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HPFT

Clinical Risk Assessment and Management Policy for Individual Service Users

HPFT Policy

Version	9
Executive Lead	Executive Director Of Quality and Medical Leadership
Lead Author	Consultant Psychiatrist
Approved Date	n/a
Approved By	n/a
Ratified Date	3rd August 2020
Ratified By	Medical Professional Leads Meeting
Issue Date	25th September 2020
Expiry Date	25th September 2023
Target Audience	- All medical staff, nursing and health care professionals and - Support staff who are involved in the assessment and management of clinical risk

Document on a Page

Title of document	Clinical Risk Assessment and Management Policy for Individual Service Users		
Document Type	Policy		
Ratifying Committee	Safety Committee		
Version	**Issue Date**	**Review Date**	**Lead Author**
9	25th September 2020	25th September 2023	Consultant Psychiatrist
Staff need to know about this policy because (complete in 50 words)	To optimise risk assessment and management of service users in keeping with best practice, including patient safety.		
Staff are encouraged to read the whole policy but I (the Author) have chosen three key messages from the document to share:	Individual service user risk assessment and management • is based on information from the service user, other people and records, and utilises structured professional judgement by staff • enable staff to practice in such a way that service users (and carers whenever possible) are 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 • uses positive risk management when appropriate		
Summary of significant changes from previous version are:	Focussed on national guidance document: "Best Practice in Managing Risk Principles and Evidence for Best Practice in the Assessment and Management of Risk to Self and Others in Mental Health Services" Made more concise, for easier readability Amendments to link in with learning themes Amendments to training arrangements		

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PART 1 – Preliminary Issues:

1. Summary

Clinical Risk Assessment and Management is part of the Trust's overall risk management strategy, and are 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, in keeping with national standards, for the management of risk related to individual service users in all clinical areas.

The content of clinical risk assessment and management training is not part of this policy, and is outlined elsewhere (both via the intranet, and during training).

The policy aims to:

- Provide a framework which enables staff to use **best and up-to-date practice in assessing** and managing clinical risk
    - the "**16 Best Practice Points for Effective Risk Management**" (Department of Health, 2009) are in Appendix 1
- Enable staff to practice in such a way that their own **structured professional judgment** is encouraged
- Enable staff to practice in such a way that **service users (and carers whenever possible) are 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
- Encourage staff **shared decision making** within the process of risk assessment and management
- Encourage **positive risk taking** where appropriate

Regular risk assessment and management training is required.

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, described in the operational policy for each Wellbeing - Improving Access to Psychological Therapies (IAPT) Service.

3. Definitions

3.1 **Risk**

Risk is the likelihood of an event occurring, and is defined (Department of Health (DoH), 2009) as
"The nature, severity, imminence, frequency/duration and likelihood of harm to self or others…."

The Royal College of Psychiatrists (2017) clarifies that:

"Risk management is a core function of all medical practitioners and some negative outcomes, including violence, can be avoided or reduced in frequency by sensible contingency planning. However, adverse outcomes cannot be eliminated. Accurate prediction is challenging for individual patients. While it might be possible to reduce risk in some settings, the risks posed by those with mental disorders are difficult to predict because of the multiplicity of, and complex interrelation between, factors underlying a person's behaviour."

In the clinical setting this can include (but is not limited to) self-harm, suicide, self-neglect, violence or harm to others, neglect/harm to children or dependents, accidental injury or harm from environment.

3.2 **Assessment** (DoH, 2009)

"The process of gathering information via personal interviews, psychological/medical testing, review of case records and contact with collateral informants for use in making decisions"

3.3 **Risk management (**DoH, 2009)

"The actions taken, on the basis of a risk assessment, that are designed to prevent or limit undesirable outcomes. Key risk management activities are treatment (e.g., psychological care, medication), supervision (e.g., help with planning daily activities, setting restrictions on alcohol use or contact with unhelpful others, and so on), monitoring (i.e., identifying and looking out for early warning signs of an increase in risk, which would trigger treatment or supervision actions), and if relevant, victim safety planning (e.g., helping a victim of domestic violence to make herself safe in the future and know better what to do in the event of perceived threat)"

3.4 **Structured professional judgement (**DoH, 2009)

"An approach toward risk assessment developed over the past decade. It involves the practitioner making a judgement about risk on the basis of combining an assessment of clearly defined factors derived from research with the use of their clinical experience and knowledge of the service user."

3.5 **Risk factors** (DoH, 2009)

“A risk factor is a personal or contextual characteristic or circumstance which is linked to a negative event and that either causes or facilitates the event to occur.”

Risk factors may be **static** or **dynamic**.

- “***Static factors*** are unchangeable historic factors, e.g. a history of child abuse or suicide attempts.”

- *“**Dynamic factors*** are those that have changed and can continue to change over time, e.g. misuse of alcohol, mental state. Dynamic factors may be aspects of the individual or aspects of their environment and social context, such as the attitudes of their carers or social deprivation. Because they are changeable, these factors are more amenable to risk management.”

Dynamic risk factors may:

- change slowly (be **stable** or **chronic**), or

- change rapidly (be **acute**) when they may act as **triggers**.

3.6 **Risk formulation** (DoH, 2009)

“Risk formulation is a process in which the practitioner decides how the risk might become acute or be triggered. It identifies and describes predisposing, precipitating, perpetuating and protective factors, and also how these interact to produce an elevation in risk. This formulation should be agreed with the service user and others involved in their care in advance, and should lead to an individualised risk management plan. Every risk formulation should have attached to it a plan for what to do when the warning signs become apparent. The plan should also include more general aspects of management, such as monitoring arrangements, therapeutic interventions, appropriate placements and employment needs.”

3.7 **Clinical Risk Assessment and Management**

Clinical Risk Assessment and Management is defined by the Trust as a continuous and dynamic process for judging risk and subsequently making appropriate plans to minimise the risks identified. Shared decision making (mental health professionals and service users working together to inform decisions and plans) should be utilised where possible during the process of risk assessment and management.

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 **Safety Committee**, 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, involvement in safety initiatives including structured post incident meetings, reflection and action following structured professional judgement reviews, and learning which will enable continual improvement of practice.
- Reviewing the quality of risk assessments to ensure risk management plans reflect the risks identified during assessment and that service users and carers (where appropriate) have been adequately involved in the process
- Compliance with up to date relevant risk training

5. Key Standards

5.1 National standards

The Trust adopts the Department of Health's "Best Practice in Managing Risk" (2009).

This details the "16 Best Practice Points for Effective Risk Management", that are listed in Appendix 1.

This document states:

"The philosophy underpinning this framework is one that balances care needs against risk needs, and that emphasises:

- positive risk management;
- collaboration with the service user and others involved in care;
- the importance of recognising and building on the service user's strengths; and
- the organisation's role in risk management alongside the individual practitioner's."

5.2 Trust standards (additional to, or clarifying national standards)

Risk assessment and management should:

- When assessing risk for children and adolescents, involve parents and carers wherever possible.
- 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 clearly and accessibly, 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

Frequent and regular supervision is important in maintaining quality and consistency of risk assessments and management plans.

The Trust provides training to ensure that staff are trained in how to assess, formulate, and manage risk.

This policy covers key elements of risk. Not all risks can be captured in this document as they relate to a particular group or particulars. Examples include:

- Dysphagia, particularly in old age services
- Epilepsy in Learning Disability (LD)
- Care of children
- Risks covered in other policies, such as:
    - Safeguarding Children Policy
    - Physical Health Policy
    - Policies that address risks related to the Covid-19 pandemic

Part 2 – What needs to be done and who by

6. Procedures

6.1 Background

Clinical risk assessment and management are intrinsic to practice. The Trust adopts the Department of Health's "Best Practice in Managing Risk" (2009). It details the "16 Best Practice Points for Effective Risk Management", that are listed in Appendix 1.

The DoH document states:

"The philosophy underpinning this framework is one that balances care needs against risk needs, and that emphasises:

- positive risk management;
- collaboration with the service user and others involved in care;
- the importance of recognising and building on the service user's strengths; and
- the organisation's role in risk management alongside the individual practitioner's."

The Trust expects all mental health professionals to undertake or contribute to the assessment and management of clinical risk.

Staff should always include consideration of risk to a person's physical health, as we know that people who experience mental health problems are much more likely than the general population to die prematurely from physical problems.

6.2 Risk Assessment and Care Coordination

The Trust's Delivery of Care Policy, Incorporating the Care Programme Approach considers current or potential risk(s) as one of the factors to consider for eligibility for use of the **Care Programme Approach** (CPA) rather than **Standard Care**.

Risk assessment takes place whether a service user receives Standard Care (that includes the **Single Assessment Process** for some**)**, or has a Care Coordination under CPA. The document it is recorded in may differ.

Changes in risk also should prompt consideration of a review of the level of Care Co-ordination.

The operational policy for each Wellbeing - Improving Access to Psychological Therapies (IAPT) Service outlines the procedure for risk assessment and escalation in that service.

All service users 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.

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.

6.3 Collaborative working and shared decision making

Risk assessments are co-produced and reviewed with service users; and for those who lack mental capacity to make risk decisions, with their family or carers. Collaborative working and shared decision making is essential when designing, implementing and reviewing interventions to minimise the risk of harm.

Achieving share understanding through individualised formulation, produced and shared with the service user, providing a detailed understanding of potential factors that contribute towards harms and what protects these from happening.

This includes communication and sharing of outcomes of the formulation and safety/care plans with the service user, involved clinical practitioners and significant others involved in the care of the service user.

6.4 Process of Risk Assessment and Risk Management

The Trust endorses the use of "**structured clinical judgment**"' or "**structured professional judgment**" as an approach to assessing risk. This approach is encouraged by the Department of Health (2009) and the Royal College of Psychiatrists (2017). It involves the use of clinical or professional 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 form(s) to guide the process of collating and considering information, and formulating the plan with regard to the relevant risks and associated contributory factors. For service users with complex needs a multi-professional and multi-disciplinary approach should be taken involving other agencies. To complete risk assessments for such patients multiple sources of information may be needed, such as, for example, the Criminal Justice System and social care.

Significant clinical risk in mental health and learning disability services includes potential for violent, aggressive and/or behaviour that challenges. All clinical practitioners should ensure they are familiar with and knowledgeable about the content and principles of Trust positive behavioural approaches to supporting people whose behaviour is described as challenging as part of their clinical risk assessment and management knowledge and skills.

The process of risk assessment and risk management may vary between services, and may vary in the order it is undertaken, and typically includes:

- Gathering information
- Categorising and detailing risks
- Risk evaluation and formulation
- Risk management

When risks are high and/ or complex and/ or concerning, they should be discussed within the multi-disciplinary team, and the outcome of the discussion documented. Some patients with a high risk profile should be subject to ongoing documented multi-disciplinary team review.

6.4.1 **Gathering information,** from:

- General practitioner or other referrer
    - Letter(s)
    - GP summary
        - May include risk history that is not already part of Trust record

- Old notes
    - Recent
    - Legacy systems
    - Other providers

- Service user
    - History
    - Mental state examination
    - Wishes and plans

- Collateral history from others
    - Family
        - from parents is essential for a child
    - Friends
    - Carer(s): professional or informal
    - Other agencies:

6.4.2 Categorising and detailing risks

Detailing risks normally arises following risk categorisation. This may be undertaken collaboratively; with service user, family, colleagues and other agencies

None of the risk sub-categories within the categories below is exhaustive. The risk categories and sub-categories are a structured guide to aid completion of a risk assessment by structured professional judgment.

Risk categories typically include:

- Risks to self

- Risks to others

- Risks from others

6.4.2.1 **Risks to self:**

- Deliberate:
    - Suicide
    - Deliberate self-harm

- Accidental
    - Overdose: unsafe alcohol/ drug use without intention of self-harm
    - Fire risk (from smoking, cooking)
    - Relating to epilepsy

- Neglect
    - Self
        - Physical health
        - Mental health
        - Social
    - Environment
    - Poor medication compliance (if this may cause harm)

6.4.2.2 **Risks to others**

- Physical aggression
- Verbal aggression
- Intimidation
- Coercion
- Neglect
- Accidents, such as from
    - Driving
    - Fire risk
- Infection such as pandemic infectious disease

6.4.2.3 **Risks from others**

- Retaliation
- Abuse/ exploitation/ coercion
- Infection such as pandemic infectious disease

6.5.3 Risk evaluation and formulation

Consider, for each risk:

- Severity
- Pattern
    - Recency
    - Frequency
    - Trigger(s)/ circumstances

For suicide and deliberate self-harm risk, also consider risk factors: that may be static or dynamic.

Risk evaluation may also be considered under headings (4 P's), for each major risk:

- Predisposing factors
- Precipitating factors
- Perpetuating (maintaining) factors
- Protective factors

Under each of these 4 headings the contribution for each of: physical, social and psychological factors may be considered.

All attempts should be made to evaluate the protective factors and factors reducing risk.

6.5.4 Risk management

Risk management follows robust risk assessment.

Risk management should:

- wherever possible, include the service user's views
- wherever appropriate, allow for positive risk taking
- be realistic

6.5.5 What risk assessment is not

Risk assessment is not

- a number/ percentage
- a checklist alone
- fixed
- unreviewable
- rigid
- an accurate predictive tool

6.5.5 Positive risk management

The Department of Health (2009), describes this as:

"Positive risk-management means being aware that risk can never be completely eliminated. Therefore, management plans inevitably have to include decisions that carry some risk. This should be explicit in the decision-making process and should be discussed openly with the service user."

"Decisions about risk management involve improving the service user's quality of life and plans for recovery, while remaining aware of the safety needs of the service user, their carer and the public. Positive risk management as part of a carefully constructed plan is a desirable competence for all mental health practitioners, and will make risk management more effective. Positive risk management can be developed by using a collaborative approach. Over-defensive practice is bad practice. Avoiding all possible risks is not good for the service user or society in the long term, and can be counterproductive, creating more problems than it solves. Any risk-related decision is likely to be acceptable if:

- it conforms with relevant guidelines;
- it is based on the best information available;
- it is documented; and
- the relevant people are informed.

As long as a decision is based on the best evidence, information and clinical judgement available, it will be the best decision that can be made at the time."

Further information is given in the Department of Health's "Best Practice in Managing Risk" accessible via a link in the "Supporting References" section.

Where possible, a positive risk strategy should be utilised. This involves the taking of carefully managed risks in the short-term with the intention of reducing risk in the longer-term. This can enhance the coping skills of service users and

improve their feelings of confidence and empowerment. The concept of positive-risk requires careful consideration in order to implement it safely and productively. Positive-risk is neither the practice of ignoring apparent concerns, nor of magnifying apparent concerns but an objective, co-produced process whereby an agreement is made with a client in the context of a shared understanding of their individual risk.

More detail is given in Appendix 2: **What is positive risk management?**

6.6 Recording the Risk Assessment

There are risk forms for different specialties on the Paris electronic patient record:

- AMH/CAMHS (Adult Mental Health/ Child and Adolescent Mental Health Services)
- Learning Disabilities (LD)
- Forensic
- Perinatal

There is separate provision for recording risk assessment on PCMIS (electronic patient record) for IAPT (Improving Access to Psychological Therapy - Wellbeing Service) service users.

6.7 Creating/ editing an alert on the electronic patient record

After the risk assessment and management is recorded, consideration of whether to create, edit or delete an **alert** relating to risk should be made. Examples of alerts are described in the Care Records Management Policy.

6.8 Discussions of high risk service users

High risk service users should be discussed within the team. Further guidance is given in the “Support to staff” section below.

7 Use of the tools

7.1. When to undertake a risk assessment

A risk assessment should be completed when there is any significant change to the mental state or circumstances of the service user which could alter risk. In addition, a risk assessment should be completed at the following points in the service user's care path:

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 help ascertain the level of urgency of each referral.

b) **When first assessed**: a full risk assessment will be completed as part of the assessment process alongside the needs agreement

c) Whenever a **CPA review takes place: a** full risk assessment will be completed, when there are significant changes of need and at least annually.

d) As a **minimum** all risk assessments should be reviewed annually.

e) When a service user is **transferred between services under CPA**, a full risk assessment will be completed. 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

g) **Step down from inpatient care** to crisis team or to community care

h) **Step down from crisis team or equivalent care** to community care

The Transfer and Discharge Policy give more detail.

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.

7.4 Risk assessment tools

7.2.1 **Standard risk assessment forms**

The appropriate risk form to use for different specialties is detailed in the appropriate operational policy. The form is on the Paris electronic patient record.

7.2.2. **Other specialist tools**

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

An overview of selection of such tools has been made by the Department of Health (Best Practice Guidance, 2009).

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.

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. These tools may be carried out by specialists in the relevant areas.

8 Support to Staff

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

8.1 **Training**

- Staff training in risk assessment will occur at a minimum of annually.

8.2 **Supervision and reporting**

- All staff involved in risk assessment and management should receive regular supervision as set out in the Performance, Review and Development Policy.
- 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
- Risk formulation meetings should take place weekly in every community team

8.3 **Allocation and workload**

- Risk status should be considered when cases are allocated
- High-risk cases should only be allocated to suitably experienced staff as judged by the line manager
- Careful workload management should ensure staff have sufficient time for the work required in such cases

8.4 **High risk**

- Staff should alert their line managers to all cases that are assessed as high risk by the multidisciplinary team
- Staff should be proactive in bringing high risk cases to supervision
- Staff should discuss high risk cases at the community team risk formulation multi-disciplinary team meetings

8.5 **Safeguarding**

- All safeguarding concerns (adult or child), must be discussed in supervision and the actions recorded on the service user's EPR.
- Patients considered high risk because of suicide or homicide, repeated admissions, or repeated referral to crisis services must be discussed at a MDT meeting and a risk management plan must be developed to address risk.

8.6 **Support**

- Staff should be made aware of internal and external staff support systems

9 Communication and Confidentiality

Risk information is shared with others as appropriate either – preferably with patient consent - or without consent if the law otherwise allows for this if such disclosure is necessary.

Details are contained in other policies.

10 Learning

As a learning organisation, the Trust expects that teams will use learning from incidents and learning from deaths to help improve care. Good practice themes and learning themes regarding risk should be used to aid training staff in risk assessment and management, both within and between formal risk training sessions. How this take place may vary between different professional groups and between specialties.

Some of the detail in Section 6.3, Process of Risk Assessment and Risk Management (above), is derived from good practice themes and learning themes from serious incidents and mortality reviews (structured judgement reviews). Information regarding learning from incidents and from deaths is available via practice governance structures.

11 Training and Awareness

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" on-line training (e-learning) at least every year
    - This may be completed by additional face to face training as appropriate
- 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 through risk management panels or structures.

Training will incorporate relevant learning from incidents and learning from deaths.

Course	For	Renewal Period	Delivery Mode	Contact Information
Clinical Risk Assessment for Individual Service Users	All clinical staff	Every year	e-learning	Discovery (Learning Management System) https://www.discoveryhpft.co.uk/
Bespoke Training in Clinical Risk Assessment	Key teams – eg. CATTs (Band 5 and above)	Every year	e-learning	Discovery (Learning Management System) https://www.discoveryhpft.co.uk/

12 Process for monitoring compliance with this document

Action:	Lead	Method	Frequency	Report to:
Review of compliance with this policy	PACE Team	Audit	Annually	Safety Committee Quality and Risk Management Committee
Check policy compliance via serious incident investigations	Patient Safety Manager	Root cause analysis	On going	
Staff supervision to assess frequency and quality of risk assessment and management	Service Line Leads	Staff supervision	Ongoing	

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.

13 Embedding a culture of equality and respect

The Trust promotes fairness and respect in relation to the treatment, care and 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 Department of Health document on which this policy is based had advice from multiple service user and carer groups. 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 care givers/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.

14 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 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

Part 3 – Document Control & Standards Information

15 Version Control

Version	Date of Issue	Author	Status	Comment
V4	Oct 2005	Head of Practice Governance	Superseded	
V5	July 2008	Head of Practice Governance	Superseded	Approved Trust Executive Team 2.7.08
V5.1	August 09	Head of Practice Governance	Superseded	Archived 20.8.10
V6	20 August 2010	Consultant Psychiatrist	Superseded	Executive agreement 17.8.10 Appendix 4 – Procedure for placing a risk of violence marker on electronic and paper records included 29.3.2011.
V7	9 September 2013	Consultant Psychiatrist	Superseded	Minor amendments – will need review and re- write following implementation of Paris Electronic Patient Record
V7.1	1 May 2015	Consultant Psychiatrist	Superseded	Updated for Care Act 2014 Addendum
V8	17 Dec 2015	Head of PG Governance	Superseded	Updated in consultation with key colleagues to reflect changes in recording policies
V8.1	17 Dec 2015	Head of PG Governance	Superseded	Changes made to 9.2 and additional appendix
V8.2	9 February 2018	Consultant Psychiatrist in Community Psychiatry	Superseded	Risk reflective group removed from policy
V9	25th September 2020	Consultant Psychiatrist	Full review	Major amendments to make more concise, for easier readability. Feedback from Clinical Directors added. Primarily focused on Department of Health

16 Associated Documents

This Policy and associated procedures should be used in conjunction with other Trust policies, including the following, which can be accessed via the staff intranet or the local Policy Guardian:

a. Acute Adult Inpatient Operational Policy
b. Adult Mental Health Community Services Operational Policy
c. Advance Decisions to Refuse Treatment and Advance Statements Policy and Procedure
d. Care Records Management Policy
e. Community Mental Health Services for Older People
f. Delivery of Care Policy
g. End of life Care Policy
h. Health and Safety Policies (Trust and Local Authority)
i. IAPT (Improving Access to Psychological Therapies) Operational Policies
j. Incident and Serious Incidents requiring investigation Policy
k. Lone Working Policy
l. Nutrition and Dysphagia Policy
m. Physical Health Policy
n. Pressure Ulcer Policy
o. Prevent Policy
p. Risk Management Policy
q. Safe and Supportive Observations Policy
r. Safeguarding Adults at Risk Policy
s. Safeguarding Children Policy
t. Service User Falls Prevention Policy
u. Service User Property Policy
v. Transfer and Discharge Policy
w. Violence and Aggression Policy

17 Supporting References

All web hyperlinks were accessible at the time of authorship, but hyperlinks may change.

Best Practice in Managing Risk
Department of Health (March 2007, updated March 2009)
https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/478595/best-practice-managing-risk-cover-webtagged.pdf

Rethinking Risk to Others in Mental Health Services
Royal College of Psychiatrists (August 2016, corrected May 2017)
https://www.rcpsych.ac.uk/docs/default-source/improving-care/better-mh-policy/college-reports/college-report-cr201.pdf?sfvrsn=2b83d227_2

22. Consultation

Job Title of person consulted
Deputy Director of Nursing & Quality
Deputy Director Safer care & Standards
Head of Recovery and Psychological Services
Head of Allied Health Professions (AHPs) and Healthy Lifestyles
Deputy Medical Director
Clinical Directors

16 Best Practice Points for Effective Risk Management (Department of Health 2007, amended 2009)

Introduction

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

Fundamentals

2. Positive risk management as part of a carefully constructed plan is a required competence for all mental health practitioners.

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

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

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

Basic ideas in risk management

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

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

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

9. 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.

Best Practice in Managing Risk

10. Where suitable tools are available, risk management should be based on assessment using the structured clinical judgement approach.

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

Working with service users and carers

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

13. Risk management must always be based on awareness of the capacity for the service user's risk level to change over time, and a recognition that each service user requires a consistent and individualised approach.

Individual practice and team working

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

15. All staff involved in risk management should receive relevant training, which should be updated at least every three years.

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

What is positive risk management?

This applies to patients with mental capacity to make such a decision.

Best Practice in Managing Risk (Department of Health, updated 2009) states:

Positive risk-management means being aware that risk can never be completely eliminated. Therefore, management plans inevitably have to include decisions that carry some risk. This should be explicit in the decision-making process and should be discussed openly with the service user.

Positive risk management includes:

- working with the service user to identify what is likely to work – and what is not;
- paying attention to the views of carers and others around the service user when finally deciding a plan of action;
- weighing up the potential costs and benefits of choosing one action over another;
- being willing to take a decision that involves an element of risk because the potential positive benefits outweigh the risk;
- developing plans and actions that support the positive potentials and priorities stated by the service user, and minimising the risks to the service user or others;
- being clear to all involved about the potential benefits and the potential risks; and
- ensuring that the service user, carer and others who might be affected are fully informed of the decision, the reasons for it and the associated plans.

Another way of thinking about good decision-making is to see it as supported decision-making. Independence, *Choice and Risk* has this to say:

“The governing principle behind good approaches to choice and risk is that people have the right to live their lives to the full as long as that does not stop others from doing the same. Fear of supporting people to take reasonable risks in their daily lives can prevent them from doing the things that most people take for granted. What needs to be considered is the consequence of an action and the likelihood of any harm from it. By taking account of the benefits in terms of independence, well-being and choice, it should be possible for a person to have a support plan which enables them to manage identified risks and to live their lives in ways which best suit them.”

Our Values

Welcoming Kind Positive Respectful Professional