Lothian NHS Board

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NHS Lothian

Date 28/08/2025
Your Ref
Our Ref 10242

Enquiries to Richard Mutch
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Direct Line 0131 465 5687
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richard.mutch@nhs.scot

Dear

FREEDOM OF INFORMATION – RESTRAINT

I write in response to your request for information in relation to children and restraints.

Question:

- A copy of the Health Board's current policy or ***policies*** governing the use of restrictive practices (such as restraint, seclusion and intramuscular injection) on children in mental health settings (including in relation to the recording and reporting of incidents). Please provide confirmation of when these were last reviewed.

Answer:

We do not have a policy as such for restrictive practice. This term covers a number of ways of working.

Enclosed our Continuous Intervention procedure as it refers to seclusion and how Continuous Intervention differs from it, to make it clear for staff.

The Management of Aggression Team have a number of procedures that sit under the Violence and Aggression policy. However, they do not refer to children separately.

Also enclosed is the acute behavioural disturbance guidelines for 12 to 17 year olds.

Question:

- The number of i) children and ii) incident of children being ***restrained*** in mental health in-patient settings operated by the Health Board in each of the last five calendar years (with an update for 2025 year to date).

Answer:

No of AE's where restraint used	CAM Inpatient Unit	RHCYP Melville Inpatient Unit	Total
2020	248	0	248
2021	45	49	94

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Headquarters
Mainpoint
102 West Port
Edinburgh EH3 9DN

Chair Professor John Connaghan CBE
Chief Executive Professor Caroline Hiscox

Lothian NHS Board is the common name of Lothian Health Board

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2022	0	67	67
2023	0	148	148
2024	0	278	278
2025	0	148	148
Total	293	690	983

Question:

- The number of i) children and ii) incident of children being subject to ***seclusion*** in mental health in-patient settings operated by the Health Board in each of the last five calendar years (with an update for 2025 year to date).

Answer:

Seclusion used	CAM Inpatient Unit	RHCYP Melville Inpatient Unit	Total
2020	5<	0	5<
2021	0	0	0
2022	0	11	11
2023	0	5<	5<
2024	0	19	19
2025	0	5<	5<
Total	5<	35	*

Question:

- The number of i) children and ii) incident of children being, subject to ***intermuscular injection*** of sedatives in mental health in-patient settings operated by the Health Board in each of the last five calendar years (with an update for 2025 year to date).

Answer:

Rapid Tranquilisation used	CAM Inpatient Unit	RHCYP Melville Inpatient Unit	Total
2020	23	0	23
2021	5<	5<	8
2022	0	20	20
2023	0	61	61
2024	0	78	78
2025	0	30	30
Total	27	193	220

Question:

- The number of i) children and ii) incident of children being ***injured*** as a result of restrictive practices in mental health in-patient settings operated by the Health Board in each of the last five calendar years (with an update for 2025 year to date).

- The number of i) children and ii) incident of children being, taken to ***A&E*** as a result of restrictive practices in in-patient settings operated by the Health Board in each of the last five calendar years (with an update for 2025 year to date).

Answer:

Restraint used by severity	No known adverse effect at this time	Harm to a person -minor	Harm to a person - moderate	Harm to a person -major	Damage or loss to property - No known adverse effect	Damage or loss to property - minor	Damage or loss to property - moderate	Total
2020	220	28	0	0	0	0	0	248
2021	74	18	0	0	0	5<	5<	94
2022	45	18	0	0	0	5<	0	*
2023	99	42	5<	0	5<	5<	0	148
2024	180	87	5<	5<	5<	5<	0	278
2025	118	27	5<	0	0	5<	0	148
Total	736	220	9	5<	5<	11	5<	*

To protect the identity of the individuals involved any figure of 5 or less has not been shown in the tables above. Since we do not have their consent to release this data from their records, the information is exempt under section 38(1)(b) of the Freedom of Information (Scotland) Act i.e. to provide it would breach the Data Protection Act (2018). *For the same reason combined figures have not been shown.

I hope the information provided helps with your request.

If you are unhappy with our response to your request, you do have the right to request us to review it. Your request should be made within 40 working days of receipt of this letter, and we will reply within 20 working days of receipt. If our decision is unchanged following a review and you remain dissatisfied with this, you then have the right to make a formal complaint to the Scottish Information Commissioner within 6 months of receipt of our review response. You can do this by using the Scottish Information Commissioner's Office online appeals service at www.itspublicknowledge.info/Appeal. If you remain dissatisfied with the Commissioner's response you then have the option to appeal to the Court of Session on a point of law.

If you require a review of our decision to be carried out, please write to the FOI Reviewer at the email address at the head of this letter. The review will be undertaken by a Reviewer who was not involved in the original decision-making process.

FOI responses (subject to redaction of personal information) may appear on NHS Lothian's Freedom of Information website at: https://org.nhslothian.scot/FOI/Pages/default.aspx

Yours sincerely

ALISON MACDONALD
Executive Director, Nursing
Cc: Chief Executive

Guidance on the Management of Acute Behavioural Disturbance in Adolescent (12-17yrs) Psychiatric Inpatients

NHS Lothian

Purpose of the guideline

This document is a good practice guideline for the treatment of acute behavioural disturbance in psychiatric inpatients. The guideline recognises that preventative skilled management with non-pharmacological measures is preferable to the use of medication.

Contents

These documents should be viewed together:		
Page 2	Algorithm for the management of acute behavioural disturbance	
Page 3	Algorithm for intramuscular treatment of acute behavioural disturbance	
Page 4	Additional notes on treatment choice and physical monitoring	

Associated Materials

Mental Welfare Commission Good Practice Guide on Medical Treatment under Part 16 of the Mental Health (Care and Treatment) (Scotland) Act 2003

Formulary | East Region Formulary (nhs.scot)

Joint BAP NAPICU Evidence-based Consensus Guidelines for the Clinical Management of Acute Disturbance: De-escalation and Rapid Tranquillisation

NHS Lothian Mental Health Services High Dose Antipsychotic Guidelines

Alternative documents for psychiatric inpatient age groups

NHS Lothian Guidance on the Management of Acute Behavioural Disturbance in Adult (18-65yrs) Psychiatric Inpatients

NHS Lothian Guidance on the Management of Acute Behavioural Disturbance in Adults (over 65 yrs) Psychiatric Inpatients

Version: 3.0
Author: REH PHARMACY

Approved by: REAS Drug and Therapeutics Committee
Date of Approval: December 2023
Review Date: December 2026

Algorithm for the Management of Acute Behavioural Disturbance Adolescent (12-17yrs) Psychiatric Inpatients

NHS Lothian

PRINCIPLES OF ACUTE BEHAVIOURAL DISTURBANCE MANAGEMENT

Individual treatment and medicine management plan should be documented in the person centred care plan

Effective interventions:
Treatment optimisation
Multidisciplinary approach
Proportionality of intervention
Treatment individualisation and choice

Continuous monitoring of:
Mental and physical health
Risk to self / others
Treatment effectiveness / harm
Patient engagement

CONSIDER AND TREAT OTHER PRECIPITANTS AND / OR PATIENT MODIFIERS

Consider and treat other possible precipitants:

Patient age / physically compromised
Drug or alcohol withdrawal
Medication changes
Electrolyte abnormalities

Hypoglycaemia
Infection
Metabolic problems
Urinary retention

Pain
Constipation
Dehydration
Hypoxia

ASSESSMENT, DE-ESCALATION AND CLINICAL PAUSE

Clinical pause documented on TRAK using canned text: \cpc

Passive and non-passive interventions:
Continuous risk assessment
Identification of needs
Self-control techniques
Distraction and reassurance / family support
Low level control and restraint

Management of environment:
Non-confrontational limit setting
Modify environment (room or ward)
Sensory modulation
Continuous intervention
Reduce stimulation / utilise seclusion

ORAL MEDICATION

Considered where de-escalation is unsuccessful or as adjunct to de-escalation

Additional considerations on treatment choice:
Patient choice / advance statement
Distress preferences / my calm card / sensory preference assessment
Patient medicines management care plan
Relevant Mental Health Act documentation (T2b/T3b)
Previous response to prescribed regular or as required medications
Previous exposure to psychotropic medications / age related neuroleptic naivety
Previous or potential drug or substance reactions

Oral medication should be documented on TRAK using canned text: \yellow

INTRAMUSCULAR MEDICATION

Considered only in urgent situations where non-pharmacological measures have been unsuccessful and where the oral route is not possible or appropriate

See attached algorithm

Version: 3.0
Author: REH PHARMACY

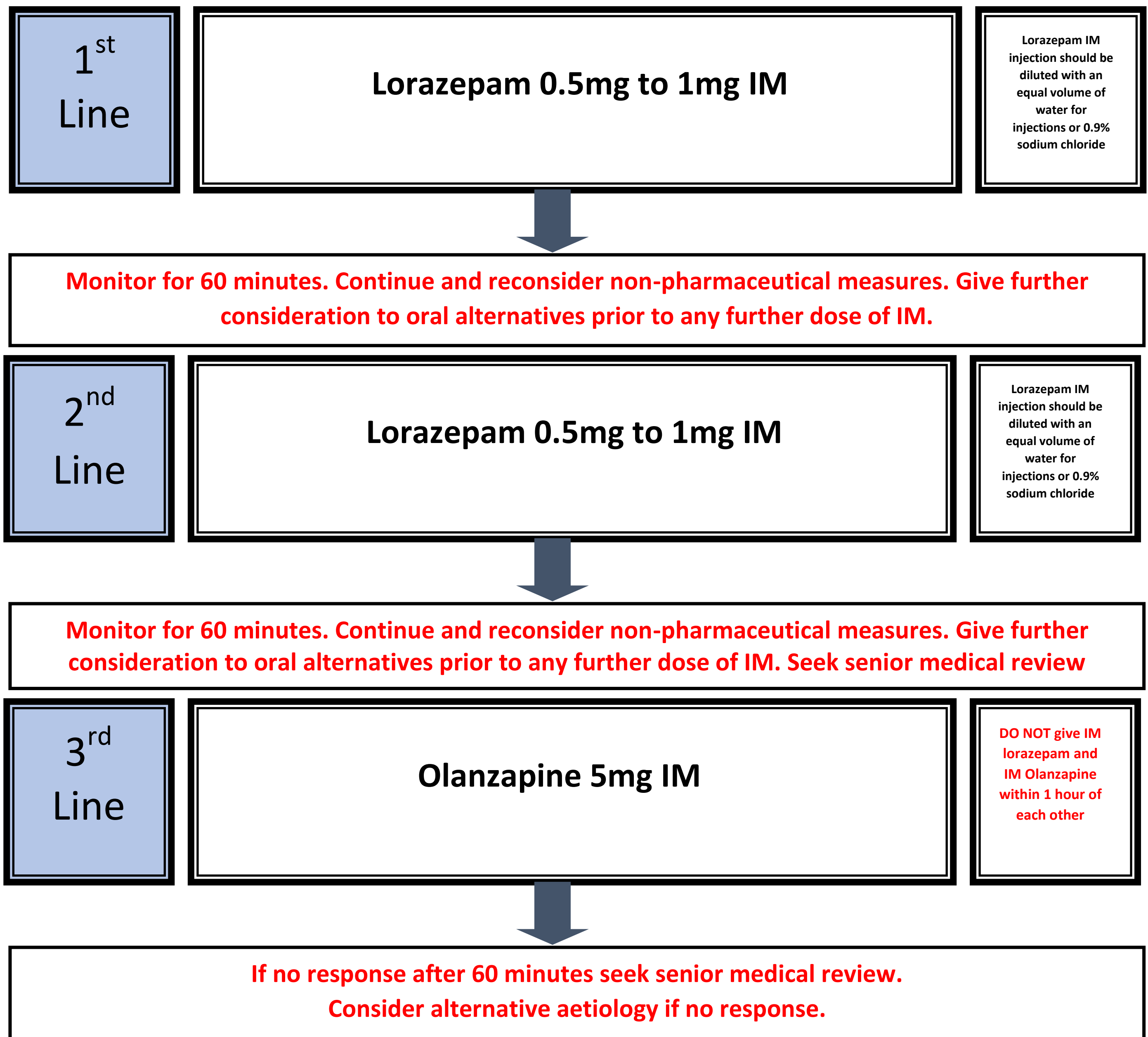
Approved by: REAS Drug and Therapeutics Committee
Date of Approval: December 2023
Review Date: December 2026

Intramuscular (IM) Treatment of Acute Behavioural Disturbance in Adolescent (12-17yrs) Psychiatric Inpatients

NHS Lothian

Lorazepam is always recommended as first line treatment
Wait minimum 60 minutes following oral medication or if patient has refused oral medication

- An appropriate dose of IM medication should be selected according to patient age, weight and presentation.
- Use the minimum effective dose to achieve symptom resolution.
- If reasons exist to consider either algorithm choices unsuitable **alternative treatment strategies should be discussed with a senior consultant** and documented.
- Where necessary relevant Mental Health Act documentation (T3b/T4) must be completed.
- Use of IM antipsychotics may require high dose monitoring. See guidance here.
- Monitoring frequency of physical observations should be at least every 10 minutes for the first hour following IM medication and then every 30 minutes until the patient is ambulatory. Consider a falls risk assessment.
- Document use of IM medication on TRAK using the canned text: \red



Version: 3.0
Author: REH PHARMACY

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Date of Approval: December 2023
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Additional notes on treatment choice

Benzodiazepine
Lorazepam is the appropriate first choice in both psychotic and non-psychotic episodes. Be aware of risk of, or any history of paradoxical disinhibition with use of benzodiazepines.

Olanzapine
Neuroleptic naïvety is more likely in adolescents and as a population they are more sensitive to adverse drug reactions and side effects. Olanzapine is considered the most appropriate antipsychotic for acute behavioural disturbance due to a lower risk of extra pyramidal side effects and little effect on QTc interval. * Use in the adolescent population is outside of product license.

Risperidone / Aripiprazole in learning disability patients
Choice of antipsychotic in learning disability patients is usually risperidone or aripiprazole. Consider previous use and response to this and use as first line antipsychotic in this patient group, if indicated.

Guidance on physical monitoring

Monitoring frequency of physical observations should be at least hourly for the first 4 hours following oral medication for acute behavioural disturbance. Seek medical advice and continue to monitor in the presence of abnormal observations.

Monitoring frequency of physical observations should be at least every 10 minutes for the first hour following IM medication and then every 30 minutes until the patient is ambulatory. Seek medical advice and continue to monitor in the presence of abnormal observations.

If monitoring of vital signs is refused or not possible then signs and symptoms of pyrexia, hypertension, over-sedation, respiratory depression, altered consciousness and general physical well being should be observed and documented.

Management of problems resulting from the use of intramuscular medication

Potential risks associated with antipsychotic injections include acute hypotension; seizures (caution with antipsychotics in alcohol withdrawal as they lower seizure threshold); cardiovascular complications; respiratory complications; extrapyramidal symptoms especially acute dystonia; CNS depression; Neuroleptic Malignant Syndrome.

Problem	Resolution
Acute dystonic reaction	IM injection: Procyclidine 5mg IM, repeat after 20 minutes, maximum 20mg daily. IV: 5mg IV usually effective after 5 minutes, occasionally 10mg may be needed.
Benzodiazepine induced respiratory depression (<10/minute)	Give flumazenil IV 200 micrograms over 15 seconds then 100 micrograms repeated at 60 second intervals. Maximum dose 1g. * Flumazenil has a short half life compared to benzodiazepines; over-sedation and consequent respiratory depression can re-emerge.
Abnormal physical observations	Continue to monitor and record observations. Seek medical advice. Consider neuroleptic malignant syndrome or arrythmias in patients with a raised temperature

NHS Lothian

Title: Standard Operating Procedure for Continuous Intervention			
Date effective from:	09/07/2020	**Review date:**	01/08/2027
Approved by:	REAS SMT		
Approval Date:	16/07/2025		
Author/s:	CI steering group		
Executive Lead:	Executive Nurse Director		
Target Audience:	Mental health in-patient services		
Supersedes:	Standard Operating Procedure for Continuous Intervention v0.2		
Keywords (min. 5):	Engagement, interventions, clinical pause, patient safety,		

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Version Control

Date	Author	Version/ Page	Reason for change
09/07/2020	Andrew Watson and Craig Stenhouse		New procedure
Feb 2021	CI Steering Group		Review of procedure
May 2025	CI Steering Group		Procedure reviewed to include Level 2 seclusion, and review of procedure

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1. 0 PURPOSE

This SOP outlines guidance for staff and procedures that should be followed in circumstances where an inpatient may require a higher level of intervention and engagement with staff to maintain safety within a mental health ward in NHS Lothian.

2.0 INTRODUCTION

This SOP was developed in accordance with Healthcare Improvement Scotland (2019) guidance on Improving Observation Practice in inpatient mental health wards in Scotland. 'From Observation to Intervention' aims to refocus the historic practice of observation towards a culture of inquiry, personalised assessment and proactive and skilful mental health care and treatment interventions for all patients.
As part of this cultural shift, the intention is to end the use of language focused on 'observation' (e.g. general, constant or special observation), replacing this with the language of 'intervention'. The intention of this is to reflect the purpose and goal of 1:1 care, which is to develop meaningful and therapeutic relationships while effectively managing safety and risk.
This procedure aims to ensure that patients receive the appropriate level of intervention and therapeutic engagement with staff, which is tailored to their specific needs, and reviewed appropriately. Healthcare Improvement Scotland (2019) directs healthcare practitioners to consider the following principles when planning and delivering general and enhanced levels of intervention:

- Involving patients, carers and families in treatment, wellbeing and recovery
- Adopting a continuum-based approach to care, treatment and safety planning
- Supporting early recognition of, and response to, deterioration
- Improving communication around clinical needs, deterioration and risk
- Promoting least restrictive practice
- Managing periods of continuous intervention or support
- Developing a trauma-informed workforce
- Supporting personalised care and treatment
- Creating an infrastructure to support learning and quality improvement
- Define roles and responsibilities of the clinical team (see appendix 2 for a detailed breakdown)

3.0 SCOPE

This procedure and guidance applies to all NHS Lothian Healthcare Practitioners and Managers working within NHS Lothian Inpatient Mental Health Services. Where required, supplementary guidance may be developed and applied by specialist areas such as Forensic Mental Health Services, Children & Adolescent Mental Health Services, Peri-natal Mental Health Services and Learning Disability Services
This SOP pertains to all members of the multi-disciplinary team (MDT) and all staff should also be familiar with the following:

- Individual patient care plans and risk assessment
- Environmental Ligature Policy

- Healthcare Improvement Scotland (2019) ‘From Observation to Intervention’ Guidance

4.0 DEFINITIONS

General Intervention: This is the expected level of care all patients should receive during an admission. These are therapeutic and meaningful interventions offered on a flexible continuum that are influenced by a patient’s clinical needs, preferences, formulation, and risk. This includes care planning individualised periods of 1:1 intervention, with attention paid to specific times or places that people may need enhanced support.

Continuous Intervention: This is an escalated level of intervention and may be used when a patient requires the continuous presence of a member of staff to support them to manage their distress and their interactions with other people safely. This period of intervention will be triggered due to patient deterioration and following risk formulation, which supports the need for the continuous presence of staff. The continuous presence of staff may be required for a full 24-hour time period or tailored according to the needs and intensity required to maintain safety during shorter, specified periods when the risk is formulated to be greater.

Clinical Pause: A Clinical Pause is triggered when patient deterioration is recognised. A Clinical Pause is a period of up to 2 hours, which is used to pause, reflect, and assess the need for Continuous Intervention. An immediate MDT meeting is arranged to respond proactively and facilitate discussion and assessment. A canned text (\cpc) should be used to structure and record the clinical discussion.

Daily Review: A Daily Review of care is required every 24 hours, once a period of Continuous Intervention has begun, until the point at which it ends. A Daily Review is used to assess and evaluate the care and treatment plan, including the ongoing requirement and therapeutic effect of Continuous Intervention. A canned text (\cireview) should be used to structure and record the clinical discussion.

Case Discussion: A Case Discussion is required following a 14-day period of Continuous Intervention. The Case Discussion is used to bring increased attention to the patient care plan and consider therapeutic options and alternatives to Continuous Intervention. This meeting should include a senior staff member such as the Clinical Nurse Manager or equivalent, who brings an objective outside perspective. A canned text (\cicasediscussion) should be used to structure and record the clinical discussion.

Seclusion: The below definition of Seclusion from the Mental Welfare Commission for Scotland (2019) is offered at the outset of this SOP so that staff can identify when Continuous Intervention amounts to Seclusion. Continuous Intervention is not Seclusion and should not be used to seclude patients.

Seclusion - Level 1

- When staff lock a person alone in a designated seclusion room or seclusion suite
- When staff lock a person alone in a room or suite of rooms
- When staff place a person in a room and prevent them from leaving either by holding the door shut, standing in the doorway or instructing them not to leave

Seclusion - Level 2

- When staff remain with a person in a room and or suite of rooms and prevent them from leaving either by holding the door shut, standing in the doorway or instructing them not to leave
- When staff place restrictions on the patient's physical environment with the intention of keeping them separated from others

5.0 RESPONSIBILITIES

Chief Executive/Boar/Associate Directors (Executive sponsors)
The Royal Edinburgh and Associated Services Senior Management Team, chaired by the Site Director, are responsible for the implementation, monitoring and review of this procedure.

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

Consultant Psychiatrist
The Consultant Psychiatrist is responsible for jointly supporting Continuous Intervention care planning and treatment alongside the multi-disciplinary team. They are responsible for ensuring that they, along with their medical team, have the required skills and access to training in order to engage in Continuous Intervention care to the standards outlined in this SOP.

Clinical Nurse Managers
Clinical Nurse Managers are responsible for planning the nursing workforce in terms of the resources, staffing, activities, and skills required to deliver preventative, early intervention-focused care, treatment and safety to a patient group. They are supported by Clinical Services Managers. They are also responsible for monitoring and support Continuous Intervention SOP implementation, including attending the Case Discussion.

Heads of Service/Professional Leads
Each Head of Service is responsible for implementing a system of governance to ensure staff supporting Continuous Intervention have the required skills and access to training to do so. They are responsible for monitoring the input of their teams into Continuous Intervention care and supporting teams to increase their input.

Senior Charge Nurse
The Senior Charge Nurse is responsible for ensuring that all nursing staff undertaking Continuous Intervention on the ward have the required skills, supervision and access to training in order to do so safely. Particular note should be made at induction when there are new staff, bank/agency staff, or staff who are unfamiliar with the clinical area. The Senior Charge Nurse is responsible for upholding the standard of Continuous Intervention care outlined in this SOP, including role modelling the required skills and behaviour, to deliver a positive and proactive culture of

Continuous Intervention. The Senior Charge Nurse must assure the Clinical Nurse Manager that this is in place and seek support where it is not.

Key/Co-worker
The Key Worker should ensure that Continuous Intervention care plans are written to the standards outlined in this SOP. This includes working collaboratively alongside the patient and their family or carer to ensure decisions are shared and care is delivered in line with their needs and preferences. The key worker is responsible for identifying any knowledge and training they require.

Healthcare Support Workers
Healthcare Support Workers must ensure they have the required skills and access to training to deliver Continuous Intervention care to the standards outlined in this SOP.

The Arts Psychotherapies
During the period of Continuous Intervention, Arts Psychotherapists will use the arts form (art, drama, music) to support the patient to manage intense and confusing emotional states. They will actively work with the patient through the art form to understand their difficulties, make sense of them and to understand why they might be happening. The use of the art form offers the patient an alternative and often more accessible means of communication.
Arts Psychotherapists will attend clinical meetings such as Clinical Pause, Daily Review and Case Discussion. They will draw on the understandings from therapy sessions to inform the ongoing formulation, assessment of patient need, and shaping of patient centred care. All interventions are tailored to the patient, personalised and in line with their individual needs and strengths.

Allied Health Professionals
The assessment and treatment skills of Allied Health Professionals (AHPs) working within mental health care services provide a range of interventions throughout a patient’s recovery journey. Therapeutic interventions may vary depending on the specific profession and experience of an AHP. They should both contribute to and inform the multidisciplinary care planning with AHPs taking an active role in clinical meetings. AHPs can provide an opportunity to look at increasing engagement and reducing symptoms of distress wherever possible during continuous intervention care. All therapeutic interventions delivered by AHP’s should be risk assessed based on a patient’s individual needs, the skill set of the AHP and the environment in which the intervention is to take place.

Occupational Therapies
The occupational therapist will work collaboratively with the person receiving continuous intervention, focusing on their values, interests, pattern of occupation and performance skills, enabling them to participate in meaningful activity. They will consider the impact of the environment, and how this may be adapted to best support the person's needs. They will explore the purpose of different activities, for example those which are alerting and those which are grounding or calming, taking into account sensory preferences, as well as activities which offer opportunities for pleasure and achievement. They will consider how activities can be adapted and graded so that they are achievable and meet the person's needs in a safe way. They may offer suitable resources which can be used by the person with the support of their whole care team, for example creative materials, access to music/playlists, games or puzzles, or support to complete a personalised activity planner. The occupational therapist offers a strengths and recovery-based approach which can support self-efficacy and enable a graded progression as the person moves through the period of intensive support.

Clinical Psychologists
Clinical Psychologists are responsible for supporting MDT formulation of the patient's difficulties and associated risk. This formulation will be used to inform risk management, decisions regarding continuous intervention, identify interventions that may reduce a patient's distress and associated risk and to assess and reduce the risk of re-traumatisation associated with restrictive interventions. Clinical Psychologists may direct psychological interventions during continuous intervention where these are indicated by a patient's formulation but may also offer a range of indirect psychological interventions. Indirect psychological interventions may include supporting the wider MDT to identify and offer psychological interventions (e.g. emotion regulation interventions), strategies to reduce the risk of re-traumatisation and/or reflective practice groups to explore, recognise and support staff with the demands of offering Continuous Intervention.
Clinical psychologists will attend clinical pauses, daily Continuous Intervention reviews and case discussions where possible. Clinical pauses should be prioritised above other clinical demands. Clinical Psychologists are responsible for ensuring that they and any junior psychology staff (assistants or trainee psychologists) are familiar with the SOP and have completed the Continuous Intervention mandatory training.

Patients Council and Advocacy Services
The Royal Edinburgh Hospital Patient's Council provides a vital role in monitoring the implementation of this procedure, and a key role in discussing further version/developments of the procedures. Representatives will continue to be members of the steering group.
Advocacy services support patients in to understand and enact their rights under the Mental Health (Care and Treatment) (Scotland) Act 2003. All patients under the Continuous Intervention SOP should be given the opportunity to engage with advocacy facilitated by the ward multi-disciplinary team.

6. STAFF EDUCATION AND SUPERVISION

Healthcare Practitioners
All Healthcare Practitioners and managers involved in Continuous Intervention practice and decision-making within inpatient mental health wards in NHS Lothian must ensure they have first completed the required Violence and Aggression Training relevant to their role and passed the Lothian: Continuous Intervention (Advanced) e-learning module available on NHS Lothian LearnPro. This can be accessed by searching or 'Continuous Intervention' within the NHS Lothian LearnPro site and search bar. Healthcare Practitioners, including bank and agency staff, must be able to provide evidence of successful completion prior to supporting patients on Continuous Intervention. Delegating Healthcare Practitioners are responsible for ensuring those undertaking Continuous Intervention have successfully completed the required training to safely undertake this role.

Student and Trainee Healthcare Practitioners
Student healthcare practitioners should not be delegated a role of Continuous Intervention with patients at any stage of their training. They may be involved in clinical discussion or support appropriately trained staff undertake this role if it supports their learning development needs and the patient consents to this. Trainee healthcare practitioners who hold employment contracts may be involved in clinical discussions and may spend time offering interventions to someone on Continuous Intervention if clinically appropriate and agreed by the supervisor.

Temporary Staff
Temporary staff, such as bank or agency staff members, should only undertake Continuous Intervention in circumstances where this cannot be avoided. Temporary staff are unlikely to have a therapeutic relationship with the patient and cannot provide the standards of safety and containment that are provided by regular staff who know patients well. If temporary staff are required to undertake Continuous Intervention, they must have completed the required training and be familiar with this SOP. Delegating staff should be mindful that Continuous Intervention is unlikely to be as effective in maintaining patient safety in these circumstances.

7. SPECIFIC PROCEDURE

This procedure aims to support the early recognition of, and response to, clinical deterioration, and improve communication around clinical concerns, needs and risks. For a brief overview of the procedural framework, see Continuous Intervention Canned Text Tools (Appendix 1) and Continuous Intervention Flow Chart (Appendix 2).

Decisions made under this SOP should be values- and rights-based and underpinned by the Millan principles of the Mental Health (Care and Treatment) (Scotland) Act 2003, the Rights in Mind pathway, and the Healthcare Improvement Scotland (2019) 'Observation to Intervention' guidance.

Clinical Pause

A Clinical Pause is triggered once patient deterioration is recognised, or earlier, if deterioration is anticipated. Any member of the MDT who has concerns regarding patient deterioration should raise their concerns with the nursing team on the ward in order to consider whether to trigger a Clinical Pause. The Clinical Pause is an assessment which lasts up to 2 hours, during which time, patients who have experienced an increase in distress or risky behaviour are given the opportunity to respond to de-escalation, psychosocial interventions and/or medication, prior to moving immediately to Continuous Intervention. It is expected that the patient will receive a very high level of input at this time. Staff should support the patient using personalised strategies and interventions. For patients who are already in hospital, personalised care plans may be available to inform supportive strategies e.g., playing cards, or watching TV. It is vital that the team are aware of the patient's mental state and location continuously throughout this period.

Once the clinical pause begins, the Nurse in Charge of the shift will allocate one member of staff to arrange and lead a rapid multi-disciplinary team meeting and review of care and intervention level. This review meeting must occur within 2 hours of the onset of the Clinical Pause and should take place 24/7 on any ward. At a minimum, this should have the participation of the Doctor on call and the relevant Senior Nurse (such as the Coordinating Charge Nurse). Inside hours it is expected that the wider ward MDT will be involved. This meeting gives the MDT the opportunity to collectively formulate the risk and care plan and consider what input each discipline can offer for the benefit of the patient. This should be documented within the Continuous Intervention Care Plan on TRAK.

A ‘canned text’ (\cpc) for structuring and documenting this review must be used and is found in Appendix 1.

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

- patient’s views
- carers’ views
- aggression rating scale, for example DASA
- risk assessment
- use and response to medications
- recent substance use or withdrawal
- care plans
- MDT Formulation or previous psychological formulations, and
- the patient’s advance statement.

Following the Clinical Pause, if the patient is escalated to Continuous Intervention, the Clinical Pause ‘Lead’ should arrange and diarise an appointment for the Case Discussion meeting. This should be held within standard working hours, approximately 14 days after continuous intervention starts. The Clinical Nurse Manager or equivalent senior professional should be invited to lead this meeting. This should be cancelled if Continuous Intervention ceases within 14 days.

If following the Clinical Pause, a patient is not escalated to Continuous Intervention, staff must review and update the patient care plan in recognition of the clinical concern.

When initiating Continuous Intervention, the Clinical Pause team should consider the potential for Continuous Intervention to expose the patient to increased harm. If Continuous Intervention is still required, staff must consider how this will be assessed and mitigated within the patient care plan.

Note: If an advanced statement exists and the service does not follow the statement, the reason for not doing so must be clearly documented in the clinical record. Consideration should be given to

engage and involve carers, family, and the Named Person when it is reasonable and practicable to do so.

Daily Review

Initially an MDT review should take place every day, including weekends and bank holidays. As a minimum, this review should a doctor and a nurse, but it is expected that it would include all relevant members of the MDT when available. Reviews that take place on a normal working day would be expected to have wider participation.

A 'canned text' (\cireview) for structuring and documenting this review must be used and is found in Appendix 1.

All reviews should clearly document the criteria for ending the period of continuous intervention agreed following MDT discussion. Reviews should also indicate which members of the MDT are responsible for and can decide that the criteria have been met. Continuous intervention should not be maintained solely to facilitate a review, although in complex situations it may be appropriate for senior staff to be available to decide on whether the criteria to end have been met.

The review may want to consider whether beginning a measurement tool, or data recording form to support information gathering related to the patient's condition would be appropriate to capture patterns of deterioration, triggers, or therapeutic or unhelpful interventions.

If the patient and/or carer were not involved in the initial decision relating to commencing Continuous Intervention, the Daily Review is an opportunity to seek patient and carer involvement. If it is not practicable for the patient to attend/contribute a formal meeting, alternative strategies must be used to gather views. Reasons for non-collaboration should be clearly documented.

Case discussion

After 2 weeks of Continuous Intervention a wider review of the ongoing goals of Continuous Intervention care is required. The MDT should be mindful of arranging this meeting in good time to ensure it is not missed and that the required attendees are present. The Clinical Nurse Manager for the ward will chair a Case Discussion, which may include the relevant Consultant Psychiatrist, Clinical Director, Clinical Psychologist, Physiotherapist, Occupational Therapist, and representative from the Arts Therapies. At the Case Discussion meeting a care plan must be developed that focuses on the interventions required to support the person use their own skills to manage safely. Clear criteria and process must be documented for ending of continuous intervention. Within the scope of this detailed personalised care plan, a decision may be taken to reduce the frequency of MDT reviews, but only with the agreement of the Service Manager, Clinical Director or Clinical Nurse Manager.

A ‘canned text’ (\cicasediscussion) for structuring and documenting the Case Discussion must be used and is found in Appendix 1.

Ending Continuous Intervention

A ‘canned text’ (\ciend) for structuring and documenting de-escalation of Continuous Intervention must be used and is found in Appendix 1.

Healthcare Practitioners should consider that risks may increase following the removal of Continuous Intervention, particularly where removal of this may trigger feelings of rejection or abandonment in the patient. A continuum-based approach may be helpful to safely manage this transition back to General Intervention.

Seclusion

The definition of Seclusion is provided within ‘Definitions’ section of this SOP so that staff can identify when Continuous Intervention amounts to Seclusion. Continuous Intervention is not Seclusion and should not be used to seclude patients.

Staff should be in no doubt when they are using Level 1 Seclusion. However, there may be times when careful scrutiny is required to assess whether Continuous Intervention meets the threshold for Level 2 Seclusion. While the intention of Continuous Intervention should always be to provide a therapeutic intervention, it is recognised that there may be times when staff approach to Continuous Intervention requires some element of supervision and restriction to maintain and support patients in the least restrictive way possible. In this case, staff should use Continuous Intervention processes (Daily Review and Case Discussion) to reflect, document and care plan how this can be avoided. Where someone enters their room by agreement, to access a low stimulus environment, this does not amount to Seclusion unless they are prevented from leaving.

In services where Seclusion is permitted as a clinical intervention staff may use Continuous Intervention to re-integrate patients back into the general ward environment. In these circumstances, staff should migrate to the Continuous Intervention SOP and associated procedure once periods of Continuous Intervention begin. The Clinical Pause canned text (\cpc) should be used to document this.

8. CARE PLANNING

A personalised Continuous Intervention Care Plan should be generated by the clinical team, in collaboration with patients and carers, as soon as Continuous Intervention begins and should be reviewed regularly. Continuous Intervention is an opportunity to develop and strengthen therapeutic relationships, supporting a patient in their recovery, while maintaining their physical and psychological safety. The Continuous Intervention Care Plan should set out the provision, nature and purpose of Continuous Intervention, and demonstrate how it relates to the patient's reason for admission and requirement for Continuous Intervention. It should be appropriately flexible, with clear criteria agreed for ending the period of Continuous Intervention documented at every MDT review.

Once it has been decided that Continuous Intervention is required, the following actions should be implemented:

- generating a multidisciplinary care plan using a formulation based approach
- assessing the need for continuous visual assessment
- putting the continuous intervention guidance into practice, and

proactive reviewing of Continuous Intervention and support as part of the patient care, treatment and safety plan

Continuous intervention should be as least restrictive and as flexible as possible. Interventions should be purposeful, specific and psychotherapeutic, aligned to the patient's needs, preferences and best available evidence. Depending on the reasons for, and nature of, Continuous Intervention and considering the associated risk formulation, there may be occasions where continuous visual assessment is not always required, for example, when using the bathroom or asleep. The level of visual assessment and proximity of staff required should be carefully communicated, and clearly documented in the patient care plan with an associated risk assessment and rationale for decision making.

Staff should be mindful of the considerable stress placed on patients when being watched during moments of intimate care, such as when using the toilet. Specific services have developed checklists for managing this. Consistency between staff is vital in helping patients to understand the level of intervention. The range of environments across NHS Lothian mean that these must be developed on a service-by-service basis.

Staff should make a sustained effort to engage and involve the patient and carers in all care decisions as far as is reasonably practical. Family and carers are vital partners in developing personalised care plans and it is expected that specific information would be sought relating to the choice and impact of potential interventions that may be effective during a period of continuous intervention.

Clinical teams must ensure that any periods of Continuous Intervention or support are guided 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.
- They are trauma-informed – considering how Continuous Intervention may interact with a patient's history of trauma, whether Continuous Intervention is associated with a risk of re-traumatisation and how interventions may mitigate or reduce the risk of re-traumatisation.
- They support the development and maintenance of the therapeutic relationship, as a means to alleviate distress, avoid harm and improve patient safety and experience.

NHS Lothian Royal Edinburgh Hospital and Associated Services are committed to providing trauma-informed care. Continuous Intervention may have a harmful impact on all patients, particularly those with a trauma history. Re-traumatisation through Continuous Intervention may have the potential, for some individuals, to exacerbate and increase rather than reduce distress and associated risk. Continuous Intervention should be as flexible and least restrictive as possible to avoid care related harm to patients. Care plans should account for trauma histories, assess and outline any risk of re-traumatisation, identify strategies to reduce and mitigate the risk of re-traumatisation where possible, and should pay particular attention to the adoption of a continuum-based approach.
Overnight, Continuous Intervention has potential to reduce sleep quality and may be particularly difficult for some patients with a trauma history. The management of overnight Continuous Intervention should be explicit within the patient care plan, including the management of sex/gender related differences between Continuous Intervention staff and the patient on Continuous Intervention.

5.5 Staff Education and Supervision

Each senior charge nurse will be responsible for ensuring all staff who are expected to undertake engagement and continuous interventions have the knowledge, skills and abilities to implement this procedure. A competency framework is found at appendix 3 and this should be used all for all staff performing continuous intervention
Support for providing intense relationship based continuous interventions should be available for all staff expected to participate in this procedure. A range of supports should be available ranging from access to training relevant to the patient group, presenting difficulty or specialty area, 1:1 supervision to ward based reflective practice groups. It should be recognised that less experienced or skilled staff will require more support to ensure therapeutic engagement and interventions.
Many people who require continuous interventions to maintain their safety have an experience of trauma. Training and support for practitioners to develop a trauma informed workforce will be vital in maintaining reliable and high-quality continuous interventions. All staff involved in continuous intervention should have a minimum of level 2 training.
Each period of continuous intervention will be monitored by the relevant service management team. This will provide the opportunity for supportive learning to take place and themes to inform ongoing training and development opportunities for staff and teams.

9. ROLE OF STAFF SUPPORTING CONTINUOUS INTERVENTION

Staff should use a wide range of interpersonal skills when undertaking Continuous Intervention with the purpose of maintaining patient safety, alleviating distress and deterioration and supporting recovery. An 'intervention' is anything used by staff to improve the way a patient thinks, feels and behaves. Interventions should encompass kindness and care, and should be supportive, non-judgemental, and embedded in a safe environment. Interventions may range from one-to-one or group activities, talking therapies and physical/social activities. Any Healthcare Practitioner having completed the required training can undertake Continuous Intervention. Staff supporting patients within the inpatient setting should have a wide range of therapeutic assessment skills in order to undertake this role, such as being able to:

- Engage and establish trust and rapport
- Develop personalised risk assessment, safety planning and clinical formulation
- Recognise triggers and early warning signs of deterioration
- Develop personalised care, treatment and safety plans
- Demonstrate knowledge and capabilities in trauma-informed care, suicide awareness and psychological interventions
- Communicate changes rapidly and consistently
- Consider a range of approaches and interventions beneficial, for example mindfulness, goal setting, distress tolerance and mentalisation
- Recognise and harness patient strengths, talents and experiences to promote self-management, and
- Ensure that clinical activity, and the nature and frequency of intervention, are all tailored to a patient's care, treatment and safety plan.

Following initiation of Continuous Intervention staff should:

- Explain to the patient, and carer or family if appropriate, that they are on Continuous Intervention, what this means and the reasons for this.
- Provide the patient with the Continuous Intervention Patient Information Leaflet (Appendix 3) and discuss aims, expectations, wishes and preferences to support the Continuous Intervention Care Plan

During Continuous Intervention staff should:

- Be aware of the care plan and risk assessment relating to the patient
- Staff must always politely introduce themselves to the patient and say goodbye during the changeover of staff.
- The named nurse responsible for the patient that day will meet at their earliest opportunity to make a plan for the day and discuss with the patient any appointments they may have.
- Undertake changeover of staff with the patient present, staff should handover how the patient has been, and the patient should also be asked for their input. Rarely this will not be possible and the reasons for not handing over with the patient should be clearly documented every day.
- Should the patient's behaviour cause concern to the staff who are carrying out the intervention then help should be summoned via the assist button on the pinpoint alarm.

- Staff should clearly document the patient's presentation and engagement during their period of continuous intervention (usually hourly) either electronically (\cirecord) or on a paper recording form
- The intention of staff on Continuous Intervention must always be to engage positively in meaningful therapeutic intervention and assessment. Staff must not engage in any activity during Continuous Intervention that does not have therapeutic intention e.g., reading magazines, personal phone use.

There is no minimum or maximum time for staff to spend on continuous intervention, as this is dependent on the level of engagement and activities being carried out, however, 1 hour may be a reasonable time frame. Considerations should be given to patient preference, level/type of therapeutic activity, familiarity of staff, staff breaks, and emotional and physical labour and fatigue. Staff should be mindful of the impact of frequent staff changes, particularly of unfamiliar staff, on the quality of Continuous Intervention.

10. ENVIROMENTAL AND PATIENT RISK ASSESSMENT

The specific environment where a person is being supported is an important factor in establishing the level of intervention required. For example, a single room that has known ligature points may require a different level of intervention to a communal ward area, where staff and fellow patients are present.
All ward areas should be subject to an environmental risk assessment to identify any specific risks in particular those associated with the use of ligature. This risk assessment should be available to all staff working on the ward.
It is expected that an initial, personalised risk assessment is completed within 2 hours of admission to hospital for all patients. This is completed by updating the Mental Health Risk Assessment in the questionnaire section of TRAK. Both environmental and individual risk should be considered when deciding the level of intervention required and this should be kept under continuous review. Risk assessment is a dynamic process that includes historical, clinical and environmental factors, and should be continually assessed throughout a patient's stay in hospital. A full review of the patient risk assessment should be triggered if:

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

If any member of staff observes these or other triggers that may indicate a potential need for Continuous Intervention they should initiate an immediate review by the nurse-in charge and/or MDT.
The 'floor nurse' should have knowledge of all patients' general whereabouts, at all times, and should complete the environmental assessment. The environmental check sheet should be completed hourly by regular, competent staff. Staff completing the environmental assessment should have a brief interaction with all patients, adopting the approach "how are you?" rather than "where are you?" allowing for a brief assessment of patient wellbeing. Where concerns are identified these should be escalated to the Nurse in Charge of the shift.
All wards use the Safe Care assessment matrix to evaluate the level of intervention a patient requires for a specific shift (see table below). These scores are aggregated for a ward and this allows for the flexible allocation of staff to a specific ward based on patient need. Staffing allocations to a ward should not be based on the number of patients requiring Continuous

Interventions, but instead on clinical need, as assessed by the Safe Care tool. This allows for an increase in staffing to provide a higher level of input to a ward that is supporting people manage a high level of a distress and/or risky behaviour, without the need for a patient to be placed on full Continuous Intervention.

Safe Care Level		Descriptors	Interventions	Consider
1,2	Low Dependency	Self-care Unescorted pass/standard pass Low risk Engaging in therapeutic activities Engaging in care planning and risk assessment processes	Encourage continued engagement with therapeutic interventions	Remember physical health
3,4a	High Dependency	May require some support with regards to safety and management May have increased agitation, distress, unpredictability Mental state may pose risk to safety of self and/or others Has escorted passes	Complete 'Plan for your day' Increase therapeutic interventions As required medication Review and update care plans Update MDT (and CCN if OOH) if behaviour is escalating	Does patient required increased interventions Consider a Clinical Pause Is an advanced statement in place? Remember physical health
4b,4b+	Continuous Intervention	Requires Continuous Intervention High risk to self and/or safety of others 4b requires 1:1 proximity, 4b+ requires 2:1 or High Dependency Unit	Ensure Continuous Intervention care plans are up-to-date and goals are completed Review every 24 hours 'Plan your day' has been completed CCN is aware	Does patient ligature risk assessment need carried out? Family and/or carers have been informed Remember physical health

11.0 APPENDICES - FORMS/TEMPLATES TO BE USED

Appendix 1: Continuous Intervention Canned Text Tools

Appendix 2: Continuous Intervention Procedural Flow Chart

Appendix 3: Continuous Intervention Patient Information Leaflet

Appendix 4: Functions of Self-Harm and Positive Risk-Taking

Appendix One: Continuous Intervention Canned Text Tools

Using canned text:

All canned texts tool can be used by entering a backslash (\), followed by the canned text code (e.g. '\cpc') into Trak, followed by the spacebar. This will populate the note with an electronic form/template for completion.

Clinical Pause

Code: \cpc
Template:
Time CP commenced:
Staff Member leading care:
Reason for Clinical Pause:
Detention status:
If Informal, does patient have capacity to consent to Continuous Intervention? [Detail assessment]
Interventions offered during Clinical Pause:
Patient Views:
Time of MDT discussion:
Staff present:
MDT discussion:
Plan of care:
Period of Continuous Intervention instigated:
If yes, criteria for ending 1:1 care:

Daily Review

Code: \cireview
Template:
Time receiving Continuous Intervention:
MDT members involved:
Engagement with staff:
Interventions used:
Medication effectiveness:
Goal of further period of Continuous Intervention:
Criteria for ending:

Case Discussion

Code: \cicasediscussion
Template:
Time receiving Continuous Intervention [days]:
Date of Case Discussion meeting:
Case Discussion chair:
Present:
Apologies:
Reason for Continuous Intervention initiation and summary:
Effectiveness of interventions offered/tried:
Patient view of Continuous Intervention and support offered:
Carer view:

Potential harmful impact of Continuous Intervention [detail]:
Plan:
Next review date:

Ending Continuous Intervention

Code: \mhciend
Template:
MDT members involved:
Reason for ending:
Patient views: (what did / didn't work)

Recording Continuous Intervention

Code: \cirecord
Template:
Length of time spent with patient:
Presentation during intervention:
Support strategies tried? What worked? What did not?:
Appendix 3 – Continuous Intervention Flow-Chart

Continuous Intervention

Information for patients

Dear:

You have been given this leaflet because your team feel you may benefit from increased support from staff at this time. The information below outlines the purpose and process of Continuous Intervention and what you should expect of your clinical team while you are on Continuous Intervention.

Before you are cared for on Continuous Intervention

If staff feel concerned about your levels of stress or distress, they may call a meeting of your clinical team; you may hear this being called a 'Clinical Pause'. This is when all staff involved with your care meet to discuss how best to support you. You can be involved with this meeting and staff should explain to you why the meeting has been called and what support options are available to you. One of these options may be to have a member of staff with you for parts of the day, or continuously throughout the day and night. This is called 'Continuous Intervention'. You should be asked whether you think that having a member of staff with you continuously would be helpful. You can suggest alternatives if you have other ideas about what staff can do to help you.

While you are cared for on Continuous Intervention

You should expect staff to engage with you when you are on Continuous Intervention. Examples of this might be: listening to you, talking to you, supporting you to develop a daily routine, identifying activities that you might enjoy or find useful, engaging you in soothing and distraction techniques and safety planning, or referring you to other people with specialist expertise who may be able to support you in other ways.

Staff will support you to make a care plan. This should be flexible and directed towards your individual strengths, preferences and needs. You may have an increase in support from other professional groups, such as Arts Therapy, Occupational Therapy or Psychology, and you should continue to attend groups or individual sessions if appropriate. In some circumstances, you may still have a pass to leave the ward.

Your care plan while on Continuous Intervention will be reviewed every day. You should be supported to be involved in this daily discussion about your care, and your care plan should be amended according to your goals and preferences.

If you are on Continuous Intervention for more than 14 days, a meeting will be arranged that includes you, your clinical team and, if you wish, your family, friend, or named person. A hospital manager will also attend this meeting. The purpose of this meeting is to discuss your strengths and needs, and to identify different options available to support you in your recovery journey.

Stopping Continuous Intervention

We hope that Continuous Intervention will be supportive and therapeutic. Sometimes patients have reported problems with Continuous Intervention related to loss of privacy, or through staff removing risks in a way which is not strengths-based and prevents self-management. For this reason, Continuous Intervention will only be used as a short-term method for keeping you and others safe. You should be involved in the decision to stop Continuous Intervention. Following this, you may still see an increase in the intensity of care compared with general care levels. Please discuss with your keyworker or clinical team if you are having any difficulties with Continuous Intervention.

Remember: You are the expert in your own care. You should be supported to be involved in making decisions with your clinical team. You may not always agree with every decision, but we believe that no decision should be made about you without you.

Appendix Four: Functions of Self-Harm and Positive Risk-Taking

West Lothian AMH EUPD & cPTSD Integrated Care Pathway

Possible sections for inclusion in Continuous Intervention SOP

Functions of Self-Harm

Klonsky (2007) highlights that understanding the functions of self-harm can inform treatment and may serve to reduce risk and improve outcomes. In a review of the literature, the author identified seven functions of non-suicidal self-injury including:

1) Affect-regulation: To alleviate high levels of acute emotional distress or arousal.

2) Anti-dissociation: To manage or end the experience of depersonalization or dissociation.

3) Anti-suicide: To replace, compromise with or avoid thoughts of impulses to complete suicide.

4) Interpersonal Boundaries: To assert one's autonomy or a distinction between self and others.

5) Interpersonal Influence: To communicate or seek help or care from others.

6) Self-punishment: To express or cope with anger towards the self.

7) Sensation Seeking: To generate positive sensation (exhilaration or excitement) to replace acute emotional distress or negative affect.

If the functions of self-harm can be understood, people can be offered interventions to address these areas of difficulty. For example, if the function of self-harm is to manage intolerable/overwhelming negative emotion, it may be appropriate to offer interventions focused on emotion regulation, whereas if the function is to communicate a need or seek help from others, the risk can be reduced by working with the individual to identify the need, meet this need where possible and to offer interventions focused on interpersonal communication and relationships. It is important to recognise however that self-harm may serve a variety of different functions at any one time for an individual.

Positive Risk Taking

Morgan (2004) defines positive risk taking as 'weighing up the potential benefits and harms of exercising one choice over another'. This means identifying the potential risks involved and developing plans and actions that reflect the positive potentials and stated priorities of the service user. It involves using available resources and support to achieve desired outcomes and to minimise potentially harmful outcomes.

Morgan (2010) outlines a structured approach to decision making in relation to positive risk taking and recommends the following factors are considered:

1) Is the required decision reactive (to what the person is doing or plans to do) or proactive (to be initiated more by service providers)?

2) Is the person using services' understanding and experiences of risk clearly understood (it may be that the individuals understanding of risk is very different from that of the clinicians or clinical team's assessment of risk)?

3) Is the carers/family members understanding, and experiences of risk clearly understood (acknowledge this may contradict the view of the person using services)?

4) What behaviours are identified as being 'risky' in relation to the specific circumstances of the decision?

5) What is the clear definition of the risk that is being taken? Have you considered the other options that are available?

6) What are the positive desired outcomes to be achieved through taking the specific risk (short term and long term)?

7) What strengths can be identified and used in pursuit of a positive risk-taking plan?

8) Are there any clearly defined stages to be accounted for in a risk-taking plan?

9) What are the potential risks and the estimated likelihood of them occurring? Have these been considered in relation to other appropriate options?

10) What are the potential safety nets (early warning signs, crisis, and contingency plans)?

11) Has this course of action been tried before, and if so, what was the outcome?

12) If tried before, how was the plan managed and what can now be done differently?

13) What is your formulation from all the above information (clearly weighting up the different alternatives considered and presenting the reasoned decision that has been taken)?

14) Who agrees (and more importantly disagrees with the plan)?

15) How will progress of the plan be monitored?

16) When will the plan be reviewed?