Clinical Risk Assessment and Management Policy
For Individual Service Users

Version: 8
Executive Lead: Executive Director of Quality & Safety
Lead Author: Consultant Psychiatrist
Approved Date: 19 November 2015
Approved By: Clinical Risk & Learning Lessons Group
Ratified Date: 17th December 2015
Ratified By: Policy Panel
Issue Date: 17th December 2015
Review Date: 17th December 2018

Target Audience: This policy is to be followed by:-
- All medical staff, nursing and health care professionals and
- Support staff who are involved in the assessment and management of clinical risk.
P1 - Version Control History:

<table>
<thead>
<tr>
<th>Version</th>
<th>Date of Issue</th>
<th>Author</th>
<th>Status</th>
<th>Comment</th>
</tr>
</thead>
<tbody>
<tr>
<td>V7</td>
<td>9th September 2013</td>
<td>Consultant Psychiatrist</td>
<td>Superseded</td>
<td>Full review and inclusion of implementation of Paris Electronic Patient Record</td>
</tr>
<tr>
<td>V7.1</td>
<td>1st May 2015</td>
<td>Consultant Psychiatrist</td>
<td>Superseded</td>
<td>Updated for Care Act 2014</td>
</tr>
<tr>
<td>V8</td>
<td>17 Dec 2015</td>
<td>Head of Practice Governance</td>
<td>Update</td>
<td>Updated in consultation with key colleagues to reflect changes in recording</td>
</tr>
</tbody>
</table>

P2 - Relevant Standards:

a) CQC Fundamental Standards – Regulation 9 Person-centered Care and Regulation 12 Safe Care and Treatment

b) Equality and RESPECT: The Trust operates a policy of fairness and RESPECT in relation to the treatment and care of service users and carers; and support for staff.

Symbols used in Policies:

RULE = internally agreed, that this is a rule & must be done the way described
STANDARD = a national standard which we must comply with, so must be followed

Managers must bring all relevant policies to the attention of their staff, where possible, viewing and discussing the contents so that the team is aware of what they need to do.

Individual staff/students/learners are responsible for implementing the requirements appropriate to their role, through reading the Policy and demonstrating to their manager that they understand the key points.

All Trust Policies will change to these formats as Policies are reviewed every 3 years, or when national Policy or legislation or other change prompts a review. All expired & superseded documents are retained & archived and are accessible through the Compliance and Risk Facilitator Policies@hpft.nhs.uk

All current Policies can be found on the Trust Policy Website via the Green Button or http://trustspace/InformationCentre/TrustPolicies/default.aspx
<table>
<thead>
<tr>
<th>PART:</th>
<th>CONTENTS</th>
<th>PAGE:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Preface</td>
<td>Preface concerning the Trust Policy Management System:</td>
<td></td>
</tr>
<tr>
<td></td>
<td>P1 - Version Control History</td>
<td></td>
</tr>
<tr>
<td></td>
<td>P2 - Relevant Standards</td>
<td></td>
</tr>
<tr>
<td></td>
<td>P3 - The 2012 Policy Management System &amp; Document Format</td>
<td></td>
</tr>
<tr>
<td>PART 1</td>
<td>Preliminary Issues:</td>
<td></td>
</tr>
<tr>
<td>1.</td>
<td>Summary</td>
<td>4</td>
</tr>
<tr>
<td>2.</td>
<td>Purpose</td>
<td>4</td>
</tr>
<tr>
<td>3.</td>
<td>Definitions</td>
<td>4</td>
</tr>
<tr>
<td>4.</td>
<td>Duties and Responsibilities</td>
<td>5</td>
</tr>
<tr>
<td>5.</td>
<td>Key Standards</td>
<td>5</td>
</tr>
<tr>
<td>PART 2</td>
<td>What needs to be done and who by:</td>
<td></td>
</tr>
<tr>
<td>6.</td>
<td>Procedures</td>
<td>7</td>
</tr>
<tr>
<td>6.1</td>
<td>Background</td>
<td>7</td>
</tr>
<tr>
<td>6.2</td>
<td>Risk Assessment and Care Coordination</td>
<td>7</td>
</tr>
<tr>
<td>6.3</td>
<td>The process of Risk Assessment and Risk Management</td>
<td>8</td>
</tr>
<tr>
<td>6.4</td>
<td>Gathering Information</td>
<td>8</td>
</tr>
<tr>
<td>6.5</td>
<td>Identifying situations and circumstances known to present increased risk (critical indicators)</td>
<td>9</td>
</tr>
<tr>
<td>6.6</td>
<td>Risk to Self</td>
<td>10</td>
</tr>
<tr>
<td>6.7</td>
<td>Risk to Others</td>
<td>12</td>
</tr>
<tr>
<td>6.8</td>
<td>Risk of Abuse</td>
<td>15</td>
</tr>
<tr>
<td>7.</td>
<td>Recording the risk assessment</td>
<td>16</td>
</tr>
<tr>
<td>7.1</td>
<td>Use of the tools</td>
<td>17</td>
</tr>
<tr>
<td>7.2</td>
<td>Adult Mental Health Risk Assessment</td>
<td>17</td>
</tr>
<tr>
<td>7.3</td>
<td>Child and Adolescent Mental Health Services Risk Assessment</td>
<td>18</td>
</tr>
<tr>
<td>7.4</td>
<td>Forensic Services</td>
<td>18</td>
</tr>
<tr>
<td>7.5</td>
<td>Other Specialist Tools</td>
<td>19</td>
</tr>
<tr>
<td>8.</td>
<td>Formulating a care plan to manage risk</td>
<td>19</td>
</tr>
<tr>
<td>9.</td>
<td>Monitoring and reviewing the situation</td>
<td>20</td>
</tr>
<tr>
<td>9.1</td>
<td>Risk Review</td>
<td>20</td>
</tr>
<tr>
<td>9.2</td>
<td>Risk Management Panel</td>
<td>21</td>
</tr>
<tr>
<td>10.</td>
<td>Support to Staff</td>
<td>21</td>
</tr>
<tr>
<td>11.</td>
<td>Communication and Confidentiality</td>
<td>22</td>
</tr>
<tr>
<td>12.</td>
<td>Carers</td>
<td>22</td>
</tr>
<tr>
<td>13.</td>
<td>Inter-professional Disagreements</td>
<td>23</td>
</tr>
<tr>
<td>14.</td>
<td>Health Professionals Regulatory Guidance</td>
<td>23</td>
</tr>
<tr>
<td>15.</td>
<td>Training /Awareness</td>
<td>23</td>
</tr>
<tr>
<td>16.</td>
<td>Equality and RESPECT</td>
<td>24</td>
</tr>
<tr>
<td>17.</td>
<td>Process for monitoring compliance with this document</td>
<td>26</td>
</tr>
<tr>
<td>PART 3</td>
<td>Associated Issues</td>
<td></td>
</tr>
<tr>
<td>18.</td>
<td>Version Control</td>
<td>27</td>
</tr>
<tr>
<td>19.</td>
<td>Archiving Arrangements</td>
<td>27</td>
</tr>
<tr>
<td>20.</td>
<td>Associated Documents</td>
<td>28</td>
</tr>
<tr>
<td>21.</td>
<td>Supporting References</td>
<td>29</td>
</tr>
<tr>
<td>22.</td>
<td>Comments and Feedback</td>
<td>30</td>
</tr>
<tr>
<td>Appendices</td>
<td></td>
<td>33</td>
</tr>
</tbody>
</table>
1. Summary
Hertfordshire Partnership University NHS Foundation Trust (referred to in this document as HPFT or the Trust) is committed to the safety and wellbeing 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 patient 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.

2. Purpose
The policy sets out the framework for the management of risk related to individual service users in all clinical areas.

The policy is followed by procedures which provide more detailed guidance on risk assessment and risk management within services. The procedures are also reflected in relevant Operational Policies.

The policy aims to:
- Provide a framework which enables staff to use best practice in assessing and managing clinical risk
- Enable staff to practice in such a way that their own professional judgment is encouraged
- Enable staff to practice in such a way that service users (and carers whenever possible) are genuine partners in considering and addressing their own areas of risk, so that they are supported to find ways to keep themselves and those around them free from harm

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 the Trust.

The procedures to be followed are described in Part 2. These apply to all services in the Trust other than the Enhanced Primary care Mental Health Services, who work with a different group of service users. They have developed separate procedures, summarised here in appendix 3. 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.

This policy should be considered in the context of several other Trust policies, which are listed below under Associated Documents.

3. Definitions
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.

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.

4. Duties and Responsibilities

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

The Clinical Risk and Learning Lessons Group, reporting to the Quality and Risk Management 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 audits, learning from incidents and other initiatives which will enable continual improvement of practice

5. Key Standards

STANDARD

The Trust employs the Department of Health’s 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, the Trust has set the following standards which are integral to how we approach risk:

- **Be a joint exercise between staff, service user and (where agreed), carers**

- **Be empowering for service users and recognize the value of positive risk-taking:**

- **Inform and guide the process of care with the service user at the centre**

- **Generate fresh ideas for positive risk management which make sense to the service user and which he or she can use**

- **Be dynamic and on-going with reviews triggered by needs or events**

- **Be recorded in a clear accessible form, and be communicated appropriately**

- **Be integral to the wider 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 – unqualified staff may not complete risk assessments independently**

- **Ensure that the care plan including the risk management plan is guided by the risk assessment.**
6. PROCEDURES

6.1. Background

Risk and risk taking are intrinsic to practice in Mental Health and 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 University NHS Foundation Trust that all mental health professionals will undertake or contribute to the assessment and management of clinical risk.

6.2 Risk Assessment and Care Coordination

For those with mental health problems, the Care Programme Approach (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. These now receive care through Standard Care, supported by a named professional.

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 with dual diagnosis, mental health and substance misuse, 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 Substance Misuse Services provided by other agencies.

Those receiving enhanced primary care mental health services (Well-being 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.

The Delivery of Care Policy (April 2015) describes how risk assessments can be recorded in different ways depending on whether a service user is on the CPA or not.
6.3 The Process of Risk Assessment and Risk Management

The Trust endorses the use of ‘structured clinical judgment’ as an approach to assessing risk. This approach is encouraged by the Department of Health and the Royal College of Psychiatrists. It involves the use of clinical judgment that is guided by a standardised format, potentially complemented by the use of clinical risk assessment tools.

When assessing risk, practitioners are expected to use the relevant 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 from the service user, carers and other relevant agencies as appropriate
- Identify situations and circumstances known to present increased risk
- Make an assessment of the risk and record the assessment
- Formulate a plan in collaboration with the service user and carer to manage the identified risks and include a Contingency/Crisis Plan
- Take the risk assessment into account in deciding if care should be provided under CPA or Standard care (see Delivery of Care policy)

6.4. 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 it 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.

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). Carers provide important information available to make an informed risk assessment, including concerns about the possible risk of deterioration in service users.
- 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 behavior 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 should 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.

6.5. **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 socio-demographic 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, (but not exclusively):

- 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 behavior 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.

6.6 Risk to Self
This can be considered under separate headings: suicide, deliberate self-harm, accidental self-harm, and self-neglect.

Suicide
Three elements are especially important in assessing the risk of suicide:

- Knowledge of general risk factors for suicide
- Knowing the individual well – their history, and their protective and vulnerability factors
- Skills in making direct enquiries about suicidal intent, based on a close and trusting therapeutic relationship

An example of general risk factors for suicide is the knowledge that at present in the UK males aged 35 to 70 are known to be at particularly high risk for suicide. This demographic factor should be taken into account in practice. The Patient Safety and Practice Governance Leads will keep staff informed about any significant demographic trends of this kind.

Patient Safety and PG leads will also use reports such as those by the National Confidential Inquiry into Suicides and Homicides to keep staff appraised of trends.

The period around inpatient discharge can be a time of particular high risk of suicide, emphasizing the need for proper assessment prior to discharge and effective follow up (see Discharge and Transfer of Service Users within the Care Planning Process Policy and Procedures (incorporating 7 day follow-up requirements). A breakdown in the continuity of care by either carers or professionals can significantly increase 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 carefully assessed with each service user each time such a statement is made.

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.

It is important always to be psychologically-minded in assessing risk for suicide. In this context, hopelessness is known to be a key factor. More recently, the feeling of being a burden to others has been confirmed as often very important.

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. Carers must always be involved at this stage, with the service user’s consent or without it if the risks are grave.

Consideration should be given to whether the use of the Mental Health Act is appropriate.

**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 behavior may be adopted by people who cannot otherwise express their distress. These factors may be prevalent in services for adults with learning disabilities.

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

**Accidental Self Harm**

Desperate or reckless behaviour can be expected to be more common in those with a diagnosis of borderline personality disorder and those with drug and/or alcohol issues. It may be hard to separate out what behaviours are intended and what are accidental.

Whether the risk is of deliberate or accidental self-harm (or a mixture of the two), it should be assessed with equal care as in each scenario the outcome can be fatal.

Service users – especially but not only frail elderly people – may be at risk of falls and pressure ulcers. See relevant practice policies.

For those with learning disabilities there is a strong role for programmes and individual support in self-care in all settings including kitchens, traffic and other potentially hazardous environments, to help service users develop their skills in staying safe.
Risk of Self-neglect.

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

- Hygiene
- Diet
- Infestation
- Household safety
- Warmth
- Hoarding behaviours

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.

Active follow up in the community may be necessary and a contingency 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.

6.7. Risks to Others.

6.7.1. 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). The Trust’s Community Forensic Service can advise staff on the process for obtaining criminal records from the Police. When assessing individuals for risk of violence and when
concerns are great, it is reasonable to seek such information through the advice of the Forensic Team

- 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.

In specific forensic settings, appropriately trained staff are expected to use the HCR – 20 to assist in the assessment of risk of violence to others.

6.7.2. Carers.
Carers are often particularly at risk of violence from the person they care for and staff should be sensitive to this (see section 11 below).

6.7.3. 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. They should also comply with Trust policy and use the protective devices now provided (see Lone Working Policy).

Alerts should be placed on the service user’s electronic patient record when significant risks have been identified, especially when these are about the safety of others.

6.7.4. 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.

When someone is transferred from inpatient status to community services including CATT, this decision should in all cases be informed by an updated risk assessment. Likewise, when someone is transferred from CATT to non-acute community services, this decision should be supported by an updated risk assessment, completed within 48 hours of the transfer.
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”.

**6.7.5. Risk to a Child or Young Person (under 18yrs old)**

Parental mental ill-health is known to be a significant factor in many cases of child abuse. Thus, risk assessments of adult service users must include gathering all child identifiable data in every case.

Information about identified children needs to be reviewed during significant changes of circumstances and care reviews, as part of the risk assessment. On the basis of the information included within this document, a decision should then be made with regards to whether a referral to Children’s Services may be necessary.

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’s Act 2014). 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 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.

6.8. 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 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 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 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 From Abuse Policy and the Head of Safeguarding.

A significant proportion of service users may be at risk of domestic violence. Whether or not the victim is considered vulnerable, staff should take the necessary steps to help the individual be safe according to policy.

Finally in this section, the Prevent Policy guides staff on their responsibilities in being vigilant to service users being groomed into extremism or terrorist activity.

### 7. Recording the Risk Assessment

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 an outpatient clinic and is assessed as low risk and maintained on Standard Care, will not need a complex care plan or complex risk assessment.

A record of a risk assessment:

- Provides an explanation of how conclusions about risk are reached which can inform the practice of all
- Captures the risk history which needs to be available to all colleagues dealing with the service user
- Captures the protective factors and strengths of the service user as a basis for them to be developed further
- Allows for reports on completion of risk assessments to be provided to managers so that good practice can be maintained

The Care Co-coordinator 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 this may be an individual worker. For CPA (or equivalent) this will be the designated Care Co-coordinator 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 responsible will be the most senior professional involved in the emergency. This is likely to be the admitting doctor and the most senior nurse present. All professionals involved in emergency 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 dependent upon whether the service user has a mental illness, a substance misuse problem or a learning disability, and on whether they are a child, young person, or adult.

7.1. Use of the tools

RULE

A risk assessment should be completed at the following points in the service user’s care pathway:

- a. On referral to the Trust, the Single Point of Access service will complete a risk assessment as part of their triage. This is not comprehensive and its prime purpose is to ascertain the level of urgency of each referral.
- b. A full risk assessment will be completed as part of the assessment process alongside the needs agreement.
- c. A full risk assessment will be completed whenever a CPA review takes place—that is, when there are significant changes of need and at least annually.
- d. For those on Standard Care, the GP letter may be used as the risk assessment record rather than the separate form; this must be done at least annually.
- e. A full risk assessment will be completed when a service user is transferred between services under CPA. This will generally be completed by the receiving team when they take over the case. The exception to this is in inpatient services, where both the risk assessment on admission and the one on transfer out of inpatient care will be completed by the named nurse.
- f. In the case of transfers from all inpatient care, when the transfer destination is a funded health or social care placement, there must be a risk assessment that the manager has signed off as up to date before transfer to the placement takes place.

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 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 judgment.

7.2. Adult Mental Health Risk Assessment Form (Appendix 1)

It is to be used for:

7.2.1. New mental health service users at initial assessment
7.2.2. Those on CPA whenever the risk assessment needs to be repeated

It may be used for those on Standard Care.

18
Who records and signs: The person conducting the initial assessment, or the Care Coordinator.

Who receives a copy: HPFT staff who need to know will access the risk assessment on the EPR.

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.
- If risk is assessed as low and the person does not require specialist mental health services but social or 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. Care Act responsibilities are significant here.

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

7.3. Child and Adolescent Mental Health Services Risk Assessment Form (Appendix 2).

CAMHS service users may experience the full range of clinical risks associated with mental ill health, including suicide. High rates of deliberate self-harm and of self-neglect associated with eating disorders can be expected, as well as risk from others including abuse and exploitation.

All service users under the care of CAMHs will receive an initial risk assessment, including Forest House and C- CATT, using the specialised CAMHS Risk Assessment Tool on the EPR. Please see tool at Appendix 3.

Those managed under CPA should have further risk assessments at review or when circumstances significantly change, documented on the same EPR form.

For those not on CPA documentation of risk and its management in the GP letter is acceptable, or else the risk assessment form must be used.

7.4. Forensic Services

In all HPFT forensic services, Structured Professional Judgment risk assessment will commence prior to admission. The mainstay of this will be a combination of HCR-20 and START. At pre-admission meetings the (H) score of the HCR-20 will be initially rated based on the preadmission assessment. This will be reviewed and updated prior to initial CPA, at 6 to 12 weeks post-admission. Initial START risk assessment will take place prior to the first
CPA. HCR-20 and START will be reviewed prior to every subsequent CPA meeting. CPA reviews will take place at minimum once every six months.

A CPA/117 meeting will take place prior to discharge from inpatient care, at which all risk assessments will be reviewed in light of the proposed discharge destination. Where an individual is due to be discharged into the care of an HPFT team or clinician, the HPFT risk assessment tool will be completed at the CPA prior to discharge, for familiarity of communication.

Other Structured Professional Judgment tools, such as SAPROF, SVR-20 will be completed as necessary, based on the clinical scenario.

7.5. 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 organised 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 Risk Assessment form.

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 that if required they are covered by a licence, before using these tools.

8. Formulating a Care Plan to Manage 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. The aim should be to identify the vulnerabilities and strengths of the service user which contribute to the risk
equation, and develop or reduce these proportionately; the risks should alter accordingly.

This is an integral part of Care Co-ordination, 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 or named professional. This may be undertaken in a multi-disciplinary forum for service users monitored on CPA and in a clinical interview or meeting for those maintained on Standard Care.

The risk management plan – often known as “Staying Safe” – forms a core part of the care plan, which is developed with and shared with the service user and carer as appropriate. This forms the basis for a partnership between staff and service user, working together to build strengths, avoid harms and move towards independence.

9. Monitoring and Reviewing the Situation

9.1. Risk Review
CPA
A review should also use Structured Clinical Judgment, following the guidance above. A new Risk Assessment form should be completed at each CPA review and at other times when risks significantly change, which should bring forward historical information from previous assessments and include new history since the last assessment.

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

Who receives a copy: All those present at the CPA or Professional Review Meeting. Where separate records are held by other disciplines a copy of the new risk assessment should be placed on each file.

With whom should the information be shared: All those contributing to the care plan should receive the information. 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 may need to know. See section 10 Communication and Confidentiality”.

Standard Care
As with initial risk assessments, risk assessments at review for those on Standard Care do not have to be recorded on the risk assessment EPR document. They can be recorded in the GP letter.

In all cases:
• risk assessments should be reviewed when there are any changes that cause concern.
• when someone is transferred from inpatient status to community services including CATT,
this decision should in all cases be informed by an updated risk assessment. Likewise, when someone is transferred from CATT to non-acute community services, this decision should be supported by an updated risk assessment, completed within 48 hours of the transfer. (See Transfer and Discharge Policy section 5).

- when someone is transferred from inpatient care to a funded placement, there should always either be a new risk assessment within 48 hours of the placement starting or a signed checklist stating that the previous risk assessment remains valid
- as a minimum all risk assessments should be reviewed annually.

In urgent situations the Care Coordinator, or during in-patient admissions the Named Nurse, may need to take immediate decisions in managing clinical risks 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 prompt consideration of a review of the level of Care Coordination.

9.2 Risk Management Panel
From time to time a team may be faced with a challenging case where they have an ongoing duty to provide care and treatment to a service user, but where it is extremely difficult to ensure that the service user and those around her or him including Trust staff can remain safe.

In some parts of the Trust risk meetings often known as professionals' meetings are already used to enable complex and high risk situations to be though through by a range of staff. Psychiatrists will also sometimes seek a second opinion when faced with a challenging or especially complex case.

The Risk Panel is available to staff when all other sources of extra advice have been exhausted.

The Panel Function - The panel's main function is to provide expert advice to the care co-ordinator and other Trust staff contributing to the care plan, on the future management of an individual service user.

It will:
- Provide a broader perspective on a case in a situation where the local ward/team may be finding it difficult to maintain a clear objective view of the needs of the service user
- Make available professional advice which brings additional expertise to the case and also a multi-disciplinary perspective

More detail is provided in Appendix 5.

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 must have regular training on the management of violence and
aggression
- Staff training in risk assessment 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 the 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 as judged by the line manager
- 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 allocated
- 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 proactive in bringing high risk cases to supervision
- 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 coordinated 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 that 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 level 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 explicitly.

In situations of high risk, 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 or 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 “Care Records Management Policy”.

12. Carers

Staff should routinely 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. Carers provide important information to make an informed risk assessment in relation to concerns about the possible risk of deterioration in service users.

When attending an appointment with the service user, a carer should be offered time to discuss privately any concerns they might have, including risks for the service user. It is not necessary for the service user to have given permission when the carer is simply sharing information that they have which helps Trust staff assess and manage any risks.

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 allies in the risk management plan. Once identified, they should always be offered a carer’s assessment.

Further details can be found in the Consensus Statement: Information Sharing and Suicide Prevention (Department of Health, January 2014).

13. Inter Professional Disagreements
It is important that all agencies involved in the care of service users 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 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.

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

14. Health Professionals Regulatory Guidance
Health professionals of all disciplines have an ongoing requirement to fulfill 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. Training / Awareness

**STANDARD**
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, will be available through supervision and informal support, and if necessary through the Risk Panel.

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.

**Training Template:**

<table>
<thead>
<tr>
<th>Course</th>
<th>For</th>
<th>Renewal Period</th>
<th>Delivery Mode</th>
<th>Contact Information</th>
</tr>
</thead>
<tbody>
<tr>
<td>Clinical Risk Assessment for Individual Service Users</td>
<td>All clinical staff</td>
<td>Every 3 years</td>
<td>Taught course – half day</td>
<td>For taught courses, contact the Learning &amp; Development Team: <a href="mailto:Learning@hertspartsft.nhs.uk">Learning@hertspartsft.nhs.uk</a> You can check for future dates here, and request a specific date.</td>
</tr>
<tr>
<td>Bespoke Training in Clinical Risk Assessment</td>
<td>Key teams – eg. CATTs (Band 5 and above)</td>
<td>Every 3 years</td>
<td>Taught course – half day</td>
<td></td>
</tr>
</tbody>
</table>

**16. Embedding a culture of Equality & RESPECT**

The Trust promotes fairness and RESPECT in relation to the treatment, care & support of service users, carers and staff.

RESPECT means ensuring that the particular needs of ‘protected groups’ are upheld at all times and individually assessed on entry to the service. This includes the needs of people based on their age, disability, ethnicity, gender, gender reassignment status, relationship status, religion or belief, sexual orientation and in some instances, pregnancy and maternity.
Working in this way builds a culture where service users can flourish and be fully involved in their care and where staff and carers receive appropriate support. Where discrimination, inappropriate behaviour or some other barrier occurs, the Trust expects the full cooperation of staff in addressing and recording these issues through appropriate Trust processes.

Access to and provision of services must therefore take full account of needs relating to all protected groups listed above and care and support for service users, carers and staff should be planned that takes into account individual needs. Where staff need further information regarding these groups, they should speak to their manager or a member of the Trust Inclusion & Engagement team.

Where service users and carers experience barriers to accessing services, the Trust is required to take appropriate remedial action.

| Service user, carer and/or staff access needs (including disability) | The Clinical Risk Policy and procedure has been developed based on feedback from service users and carers and piloted in service areas with service users. As an important part of the clinical process, it is important that all staff working within the Trust are aware of issues relating to equality and diversity for service users and carers and are able to understand how to ask the questions to ensure the needs of protected groups are upheld at all times and assessed appropriately whilst under Trust services. A minimum requirement consistent with the promotion of equality of opportunity for service users and carers is to make all reasonable efforts to ensure that an appropriate interpreter is able to facilitate communication between Trust staff and service users and carers if their preferred spoken language is not English including ensuring availability of British Sign Language (BSL) interpreters. Being aware of alternative methods of communication for profoundly deaf services users during the clinical risk assessment process. Ensuring that people with learning disabilities do not suffer disadvantages and are supported appropriately during the risk assessment process. Understanding the needs of all protected groups and what issues they might be experiencing that has led to them accessing the service. Observing the principles of the RESPECT campaign at all times. |
| Involvement | The development of the clinical risk assessment process has been based on trials involving a diverse range of staff, service users and groups in shaping and testing the tools. This has enable consultation that is informative and meaningful, and ensures there has been no unlawful discrimination in the development of policy and procedures. |
| Relationships & Sexual Orientation | Clinical risk assessment is an assessment tool and as such take into account the needs of service users. Staff will document any risks associated with relationships, existing or not, for the information of staff responsible for the care and treatment and they may be factored into the risk management plan.  
They will likewise take account of any issues around sexual orientation (and any barriers for people around their orientation) as well as any relevant issues regarding nearest relatives and family carer or pregnancy during the risk assessment. |
| Culture & Ethnicity | Trust staff will take account of the needs of people based culture and ethnicity – gathering relevant information such as language, and diet and any other cultural needs identified during the risk assessment process. |
| Spirituality | Trust staff will take account of any expressed spirituality that is identified in the initial clinical risk assessment. |
| Age | Clinical risk assessment is undertaken to all service users regardless of age and will ensure that older adults and young people do not suffer disadvantage and are supported appropriately through the service and communicated with in a way that they respond to. |
| Gender & Gender Reassignment | Trust staff will take account of the gender of all service users they undertake a clinical risk assessment on and consider the needs and risks associated with transgender service users and carers. This will be used to inform appropriate gender of onward carers/assessors/clinicians. |
| Advancing equality of opportunity | Staff have a responsibility to challenge any discrimination they may witness and report back in accordance with risk management and incidents processes. |

### Promoting and considering individual wellbeing

Under the Care Act 2014, Section 1, the Trust has a duty to promote wellbeing when carrying out any of their care and support functions in respect of a person. Wellbeing is a broad concept and is described as relating to the following areas in particular:

- Personal dignity (including treatment of the individual with respect);
- Physical and mental health and emotional wellbeing;
- Protection from abuse and neglect;
- Control by the individual over day to day life including over the care and support provided and the way in which it is provided;
- Participation in work, training, education, or recreation;
- Social and economic wellbeing;
- Domestic, family and personal;
- Suitability of living accommodation;
- The individual’s contribution to society.

There is no hierarchy and all should be considered of equal importance when considering an individual’s wellbeing. How an individual’s wellbeing is considered will depend on their individual circumstances including their needs, goals, wishes and personal choices and how these impact on their wellbeing.

In addition to the general principle of promoting wellbeing there are a number of other key principles and standards which the Trust must have regard to when carrying out activities or functions:

- The importance of beginning with the assumption that the individual is best placed to judge their wellbeing;
- The individual’s views, wishes, feelings and beliefs;
- The importance of preventing or delaying the development of needs for care and support and the importance of reducing needs that already exist;
- The need to ensure that decisions are made having regard to all the individual’s circumstances;
- The importance of the individual participating as fully as possible;
- The importance of achieving a balance between the individuals wellbeing and that of any carers or relatives who are involved with the individual;
- The need to protect people from abuse or neglect;
- The need to ensure that any restriction on the individuals rights or freedom of action that is involved in the exercise of the function is kept to the minimum necessary.

17. Process for monitoring compliance with this document –

<table>
<thead>
<tr>
<th>Action:</th>
<th>Lead</th>
<th>Method</th>
<th>Frequency</th>
<th>Report to:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Review of compliance with this policy</td>
<td>PACE Team</td>
<td>Audit</td>
<td>Annually</td>
<td>Clinical Risk and Learning Lessons, Quality and Risk Management Committee</td>
</tr>
<tr>
<td>Check policies compliance via serious incident investigations</td>
<td>Patient Safety Manager</td>
<td>Root cause analysis investigation</td>
<td>On going</td>
<td></td>
</tr>
<tr>
<td>Use of the new supervision tools in AMH community</td>
<td>SLLs</td>
<td>Supervision</td>
<td>Ongoing</td>
<td></td>
</tr>
</tbody>
</table>

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.
18. Version Control

**STANDARD**

<table>
<thead>
<tr>
<th>Version</th>
<th>Date of Issue</th>
<th>Author</th>
<th>Status</th>
<th>Comment</th>
</tr>
</thead>
<tbody>
<tr>
<td>V4</td>
<td>Oct 2005</td>
<td>Head of Practice Governance</td>
<td>Superseded</td>
<td></td>
</tr>
<tr>
<td>V5</td>
<td>July 2008</td>
<td>Head of Practice Governance</td>
<td>Superseded</td>
<td>Approved Trust Executive Team 2.7.08</td>
</tr>
<tr>
<td>V5.1</td>
<td>August 09</td>
<td>Head of Practice Governance</td>
<td>Superseded</td>
<td>Archived 20.8.10</td>
</tr>
<tr>
<td>V7</td>
<td>9th September 2013</td>
<td>Consultant Psychiatrist</td>
<td>Superseded</td>
<td>Minor amendments – will need review and re-write following implementation of Paris Electronic Patient Record</td>
</tr>
<tr>
<td>V7.1</td>
<td>1st May 2015</td>
<td>Consultant Psychiatrist</td>
<td>Current</td>
<td>Updated for Care Act 2014 Addendum</td>
</tr>
<tr>
<td>V8</td>
<td>17 Dec 2015</td>
<td>Head of PG Governance</td>
<td>Interim update</td>
<td>Updated in consultation with key colleagues to reflect changes in recording</td>
</tr>
</tbody>
</table>

19. Archiving Arrangements

**STANDARD:** All policy documents when no longer in use 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 available on the Trust Intranet

A database of archived policies is kept as an electronic archive administered by the Policy Coordinator. This archive is held on a central server and copies of these archived documents can be obtained from the Policy Coordinator on request.

20. Associated Documents

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:

a. Supportive Observation of Service Users at Risk
b. Non Physical and Physical Assaults (Violence and Aggression)
c. Lone Worker Policy
d. Delivery of Care Policy (Incorporating the Care Programme Approach)
e. Falls Prevention Policy
f. Pressure Ulcer Prevention Policy
g. Learning from Incidents
h. Risk Management Policy
i. Safeguarding Adults and Children
j. Care Records Management
k. Lone Working Policy
l. Searching Service Users and their Property
m. Advance Directives Policy
n. Health and Safety Policies (HPT and ACS)
o. Discharge and Transfer Policy
p. Operational Policy, Adult Mental Health Community Services
q. Operational Policy, Mental Health Teams for Older People
r. Acute Ward Operational Policy
s. Dysphagia and Nutrition Policy
t. Physical Health Assessment and Physical Monitoring

21. Supporting References

STANDARD

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

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
The Children’s Act 2014
The Care Act 2014

Preventing Suicide: A toolkit for Mental Health Services 2003
Safeguarding Adults from Abuse: a Hertfordshire Inter-agency protocol
Avoidable Deaths: Five Year report of the national Confidential Inquiry into suicide and homicide by People with mental Illness (2006)
Best Practice in Managing Risk: Department of Health (2009)
Refocussing the Care Programme Approach (2008)

22. Comments and Feedback

Comments and Feedback on this document were obtained from:

<table>
<thead>
<tr>
<th>Head of Social Work and Safeguarding</th>
</tr>
</thead>
<tbody>
<tr>
<td>Associate Medical Director (Practice Governance)</td>
</tr>
<tr>
<td>Deputy Director – Safer Care and Standards</td>
</tr>
</tbody>
</table>
### APPENDICES

<table>
<thead>
<tr>
<th>Appendices</th>
</tr>
</thead>
<tbody>
<tr>
<td>Appendix 1 – Risk Assessment Form AMHS</td>
</tr>
<tr>
<td>Appendix 2 - Risk Assessment Form CAMHS</td>
</tr>
<tr>
<td>Appendix 3 – Risk Assessment Form LD</td>
</tr>
<tr>
<td>Appendix 4 - Procedures for Well-being/IAPT services</td>
</tr>
<tr>
<td>Appendix 5 - Risk Management Panel Guidance</td>
</tr>
<tr>
<td>Appendix 6 – Learning from Serious Incidents</td>
</tr>
</tbody>
</table>
# AMH Risk Assessment Tool

<table>
<thead>
<tr>
<th>Amh/Camhs Risk Assessment USER(141885)</th>
<th>PROFESSOR. TEST SERVICE</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Person Details</strong></td>
<td></td>
</tr>
<tr>
<td>Name</td>
<td>PROFESSOR. TEST SERVICE USER</td>
</tr>
<tr>
<td>Address 5TL</td>
<td>HERTFORDSHIRE PARTNERSHIP NHS TRUST, 99 WAVERLEY ROAD, ST. ALBANS, HERTFORDSHIRE, AL3</td>
</tr>
<tr>
<td><strong>Telephone Status</strong></td>
<td>ID</td>
</tr>
<tr>
<td><strong>Header Details</strong></td>
<td></td>
</tr>
<tr>
<td>Type</td>
<td>AMH/CAMHS RISK ASSESSMENT</td>
</tr>
<tr>
<td>Date Started</td>
<td>18/12/2014</td>
</tr>
<tr>
<td>Time Started</td>
<td></td>
</tr>
<tr>
<td>Reason for Assess.</td>
<td></td>
</tr>
<tr>
<td>Location</td>
<td></td>
</tr>
<tr>
<td>Team</td>
<td>INFORMATICS2</td>
</tr>
<tr>
<td>Carried Out By</td>
<td>ROBERT XXHARRIS</td>
</tr>
<tr>
<td>Recorded By</td>
<td>ROBERT XXHARRIS</td>
</tr>
<tr>
<td>120431</td>
<td>Assessment ID</td>
</tr>
<tr>
<td><strong>Planned Next Review Date</strong></td>
<td></td>
</tr>
<tr>
<td><strong>Goal at Time of Ass.</strong></td>
<td></td>
</tr>
</tbody>
</table>

Which HPFT Service

Please Select if this is an AMH/CAMHS Assessment | AMH
### Risk Screening - AMH Version

<table>
<thead>
<tr>
<th>Risk of self harm or suicide</th>
<th>YES</th>
<th>NO</th>
<th>INSUFFICIENT INFORMATION</th>
</tr>
</thead>
<tbody>
<tr>
<td>Risk of self neglect</td>
<td>YES</td>
<td>NO</td>
<td>INSUFFICIENT INFORMATION</td>
</tr>
<tr>
<td>Risk of harm to others</td>
<td>YES</td>
<td>NO</td>
<td>INSUFFICIENT INFORMATION</td>
</tr>
<tr>
<td>Risk of abuse or neglect by others</td>
<td>YES</td>
<td>NO</td>
<td>INSUFFICIENT INFORMATION</td>
</tr>
</tbody>
</table>

**Does the patient have children under the age of 18, are they pregnant, do they have close contact with children?**

|YES| NO|

### Risk Screening Authorisation - AMH Version

<table>
<thead>
<tr>
<th>Authorise Section</th>
<th>Authorised By</th>
<th>Date</th>
</tr>
</thead>
</table>

### List People Involved In Risk Assessment

- **Name**
- **Role**
- **Contact Details**

### Amh/Camhs Risk Assessment

**PROFESSOR. TEST SERVICE USER(141885)**

Patients with suicidal ideas/thoughts please consider completing Beck Hopelessness Scale and attaching to this Risk Assessment.

### History Of Risks

- dsadsawrtgwh

### Other Concerns

- asdasdew4yw4

### Protective Factors

- ewetw4t

### Risk Management/ Contingency & Crisis Plan

- ertete

### Please Select To Indicate The Following Has Been Discussed

- Information sharing / confidentiality discussed with Service User
  - [ ] YES
  - [ ] NO

- Consent to sharing risk assessment given by Service User
  - [ ] YES
  - [ ] NO

- Service User and/or Carer informed of this plan
  - [ ] YES
  - [ ] NO

With whom will this risk assessment and management plan be shared?

- Carer
  - [ ]
- GP
  - [ ]
- Service User
  - [ ]
- Other Agencies (Please specify)
  - [ ]

### Attachment Search

<table>
<thead>
<tr>
<th>File</th>
<th>Document Type</th>
<th>Reason</th>
<th>Title</th>
<th>Recorded By</th>
<th>Recorded On</th>
<th>Recorded At</th>
</tr>
</thead>
<tbody>
<tr>
<td>Authorise Section</td>
<td>Authorised By</td>
<td>Date</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>-------------------</td>
<td>---------------</td>
<td>------</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Risk Assessment Authorisation
CAMHS Risk Assessment Tool

<table>
<thead>
<tr>
<th>Header Details</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Type</strong></td>
<td>AMH/CAMHS RISK ASSESSMENT</td>
</tr>
<tr>
<td><strong>Date Started</strong></td>
<td>07/05/2015</td>
</tr>
<tr>
<td><strong>Time Started</strong></td>
<td></td>
</tr>
<tr>
<td><strong>Reason for Assess</strong></td>
<td></td>
</tr>
<tr>
<td><strong>Location</strong></td>
<td></td>
</tr>
<tr>
<td><strong>Team</strong></td>
<td>INFORMATICS</td>
</tr>
<tr>
<td><strong>Carried Out By</strong></td>
<td>CLAIRE XXHARTLEY</td>
</tr>
<tr>
<td><strong>Recorded By</strong></td>
<td>CLAIRE XXHARTLEY</td>
</tr>
<tr>
<td><strong>Planned Next Review Date</strong></td>
<td></td>
</tr>
<tr>
<td><strong>Goal at Time of Ass.</strong></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Which HFFT Service</th>
</tr>
</thead>
<tbody>
<tr>
<td>Please Select if this is an AMH/CAMHS Assessment</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Risk Screening - AMH Version</th>
</tr>
</thead>
<tbody>
<tr>
<td>Risk Screening Authorisation - AMH Version</td>
</tr>
<tr>
<td>Risk Screening - CAMHS Version</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Risk of self harm or suicide</th>
<th>YES</th>
<th>NO</th>
<th>INSUFFICIENT INFORMATION</th>
</tr>
</thead>
<tbody>
<tr>
<td>Risk of self neglect</td>
<td>YES</td>
<td>NO</td>
<td>INSUFFICIENT INFORMATION</td>
</tr>
<tr>
<td>Risk of harm to others</td>
<td>YES</td>
<td>NO</td>
<td>INSUFFICIENT INFORMATION</td>
</tr>
</tbody>
</table>
Safeguarding children:  
- YES  
- NO  
- INSUFFICIENT INFORMATION

Write paragraph outlining concerns and giving details as outlined in Guidance Notes:

If you have concerns with regards to a child in need, the safety of an unborn child, or a child/children in significant harm, refer to the Trust's Safeguarding Children Policy. Advice is also available from your manager, a Senior Social worker, the Safeguarding Practice Team.

Risk Screening Authorisation - CAMHS Version

<table>
<thead>
<tr>
<th>Authorise Section</th>
<th>Authorised By</th>
<th>Date</th>
</tr>
</thead>
</table>

List People involved in Risk Assessment

<table>
<thead>
<tr>
<th>Name</th>
<th>Role</th>
<th>Contact Details</th>
</tr>
</thead>
</table>

Current Risks

- [list of current risks]

Patients with suicidal ideas/thoughts please consider completing Beck Hopelessness Scale and attaching to this Risk Assessment

History Of Risks

- [list of history of risks]

Individual Vulnerability, Familial & Social Factors - CAMHS Only

- [list of individual vulnerability, familial & social factors]

Other Concerns

- [list of other concerns]
## LD Risk Assessment Tool

### Person Details

<table>
<thead>
<tr>
<th>Name</th>
<th>Role</th>
<th>Contact Details</th>
</tr>
</thead>
<tbody>
<tr>
<td>PROFESSOR. TEST SERVICE USER</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Address</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>HERTFORDSHIRE PARTNERSHIP NHS TRUST, 99 WAVERLEY ROAD, ST. ALBANS, HERTFORDSHIRE, AL3 5TL</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Telephone</th>
<th>ID</th>
<th>NHS No.</th>
<th>Status</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>141885</td>
<td>999 999 9999</td>
<td></td>
</tr>
</tbody>
</table>

### Header Details

<table>
<thead>
<tr>
<th>Type</th>
<th>Date Started</th>
<th>Time Started</th>
<th>Reason for Assess.</th>
<th>Location</th>
<th>Team</th>
<th>Carried Out By</th>
<th>Recorded By</th>
<th>Link Info</th>
<th>Ref</th>
<th>Assessment ID</th>
<th>Planned Comp Date.</th>
<th>Reason for Delay</th>
</tr>
</thead>
<tbody>
<tr>
<td>LD RISK ASSESSMENT</td>
<td>13/10/2014</td>
<td></td>
<td></td>
<td></td>
<td>INFORMATICS2</td>
<td>ALIJA XXHAMULIC</td>
<td></td>
<td></td>
<td></td>
<td>156326</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

### List People Involved In Risk Assessment

<table>
<thead>
<tr>
<th>Name</th>
<th>Role</th>
<th>Contact Details</th>
</tr>
</thead>
</table>

### History Of Risk

No Change

### Current Risks

No Change

### Early Warning Signs

No Change

### Physical Health

No Change

### Mental Health

No Change
### Current Personal And Contextual Risk Factors

<p>| | | | | | |</p>
<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Ld Risk Assessment</strong></td>
<td>PROFESSOR. TEST SERVICE USER(141885)</td>
<td><strong>Factors Potentially Reducing Risk</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

### Child Need Screening

- **Date of Completion**: 07/04/2014
- **Carried Out By**: DR ADEEBA ABBASI

**Is the service user pregnant or have dependant children or close contact with children? (e.g. adult who lives with another person who has children, adult who is given responsibility by the parent for caring for the children, adult who is engaged in close relationship with a parent and spends time in the home where children reside).**

**YES**

### Children's Details

<table>
<thead>
<tr>
<th>Name</th>
<th>Dob</th>
<th>Age</th>
<th>Primary Carer</th>
<th>Gp</th>
<th>Current School</th>
</tr>
</thead>
</table>

### Associated People

**Contact Name**

**Relationship**

**Association**

**DoB / Age / Sex**

**Ethnicity**

**Client / Person Status**

**Client / Person ID**

**Parental Responsibility?**

**PR Reason**

**Association From**

**To**

**Address**

**Primary**

**Contact lblTel1**

**lblTel2**

**Contact Name**

**Relationship**

**Association**

**DoB / Age / Sex**

**Ethnicity**

**Client / Person Status**

**Client / Person ID**

**Parental Responsibility?**

**PR Reason**

**Association From**

**To**

**Address**

**Primary**

**Contact lblTel1**

**lblTel2**

**Contact Name**

**Relationship**

**Association**

**DoB / Age / Sex**

**Ethnicity**

---

Print Date: 06/10/2015
Client / Person Status
Client / Person ID
Parental Responsibility?
PR Reason
Association From
To

**Ld Risk Assessment**

**PROFESSOR. TEST SERVICE USER (141885)**

Address
Primary Contact
lblTel1
lblTel2

**Child Need Screening Assessment**

**Mental Health Act**

Is the mental health of the service user likely to impact significantly on his/her ability to meet the needs of the child/children

Assessment of mental health should take into account:

- The present mental state of the service user and any relevant history
- The service user's use of/attitude towards use of treatment and the impact of treatment:

Some things you might consider are the ages of the children, support networks and capacities for parenting

**Alternative Parenting Arrangements**

If the parent/service user is unable to fulfil one or more of these, is there an identified parent/carer (such as co-parent or grandparent) who is able to and does fulfil these needs?

**Concern Child Needs Not Being Met**

Could the presenting behaviour of the adult impact on the Childs' needs not being met? (If 'Yes' then action taken must be specified below)

**Additional Comments**

Including relationship, age of child/children, and frequency of contact, it the service user does not have parental responsibility for the child/children

**Action Required**

Refer to trust's Safeguarding Children Policy, it provides all contact details about who to discuss concerns with and how to make a referral, if necessary to Children's Services (If 'No' please explain)

**Other Relevant Assessments**

Including relationship, age of child/children, and frequency of contact, it the service user does not have parental responsibility for the child/children (Consider referral to Children's Services)

If 'Yes' initiate a Young Carer's Assessment and consider a referral to Children's Services

This document must be reviewed and re-assessed at Care Coordination meetings and at any change of circumstances.

**Risk Assessment : Sign Off**

Section Completed? [ ]
Completed When
Completed By
On Behalf Of

Print Date: 06/10/2015
<table>
<thead>
<tr>
<th>Trigger</th>
<th>Contingency/crisis Plan</th>
<th>By When</th>
<th>By Whom</th>
</tr>
</thead>
</table>

### Su's Views Of The Risk Management Plan

- No Change [ ]

### Carers View Of Risk Mgmnt Plan

- No Change [ ]

### Please Select To Indicate The Following Has Been Discussed

- Service User and/or Carer informed of this plan [ ] YES [ ] NO
- Information sharing / confidentiality discussed with service user [ ] YES [ ] NO
- Consent to sharing risk assessment given by service user [ ] YES [ ] NO

- With whom will this risk assessment and management plan be shared?

<table>
<thead>
<tr>
<th>Carer</th>
<th>Other HPFT Staff</th>
<th>CLDT</th>
<th>Other Agencies (Please specify)</th>
</tr>
</thead>
</table>

### Risk Management : Sign Off

- Section Completed [ ]
- Completed By [ ]
- Completed When [ ]
- On Behalf Of [ ]

### Attachment Search

<table>
<thead>
<tr>
<th>File</th>
<th>Document Type</th>
<th>Reason</th>
<th>Title</th>
<th>Recorded By</th>
<th>Recorded On</th>
<th>Recorded At</th>
</tr>
</thead>
</table>
Procedures for Well-being/IAPT 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
Risk Management Panel Guidance

1. Background.

From time to time a team may be faced with a challenging case where they appear to have an on-going duty to provide care and treatment to a service user, but where it is extremely difficult to ensure that the service user and those around her/him including Trust staff can remain safe.

With regard to inpatients, various options are available to ward staff to ensure patient safety. These include a range of medical and psychological treatments, use of the provisions of the Mental Health Act, use of increased observation levels with where necessary extra staff to undertake the role, and the interventions described in detail in the Non-physical and Physical Assault Policy (July 2012).

Despite this, data shows that significant numbers of incidents of actual or threatened aggression from service users to staff or to other service users take place, especially on older people’s inpatient units and inpatient units for people with learning disabilities. The Trust is committed to reducing these incidents so that staff can feel safe and confident in their practice.

In community services, there can be high risk cases where a team is faced with clinical, legal and at times ethical dilemmas about how to continue to provide care when risk factors appear unmanageable. In such scenarios, the risks can be more entrenched and well known, but the options available to staff, and the ability to control the behaviour of the service user, are often more limited.

The risk management panel aims to better support staff in inpatient and community settings in the sometimes very pressurized work that they do.

2. The Panel

2.1. Function.

The panel’s main function is to provide expert advice to the care co-ordinator and other Trust staff contributing to the care plan, on the future management of an individual service user.

It will:
- Provide a broader perspective on a case in a situation where the local ward/team may be finding it difficult to maintain a clear objective view of the needs of the service user
- Make available professional advice which brings additional expertise to the case and also a multi-disciplinary perspective

It will not:
- Provide an emergency service e.g. dealing with inappropriate placements of service users or dilemmas about acute admission and bed availability
- Replace the standard responsibilities of the care co-ordinator and their team to assess and manage clinical risks in line with this policy
2.2. **Panel Membership**
A pool of Trust staff will be available to act on the panel of 3.

This will comprise:
- Head of practice governance
- Practice governance leads
- Consultant Psychiatrists
- Heads of Nursing
- Personality Disorder Therapists
- Incident Investigator
- Senior social worker
- Consultant clinical psychologist
- Allied health professional
- Lead for prevention and management of violence and aggression

In exceptional circumstances the chair will co-opt others onto the panel. Legal advice may also be sought via the Patient Safety manager.

2.3. **Criteria.**
The Multidisciplinary Team should consider referring a case to the panel when the following applies:
- The care team is facing a dilemma in terms of safe and clinically appropriate management of an individual
- All available options in terms of staffing levels, statutory powers, specialist services and treatments appear to have been exhausted
- There are likely to have been recent incidents of threatened or actual assault or other unacceptable behaviour under the RESPECT standards

If a second opinion could be expected to facilitate a solution this should be arranged first (see Second Opinions and Transfer of Consultant Psychiatrist Policy July 2009).

The panel will meet monthly with 3 slots.

2.4. **Process.**
Referrals to the panel should always be made by the care co-ordinator or Named Nurse, and with the agreement of the responsible manager.

Referrals should be made on the referral form (see below), to the Head of Practice Governance, who will organise the panel response.

The panel will comprise a chair and at least two others from the membership list above.

The care co-ordinator or Named Nurse will attend and will organise attendance of key colleagues as necessary.

The meeting will examine the impact of the current care plan, and generate ideas for proactive interventions which will enable staff to gain greater control of the risks being presented by the service user.

The chair will therefore ensure that the meeting is solution-focussed.
The service user and carers will not attend, but the care co-ordinator or Named Nurse will inform them the meeting is taking place and feedback the outcome.

The panel chair will provide a written record of the meeting to the care co-ordinator or Named Nurse who will enter it into the patient record.

---

**Risk Management Panel**

<table>
<thead>
<tr>
<th>Name of service user</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Care co-ordinator</td>
<td></td>
</tr>
<tr>
<td>Team</td>
<td></td>
</tr>
<tr>
<td>Named nurse (if</td>
<td></td>
</tr>
<tr>
<td>appropriate)</td>
<td></td>
</tr>
<tr>
<td>Consultant Psychiatrist</td>
<td></td>
</tr>
<tr>
<td>Is service user an</td>
<td>Yes/No</td>
</tr>
<tr>
<td>inpatient at present?</td>
<td></td>
</tr>
<tr>
<td>If Yes, name of ward</td>
<td></td>
</tr>
<tr>
<td>Current care plan</td>
<td></td>
</tr>
<tr>
<td>Current risks</td>
<td></td>
</tr>
<tr>
<td>Form completed by</td>
<td></td>
</tr>
<tr>
<td>Name of manager (taken as their consent to the referral)</td>
<td></td>
</tr>
<tr>
<td>Date of completion</td>
<td></td>
</tr>
</tbody>
</table>
Shown below are the main recommendations that have arisen from Serious Incidents involving unexpected deaths in the past year. These give important pointers for all staff about how to manage such cases most effectively.

Further information is available from the Patient Safety team or Practice Governance leads.

**Unexpected Deaths**

1. Consideration of stepping up from Wellbeing to secondary MH services when clinically indicated
2. Engagement with, and support of, families/carers post incident
3. Access to all available information on different EPR systems to inform assessment of risk
4. Evidencing that carers assessments are being offered, undertaken and recorded
5. Recording of key decisions in the electronic record
6. All identified risks had not been documented on the latest risk assessment
7. A paper file was in use by some staff involved in the care pathway and not all information in that file had been added to the electronic record
8. Key risk information not shared between teams which led to a missed opportunity to review the risk management plan
9. No record of carer/next of kin in the electronic record
10. Recording of rationale for discharge in the electronic record
11. Decision to discharge did not involve all key individuals
12. Information not always shared with the GP
13. Missed opportunity for case review prior to discharge
14. Risk factors and safeguarding issues were not properly identified, acknowledged or addressed
15. Absence of a risk assessment used to formulate a suitable follow-up care plan in accordance with the DNA policy
16. Joint working with D&A services – service user discharged from Spectrum and HPFT at the same time removing all support
17. Accessing all available corroborative information to inform the assessment and management plan
<table>
<thead>
<tr>
<th>Our Values</th>
<th>we are...</th>
<th>you feel...</th>
</tr>
</thead>
<tbody>
<tr>
<td>Welcoming</td>
<td>✓ Valued as an individual</td>
<td></td>
</tr>
<tr>
<td>Kind</td>
<td>✓ Cared for</td>
<td></td>
</tr>
<tr>
<td>Positive</td>
<td>✓ Supported and included</td>
<td></td>
</tr>
<tr>
<td>Respectful</td>
<td>✓ Listened to and heard</td>
<td></td>
</tr>
<tr>
<td>Professional</td>
<td>✓ Safe and confident</td>
<td></td>
</tr>
</tbody>
</table>