Lothian NHS Board

Lothian NHS Board
Mainpoint
102 Westport
Edinburgh
EH3 9DN
Main Switchboard: 0131 242 1000

www.nhslothian.scot

Date 03/03/2026
Your Ref
Our Ref 11123

Enquiries to Richard Mutch
Extension 35687
Direct Line 0131 465 5687
loth.freedomofinformation@nhs.scot
richard.mutch@nhs.scot

Dear

FREEDOM OF INFORMATION – FALLS POLICY/GUIDANCE

I write in response to your request for information in relation to falls policy/guidance.

Question:

1. A copy of the prevention and management of falls policy/guidance available to staff working within the Adult Psychiatric Unit and St John's Hospital on 19/07/2023.
2. A copy of the management of confused and delirious patients' policy/guidance available to staff working within the Adult Psychiatric Unit and St John's Hospital on 19/07/2023.
3. A copy of the falls prevention risk assessment and care plan used to assess patient risk available to staff working within the Adult Psychiatric Unit and St John's Hospital on 19/07/2023
4. A copy of the level of observation policy/guidance for patient's suffering from confusion/delirium available to staff working within the Adult Psychiatric Unit and in St John's hospital on the 19/07/2023.

Answer:

Please see enclosed documents and screenshoots to answer your request.

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
Enc.

Procedure for the Prevention and Management of Adult Inpatients Falling in Hospital Settings

Category/Level/Type:
Status: Final
Date of Authorisation: April 2018
Date added to Intranet:
Key Words: falls, hospital inpatients, older people, osteoporosis

Unique ID: NHSL.
Author(s): Falls Co-ordinators
Approval by: Policy Approval Group
Version: 5.0
Review date: Jan 2021

1. Falls in Hospital

A fall is defined as an unintentional or unexpected loss of balance resulting in coming to rest on the floor, the ground or an object below knee level. A fall is distinguished from a collapse that occurs as a result of an acute medical problem such as an acute arrhythmia, a transient ischaemic attack or vertigo.

[Adapted from Falls – risk assessment (NICE clinical knowledge summary)]

Falls are a common problem in hospitals and are associated with significant morbidity and mortality. Hospital inpatients, particularly older people are at increased risk of falls, largely because of their co morbidities rather than by virtue of advanced age alone.

Consequences of hospital falls include injury, depression, and loss of confidence, loss of functional ability and increased length of stay. The most significant injuries are fractures, especially fractured neck of femur, which can be devastating for the individual. A small number of patients die each year in hospital as a direct result of a fall.

Falls which occur in hospital cause distress to patients and can result in anxiety amongst relatives. Falls are a source of complaints that can relate to the injuries sustained, the distress caused, or to communication issues surrounding the circumstances. Staff may feel guilty and demoralised. It is vital therefore that a standardised approach to the management of falls is in place, so that staff are supported in managing falls risk, and patients, relatives and carers can be informed of the steps taken to prevent falls and ensure patient safety.

Risk factors for falling include unsteadiness, muscle weakness, a previous history of falls, poor vision, cognitive impairment, urinary incontinence, poly-pharmacy, postural hypotension, delirium and environmental hazards. It is recognised that acute illness in older people can lead to worsening of gait problems, increased confusion and unsteadiness. On occasion, a fall may be the only presenting feature of such an acute illness. A fall in hospital may be the first sign that a patient has acutely deteriorated. Those who have a history of substance misuse have an increased risk of falling. The interaction between risk factors is complex and a multidisciplinary review to address prevention is required.

Published evidence no longer recommends using falls risk prediction tools (NICE 2013), however Care Bundles based on multi-factorial falls assessment followed by multidisciplinary intervention, tailored to the individual should be initiated (Falls Safe Quality Improvement Project RCP 2013).Components of the multidisciplinary intervention are nursing, medical, physiotherapy, occupational therapy and pharmacist .Other useful interventions include optometry, podiatry and bone health services.

2. Evidence Base:

Published evidence supports multidisciplinary assessment of risk factors and targeted interventions to reduce or reverse these risks. There is a small body of evidence from randomised controlled trials in older people in a variety of hospital settings which supports this. The best evidence for falls prevention comes from community studies with generally healthier, fitter individuals. In hospital settings the studies are difficult to compare as they are heterogeneous however some studies mainly in Medicine of the Elderly wards have reported up to a 30% risk reduction of falling using this approach. These studies looked at wards with no prior falls risk strategies in place. More recently the patient safety literature supports a methodology using high impact actions to prevent falls in a hospital setting which may be effective in reducing harm rather than overall falls rates. There are no long term studies of these interventions as yet to support them in terms of sustainability. (Appendix 1)

3. Identification and Assessment of those at Risk

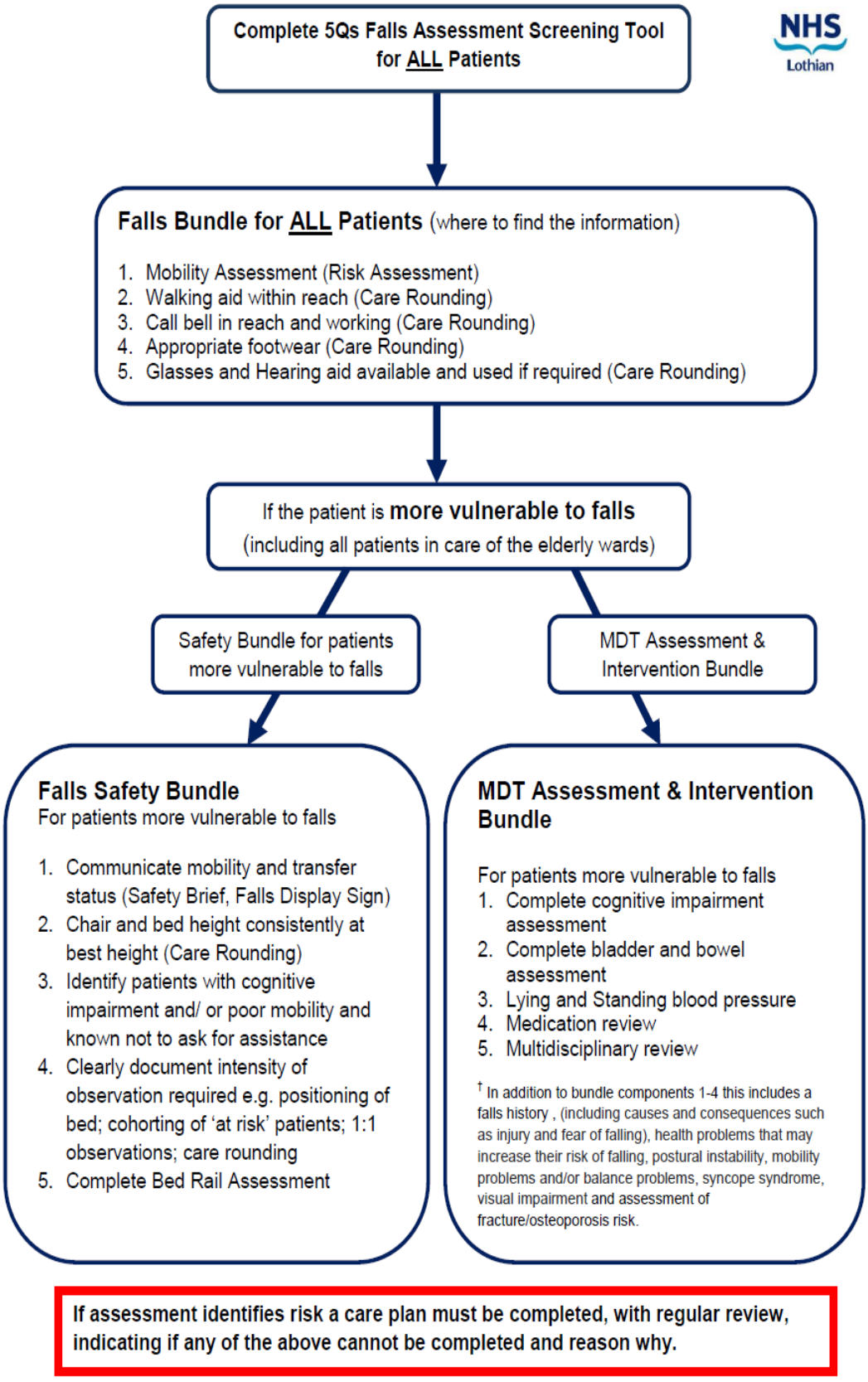
All adult patients should have the falls bundle (see page 4) for inpatients commenced as soon as possible on admission and at least within 24 hours of admission to the ward or department. This includes the following:

- Assess whether falls risk is considered likely at this admission. If deemed not relevant at this time a rationale **must** be provided, otherwise continue to complete 5 questions
- Complete and document the screen for more vulnerable patients (5Qs) see below

The 5Qs (if answers “yes” to any of the five questions, the patient is identified as “more vulnerable” to falling):

1. Has the patient had a fall in the last 6 months – including during this admission?
2. Does the patient have an AMT less than 8 (or 4AT greater than 0) or acute confusion (delirium)?
3. Does the patient attempt to walk alone although unsteady or unsafe?
4. Does the patient or their relative/s have fear or anxiety re falling?
5. Based on your clinical judgement, is this patient at high risk of falling?

Follow the flowchart below
Available on the intranet:
http://intranet.lothian.scot.nhs.uk/Directory/FallsPrevention/In%20patient%20falls%20prevention/Pages/FallsBundle.aspx


Complete 5Qs Falls Assessment Screening Tool for ALL Patients
NHS Lothian
Falls Bundle for ALL Patients (where to find the information)
1. Mobility Assessment (Risk Assessment)
2. Walking aid within reach (Care Rounding)
3. Call bell in reach and working (Care Rounding)
4. Appropriate footwear (Care Rounding)
5. Glasses and Hearing aid available and used if required (Care Rounding)
If the patient is more vulnerable to falls
(including all patients in care of the elderly wards)
Safety Bundle for patients more vulnerable to falls
MDT Assessment & Intervention Bundle
Falls Safety Bundle
For patients more vulnerable to falls
1. Communicate mobility and transfer status (Safety Brief, Falls Display Sign)
2. Chair and bed height consistently at best height (Care Rounding)
3. Identify patients with cognitive impairment and/ or poor mobility and known not to ask for assistance
4. Clearly document intensity of observation required e.g. positioning of bed; cohorting of 'at risk' patients; 1:1 observations; care rounding
5. Complete Bed Rail Assessment
MDT Assessment & Intervention Bundle
For patients more vulnerable to falls
1. Complete cognitive impairment assessment
2. Complete bladder and bowel assessment
3. Lying and Standing blood pressure
4. Medication review
5. Multidisciplinary review
† In addition to bundle components 1-4 this includes a falls history , (including causes and consequences such as injury and fear of falling), health problems that may increase their risk of falling, postural instability, mobility problems and/or balance problems, syncope syndrome, visual impairment and assessment of fracture/osteoporosis risk.
If assessment identifies risk a care plan must be completed, with regular review, indicating if any of the above cannot be completed and reason why.

4. Falls Risk Assessment

It is recognised that acute illness in older people can lead to worsening of gait problems, increased confusion and unsteadiness. On occasion, a fall may be the only presenting feature of such an acute illness. A fall in hospital may be the first sign that a patient has acutely deteriorated. The interaction between risk factors is complex and a multidisciplinary review to address prevention is required.

Published evidence recommends risk assessment followed by multidisciplinary intervention tailored to the individual. Components of the multidisciplinary intervention are nursing, medical; physiotherapy, occupational therapy and pharmacist .Other useful interventions include optometry, podiatry and bone health services.

It is important to identify any concern with the patient's balance, mobility, nutritional status, continence issues or confusion through individual assessment as these factors contribute to falls risk. Acute and chronic conditions can also impact on a person's falls risk and should also be considered when making a clinical judgement about a person's risk of falls when in hospital.

Risk factors identified for patients who fall are listed below. These include multiple co morbidities. The more risk factors an individual has, the greater the risk of a fall with associated harm. A serious injury e.g. hip fracture may occur if the individual also has osteoporosis.

Acute illness
History of previous falls e.g. previous admissions with fall or fracture
Cognitive impairment: delirium (acute confusion) or dementia
Bladder and bowel dysfunction
Postural hypotension
Unsteadiness or gait problem from any cause
Polypharmacy (4 or more drugs) especially psychotropics/sedatives
Inappropriate foot wear or foot problems
Lower limb weakness or joint disease
Cardiac disease e.g. arrhythmia or aortic stenosis if syncope is suspected
Neurological disease e.g. Stroke, Parkinson's/peripheral neuropathy
Visual impairment e.g. cataracts, macular degeneration, poor glasses
Age>75

5. Management of patients at risk of falls

Patients who are identified as at risk of falling require to be identified at the ward safety brief and may be escalated at the site safety huddle. A safety bundle should be initiated and a person centred plan of care completed with input from the patient, and if appropriate, their relatives. Falls prevention information should be provided on admission and relatives / carers encouraged to actively participate in minimising the risk of falls (See Appendix 2 & 3)

Staff should identify communication needs and provide appropriate support to enable this risk assessment to take place. For translation assistance please click on link below:
http://intranet.lothian.scot.nhs.uk/NHSLothian/Healthcare/A-Z/translationinterpretationandcommunicationsupport/Pages/default.aspx

Actions taken will vary from individual to individual depending on their risk factors. Some risk factors may not be modifiable but should be identified and acknowledged. Patients and families should take an active role in care planning to ensure that it is person centred**.** (Appendix 4)

Patients identified at risk of falling should have a multidisciplinary assessment and intervention bundle completed and documented management plan completed.

1 Patients identified at risk of falls should be identified at the ward safety brief/ huddle, patient at-a-glance board or, if agreed, by a sign by the bed-side

2 For patients admitted due to a fall or collapse, or who have a history of falls, first line management requires a medical review in order to establish whether there is an acute illness. This will include a history, full physical examination and medication review.

3 A medication review is also vital if the patient is found to have significant postural hypotension (defined as a drop of 20mmHg or more in systolic BP +/ minus a drop of 10mmHg in diastolic). BP measurements should be repeated if patients experience light-headedness on standing, as blood pressure varies throughout the day. Culprit medications should be reviewed and it may be appropriate to withhold them until the patient improves or discontinue altogether. There should be a documented plan of care for any multidisciplinary assessment and intervention within the patient's record.

4 Anticoagulation with heparin or warfarin may not be safe in an individual with recurrent falls, particularly if they sustain a head injury. Ward teams should seek pharmacist's advice.

5 Vision corrected: If reversible visual problems are suspected such as poor glass prescriptions, or cataracts then an ophthalmology review may be indicated.

6 Active treatment and investigation of any cardiac problems such as arrhythmia is important if syncope is suspected as the cause for the fall.

7 Treatment of specific neurological or joint disease (where possible).

8 Ensure patients have appropriate footwear and access to podiatry

9 Physiotherapists assess gait, posture and mobility aids, and provide strength and balance training. Exercise programmes have been found to be the most effective interventions in randomised controlled trials and ones targeting these specific areas e.g. OTAGO strength and retraining programme should be prescribed. Staff should ensure that the patient is as mobile as possible according to management plan

10 Occupational therapists assess risk of falls and environmental hazards when engaging in everyday functional tasks with patients e.g. transfers and personal care. If problems are identified appropriate modifications and equipment can be provided.

11 If osteoporosis is suspected (e.g. previous history of fracture or obvious spinal vertebral deformity such as kyphosis) DEXA scanning and bone protection therapy should be considered.

12 Information should be provided about the process of risk assessment and management to relatives and carers. A leaflet is available for this purpose for inpatients and written information should be displayed on the wards

6. Patients with Delirium (Acute Confusion) or Dementia

Patients who are confused are one of the largest groups of individuals at risk of falls within the hospital setting because of their reduced safety awareness. Confusion, whether acute (secondary to an acute illness i.e. delirium) or chronic, (secondary to dementia) should be screened for using the 4AT, or if a fuller screening is required, a Mini-Mental State Examination (MMSE). It is essential to establish a collateral history from carers and relatives to try to determine if the problem is acute or chronic.

If delirium is suspected it is imperative to initiate investigation of triggers and commence treatment of underlying causes

http://intranet.lothian.scot.nhs.uk/NHSLothian/Healthcare/ClinicalGuidance/General/Delirium%20Pathway.pdf

Patients with dementia or delirium can become disorientated when in an unfamiliar environment increasing their risk of wandering. This combined with poor safety awareness makes these individuals particularly vulnerable. It is important to ask whether the patient has a diagnosis of dementia, whether these episodes have occurred before and under what circumstances.

These individuals require careful management with regular orientation and nursing in a well-lit environment. Medical problems such as urinary retention, constipation, pain or sepsis should be considered, particularly in patients who are unable to communicate the source of their distress.

In order to reduce the risk of injury, the bed can be lowered nearer the floor. Sedatives should be avoided if possible as they often worsen unsteadiness and can cause paradoxical agitation. Risk assessment and nursing / multifactorial interventions should be employed to help reduce the risk of falling

If the patient is identified as at risk of falls but also requires supervision to ensure safety it is appropriate to consider the patients individual needs and increase the frequency of care rounding to accommodate this. It may be necessary to provide supervision whilst the patient is in the toilet and/ or bathroom and this must be carried out whilst preserving their dignity and privacy as much as possible.

Use of the “Getting to know me” document will help to provide useful personal information for staff to provide person centred care.

An assessment of patient’s capacity should be made in order to determine whether treatment should be carried out under the guidance of Adults with Incapacity Act and if uncertain, psychiatry advice should be sought. This is particularly important if considering the use of falls sensors, bed rails or wander guard. Staff can also refer to the Safe and Effective use of Bed Rails policy.

7. Patients requiring Increased Supervision

An increased risk of falls may require the person to be placed in an observable area e.g. near the nurses’ station.

A consideration may be to co-hort the person into a multi-bedded room and ensure that a member of staff is always present to assist.

If the person is showing signs of stress or distress then a systematic approach to identify the cause is recommended to help identify possible trigger. Challenging behaviour – a systematic approach to assessment

All other alternatives should be considered before requesting 1:1 observation. Please see (Appendix 5)

If 1:1 care is provided then an hourly summary of the person's presentation must be recorded.

1:1 care should be assessed every 24 hours by the multi-disciplinary team (if possible) and stepped down as soon as the person's safety has improved.

8. Management of a fall within a Hospital Setting

All staff must ensure that the Incident Management Policy is followed and the incident recorded on DATIX, ensuring that the rating of severity of harm follows the definitions as defined in the policy.

Post fall bundle

- The person should not be moved until they have been checked for signs and symptoms of fracture or potential spinal injury. The top to toe assessment should be completed and documented
- Safe manual handling methods must be used if there are any signs and symptoms of fracture or potential for spinal injury
- Where head injury has occurred or cannot be excluded (e.g. un-witnessed fall) neurological observations must be recorded and the frequency and duration documented, based on medical guidance
- Medical examination should take place within agreed timescales following a fall especially those with a high vulnerability to injury, or who have been immobilised due to injury
- Conduct a post fall review / rapid root cause analysis to learn how further falls can be prevented for the person and for wider learning

Please refer to the Post-falls flowchart (Appendix 6),

What to do if a patient falls:

1 The staff member who witnesses the patient fall or finds the patient on the floor should assess responsiveness. If unresponsive, open airway and look for signs of life. If no signs of life call cardiac arrest team and perform CPR according to current guidelines. If responsive ask about pain, assess for injury, consider first aid and how best to assist the individual off the floor. The patient should be reviewed according to the NHS Lothian **ABCDE** assessment which assesses airway, responsiveness, breathing, circulation signs of injury and exposure due to injury. This is particularly important prior to moving the patient and if a spinal injury is suspected a spinal board or advice re this must be sought. It is also important to assess the environment of the fall to ensure it is safe.

2 A ‘Top to Toe’ assessment should be performed by staff to confirm signs of injury. This assessment can be performed by nursing staff if confident and trained or by medical staff. The top to toe examination should be documented in full in the case notes and analgesia should be given as required.

3 If a head injury occurs, or is suspected in an un-witnessed fall, neurological observations should be commenced immediately. The Glasgow Coma scale marked out of 15 should be used as standard. The doctor should be informed immediately.

4 All falls should be reported to the medical staff and they should review the patient as soon as possible, especially if there are obvious signs of injury or if nursing staff are concerned. If no injury is present and the top to toe has been performed the doctor (or HAN team if out of hours) should be informed at the time. An immediate review may not be available in which case the medical and nursing staff must arrange assessment within 12 hours if deemed safe and appropriate to do so.

5 The individual’s next of kin should also be contacted about the incident as soon as possible and the situation explained. The nursing staff should complete the DATIX form and note the incident number for investigation by the charge nurse. The outcome of any assessment should be recorded fully in patient’s case notes. If a patient sustains a serious injury their treating consultant should also be notified.

6 DATIX recording should include details of the circumstances of the fall and actions taken. All falls which involve harm are subject to incident investigation and if a fracture or death occurs they are reviewed by senior management teams. This is important to ensure safety and enable reflective practice so that lessons may be learned.

7 If not previously noted to be a falls risk, then place falls risk notice above the bed, institute nursing care plan and multidisciplinary falls risk assessment and interventions should be initiated and documented. Information and advice on reducing falls risk should be given to patient and relatives.

9. Discharge from Hospital

Upon discharge from hospital, information will be provided by relevant members of the multi-disciplinary team to inform the person and/ or other healthcare providers, how to help prevent further falls and phone numbers provided for services in the community setting.

Appendix 1: References

Many guidelines exist about falls prevention, and some of the best evidence for prevention of falls in the hospital setting is cited below:

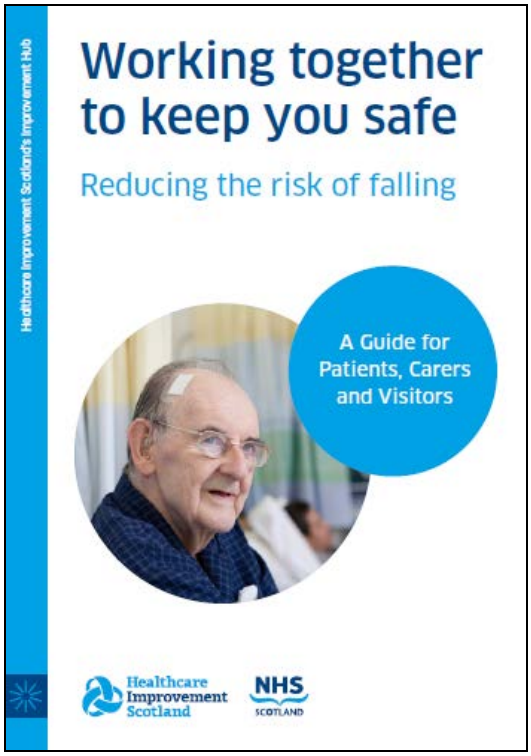
1. National Patient Safety Agency *Slips, trips and falls in hospital*, London, 2007 NPSA www.npsa.nhs.uk
2. National Institute for Health and Clinical Excellence. *Falls: assessment and prevention of falls in older people. Clinical guideline 161 (2013*) Available at: www.nice.org.uk/guidance/CG21/Guidance/pdf/English
3. Department of Health. *The National Service Framework for Older People. (2001)*
4. Haines TP, Bennell KL, Osborne RH, Hill KD. Effectiveness of targeted falls prevention programme in sub acute hospital setting: randomised controlled trial. *BMJ 2004;328*:
5. Healy F, Monro A, Cockram A, Adams V, Heseltine D. Using targeted risk factor reduction to prevent falls in older hospital inpatients: A randomised controlled trial. *Age and Ageing 2004; 33:390-5*
6. Oliver D et al. Risk factors and risk assessment tools for falls in hospital inpatients; a systematic review*. Age and Ageing*. *2004;*33:122-130
7. Fonda D, Cook J, Sandler V, Bailey M. Reducing serious falls-related injures in hospital. *Med J Australia 2006;184:379-382*
8. Cameron, I.D. et al., 2010. Interventions for preventing falls in older people in nursing care facilities and hospitals (Review). Cochrane Database of Systematic Reviews
9. NHS Quality Improvement Scotland (2010) Up and About pathways for the prevention and management of falls and fragility fractures, Edinburgh: NHS QIS
10. Scottish Executive. Coordinated, integrated and fit for purpose. A delivery framework for adult rehabilitation in Scotland. 2007
11. American Geriatrics Society, British Geriatrics Society, American Association of Orthopaedic Surgeons Panel on Falls Prevention. Guideline for the prevention of falls in older persons. *Journal of the American Geriatrics Society. 2011*
12. Management of Hip Fracture in Older people Sign Guideline 111 (2009)
13. Vassallo M, Poynter L, Sharma J et al. Falls risk assessment tools compared with clinical judgement: an evaluation in a rehabilitation ward. *Age and Ageing 2008;37:277-81*
14. Royal College of Physicians (2012) Implementing fallsafe: Care bundles to reduce inpatient falls London https://www.rcplondon.ac.uk/projects/falls-prevention-hospital

Appendix 2: Patient and carer leaflet and signage

Falls Prevention in Hospital Leaflet

A Patient information leaflet was developed to support the Falls Prevention work and is available via the link below:

http://www.healthcareimprovementscotland.org/our_work/person-centred_care/opac_improvement_programme/falls_prevention_leaflet.aspx



Falls Risk Sign

Please display the falls risk sign below in a place where it can be seen by staff and visitors e.g. behind the bed. These signs should be used for patients determined as at risk using the falls risk assessment tool. The signs should be reproduced in a format that is easy to wipe clean. They are available on the intranet at the link above.

Available on the intranet:
http://intranet.lothian.scot.nhs.uk/Directory/FallsPrevention/In%20patient%20falls%20prevention/Pages/Fallsrisksignsandinformationposter.aspx

Appendix 3: Falls risk information poster

Falls Risk Information Poster

Information for Patients, Carers and Visitors

NHS Lothian

This information is written to help reduce the risk of falling whilst in hospital

Why people are at risk of falls

We know that some people fall whilst in hospital. This may be as a result of the illness or injury that brought them into hospital, the medicines they take, being confused, or as a result of losing their confidence. Even people who have never had a fall before can be at risk because of these problems

What we will do

All patients have a falls assessment completed on admission to the ward to identify their falls risks. If they are identified as being at risk of falls a care plan will be commenced to help reduce the risk of falling whilst in our care

Patients are advised to

- Listen to the advice about moving around given by the ward staff.
- Ask for help by using your call bell
- Take your time when moving and get up slowly
- Keep everything within reach and don't stretch
- Use walking sticks or frames in the way the physiotherapists tell you
- Make sure your shoes or slippers are non-slip, well fitting and in good repair

Carers are advised to

- Tell staff anything you think is important – relating to falls risk
- Tell staff if you have any concerns about your relative
- Tell staff about spills, trailing cables or anything untidy
- Make sure the patient area is clear and put chairs back before leaving
- Make sure your relative knows you are leaving
- Take any unnecessary things home to stop clutter
- Make sure your relative can reach the call bell

Remember

The advice is reviewed regularly and updated as you (or your relative) improve. If you are unsure of what to do, please ask a member of staff

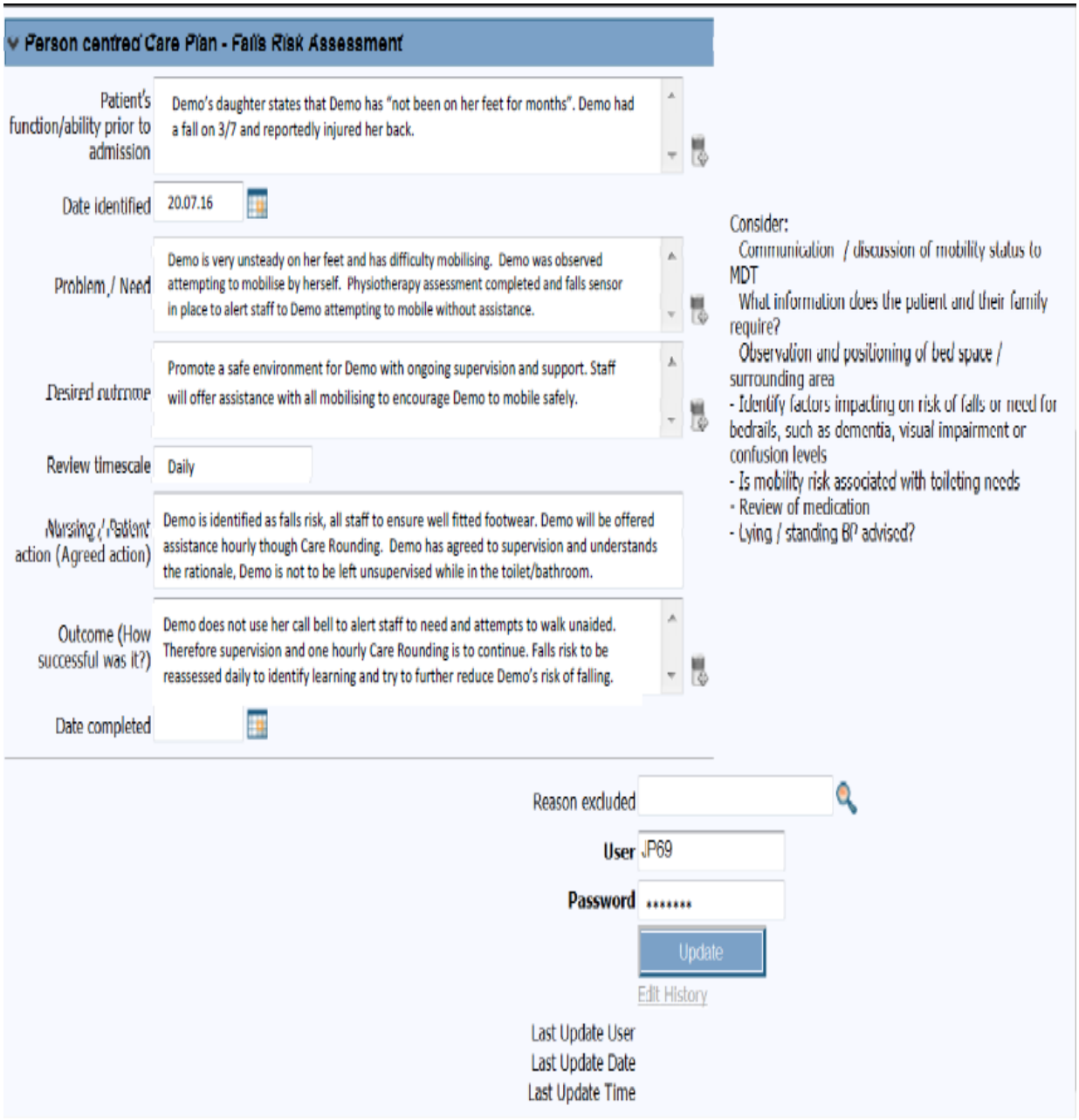
Unfortunately it is NOT possible to prevent all falls in hospital. We will stick to the patient's wishes, or act in their best interests if they are unable to communicate their wishes

By clearly identifying people who are at risk, everyone involved in their care, including you, can help. If you see anyone on the ward who looks unsafe and might fall please alert a member of staff as quickly as possible

An information leaflet is available, please as a member of staff.

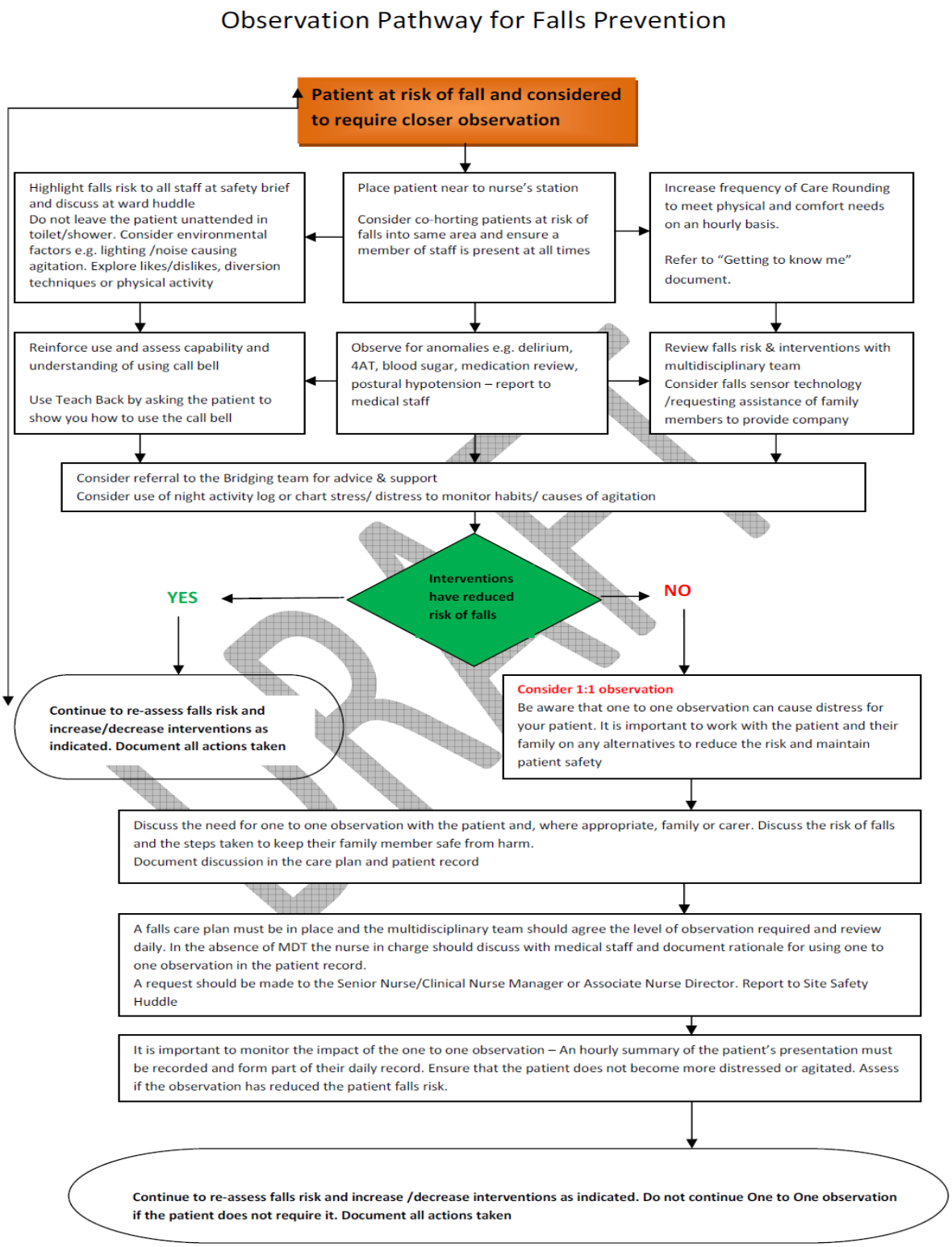
DRAFT V6 April 2017

Appendix 4:Nursing Care Plan - Example

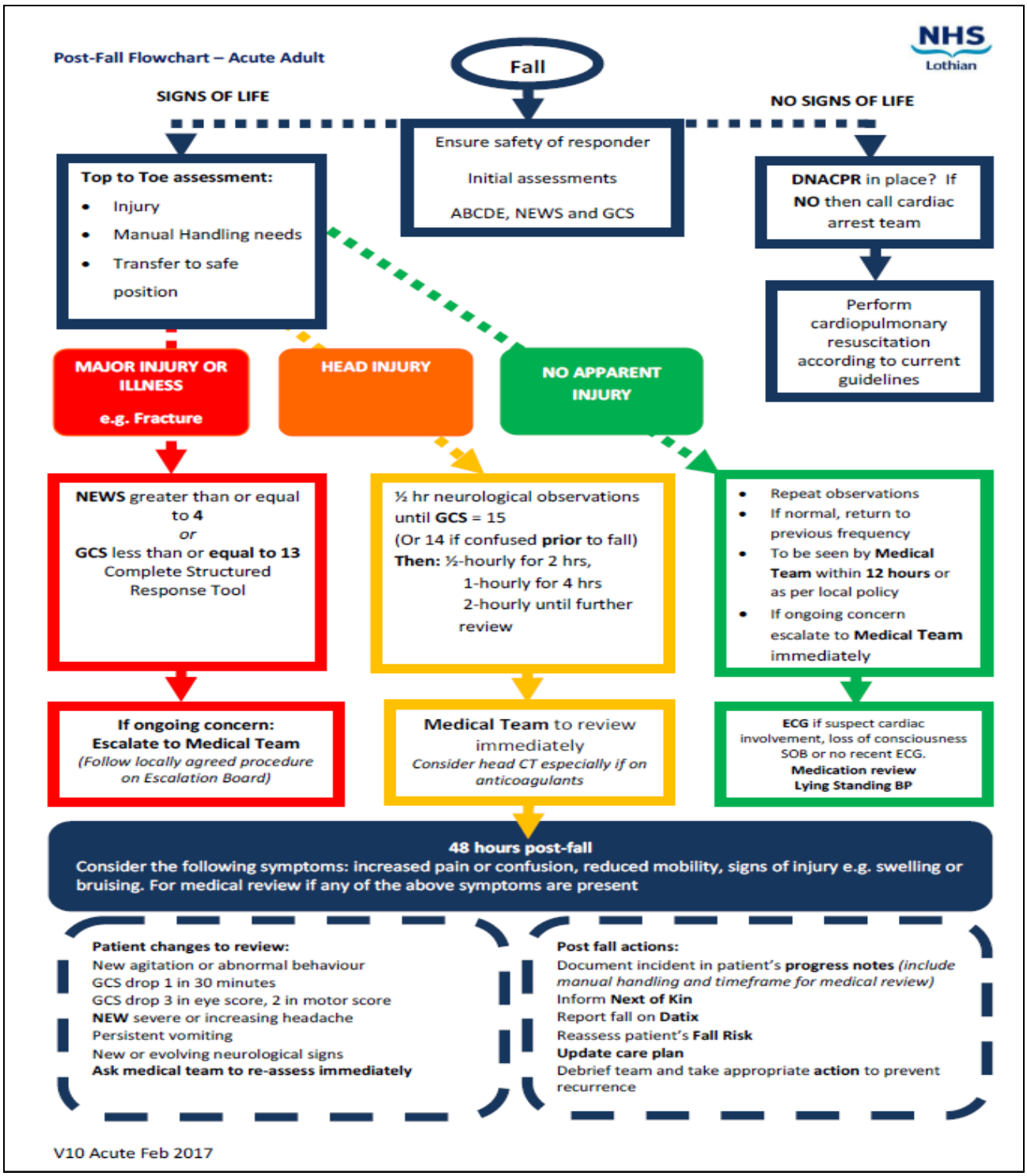


Available on the intranet:
http://intranet.lothian.scot.nhs.uk/Directory/FallsPrevention/Documents/Falls%20Care%20Plan%20-%20MOE.pdf

Appendix 5: Observation Pathway for Falls Prevention



Appendix 6: Post-Fall Flow Chart



Available on the intranet:
http://intranet.lothian.scot.nhs.uk/Directory/FallsPrevention/In%20patient%20falls%20prevention/Pages/Postfallcareinhospital.aspx

ABCDE Assessment

	ASSESS	POSSIBLE ACTIONS
AIRWAY	**Is the Airway –** ▪ **PATENT** ▪ **AT RISK** ▪ **OBSTRUCTED**	→ Suction if indicated, → Head positioning, → Airway adjuncts, → Administer oxygen, → Call 2222 if at risk.
BREATHING	▪ Respiratory rate ▪ Spo2 ▪ Accessory muscle use ▪ Noises+/- Percussion, Palpation & Auscultation ▪ Position/posture	→Administer high flow O2 (NB: caution with type 2 Respiratory failure), → Summon help → Monitor SpO2/ABGs → Treat underlying cause, → Call 2222 if not breathing.
CIRCULATION	▪ Pulse ▪ Blood pressure ▪ CRT ▪ Core temp/colour ▪ Urine output ▪ Conscious level ▪ Other losses i.e. drains	→ Obtain IV access, → Administer O2, → Summon help, → Prepare fluid challenge, → Initiate Fluid Balance Chart → Call 2222 if no circulation
DISABILITY	▪ AVPU/GCS, ▪ ABG's & treat Hypoxia or Hypovolaemia, ▪ Blood glucose ▪ Drugs.	→ Bedside blood glucose → Check drug chart → Assess pupils → Nurse in lateral position → Summon help
EXPOSURE	▪ Top to Toe examination, ▪ Look for evidence of blood loss / rashes / drains / wounds etc, ▪ Temperature	→ Control bleeding → Treat any underlying conditions identified → Temperature control → Reassess → Maintain patient's dignity

Remember:

To record all observations on NEWS chart & document any deterioration in the notes.

If at any point during your assessment you are concerned about your patient **- Call for help.**

Appendix 8: 'Top to Toe' Survey

Skull	**Scalp wound / haematoma** **Depression / ridge in skull**	
Eyes	**Pupils- ? Equal and react to light**	
Ears	**Discharge / bleeding**	
Nose	**Discharge / bleeding**	
Skin	**Colour** **Laceration / graze** **Bruising** **Bleeding**	
Mouth	**Bitten tongue /dislodged teeth or dentures**	
Neck	**Tenderness**	**If concerns over neck or spinal injury do not move**
Spine	**Tingling or weakness in the limbs**	
Chest	**Difficulties breathing** **Collarbones / ribs**	
Abdomen	**Tenderness**	
Pelvis	**Pain on pressing over hip/ groin** **Blood in urine / catheter**	
Arms	**Deformity**	
Legs	**Joint movements – range and pain**	

Remember not to mobilise any patient in whom you suspect a spinal injury without the use of a spinal board. Summon help if unsure about manual handling.

Document and record any injuries and if fracture suspected order x-rays immediately once patient is stable. If concerned at any point summon help.

Available on the intranet:
http://intranet.lothian.scot.nhs.uk/Directory/FallsPrevention/In%20patient%20falls%20prevention/Pages/Postfallcareinhospital.aspx

Policy for the Prevention and Management of Adult Inpatients Falling in Hospital Settings

Unique ID:	Author (s): Falls Co-ordinators
Category/Level/Type: 1- Policy	Version: 5.0
Status: Final	Approved by: Policy Approval Group
Date of Approval: Jan 2018	Review Date: Jan 2021
Date added to Intranet: Apr 2018	
Key Words: Falls Prevention, Falls Assessment Slips, Trips, Inpatient	

Policy for the Prevention and Management of Adult Inpatients Falling in Hospital Settings

Key Messages

- This policy applies to all healthcare professionals /care staff (including bank, agency and locum staff) working in all inpatient hospital settings who are involved in the direct care, treatment and provision of services to adult patients who are at risk of falling.

- All adult in-patients should have a falls risk assessment completed by healthcare professionals with the appropriate training and skills, within 24 hours of admission and their care should be documented in their healthcare record. All in-patient falls must be assessed and managed according to the policy and procedure to ensure any injury is promptly identified and treated.

- A maternity in-patient will be identified as at risk of falls on an individual basis following assessment as per admission protocol

- All relevant departments should have systems in place to ensure that this policy and procedure are effectively implemented in their area. Local ward and service teams shall monitor the implementation of aspects of this policy and procedure, and the results measured against the Scottish Patient Safety Programme Care Bundle using the Quality Improvement Data System (QiDS), plus information from local audits and adverse events.

- This policy and procedure are available on the Intranet:- http://intranet.lothian.scot.nhs.uk/NHSLothian/Healthcare/ClinicalGuidance/Pages/ClinicalGuidance-1.aspx

Minimum Implementation Standards

Good Practice for Managers

- All line managers should have local dissemination and implementation plans in place to ensure all staff are familiar and adhere to all aspects of this policy.

Good Practice for Employees

- Has read the policy (or selected excerpts) and considered what it means for him or her, in terms of how to conduct his or her duties
- Has undertaken the e-learning module “Falls Prevention for Adult In-patients” which is essential training to support the implementation of the policy. Please contact the falls coordinator for further information.
- Has altered working practices as expected by the policy

1. Why do we have this Policy?

1.1 Falls are a common problem in hospitals and are associated with significant morbidity and mortality. Hospital inpatients, particularly older people are at increased risk of falls, largely because of their co morbidities rather than by virtue of advanced age alone.

1.2 This policy and the associated procedure support the need to reduce the risk of falls for in-patients in hospital and improve patient experience and outcome of care.

1.3 NHS Lothian also has a NHS Lothian Preventing Slips, Trips and Falls Policy, which covers the general need to identify and manage the risks of slips, trips and falls in our premises. By successfully implementing that policy, this will help reduce the risk of patients falling too.

1.4 Many of the general principles and approaches described in this policy are appropriate for community patients but for further information, this policy should be read in conjunction with The Prevention and Management of Falls in the Community: A Framework for Action for Scotland 2014/15, the NHS Lothian Falls Prevention and Bone Health Strategy 2011-2016, and the referral pathway for older patients discharged from the emergency department after a fall.

2. Policy Statement

2.1 NHS Lothian shall provide safe, person-centred care in a manner that is fully consistent with the Delivery Framework for Adult Rehabilitation: Prevention of Falls in Older People (HDL 2007) 13), the Scottish Patient Safety Programme for Acute Adults, Healthcare Improvement Scotland's 9 points of care priorities, and Standard 11 of Healthcare Improvement Scotland's Care of Older People in Hospitals Standard (June 2015), in order to reduce the risk of falls in its hospitals.

2.2 NHS Lothian shall implement this policy by providing a framework which supports a multidisciplinary and co-ordinated approach to falls prevention and management within hospitals in NHS Lothian. Healthcare Improvement Scotland (HIS) supports NHS Lothian to deliver evidence based, safe, effective, high quality person-centred care for falls prevention and management.

3. Policy Scope

3.1 This policy applies to all healthcare professionals /care staff (including bank, agency and locum staff) working in all inpatient hospital settings who are involved in the direct care, treatment and provision of services to adult patients who are at risk of falling. A maternity in-patient will be identified as at risk of falls on an individual basis following assessment as per admission protocol.

4. Roles & Responsibilities:

4.1 Executive Director Nursing, Midwifery and Allied Health Professionals

The Director of Nursing, Midwifery and Allied Health Professionals has delegated responsibility on behalf of the Chief Executive for leading on the implementation of the policy and procedure.

4.2 Medical Directors, Associate Nurses Director and Allied Health Professional Lead

4.2.1 Senior Clinical Managers are responsible for the operational implementation of the policy and procedure within their clinical areas

4.2.2 Ensure that the findings from audit of falls risk assessments and learning points from Significant Adverse Event reports are reviewed and have improvement plans. That the findings and improvement plans are communicated to the service, Board and Healthcare Improvement Scotland via the Scottish Patient Safety Programme

4.3 Clinical Managers

4.4.1 The clinical manager identifies which staff in his or her area the policy and procedure applies to and can direct staff to where to access on the intranet

4.4.2 The clinical manager has systems in place to provide assurance to him or her that the policy and procedure is being implemented as intended in their area of responsibility.

4.4.3 Ensuring that the findings from audit of risk assessments and learning points from Adverse Event reports are reviewed and communicated to the service, Site Directors and Senior Managers, and inform improvement plans.

4.4.4 All ward managers must ensure that a review of all falls assessments and care planning are audited and reviewed for compliance on a monthly basis via Quality Improvement data System (QiDS) and this is monitored via clinical and management structures.

4.4 Quality Improvement Support Team

4.3.1 Provides improvement advice and supports helping local and service teams analyse data/information to inform local improvement plans

4.3.2 Support data systems such as QiDS to inform improvement planning.

4.3.3 Adverse event management support and advice including the provision of Datix on which all falls should be recorded. See below link to Adverse Event Management Policy and Procedure:
Adverse Event Management Policy
Adverse Event Management Procedure

4.4.4 Within the team are Falls Co-ordinators who support clinical staff where falls are identified as a high priority to develop improvement plans and apply improvement methodology including training/education and specialty clinical support.

4.5 All Staff

4.5.1 All staff involved in the direct care of the patient are expected to follow the procedures and systems that have been put in place to implement the policy.

4.5.2 Follow all policies and procedures designed to ensure safer ways of working including actions to prevent slips, trips and falls.

4.5.3 Report any hazards or concerns relating to falls prevention and management to their line manager.

5 Associated Procedures and Guidelines:

5.1 Further guidelines for the Identification and Assessment of patients at risk of falls, Management of adult inpatients at risk of falls in the hospital setting, and Managing patients with delirium (acute confusion) and dementia guidelines are available within the Procedure for the Prevention and Management of Adult Inpatients Falling in Hospital Settings.

5.2 NHS Lothian has agreed to use the National Guidelines developed by consultation across NHS Scotland and Healthcare Improvement Scotland. The Acute Adult Programme advises the use of Care Bundles from the
Prevention of Falls Driver Diagram and Change Package

5.3 All adult patients should have the falls bundle for inpatients commenced as soon as possible on admission and at least within 24 hours of admission to the ward or department. **See link above for further details**

6. Management of an in-patient fall within a Hospital Setting

6.1 Post-fall care must be in accordance with the National Guidelines and falls bundle. The first priority is to ensure the needs of people affected by the fall are attended to, including any urgent clinical care which may reduce the harmful impact. If there are steps that can be taken immediately to reduce the risk of recurrence, then these should be implemented.

6.2 It is the responsibility of all staff to report and record all falls and near-misses on the Datix system, in line with the Adverse Event Management Policy.

6.3 All ward managers must ensure that a review of the fall and lessons learned are shared with the ward team and includes the patient and their relatives (with patient permission).

6.4 There are some in-patient falls, which need to be reported under RIDDOR to the HSE. Clear guidance on this can be found on the link below:-
http://intranet.lothian.scot.nhs.uk/Directory/HealthandSafety/Reference%20Library/RIDDOR/Pages/default.aspx

For any queries regarding RIDDOR please contact the Health and Safety Service - details on intranet or on link below:-
Corporate > A-Z> Health & Safety > HS Contact Details

7. Evidence Base

7.1 Published evidence supports multidisciplinary assessment of falls risk factors and targeted interventions to reduce or reverse these risks. There is a small body of evidence from randomised controlled trials in older people in a variety of hospital settings which supports this

7.2 More recently the patient safety literature supports a methodology using high impact actions to prevent falls in a hospital setting which may be effective in reducing harm rather than overall falls rates. There are no long term studies of these interventions as yet to support them in terms of sustainability.

National Institute for Health and Clinical Excellence. *Falls: assessment and prevention of falls in older people. Clinical guideline 161 (2013*) Available at: www.nice.org.uk/guidance/CG21/Guidance/pdf/English

National Patient Safety Agency *Slips, trips and falls in hospital*, London, 2007 NPSA www.npsa.nhs.uk

Department of Health. *The National Service Framework for Older People. (2001)*

Cameron, I.D. et al., 2010. Interventions for preventing falls in older people in nursing care facilities and hospitals (Review). Cochrane Database of Systematic Reviews

NHS Quality Improvement Scotland (2010) Up and About pathways for the prevention and management of falls and fragility fractures, Edinburgh: NHS QIS

Scottish Executive. Coordinated, integrated and fit for purpose. A delivery framework for adult rehabilitation in Scotland. 2007

Royal College of Physicians (2012) Implementing fallsafe: Care bundles to reduce inpatient falls London
https://www.rcplondon.ac.uk/projects/falls-prevention-hospital

8 Monitoring and Learning

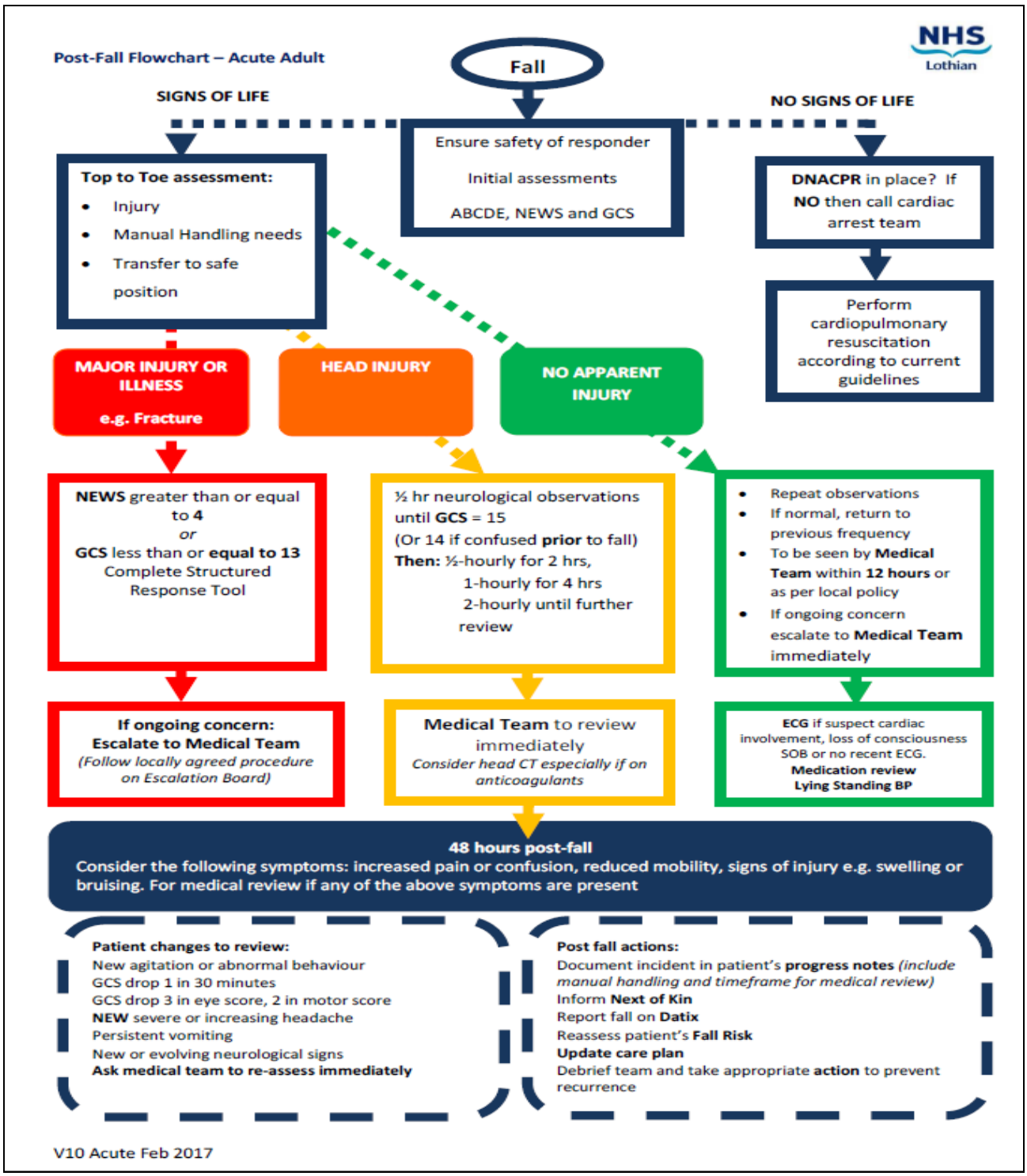
Element to be monitored	How	Frequency	Reporting to
Reliable Care • Bundle Compliance from falls risk assessment to post-fall assessment • Compliance with AE procedure - Datix	• Quality Improvement Data System • TRAK Boxi reports • Local audits • Observation • Datix Dashboards • Data generated from improvement plans in areas of high priority • Complaints • Thematic learning at ward and service area level	Monthly	• Ward staff • Service Team • Clinical Management Group • Acute Hospitals Committee • Through SPSP to Healthcare Governance • Board Quality & Performance report
Outcome Measure • Rate of falls resulting in significant harm or death per 1,000 occupied bed days	Datix Reporting System Monthly Site Reports	Monthly Monthly	Healthcare Governance Committee/CMG Site Directors/Chief Nurses/Clinical Directors

9. Review of policy

This policy will be audited via the Quality Improvement Department using both the Healthcare Improvement Scotland Acute Adult Programme, Prevention of falls audit and the Quality Improvement Data System measures. This is a compliance measure of falls assessment, prevention and management.

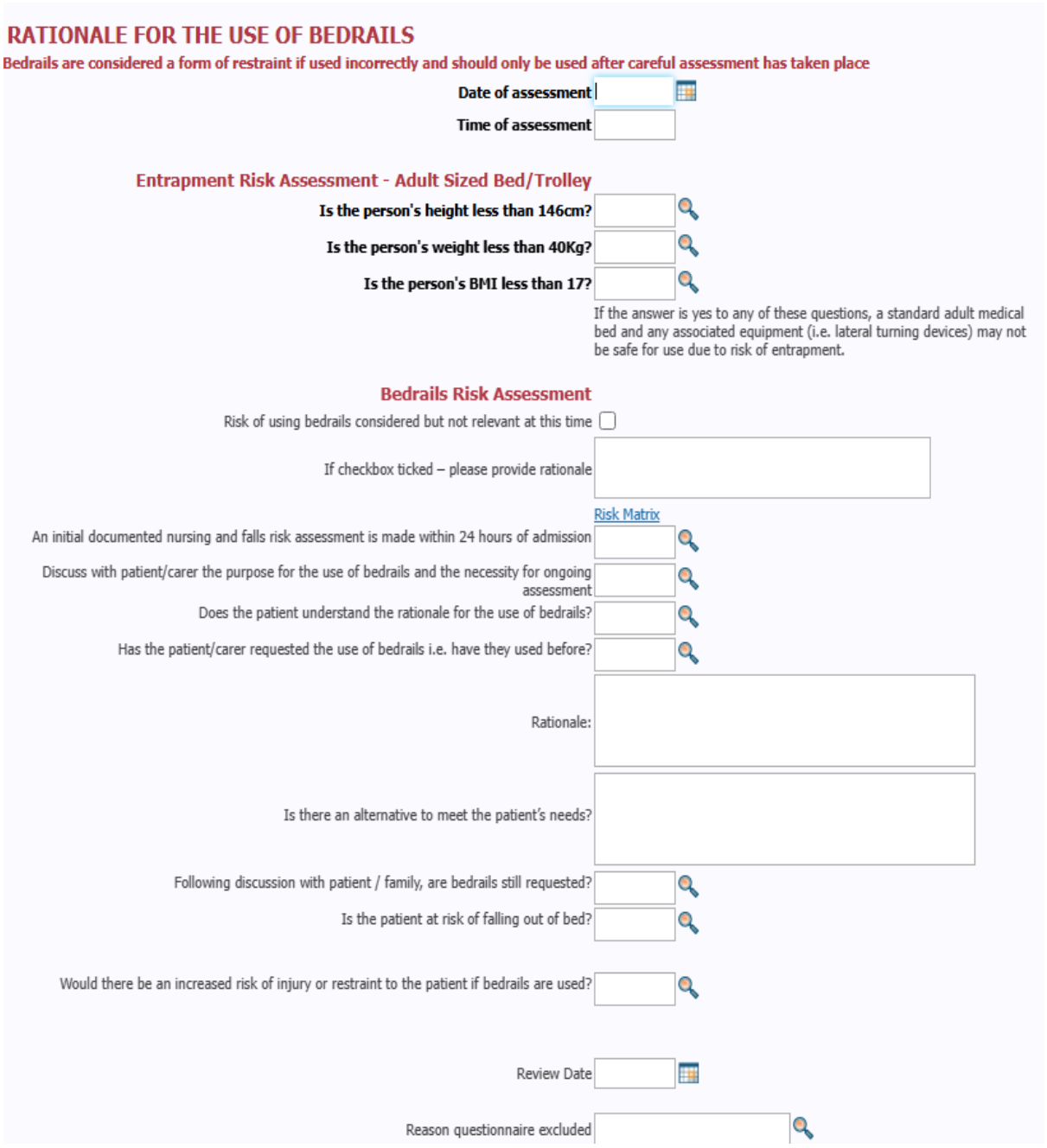
This policy will be reviewed and revised every 3 years or as a result of any changes in legislation.

Post-Fall Flow Chart



Available on the intranet:
http://intranet.lothian.scot.nhs.uk/Directory/FallsPrevention/In%20patient%20falls%20prevention/Pages/Postfallcareinhospital.aspx

Risk Assessments related to Falls and Mobility



RATIONALE FOR THE USE OF BEDRAILS

Bedrails are considered a form of restraint if used incorrectly and should only be used after careful assessment has taken place

Date of assessment

Time of assessment

Entrapment Risk Assessment - Adult Sized Bed/Trolley

Is the person's height less than 146cm?

Is the person's weight less than 40Kg?

Is the person's BMI less than 17?

If the answer is yes to any of these questions, a standard adult medical bed and any associated equipment (i.e. lateral turning devices) may not be safe for use due to risk of entrapment.

Bedrails Risk Assessment

Risk of using bedrails considered but not relevant at this time

If checkbox ticked – please provide rationale

Risk Matrix

An initial documented nursing and falls risk assessment is made within 24 hours of admission

Discuss with patient/carer the purpose for the use of bedrails and the necessity for ongoing assessment

Does the patient understand the rationale for the use of bedrails?

Has the patient/carer requested the use of bedrails i.e. have they used before?

Rationale:

Is there an alternative to meet the patient's needs?

Following discussion with patient / family, are bedrails still requested?

Is the patient at risk of falling out of bed?

Would there be an increased risk of injury or restraint to the patient if bedrails are used?

Review Date

Reason questionnaire excluded

MOBILITY ASSESSMENT

KEY FACTORS TO CONSIDER

- The patient's physical abilities, cognition (4AT), communication, weight/shape/size, environment -including set up of furniture and equipment
- If it is identified that the patient requires control and restraint techniques to be used as part of personal care tasks, this must be assessed and fully documented in their restraint care plan

This assessment should be undertaken on admission and reviewed regularly, updating when the patient's handling needs changed

Date of assessment

Time of assessment

Risk considered but not relevant at this time

If checkbox ticked - please provide rationale

Full body lifting hoist - please specify

Sling S / M / L / XL

Rolling in bed

Remove

Moving up the bed

Remove

Getting out of bed

Remove

Getting into bed

Remove

Sit to Stand to Sit

Remove

Walking

Remove

Toileting

Remove

Bathing / Showering

Remove

Lateral transfers

Remove

Up from floor

Remove

Key handling information - e.g.

- Hoist/sling - type/size/configuration; if appropriate, complete a sling compatibility assessment
- Glide sheet - type/style used
- Furniture/equipment - specific setup
- Specific instructions to patients

FALLS RISK ASSESSMENT

- Assessment should be carried out for all adult patients within 24 hours of admission
- Clinical judgement regarding falls risk should be considered from the questions below
- If the patient answers YES to any of the 5 questions OR the patient is in a Care of the Elderly ward, they are considered more vulnerable to falls and must have the Safety Bundle and the Multidisciplinary Assessment and Intervention Bundle initiated and a documented plan of care to evidence steps taken to monitor and prevent falling where possible
- Re-assess falls risk if the patient falls, their condition deteriorates, following transfer to another ward or anytime deemed appropriate
- Otherwise re-assess weekly

Date of assessment

Time of assessment

Risk considered but not relevant at this time ☐

If checkbox ticked - please provide rationale

Has the patient fallen in the last 6 months - including during admission?

Does the patient have a 4AT greater than 0 or acute confusion (delirium)?

Does the patient attempt to walk alone although unsteady or unsafe?

Does the patient or their relative/s have fear or anxiety re falling?

Based on your clinical judgement, is this patient at high risk of falls?

Fall Safety Bundles

Review date

4AT New

Questionnaire	Score	Date Updated	Update User

PAIN ASSESSMENT TOOL

Date of pain assessment

Time of pain assessment

Do you have any pain or discomfort Yes

Is this a new pain

How long have you had this pain for

Where is your pain

Does this pain limit your activity

This could be an observation by nursing staff, or a question asked to patient

Do you / the patient have a background of chronic pain

What is your average pain score on a normal day (Pain score, 0-10)

Do you / the patient take any pain relief / analgesia. Do you use any other strategies to alleviate pain e.g., movement, heat, distraction

Do you / the patient take any non prescription medication or drugs e.g., over the counter medications, herbal medication, illicit or recreational drugs

Review date

Lothian Guidance

Pain Score (0-10)
0 None: Continue to assess pain at least daily
1-3 Mild: Continue to assess pain with routine observations, must be at least daily
4-5 Moderate: Assess, administer and review analgesia as appropriate for patient
6-10 Severe: Assess, administer and review analgesia as appropriate for patient

Abbey Pain Scale (0-18)
0-2 No pain
3-7 Mild
8-13 Moderate
14+ Severe

Adult Inpatient Pain Management Website
Abbey Pain Scale

4AT

Date of assessment

Time of assessment

Alertness

AMT4

Age, date of birth, place (name of the hospital or building), current year.

Attention: months of the year backwards

Acute change or fluctuating course

Arising over the last 2 weeks and still evident in last 24hrs.

Last recorded score

4AT SCORE

4 or above: possible delirium +/- cognitive impairment
1-3: possible cognitive impairment
0: delirium or cognitive impairment unlikely (but delirium still possible if [4] information incomplete)

Review date

For Guidance Notes - click here

Please note the 4AT is a screening assessment only, diagnosis should always be based on clinical global impression

Pressure Area Care

Goal

Patient goal

Aim of care

Remove

Aim of care - Patients with pressure damage

Remove

Specific personalised aim

Observation

Observation on assessment

Refresh

Intervention

Intervention

Remove

Intervention - Patients with pressure damage

Remove

Specific personalised interventions

Daily Progress

[Tissue Viability Website]
[Lothian Pressure Ulcer Policy]
[Dry Black Heel Guide]
[Pressure Damage Prevention and Management Pathway] **for patients in Hospital Settings**
Link to [ANTT]

REFERRALto TISSUE VIABILITY SERVICE - Staff to complete the referral form which is on the Tissue Viability website on the intranet. Once completed, email form to tissue.viability@nhslothian.scot.nhs.uk For contact telephone numbers see Tissue Viability service provision document

Link to Prevent Pressure Ulcers Patient Information [leaflet]. Order via PECOS system - (Lot 1452, Panda Print<£2 per 100)
Link to [Adult Skin Care Guidelines]

Write a nursing care plan after discussion with patient and or carer which ensure continuous evaluation using SSKIN bundle elements:
Surface
-Ensure the patient has the correct support surface, which meets their pressure needs, comfort and consent and capacity
-Consider what equipment is required, based on health status, lifestyle abilities, care need and acceptability of proposed equipment to patient and or carer
-Fitted sheets should not be used on a dynamic mattress, use a flat bed sheet instead.
Skin Assessment
-Check for changes in colour, moisture and temperature
-Early inspection means early detection
-Note any longstanding skin conditions such as previous pressure ulcers determined from scarring/patient history
-Evaluate skin regions with any medical devices present e.g splints, masks,venflons, NG tubes, catheter tubes, gastrostomy and anti-embolism stockings, atleast twice a day
Keep Moving
-Assess patients mobility, if assistance to reposition is required then reposition according to risk level and skin assessment using most appropriate moving and handling techniques
-Involve patient in determining repositioning regime
-Use the thirty degree tilt to reposition
-Ensure bed sheets are kept clean, dry and uncreased
Incontinence
-Protect skin, manage continence, see Skin Cleansing Guidelines
-Keep the skin clean and dry
-Keep skin at normal temperature
Nutrition
-Ensure adequate fluids and diet
-Complete the MUST score and if high risk, poor wound healing and / or grade 3 or above pressure damage, refer to Dietetics

Stress and Distress

Not relevant at this time for this patient ☐

Goal

Patient goal

Aim of care

Remove

Specific personalised aim

Observation

Observation on assessment

Refresh

Intervention

Intervention

Remove

Specific personalised interventions

Daily Progress

If Patient is showing signs of distress, please consider use of the Distressed patient pathway

Biological–Pain, Thirst, Hunger, Constipation
- Start a behaviour frequency chart
- Could the patient be in pain? Review analgesia and use pain scale such as Abbey Pain Scale
- Complete 4AT to rule out new delirium
- Does the patient have a new or untreated infection?
- Does the patient need to use the toilet? Check last time patient went to the toilet/had a bowel movement
- Any physical disabilities including visual / auditory deficit?

Psychological–Lonely, scared, low mood, bored, confused, worried, lack of understanding, different routine
- Start a behaviour frequency chart
- Complete a Getting to Know Me
- What matters to me
- Speak to patient's family/loved ones
- Consider meaningful activity (use information from the GTKM to understand what a meaningful activity would look like for each individual patient)
- Could the patient have a new or undiagnosed cognitive impairment? Please consider using MoCA or MMSE
- Could the patient be low in mood?
- Could the patient be scared to take their medication? Consider covert medication pathway

Social –Noisy ward, too bright/dark, disorientated, too hot/cold
- Start a behaviour frequency chart
- What matters to me
- Is there somewhere quieter in the ward the patient can go?
- Can the staff be quieter during interactions?
- Can you write things down for the patient, so they don't have to always ask?
- If signage is poor in the ward, print signs off so patients can orientate themselves e.g.find the toilet
- History of trauma?

Altered State of Cognition

Goal

Patient goal

Aim of care

Remove

Specific personalised aim

Observation

Observation on assessment

4AT New

Icon Profile	Questionnaire	Score	Last recorded score	Date	User

KIS

Key Information Summary

Generate KIS Report

Date Created	Time Created	Path	User Created

Mobility

Goal

Patient goal

Aim of care

Remove

Specific personalised aim

Observation

Observation on assessment

4AT New

Icon Profile	Questionnaire	Score	Last recorded score	Date	User

Falls Assessment New

Icon Profile	Questionnaire	Date	User

Mobility Risk Assessment New

Icon Profile	Questionnaire	Date	User

Rationale for use of Bedrails New

Icon Profile	Questionnaire	Date	User

Pain Assessments Tool (Adults only) New

Icon Profile	Questionnaire	Date	User

Pain Score Observations [Across All Episodes] New

Search

Lothian Guidance
Pain Score (0-10)
0 None: Continue to assess pain at least daily
1-3 Mild: Continue to assess pain with routine observations, must be at least daily
4-5 Moderate: Assess, administer and review analgesia as appropriate for patient
6-10 Severe: Assess, administer and review analgesia as appropriate for patient

Refresh

Intervention

Intervention

Remove

Specific personalised interventions

Daily Progress

Person-Centred Care

Goal

Patient goal

What matters to you

Aim of care

Remove

Specific personalised aim

GUIDANCE

How to start a Person-Centred Care Plan
Care planning is a conversation between the person and the healthcare practitioner about the impact their condition has on their life, and how they can be supported to best meet their health and wellbeing needs in a whole-lifeway. It is part of the nursing process to establish a relationship with the patient and identify details of preferences and /or goals. The care plan is owned by the individual and shared with others with their consent. It is important that when a discussion takes place, there is a record of it, and people know they have a plan.

Goal (Patient)
It is important that if the patient has identified goals for the specific aspect of care that these are documented here in a person-centred way. This section gives you an opportunity to get to understand what is important to your patient.

How do you ask your patient what their goal is?
Think about **"What matters to you"** conversations

1. What's important to you at this moment?
2. What are some of the things you would like to achieve as a result of this support or from being in hospital?
3. When you have a good day, what are the things that make it good?
4. Have you considered the spiritual care needs of your patient? ***(Spiritual care can help a person reconnect with what really matters to them)***
5. Does your patients have beliefs or values which are important / affect them currently? ***A person's beliefs and values may support or challenge them at times of illness and may influence how they think about aspects of their care (e.g., attitude to taking medication, dietary requirements, Bereavement or at End of Life)***

http://intranet.lothian.scot.nhs.uk/Directory/spiritualcare/Documents

For advice & referrals contact the Spiritual Care Team

http://intranet.lothian.scot.nhs.uk/Directory/spiritualcare/Pages

Anything recorded in here must evidence that a person-centred conversation has occurred, and the nurse has understood what matters to the patient with regards to that specific aspect of care

Observation

Observation on assessment

Intervention

Intervention

Remove

Specific personalised interventions

Daily Progress

PERSON-CENTRED CARE PLAN

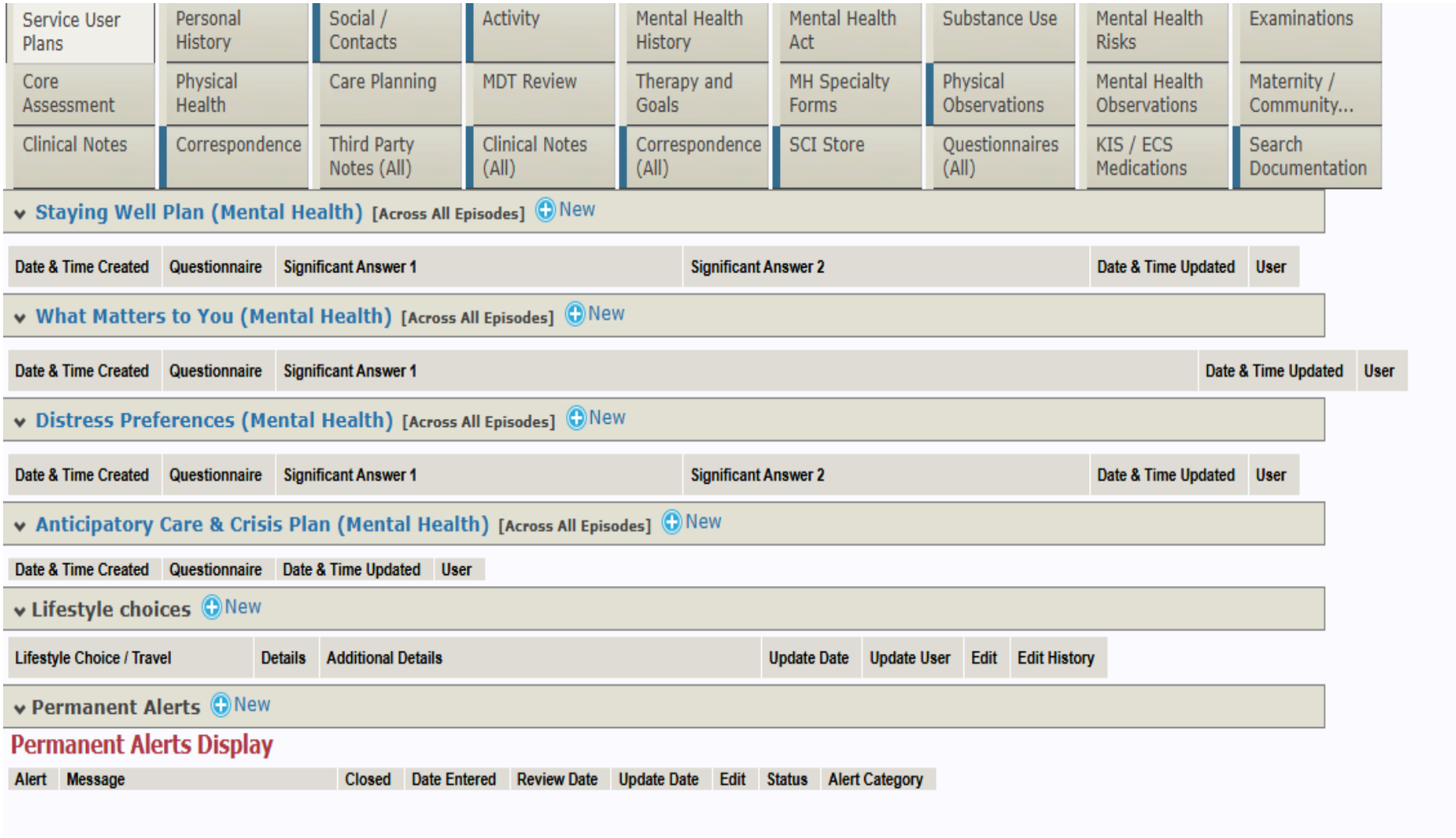
Section: Show All Hide All

- Person-Centred Care
- Deterioration and Escalation
- Pressure Area Care
- Mobility
- Bladder and Bowel Function
- Medicine Management
- Pain Management
- Infection Prevention and Control
- Food, Fluid and Nutrition
- Altered State of Cognition
- Vulnerable Person
- Stress and Distress
- End of Life Care
- Discharge Planning

Care Plan Summary

Tick here to create Care Plan Summary ☐

Reason excluded


Service User Plans
Personal History
Social / Contacts
Activity
Mental Health History
Mental Health Act
Substance Use
Mental Health Risks
Examinations
Core Assessment
Physical Health
Care Planning
MDT Review
Therapy and Goals
MH Specialty Forms
Physical Observations
Mental Health Observations
Maternity / Community...
Clinical Notes
Correspondence
Third Party Notes (All)
Clinical Notes (All)
Correspondence (All)
SCI Store
Questionnaires (All)
KIS / ECS Medications
Search Documentation
Staying Well Plan (Mental Health) [Across All Episodes] New
Date & Time Created
Questionnaire
Significant Answer 1
Significant Answer 2
Date & Time Updated
User
What Matters to You (Mental Health) [Across All Episodes] New
Date & Time Created
Questionnaire
Significant Answer 1
Date & Time Updated
User
Distress Preferences (Mental Health) [Across All Episodes] New
Date & Time Created
Questionnaire
Significant Answer 1
Significant Answer 2
Date & Time Updated
User
Anticipatory Care & Crisis Plan (Mental Health) [Across All Episodes] New
Date & Time Created
Questionnaire
Date & Time Updated
User
Lifestyle choices New
Lifestyle Choice / Travel
Details
Additional Details
Update Date
Update User
Edit
Edit History
Permanent Alerts New
Permanent Alerts Display
Alert
Message
Closed
Date Entered
Review Date
Update Date
Edit
Status
Alert Category

Risk Assessment

Print

Risk Assessment

Mental Health, Intellectual Disabilities and Substance Use

Guidance for staff

Guidance about Risk Assessment

Introduction

Sources of Information

- ☐ Patient
- ☐ TRAK
- ☐ Paper Notes
- ☐ GP
- ☐ Carer
- ☐ Psychiatrist
- ☐ CPN
- ☐ Social Worker
- ☐ OT
- ☐ Psychologist
- ☐ Ward Nurse
- ☐ Third Party
- ☐ Other

If Other, please specify

Other Structured Risk Assessments Available

- List these and say where they are located (e.g. uploaded to SCI Store on date DD/MM/YYYY)

Risk Domains

In the 'Risk' free text areas below, summarise each type of risk. Give dates where possible and indicate if it is still ongoing

Risk to Self

- Include previous acts of self-harm / attempted suicide, altered mood / psychosis, impulsivity, recent change in circumstances

Risk to Others

- Include previous or current acts of violence, especially if linked to altered mood / psychosis

- Previous admissions to secure unit, convictions for violence, threats or allegations to service providers

Risk from Others

- Include past or present indicators of violence or neglect from others, including domestic abuse

Risk to Children

- Consider risks to the service user (if a child), or any children in contact with an adult service user, caused by their mental state or behaviour

- If a child might be at risk of significant harm, then you MUST discuss this with a Consultant or Line Manager

Risks associated with Disability or Medical Issues

- Physical health, cognitive impairment, sensory impairment, neglect or falls risk

Risk of Neglect

- Past periods of neglect, lack of social contacts, difficulty communicating needs

Speciality-specific Risks - Forensic, Perinatal

- Past periods of neglect, lack of social contacts, difficulty communicating needs

Risk Management

In this section, ensure each box contains a SUMMARY of the issues - this is a LIVE plan of the risks now
Do not add dates in this section (dated updates should be added to the relevant domain above)

Service User and Carer view of risk

- Can the Service User or Carer contribute a view of this risk? See the tick-boxes below about their involvement

Risk Overview and Formulation

- What are the main risks? Who are they to? How severe are they?

Triggers / Stressors / Protective Factors

- What might change the risk in the future?

Risk Management Plan (Strategic)

- Summarises the overarching and ongoing risk management plan

Risk Management Plan (Strategic)

- Summarises the overarching and ongoing risk management plan
- What reduces the risk? What protects against the risk?
- If relevant, refer to other Care Plans that address some of the risk identified
- You can use the canned text \|rmp to structure this section

Immediate and Short-Term Management

- Add recent events with dates and short-term plans. This box is NOT included in the printout
- These should be incorporated regularly into the relevant box above
- This MUST be done at admission, discharge, transfer or referral, so that this form remains readable by others who do not know the patient as well
- SPECIFIC INPATIENT RISKS INCLUDING LIGATURES: use the canned text \|iprisk

Say who was involved with developing this plan and if they agree

Service User Involved	☐ Yes	☐ No		
Service User Agrees	☐ Yes	☐ No		
Carer Involved	☐ Yes	☐ No	☐ Not Possible	☐ Not Recommended
Carer Agrees	☐ Yes	☐ No		

For detailed information about how to use this form and do a risk assessment in mental health, see this guidance

Any Other Comments

Core Assessment

Print

CORE ASSESSMENT

Mental Health, Intellectual Disabilities and Substance Use

Guidance for Staff

Presentation

Why are you seeing the person today and how are they?

Reason for attending / referral

Review and edit the Mental Health charts. It is recommended to click through them all in order
As a minimum, review and / or edit these charts and tick to confirm

	Reviewed	Edited
Service User Plans (includes Staying Well Plan, What Matters to You)	☐	☐
Risk Assessment (add risks to this and not only in your notes below)	☐	☐
Mental Health Act (read only list of active detentions)	☐	

Current Situation

What led up to the attendance? What is the history of the presentation condition?
If wished you can use the canned text |mhca here
When clerking in hospital admissions you should use |mhclerking here

Format Font Size

MENTAL STATE EXAMINATION

Record the current mental state examination (or equivalent)- the date is stored automatically
View a chronology of past entries under the 'Mental State Examination' tab

Guidance for Staff

Clinician undertaking examination

Episode Specialty

Setting ☐ Inpatient ☐ Unscheduled Care ☐ Scheduled Care

Mental State Examination

APPEARANCE & BEHAVIOUR

SPEECH

MOOD & AFFECT

THOUGHT FORM & CONTENT

ABNORMAL PERCEPTIONS

COGNITIVE FUNCTIONING

INSIGHT

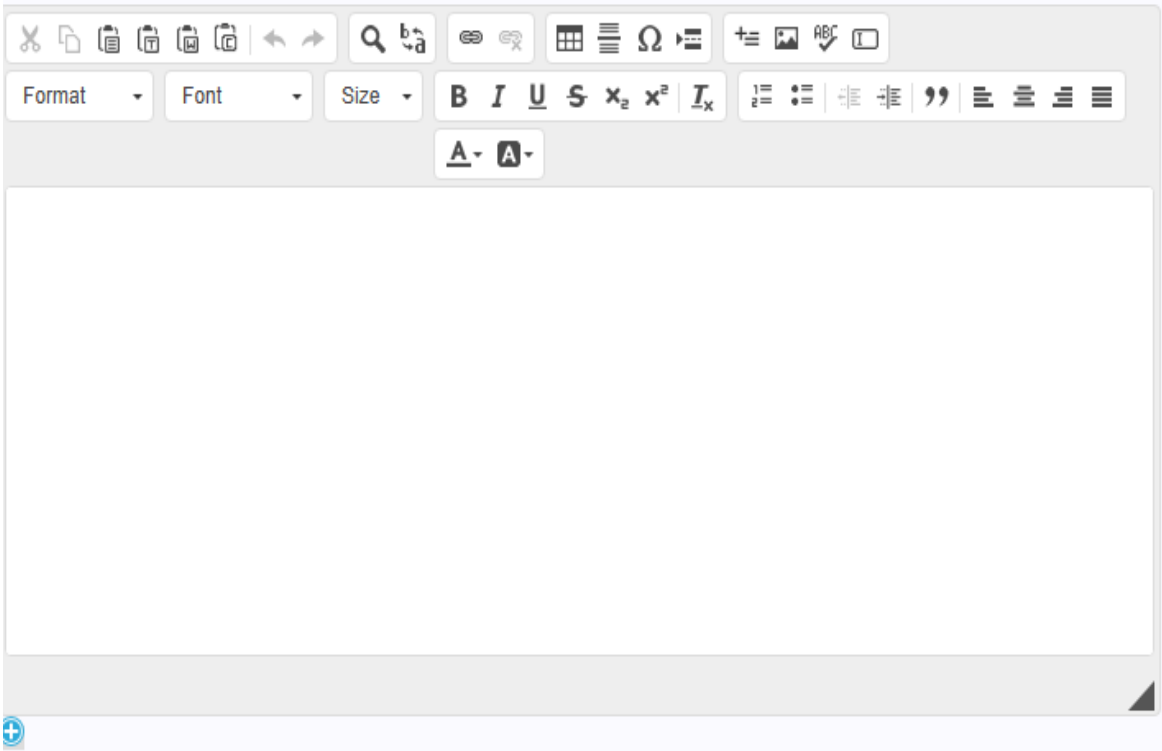
Create Clinical Note ☐

Examinations

>> See previous Mental State Examination entries under "Examinations"
>> See previous Physical Examination entries under "Examinations"
Update both as needed - these can be included into an export below

Plan

Actions to be undertaken, who by and by when
When clerking in hospital admissions you should use |mhclerkingplan here



Export to Clinical Notes and Correspondence

- [ ] Export to Correspondence
- [ ] Export to a Clinical Note
- [ ] Export Plan ONLY to a Clinical Note
- [ ] Export (with MSE) to Correspondence
- [ ] Export (with MSE and Phys Exam) to Correspondence

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,		

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

Contents

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?