

THE STATE HOSPITALS BOARD FOR SCOTLAND

CLINICAL CARE POLICY

(This is an entirely new policy and replaces all observation practice documentation used within The State Hospital)

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	Clinical Quality Department	
	Clinical Care Policy Short Life Working Group	
Advisory Group	Patient Safety Group	
Approval Group	Policy Approval Group	
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Accountable Executive Director	Director of Nursing and Operations	

The date for review detailed on the front of all State Hospital policies / procedures / guidance does not mean that the document becomes invalid from this date. The review date is advisory and the organisation reserves the right to review a policy/procedure/guidance at any time due to organisational/legal changes.

Staff are advised to always check that they are using the correct version of any policy / procedure / guidance rather than referring to locally held copies.

The most up to date version of all State Hospital policies/procedures/guidance can be found on the intranet: <http://intranet.tsh.scot.nhs.uk/Policies/Policy%20Docs/Forms/Category%20View.aspx>

CONTENTS

1	INTRODUCTION AND BACKGROUND.....	3
2	PURPOSE	3
3	AIMS.....	3
4	SCOPE	3
5	OVERARCHING PRINCIPLES	4
6	DEFINITIONS AND DESCRIPTIONS OF CARE	4
7	PROCEDURE.....	6
8	RECORD KEEPING	7
9	REVIEWS.....	7
10	STAFF RESOURCES	8
11	DUTIES AND RESPONSIBILITIES	8
12	RECORDS	10
13	RAISING CONCERNS	10
14	COMMUNICATION, IMPLEMENTATION, MONITORING AND REVIEW OF POLICY	10
15	EQUALITY AND DIVERSITY	11
16	STAKEHOLDER ENGAGEMENT	11
17	REFERENCES.....	11
	APPENDIX 1: PATIENT SAFETY PLAN.....	13
	APPENDIX 2: BEDROOM VISUAL CHECK RECORDING SHEET	14
	APPENDIX 3: ENHANCED CARE PLAN.....	17
	APPENDIX 4: WHAT MATTERS TO ME PLAN	18
	APPENDIX 5: CLINICAL PAUSE DOCUMENTATION.....	19
	APPENDIX 6: CLINICAL CARE FLOWCHART.....	20

1 INTRODUCTION AND BACKGROUND

In 2015 the Scottish Government committed to the development of new observation guidance in response to concerns about the effectiveness of existing policies and practices used within mental health services. These concerns had arisen following an increase in the number of recorded self-harm and suicide incidents by patients who were being cared for using either general or increased levels of observation. Similarly, this same issue was highlighted by the Mental Welfare Commission (MWC) after a series of unannounced visits to patients across Scotland identified concerns for those who were being cared for using increased levels of observations (Mental Welfare Commission, 2015).

With support from a number of NHS test sites, Healthcare Improvement Scotland began to consider and develop new ways of working with respect to observation practices in mental health care. This work resulted in the publication "[From Observation to Intervention: A proactive, responsive and personalised care and treatment framework for acutely unwell people in mental health care](#)". From Observation to Intervention (IOP) is underpinned by a number of guiding principles that support a multidisciplinary approach to person centred, least restrictive, care that is delivered by a trauma-informed workforce and involves the patient and their families wherever possible. The guidance also outlines the need to move away from the use of historical language (i.e. general, close, and constant observation) used to describe observation practices, replacing these terms with two broad approaches towards care. In The State Hospital (TSH) we will refer to these approaches as **General Care** and **Enhanced Care**.

2 PURPOSE

This policy is intended to provide a framework for person-centred, least-restrictive care that is responsive to patient need and not dictated by observation status. The policy supports and promotes a culture where decisions about a patient's care are based on best available evidence and effective multidisciplinary working.

3 AIMS

This policy aims to:

- Ensure that every patient in TSH receives the appropriate level of personalised care, treatment and safety planning relevant to their mental health and/or risk needs at any given time.
- Ensure there is a focussed effort from the multidisciplinary team (MDT) to support the early recognition of, and response to, any deterioration in the mental health and/or increase in risk of a patient under their care.
- Ensure there is a focussed effort from the MDT to support patients to return to general care following a period of Enhanced Care.
- Set out the expectation of all staff who are involved in the delivery of patient care and safety planning using the IOP framework.
- Ensure there are evidence-based processes and procedures in place for requesting and making changes to a patient's care.
- Ensure there are procedures in place for recording and monitoring these changes to care.
- Set out the expectations on staff to involve patients and carers in decisions about their care, ensuring they also have access to independent advocacy if they wish.
- Ensure that all members of staff involved with the patient's care have the autonomy to request a review of the patients Clinical Care.

4 SCOPE

This policy applies to all staff who contribute to the delivery of direct patient care within TSH. The policy only applies to the mental health care and risk management of patients. It does not cover

the management of physical health disorders. Any issues pertaining to physical health should be addressed in nursing care plans and reviewed through the weekly Multidisciplinary Team (MDT) meetings and six-monthly Care Programme Approach (CPA) process.

5 OVERARCHING PRINCIPLES

All care and treatment in TSH must be consistent with the principles of relevant legislation, including the Mental Health (Care and Treatment) (Scotland) Act 2003 and the Adults with Incapacity (Scotland) Act 2000. These principles include (but are not limited to) participation of patients in care planning, respect for the views of carers, benefit to patients, least restrictive practices and reciprocity. Efforts should always be made to involve patients in decisions about their care and consideration given to the format in which information is shared in order to maximise this involvement (e.g. adaptations to reading materials; information provided in picture format; use of talking mats etc.). The principles and procedures set out in this policy apply to patients at all stages of their journey in TSH. A least restrictive approach should always be adopted across all clinical service areas and any changes to care should be evidence-based. Thresholds for implementing risk management strategies may vary between services however the practices that each service puts in place must be proportionate to the risk posed by the patient at that time.

6 DEFINITIONS AND DESCRIPTIONS OF CARE

6.1 General Care

At any one time, the majority of patients in TSH will be receiving care using this approach. Patients who are displaying no significant mental health and/or risk concerns should be cared for on General Care. It is recognised that all patients have different needs and will require individualised, person-centred, responses to care and risk management. These needs should be regularly monitored and reviewed by the MDT. Within General Care MDTs have discretion to adapt or adjust their approaches to meet those needs accordingly.

Visual Checks

Day Areas

As a minimum, checks of the patient's whereabouts should be undertaken and recorded in line with the timescales identified on Daily Patient Checklist (which can be found within the security folder of each ward). Patients who are on grounds access will be monitored as per CCTV systems.

Bedroom

Visual checks of patients on General Care, who are spending time in their bedroom, should be undertaken at least once in every 60 minute period (daytime and overnight). This is to ensure that the patient's safety and welfare is regularly reviewed.

6.2 General Care with Patient Safety Plan (PSP)

There may be occasions when a patient's care needs to alter in response to increasing risk management concerns which might, or might not, be connected to their mental health. Where the risk is deemed to be imminent and/or significant then the patient should be cared for using an Enhanced Care Approach. However, where the risk is not considered to be imminent and/or significant then patients should still be cared for using a General Care approach but with the addition of a Patient Safety Plan (Appendix 1). The PSP must clearly outline the specific identified concerns and risk management approaches that will be put in place to support a least restrictive approach to care.

The Patient Safety Plan will most likely be initiated by nursing staff in response to perceived risk(s) but should be further developed collaboratively by all members of the MDT at the first available opportunity based on all available clinical and risk assessment information.

Concerns about a patient's presentation should always be discussed with the patient and efforts made to include their views and wishes in any changes to their care, where possible. The PSP can be found in the MDT folder of the patient's RiO notes.

Visual Checks

Day Areas

As a minimum, checks of the patient's whereabouts should be undertaken and recorded in line with the timescales identified on Daily Patient Checklist (which can be found within the security folder of each ward). Patients who are on grounds access will be monitored as per CCTV systems.

Bedroom Areas

Patients who require a Patient Safety Plan should be observed within their bedrooms, as a minimum, every 15 minutes. This should be recorded on the Bedroom Visual Check Recording Sheet (Appendix 2).

6.3 Enhanced Care

There are occasions when patients present an imminent and/or significant risk of harm either to themselves and/or others. In these instances, patients should be cared for using an Enhanced Care approach. The purpose of Enhanced Care is to manage acute periods of risk and to provide the patient with therapeutic support. **Patients who are placed on Enhanced Care will require support from staff who are immediately available and therefore members of staff will need to be with the patient continuously in order to manage the risk(s) that they present.**

Dependent on the nature and level of risk posed supporting staff should either be within close proximity (i.e. able to intervene quickly to prevent the patient either harming themselves and/or others) or within arm's reach of the patient. This tailored approach should be documented in the patient's Enhanced Care Plan (See also Section 6.4).

It is expected that all members of the MDT will provide regular input and support to patients who require periods of Enhanced Care in order to enable a return to General Care (with or without a Patient Safety Plan).

Patients should be cared for using an Enhanced Care approach for the shortest time possible.

Day Areas and Bedroom

Patients on Enhanced Care should be observed at all times. Such observation can be within close proximity or within arm's reach, dependent on risk. This tailored approach should be documented in the patient's ECP.

It may be appropriate for patients to required periods of Enhanced Care in certain circumstances (e.g. Enhanced Care when out with their bedroom but not when they are in their bedroom or vice versa).

6.4 Enhanced Care Plan (ECP)

An ECP is a support plan that sets out the therapeutic interventions each member of the MDT will provide in order to help support a patient, with the aim of improving their mental wellbeing and/or reducing risk (Appendix 3). The ECP outlines the specific therapeutic interventions and risk management approaches required to deliver day-to-day care as safely as possible. ECPs will initially be drafted by nursing staff however MDT members will have a key role in their ongoing development and review. ECPs should be informed by all available clinical and risk assessment information. In order to facilitate this a Clinical Pause meeting should be arranged at the earliest opportunity where MDT members can discuss their input into the ECP. A copy of the ECP can be found within the MDT folder in RiO (Electronic Patient Record system).

All clinical and environmental risks should be incorporated into the Enhanced Care plan, where possible drawing, from the patients risk assessment and formulation. Consideration should also be given to the patient's "What Matters to Me" Plan (see below) when devising an ECP.

6.5 What Matters to Me Plan

Every patient is invited to complete a “What Matters to Me Plan” (Appendix 4) as part of their care and treatment in TSH. The “What Matters to Me” plan provides the patient with an opportunity to outline what and who is important to them at any given time in their care journey. The document can be completed by the patient on their own, with support from their keyworker or another member of the MDT, or with the support of Independent Advocacy. When completed the keyworker will populate the What Matters to Me Plan in the MDT section of RiO and any paper copies with handwritten notes should be signed by the patient and then scanned into RiO by hub secretaries. All members of the MDT should be familiar with this document and ensure that it is used to inform care planning. The “What Matters to Me” Plan is intended to provide a holistic view of what is important to a patient and sits alongside the Advanced Statement, if the patient has one. This plan will be reviewed and updated, as a minimum, at the patient’s Intermediate and Annual CPA review. Updates can either be completed within the meeting or afterwards by the patient’s keyworker. Similar to an Advanced Statement, the “What Matters to Me” Plan would not negate a patient moving onto Enhanced Care if the perceived risk deemed this necessary.

6.6 Clinical Pause

A Clinical Pause is an opportunity for the MDT to share and talk through specific clinical or risk concerns they have about a patient. The Clinical Pause focuses on MDT care planning for patients who pose increased levels of risk either to themselves, others, or the organisation. Clinical Pause meetings are designed to be responsive, flexible, processes that support collaborative decision making. The meetings make use of everyone’s knowledge of the patient, their formulation and risk assessment. The Clinical Pause documentation (Appendix 5) sets out the structure of Clinical Pause meetings. Clinical Pause documentation can be found within the MDT folder in RiO.

7 PROCEDURE

Any member of staff can raise their concerns about a patient's mental health and/or risk. These concerns should initially be discussed with the Nurse in Charge and/or Senior Charge Nurse (SCN) for that area and then subsequent discussion with the patient’s Responsible Medical Officer (RMO)/on call RMO, and the duty Clinical Security Liaison Manager (CSLM), if required. Where it is safe to do so concerns about a patient’s presentation should always be discussed with the patient and efforts made to include their views and wishes in any changes to their care.

The following procedures apply to patients at all stages of their journey in TSH. Thresholds for implementing these procedures may vary between services however the risk management practices that each service puts in place must be proportionate to the risk posed by the patient at that time. Discussions about risk management strategies and subsequent care decisions should also be informed by the Clinical Guidance specific to that service. Consideration should also be given to input from Independent Advocacy to support the patient during this process.

To manage any concerns about increasing risk, the following options should be considered:

- 1) Is there a need for the introduction of a Patient Safety Plan or;
- 2) Is there a need for Enhanced Care?

If there are concerns that a patient poses a significant risk to either themselves, others or the wider organisation then an ECP should be introduced immediately and a Clinical Pause arranged at the first available opportunity. Additional staffing should also be discussed by the Nurse in Charge with the SCN for that area or SCC in their absence.

Patient who are experiencing periods of Enhanced Care should expect input from all members of the multidisciplinary team and planned interventions should take cognisance of the patient’s formulation and risk assessment needs. The patient should experience periods of Enhanced Care

as a continuum of their care and treatment not a standalone “observation” task. Periods of Enhanced Care should be purposeful and for as brief a period as necessary.

Appropriate carer(s) or Named Person(s) should be informed of any use of Enhanced Care by the Nurse in Charge at the earliest opportunity (N.B. this task can be delegated if appropriate). The patient’s consent is required prior to advising the patient’s carer/ Named Person. This consent should be recorded within the ECP along with any points of note or relevant information. Where a patient lacks capacity to consent to sharing information with a carer/Named Person then advice from the RMO (covering RMO) should be sought at the earliest opportunity. A note of the discussion should be made within the patient’s ECP.

8 RECORD KEEPING

Concerns about changes in a patient’s presentation should always be discussed with the patient and efforts made to seek their views and wishes about any proposed changes to care, where possible. Input from the Independent Advocacy service can support this process. These initial discussions should be recorded in the patient’s progress notes and any relevant associated documentation. Thereafter, any review or changes to care should be recorded using the relevant documents found in the MDT folder of RiO.

9 REVIEWS

9.1 Clinical Pause

At the initial Clinical Pause meeting a date for review of follow-up Clinical Pause meetings should be agreed, with the inclusion of Independent Advocacy if appropriate. A note of any further meetings should be recorded within the Clinical Pause paperwork.

9.2 Patient Safety Plan

The Patient Safety Plan should be discussed and reviewed at the weekly Clinical Team Meeting (CTM).

9.3 Enhanced Care Plan

On initiation of Enhanced Care the RMO/on-call RMO should be informed along with the Senior Charge Nurse for that area (or SCC in their absence). This can be done by either the Nurse in Charge or another member of nursing staff who is on duty within the clinical area.

A review of the ECP should take place daily by the Nurse in Charge and the RMO/on-call RMO for the first seven days. At least two of these reviews should be conducted in person. Additional reviews can be conducted by telephone. A note of all reviews should be recorded by the Nurse in Charge within the ECP, which can be found in the MDT folder on RiO.

After the first seven days all reviews of the ECP and progress towards a return to General Care with a PSP/General Care should be undertaken at the weekly CTM however updates by those involved in the patient’s care should continue to be recorded in the ECP. On transfer to General Care with a PSP/General Care the Nurse in Charge should close off the ECP.

Any alteration to the Enhanced Care Plan should be discussed and agreed with the RMO/on-call RMO with a review taking place at the discretion of the RMO/on-call RMO.

In line with the least restrictive principle, any member of the multidisciplinary team can request a meeting to discuss a return to General Care with PSP/General Care. The final decision to end Enhanced Care rests with the RMO/on-call RMO. The decision should evolve from a careful assessment of the available evidence. **The relevant RMO/on-call RMO must interview the patient prior to the ending of Enhanced Care.** The general expectation would be that such reviews would not require to take place out of hours as any decision to end Enhanced Care

requires careful multidisciplinary consideration. This interview must be recorded within the ECP on RiO.

9.4 Independent Review

Should a patient remain on Enhanced Care for a period of greater than 28 days then the RMO will request an independent review from the Associate Medical Director (or nominated deputy), who will be responsible for arranging the review through a Clinical Service Lead. A Clinical Service Lead and Lead Nurse (or Deputy) will review the patient and provide feedback to the patient's RMO and Associate Medical Director within 7 days. The outcome of the Independent Review, including the patient's views should be documented within the ECP plan.

In the case where there is a difference of opinion this should be discussed with the Associate Medical Director in the first instance. The outcome of any reviews should be shared with the patient. This process can be supported by Independent Advocacy. Thereafter if the patient remains on Enhanced Care after 6 months then a further Independent Review as described above will take place. Subsequently independent reviews will take place every 6 months. Again, the process as described above will be used to arrange said reviews.

As a matter of good practice the RMO will inform The Mental Welfare Commission (MWC) of any patients who have been on Enhanced Care for a period of three months. This will be discussed as part of the pre-visit meetings that are undertaken between TSH and the MWC.

10 STAFF RESOURCES

Clinical or risk management concerns that raise the need for additional staffing should be discussed by the Nurse in Charge and SCN for that area (or SCC in their absence). The Duty CSLM should also be made aware of the requirement for an ECP if there are considered risks to the safety and security of others, or to the organisation. The requirement for additional staffing should be supported by the use of risk assessment tools (e.g. DASA, HCR-20, RSVP, DRAMS) and evidence for any decisions should be documented in the associated ECP paperwork.

Any review of associated staffing resources will thereafter be discussed with either the SCN for that area or SCC. Each review and/or any changes to the ECP, and the reasons for these changes, should be documented in the ECP by the Nurse in Charge. Under no circumstances should a patient whose clinical risk management requires additional staffing have these removed for resourcing reasons.

11 DUTIES AND RESPONSIBILITIES

Staff member supporting Patient on Enhanced Care will:

- Be responsible for familiarising themselves with the content of the ECP
- Be responsible for therapeutically engaging with the patient they are supporting and encouraging any helpful strategies that promote a return to General Care with a PSP/General Care
- Share any observations, information, or concerns about a patient's presentation or the content of their ECP plan with the patient (if clinically appropriate to do so) and the Nurse in Charge
- (outwith exceptional circumstances) rotate on a regular basis, (no longer than 1 hour where possible but should not exceed 2 hours) to minimise fatigue and increase assessment objectivity
- Not undertake any other duties whilst supporting a patient on an ECP

Nurse in Charge will:

- Have responsibility for highlighting with all relevant personnel any clinical concerns and discussing the requirement for changes to a patient's care (i.e. a move away from General Care)
- Discuss any requirements for additional staffing with either the SCN for that area or SCC, making sure the requirements for additional staffing are evidence-based
- Ensure that the introduction of any ECP/PSP is discussed with the patient where possible
- Ensure that the Carer/Named Person is aware of changes to the patient's care, providing consent has been given by the patient for contact to be made and a record of this has been made in the ECP/PSP.
- Ensure that the care outlined in the ECP/PSP is being delivered through regular monitoring and review.
- Ensure that those undertaking the role of supporting an ECP are not assigned to any other duties
- Ensure that the patient is provided with a copy of their ECP/PSP, if clinically appropriate to do so, or as a minimum an attempt made to discuss it with the patient, making a note of this in the relevant documentation
- Ensure that any member of staff supporting a patient with an ECP/PSP is aware of their responsibilities and has the necessary support and information to carry out their role safely and effectively
- Ensure that all staff with the patient, other than exceptional circumstances, are rotated on a regular basis, (no longer than 1 hour where possible but should not exceed 2 hours) to minimise fatigue and increase assessment objectivity

Senior Charge Nurse (or SCC) will:

- Have responsibility for ensuring that every member of staff in their area is aware of the Clinical Care Policy and has the necessary knowledge, information, training and support to carry out their role, both safely and effectively
- Have responsibility for ensuring that every member of staff in their area know how and where to raise any clinical concerns about any aspect of patient's care
- Have oversight and input into ECPs and the subsequent review of these plans, for any patient within their area
- Monitor and review any associated staffing concerns in line with the Clinical Care Policy

Multidisciplinary Team Members will:

- Be responsible for ensuring that the ethos of the Clinical Care Policy is central to the treatment of patients in their care
- Ensure that they are fully briefed in relation to the requirement of an ECP/PSP, the contents within these plans, and their responsibilities attached to plans
- Ensure that they record their contribution to the ECP
- Ensure that they provide weekly updates to the MDT for each of the weekly CTMs

Lead Nurse will:

- Ensure safe and effective staffing to meet Enhanced Care needs, including maintaining an oversight of any additional training requirements of staff in relation to the Clinical Care Policy
- Support the SCN's as and when necessary in the monitoring and timeous review of ECPs, and any associated staffing
- Ensure any audit activity associated with the Clinical Care Policy is completed
- Carry out an independent review at the request of the Associate Medical Director/Nominated Deputy if a patient remains on an ECP for a period of greater than 28 days

RMO/on-call RMO will:

- Contribute to, and review, ECPs/PSPs using the processes and procedures highlighted in this policy

- Support relevant medical staff involved in caring for patients who require either a PSP or ECP to be put in place
- Conduct any required Enhanced Care reviews
- Request an independent review from the Associate Medical Director for any patients under their care who are on an ECP for a period greater than 28 days
- Inform the Mental Welfare Commission, as part of their six-monthly visits to The State Hospital, of any patients who have been on Enhanced Care for a period of greater than 3 months.

Medical/Associate Medical Director will:

- Ensure relevant medical staff are equipped with the necessary knowledge of the Clinical Care Policy and associated paperwork
- Ensure relevant medical staff are equipped with the appropriate experience, supervision and skills to adhere to the overarching principles and procedures set out in this policy
- Arrange for an independent review to be undertaken by a Clinical Service Lead and a Lead Nurse if a patient remains on Enhanced Care for a period of greater than 28 days

Director of Nursing and Operations will:

- Have overall responsibility for policy development, implementation, governance, and monitoring.

Nursing Practice Development will:

- Support the implementation of this policy through induction, awareness training, and support for all clinical staff who have direct patient care.

Clinical Quality Department will:

- Ensure all Enhanced Care Plans are audited by the Clinical Quality Department to provide assurance to the organisation that process is being adhered to.

Please see Appendix 6 for Clinical Care Flowchart.

12 RECORDS

All decisions and reviews relating to a patient's care, or changes to that care, should be documented using the appropriate documentation on RiO by the relevant parties.

13 RAISING CONCERNS

Any member of staff can raise concerns about a patient or their care. These concerns can be raised via the Nurse in Charge, SCC, the patient's RMO, or any member of the MDT. All members of the MDT have a professional and legal responsibility for the care and treatment of patients in their care.

14 COMMUNICATION, IMPLEMENTATION, MONITORING AND REVIEW OF POLICY

This policy will be communicated to all stakeholders within TSH via the intranet and through the staff bulletin. If required the Person Centred Improvement Service will facilitate communication with Patients.

The Patient Safety Group will be responsible for the implementation and monitoring of this policy. Any deviation from policy should be notified directly to the policy Lead Author. The Lead Author will be responsible for notifying the Advisory Group of the occurrence.

This policy will be continuously reviewed for the first twelve months following implementation.

15 EQUALITY AND DIVERSITY

The State Hospitals Board (The Board) is committed to valuing and supporting equality and diversity, ensuring patients, carers, volunteers and staff are treated with dignity and respect. Policy development incorporates consideration of the needs of all Protected Characteristic groups in relation to inclusivity, accessibility, equity of impact and attention to practice which may unintentionally cause prejudice and / or discrimination.

The Board recognises the need to ensure all stakeholders are supported to understand information about how services are delivered. Based on what is proportionate and reasonable, we can provide information/documents in alternative formats and are happy to discuss individual needs in this respect. If information is required in an alternative format, please contact the Person-Centred Improvement Lead on 01555 842072.

Line Managers are responsible for ensuring that staff can undertake their role, adhering to policies and procedures. Specialist advice is available to managers to ensure that reasonable adjustments are in place to enable staff to understand and comply with policies and procedures. The EQIA considers the Protected Characteristic groups and highlights any potential inequalities in relation to the content of this policy.

Patient pre-admission assessment processes and ongoing review of individual care and treatment plans support a tailored approach to meeting the needs of patients who experience barriers to communication (e.g. Dementia, Autism, Intellectual Disability, sensory impairment). Rapid access to interpretation / translation services enables an inclusive approach to engage patients for whom English is not their first language. Admission processes include assessment of physical disability with access to local services to support implementation of reasonable adjustments. Patients are encouraged to disclose their faith / religion / beliefs, highlighting any adapted practice required to support individual need in this respect. The EQIA considers the Protected Characteristic groups and highlights any potential inequalities in relation to the content of this policy.

Carers / Named Persons are encouraged to highlight any barriers to communication, physical disability or anything else which would prevent them from being meaningfully involved in the patient's care (where the patient has consented) and / or other aspects of the work of the Hospital relevant to their role. The EQIA considers the Protected Characteristic groups and highlights any potential inequalities in relation to the content of this policy".

16 STAKEHOLDER ENGAGEMENT

Key Stakeholders	Consulted (Y/N)
Patients	Y
Staff	Y
The Board	N
Carers	N
Volunteers	N

17 REFERENCES

- Health Improvement Scotland. (2019). *From Observation to Intervention: A proactive, responsive and personalised care and treatment framework for acutely unwell people in mental health care*. Edinburgh: Health Improvement Scotland: <https://ihub.scot/media/5508/spsp-iop-from-observation-to-intervention.pdf>.
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<https://www.nationalpreventivemechanism.org.uk/publications-resources>.
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<https://www.legislation.gov.uk/asp/2003/13/contents>.
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<https://www.gov.scot/publications/mental-health-strategy-2017-2027>.
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APPENDIX 1: PATIENT SAFETY PLAN

Patient Safety Plan

Client Ms L. Muffet

Date and Time of **Patient Safety Plan** Commencing

[Hyperlink to Care Plans Formulation](#)
[Initial Admission Risk Assessment](#)

Reason for Commencement

Notification

Agreed by Nurse in Charge Yes No Nurse in Charge Name

Agreed with SCC/SCN Yes No SCC/SCN Name

Agreed with RMO/On-Call RMO Yes No RMO/Duty RMO Name

Risk Considerations

Personal Care (e.g access to razor)

Fluids and Nutrition (e.g dining alone / plastic cutlery)

Telephone / Visits / Correspondence (e.g any known triggers to be aware of)

Activity (e.g escorted by staff member who knows them / escorted by male staff)

Personal Time in Room (e.g time in room supports mental health and can minimise distress)

Spiritual Needs (e.g how to safely support someone to meet their spiritual needs)

Suspension of Detention (e.g specific skill / gender mix)

Medication (e.g secretion of medication)

Sensory Issues (e.g sensitive to noise)

What are we Working Towards

Any Other Considerations (e.g to be linked to risk assessment and formulation)

Named Person/Carer Notification

Was the patient involved in development of the **Patient Safety Plan**? Yes No

Has the patient given consent to contact Named Person/Carer to discuss proposed changes to care? Yes No

Has the Named Person/Carer been informed of the proposed changes to care? Yes No

Weekly Clinical Team Review

Patient Safety Plan should be reviewed weekly as a minimum at the Clinical Team. This can be reviewed out with this time frame and the patient transitioned to general care following discussion by the RMO and the Nurse in Charge.

Nurse in Charge/RMO	Review of Patient Safety Plan	Review Date	Action
Please Select <input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="button" value="Add"/>

End of Patient Safety Plan

Date and Time of Ending

Reason for Ending (e.g. return to care as normal)

Nurse in Charge Close Record

The Close Record tick box should only be checked once all information has been entered correctly AND the **Patient Safety Plan** has ended. Please be aware that once this has been selected no further edits can be made to this form but it will still be available to view as Read Only.

Close Record?

APPENDIX 2: BEDROOM VISUAL CHECK RECORDING SHEET

Key: Enter a brief description of what you observe patient doing along with your signature

Appears Asleep	Lying on front (A1)	Lying on back (A2)	Lying on left side (A3)	Lying on right side (A4)			
Awake	Sitting on bed watching TV (B)	Lying on bed watching TV (C)	Pacing room (D)	Reading (E)	Listening to music (F)	Laying on bed (G)	Other (H) (Provide brief description)

Patient Name	0700-0715	0715-0730	0730-0745	0745-0800	0800-0845	0845-0900	0900-0915	0915-0930
Staff Signature:								

Patient Name	0930-0945	0945-1000	1000-1015	1015-1030	1030-1045	1045-100	1100-1115	1115-1130
Staff Signature:								

Patient Name	1130-1145	1145-1200	1200-1215	1215-1230	1230-1300	1300-1315	1315-1330	1330-1345
Staff Signature:								

Patient Name	1345-1400	1400-1415	1415-1430	1430-1445	1445-1500	1500-1515	1515-1530	1530-1545
Staff Signature:								

Patient Name	1545-1600	1600-1615	1615-1630	1630-1645	1645-1700	1700-1715	1715-1730-	1730-1745
Staff Signature:								

Patient Name	1745-1730	1730-1745	1745-1800	1800-1815	1815-1830	1830-1845	1845-1900	1900-1915
Staff Signature:								

Patient Name	1915-1930	1930-1945	1945-2000	2000-2015	2015-2030	2030-2045	2045-2100	2100-2115
Staff Signature								

Patient Name	2115-2130	2130-2145	2145-2200	2200-2215	2215-2230	2230-2245	2245-2300	2315-2330
Staff Signature								

Patient Name	2330-2345	2345-0000	0000-0015	0015-0030	0030-0045	0045-0100	0100-0115	0115-0130
Staff Signature								

Patient Name	0130-0145	0145-0200	0200-0215	0215-0230	0230-0245	0245-0300	0300-0315	0315-0330
Staff Signature								

Patient Name	0330-0345	0345-0400	0400-0415	0415-0430	0430-0445	0445-0500	0500-0515	0515-0530
Staff Signature								

Patient Name	0530-0545	0545-0600	0600-0615	0615-0630	0630-0645	0645-0700
Staff Signature						

APPENDIX 3: ENHANCED CARE PLAN

Enhanced Care Plan

Client: Ms. L. Muffot

Date/line of ECP Commencing:

Reason for ECP Commencing:

Section 1: Notifications and Staffing Resources

Discussed/Agreed by Nurse In Charge: Yes No Nurse In Charge Name:

Discussed/Agreed with SCC/SCN: Yes No SCC/SCN Name:

Discussed/Agreed with RMO/On-Call RMO: Yes No RMO/Duty RMO Name:

Patient will require additional support from staff

Ward Area: Yes No Staffing Resources:

Other (e.g. Hub, Skye Centre, Grounds, S.O.D.): Yes No Staffing Resources:

Bedroom Area: Yes No Staffing Resources:

Section 2: Risk Considerations

Personal Care (e.g access to razor)

Fluids and Nutrition (e.g dining alone / plastic cutlery)

Telephone / Visits / Correspondence (e.g any known triggers to be aware of)

Activity (e.g escorted by staff member who knows them / escorted by male staff)

Personal Time in Room (e.g time in room supports mental health and can minimise distress)

Spiritual Needs (e.g how to safely support someone to meet their spiritual needs)

Suspension of Detention (e.g specific skill / gender mix)

Medication (e.g secretion of medication)

Sensory Issues (e.g sensitive to noise)

Any Other Considerations (e.g to be linked to risk assessment and formulation)

[Initial Admission Risk Assessment Formulation](#)

Section 3: Interventions

Please detail each individual intervention in the below table, and click ADD button when completed.

To add Date Completed to an existing intervention, insert the date and then save the form.

Responsible Person	Specific Intervention	Date Completed	Action
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="button" value="Add"/>

What are we Working Towards

Section 4: Enhanced Care Intervention Updates

Please detail each individual intervention update in the below table, and click ADD button when completed.

To add Date of Update to an existing intervention update, insert the date and then save the form.

Responsible Person	Intervention Update	Date of Update	Action
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="button" value="Add"/>

Section 5: Daily review for first seven days

Please detail each individual review in the below table, and click ADD button when completed.

To add Review Date to an existing Review, insert the date and then save the form.

Nurse In Charge	Review of requirement for enhanced care	Review Date	Action
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="button" value="Add"/>

RMO/RMO On Call	Review of requirement for enhanced care	Review Date	Action
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="button" value="Add"/>

Section 6: After first seven days, weekly review by the clinical team.

Nurse In Charge/RMO	Review of Enhanced Care Plan	Review Date	Action
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="button" value="Add"/>

Requirement for Independent Review (After 28 Days)? Yes No

Section 7: Named Person/Carer Notification

Was the patient involved in development of the ECP? Yes No

Has the patient given consent to contact Named Person/Carer to discuss proposed changes to care? Yes No

Has the Nearest Named Person/Carer been informed of the proposed changes to care? Yes No

Section 8: Decision to return to general care or general care with patient safety plan.

RMO/RMO On-Call:

Nurse In Charge:

Date transitioned to general care with patient safety plan:

Date transitioned to general care:

Section 9: Nurse in Charge Close Record


Once all relevant information has been entered, please select the 'Close Record' box below. Please note, once this box has been selected the form will become 'Read Only' and no further edits will be possible.

Close Record?

APPENDIX 4: WHAT MATTERS TO ME PLAN

What Matters To Me

Client

Date/time 

I would like you to know... (e.g. my preferred name, likes, dislikes)

The important people/things in my life are...


What matters most to me at the moment.

What works for me when I am under pressure or feeling stressed... (e.g. time to myself, talking things through)

What doesn't work when I am feeling under pressure or feeling stressed... (e.g. lots of questions at that time, being in a noisy area)


If I am having a difficult time, I would like you to...

If the way I am being cared for needs to change, I would like you to contact... (e.g. family, friend, advocacy, MHO, no one)

If I don't bring it up with you, I would like us to next talk about what is important to me around this date... 

I have an advance statement Yes No

[Link to 'Advance Statement' screen](#)

 Once all information has been entered correctly please select the Close Record tick box below. Please be aware that once this has been selected no further edits can be made to this form but it will still be available to view as Read Only.

Close Record?

APPENDIX 5: CLINICAL PAUSE DOCUMENTATION

Clinical Pause
MR Chart

Client FERRI, Declan Declan Declan Declan Declan (Mr) - 1001036

Date and Time of Form Creation: 22 December 2022 12:31

Client Test: 1001036

Date Form Created Test: 22 December 2022 12:31

1 Use the discussion to devise a set of agreed interventions for the clinical team to manage the current risks. Be creative. Remember, the CIP is the product of an MDT discussion by experienced professionals, informed by existing risk assessment, formulation and the patient's wishes. Consider what has and has not worked in the past for this patient (or for other patients in similar circumstances). If continuous intervention is deemed necessary, consider what the staff involved will be doing whilst with the patient that could be therapeutic and helpful to support a return to general care.

[Click here to download Clinical Pause guidance documentation](#)

Preparation - Before the Clinical Pause meeting, consider:

1 Has the plan for a Clinical Pause meeting been communicated adequately to the relevant members of the clinical team?

1 If appropriate, has the patient had an opportunity to contribute to the Clinical Pause?

1 If appropriate, has the carer/named person had an opportunity to contribute to the Clinical Pause?

1 Do you need to organise telephone conference equipment?

1 Does the patient have a Patient Safety Plan?
1 Do you need to organise telephone conference equipment?

1 Does the patient have a Patient Safety Plan?

1 Bringing copies of the following documents to the meeting:

Formulation
Advance Statement
VRAMP/Patient Safety Plan
DASA

Section 1: Meeting Details

Date and Time of Meeting: 22 December 2022 12:32

Clinical Pause Requested by: _____ **Role:** _____

Location: _____ **Room:** _____

1 Please provide details of each attendee in the table below. **than press 'Save'**

Name	Role	Action
No data to display		

Comments (e.g. details of attendees who are not in Rio)

Section 2: Trigger for Clinical Pause Meeting

1 Please tick all that apply.

Review of Clinical Pause CIP	<input type="checkbox"/>	Concern regarding mental health	<input type="checkbox"/>
Violence or aggression	<input type="checkbox"/>	Concern regarding physical health	<input type="checkbox"/>
Self harm	<input type="checkbox"/>	Significant life event	<input type="checkbox"/>
Threat(s) to others	<input type="checkbox"/>	Adult Support and Protection concerns	<input type="checkbox"/>
Threat(s) to self	<input type="checkbox"/>	Other (please see comments)	<input type="checkbox"/>
Actual or attempted security breach	<input type="checkbox"/>		

Comments

Has a Patient Safety Plan been Completed? No

Section 3: Current Circumstances

1 What is happening for the patient? Give a brief description of what has happened. Try and consider events from the patient's perspective. What has triggered events? Reflecting on the Warning Signs from the VRAMP to identify risks and the information in the Getting to Know me Plan and Formulation to understand what happened will help with this.

1 What are the concerns of the clinical team? Focus on what specific concerns the team has. What are the risks at the current time and how are these best managed? The discussion here will form the basis of the CIP. Reflecting on the scenario plans from the VRAMP may be helpful. Pull together all the information you have on the patient to devise tailored interventions. If possible, take into account the patient's and carer's views about what works for them at times of crisis (e.g. what have they written in their What Matters to Me Plan?).

1 Are there any known factors present currently or in the past that are protective against the risk(s) being considered?

Section 4: Patient and Carer/Named Person Views

Views of patient

Views of Carer/Named Person

Section 5: Agreed Outcomes

Agreed outcome Comments

Section 6: Sign Off

Duration of Meeting (mins):

Document Completed by: _____ Role: _____

1 Once all relevant information has been entered, please select the 'Close Record' box below. Please note, once this box has been selected the form will become 'Read Only' and no further edits will be possible.

Updated by: Andrew Service

Updated on: 22 December 2022 12:32

APPENDIX 6: CLINICAL CARE FLOWCHART

