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Introduction

The Scottish Patient Safety Programme Improving Observation Practice (SPSP-IOP) is part of Healthcare Improvement Scotland’s ihub supporting improvement across health and social care.

This is a transformational programme with the main aim to end the historical practice of enhanced observation, and replacing this practice with a framework of proactive, responsive and personalised care and treatment, which focuses on prevention and early intervention in the context of a deterioration in patients’ mental health.

The programme’s aims are to:

- produce a refreshed national observation practice guidance centred on human rights principles and recovery focused practice, and
- ensure safe and reliable observation practice that values prevention, early recognition and response, in order to improve patient and family experience and reduce harm.

This report sets out a summary of our key activity in phase 2 of the programme and describes the next steps for phase 3.

Background

In 2016-2017, a prototyping approach was adopted with boards, and six boards were selected to form initial test sites. The focus of this phase was the establishment of local IOP leads, local governance to support the programme and Scottish Patient Safety Programme for Mental Health (SPSP-MH)/SPSP-IOP support to enable boards to test ways of working to improve observation practice.

Following the success of this phase and early indications of positive impact, Scottish Government extended funding for SPSP-IOP. The remaining mainland boards were invited to participate in phase 2 (2018-2019). A buddy system was introduced to align established test sites with the new mainland boards.

Buddy system

<table>
<thead>
<tr>
<th>Existing sites</th>
<th>Linked to new sites</th>
</tr>
</thead>
<tbody>
<tr>
<td>NHS Ayrshire &amp; Arran</td>
<td>NHS Dumfries &amp; Galloway and the Priory Group</td>
</tr>
<tr>
<td>NHS Lanarkshire</td>
<td>The State Hospitals Board for Scotland</td>
</tr>
<tr>
<td>NHS Grampian</td>
<td>NHS Highland</td>
</tr>
<tr>
<td>NHS Borders</td>
<td>NHS Forth Valley</td>
</tr>
<tr>
<td>NHS Greater Glasgow and Clyde</td>
<td>NHS Fife</td>
</tr>
<tr>
<td>NHS Lothian</td>
<td>NHS Tayside</td>
</tr>
</tbody>
</table>
All 12 mainland boards are now engaged in the programme with IOP leads appointed and testing under way. In addition to the support and active testing, SPSP-IOP has worked with the IOP leads to develop new guidance. ‘From Observation to Intervention’ was officially launched on 14 January 2019. This has provided clarity and structure about how to deliver improved observational practice.

The phases of the SPSP-IOP programme

<table>
<thead>
<tr>
<th>Year zero</th>
<th>Pre-work</th>
<th>January 2016 – September 2016</th>
</tr>
</thead>
<tbody>
<tr>
<td>Phase 1</td>
<td>Testing in six mainland boards (inpatients)</td>
<td>September 2016 – March 2018</td>
</tr>
<tr>
<td>Phase 2</td>
<td>Expanding test sites to include all mainland boards.</td>
<td>April 2018 – April 2019</td>
</tr>
<tr>
<td>Phase 3</td>
<td>Consolidation and spread to all acute adult mental health settings</td>
<td>April 2019 – March 2020</td>
</tr>
</tbody>
</table>

Programme resources

A Clinical Lead and Associate Improvement Advisor have been funded on a non-recurring basis to develop the SPSP-IOP programme and support national and local improvement activities. IOP leads were initially funded in the six test boards, and this funding was increased to each of the 12 participating boards in 2018. The role of the IOP lead is to co-ordinate and lead on improvement work within their own board which is supported by the Clinical Lead and Associate Improvement Advisor.
The new approach

The new guidance ‘From Observation to Intervention: A proactive, responsive and personalised care and treatment framework for acutely unwell people in mental health care’, replaces the 2002 Clinical Resource and Audit Group (CRAG) observation guidance document ‘Engaging People: Observation of People with Acute Mental Health Problems’. As observation practice and experience may also be indicative of wider mental health care practice and experience, the guidance also contributes to a refocusing and refreshing of mental health care practice as a whole.

The guidance views observation practice as one small part of mental health care practice and recommends that it cannot be undertaken as a standalone task, at a distance from a patient’s wider clinical needs. There are ongoing concerns that observation status should not be used to determine the extent of interaction, care and treatment that a patient receives.

Diagram 1: Continuum-based approach to care, treatment and safety planning
The guidance also proposes a continuum-based approach (see Diagram 1) that utilises specific nursing or multidisciplinary interventions of a nature, frequency and intensity that is tailored to the clinical and personal needs of each patient and is therefore flexible and patient led. The new guidance is underpinned by seven key principles that reflect the ethos and philosophy of the new approach.

### The underpinning principles of the guidance

<table>
<thead>
<tr>
<th>Principle</th>
<th>Details</th>
</tr>
</thead>
<tbody>
<tr>
<td>Understanding the lived experience of patients and their families and engaging their participation, consent and choice about treatment and care.</td>
<td>Creating physical environments which are fit for purpose, therapeutic and as far as possible hazardous free. This should be supported by regular audits which takes account of any recent safety notices.</td>
</tr>
<tr>
<td>Creating physical environments which are fit for purpose, therapeutic and as far as possible hazardous free. This should be supported by regular audits which takes account of any recent safety notices.</td>
<td>Creating ward systems that value anticipation, early recognition of deterioration and triggers for harm, as well as personalised early response mechanisms and support for all patients.</td>
</tr>
<tr>
<td>Creating ward systems that value anticipation, early recognition of deterioration and triggers for harm, as well as personalised early response mechanisms and support for all patients.</td>
<td>Introducing education, training and clinical supervision or action learning for staff to ensure they have the competencies and capabilities to respond to the demands of contemporary, complex, mental health care delivery.</td>
</tr>
<tr>
<td>Introducing education, training and clinical supervision or action learning for staff to ensure they have the competencies and capabilities to respond to the demands of contemporary, complex, mental health care delivery.</td>
<td>Supporting a relational-based approach to care and treatment in order to foster engagement with patients.</td>
</tr>
<tr>
<td>Supporting a relational-based approach to care and treatment in order to foster engagement with patients.</td>
<td>Embedding a human rights based approach and engaging with the Rights in Mind pathway to support patients’ rights in all mental health settings.</td>
</tr>
</tbody>
</table>
What progress have we made?

Boards are submitting leadership reports every two months on IOP activity and test of change ideas. These are collated and disseminated across all boards. In 2018, the private sector joined the mainland boards to support testing in improving observation practice, in order to share ideas and best practice.

<table>
<thead>
<tr>
<th>What we are finding in our test sites</th>
<th>A preventative, proactive approach to observation practice may be associated with:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Strong leadership</td>
<td>Staff training in therapeutic skills – for example mindfulness</td>
</tr>
<tr>
<td>Foundational work with SPSP-MH improvement methodology</td>
<td>Structured staff activity Continental Shift Patterns</td>
</tr>
<tr>
<td>Clinical pause</td>
<td>Less enhanced observation practice</td>
</tr>
<tr>
<td>Creativity and increased therapeutic activity</td>
<td>More confidence in engaging with enhanced observation practice</td>
</tr>
<tr>
<td>Better recognition of deterioration</td>
<td>Change of language</td>
</tr>
<tr>
<td>Early intervention</td>
<td>Positive patient experience</td>
</tr>
<tr>
<td>Flexibility</td>
<td></td>
</tr>
</tbody>
</table>

The test sites have reported that the accumulative effect of these changes has resulted in positive patient experiences and an increase confidence of staff to detect, engage and manage deterioration.
Using the guidance in practice

The data in Figure 1 below shows an example of local practice where NHS Tayside’s intensive psychiatric care unit (IPCU) set out to have a 50% reduction in 1:1 observations by July 2019.

“[The IPCU] set out to have a 50% reduction in 1:1 observations by July 2019...it feels that that wasn’t ambitious enough. The change and feel in the ward over the last year has been significant and being the initial IOP pilot ward in NHS Tayside has been one of the contributory factors. To challenge the model and concept of the traditional ‘obs’ has been described by some in the team as challenging, uncomfortable even, but now, being able to reinvest time saved into therapeutic engagement is beginning to pay off. In what way? Staff sickness is down from 3,418 hours in 2017 to 1,169 in 2018, there’s now a gym where people can go for activity, distraction, de-escalation – it’s a therapeutic space that wasn’t there before. Ultimately the ward is investing in engagement, culture change and development of the therapeutic milieu where 2:1 is not the standard operating procedure (SOP) on admission, improving patient experience and outcomes is.” (NHS Tayside)
Changes to observation practice at a local level have been supported by regular communication and site visits from the SPSP-IOP Associate Improvement Advisor and Clinical Lead. This has involved a series of meetings which included the national SPSP-IOP steering group and local steering groups.

Using a variety of communication strategies, which included emails, WebEx, twitter, telephone, video-conference and IOP leads network events, this has underpinned the importance of the cohesive relationships with all the SPSP-IOP leads. This has resulted in the spread, consolidation and sustainability of changes to best practice in observation practice. The SPSP-IOP Associate Improvement Advisor and Clinical Lead have also presented their work at various national and local meetings and events. The IOP leads have reflected on the support provided by the programme and the following comments are some examples of the positive feedback received.

“The support I have received from Andrea and Mark has been crucial and invaluable especially in helping me to set up the NHS Lothian Steering Group.” (NHS Lothian)

“I have found Mark and Andrea support at the steering groups incredibly helpful, they are my ‘go to’ people and manage to keep me on the right track. Andrea is also great at keeping in touch and updating trusts with latest information.” (NHS Borders)

“Both you and Mark demonstrate enthusiasm for the project and have been supportive at answering any query not matter how small, this enthusiasm is infectious and certainly motivates me to strive for excellence and improvement in and around observation practice.” (NHS Dumfries & Galloway)

“I would say that your support has been fantastic in terms of being able to pick up the phone and ask you anything!! In times of stress and hitting that challenging period of change management, you have always been available. You are kind and compassionate and your regular emails always make me smile, or chuckle!! I would also add that Mark is very engaging when talking about IOP and there were lots of comments from staff after he visited NHSG about how he inspired people and they loved his enthusiasm and passion for the subject. The whole HIS team that I have met have all been friendly and approachable. They have visited both Aberdeen and Inverness to offer support for both the IOP Lead and the senior leadership team, which is fab as we can sometimes feel isolated in the North of Scotland.” (NHS Grampian)
The nine strands

To consolidate, sustain and support improving observation best practice, the guidance has set out underpinning principles and nine strands to be implemented in practice.

<table>
<thead>
<tr>
<th>The nine strands of the guidance</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Strand 1</strong>: Involving carers and families in treatment, wellbeing and recovery</td>
</tr>
<tr>
<td><strong>Strand 2</strong>: Adopting a continuum-based approach to care, treatment and safety planning</td>
</tr>
<tr>
<td><strong>Strand 3</strong>: Supporting early recognition of, and response to, deterioration</td>
</tr>
<tr>
<td><strong>Strand 4</strong>: Improving communication around clinical needs, deterioration and risk</td>
</tr>
<tr>
<td><strong>Strand 5</strong>: Promoting least restrictive practice</td>
</tr>
<tr>
<td><strong>Strand 6</strong>: Managing periods of continuous intervention or support</td>
</tr>
<tr>
<td><strong>Strand 7</strong>: Developing a trauma-informed workforce</td>
</tr>
<tr>
<td><strong>Strand 8</strong>: Supporting personalised care and treatment</td>
</tr>
<tr>
<td><strong>Strand 9</strong>: Creating an infrastructure to support learning and quality improvement</td>
</tr>
</tbody>
</table>

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

This guidance is therefore aimed at mental health care practice as a whole and recommends that personalised care, treatment and safety planning should be determined and informed by using information from the patient. This would include patient’s clinical needs, strengths, and indicators of deterioration and harm, alongside their advance statement, carer’s views and the purpose of their admission to hospital. Diagram 2 illustrates a systematic approach to prevent, recognise and respond to deterioration.
Diagram 2: Factors involved in deterioration and the features of a systematic approach to prevent, recognise and respond to deterioration

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

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

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

The following case studies highlight examples of good practice as well as some of the project ideas initiated and shared by IOP leads across Scotland.

Case study 1 - NHS Borders

Miss X was admitted to the ward for a period of assessment and a reduction in medication with an initial diagnosis of Bipolar Affective Disorder. Following frequent absences from the ward and attempts to harm herself, she was placed on constant observation. During this level of observation Miss X talked about feeling ‘uncomfortable...I hate staff following me around...I feel like I’m in prison.’

The Improving Observation Programme provided a platform for staff engagement in therapeutic activity, Miss X was more able to take responsibility for her own safety, staff were able to quickly identify any deterioration in her mental state and intervene early using therapeutic activity. Any deterioration would be documented in the safety brief and handed over to staff on each shift. This meant that staff could increase or decrease the levels of engagement dependent on her mental state. Through IOP this shift in practice was enabled and the ward are now working with SPSP-IOP to embed this practice. Diagram 3 is a visual representation of the process that NHS Borders has developed for early recognition and deterioration.

Case study 2 - NHS Forth Valley

The team has implemented a Patient Interaction Record with a Red, Amber, Green signifier to allow staff to identify any patient who is potentially at risk. This is a more proactive way to engage with patients, to provide relevant therapeutic interventions and to identify patients at risk of deterioration at an early stage. During the testing of this approach, patients have been involved in discussions about how best to manage their symptoms.

An example of the impact of this at an individual level, patient X was identified as being at risk. The patient worked with staff to develop a preventative relapse plan which identifies relapse signifiers and how she and staff will manage this together. Staff in the team are being more proactive and considering alternative interventions rather than continuous observation being the first port of call. Therapeutic interventions were chosen by the patient and included particular interests such as physical fitness and cycling.

<table>
<thead>
<tr>
<th>Traditional practice</th>
<th>New practice</th>
</tr>
</thead>
<tbody>
<tr>
<td>Categorisation, fixed</td>
<td>Holistic approach, flexible</td>
</tr>
<tr>
<td>Managing risk</td>
<td>Preventing and managing deterioration and risk of harm</td>
</tr>
<tr>
<td>Reactive</td>
<td>Proactive (for example, early intervention, clinical pause)</td>
</tr>
<tr>
<td>Observation and proximity focused, service led</td>
<td>Needs and intervention focused, person led</td>
</tr>
<tr>
<td>Interventions not specific to patients’ needs or reason</td>
<td>Holistic approach, flexible</td>
</tr>
</tbody>
</table>

Other examples of good practice across Scotland

**NHS Borders – Positive Steps Group**

A morning session facilitated by support staff to normalise daily routines by having an informal discussion with a cup of tea, biscuits or baking completed on the ward, raising any wards issues, tasks to be delegated, for example setting the table and setting a goal for the day, choosing an activity or activities that everyone wants to take part in. A simple idea but so effective.

**NHS Greater Glasgow and Clyde – Health Improvement Toolkit**

A Health Improvement Toolkit has been developed on the ward to help support reduction in stress and distress. Patients create and design their own box which is then filled with personal messages, affirmations and images, for example, that will help reduce periods of distress.
**NHS Ayrshire & Arran – Floor Nurse**
Establishment of the ‘Floor Nurse’ role, this is a member of staff who is designated to be on the ward, observing and engaging with patients in an informal manner. This approach has underpinned a proactive, risk prediction approach and anticipatory models of care.

**The State Hospitals Board for Scotland – Implementation of the ‘Clinical Pause’**
Dr Gordon Skilling (Consultant Psychiatrist) has informed clinical practice with the use of the ‘Clinical Pause’ where observation periods are reviewed using a team discussion format.

Clinical pause meeting: when this is arranged all team members are invited, and those who cannot attend in person are invited to phone in to take part in the discussion. There is a form to complete with a team action plan at the end about observation. The other reported benefit from this approach is the perception that all staff at every level felt involved and that their views were considered.

**NHS Grampian – Patient Interaction Record**
A 24-hour Patient Interaction Record (traffic light system) has been devised which replaces the hourly general check. A member of nursing staff engages with every patient on the ward, every hour, making every opportunity count. The main emphasis of this has been to recognise early warning signs and identify the deteriorating patient, allowing for early prevention and supportive interventions to be commenced as early as possible. Other benefits identified from this, such as recognising patterns in behaviour that may not have been noted prior to recording this.
Service user and carer involvement

Engaging service users, carers and families is essential to the work of the programme and is achieved through learning sessions, delivery and steering groups.

Additionally, links and relationships have been made with a wide range of third sector service user and carers organisations who feed into the programme through being members of the delivery and steering groups as well as in less formal ways such as catch-up meetings or attending localised third sector events. The participating boards have actively encouraged carer representation on local steering groups.

This has been reflected in the increasing numbers of service users and carers that are attending the regional learning sessions. The programme also has active service user and carer representation on the SPSP-MH & SPSP-IOP delivery group.

“When I was cared for after injuring myself – the nurse was gentle and respectful.” (Service user)

“I feel included and welcome.” (Carer)

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

“Rapport is vital.” (Service provider)

“Staff are now engaging with patients every hour rather than just looking or checking in on the patient, so we are able to identify and respond to the deteriorating patient quicker.” (NHS Grampian - Crathes ward, Senior Charge Nurse)

SPSP-MH and SPSP-IOP has adopted a Human Rights Based Approach through using the PANEL principles (P – participation, A – accountability, N – non-discrimination, E – empowerment, L – Legality) working with partners such as the Scottish Human Rights Commission and Mental Welfare Commission for Scotland to ensure that service users’ rights are being upheld.
Next steps

Throughout phase 2, visits to participating boards have continued with the aim of maintaining strong links with all the IOP leads and to share best practice. The following themes have been highlighted.

| Ongoing Quality Improvements | • Patient and carer involvement  
| | • Patient impact stories/case studies  
| | • Importance of therapeutic interventions on the ward  
| | • Importance of individualised care plans/person-centred care  
| | • Safety huddles – identify patients at risk  
| | • Tapping into hidden talents to use staff skills, for example hobbies/leisure  
| | • Documentation of observation to support meaningful handovers  
| Policy Development | • Challenge of changing the culture in line with new guidance  
| | • Importance of steering groups and working groups  
| | • Policy – rewriting this in relation to new guidance  
| Workforce Planning | • Clinical supervision  
| | • Continental shifts – in place or being considered  
| | • Use of agency and bank staff due to staff shortages  
| Education and Training | • Training identified – facilitation of meaningful/therapeutic interventions  
| | • IOP guidance awareness sessions for staff to attend  
| | • Changing the language of observation to general care and continuous intervention  
| Data Measurement | • Celebrating success  
| | • Project work being shared and piloted in other boards  

These themes have informed the next steps for SPSP-IOP phase 3.

- Consolidation of IOP guidance into acute adult mental health settings, with an emphasis on supporting policy development, workforce planning, education and training and data measurement.
- Promoting the guidance with the development of patient and staff posters, staff handy guide and a carers/patient booklet.
- Collation of impact stories and case studies from across Scotland.
- Raising awareness through publication of articles in academic journals about improving observation practice.
- Data measurement will include the following measures which will be reported through the SPSP-MH toolkit:
  - [IOP 1] the percentages of patients with tailored interventions, and
  - [IOP 2] the percentages of patient engaged with daily therapeutic activity.
- In addition, there will be supplemental SPSP-IOP measures that have been identified as helpful to support local improvement and learning. These include:
  - the total numbers of hours patient are receiving continuous interventions
  - the percentage of patients receiving continuous individualised interventions
  - the average hours per patient on continuous individualised interventions
  - the total number of patients who receive continuous interventions whose care plan evidence engagement with therapeutic activity, and
  - the average length of inpatient admission.
- This data will be collected alongside the SPSP-MH measures of restraint, self-harm and violence rates. For additional information, please see the Change Package in Appendix 1.
Conclusion

As we come to the end of phase 2 of the programme, as this report has demonstrated, there is ongoing and excellent engagement across Scotland and promising improvements in key outcomes within all mainland boards and the private sector.

The challenges that we now face are the consolidation and ongoing focus on work within adult acute mental health inpatient services, with consequent improvement in changing the focus of care from observation to intervention.

This is an exciting and crucial time for the new SPSP-IOP guidance. The initial reviews have commented on the transformational nature of the guidance and the wider impact of its principles to the quality and standard of care patients receive in acute mental health inpatient services in Scotland.

Mark Gillespie (SPSP-IOP Clinical Lead)
Andrea Boyd (SPSP-IOP Associate Improvement Advisor)
Appendix 1: Change Package

Change Package

Purpose of the Change Package
There are three distinct parts: Driver Diagram, Change Ideas and Measures. It is a toolkit containing:

- evidence informed interventions and practices
- implementation strategies, and
- a list of possible measures that can be used to measure progress.

It is used as a resource for teams as they plan, design, test and apply the evidence-informed practices in their local environments. When used and applied together, the Quality Improvement teams can expect to achieve breakthrough improvement, with the ability to spread their learning across the health system as appropriate to aid in system-wide improvement.

How to use this Change Package
Using the rapid spread methodology, the multidisciplinary Team Leads/Clinical Leads are encouraged, with their teams, to review the change package to:

- determine what practices might already be in place in their area and decide if further work is needed
- identify and prioritise the changes the team will undertake, and determine what improvements these changes will lead to
- determine what other changes may be required at a later date, and
- identify any challenges and barriers that may impede change and work with local Management Teams to remove them.
**Driver Diagram**

The following driver diagram provides an overview of the key practices and describes the elements that need to be in place to achieve an improvement in observation practice in mental health care settings. The driver diagram has been developed by Healthcare Improvement Scotland and IOP leads based on:

- best evidence available
- learning from testing, and
- taking into consideration the key areas that senior leaders and frontline staff could have an impact on.

**Primary and Secondary Drivers**

The primary drivers are high level ideas that if implemented, will achieve the improvement aim. The best way of implementing primary drivers is to identify a series of actions (secondary drivers) which, when undertaken, will contribute to the primary drivers and in turn the aim.

**Change Ideas**

A change concept is a general notion or an approach to improving an aspect of care. A change idea is an action which is expressed as a specific example of how a particular change concept can be applied in real life. Also included in this package is a series of different measures. These measures are important as we need to know if the changes we are making are an improvement.
Driver Diagram

<table>
<thead>
<tr>
<th>Primary Driver</th>
<th>Secondary Driver</th>
</tr>
</thead>
<tbody>
<tr>
<td>Infrastructure at national and local level to support implementation of guidance</td>
<td>• Health and Social Care Partnerships (HSCPs) will provide leadership and support to clinical areas to facilitate the development of conditions for new practice and investigate potential development or potential requirements around workforce planning, shift patterns, ward structures or activity.</td>
</tr>
<tr>
<td>Early detection, prevention and intervention with patients at risk or potential risk of mental health deterioration or harm</td>
<td>• Healthcare Improvement Scotland's ihub will provide improvement support and advice for boards in testing changes in practice and measurement of outcomes.</td>
</tr>
<tr>
<td>Care, treatment and safety interventions are delivered by core, familiar and skilled staff.</td>
<td>• Ward activity and/or shift patterns maximise staff visibility, interaction, therapeutic milieu and continuity of care within the clinical environment.</td>
</tr>
<tr>
<td>Individualised care, treatment and safety planning are centralised within a human rights and recovery focused practice culture.</td>
<td>• Workforce planning considers staffing activities and skills required to deliver preventative, early intervention focused care, treatment and safety interventions.</td>
</tr>
<tr>
<td>Individualised interventions are delivered within a context of highly flexible, tailored and continuum based care and treatment driven by an individual’s care, treatment and safety plan</td>
<td>• Align local policy to principles of guidance</td>
</tr>
<tr>
<td></td>
<td>• Implement SPSPMH Safety Principles</td>
</tr>
</tbody>
</table>

**Aim**

Support the national implementation of flexible, continuum based care and treatment to meet the identified mental health and safety needs of individuals admitted to mental health inpatient settings.

**Quality of risk assessment and measurement of outcomes.**

- All therapeutic activity, including all psychotherapeutic, individualised intervention:
  - Is delivered by core, familiar, staff who are skilled in a range of psychotherapeutic interventions
  - Varies in frequency, nature and intensity in response to patient deterioration factors and known risk factors.
  - Is forward planned collaboratively to encourage scaling back and increasing of intervention in a flexible, least restrictive manner.
  - Is experienced as a continuation of care and treatment which is responsive to individuals’ needs at the time.
  - Is specific, psychotherapeutic and purposeful and aligned with the individual’s needs, strengths, purpose of admission and evidence based practice

- Periods of continuous intervention should be individualised intervention are purposeful and demonstrate a collaborative balance between therapeutic intervention and individual activity. If physical containment of the patient is necessary for a period of time this should be governed by boards’ seclusion / time out policies.

- The need for continual visual assessment of engagement and impact of psychotherapeutic intervention during periods of continuous intervention is dynamic and determined by the patient’s individualised care, treatment and safety plan and collaborative decision making.

- Review patients requiring periods of continuous intervention every 8-12 hours as minimum to identify continued need or alternatives, and evidence effectiveness of intervention, as this should have a purpose and be goal directed.
Core IOP Measures
These measures are reportable through the SPSPMH toolkit:

- [IOP1] Percentage of patients with tailored interventions
- [IOP2] Percentage of patients engaged with daily therapeutic activity

Supplemental IOP Measures
These measures have been identified as helpful to support local improvement and learning:

- Total number of hours of patients receiving continued individualised intervention
- Percentage of patients receiving continued individualised intervention
- Average hours per patient on continued individualised intervention
- Total number of patients who receive continued individualised intervention whose care plan evidence engagement with therapeutic activity
- Average length of inpatient admission

It is recommended this data will be collected alongside the SPSP-MH measures of restraint, self-harm and violence rates.
### Change Ideas

<table>
<thead>
<tr>
<th>Secondary Driver</th>
<th>Change Ideas</th>
</tr>
</thead>
<tbody>
<tr>
<td>Health and Social Care Partnerships (HSCPs) will provide leadership and support to clinical areas to facilitate the development of conditions for new practice and investigate potential development or potential requirements around workforce planning, shift patterns, ward structures or activity.</td>
<td>Potential trialling of continental shift patterns.</td>
</tr>
<tr>
<td>Healthcare Improvement Scotland’s ihub will provide improvement support and advice for boards in testing changes in practice and measurement of outcomes.</td>
<td>Quality Improvement WebEx series for IOP leads.</td>
</tr>
<tr>
<td>Ward activity and/or shift patterns maximise staff visibility, interaction, therapeutic milieu and continuity of care within the clinical environment.</td>
<td>Structuring staff and ward activity to increase capacity for early and planned intervention with patients delivered by skilful practitioners.</td>
</tr>
<tr>
<td>Workforce planning considers staffing activities and skills required to deliver preventative, early intervention focused care, treatment and safety interventions.</td>
<td>Staff training and education to increase capability for intervention.</td>
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<tr>
<td>Align local policy to principles of guidance.</td>
<td>Development of standards for minimum competencies and capabilities for working with people with acute mental health problems.</td>
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<tr>
<td>Implement SPSP-MH Safety Principles.</td>
<td>Introducing IOP guidance as part of staff induction.</td>
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<td>Awareness sessions for patients and carers to increase knowledge of new IOP guidance.</td>
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<td>Development of a ‘handy guide’ to support staff with implementation.</td>
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<td></td>
<td>Use of specific assessment tools and/or interventions to target specific areas of need or harm – for example STORM assessment and interventions; mentalisation, mindfulness, distress tolerance for self-harm; and Broset Violence Prediction Checklist for violence.</td>
</tr>
<tr>
<td>Anticipatory care planning.</td>
<td>A system is in place to identify patients at risk of deterioration, for example traffic light system, early warning score.</td>
</tr>
<tr>
<td>Assessment of needs, risk, and potential harm or deterioration, and care, treatment and safety planning are individualised and synergised.</td>
<td>A system is in place to rapidly follow up with intervention for patients identified during awareness checks as not engaging appropriately, reluctant to engage or as potentially deteriorating.</td>
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<tr>
<td>Recognition of early warning signs to aid prevention and early intervention.</td>
<td>Where actual or potential deterioration or harm is identified, care plans reflect relevant intervention plan, communication and review of impact, for example clinical pause.</td>
</tr>
<tr>
<td>High visibility and accessibility of all levels of core nursing staff for patients</td>
<td>Safety huddles and safety briefings highlight deteriorating or potentially deteriorating patients and describe action, review and communication plan.</td>
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<tr>
<td>Checks to determine awareness of patients’ whereabouts are interaction based and focused on assessment of wellbeing.</td>
<td>Where known factors for potential mental health associated harm or deterioration are present there is early</td>
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<td>Safety huddles and safety briefings highlight deteriorating or potentially deteriorating patients and describe action, review and communication plan.</td>
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<tr>
<td>Secondary Driver</td>
<td>Change Ideas</td>
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| use of allied, specific assessments or interventions and adoption of these into individualised care, treatment and safety plans.  
- Learning, training and education support development of preventative approaches. |  
- Patient Safety Community meetings for patients and staff to collaborate on identified safety issues.  
- Involvement of peer support workers and the ‘floor nurse’ to communicate any clinical deterioration or risk and to have identified interventions in place using an individualised care plan.  
- Core staff are skilled in a range of psychotherapeutic interventions and can deliver least restrictive, rights and evidence-based care and treatment aligned with individualised need.  
- Workforce planning considers staffing activities and skills required to deliver preventative, early intervention focused care, treatment and safety interventions.  
- Diarised, individualised interventions to ensure and maximise patient contact  
- Group activities are decided in partnership with patients and their identified needs, for example ‘positive steps’ group developed in NHS Borders, Health Improvement Toolkit developed in NHS Greater Glasgow and Clyde and memory boxes developed in NHS Tayside.  
- Floor nurse.  
- Activity coordinator.  
- Volunteers supporting various therapeutic activities, for example aromatherapy, relaxation sessions and pet therapy.  
- Encouraging staff to ‘tap into hidden talents’ to support therapeutic interventions. |
| Care, treatment and safety plans demonstrate prescribed and targeted individualised interventions as part of a responsive process to address specific patient problems and strengths, and purpose of admission.  
- Care, treatment and safety planning is delivered within a collaborative culture of trauma informed care.  
- Learning and development culture supports continual improvement in recovery, rights and trauma informed care approaches.  
- Quality assurance is linked to learning and development to support consistency and best practice in standards for purpose and quality of risk assessment and safety planning process. |  
- Care and treatment plans evidence family involvement or contribution as part of the wider team.  
- Collaborative (daily) goal setting and safety planning underpins all therapeutic care and treatment intervention.  
- Align knowledge, purpose and activity of ward setting with a trauma informed care approach and culture, utilising NES trauma training framework.  
- Consider testing aspects of See Think Act and/or Safewards.  
- Creative approaches to clinical supervision, for example action learning sets, peer supervision and reflective practice. |