CLINICAL RISK ASSESSMENT AND MANAGEMENT FOR INDIVIDUAL SERVICE USERS POLICY AND PROCEDURES

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Signature Of Authorising Officer:	
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Name of responsible committee/lead individual:	Head of Practice Governance
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Summary: This policy defines the overarching standards relating to the risk assessment and management of individual service users.	
Target audience: The policy is to be followed by all medical staff, nursing and other health care professionals and support staff who are involved in the assessment and management of clinical risk.	

Hertfordshire Partnership NHS Foundation Trust is committed to providing an environment where all staff, service users and carers enjoy equality of opportunity.

The Trust works to eliminate all forms of discrimination and recognise that this requires, not only a commitment to remove discrimination, but also action through positive policies to redress inequalities. Providing equality of opportunity means understanding and appreciating the diversity of our staff, service users & carers and ensuring a supportive environment free from harassment. Because of this Hertfordshire Partnership NHS Foundation Trust actively encourages its staff to challenge discrimination and promote equality of opportunity for all.

Version Control

Version	Date	Author	Status	Comment
V4	Oct 2005	Head of Practice Governance	Superseded	
V5	July 2008	Head of Practice Governance	Superseded	Approved Trust Executive Team 2.7.08
V5.1	August 09	Head of Practice Governance	Superseded	Archived 20.8.10
V6	20th August 2010	Billy Boland, Consultant Psychiatrist	Current	Executive agreement 17.8.10

National Health Litigation Authority Risk Management Standards Standard 2 Competent & Capable Workforce

Level 1.2.7 The organisation has approved documentation which describes the process for ensuring staff who undertake assessments of service users are competent in relation to clinical risk assessment and the management of clinical risk.

Level 2.2.7

The organisation can demonstrate compliance with the objectives for:

- Organisation's expectations in relation to staff training as identified in the training needs analysis
- Tools/process authorised for use within the organisation

Comments and Feedback on this document were obtained from:

- Risk manager
- Service managers
- Ward managers
- Clinicians
- Clinical Risk Trainers
- Professional Leads
- Joint Heads of Service
- Safeguarding Leads
- IAPT Lead
- CAMHS Lead
- Suicide Prevention Group
- Service User and Carer Representatives

Hertfordshire Partnership NHS
NHS Foundation Trust

PART ONE

Policy On
Clinical Risk Assessment And Management For Individual Service Users

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PART ONE

Policy On Clinical Risk Assessment And Management For Individual Service Users

1.1 Introduction

Hertfordshire Partnership NHS Foundation Trust (referred to in this document as HPFT or the Trust) is committed to the safety and well being of service users, staff and all people visiting or working within the Trust.

Clinical Risk Assessment and Management is part of the Trust's overall risk management strategy and is fundamental to maintaining safety. This policy defines the overarching standards to be employed within all local services relating to the risk assessment and management of individual service users. It should be used by all staff involved in the assessment and management of clinical risk.

The procedures to be followed are described in Part 2. These apply to all service in the Trust other than the Enhanced Primary care Mental Health Services, who work with a different group of service users. They are developing separate procedures, summarised here in appendix 4. Procedures are designed to support *structured clinical judgment* (defined below), the approach to clinical risk assessment and management that is favoured both by the Department of Health (DH) (Best Practice in Managing Risk March 2009) and the Trust. Where appropriate excerpts from this document are taken below.

This policy should be considered in the context of other Trust policies, particularly those on supportive observation and the prevention and management of aggression and health and safety.

1.2 Definition of Clinical Risk Assessment and Management

Clinical Risk Assessment and Management is defined by the Trust as a continuous and dynamic process for judging risk and subsequently making appropriate plans considering the risks identified.

1.3 Categories of Risk

This policy relates specifically to three main area of clinical risk: harm to others, suicide/self-harm and self neglect. However it is recognised that service users are exposed to a range of other risks. Care providers should be mindful of these other risks when considering management plans with service users. Other risks may relate to risk of experiencing abuse, risk of disengaging from treatment and risk of accidental harm. Care management processes used in the Trust (e.g. CPA, SAP etc.) should aim to identify such risks and arrange management as appropriate. Staff may find some of the principles outlined in this document helpful when considering these other risks.

1.4 The main aims of the Clinical Risk Management Process

Safety is at the heart of the Trust's approach to clinical risk assessment and management. The policy and procedures aim to give a framework to staff in the Trust so that they can provide the safest possible services to our service users. It is intended that the procedures support staff, service users and carers so that risk assessment and

management becomes a meaningful process that integrates well with and adds value to the wider care plan. In order to achieve this we adopt the underlying principle that

'modern risk assessment should be structured, evidence based and as consistent as possible across settings and across service providers' (Best Practice in Managing Risk, Department of Health, March 2009 – see below)

Essentially clinical risk assessment and management is fundamental so that:

- Risks to the wellbeing of service users, staff and others are assessed and identified
- Indicators of possible adverse outcomes e.g. non-compliance with treatment or non-attendance at appointments are addressed
- Risks to service users, staff and others are regularly reviewed
- Risks to service users, staff and others are communicated appropriately
- Shortfalls in services are identified and addressed

And ultimately

- Service users, staff and others are safeguarded.

1.4.1 Our 10 Underpinning Values

When approaching clinical risk assessment and management the Trust endorses the DHs underlying principles:

1) *'Best practice involves making decisions based on knowledge of the research evidence, knowledge of the individual service user and their social context, knowledge of the service user's own experience, and clinical judgment.*

2) *Positive risk management as part of a carefully constructed plan is a required competence for all mental health/learning disability practitioners*

3) *Risk management should be conducted in a spirit of collaboration and based on a relationship between the service user and their carers that is as trusting as possible.*

4) *Risk management must be built on a recognition of the service user's strengths and should emphasize recovery.*

5) *Risk management requires an organisational strategy as well as efforts by the individual practitioner.*

<u>Working with service users and carers</u>

6) *All staff involved in risk management must be capable of demonstrating sensitivity and competence in relation to diversity in race, faith, age, gender, disability and sexual orientation.*

7) *Risk management must always be based on awareness of the capacity for the service user's risk level to change over time, and a recognition that each service user requires a consistent and individualized approach.' (Best Practice in Managing Risk March 2009)*

In addition, our Trust holds the following values which are fundamental to how we provide our services:

8) Any intrusion into people's lives, or constraints imposed on their right to self-determination, must be both within the law, mindful of their human rights and at the minimum level necessary in order to maximise privacy and dignity whilst keeping them safe

9) Carers must be treated with respect, taking into account their relationship with the service user; their special knowledge of the situation and their actual and potential contribution to the service user's well being should be fully acknowledged and utilised

10) It must be recognised that all staff working within high risk situations may be subject to stress and have the right to receive appropriate support and supervision

1.5 Implementation and levels of responsibility

The Chief Executive is ultimately responsible for Trust delivery of services in accordance with this policy.

The Risk Management and Patient Safety Group, reporting to the Integrated Governance Committee, is responsible for monitoring implementation of and compliance with this policy.

All operational managers are responsible for ensuring staff who report to them are familiar with this policy.

All operational staff are expected to comply with this policy.

Each service is responsible for:

- The implementation and evaluation of risk assessment and management procedures described in Part 2

- The supervision of staff in the use of procedures and risk assessment tools

- Contributing to the audit and research programmes which will inform the continual process to improve practice

1.5.1 Key Standards

When approaching implementation the Trust employs the DHs best practice points 'Basic ideas in risk management' and 'Individual practice and team working':

Basic Ideas in Risk Management

- *'Risk management involves developing flexible strategies aimed at preventing any negative event from occurring or, if this is not possible, minimizing the harm caused.*

- *Risk management should take into account that risk can be both general and specific, and that good management can reduce and prevent harm.*

- *Knowledge and understanding of mental health legislation is an important component of risk management.*

- *The risk management plan should include a summary of all risks identified, formulations of the situations in which identified risks may occur, and actions to be taken by practitioners and the service user in response to crisis.*

- *Where suitable tools are available, risk management should be based on assessment using the structured clinical judgment approach.*

- *Risk assessment is integral to deciding on the most appropriate level of risk management and the right kind of intervention for the service user.*

Individual practice and team working

- *Risk management plans should be developed by multi-disciplinary teams and multi-agency teams operating in an open, democratic and transparent culture that embraces reflective practice.*

- *All staff involved in risk management should receive relevant training, which should be updated at least every 3 years.*

- *A risk management plan is only as good as the time and effort put into communicating its findings to others.*

In addition, our Trust has set the following standards which are integral to how we approach risk:

- The process of risk assessment should essentially be helpful – both to service users and carers through providing considered plans delivered by safe services, and to staff through informing clinical decision making and promoting a considered, organised and structured approach to risk.

The assessment should:

- Inform and guide the process of care with the service user at the centre
- Be dynamic and ongoing with reviews triggered by needs and/or some events
- Be recorded in a clear accessible form, and be communicated appropriately
- Be integral to the wider clinical assessment and care planning process for each service user. (e.g. should be fully compatible with the Care Programme Approach and other care planning processes.)
- Be carried out by suitably trained and competent staff
- Ensure that the risk management plan is guided by the risk assessment.
- Be linked to Trust audit and research programmes

1.6 Staff Training and Support

Training will be available to all members of staff who are involved in the assessment and management of clinical risk.

Following training needs analysis, these categories of training have been agreed:

- New practitioners including doctors, will be introduced to the clinical risk policy and procedures as part of local induction
- All practitioners will receive "refresher" training at least every 3 years
- Staff in specialist settings, and/or who need to use specialist risk assessment tools, will receive additional training as necessary

The Trust will ensure that such training is provided, and staff will attend as directed.

Further support and advice for staff in risk assessment and management practices, must be identified within local services. In carrying out risk assessment and management, professionals will refer to the guidance given by the Department of Health ("Best Practice in Managing Risk" (March 2009)), the Royal Colleges, the Nursing and Midwifery Council or other professional organisations.

1.7 Consultation, Approval and Ratification Process

This policy was written and subsequently reviewed by multidisciplinary groups consisting of representatives of Managers and Clinicians and members of the Risk Management and Patient Safety Group.

The policy has been ratified by the Risk Management and Patient Safety Group and will be accepted as an organisation-wide policy by the Trust Executive Committee.
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1.8 Process for monitoring compliance with this document

This section sets out how the Trust monitors compliance with and the effectiveness of this policy.

Service users, staff and carers are encouraged to express any safety and security risks to staff at a local level. Information should be gathered to highlight concerns which may trigger the need for local audit and review, or to highlight good practice.

In addition the Trust will monitor the risk assessment/management process through the standards set down by the NHS Litigation Authority. This will include demonstrating monitoring in relation to:

- Organisation's expectations in relation to staff training as identified in the training needs analysis
- Tools/process authorised for use within the organisation

Compliance with these procedures will be audited annually as part of the Clinical Effectiveness programme for the year.

1.9 Process for reviewing, approving and archiving this document

1.9.1 This document will be reviewed every two years or whenever national policy or guideline changes are required to be considered (whichever occurs first), by the Practice Governance Lead following which it will be subject to re-ratification by the organisation-wide Risk Management and Patient Safety Group.

1.9.2 All procedural documents must be retained for a period of 10 years from the date the document is superseded as set out in the Trust Business and Corporate (Non-Health) Records Retention Schedule, which is part of the Records Management Policy (non-clinical).

1.9.3 A database of archived procedural documents is kept as an electronic archive by the Director of Workforce and Organisational Development. This archive is held on a central server.

1.10 Dissemination and Access to this document

This policy is disseminated throughout the Trust following ratification via the policy guardians. and will be published on the HPFT staff website. Access to this document is open to all via the Trust public website.

Section 1.5 sets out the responsibilities with regard to the implementation of this document.

1.11 Associated Documents

The risk management process should take into account relevant legislation and existing policies and guidance.

This Policy and associated procedures should be used in conjunction with the following Hertfordshire Partnership NHS Foundation Trust policies all of which can be accessed via the staff intranet or the local Policy Guardian:

Supportive Observation of Service Users at Risk
Prevention And Management Of Violence And Aggression
Lone Worker
Integrated Care Programme Approach and Care Management
Learning From Adverse Events
Management of Care Records
Searching Service Users and their Property
Advance Directives Policy
Single Equalities Scheme
Safeguarding Adults from Abuse: a Hertfordshire Inter-agency protocol
Safeguarding children
Medicines Policy

The most relevant legislation is:

The Children Act 1989
The Children Act 2004
The Mental Health Act 1983 and Codes of Practice
The Mental Health Act 2007
The Mental Capacity Act 2005
The Human Rights Act 1998
The Data Protection Act 1998
The Health and Safety at Work Act 1976
The Race Relations Amendment Act 2000
The Disability Discrimination Act 2005
The Equality Act 2006

NHS Litigation Authority Risk Management Standards for Mental Health and Learning Disability Trusts

National Suicide Prevention Strategy for England 2002
Preventing Suicide: A toolkit for Mental Health Services 2003

1.12 Supporting References

Safety of Client/Patients with Mental Health Needs, The Essence of Care, Department of Health, February 2001
An Organisation with a memory. Report of an expert group on learning from adverse events in the NHS. Department of Health 2000
Avoidable Deaths: Five Year Report of the National Confidential Inquiry into Suicides and Homicides. Department of Health 2006
Refocusing the Care Programme Approach: Department of Health 2008
Best Practice in Managing Risk, Department of Health, 2009

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CLINICAL RISK ASSESSMENT & MANAGEMENT FOR INDIVIDUAL SERVICE USERS

PART TWO

Procedures

Procedures

PROCEDURES

1. Purpose

The Hertfordshire Partnership NHS Foundation Trust policy "Clinical Risk Management for Individual Service Users" sets out the framework for the management of risk in all clinical areas.

This guidance should be regarded as complementary to the policy and is aimed to further extend staff awareness of the complexity and detail involved in risk assessment and risk management within services. Essentially the assessment and management of risk must be an integral element of the Care Programme Approach , the Single Assessment Process, Models of Care within substance misuse services, and any other care planning process.

The guidance is not intended as a substitute for specific training of staff in this area of work. Training on the assessment and management of risk remains a priority area for Hertfordshire Partnership NHS Foundation Trust.

NB: For convenience the term "mental health professional" may be used, but this should be taken as referring to all staff working with service users in this Trust.

2. Background

Risk and risk taking are intrinsic to practice in Mental Health/Learning Disability Trusts. Properly managed they are a means of encouraging autonomy, choice and participation for users of mental health services and combating their stigmatisation and social exclusion.

It is the policy of Hertfordshire Partnership NHS Foundation Trust that all mental health professionals will undertake or contribute to the assessment and management of clinical risk.

This procedures document is complementary to the clinical risk management policy (part 1, see above), and outlines how the policy may be implemented.

3. Risk Assessment and Care Coordination

Care co-ordination is required by all those receiving services from the Trust. The purpose of care coordination is to ensure all Trust service users receive appropriate interventions efficiently with good communication between users, carers and services.

For those with mental health problems, CPA was introduced in 1991 and reviewed in 1999 and again in 2008. CPA is the approach to care coordination that is applicable to those people under the care of Mental Health Trusts with mental health problems and the most complex needs, whether they are receiving adult (working age or older people's) mental health services, specialist learning disability services, or child and

adolescent mental health services. From 2008 there is only one level of CPA. Consideration of risk issues plays an important role in deciding eligibility for CPA.

The Trust continues to provide care and treatment to service users who will no longer receive care co-ordination through CPA. The vast majority of those previously on Standard CPA will now receive care co-ordination through Standard Care.

Many service users in older people's mental health services and in specialist learning disabilities services have their care coordinated through the Single Assessment Process (SAP).

Those receiving Community Drug and Alcohol Services should have their care co-ordinated through Models of Care, as prescribed by the National Treatment Agency. Those with dual diagnosis should be care co-ordinated in mental health services and are likely to be on CPA. They may at the same time receive treatment from the CDAT or an alternative organisation.

Those receiving enhanced primary care mental health services from the Trust, and some of those under the care of CAMHS or specialist learning disability services, will be exempt from CPA and will not require any other formal system of care co-ordination. They should however all have an assessment of needs including risk assessment once accepted into the service, and they should all know who to contact in the Trust if they have a problem.

All these approaches to care coordination place the service user at the centre of their own care planning and reflect Trust values and the principles of the recovery approach as adapted by the Trust, encouraging staff to recognise fully **the strengths** of those with whom they are working and to treat them as individuals.

Please see the Trust Care Coordination Policy (Incorporating the Care Programme Approach) Integrated Care Programme Approach and Care Management Policy" for further information

All Trust service users will receive risk assessment and management as part of care coordination. This should inform the process of care planning as a whole, and be complementary to assisting the process of recovery.

4. The Process of Risk Assessment and Risk Management

The Trust endorses the use of 'structured clinical judgment' as an approach to assessing risk. This approached is endorsed by the Department of Health and the Royal College of Psychiatrists, and is felt as the safest strategy to address clinical risk. It essentially involves the use of clinical judgment that is guided by a standardised format, potentially complemented by the use of clinical risk assessment tools.

The Trust has 2 standardised forms to help guide clinical judgment – the 'standard' and 'enhanced' risk assessment forms. When assessing risk, practitioners are advised to use these forms to guide the process of collating and considering information, and formulating the plan with regard to the relevant risks and associated contributory factors.

Some important steps in risk assessment include:

- Consider the clinical risk management policy and procedures
- Gather information
- Identify situations and circumstances known to present increased risk
- Make an assessment of the risk and record the assessment
- Formulate a plan ideally in collaboration with the service user and carers to manage the identified risks and include a Contingency/Crisis Plan
- Monitor and review the situation as appropriate
- Identify shortfalls in service (unmet needs)

4.1 Gathering Information

The quality of the risk assessment depends on the information available. The amount and accuracy of the information available may vary considerably according to the circumstances and setting where the initial assessment is carried out. For example, the information available to make an informed risk assessment on an unknown patient newly admitted to a hospital ward in the middle of the night may greatly contrast with the extent of information known about a patient already subject to CPA (or equivalent processes).

The three main sources of information available to staff are:

- Clinical interview and observation
- Information from informants (these may be relatives or carers and people from any agency involved in the person's care)
- Documentary evidence available in care records

Therefore, in certain cases, staff will not have full information and will have to make the best possible assessment based upon what information is available. As more information comes to light, and with the person better known, the risk assessment and care plan should be reviewed and updated.

Anyone assessed as posing a risk of harm to self or others should not suffer discrimination because of that assessment. The behaviour may be assessed as potentially harmful or dangerous and may legitimately restrict certain services options. It may also entitle the person assessed to special provision because of those needs.

When considering information about history of harm to self or others, there are four components which could be considered:

- Severity
- Recency
- Frequency
- Pattern

Attention must be paid not only to actual past harm committed by the person but also to the potential of likely harm and acts of harm which were intended but prevented. These must be given proper consideration and weight so as to avoid the tendency to minimise the potential of harm.

4.2. Identifying Situations and Circumstances Known to Present Increased Risk (Critical Indicators)

There are certain general circumstances that may increase a level of risk, such as violence being more likely when drug or alcohol abuse co-exist with major mental illness or when a patient has multiple psychiatric diagnoses. Research has also shown that certain factors including sociodemographic data, past history, and situational factors can particularly be associated with increased likelihood of violence and suicide.

As well as general circumstances it is also often possible to identify circumstances in which, based on past experience, it is likely that a particular person will present an increased risk. For example:

- When a person stops medication and has previously been aggressive during an acute phase of an illness
- When a person who has been suicidal in one particular situation, such as the ending of a close relationship, is faced with another similar situation
- When a person who has previously offended under the influence of drugs and alcohol starts drinking again, or enters an environment where drugs or alcohol are available
- When there is an apparent improvement in health though history suggests that this maybe short lived and requires careful monitoring over a longer period of time
- Where a service user with a learning disability previously inclined to challenging behaviour after bereavement suffers a further loss

Environmental conditions or events which have been associated with dangerous behaviour or risks in the past should be considered.

Situational factors can include loss of employment, financial difficulties, the ending of a relationship and sexual exploitation. Evidence of perpetration of, or risk of being subject to, domestic violence should be included in risk assessment.

Personal triggers are factors internal to the person which have been historically identified as related to risk e.g. deterioration in mental state stress reactions, loneliness or other emotional states. These should also be considered.

The person may demonstrate warning signs of risk behaviours. They are observable behaviours which have been noted to be present when harm is about to happen. For example, pacing, swearing, threats of self harm, stalking, refusal to eat, refusal of medication.

Wherever possible, staff should consider both general factors and information relevant to the individual based on their history. Staff must use their professional judgment to decide on the weight to give each factor. Wherever possible this should be done in a multi-disciplinary setting in order to capture the most complete picture of risk.

5. Categories of Risk

Three categories are considered here.

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5.1 Risk of Harm to Self

This can be considered under separate headings: Suicide, deliberate self-harm, accidental self-harm, neglect and risk of harm to a service user if a required admission to hospital cannot be arranged.

5.1.1 Suicide

Two elements are important in assessing the risk of suicide:

- Knowledge of general risk factors for suicide
- Skills in making direct enquiries about suicidal intent

The period around inpatient discharge is a time of particular high risk of suicide, emphasising the need for proper assessment prior to discharge and effective follow up afterwards (see “Follow-up After Discharge “ policy).

Recent research evidence suggests that a breakdown in the continuity of care by either carers or professionals significantly increases the risk of suicide post discharge. This could include key personnel being on leave or leaving or a change of consultant since the admission.

The most obvious warning sign is a direct statement of intent. This should never be ignored, although it needs to be considered within the context of the individual service user.

Those who are suicidal can fluctuate between a wish to live and a wish to die. More than half of those under the care of the Trust who commit suicide have contact with a member of staff within 7 days of the event. With skilled questioning on the basis of a strong therapeutic relationship, staff can be well placed to elicit signs of high suicidal intent. However an expression of lack of suicidal intent does not necessarily indicate lack of risk. It may be that the service user is trying to avoid accessing services so that they can commit an act of self harm or suicide, or their intent may be fluctuating.

A care plan to manage the risk must urgently be put in place when risk of suicide is expressed. The care co-coordinator and the Consultant Psychiatrist (where there is one) may need to be informed and this will trigger a review of the risk assessment and care plan. Consideration should be given to whether the use of the mental health act is appropriate.

5.1.2 Deliberate Self Harm

People who have committed non-fatal acts of self-harm are at an increased risk of committing suicide at a later date. The highest risk is in the first three years, especially the first six months following an overdose.

Factors associated with a higher risk of repetition of deliberate self-harm include:

- Substance misuse problems
- Diagnosis of personality disorder
- Previous psychiatric inpatient treatment

For those in longer term care, deliberate self-harm can be a feature of frustration and boredom. For those with limited verbal skills, this pattern of behaviour may be adopted by people who cannot otherwise express their distress. The factors may be prevalent in services for adults with learning disabilities.

Deliberate self-harm is also a common pattern of behaviour amongst adolescents and such incidents should always be carefully assessed.

5.1.3 Self Neglect

Assessment of risk of self-neglect may include assessment of:

- Hygiene
- Diet
- Infestation
- Household safety

- Warmth

A failure to eat or drink adequately may be acute, severe and life threatening. On the other hand, it may result in slow deterioration in health and nutritional status and not be recognised initially by professionals or carers.

This is a complex area for assessment. Professionals have to balance an acknowledgement of relative standards and the service user's right to be protected from unnecessary interference against the need for accurate assessment of a person's circumstances and responsibility for intervention where severe self neglect is likely.

Also included under this heading are risks of:

- Losing contact with services

- Relapse due to not taking medication

Active follow up in the community may be necessary and a contingency/crisis plan should be in place when a service user who is considered high risk does not keep an appointment or is not at home when visited.

Wherever possible interventions should be with the consent of the service user however when the situation may be life threatening then consideration needs to be given to the use of the Mental Health Act.

5.2 Risk to Others

5.2.1 General

Predicting dangerous or violent behaviour is an inexact science. The most reliable long term predictor of violent behaviour is previous violent behaviour, hence the importance of full, accurate and up to date information, communication and recording. This should include any incidents of harm to others (including history of offending) and any history of carrying of instruments that have potential to cause harm, including knives.

Victims are more likely to be family members or those trying to deliver care and support. In assessing risk of violence, consideration should be given to the risk for family and carers and in addition the need to protect any particularly vulnerable adults or children in the household.

Assessing the Risks of Violence

- Identifying situations or circumstances in which, based on previous experience, the service user is likely to become violent. Trying to see the behaviour from a service user's point of view can be very revealing in terms of risk assessment.

- Liaison may occur with the probation and police service if they are currently involved with the service user or have had previous involvement in order to exchange appropriate information and to develop a jointly agreed risk management plan. (Multi-agency public protection panels should be used where appropriate).

- Attention must be paid not only to actual past harm committed by the person, but also to the potential for harm. Acts that were intended to harm or could have harmed but which were prevented, must be given proper consideration and weight so as to avoid the tendency to minimise the potential risk of harm.

- The assessment should aim to identify not only the nature of the risk of violence but also identify who is at risk.

5.2.2. Carers.
Carers are often particularly at risk of violence from the person they care for and staff should be sensitive to this (see section 16 below).

5.2.3 Risk to Staff

Managers within the Trust must comply with the legislative requirements set out in the Health and Safety procedures relevant to their Departments. In particular this requires managers to undertake health and safety risk assessments to identify hazards and evaluate risks to staff. Physical and verbal violence towards staff requires immediate management action.

Trust managers are responsible for the development, implementation, monitoring and review of safe working practices and procedures in all environments where staff have contact with service users. This is particularly important where staff are working alone in the person's home or in community settings such as dispersed day care activities. Each team should review its safe working procedures annually or more often if the need arises.

Staff also have responsibilities and need to ensure they consider the risks that may occur during the course of their work. In order to do this they need to check on current risk status before interviewing a service user and take all appropriate steps to ensure their own safety during any encounter.

Further information is to be found in the policies listed below.

- Trust and Adult Care Services Health and Safety policies

- Lone Worker and Essential Travellers Policy

- Staff Safety, Prevention and Management of Aggression

- Learning from Adverse Events Policy

- Post Incident Support of Staff Guidance

5.2.4 Risk to staff in other Provider Agencies

It is essential that with any referral to a care provider within the Trust or outside the Trust, consideration should be given to provision of an unambiguous, accessible and up to date risk assessment and management plan, with the new provider's responsibilities clear, and agreed by them. Service users **must** be consulted, understand the reasons for sharing the information and agree to this action. If service users refuse to share the information then it may not be possible to commission a particular service.

There are some particularly dangerous situations when information needs to be shared without consent. Professionals should adhere to the principles and guidance offered by their professional body that clarifies the circumstances in which confidential information may be shared with other agencies in the public interest. Further information regarding this can be found in "HPFT Policy, Procedure and Guidance on the Management of Care Records" and "Inter-agency guidance on sharing information".

5.2.5 Risk to a Child or Young Person (under 18yrs old)

Assessment of adult service users must include asking if there are children in the household. The child need screening form (on CareNotes) provides a prompt for professionals to ensure they take account of the needs and risks to children which should be routinely documented. This is of particular importance when the adult is a lone parent or the main carer of children. Where possible the mental health professional involved in the case should meet the children and observe their physical condition and behaviour.

Concerns should always be discussed with the parent. However, where doubts remain the line manager must always be informed and advice should be sought from the Trust's Safeguarding Children lead (Named Nurse or Named Doctor).

If a referral to Children's Social Care is required, there should be two separate but integrated care plans - one, focusing on the needs of the child managed by the children's service and another focusing on the needs of the adult managed by the Trust services. The respective care co-ordinators should work in close liaison and attend care planning and review meetings for both child and adult as necessary.

The welfare of a child is paramount (Children Act 1989), timely communication and the sharing of information is a key factor in ensuring that children are protected from harm. Confidentiality of the parent or service user may be overridden in these circumstances.

The team manager must be informed about concerns in the response by children's social care to a referral. If the team manager cannot resolve the concerns through discussions with the other agency it must be escalated to the Trust safeguarding children lead (Named Nurse or Named Doctor).
In all cases a further referral must be made if new concerns arise..

Consultant Psychiatrists must always be informed and directly involved in clinical decisions for service users who express delusional beliefs or suicidal ideation that may involve and pose a risk to children. Where the service user is an inpatient this will include any decision regarding discharge, leave, CPA reviews or contact arrangements with children. These decisions must not be delegated to a junior doctor.

The above cases are likely to be the small minority. Therefore, Care Coordinators must have a low threshold for acting in cases where there may be a significant risk to children. All such cases must be discussed in the multi disciplinary team meeting to ensure a group decision is taken about how to manage risks and plan actions. When a consultant psychiatrist is not present at the meeting the discussion must include whether it is necessary for the consultant to be alerted to the case to make a decision about whether there is a need for direct consultant involvement and / or oversight of the case.

If urgent action is required to safeguard a child, before the routine team meeting, the clinician must seek advice from the manager or senior clinician immediately and make a referral to Children's Social Care. If in any doubt advice should be sought from the Trust safeguarding children lead (Named Nurse or Named Doctor), although this should never cause a delay to safeguard a child..

When considering the risk presented by mental illness or substance misuse from someone who is also a parent, or is significantly involved in the care of children, it is important to consider specifically the risks that the children may encounter as a result of the parent's potentially impaired parenting abilities.

The following are examples of specific risks to children:

- Severe postnatal depression and puerperal psychosis carry particular risks for babies and young children.

- Adults with moderate to severe learning disabilities may lack the knowledge and skills to provide adequate parental care.

- Continuous or frequent intoxication due to alcohol or drug misuse can lead to dangerously low levels of parental care and supervision.

- Psychosis can result in physical or emotional neglect or abuse of children. The risk is high if an adult has delusional beliefs which involve a child

- Severe obsessive compulsive disorder can place children under intolerable pressure to comply with rituals and routines resulting in impaired social development and schooling.

- Suicidal thinking that includes a child in a suicide pact

Children should not be expected to be the main carers for adults to the detriment of their own needs for care and development.

5.3 Risk of Abuse or Exploitation by Others – Safeguarding Adults

All staff, agencies and service providers must work within the law and must not support or condone abuse to vulnerable adults. Where abuse is occurring or believed to be occurring then staff must pass their concerns on to a responsible person. The Safeguarding Adults from Abuse procedures must be followed where there is concern that abuse of a vulnerable adult may have occurred.

In all cases where there is actual or risk of potential abuse or exploitation, staff should consult the HPFT Safeguarding Adults link policy read in conjunction with the following policies and procedures:

For staff working in the geographical location of Hertfordshire, the HPFT policy and procedure is adapted from and must be used in conjunction with the Hertfordshire Interagency Procedure for the Protection of Vulnerable Adults (Safeguarding Adults from Abuse) which is established as the one procedure in the county, used by public agencies and private voluntary services in the protection of vulnerable adults from abuse.

For staff working in the geographical location of Norfolk, the HPFT policy and procedure is adapted from and must be used in conjunction with the Norfolk Vulnerable Adults at Risk of Abuse, Joint Policy and Operational Procedures developed by Norfolk Social Services, Norfolk Constabulary and Norfolk Primary Care Trust.

For staff working in the geographical location of Essex, the HPFT policy and procedure is adapted from and must be used in conjunction with the Southend Essex Thurrock (SET) Safeguarding Adults Guidelines.

In situations where staff have concerns about a vulnerable adult it is essential to consider whether there are grounds for using legal powers to protect the service user and/or their assets. Risk assessment and protection planning are of paramount importance in supporting and reducing any further risk of abuse to the vulnerable adult. Further guidance and contact details can be obtained from the HPFT link Safeguarding Adults Policy and the Safeguarding Adults Manager.

6. Using Structured Clinical Judgment and Recording the Risk Assessment and Management Plan

The nature of the risk assessment will be dependent upon how well known the service user is to the professionals completing the assessment. A risk assessment that takes place within an initial interview in Accident and Emergency or when someone is admitted as an emergency in the middle of the night will be different from a risk assessment that is part of the ongoing management of a long term case.

In a similar manner a service user who is only seen in outpatient clinic and is assessed as low risk and maintained on Standard Care/SAP, will not need a complex care plan or complex risk assessment.

The risk status of a service user is a key item of information and must be recorded on the appropriate forms as described below. Using the Trusts risk assessment forms not only guides a professional's judgment but also serves as a record of the risks assessed and the subsequent plan. A copy of the assessment must be filed on the care record. Where separate records are held, for example when there are separate medical, nursing or social care notes, a copy must be placed on each file.

The Care Co-ordinator is normally responsible for ensuring the appropriate risk assessment is completed (during an in-patient admission the role may be delegated to the named nurse). For Standard Care/SAP (or equivalent substance misuse services) this may be an individual worker. For CPA (or equivalent) this will be the designated Care Co-ordinator or named nurse in discussion and agreement with the multi-disciplinary team where appropriate.

When a risk assessment has to be completed at the time of an emergency, such as an unplanned admission to hospital, the person/s responsible will be the most senior professional/s involved in the emergency. This is likely to be the admitting doctor and the most senior nurse present. All professionals involved in emergency/crisis admissions should jointly participate in the completion of the risk assessment and sign the record. Risk assessments made during emergencies should clearly state the review date and consideration should be given to an early review. When necessary, in high-risk situations, this may need to be within 72 hours.

Assessing risk and the attendant management plan will have a slightly different focus dependant upon whether the service user has a mental illness, a substance misuse problem or a learning disability.

6.1 Use of the tools

The descriptions of the risk assessment tools that follow are to be considered just that; Tools to assist in the process of risk assessment. They are not only a format to record risk, but act as a structure to guide the clinician in their thinking, so that the risk assessment can be as comprehensive as possible. The document is intended to be live – that is, not something that is completed once the risks have been assessed but a tool that structures the consideration of the risks with the information presented. By prompting the clinician to consider details that are relevant to risk assessment that may be over looked, e.g history of substance using behaviour, it supports the clinicians in considering a variety of possibilities. Clinicians are then better placed to make more sophisticated and meaningful management plans. This is the essence of *structured clinical judgement.*

6.2. The Standard Risk Assessment Tool appendix 1

This form is to be used for:

- New mental health service users at first clinical interview/meeting
- For Standard Care

- Those under the care of services for people with learning disabilities – who are not on CPA

Who records and signs: The person or persons conducting the clinical interview for new service users, or the care co-ordinator.

When: At the first clinical interview or at times of crisis/emergencies when no other, or up to date, risk assessment is available, or when review is required (see section 9)

Who receives a copy: All HPFT staff and seconded ACS staff who are involved with the service user should be informed of the risk assessment and a copy should be placed on the care record. Where separate records are held by other disciplines a copy should be placed with each set.

With whom should the information be shared: This is a professional decision however in situations of high risk it is important to consider the need to share information with other agencies, carers, and providers of other services. See section 11 "Communication and Confidentiality".

When completing the form for new users of the service consideration should be given to the appropriate level of CPA or whether no further input is required by the specialist services. The management plan should detail these issues.

For example:

- If high risk has been recorded the assessor may then be discussing the case in a multi-disciplinary forum such as a ward or CMHT meeting. This would form part of the immediate management plan and be recorded in Section 6 of the form.

- If risk is assessed as low and the person does not require specialist mental health services but social/family factors cause some concern the immediate management plan may be giving information on community agencies such as CAB and Relate and referring back to the GP.

When a Standard Risk Assessment is being completed it may identify, in sections 2 – 5, that insufficient information is available to comprehensively assess the risk. In such situations the collection of more information is likely to form part of a management plan.

6.3. The Enhanced/Comprehensive Risk Assessment, appendix 2

This form is to be used for:

- All service users on CPA.
- For service users on standard care if this is preferred.

Who records and signs: The Care Co-ordinator or their delegated representative on behalf of the multi disciplinary team who have participated in the assessment. Whilst a service user is an in-patient, the delegated

representative could be the named nurse or another community worker attending an in-patient CPA meeting.

When: At the first CPA or Professionals meeting (or equivalent), or when review is required see section 9

Who receives a copy: All those present at the CPA or Professional meeting. A copy of the risk assessment should be placed on the care record. Where separate records are held by other disciplines a copy should be placed with each set.

With whom should the information be shared: This is a professional decision however in situations of high risk it is important to consider the need to share information with other agencies, carers, and providers of other services who were not present at the CPA or Professional meeting. See Section 14 "Communication and Confidentiality"

Professionals attending any meeting in which the Risk Assessment/Risk Management plan will be completed should prepare for this by ensuring they have collected all the information available to them and pertinent to the risk assessment. See Section 7, Gathering Information.

Information recorded on all risk assessment forms should be verified and the source identified on the record.

It is not intended that any information should be duplicated therefore when the Enhanced/Comprehensive Risk Assessment is carried out at a CPA meeting the risk management plan, the crisis/emergency plan and those present should be recorded on the CPA documentation. The Enhanced/Comprehensive Risk Assessment form makes provision for this information to be recorded as it will be relevant when risk is assessed outside a formal CPA meeting, for example, at a professionals meeting.

6.4. Substance Misuse Services

Those under the care of Community Drug and Alcohol Teams will be assessed through their addictions risk screening tool.

Those identified as having dual diagnosis – severe mental illness and drug and/or alcohol problems – will receive an Enhanced risk assessment at that point.

6.5. Child and Adolescent Mental Health Services

Those under the care of Specialist services

- Forest House
- Outreach
- Adolescent Drug and Alcohol Service Hertfordshire

will receive Enhanced risk assessment.

All others under the care of CAMHs will receive risk assessment to a common standard to be agreed..

7. Other Specialist Tools

For specialist settings, or for individuals with particular areas of risk, many tools have been developed to assist in the risk assessment.

A selection of such tools has been made by the Department of Health (see “Best practice guidance” June 2007). The Trust has centrally approved for use the Beck Hopelessness Scale and has organized licenses for teams. All services are now able to use this tool to inform their risk assessment if they feel it is appropriate. Manuals for use have been distributed to teams along with the assessment forms. If practitioners use this scale, it is appropriate to scan the original form onto the electronic care record. Reference to the use of the scale should be made in the standard or enhanced risk assessment tool. Further copies of the scales are available from the Risk Management Department via the Clinical Risk Management Lead.

Use of any such tools would complement the regular Trust risk assessment procedures outlined above, and not replace them.

A range of other tools may be helpful in assessing clinical factors relevant to risk. These include:

- Beck Depression Inventory
- HCR - 20
- Hare Psychopathy Checklist
- Edinburgh Post-natal Depression Scale
- MHSOP Falls Risk Assessment Tool
- Waterlow Pressure Sore scale
- HPFT Dysphagia and Nutrition Screening Tool
- Clifton Assessment Procedures for the Elderly
- Geriatric Depression Scale
- START (Short-Term Assessment of Risk & Treatability)

It is the responsibility of individual staff to ensure that they are appropriately trained and licensed before using these tools.

8. Formulating a Care Plan to Manage the Risk

In order to be effective a risk assessment must be communicated and acted upon.

Risk management is about evaluating the risks identified in the risk assessment process, taking into account the possible beneficial and harmful outcomes, and subsequently planning and implementing appropriate strategies to reduce these identified risks. Really the aim should be to identify the vulnerabilities and strengths of the service user which contribute to the risk equation, and develop/reduce these proportionately; the risks should alter accordingly.

This is an integral part of CPA, Standard Care, SAP and Models of Care Substance Misuse and the Care Plan produced needs to clearly specify how needs are to be met and the risks managed. It should ideally be planned in collaboration with the service user and carer (where appropriate), and copies of the written plan should be provided to the service user and carer (if the service user consents).

Using the information gained from the risk assessment and the assessment of need, the care plan is formulated and recorded by the Care Co-ordinator. This may be undertaken in a multi-disciplinary forum for service users monitored on CPA (or equivalent substance abuse services) and in a clinical interview/meeting for those maintained on Standard Care/SAP.

For CPA levels of Care Planning it may be appropriate for all members of the multidisciplinary team, providers of services, involved external agencies and the GP to be provided with a copy of the care plan. This may contain a variety of strategies and agreements, which could include the following:

- The services that are to be provided by each agency within a given timescale
- Any care responsibilities that the relative or carer has agreed to take on
- How any assessed risk of harm will be managed and by whom
- The likely warning signs or triggers that may suggest an increase in risk
- The time period a risk situation will be allowed to continue before a new review occurs
- Details of who to contact in a crisis and how to do so
- Details of the GPs involvement
- Support that may be made available for the relative or carer
- Contingencies in the event of default by the service user or any service provider
- Details of the service users care co-ordinator and how they may be contacted

The service user should be asked to sign the Care Plan to signify agreement with the plan. If the service user has any objections these should be recorded. It is not necessary for the plan to be signed at the CPA meeting as this may present administrative difficulties however good practice would suggest the plan is sent to the service user for signature as soon as possible, say, within a maximum of two weeks .

The Care Co-ordinator will normally be responsible for co-ordinating interventions as necessary, and ensuring that the care plan is adhered to. During periods of in-patient care the named nurse will undertake this duty however it is important the Care Co-ordinator remains in contact with the service user and is aware of events and plans being made during the in-patient admission. In situations of high risk a

back up for the Care Co-ordinator/named nurse should be identified as a contact point in the absence of the Care Co-ordinator/named nurse.

9. Monitoring and Reviewing the Situation

Risk Review

A review should also use structured clinical judgment, following the guidance above. A new Standard or Enhanced/Comprehensive Risk Assessment form should be completed at each review, which should bring forward historical information from previous assessments and include new history since the last assessment. Using the electronic care record, practitioners can create a new assessment, using a previous assessment (see Carenotes manual)

Who records and signs: Care Co-ordinator with input from any other professional involved in the care plan.

When: At the agreed review date or when circumstances change, cause concern and an early review is arranged.

Who receives a copy: All those present at the CPA or Professional review meeting. A copy of the risk assessment should be placed on the care record. Where separate records are held by other disciplines a copy should be placed on each file.

Standard Care/SAP review. The person reviewing should ensure that any other HPFT staff and seconded ACS staff who are involved with the service user are informed of the risk assessment and a copy should be placed on the care record. Where separate records are held by other disciplines a copy should be placed with each set.

With whom should the information be shared: This is a professional decision however in situations of high risk it is important to consider the need to share information with other agencies, carers, and any providers of other services who were not present at the review. See section 11 Communication and Confidentiality"

Active monitoring and regular review of the care plan are essential. High-risk cases are a priority for the multidisciplinary team and should be subject to regular review. The care coordinator/named nurse is the responsible member of the multi-disciplinary team for ensuring the care plan is monitored and for convening reviews when required. For service users on CPA the review would normally take place at the CPA review.

- All risk assessments should be reviewed when there are any changes that cause concern.

- As a minimum all risk assessments should be reviewed annually.

Where staff involved in a service users care plan consider that a change in mental state has occurred and risk has increased, the Care Co-ordinator and the RC should be informed as soon as possible so that action can be taken to reassess the individual's needs. The Care Co-ordinator is also responsible for ensuring the information on the increased risk is appropriately shared with other involved team members, providers of services and carers.

In urgent situations the Care Co-ordinator, or during in-patient admissions the named nurse, may need to take immediate decisions without a formal review of the care plan and in these circumstances this should be communicated to the multi-disciplinary team and a formal review arranged as soon as possible.

Changes in risk also should lead to a review of the level of CPA (or equivalent substance misuse services).

10. Support to Staff

Working with high risk can be stressful and time consuming. To support this process, staff and their managers must ensure the following are in place:

- All HPFT staff and seconded ACS staff must have regular training on the management of violence and aggression
- Staff training will occur at a minimum of 3 yearly as recommended by the National Confidential Inquiry into Suicide and Homicide by people with Mental Illness and Department of Health
- All staff involved in risk assessment and management should receive regular supervision as set out in the HPFT Performance, Review and Development Policy.
- High-risk cases should only be allocated to suitably experienced staff
- Staff should alert their line managers to all cases that are assessed as high risk by the multidisciplinary team
- Risk status should be considered when cases are prioritised for allocation
- Careful workload management should ensure staff have sufficient time for the work required in such cases
- Staff should be clear about line management accountability and to whom they should report any clinical concerns. In the case of any situation which is identified as high unmanaged risk this must always be reported immediately
- Staff should be made aware of internal and external staff support systems

11. Communication and Confidentiality

Issues of good communication and of sharing relevant information amongst members of the multi-disciplinary team are fundamental to the operation of an effective co-ordinated service and yet may appear, at times, to be at odds with the safeguards around confidentiality which are required by many professional organisations.

The key to successfully treading this course is to ensure the service user is consenting to the sharing of relevant information with other agencies who have legitimate grounds for being advised of such information. By the nature of some meetings, such as multi-disciplinary CPA meetings, this may be self evident to the service user, particularly if thorough and adequate introductions are undertaken at the commencement of the meeting.

In other cases, often those at Standard Care/SAP level (or equivalent substance misuse services) where there is pre-dominantly uni-disciplinary working it may be much less clear to a person that information may need to be shared with other agencies. Therefore the agreement and consent of the person to relevant disclosure, needs to be sought much more explicitly.

Discussions with service users about sharing information with other agencies should be documented in the professional's own records. If necessary signed agreement should be requested.

However, in all cases there needs to be a final judgment by the relevant Consultant and/or Care Co-ordinator as to whether there may be sufficiently strong grounds for over-ruling the request of a service user who has asked that information not be shared with other disciplines/agencies. This may be considered appropriate where it is judged that the public interest outweighs the duty of confidentiality. Issues of safety to the public, carers, staff and children may take priority over the right to confidentiality.

For further information please see "Policy, Procedure and Guidance on the Management of Care Records."

12. Carers.

Staff should make every effort to work in partnership with carers in assessing and managing risk. Carers can often contribute very sensitive information about risk factors for the person they care for, and they are also often in a position to be managing most of the risks presented on a daily basis.

Confidentiality rules should not be used as an automatic barrier to communicating with carers. Staff should explain to service users both the importance of confidentiality rules but also the advantages of permission being given for carers to be given clinical and risk information so that they are fully equipped to help ensure the safety of the person they care for (and also of themselves).

Carers should be treated as key potential allies in the risk management plan. Once identified they should always be offered a carer's assessment.

13. Interprofessional Disagreements

It is important that all agencies involved in the care of the patients clearly and openly debate the issues involved in risk assessment and risk management and agree a single care plan which is owned by all parties.

Staff of the Trust and seconded staff have a responsibility to ensure that their professional and/or employing agencies concerns are taken note of and fully considered in drawing up a risk management plan. Equally, contradictory or conflicting approaches to management of risk within a single case may not be helpful and can be potentially divisive for the patient.

Where local discussions within a multi-disciplinary team cannot resolve issues such as inter-professional differences, staff should inform their line managers so that issues can be addressed at a higher management level.

14. Health Professionals Regulatory Guidance

Health professionals of all disciplines have an ongoing requirement to fulfil the registration requirements of their own professional regulatory body i.e. the GMC (medical staff), NMC (nursing staff) or HPC (AHPs).

These regulatory bodies may periodically issue their own guidance, standards, advice or position statements with which professionals are required to comply as a condition of their continuing professional registration. This policy is not intended to supersede or override guidance as provided by a regulatory body.

15. Supporting References

The risk assessment and management process should take into account relevant legislation and existing policies and guidance including:

Hertfordshire Partnership Foundation Trust policies:

Clinical Risk Assessment and Management for Individual Service Users
Health and Safety Policies (HPT and ACS)
Integrated Care Programme Approach and Care Management
Lone Worker and Essential Travelers Policy
Policy, Procedure and Guidance on the Management of Care Records
Prevention and Management of Violence and Aggression
Learning from Adverse Events
Follow-up after Discharge from Mental Health Units
Nursing Care-Plan Policy and Procedure – Inpatient Mental Health units
Supportive Observation of Service Users at Risk
Operational Policy, Community Mental Health Teams
Operational Policy, Specialist Mental Health Teams for Older People
Acute Ward Operational Policy
Dysphagia and Nutrition Policy

Legislation:

The Mental Health Act 1983 and Codes of Practice
The Mental Health Act 2007
The Mental Capacity Act 2005
The Human Rights Act 1998
The Data Protection Act 1998
The Health and Safety at Work Act
National Assistance Act 1948
NHS and Community Care Act 1990
The Children Act 1989

Guidance:

Safeguarding Adults from Abuse: a Hertfordshire Inter-agency protocol
Safety First, Five year report of the National Confidential Inquiry into Suicide and Homicide by People with Mental Illness (2000)
Avoidable Deaths: Five Year report of the national Confidential Inquiry into suicide and homicide by People with mental Illness (2006)
Sainsbury Centre “Clinical Risk Management (2000)
Risk Management in the NHS. NHS Executive (1993)
Assessment and Clinical Management of Risk. The Royal College of Psychiatry Special Working Party (CR53 April 1996)
The Mental Health Act Commission “Thresholds for Admission and the Deteriorating Patient”
National Suicide Prevention Guidance for England (2002)
Best Practice In Managing Risk: Department of Health (2009)
Refocusing the Care Programme Approach (March 2008)

16. Review

These procedures will be reviewed as set out in section 1.9.

Appendices.

1 and 2: Generic Risk Assessment Tools

- Standard Risk Assessment Tool Mental Health Services
- Enhanced /Comprehensive Assessment and Management of Risk

The status of other risk assessment tools is described in sections 10 and 11 above.

3 : Equality Impact Assessment

APPENDIX 1

Standard Risk Assessment Tool Mental Health Services

This form is to be used for:

- New service users at first clinical interview/ meeting.
- For Standard Care
- For emergency/crisis situations when no other, or up to date, risk assessment is available.

Date of this assessment: …….

Service users name, address, date of Birth or hospital number.
Please print or affix sticker

1. Health and Safety – Risk to Staff

Additional or specific risks to the Health and Safety of Staff **Yes** / **No** / **None Apparent**
If "yes" please describe and suggest possible strategies to manage.

2. Behaviour that causes concern

Please circle as appropriate

A. Record of previous self harm	Yes	No	Insufficient information
B. Currently threatening suicide and/or self harm	Yes	No	Insufficient information
C. Previous or current incidents of actual or threatened violence	Yes	No	Insufficient information
D. Previous dangerous and impulsive acts	Yes	No	Insufficient information
E. Previous use or current threat to use weapons	Yes	No	Insufficient information
F. Threatened or actual aggression to carers	Yes	No	Insufficient information
G. Arson (deliberate act) or Accidental fire risk	Yes	No	Insufficient information
H. Misuse of drugs (prescribed or illegal)	Yes	No	Insufficient information
I. Excessive use of alcohol	Yes	No	Insufficient information
J. Evidence of self neglect (such as poor hygiene)	Yes	No	Insufficient information
K. Evidence of risk through abuse/exploitation by others	Yes	No	Insufficient information
L. Sexually inappropriate behaviour	Yes	No	Insufficient information
M. Other reports or evidence of current risk behaviour	Yes	No	Insufficient information

Please comment on "Yes" and "Insufficient information" answers. Also consider recency, frequency, severity and pattern

Please continue overleaf. If necessary record additional information on a separate sheet.

3. Cognition/Physical Health

A. Expressing suicidal ideas and/or plans for suicide	Yes	No	Insufficient information
B. Feels hopeless about the future	Yes	No	Insufficient information
C. Mental disorder and sustained anger and fear	Yes	No	Insufficient information
D. Paranoid delusions about others	Yes	No	Insufficient information
E. Mental disorder and plans for, or fantasies of, attack	Yes	No	Insufficient information
F. Morbid jealousy	Yes	No	Insufficient information
G. Loss of memory/disorientation/wandering	Yes	No	Insufficient information
H. Physical health problems causing concern	Yes	No	Insufficient information
I. Other reports or evidence that cause concern	Yes	No	Insufficient information

Please comment upon "Yes" and "Insufficient information" answers. Also consider recency, frequency, severity and pattern

4. Risks to Children

A. Evidence of current neglect/violence/emotional abuse	Yes	No	Insufficient information
B. Other reports or evidence of risks to children	Yes	No	Insufficient information

5. Social/Home situation

A. Homeless or about to become homeless	Yes	No	Insufficient Information
B. Relationship breakdown	Yes	No	Insufficient Information
C. Recent bereavement	Yes	No	Insufficient Information
D. Financial problems	Yes	No	Insufficient Information
F. Unemployed	Yes	No	Insufficient Information
G. Recent significant life events	Yes	No	Insufficient Information

Please briefly comment upon above two sections

6. Please describe the immediate plan to manage any behaviours, understandings or physical health problems that cause concern. Specify when CPA level and/or Enhanced/Comprehensive Risk Assessment will be discussed for service users assessed as high risk.

Action	Date by When	By whom

With whom will this risk assessment be shared. Please tick: Carer ❒ Other HPT staff ❒ CST ❒ Other Agencies ❒ ……

Assessor's Name/s. Please print …… Signed: …….

Date: …… Date of Review: ……
Consider review within 72 hours when high risk has been assessed

Please continue on a separate sheet if required

Hertfordshire Partnership NHS Trust

Enhanced /Comprehensive Assessment and Management of Risk
Mental Health Services

- To be completed for all service users on CPA
- Can be used, if preferred, instead of the Standard Risk Assessment tool

To be recorded by Care Co-ordinator or a delegated representative when risk is assessed at CPA or Professionals meetings.

Reviews can be recorded on this form or on the separate review form

Please refer to Policy Guidelines for further information

Service users name, address, DoB or hospital number. Please print or affix sticker

Date of Assessment: ……

Please tick to indicate the following have been discussed		
Service User/carer informed of this plan	Yes	No
Information sharing/confidentiality discussed with service user	Yes	No
Consent to sharing information discussed with service user	Yes	No

- When the risk assessment is completed at Enhanced CPA meetings those present will be listed on the CPA documentation.

- If the assessment is completed outside a formal CPA meeting please list, in the box below, those present:

Name	Role	Contact Details

Please continue overleaf

Service users name, dob or hospital number ……

CRITICAL INDICATORS

Please note this list is not exhaustive and other risks may be identified

1. History of Risk **Please tick. To self To others To child vulnerability**	Please consider the following: ▪ Aggression inc. threats / verbal abuse by service user.(see below for separate section on risks to staff or carers) ▪ Neglect / accidental self-harm by service user ▪ Violence / abuse to service user ▪ Arson, deliberate or accidental ▪ Damage to property ▪ Exploitation / vulnerability of service user ▪ Previous admissions to inpatient mental health services ▪ Previous admissions under MHA 1983 ▪ Forensic history ▪ Current legal status - probation / remand / bail - public protection register - -Schedule 1 offender ▪ CPA status ▪ Recency of risk behaviour ▪ Frequency of risk behaviour ▪ Severity of risk behaviour ▪ Pattern – e.g. planned intent ▪ Awareness of consequences of behaviour ▪ Awareness of danger ▪ Risks to health and welfare ▪ Risks to autonomy ▪ Risks to involvement in family and wider community life ▪ Risks relating to purchase of illegal drug use or from drug dealers ▪ Adverse reaction to prescribed medication ▪ A breakdown in the continuity of care from professionals or carers ▪ Over reliance on services ▪ Danger of institutionalisation
2. Current (and possible future) Risks **Please tick. To self To others To child vulnerability**	
3. Specific Risks to Staff or Carers	▪ Known physical or verbal attacks ▪ Spurious accusations by service user against staff of HPT or any other agency
4. Clinical Factors	**Diagnosis/mental illness** Does the service user currently have any active symptoms: • Delusions • Delusional Jealousy • Hallucinations inc. voices • Suicidal Ideation • Organic Psychosis • Other (specify) **Diagnosis Substance Misuse** • Blood born virus • Unsafe injecting habits • Infected injection sites • Evidence of jaundice • Risks associated with withdrawal • Memory deficiencies **Any known non-compliance**: • With medication? • Avoidance of care team • With Care Plan? • With attendance at OP appts? Any important co-morbidity eg painful / debilitating / terminal illness?

Enhanced/Comprehensive Risk Assessment continued

Service users name, dob or hospital number ……

5. Warning Signs (past indicators of relapse)	**Any known antecedents / triggers. For instance:** • Relationship breakdown • Stopping medication • Disordered patterns of eating • Withdrawing or refusing services • Started seeing/doing things that heralded relapse in the past • Offending behaviour • Bereavement • Unprecedented non-compliance
6. Current Personal and Contextual Factors	**Please consider the following**: **Age / Sex / Ethnicity** Marital / Relationship status Financial Situation Family Networks – children Risks to children / child protection Main carer Dependant relatives Single parent/no family support Sexual abuse Concurrent physical illness Any known stressors Employment Status Living arrangements Recent significant life events Any other risk indicators e.g. **Learning Disability** / **Physical Disability**
7. Factors Potentially Reducing Risk	***Please consider*** Supportive family network Employment Motivation Supportive friends/neighbours Agreeing to and engaging with the care plan

Based on your assessment, what is the appropriate level of CPA?

Standard Care	**CPA**	**Discharge from Service**
Criteria	***Criteria***	
Little danger to self or others Good informal support network Able to self-manage Low support needs Maintains contact with services	Likely to harm self or others Multiple care needs Likely to disengage Frequent and intensive interventions Possible dual diagnosis Medication management	No specialist service required

Please refer to CPA guidelines for full description of criteria

Enhanced/Comprehensive Risk Assessment continued

Service users name, dob or hospital number ……

- *When the risk assessment has been completed at a multi-disciplinary CPA meeting sections 8-11 can be recorded on the CPA documentation. Please complete Section 12, sign at Section 13 and enter CPA review date.*

- **Complete all following sections for Risk Assessments completed outside formal CPA meetings.**

8. Risk Management Plan With whom will plan need to be shared? Please tick Children & Families Learning Disabilities Elderly / Phys. Dis. CST A&E Police Probation Housing OT GP Other agencies (Please state which) ……	**Please consider:** Benefit Harm Time frame Personnel involved
9. Contingency/Crisis Plan	**Please specify:** **What is the Contingency Plan?** And what will trigger it? Who will facilitate? information exchange? Who will do what if a crisis occurs?
10. Service Users Views of the Risk Management Plan	
11. Carers Views of the Risk Management Plan	
12. With whom will this risk assessment be shared. Please tick: Carer ❒ Other HPT staff ❒ CST ❒ Other Agencies ❒ ……..	

13. Signed, on behalf of all present at the meeting. (This should be the Care Co-ordinator or their delegated representative)

Signature ……. **Print Name / Profession ……**

Date:…….

Date for review:……

Enhanced/Comprehensive Risk Assessment cont

Appendix 4 – Procedures for Enhanced Primary Mental Health Services

Assessing whether clients are a risk to themselves or others is an area which should be prioritised within the IAPT service. Although level of risk will have been assessed at Triage, the client's level of risk may change on a daily basis, and therefore workers should maintain a constant awareness of this issue. For this reason risk assessment is a mandatory field for every contact on PC-Mis. In assessing risk the following areas are good indicators of level of risk to self:

Level of **ideation** and hopelessness
Extent of **planning**
Likelihood of **action** and previous attempts

At each contact the IAPT minimum data set questionnaires should be completed.

Attend particularly to PHQ 9 item 9: "Thoughts that you would be better off dead or thoughts of hurting yourself in some way". If the response is 1 or above (several days or more), then the following questions from PC-Mis should be asked:

Q1. Do you ever feel that bad that you think about harming or killing yourself?
Q2. Do you ever feel that life is not worth living?
Q3. Have you made plans to end your life?
Q4. Do you know how you would kill yourself?
Q5. Have you made any actual preparations to kill yourself?
Q6. Have you ever attempted suicide in the past?
Q7. How likely is it that you will act on such thoughts and plans? (0 – 10, 10 being certain)
Q8. What is stopping you killing or harming yourself at the moment?

In particular if the client answers yes to questions 1, 3, 4, or 5 then this together with the intent rating on question 7 may indicate a high level of risk. If you think that the client may present a level of risk to themselves or others or then speak to the duty worker or a qualified clinician as soon as possible. In terms of risk to others supplementary questions will need to be asked if there are indications that the client may pose a risk to others. eg anger problems. Also consider child protection issues. Again, areas to assess include level of ideation, extent of planning and previous history. The police may need to be informed if a serious crime is planned or disclosed. If that is the case, the duty worker should be consulted.

If for any reason a qualified clinician is not available and you feel that there is a high level of risk then phone the crisis team. The client can also access the crisis team by attending the local hospital A & E department. The GP should also be informed in writing by fax as soon as possible.

For further guidance please refer to the CORE guidance on risk assessment.

Appendix 3 Equality Impact Assessment (EIA) Stage 1

Policy or service being assessed: Clinical Risk Assessment and Management of Individual Service Users – Policy and procedures		
Summary of Policy (As all policies cannot be read completely when checking assessments, it is necessary that you give us an overview) This is a revision of a well known practice policy. It describes how staff should assess and manage the risks presented by individual service users across the Trust.		
Lead Person: Jonathan Wells – practice governance lead		
Date of Assessment: 20th May 2008		
1. Is this a new or existing policy or service?	**New:**	**Existing: Yes**
2. What is the expected outcome of the service/policy (e.g. aims, objectives and purpose of the service/policy, standards for practice)	Effective assessment and management of clinical risk by all front line staff.	
3. Does this policy/service link to others? If yes please state link below:	**Yes:** Many practice policies, above all CPA policy.	**No:**
4. Does the Policy/Service show that the 11 principles of mental health recovery have been taken into account? (See supporting information in main Impact Assessment toolkit) **If yes, please give evidence: see above.**	Yes: It does. There is an emphasis on positive risk management and good clinical engagement with service users, and acknowledgment that our services and treatments can bring risks with them. See also section 1.5.1. Underpinning Values.	
5. Who is intended to benefit from the policy/service: In what way.	All service users, carers and all front line staff are affected by this policy and should benefit from it.	
6. How is the policy/service to be put into practice? Who is responsible?	There is an ongoing training programme for staff (mandatory) – co-ordinated by Jonathan Wells. Implementation will also be audited.	
7. How and where is information about the policy/service publicised?	Through the intranet, policy guardians and training.	
8. What regular consultation do you carry out with different communities and groups re the policy/service?	Review of this policy involved a range of managers and frontline staff.	
9. Are there concerns that the policy/service could have an adverse impact* because of: (Please refer to supporting information)	**Yes:**	**No:**
Age		x
Disability		x
Gender		x
Ethnicity		x

Sexual Orientation		x
Religion/Belief		x
10. If YES to one or more of the above please state evidence.		
11. Do the differences amount to discrimination?*	**Yes:**	**No:** n/a
12. If YES could it still be justifiable e.g. on grounds of promoting equality of opportunity for one group? I.e. Indirect discrimination can be justifiable sometimes when a service is being provided for a particular target group E.g. Asian women's breast screening, Gay men's sexual health clinic, Mental Health Services for Older People etc.	**Yes:**	**No:**
If Yes: Please give reasons below:		
13. Do you think this policy/service specifically contributes to promoting equality and diversity in Hertfordshire? If so, in what way? Please note any examples of good practice.	The policy refers to demographic factors which affect clinical risk (eg suicide being more likely amongst older people and males). In this way, it supports practice which is sensitive to age and gender.	
14. What approaches will you take to get feedback on your assessment?	The EIA scrutiny group.	
15. How will the assessment link to other mainstream service planning or review processes?	This assessment and revised policy will inform review of CPA later this year.	
16. Should there now be a Full Impact Assessment and if so what are the reasons?	No.	
17. What further data, information or assistance do you need to carry out a full assessment?	n/a.	

GETTING FEEDBACK AND ADVICE

What feedback was given about Stage 1?
The following feedback was given by the EIA scrutiny group on 27/05/08: • List of Legislation – As the Race Relations Amendment Act is included, this should also include the Disability Discrimination Act 2005 and the Equality Act 2006. • Where there is a list of equalities areas it should appear alphabetically like the following: Age, disability, ethnicity/culture, gender, religion and beliefs, sexual orientation. • Where diversity relates to the mental health, the policy should be cross referenced with the Single Equalities Scheme The following changes will be made to the policy: • The policy was amended on 29/05/08 to reflect all the above points