progress

consider the views of the patient themselves, and/or their carer, when developing interventions – this is just as important at times of potential deterioration or crisis and it must not be assumed that the patient cannot or does not want to engage

think 'out of the box' to develop meaningful activities that may be indirect or non-invasive for patients who find it difficult to engage directly with staff – remember that it's rare for an individual's purpose of admission to either necessitate, or benefit from, prolonged periods of isolation or disengagement

ensure that the nature, frequency and intensity of interventions are personalised and therefore responsive to the patient's reason for admission, clinical needs, preferences and/or advance statement[8] – not solely on the presence or lack of risk

Breaking the cycle of harm and intervention for Margaret

When 25 year-old Margaret was admitted to the acute mental health admission ward following self-harm, she repeated this self-harm on a number of occasions, always following periods of enhanced observation. The ward team reflected on this harm–observation cycle with Margaret and agreed that enhanced observation was unhelpful.

Margaret identified flashbacks to traumatic events in her past as being the triggers for her desire to self-harm and revealed that the restriction of activities she enjoyed, and isolation on the ward during observation, led to her dwelling on her problems. With the ward team, she discussed activities that usually helped her to cope with these feelings at home and also boosted her self-esteem. These included housework, walking her dog, exercising and meeting up with her family and friends.

The ward team drew up a new plan with Margaret that allowed her to engage in the occupational activities she enjoyed, to keep her busy and help her self-esteem. She also began to attend two sessions each day with her named nurse, doing focused work on her background issues and developing strategies to manage her flashbacks.

Exploring good practice

Ward 24 at Monklands Hospital (NHS Lanarkshire) uses personalised STORM assessments with patients identified as being at risk of self-harm to collaborate with them on personal interventions to address this risk. A similar process is used to identify and support patients who may be at risk of unscheduled absences from the ward. Monklands uses various psychotherapeutic interventions, ranging from high-level psychological therapies (which nursing staff have been trained in) to interpersonal interventions including mindfulness, mentalisation and distress tolerance, as well as other approaches such as hand massage and relaxation therapy.

These interventions are used as a continuation of, or alternative to, treatments in community settings – in some cases, with patients who are discharged from hospital but benefit from the security of attending the ward for treatment – and can help patients to develop skills and coping strategies. Monklands prescribes patient contact time for these interventions on a frequency of one to three times a day, depending on the patient's needs, signs of deterioration or crisis.

Ward 3 at Parkhead Hospital (NHS Greater Glasgow and Clyde) and Huntlyburn Ward at Borders General Hospital (NHS Borders) both use some of these psychotherapeutic approaches in a flexible and scaled way to meet the needs of their patients, particularly when they require periods of continued intervention. Clinical formulations – theoretically based explanations based on information obtained from a clinical assessment – with the support of allied health professionals where indicated can help to tailor these interventions to ensure they are personalised.

Communication within and across teams, and with patients, their families and carers, is central to anticipatory care and the recognition of and response to patient deterioration, in mental health settings.

Getting to know patients, their families and carers well, and spending time with them, provides a valuable benchmark against which to recognise and assess subtle changes in presentation or behaviour which may indicate a potential deterioration in mental health or a potential risk of harm. Communicating concerns about a patient's progress – or lack of progress – in a structured way can then raise early awareness and early facilitation of any specific interventions required.

Putting guidance into practice

Multidisciplinary, patient-focused communication systems such as SBAR (Situation, Background, Assessment, Recommendation), safety briefings and safety huddles must be in place during each shift to facilitate rapid communication about patients at risk of actual or potential deterioration as well as those at risk of harm to themselves or to others. Safety huddles are an extremely effective way of closing the loop of communication by putting personalised action plans in place for patients who require early intervention in the form of increased activity or approaches which could mitigate deterioration or further deterioration. These personalised action plans should include a mechanism for reviewing progress – for example, at the next safety huddle, safety briefing or handover.

"I was on obs when I was admitted at 19 – I had had serious incidents in my life and was very depressed. If that nurse hadn't been there I wouldn't be here now – in the course of me having reduction of mood and him being so close and looking after me, when I started to speak I was able to say for the first time in months about the horrible things that had been happening to me – it was a life saver."

Service user

Ward staff should:

take the opportunity to determine a patient's wellbeing regularly, during planned contact time and whenever an opportunity presents itself – for example, during ward activity planning meetings or staff and patient community meetings

ensure that routine checks to determine awareness of a patient's whereabouts (in line with environmental safety and fire regulations) are interaction-based and focus on a brief assessment of wellbeing should any concerns arise

communicate any concerns about wellbeing that are indicative of potential deterioration to the team and put a personalised action plan in place, collaboratively with the patient, to support them – this should be followed up during the next safety huddle

Diagram 3: NHS Borders' early recognition and intervention approach for deterioration

Ward programme

- daily one-to-one time
- personalised care plan
- systems to identify deterioration – safety brief
- MDT plan

Ward programme

- daily one-to-one time
- personalised care
- systems to identify deterioration – safety brief
- action plans to reduce deterioration
- MDT plan
- increase activity
- review

Ward programme

- daily one-to-one time
- personalised care
- systems to identify deterioration – safety brief
- action plans to reduce deterioration
- MDT plan
- increase activity
- proactive approach with risks identified
- plan from MDT to reduce risk
- review

Using effective communication methods to support Julie's engagement with treatment

25 year-old Julie, a young mum, had a long history of self-harm and alcohol misuse and previous mental health admissions and was admitted to the acute mental health ward from a medical ward, following an overdose of paracetamol. The initial STORM assessment identified an ongoing risk of self-harm, so Julie and her clinical team drew up a support plan and its purpose and progress were communicated during the daily safety huddles. The plan included the need for the duty nurse to check in with Julie at the times of day she found most challenging or was most likely to self-isolate, and this worked for some time when Julie also engaged with group and individual therapeutic activities.

Exploring good practice

Crathes Ward and the Intensive Psychiatric Care Unit (IPCU) at the Royal Cornhill Hospital (NHS Grampian) have adopted an approach that focuses on "How are you?" rather than "Where are you?" during routine ward environment and fire safety checks. If patients are identified as potentially deteriorating or at risk of harm – self-isolating, experiencing distress due to psychotic symptoms, being verbally or physically disinhibited or aggressive – they are rapidly followed up with an engagement activity or intervention as part of an immediate personalised action plan.

Ward 10 at Woodland View (NHS Ayrshire & Arran) is working to ensure that there is always core, familiar nursing visibility in communal ward areas so that patients have constant access to support. This increases the opportunity for early nursing intervention where it may be required – for example, to reduce distress or de-escalate a situation. This approach has led to an improved quality of information being shared during safety huddles and a quicker, more proactive response to signs of deterioration.

Strand 5 | Promoting least restrictive practice

Restrictive practice, including restraint, seclusion and the 'informal seclusion' that often results from current enhanced observation practice, can increase stigma, isolation and the risk of harm; it can adversely affect people with a trauma background and this too can increase the risk of harm.

Restrictive practice reduces the potential to share risk between mental health practitioners and patients because it reduces the opportunity for trust to be built and for collaborative work to emerge on safety planning to support a patient's autonomy. It also impacts negatively on the personal development of skills and coping strategies which can support the development of resilience and positive risk taking (weighing up the potential benefits and harms of choosing one course of action over another). In addition, social isolation may actually serve to increase risk, as may having a staff member alongside a patient for a prolonged period of time, especially where this is continually non-interactive.

Changes currently being tested as part of this new guidance indicate that increased or improved therapeutic intervention and activity may effectively reduce the need for restrictions on activity. However, where physical containment – for example, a patient in a room with the door locked or unlocked and with a member of staff outside, preventing free movement and engagement in the care, treatment and safety plan – is deemed necessary following risk assessment, this must be clearly justified and recorded, with any restrictive practice aligned to the individual board's seclusion policy.

"It [enhanced observation] feels very restrictive and intrusive… like being in prison."

Service user

Putting guidance into practice

Restrictive practice should be minimised, with ward staff ensuring that any uninterrupted, continued periods of individual intervention are temporary and do not resemble informal seclusion or physical containment. Any care and interventions delivered during these periods must be of the highest standard and equitable to those received by all other individuals.

Ward staff should:
justify and document any restriction to privacy or activity and ensure that such restrictions are made due to an immediate, significant risk of harm where the patient is assessed as being unable to spend time alone or to safely interact with others
ensure that the justification for restriction is not simply to 'prevent or reduce risk', as this should not be the sole purpose of the intervention – there must be evidence of meaningful goal-directed activity or intervention being planned and offered
align interventions with the Millan Principles[9] and the Rights in Mind[8] pathway so that patients are free of restrictions on their independence, choice or control, unless those restrictions are for clearly identified and documented reasons and as long as they are the least necessary
involve patients as much as possible in agreeing to restrictions
review restrictions regularly to determine whether they are still necessary
address medical emergencies, such as severe violence and aggression associated with novel psychoactive substances ('legal highs') in the appropriate medical environment

Dealing with incidents of violence or aggression

It is recognised that incidents of violence, which are followed by a reactive response including containment measures (such as restraint or enhanced observation), can escalate to further violence. Containment is not a recommended course of action and preventative de-escalation measures should be introduced instead. Emerging evidence suggests that reducing the potential for conflict by facilitating a calm and less rigid ward environment may help to reduce violence, as may approaches that anticipate patients' needs and respond early to them.

The Brøset Violence Checklist (BVC)[10] assesses the presence or absence of six factors – confusion, irritability, boisterousness, verbal threats, physical threats and attacks on objects – as an indicator of the likelihood of violence in the next 24-hour period. Using the BVC can go some way to helping ward staff anticipate and intervene early in a positive way to reduce violence.

This guidance recommends that instead of resorting immediately to constant observation following incidences of violence, a cooling-off period or a clinical pause of one to two hours should be introduced – this can also work in response to other brief crisis situations such as verbal aggression or self-harm. This can help to reduce a reactive and cyclical approach to using enhanced observation and focus instead on continuous intervention.

"Clearly, the BVC is not the only answer – it's just a risk assessment tool. What I like about it, however, is that it's nurse-led. It empowers registered and unregistered nursing staff to be proactive and take the lead on reducing violence. If a patient is becoming aggressive, there's no point in waiting until the ward round to mention it to the consultant. Staff should do something about it then and there."

Staff nurse

Ward staff should:

de-escalate the situation (in line with BVC guidance) that has triggered concern and/or has potential for continuous intervention and further assessment of risk and clinical needs

have a debrief with the patient and the clinical team involved to explore and understand the factors that have triggered the violence or aggression (such as increased distress, a crisis or incident)

formulate a personalised action plan, developed in collaboration with the patient, the staff who have spent time with the patient during the cooling-off period (and will therefore be familiar and known) and the clinical team to address the triggers for the violent or aggressive incident and put in place specific personalised interventions tailored to the patient's needs, strengths and protective factors

Strand 6 | Managing periods of continuous intervention or support

There will be times when a patient will be assessed as requiring brief periods of continuous intervention. This may be because early intervention activity has proved unsuccessful – for example, to reduce self-isolation – or to provide reassurance when a patient has expressed that they are feeling unsafe, at immediate risk of harm, or unable to engage in a planned activity within their care, treatment and safety plan.

Continuous intervention, however, is not necessarily only required at times of potential risk, it may also be employed to reduce distress or vulnerability or to promote dignity if disinhibition is present. Within the context of a care, treatment and safety plan, continuous intervention should always be used as a last resort and as a means of exploring a more focused programme of personalised intervention. Any proposed continuous intervention must be backed by evidence that alternative interventions, with more frequent contact, have already been tried.

Findings from our work in test sites indicate that psychotherapeutic and other personalised, activity-based interventions are leading to a reduction in the length of time that patients need continuous intervention. Approaches can range from distress tolerance, mindfulness and goal setting to cognitive analytical approaches and other group or individual activities, tailored to patients' strengths and interests both within and outside the ward setting.

"When I was cared for after injuring myself the nurse was gentle and respectful."

Service user

Continuous intervention as part of the continuum-based approach

Any identified requirement for periods of continuous intervention or support should, as far as possible, be anticipated, planned and specific. The intervention must be delivered with multidisciplinary involvement and based on clinical or psychological formulation of needs, especially where higher intensity interventions (such as dialectical behaviour therapy) are proposed. The patient should experience such periods of continuous intervention or support as a continuum of their care, treatment and safety plan – not a standalone task – and, as such, these periods should be as brief and as purposeful as possible. Parameters should always be set for the duration of the continuous intervention and its review.

Evidencing the need for continuous intervention or support

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

- they are **purposeful** – clearly planned with specific psychotherapeutic interventions and/or activities, related to the patient's clinical needs and strengths

- they are **goal-directed** – aiming to return to a frequency of interventions that is less intrusive, as quickly as possible

"Very mixed feelings… having someone at your bedside who does not engage in the whole time you are there seems like a waste of resource. Reading magazines, being on the phone, defeats the purpose – I have been in situations where I have had to tell staff that people are at risk, or so and so has run off."

Service user

Generating a multidisciplinary care plan

Continuous intervention should be as least restrictive as possible. It should be specific, psychotherapeutic and purposeful, aligned with the patient's needs, strengths, purpose of admission and evidence-based practice. A care, treatment and safety plan, generated by the patient's named nurse, senior charge nurse, known psychiatrist, the patient themselves and/or their carer, as well as any other relevant parties (such as third sector care providers), should set out the provision, purpose and nature of the continuous intervention and demonstrate how it relates to the patient's reason for admission and their existing care, treatment and safety plan.

Assessing the need for continuous visual assessment

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

Putting guidance into practice

After an initial 8-12 hours on continuous intervention, a review – which should consider scaling down the intervention – must take place to assess its effectiveness. The review should involve the senior or deputy charge nurse as well as medical staff (of appropriate seniority) and allied health professionals who know the patient and the patient's care, treatment and safety plan well.

If the continuous intervention is still in place and deemed to be appropriate up to or after 24 hours, its purpose, the nature of the intervention and alternative plans to scale it back should be reviewed every 8-12 hours (minimum) by the clinical team involved in the patient's care, the multidisciplinary staff who have spent time with the patient, and the patient themselves.

Proactive reviewing of continuous intervention and support as part of the patient care, treatment and safety plan

Proactive reviewing seeks to understand any benefit that the continuous intervention is providing – from both the patient's and the staff's perspectives – and to provide carefully considered alternatives – for example, a move towards more frequent interaction or interventions which monitor wellbeing (such as mood diaries, the Mental Health Triage Scale, the Brief Psychiatric Rating Scale (BPRS) or PHQ-9) along with other planned self-help, social or group activities based on what the patient and their family or carer advise usually helps them.

Ward staff should:

ensure that all specific, personalised activity is delivered by core, familiar staff who are skilled in a range of psychotherapeutic interventions

ensure that any continuous intervention is experienced by the patient as a continuum of their care, treatment and safety plan and is responsive to their individual needs at the time and not solely dependent on risk, while staying focused on the safety of the patient and other individuals

understand that areas of risk can be addressed through psychotherapeutic intervention on a frequent or structured basis, without necessarily requiring continuous intervention

focus on being 'with or alongside' the patient to provide support, structured intervention, ongoing assessment and reassurance – not watching the patient from a distance

promote activities that enhance the patient's ability to engage with others and develop coping skills and self-esteem during all personalised interventions

ensure that patients do not face any undue restrictions, such as withdrawal of rights to see their family or engagement in day-to-day activities, unless there are evidenced and documented significant risks in doing so

avoid informal seclusion or physical containment of a patient in their room with staff seated outside and minimum interaction – this is unacceptable unless the patient is at risk of violence or has requested isolation, in which case the rationale and value of continuous intervention should be reassessed

Trauma-informed care is an approach to care and treatment, and also to service structure and leadership behaviour. It recognises the impact of trauma on health, social and emotional wellbeing and on the functioning of people accessing mental health care services. It aims to design and deliver care services that will minimise the risk of further trauma.

The core principles of trauma-informed care are **choice, collaboration, trust, empowerment** and **safety**. Experienced staff, who are knowledgeable about the effects of trauma on relationships and recovery, should have the skills to build a positive, trusting relationship with their patients and deliver an effective range of care and treatment interventions.

Individuals who have a trauma background may experience:

- emotional dysregulation – difficulty communicating, recognising, managing and expressing their emotions in an adaptive way
- poor peer relationships, social isolation, feeling stigmatised, difficulty in trusting others
- disconnection from others and feelings of disempowerment
- anxiety, hypervigilance and hyperarousal
- difficulty in thinking clearly, concentrating, interpreting the world and other people's intentions accurately
- cognitive distortions
- physical health comorbidity
- increased risk of self-harm or suicide

"No matter what someone is going through, they are a human being."

Service provider

In response to this, trauma-informed culture and practice in services should be woven through the values of the whole organisation and focus on being:

- patient-led rather than service-led
- flexible rather than rules-led
- non-stigmatising and protective of human rights
- cognisant of an individual's past events and the impact these may have on current interactions with staff
- about interactions and interventions that promote engagement and recovery
- non-coercive and without overt displays of authority or power (such as keys, personal attack alarms or restraint)

Trauma-informed care and treatment principles

Recognition of trauma and adversity background	Patient collaboration and empowerment	Choice and control
Relational support to promote safety	Promoting strengths and self-efficacy; non-blaming	Efforts to minimise re-traumatisation
Service collaboratively designed	Trauma-informed staff	Recovery orientation
Primary focus on experiences rather than illness or diagnosis	Holistic approach to support physical, cognitive, emotional and social functioning	Personalised and inclusive of sport, art and community activities to build resilience

The importance of core, familiar staff and trauma-informed leadership

Core, familiar nursing staff and allied health professionals such as occupational therapists or psychologists, who are skilled and have capabilities in a range of clinical, interpersonal and therapeutic interventions, are essential to the success of this guidance and to the change in approach from observation to intervention. High visibility and accessibility of all levels of core nursing staff can help facilitate early identification and therefore early intervention of deterioration and increased risk.

Individuals being admitted to hospital, and indeed a range of care settings, are increasingly presenting with a higher degree of complexity and/or comorbidity. This requires a skilled – and in many cases expert – provision of up-to-date and modern interventions to help people with specific conditions or experiences.

Evidence is emerging, through both research and practice being tested in Scotland, that a range of psychotherapeutic interventions are of great benefit to inpatients when they are personalised to the needs, risks and strengths they present. There is also growing evidence around the experience of trauma and its impact on mental health such as the development of psychosis, personality disorder and depression. Many people accessing services for mental health care and treatment present with a trauma background and describe further stress and trauma when subjected to restrictive, coercive or inflexible practices in hospital[11]. Childhood abuse or adversity can impair social, emotional and cognitive functioning as well as physical health, while trauma history and stigma[12] are associated with self-harm and suicide. Trauma-informed leadership and practice can help to improve outcomes and experiences.

"Education of student nurses and psychiatrists is essential for culture and therefore observations."

Service provider

Putting guidance into practice

This guidance recognises that education and training may be required during the implementation phase of the transition from observation to intervention in practice. Patient-facing staff should receive education and training (or have this facilitated) on trauma-informed care and practice in collaboration with every health boards' psychology colleagues. Local health boards are responsible for organising this training and for benchmarking practice and culture change. The publication *Transforming Psychological Trauma: A Skills and Knowledge Framework for the Scottish Workforce*[13] may support this training and we recommend that mental health staff reach 'trauma enhanced' practice levels.

Arming core, familiar staff with knowledge and skills

Senior management should ensure that core nursing staff and allied health professionals are armed with core knowledge and skills, including:

- a wide range of therapeutic assessment skills
- good medicine safety knowledge
- the ability to engage and establish trust and rapport with patients
- personalised risk assessment, safety planning and clinical formulation knowledge
- the ability to recognise triggers and early warning signs of deterioration and to develop highly personalised care, treatment and safety plans
- expertise and capabilities in trauma-informed care, suicide awareness and psychological interventions and the ability to use these in a flexible way with patients experiencing psychosis or personality disorder and with patients who self-harm or live with conditions such as dementia
- the ability to plan and communicate changes rapidly and consistently
- the ability to support their own learning and development through engaging in debriefing, clinical supervision or action learning

"Staff have been respectful and tried to engage with me."

Service user

- the ability to utilise a range of approaches and interventions such as mindfulness, goal setting, distress tolerance and mentalisation
- the ability to align therapeutic approaches, the principles of human rights and least restrictive practice to support patients' psychological and physical activity and to avoid physical containment, informal seclusion and other restrictive practices, particularly when patients require increased and continuous supervision or support
- an existing relationship with the patient, based on an understanding of their health and care needs, and the ability to assess and respond early and proactively to any change in presentation and wellbeing
- the ability to recognise and harness patients' strengths, talents and experiences in order to promote self-management
- the ability to ensure that clinical activity, and the nature and frequency of intervention, are all tailored to a patient's care, treatment and safety plan – as frequent interaction and intervention may be required as part of this plan to recognise, respond to and prevent patient deterioration or to alleviate underlying issues relating to the patient's reason for admission

Senior management should:

ensure that only core or regular, familiar staff with the trauma-informed skills outlined above carry out personalised psychotherapeutic interventions as indicated within the patient's care, treatment and safety plan – this includes unregistered nursing staff and peer support workers who may have these skills, as well as allied health professionals such as occupational therapists or psychologists, and is particularly important when:

- – the patient's clinical needs are complex
- – there is the presence or risk of harm or deterioration
- – the patient requires personalised interventions or interventions targeted at specific issues such as self-harm

structure ward activity and/or shift patterns to maximise staff visibility, interaction, therapeutic milieu and continuity of care within the clinical environment

plan workforces in terms of the resources, staffing, activities and skills required to deliver preventative, early intervention-focused care, treatment and safety to a patient group with increasing complexity and often multiple morbidities

explore continental (short-day) shift patterns in line with emerging information about the ease of use for core nursing staff, visibility of nursing staff and continuity of relationships, care, treatment and safety planning

The role of nursing staff

Within teams, nurses are well placed to facilitate and coordinate multidisciplinary input (including allied health professionals such as occupational therapists and psychologists) to patient care. At the same time, we acknowledge the limited resources and sessional availability of those allied health professionals in hospital settings. Nurses and healthcare support workers are ideally placed to work together with multidisciplinary team members to further develop knowledge and skills that will benefit both patient experience and outcomes.

The role of student mental health nurses

Supported by their mentors, student mental health nurses may provide day-to-day, proactive, planned interventions as part of their patients' care, treatment and safety plans. In situations where students are expected to develop specific therapeutic nursing skills as part of their set learning objectives, these should be tailored and specific to the needs of the patient, and should reflect the goals and interventions set out in patient care, treatment and safety plans.

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

The role of allied health professionals

Drawing on the assessment and treatment skills of allied health professionals working within mental health care services should be considered throughout a patient's recovery journey. Therapeutic interventions may vary depending on the specific profession and experience of an allied health professional and should both contribute to and inform the multidisciplinary care planning that supports services to provide a range of interventions. Including allied health professionals in this planning provides an opportunity to look at increasing engagement wherever possible. All therapeutic interventions delivered by allied health professionals should be risk assessed based on a patient's individual needs, the skill set of the allied health professional and the environment in which the intervention is to take place. In addition, all allied health professionals should be trained in line with local or national requirements in risk assessment relevant to their area of practice and should work within their level of competence. Supervision should be routine to practice.

"I was told off for attempting to self-harm by inexperienced staff as it was stressful for them… in retrospect, they should not have been in that position, rather than me feeling guilty about it."

Service user

Strand 8 | Supporting personalised care and treatment

Observation status and associated questions about how many patients are on general and enhanced levels of observation are commonly used to describe and determine clinical need, clinical risk, related staff activity and projected staffing requirements.

However, it's important to remember that observation and risk status (as outlined in Strand 2) do not always accurately reflect the underlying care and treatment needs of all patients, which are often acute, complex and challenging. In isolation, observation and risk status do not accurately indicate the true extent of the therapeutic activity required to deliver personalised and proactive care and treatment interventions to prevent or respond to deterioration. A focus on clinical needs and purpose of admission, as well as deterioration or risk factors, is required.

"It is saying 'How are you?' – not just 'Oh, she is agitated!' – more 'How are you feeling? What is making you feel this way? What can we do to help?' That would help me."

Service user

Case study

Engaging Melinda through a collaborative and personalised care plan

When 34 year-old Melinda was admitted following an episode of psychosis, she was experiencing low moods and described hearing troublesome voices. Although there were no specific risks identified, Melinda appeared to be reluctant to engage with anyone on the ward and seemed afraid and suspicious.

Melinda's named nurse, John, found out about her hobbies and persuaded her to join the ward's art and gardening activities as well as its mindfulness group, with the aid of a healthcare support worker, Alison, who would initially attend activities with her. Melinda also agreed to spend time each day with John to explore and develop strategies to cope with the voices she was hearing, supported by self-help materials. Melinda was introduced to the duty nurse, Samantha, who explained that she, John or Alison would check in regularly with Melinda to see how she was coping and if there was anything she needed.

Melinda's multidisciplinary team agreed that any signs of deterioration would be discussed at the daily safety huddle and a personalised action plan for additional support made if required. However, it was hoped that with the initial support in place, Melinda would gradually attend the daily ward diary meetings to set goals for the day and engage in follow-up meetings later in the day.

Putting guidance into practice

A close understanding of a patient's clinical needs and strengths, as well as the risks or triggers for harm or deterioration, will help staff to develop collaborative relationships with patients and then align these needs with appropriate, specific and personal interventions.

"Rapport is vital."
Service provider

Developing personalised care, treatment and safety plans

Ward staff should ensure that each patient has a care, treatment and safety plan in place that:

- is collaborative, anticipatory and designed around the needs of the individual patient

- is recovery focused and involves the patient in their development and review, in line with the Rights in Mind pathway

- is focused on addressing identified risks and triggers for deterioration or harm

- addresses the issues (if known) causing or worsening symptoms or the risks, triggers or issues behind the patient's admission to hospital, ensuring that the patient has access to activity, therapeutic intervention and recreation, and is supported to maintain family relationships in line with the Rights in Mind pathway

- will flexibly scale up or down the nature or frequency of relevant, interpersonal, evidence or values-based interventions to meet the health care needs of the patient during the day or night – for example, by increasing the frequency of personalised intervention or contact to build a relationship and sense of continuity when the patient is early on in the admission process and/or at risk of deterioration, unscheduled absence, self-harm, self-isolation, expressing suicidal ideas, violent, or at risk of physical harm associated with confusion or the risk of falling

- will seek to provide evidence of a patient's consent to temporary and continuous intervention

- will have multidisciplinary consideration, forward planning and decision-making at its centre, enabling nursing staff to flexibly scale up or down the intensity of intervention

Ward staff should:

ensure that care and treatment interventions are aligned to the documented clinical needs and triggers for deterioration or risk for each patient and carried out with their involvement or with carer involvement where consent is given

seek to understand the lived experience of patients and their families and engage their participation, consent and choice about care and treatment – care, treatment and safety plans should evidence carer or family consultation and engagement

utilise advance statements wherever possible (in line with the Rights in Mind pathway) with care plans evidencing discussion and collaboration with patients and a rationale for not complying with an advance statement being provided, in writing, to the Mental Welfare Commission for Scotland and the patient themselves

Strand 9 | Creating an infrastructure to support learning and quality improvement

Being able to test small changes in health care practice can help to engage nursing teams in improvement activity. Monitoring outcomes through improvement data can help those teams to identify and evaluate improvements in both patient and staff experiences.

This guidance reflects the need for the promotion of continuous improvement and discussion of this at all levels to support the creation of a learning and development culture.

Putting guidance into practice

Boards should systematically seek and review feedback from both staff and service users across a range of issues – for example, service users' experiences of care and treatment and both service users' and staff's perceptions of safety.

"It is the way people are trained – there is too much of 'we are in charge' and it is therefore what we are doing *to* you rather than *with* you."

Service provider

Ward staff should:
set aims and objectives for improvements to patient experience and gather data to identify whether tests of change are effective in achieving these aims
use the Change Action Package and Measurement Plan that accompany this guidance to test and monitor improvements in practice
discuss learning from data to facilitate an understanding of the context of any improvement activity and use this learning to stimulate further tests or the spread of change and improvement

Incidents of harm and patient suicide have occurred during both general and enhanced levels of observation practice. It is these events, along with inconsistencies in the quality, safety and patient experience of observation practice, which have necessitated the need for change and improvement in order to develop new and effective ways of working with the most unwell, complex or vulnerable patients in our care, built on treatment with a person-centred approach[14].

Concerns around human rights within restrictive practices have been highlighted by the World Health Organization[15] while the *National Confidential Inquiry into Suicide and Homicide by People with Mental Illness: Inpatient Suicide Under Observation* (2015) highlighted safety concerns around the current approach to observation practice and recommended new models of practice. The inquiry recommended that observation practice should[14]:

- not be seen as a standalone component of care but as interaction focused and part of a clear and dynamic risk assessment and care, treatment and safety plan
- be seen as an acute intervention with a planned approach to general observation
- be a skilled intervention, carried out by staff with appropriate seniority, training and capability
- ensure that all breaches of protocol, or failure to follow a patient's care, treatment and safety plan, which lead to self-harm or unscheduled absence are investigated under incident investigation procedures to facilitate learning and improvement

Examining concerns around observation practice

A number of concerns around observation practice have been raised through personal experience and also through published resources and can be summarised as follows.

- Observation procedures are not consistently explained to patients and their consent is not always sought.

- Not all staff interpret observation procedures, or the purpose of the intervention, correctly or in the same way, which can lead to non-adherence of observation policies and, sometimes, patient harm.

- Enhanced observation is sometimes used to raise staffing levels rather than address the clinical needs of individual patients.

- There is frequent use of agency or bank staff who may not know the patient they are observing or understand safety issues within the ward environment.

- Observation practice is often carried out by unfamiliar and/or junior staff who may not necessarily be equipped with the skills or knowledge to identify, address or respond to the problems experienced by the most unwell or complex patients – as a result, the patient's care, treatment and safety plan may not be followed during such observations.

- Observation practice can be viewed as a standalone task and can therefore be focused on proximity – watching and checking a patient's whereabouts – rather than being intervention or interaction focused. This also serves to devalue the role of the mental health nurse in the care, treatment and safety planning of unwell or complex patients.

- Using observation as a method of surveillance can inhibit direct assessment, engagement and interaction around what is happening for the patient as well as inhibiting proactive care planning.

- The lack of a care, treatment and safety plan, alongside an aligned and collaborative person-centred risk assessment, can affect the nature and quality of engagement, care and treatment with the patient, and communication within the care team, during observation practice.

- Both general and enhanced observation can lead to an increased risk of violence against members of staff – this can consequently cause harm to both those who experience violence and those who witness it.

The challenges of using observation status as an indicator of risk and clinical need

In practice, observation status is often used as a shorthand indicator of the presence or level of patient risk and therefore is perceived as an indicator of a patient's clinical needs. As such, observation status can adversely influence the nature and quality of care, treatment and safety planning.

Generic or standardised care planning can often occur for patients on general observation as such patients are deemed low risk. As a result, there can be a lack of personalised or specific treatment interventions in relation to those patients' clinical needs or their purpose of admission. However, this can also be the case for patients who are deemed as high risk or on enhanced observation. Observation practice can sometimes seem to be the main intervention but, equally, is sometimes used to the detriment of other, more effective, interventions. When risk factors are perceived to have changed, this can lead to changes in observation status rather than the development of specific and personalised care and treatment interventions. Without proper alignment against a patient's clinical needs, general and enhanced observation status can reflect the same practice, albeit that the latter is carried out continuously.

Evidence shows that many to most suicides happen among patients on general observation[15]. In other words, a general observation status does not reliably indicate low risk. Clinical needs, purpose of admission and what is going on for the patient – rather than observation status – should guide planning and intervention.

In situations where death by suicide has occurred, there has not always been a clear and personalised care, treatment and safety plan in place to address either specific triggers, or the patient's clinical needs, even where a risk assessment has been completed. In other words, risk assessment is not consistently aligned with care, treatment and safety planning, and communication about the nature of the patient's plan, interventions and purpose of admission is not always clear[16].

The challenges of relying on patient classification through risk assessment and risk status

Risk assessment, when it becomes solely about *defining* the level of risk and therefore observation status, can prohibit the ability to get to know the patient and support the development of their personalised care, treatment and safety interventions. Such a narrow focus can therefore limit the boundaries and scope of care and treatment and may actually increase the risk of harm rather than reduce it.

It is widely acknowledged[17,18,19] that risk of harm, particularly suicide, is dynamic, complex and extremely difficult to predict, manage and eliminate in mental health care because of a myriad of human factors (both patients and staff) and unknown chance factors (such as access to means of lethality, recent loss or bereavement) even with the use of risk assessment and observation practice. Recent meta-analytic studies are challenging traditionally held assumptions around suicide risk assessment by discovering that such assessments (including checklist format suicide risk assessment) do not accurately predict or prevent suicide or self-harm[17,18,19]. These findings demonstrate only weak or modest links between suicidal intent, suicidal behaviour and death by suicide, with accurate predications only marginally greater than chance predictions[17]. As such, a narrow focus on risk assessment, and the reliance on risk scales or checklists to identify and classify patients as high or low risk, may provide inaccurate and false reassurances about risk of harm[17,18,19,20].

Adopting a holistic and personalised approach

Such findings challenge all of us working in mental health care to address the usefulness of classifying patients according to potential suicide risk and observation status and instead, to take a holistic and personalised approach to risk assessment that encompasses a wider assessment of the patient and their health needs and circumstances. Underpinned by professional curiosity and clinical judgement, such an approach should encourage the development of a universally higher standard of personalised care and treatment for all patients, and may also potentially reduce harm by better supporting individuals whose risk of harm is unknown or has not been disclosed to the clinical team[20,21,22].

Recommendations for change

These findings recommend that risk assessment should not be carried out as a standalone exercise to be checked off, but instead should be personalised and incorporated into comprehensive, psychological assessment and care, treatment and safety planning for each individual patient. Doing this, and addressing clinical needs as well as risk factors, may identify and reduce potential harm[17,19].

Recommendations around targeting clinical needs include providing good minimum standards of quality, general support and care – for example, relationships, financial advice, social and family support – through to specific interventions for borderline personality disorder, psychosis and depression. Some of these interventions are currently under utilised in practice but are known to be effective – for example, in reducing self-harm[17], stress or distress – and can be used without classifying patients in risk categories.

An approach that raises the minimum standards of care and treatment for all patients, irrespective of traditional observation status – and therefore, by default, risk status[17,20,23] – will move care away from a level of intervention determined solely by risk towards care defined by clinical need. This will therefore be wider and more inclusive of those patients who are deemed low risk but are statistically more likely to be involved in an adverse or tragic event[20].

Appendix 2 | Care and treatment interventions

This guidance recognises that a wide range of interpersonal and low to high intensity psychotherapeutic or psychological interventions, are welcomed by patients in mental health settings and can help to alleviate distress and deterioration and support recovery.

These interventions include a range of individual, one-to-one or group activities and can include talking therapies, physical or social activities, self-help activities and medicines. The environmental, therapeutic and relational context in which these interventions take place is crucial to effectiveness, as is a patient's ability to engage.

High intensity psychological interventions – such as cognitive analytic therapies or dialectical behaviour therapies – will require clinical and psychological formulation in order to tailor and align them both to a patient's clinical needs and their capacity to engage with them. It's important to highlight the value of clinical teams being able to access the expertise of psychology colleagues or nurses who may be skilled in higher intensity psychological interventions.

"Therapies like mentalisation can be a good way of seeing things from other folks' point of view – this could lead to culture change."

Service provider

Examples of psychotherapeutic and psychological interventions

The interventions below represent practice-based alternatives to the use of containment and other restrictive approaches to care currently being used in the 12 test sites for this guidance, as well as other mental health settings in Scotland. Some of these are also emerging in literature around best practice in the care and treatment of patients with a variety of mental health issues.

These interventions are being used with patients experiencing a range of mental health issues – such as psychosis, personality disorder, trauma, self-harm, emotional dysregulation or violence – and/or who may be at risk of unscheduled absence from hospital. Again, it is important to highlight that the higher intensity psychological interventions should only be undertaken after clinical formulation of a patient's specific needs. As testing across a wider range of sites take place – including in older adult settings – further interventions will be added.

Higher intensity psychological interventions include:
cognitive analytic approaches
dialectical behaviour therapy approaches
Lower intensity psychological interventions include:
mentalisation
mindfulness
distress tolerance

Risk assessment and safety management interventions include:
STORM risk assessment and action planning
Brøset Violence Checklist
community patient safety meetings
relational security skills
up and down scaling of nature, intensity and frequency of daily activities and relational security

Psychotherapeutic interventions include:
anxiety management
structured daily activity
goal setting
gardening and access to outdoor green space
guided self-help

Safe use of medicines

The safe use of medicines should involve the participation and choice of patients, unless the capacity to consent or choose is not present. Medicine reconciliation, assessment of high-risk medicines used alongside as-required medicines, and the assessment of the effects of medicine use, are all crucial factors in optimising therapeutic dosage, effects and concordance. Wherever possible, carers should be involved in discussion and education around medicines and can help to support safety and concordance.

This guidance evolved between 2016 and 2017 and is based on the improvement work of 12 test boards, the emerging evidence base this work produced, review findings, and the discussions, consultations and engagements with various groups and organisations.

This final version of the guidance has been updated following feedback from wider consultation with health boards' mental health care services from 24 July to 7 September 2017. The guidance and our understanding of current practice will continue to develop following further testing and learning.

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