

**CLINICAL ASSESSMENT AND MANAGEMENT  
 OF RISK OF HARM TO SELF AND OTHERS POLICY**

|                                       |   |
|---------------------------------------|---|
| Version:                              | 5   |
| Ratified by:                          | Senior Managers Operational Group   |
| Date ratified:                        | August 2015   |
| Title of originator/author:           | Chair of SIRC Review Group  |
| Title of responsible committee/group: | Clinical Governance Group   |
| Date issued:                          | <b>August 2015</b>  |
| Review date:                          | <b>July 2018</b>  |
| Relevant Staff Group/s:               | All Clinical Staff who are involved with the assessment and management of risk of harm to self and others |

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## DOCUMENT CONTROL

|  |                                   |  |   |
|--|-----------------------------------|--|---|
| <b>Reference</b><br>JH/Aug15/CAMR  | <b>Version</b><br>5               | <b>Status</b><br>Final                     | <b>Author</b><br>Chair of SIRI Review Group |
| <p><b>Amendments:</b> RiO Risk Module functionality updated. Clinical Audit Standards expanded. Clear instruction for risk assessment and documentation. Safeguarding issues. References updated. Monitoring arrangements improved. Revised NHSLA Risk Management Standards. Confidentiality and Disclosure updated. Addition to include advice for non-Mental Health trained staff. Clinical risk assessment summary added. Treatment refusal appendix added.</p> |                                   |  |   |
| <p><b>Document objectives:</b> To provide an overarching structure and best practice guidance for the way the Trust manages the clinical assessment and management of risk of harm to self and others.</p>   |                                   |  |   |
| <p><b>Intended recipients:</b> Applicable to all clinical staff who are involved with the assessment and management of risk of harm to self and others.</p>  |                                   |  |   |
| <p><b>Committee/Group Consulted:</b> Serious Incidents Requiring Investigation (SIRI) Review Group.</p>  |                                   |  |   |
| <p><b>Monitoring arrangements and indicators:</b> Key indicators include numbers of staff achieving compliance with each area of training in assessment and management of risk of harm to self and others. Audit of completion of Risk Screen reported via Balanced Scorecard. Audit of Risk Assessment module (completion on reaching risk screen threshold and correlation with Recovery Care Plan).</p>   |                                   |  |   |
| <p><b>Training/resource implications:</b> The Trust supports a rolling programme of mandatory training.</p>  |                                   |  |   |
| <b>Approving body and date</b>   | Clinical Governance Group         | Date: August 2015                          |   |
| <b>Formal Impact Assessment</b>  | Impact Part 1                     | Date: August 2015                          |   |
| <b>Clinical Audit Standards</b>  | YES                               | Date: scheduled within Clinical Audit Plan |   |
| <b>Ratification Body and date</b>  | Senior Managers Operational Group | Date: August 2015                          |   |
| <b>Date of issue</b>   | <b>August 2015</b>                |  |   |
| <b>Review date</b>   | <b>July 2018</b>                  |  |   |
| <b>Contact for review</b>  | Chair of SIRI Review Group        |  |   |
| <b>Lead Director</b>   | Medical Director                  |  |   |

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## 1. INTRODUCTION

- 1.1 The clinical assessment and management of risk of harm to self and others is a key component of the Trust's work. Best practice is constantly informed by national guidance and lessons learnt locally from analysis of unexpected deaths and serious incidents (SIRIs).
- 1.2 The Trust aims to inform, update and train its staff in best practice to improve patient care and to minimise risk of harm to self and others whenever possible. Updated guidance is included to assist staff in this aim.

## 2. PURPOSE & SCOPE

- 2.1 This policy provides an overview of guidance and training available to all staff who are involved with the assessment and management of risk of harm to self and others.
- 2.2 It is the Trust's policy to ensure that appropriate staff are informed, updated and equipped to carry out assessment and management of risk of harm to self and others in the course of their work.
- 2.3 This Policy should be read in conjunction with the Observations while maintaining Safety and Patient Engagement Policy, Detained Patients AWOL Policy inc. Missing Persons Guidance, the RCPA Policy, Safeguarding Children policy and the Safeguarding Vulnerable Adults policy:

## 3. DUTIES AND RESPONSIBILITIES

- 3.1 The **Trust Board** has overall responsibility for procedural documents and delegate's responsibility as appropriate
- 3.2 The **Lead Director** with responsibility for Clinical Assessment & Management of Risk of Harm to Self and Others Policy is the Medical Director.
- 3.3 The **Identified Lead (Author)** is the Chair of the Serious Incidents Requiring Investigation (SIRI) Review Group and he will be responsible for producing written drafts of the document and for consulting with others and amending the draft as appropriate. This role is delegated to the Identified Lead by the Medical Director.
- 3.4 The **SIRI Review Group** is responsible for:
  - a) reviewing and updating this policy, with the Clinical Governance Group being the approving group;
  - b) ensuring there are adequate controls to provide safe clinical risk assessment practice in line with national guidelines
  - c) advising on training requirements for individual staff groups

- d) the Identified Lead will Chair the SIRI Review Group that monitors the update of training and audit of clinical risk practice.
- 3.5 Overall monitoring will be by the **Clinical Governance Group** who monitor clinical audit.
- 3.6 **Clinical Directors/Service Managers/Heads of Service:** responsibility for implementing this policy is devolved to Clinical Directors, Heads of Service and Service Managers.
- 3.7 The **Claims and Litigation Manager** has responsibility for holding the central database of procedural documents including this policy and for providing review reminders. The team also have responsibility for dissemination of the final document and archiving old versions.
- 3.8 **Ward / Team Managers** are responsible for ensuring that they have a planned programme of training for staff in their team in accordance with the Trustwide Staff Training Matrix.
- 3.9 **All Staff** involved in the assessment and management of risk of harm to self and others, including temporary staff, are individually responsible for complying with this policy. This includes (a) attending training and updating risk assessment skills as directed by this policy, (b) reporting concerns to their line manager, (c) initiating alerts in line with the policy and (d) regularly updating risk related sections within the Electronic Patient Record and also completing an Untoward Event report form in line with the Trust's Untoward Event Reporting Policy accessible on the Trust Intranet.
- 3.10 **Non-mental health staff** should be aware of the need to refer, sometimes urgently, to locality mental health services when they encounter patients who may be at risk of harm to themselves or other people.
- 3.11 **Learning and Development Facilitators** are responsible for ensuring attendance records are signed by each participant and forwarded to the Learning and Development Department;
- 3.11 **The Learning and Development Department** is responsible for entering all data relating to Mandatory and Non-Mandatory training attendance onto the Electronic Staff Record (ESR) system and reporting non-attendance to Local Managers and overall compliance to the SIRI Review Group.

#### 4. EXPLANATION OF TERMS USED

- 4.1 **Care Programme Approach (CPA):** the national framework for effective mental health care with its principles of assessment, care plan, care coordination and review.
- 4.2 **CPA Review (or Care Plan Review):** the periodic evaluation and review of a patient's care and treatment by all those involved (including the patient, family/carers, other agencies) to ensure that needs are being met in the best interests of the patient (mental health only).

- 4.3 **Electronic Patient Record (EPR):** a computerised system to record demographic details, episodes of care and all clinical notes in a structured, systematic way.
- 4.4 **Recovery Care Programme Approach (RCPA):** the local term for CPA and used for mental health only.
- 4.5 **RiO:** the Electronic Patient Record system supplied by CSE Healthcare in use within the Trust for mental health services and some community based community services.
- 4.6 **What's On @ Sompar:** The Trust newsletter to keep staff updated with developments.
- 4.7 **MDT – Multi-disciplinary Team:** community based teams with professionals from a range of backgrounds working together.
- 4.8 **ASIST – Applied Suicide Intervention Skills Training,** recommended by the Department of Health for Suicide Prevention training.

## 5. BACKGROUND AND GENERAL PRINCIPLES

- 5.1 This policy lies within the overall framework of the Trust's Risk Management Strategy and Risk Management Policy and Procedure and is concerned with clinical risk. It provides a framework for detailed guidance and training around assessment and management of risk of harm to self and others encountered by Trust staff.
- 5.2 The policy and guidance takes into account national and local guidance and lessons learned. In particular 'Best Practice in Managing Risk' (DoH, June 2007), 'Avoidable Deaths' and Annual Reports (National Confidential Inquiry up to 2014) and 'No Health without Mental Health' (HM Government 2011).
- 5.3 Staff must ensure they are familiar and up to date with best practice guidance as summarised in Appendix A 'Best Practice Guidance in the Clinical Assessment and Management of risk of harm to self and others'
- 5.4 Best practice is demonstrable in clinical audit and in analyses of serious incidents.
- 5.5 All staff undertaking assessments of risk and its management will fully take into account issues of gender, age, sexuality, race, disability and belief/religion and how these may or may not affect the level of risk presented by the patient. In particular, where the patient does not speak English, or does so as a second language, or has a sensory impairment, staff should consider requesting a suitable interpreter to be present when making the assessment (see [Interpreting Policy](#) accessible on the Trust Intranet).
- 5.6 All staff should ensure the outcome of the assessment and the resulting care plan is discussed with, explained to and given to the patient, and where

appropriate their carers, in a language and format which they are easily able to understand.

## 6. TRAINING REQUIREMENTS

6.1 The Trust will work towards all staff being appropriately trained in line with the organisation's Staff Training Matrix/training needs analysis. All training documents referred to in this policy are accessible to staff within the Learning and Development Section of the Trust Intranet.

6.2 Training in assessment and management of clinical risk is mandatory for all clinical qualified staff working in mental health services who have patient contact, and highly recommended for all other staff who have patient/service user contact and delivered at a level applicable to their role and experience.

6.3 Training will be divided into seven areas:

- **Introduction to RiO and RCPA** – part of initial mandatory training for all clinical and social care staff.
- **The clinical assessment and management of risk of harm to self and others** - Mandatory for all clinical qualified staff with patient contact and highly recommended for all other staff who have patient/service user contact refreshed every three years.
- **Safeguarding Adults** – Level A mandatory for all staff with patient contact refreshed every three years. Advanced training for some staff in Adult and Older People's teams. Level 1 training is delivered at Corporate Induction.
- **Domestic Abuse Training** – One-off training to be delivered to all frontline staff in teams to raise awareness of issues.
- **Safeguarding Children** – Safeguarding children training is mandatory for all staff including volunteers, agency staff and subcontractors. All Trust staff access level 2 training at Corporate Induction on a three yearly basis. Level 3 *Core Competences* training is mandatory for Minor Injury Unit staff, Learning Disability staff, Contraceptive and Sexual Health staff, Dental staff and all Adult Mental Health staff, (including Talking Therapies staff), on an annual basis. Level 3 *Additional Specialist Competences* training is mandatory for all Children and Young People's services staff, Locality Safeguarding Children Nurses, Children Looked After Nurses and Dentists with a lead role in child protection.
- **HCR20** – Two day course in using the HCR-20 Risk screening tool, recommended for qualified clinical staff working in mental health services.

- **ASIST training** – Suicide Prevention Training – a two day course available in-house and through external trainers. Recommended for mental health staff with contact with patients.
- **Suicide Prevention Awareness Training** a session is available for non-mental health trained staff. The session is designed to raise awareness about suicide and risk factors, and provide information about what is helpful and what to do.

6.4 All **Learning and Development Facilitators** will ensure attendance records are signed by each participant and forwarded to the Learning and Development Department;

6.5 The **Learning and Development Department** will enter all data relating to Mandatory and Non-Mandatory training attendance onto the Electronic Staff Record (ESR) system and reporting non-attendance to Local Managers and the Chair of the SIRI Review Group monthly.

## 7. **EQUALITY IMPACT ASSESSMENT**

7.1 All relevant persons are required to comply with this document and must demonstrate sensitivity and competence in relation to the nine protected characteristics as defined by the Equality Act 2010. In addition, the Trust has identified Learning Disabilities as an additional tenth protected characteristic. If you, or any other groups, believe you are disadvantaged by anything contained in this document please contact the Equality and Diversity Lead who will then actively respond to the enquiry.

## 8. **MONITORING COMPLIANCE AND EFFECTIVENESS**

### 8.1 **Monitoring arrangements for compliance and effectiveness**

- Overall monitoring will be by the Clinical Governance Group who monitor clinical audit and the Serious Incidents Requiring Investigation (SIRI) Review Group regarding training.

### 8.2 **Responsibilities for conducting the monitoring**

- Clinical Audit Standards will be agreed by the Serious Incident Requiring Investigation (SIRI) Review Group to be incorporated into the Trust's clinical audit plan and ensure audit is appropriately prioritised.
- The delivery and monitoring of the uptake of training will be the responsibility of the training team who will report this to the operational service managers.
- The uptake of clinical risk training will be monitored at the Workforce Group. Shortfalls will be addressed by agreeing an action plan that will be monitored at every meeting.



### 8.3 **Process for reviewing results and ensuring improvements in performance occur.**

Audit results will be presented to the relevant Best Practice Group meeting for consideration, identifying good practice, any shortfalls, action points and lessons learnt. This Group will be responsible for ensuring that the relevant operational Best Practice Group implements all actions identified through the audit process.

Lessons Learnt will be incorporated in to the SIRI Review group Quarterly Report to the Clinical Governance Group. Following each SIRI meeting relevant lessons learnt will be highlighted in the 'What's on @ Sompar' newsletter to raise awareness.

A briefing of audits will also be provided to staff to raise awareness through the 'What's on @ Sompar' newsletter.

## 9 **COUNTER FRAUD**

The Trust is committed to the NHS Protect Counter Fraud Policy – to reduce fraud in the NHS to a minimum, keep it at that level and put funds stolen by fraud back into patient care. Therefore, consideration has been given to the inclusion of guidance with regard to the potential for fraud and corruption to occur and what action should be taken in such circumstances during the development of this procedural document.

## 10. **RELEVANT CARE QUALITY COMMISSION (CQC) REGISTRATION STANDARDS**

10.1 Under the **Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 (Part 3)**, the **fundamental standards** which inform this procedural document, are set out in the following regulations:

|                 |  |
|-----------------|--|
| Regulation 9:   | Person-centred care  |
| Regulation 10:  | Dignity and respect  |
| Regulation 11:  | Need for consent   |
| Regulation 12:  | Safe care and treatment                                      |
| Regulation 13:  | Safeguarding service users from abuse and improper treatment |
| Regulation 17:  | Good governance  |
| Regulation 18:  | Staffing   |
| Regulation 19:  | Fit and proper persons employed                              |
| Regulation 20:  | Duty of candour  |
| Regulation 20A: | Requirement as to display of performance assessments.        |

10.2 Under the **CQC (Registration) Regulations 2009 (Part 4)** the requirements which inform this procedural document are set out in the following regulations:

|                 |   |
|-----------------|---|
| Regulation 11:  | General   |
| Regulation 16:  | Notification of death of service user   |
| Regulation 17:  | Notification of death or unauthorised absence of a service user who is detained or liable to be detained under the Mental Health Act 1983 |
| Regulation 18:  | Notification of other incidents   |
| Regulation 22A: | Form of notifications to the Commission (although this is in Part 5, it relates to regulations in Part 4).                                |

- 10.3 Detailed guidance on meeting the requirements can be found at <http://www.cqc.org.uk/sites/default/files/20150311%20Guidance%20for%20providers%20on%20meeting%20the%20regulations%20FINAL%20FOR%20PUBLISHING.pdf>

### **Audit Standards for Mental Health Patients**

- All clients should have a RiO Risk Screen completed at assessment, on admission, updated at RCPA reviews and as appropriate when changes to risk occur (see Appendix A section 26).
- Clients with an identified area of significant risk should have the RiO Risk Formulation module completed.
- Actions identified in the RiO Risk Formulation should be reflected in risk management items in the Recovery Care Plan.

### **Relevant National Requirements**

See reference list of Appendix A

#### **Key documents and NICE guidance:**

Avoidable Deaths. Five Year Report of the National Confidential Inquiry into suicide and homicide by people with mental illness. University of Manchester, December 2006.

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. Department of Health, June 2007.

National Institute for Health and Clinical Excellence, *Violence: The short-term management of disturbed/violent behaviour in in-patient psychiatric settings and emergency departments*, NG10, London: 2015.

National Institute for Health and Clinical Excellence, *Self-harm: The short-term physical and psychological management and secondary prevention of self-harm in primary and secondary care*, Clinical Guideline 16, NICE, London, July 2004

National Institute for Health and Clinical Excellence, *Self-harm: longer term management*, Clinical Guideline 133, NICE, London, November 2011

HM Government (2011) *'No Health without Mental Health: a cross government mental health outcomes strategy for people of all ages'* New Horizons. A shared vision for mental health.

National Confidential Inquiries into Suicide and Homicide by people with Mental Illness (NCI/NCISH):

<http://www.bbmh.manchester.ac.uk/cmhs/centreforsuicideprevention/nci/reports/Annualreport2014.pdf>

## 11. REFERENCES, ACKNOWLEDGEMENTS AND ASSOCIATED DOCUMENTS

### References

As above

### Cross reference to other procedural documents

Being Open and Duty of Candour Policy

Clinical Supervision Policy

Confidentiality and Data Protection Policy

Consent and Capacity to Consent to Treatment policy

Detained Patients AWOL Policy inc. Missing Persons Guidance

Mandatory Training Matrix (Training Needs Analysis)

MAPPA Guidance 2009

MAPPA Referral Form

Medicines policy

Observations whilst Maintaining Safety and Patient Engagement Policy

Physical Assessment and Examination of Service Users Policy

Proactive Care Policy

Professional Interpreting and Translation Service Policy

Records Keeping and Records Management Policy

Recovery Care Programme Approach (RCPA) Policy

Risk Management Policy and Procedure

Risk Management Strategy

Safeguarding Children's Policy

Safeguarding Vulnerable Adults Policy

Serious Incidents Requiring Investigation (SIRI) Policy

Serious Incidents Requiring Investigation (SIRI) Review Group Learning Points

Trust Business Plan

Untoward Event Reporting Policy and Guidance

All current policies and procedures are accessible in the policy section of the public website (on the home page, click on 'Policies and Procedures'). Trust Guidance is accessible to staff on the Trust Intranet.

### Relevant Objective within Trust Strategy

Five year Integrated Business Plan

Develop a more responsive service:

We will develop services to increase choice, to enable service users to participate fully in care delivery decisions, to improve outcomes and to reduce waiting times.

## **12. APPENDICES**

12.1 For the avoidance of any doubt the appendices in this policy are to constitute part of the body of this policy and shall be treated as such.

Appendix A 'Best Practice Guidance in the Clinical Assessment of Risk of Harm to Self and Others'

Appendix B Clinical Audit standards

Appendix C Senior Clinical Review Group Terms of Reference

Appendix D Treatment Refusal / Self Discharge Algorithm

Appendix E Assessing risk of harm to self and others – a checklist for clinicians

Somerset Partnership NHS Foundation Trust

**BEST PRACTICE GUIDANCE IN THE  
CLINICAL ASSESSMENT OF RISK OF HARM  
TO SELF AND OTHERS**

## INTRODUCTION

Risk management is a core component of mental health and social care and the Recovery Care Programme Approach (RCPA). Effective care includes an awareness of a person's overall needs as well as an awareness of the degree of risk that they may present to themselves or others. Many practitioners make decisions every day about how to help a service user to manage their potential for violence, self-harm, suicide or self-neglect. This guidance is based on the principle that modern risk assessment should be structured, evidence-based and as consistent as possible across settings and across service providers.<sup>1,2,3</sup> This consistency is essential for good communication between agencies and practitioners. A consistent approach to risk and its management will enable better communication and will contribute to improved care.

All service providers should have in place a set of policies and procedures relating to the management of risk.<sup>4,5</sup> Somerset Partnership has a Risk Management Strategy and Risk Management Policy and Procedure that integrates the management of all aspects of corporate and clinical risk encountered by the Trust.

In addition, this guidance adds further specific advice around best practice to Trust staff and users of the service around assessment of clinical risk and is an appendix to the 'The Clinical Assessment and Management of Risk of Harm to Self and Others' policy. It draws heavily on 'Best Practice in Managing Risk' (DoH, June 2007),<sup>6</sup> and uses sub-headings and text from this document as an underlying structure with additional updated sections and Trust specific sections describing the Trust's particular procedures and documentation systems.

Related Trust policies are the Safeguarding Children policy and the Safeguarding Vulnerable Adults policy; Observations while maintaining Safety and Patient Engagement Policy and the Recovery Care Plan Approach (RCPA) Policy:

This guidance aims to answer this question: What is best practice for conducting risk management in the areas of risk of harm to self and others? Best practice involves combining the highest quality evidence with professional judgement about the person who is being assessed. The main principles of best practice are set out here and 'Further Information' contains a link to some tools that can guide risk decision-making.

The principles set out here are applicable in all care settings – from community-based care, including crisis intervention, assertive outreach and early intervention services, through to intensive and more secure care, adult, learning disability, older persons and child and adolescent mental health services. Tools may then be used to supplement clinical risk decision making. They are listed in 'Further Information' at the end of this guidance because they can support effective and consistent risk

management decision-making. They are an aid to clinical decision-making, not a substitute for it.

Teams should consider how their risk management procedures could be improved by integrating the principles here and one or more of the tools into their overall approach. By effectively combining research evidence with clinical expertise in a collaborative approach, teams will be implementing the highest standards of evidence-based practice.<sup>7</sup>

## **FUNDAMENTALS AND PRINCIPLES OF MANAGEMENT OF RISK OF HARM**

### **1. POSITIVE RISK MANAGEMENT**

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.<sup>8</sup> Positive risk management as part of a carefully constructed plan is a desirable competence for all practitioners, and will make risk management more effective.<sup>9,10</sup> Positive risk management can be developed by using a collaborative approach.<sup>11</sup> 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.<sup>1,2</sup>

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

#### **What is positive risk management?**

Positive risk management means being aware that risk can never be completely eliminated, and aware that 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;
- paying attention to the views of carers and others around the service user when deciding a plan of action;
- weighing up the potential benefits and harms 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;
- being clear to all involved about the potential benefits and the potential risks;

- developing plans and actions that support the positive potentials and priorities stated by the service user, and minimise the risks to the service user or others;
- 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; and
- using available resources and support to achieve a balance between a focus on achieving the desired outcomes and minimising the potential harmful outcome.

**Another way of thinking about good decision-making is to see it as supported decision-making. ‘Independence, choice and risk’<sup>13</sup> 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.”*

## **2. SAFETY FIRST**

Given the nature of severe mental illness, there will always be circumstances in which decisions about the care plan are going to be dominated by immediate concerns about the safety of the service user and others including risks around safeguarding children and safeguarding adults. Lack of insight and non-adherence to treatment plans that have been put in place to reduce psychopathological symptoms are particularly challenging aspects of the relationship between the service user and the practitioner. Psychopathological symptoms can seriously impact on a service user’s ability to critically assess the implications of some of their actions, and this can result in unpredictable and potentially dangerous behaviour. In these situations, practitioners have to take decisions on behalf of a service user with their best interests in mind. The use of the Mental Health Act and consideration of capacity legislation may well be part of the most appropriate risk management strategy here. Appendix D offers a Treatment Refusal / Self Discharge algorithm to support decision making around issues of consent and capacity. A collaborative approach based on the principles of positive risk management is still the aim, but clearly this will require special efforts in these situations.

## **3. A COLLABORATIVE APPROACH TO RISK MANAGEMENT**

The key to effective risk management is a good relationship between the service user and all those involved in providing their care. A three-way collaboration between the service user, carers and the care team can often be established, and this relationship should be based on warmth, empathy and a sense of trust – with the aim of involving the service user in a collaborative approach to planning care. Full engagement is sometimes not possible, but the potential for it should always be considered. If there is doubt about the service user’s capacity to be fully involved in decision making, capacity should be assessed formally in relation to any particular

decision, using the Consent and Capacity functionality within RiO. This means that the process of risk management should be explained to everybody involved at the earliest opportunity. The development of the Recovery Care Plan to address risk management issues should be carried out in an atmosphere of openness and transparency. If, for whatever reason, the service user is not involved in some element of risk management, this should be documented.

#### **4. COMMUNICATION**

Best practice guidance cannot emphasise enough the value of clear and timely communication between professionals involved in the care of a client. This involves communication between members of a team, particularly when cover arrangements are in place, at times of transition in care and service redesign, as well as communication between other teams and agencies involved in the care of the client. These agencies include, among others, Primary Care, the Local Authority, police, probation, local MARAC and MAPPA, 'third sector' providers and Children's services across Somerset. Wherever possible, information should be shared with the client's informed consent and on a need to know basis (that is to say that information should be shared in a proportionate way to reflect the level of information needed to be shared to allow good care to be provided and risk to be adequately managed). For more advice on confidentiality and information sharing see section 20 and refer to the Safeguarding Children Policy and Safeguarding Vulnerable Adults Policy.

#### **5. RECOGNISING STRENGTHS AND PROTECTIVE FEATURES**

Risk management works best when a service user's strengths are recognized alongside the possible problems that they might encounter and with which they might present.<sup>14</sup> Every time a problem is identified, a strategy should be suggested and discussed, building on the positive skills of the service user. The emphasis should always be on a recovery approach and on the next stage in developing the service user's ability to cope when they are feeling vulnerable or having difficult demands placed on them.

#### **6. RISK MANAGEMENT AT THE ORGANISATIONAL LEVEL**

Risk management is not just the responsibility of individual practitioners. Organisations must adopt an integrated risk management approach in which risks are systematically identified, managed and reduced. The framework given in *Seven Steps to Patient Safety* should guide the development of a safety culture that learns from negative events and builds good practice.<sup>5</sup>

The seven steps are to:

1. build a safety culture;
2. lead and support your staff;
3. integrate your risk management activity;
4. promote reporting;
5. involve and communicate with service users and the public;
6. learn from and share safety lessons; and



7. implement solutions to prevent harm.

Services for people at risk of suicide and self-harm should also be designed with the '12 Points to a safer service' recommendations in mind.<sup>15,16</sup>

The 12 points recommend:

1. staff training in the management of risk – both suicide and violence every three years;
2. all patients with severe mental illness and a history of self-harm or violence to receive the most intensive level of care;
3. individual care plans to specify action to be taken if patient is noncompliant or fails to attend;
4. prompt access to services for people in crisis and for their families;
5. assertive outreach teams to prevent loss of contact with vulnerable and high-risk patients;
6. atypical anti-psychotic medication to be available for all patients with severe mental illness who are non-compliant with 'typical' drugs because of side-effects;
7. strategy for dual diagnosis covering training on the management of substance misuse, joint working with substance misuse services, and staff with specific responsibility to develop the local service;
8. in-patient wards to remove or cover all likely ligature points, including all non-collapsible curtain rails;
9. follow-up within seven days of discharge from hospital for everyone with severe mental illness or a history of self-harm in the previous three months;
10. patients with a history of self-harm in the last three months to receive supplies of medication covering no more than two weeks;
11. local arrangements for information-sharing with criminal justice agencies; and
12. policy ensuring post-incident, multidisciplinary case review and information to be given to families of involved patients.

## **SENIOR CLINICAL REVIEW GROUP**

The option of a Senior Clinical Review Group can be considered. The group can be convened where decision making regarding risk management is particularly complex and the inclusion of a panel of senior staff (external to the immediate treatment team) would be helpful. The terms of reference of this panel are included in Appendix C.

## **7. DEFINING RISK AND RISK MANAGEMENT**

It is important to be clear about the basic ideas underpinning the notion of risk. Risk relates to a negative event (i.e. violence, self-harm/suicide or self-neglect) and covers a number of aspects.

- how likely it is that the event will occur?
- how soon it is expected to occur?

- how severe the outcome will be if it does occur?

Risk assessment involves working with the service user to help estimate each of these aspects. Information about the service user's history of violence, self-harm or self-neglect, their relationships and any recent losses or problems, employment and any recent difficulties, housing issues, their family and the support that's available, and their more general social contacts could all be relevant. Risk management then involves developing one or more flexible strategies aimed at preventing the negative event from occurring or, if this is not possible, minimising the harm caused. Risk management must include identified actions in the Recovery Care Plan (RCPlan), the allocation of each aspect of the plan to an identified person (including the service user) and a date for review of the RCPlan.

## 8. DEFINING RISK FACTORS

A risk factor is a personal characteristic or circumstance that is linked to a negative event and that either causes or facilitates the event to occur. Risk factors can be categorised in a number of ways.<sup>17</sup>

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

**Dynamic factors** are those that change over time, e.g. misuse of alcohol. Dynamic factors can 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 management. Dynamic risk factors that are quite stable and change only slowly are called **stable** or **chronic** risk factors. Those factors that tend to change rapidly are known as **acute factors** or **triggers** and, as they do change rapidly, their influence on the level of risk may be short-lived.

The key risk factors identified through research on violence and suicide, in adults, are:

### *Risk factors for violence*

#### **Demographic factors**

- Male
- Young age
- Socially disadvantaged neighbourhoods
- Lack of social support
- Employment problems
- Criminal peer group

### *Background history*

- Childhood maltreatment
- History of violence
- First violent at young age
- History of childhood conduct disorder
- History of non-violent criminality

### *Clinical history*

- Anti-social personality traits
- Substance abuse
- Personality disorder
- Schizophrenia
- Executive dysfunction
- Non-compliance with treatment

### *Risk factors for violence and suicide*

#### **Psychological and psychosocial factors**

- Anger
- Impulsivity
- Suspiciousness
- Morbid jealousy
- Criminal/violent attitudes
- Command hallucinations (hallucinations instructing the client to do things)
- Lack of insight

#### **Current 'context'**

- Threats of violence
- Interpersonal discord/instability
- Availability of weapons

Ref: 33,34,

### *Risk factors for suicide*

#### **Demographic factors**

- Male
- Men aged 15-44
- Women aged 45-74
- Low socioeconomic status
- Unmarried, separated, widowed
- Living alone
- Unemployed

#### **Background history**

- Deliberate self-harm (especially with high suicide intent)
- 'Rehearsals' of violent methods of suicide
- Childhood adversity (e.g. sexual abuse)
- Family history of suicide
- Family history of mental illness

#### **Clinical history**

- Mental illness diagnosis (e.g. depression, bipolar disorder, schizophrenia)
- Personality disorder diagnosis (e.g. borderline personality disorder)
- Physical illness, especially chronic conditions and/or those associated with pain and functional impairment (e.g. multiple sclerosis, malignancy, pain syndromes)
- Recent contact with psychiatric services
- Recent discharge from psychiatric in-patient facility

## **Psychological and psychosocial factors**

- Hopelessness
- Impulsiveness
- Low self-esteem
- Life event
- Relationship instability
- Lack of social support

## **Current 'context'**

- Suicidal ideation
- Suicide plans and 'rehearsals'
- Availability of means
- Lethality of means

Ref: 35,36

Particular sensitivity should be exercised when discussing historical factors from earlier in the life of the service user. The relevance and accuracy of these may need to be explained to the service user, and it is possible that carers may be unaware of these historical events or of their significance so many years on.

## **9. THE PURPOSE OF RISK MANAGEMENT**

The aim of risk management is first to assess the likelihood of risk events and then to work with the service user to identify ways of reducing the likelihood of them occurring. Risk management should be based on a plan to reduce the risk of harm occurring and increase the potential for a positive outcome. It is important that care teams and the service user have a clear idea about what risk they are assessing and why they are carrying out a risk assessment.<sup>18</sup> Risk assessment should be used to identify the circumstances in which a particular harmful behaviour could possibly take place, and this information can then be used to focus efforts and expertise on dealing with the most relevant triggers. A risk management plan includes an awareness of the potential for changes in the level of risk over time. This requires a particular emphasis on the dynamic factors outlined above, as well as attention to regularly review risks and their management.

## **10. RISK MANAGEMENT IN PRIMARY CARE SETTINGS**

There is a number of Somerset Partnership staff working within primary care whose work will include the assessment and management of risk, for example; The Right Steps Psychological Therapy Service, and Minor Injuries Units.

**Somerset Partnership Talking Therapy** staff would be expected to undertake an initial risk screen; informed both by the PHQ outcome measure and clinical interview. This screen will draw upon the risk assessment guidance outlined above. Where risk is identified an assessment of both acute and protective factors will be undertaken, and a risk management plan drawn up with the patient. This information will be recorded on IAPTUS (the electronic patient record used in the Talking Therapy service) and shared with the patients GP. The risk assessment and management plan should be discussed and reviewed in line management supervision and / or with a senior member of staff if an earlier review is appropriate.

Where risk cannot be sufficiently managed by the above, a discussion needs to take place with a team leader and where appropriate referral to secondary care.

**Minor Injury Unit (MIU)** - Mental Health presentations comprise of approximately 2% of all MIU and emergency department visits in the UK. Psychiatric symptoms are often associated with DSH, but tend to be transient and predominantly related to social or emotional factors.<sup>39</sup>

Useful guidance on the management of self-harm in minor injury units and emergency departments has been published by NICE ([www.nice.org.uk](http://www.nice.org.uk)).

The clinician involved with assessing the patient should adopt the same approach to history taking and examination as with other general medical problems. A careful systematic approach will help in obtaining an accurate diagnosis, if this is not possible, the information gained will at least assist referral to the appropriate service.

Patients who present to minor injury services following an episode of physical self harm and/or overdose require rapid initial assessment in order to establish the degree of urgency of the situation, mental capacity, and willingness to stay, distress levels, and the presence of mental illness. Factors that may render the situation more urgent include:

- Need for urgent treatment for physical injury and/or overdose;
- Immediate risk of violence to others;
- Immediate risk of further self-harm;
- Need for treatment, but patient threatening to leave.

For patients who are considered not at significant risk there are established lines of communication and referral within both Somerset Partnership (mental health and social care) and General Practice for patient follow up. There is currently no direct access to Rio for minor injury and urgent care staff. Clinical assessments made are contemporaneously recorded in the clinical notes, likewise discussions / referrals with mental health clinicians, and initial management plans are recorded.

## **11. RISK MANAGEMENT AND THE RECOVERY CARE PROGRAMME APPROACH**

Risk management is part of the Recovery Care Programme Approach (RCPA) and should be aligned closely with it.<sup>19</sup> The RCPA involves identifying specific interventions based on an individual's support needs, taking into account safety and risk issues. RCPlans should be drawn up to meet all of the relevant service user's needs, including those needs relating to risk. This creates a documented management plan for the elements of risk to both self and others.<sup>20</sup> The outcome of the risk assessment should also feed back into overall clinical management, since it should be applied in cases where there is an increased risk related to mental health problems of harming oneself or others. It may be necessary to liaise closely with other organisations and agencies and to be aware that they may have their own risk management systems that need to be taken into account (see 4, above). These steps help to support the continuity of care, which is essential for effective risk management.

## **Figure 1: Best Practice Box**

### **Supplementary NICE guidance on the short-term management of self-harm<sup>21</sup>**

#### ***Respect, understanding and choice***

People who have self-harmed should be treated with the same care, respect and privacy as any patient. In addition, healthcare professionals should take full account of the likely distress associated with self-harm.

#### ***Triage***

All people who have self-harmed should be offered a preliminary psychosocial assessment at triage (or at the initial assessment in primary or community settings) following an act of self-harm. Assessment should determine a person's mental capacity, their willingness to remain for further psychosocial assessment, their level of distress and the possible presence of mental illness.

#### ***Assessment of risk***

All people who have self-harmed should be assessed for risk. This assessment should include identification of the main clinical and demographic features known to be associated with the risk of further self-harm and/or suicide, and identification of the key psychological characteristics associated with risk – in particular depression, hopelessness – and continuing suicidal intent.

#### ***Psychological, psychosocial, and pharmacological interventions***

Following psychosocial assessment for people who have self-harmed, the decision about referral for further treatment and help should be based upon a comprehensive psychiatric, psychological, and social assessment, including an assessment of risk, and should not be determined solely on the basis of having self-harmed.

## **12. RISK MANAGEMENT AND THE MENTAL HEALTH ACT**

Given the nature of mental health problems, there are occasions where services have to intervene without the user's consent: the Mental Health Act is used regularly to manage a risk of harm to self and others. It should always be seen as a last resort and it is important that service users who need to be treated under conditions of compulsion get the help that they need. Using the Act does not remove the need for discussion with the service user – it is still necessary to maximise the service user's autonomy as much as possible within the restrictions. A good knowledge of the Act – and its associated Code of Practice and Memorandum – is essential to good risk management in mental health. Appendix D offers a Treatment Refusal / Self Discharge algorithm to support decision making around issues of consent and capacity and the use of the Mental Health Act.

## **13. SCREENING AND PRIORITISING CASES**

Service users will vary in the degree to which they need a formal risk management plan as part of their RCPlan. Screening for risk and needs should be part of a

routine mental health assessment, but is not an end in itself and should, where necessary, lead to further action. **The RiO Risk Screening should be completed for all clients.**

The RiO Risk Screen should be carried out at:

- Admission/assessment;
- Update after every risk incident (as stated within the Clinical Audit Standards);
- Planned and actual leave;
- At lines of significant service redesign/reconfiguration;
- MDT care reviews/discussions;
- Discussion of client risk in clinical supervision;
- CPA reviews;
- 7-day follow-up contact;
- Discharge.

The RiO Risk Screen rates risk in two time dimensions: 1. Acute Risk rates the likelihood of a particular risk event occurring in the short-term and often rises during a crisis or relapse for the service user, and is likely to reduce during recovery. 2. Long term risk reflects a more stable level or chronic risk that is related to the more persistent difficulties and mental health problems experienced by the service user.

Following completion of the RiO Risk Screen, some service users will then be identified as a priority for more in-depth assessment and intervention as a result of this routine screening, or will identify themselves as in need. **Any screening factors that rate as 'significant' or 'high' triggers the completion of the RiO Risk Information and actions to mitigate identified risk should then be incorporated directly into the RCPlan.** General and forensic services have different degrees of experience of working with violence, and so they should work together to ensure that the right level of assessment is conducted in all cases. A second opinion should be sought from specialist services when appropriate, for instance if a service user has a history of serious violence.

**Figure 2: RiO Risk Screening**

| Risk Screening   |  |   |  |
|--|--|---|--|
| Client   |  | [REDACTED]  |  |
| Date/time  |  | [REDACTED]  |  |
| <p><b>0 - No apparent risk (no further action required)</b><br/> <b>1 - Low risk (use discretion as to whether or not to document further via Risk Information and Recovery Care Plan)</b><br/> <b>2 - Significant risk (requires further appraisal via Risk Information and consideration within Recovery Care Plan)</b><br/> <b>3 - High risk (requires further appraisal via Risk Information and consideration within Recovery Care Plan)</b></p> <p><b>Acute Risk should be reviewed more frequently during times of rapid change in presentation such as admission and crisis.</b></p> |  |   |  |
| <b>Long Term Risk</b>  |  | <b>Acute Risk</b>   |  |
| Violence/harm to others  | <input type="text" value="Please Select"/> | Violence/harm to others   | <input type="text" value="Please Select"/> |
| Suicide  | <input type="text" value="Please Select"/> | Suicide   | <input type="text" value="Please Select"/> |
| Deliberate self harm   | <input type="text" value="Please Select"/> | Deliberate self harm  | <input type="text" value="Please Select"/> |
| Accidental self harm/neglect (include wandering/disorientation)  | <input type="text" value="Please Select"/> | Accidental self harm/neglect (include wandering/disorientation)       | <input type="text" value="Please Select"/> |
| Leaving without prior agreement (inpatients only)  | <input type="text" value="Please Select"/> | Leaving without prior agreement (inpatients only)                     | <input type="text" value="Please Select"/> |
| Neglect/abuse/exploitation by others   | <input type="text" value="Please Select"/> | Neglect/abuse/exploitation by others                                  | <input type="text" value="Please Select"/> |
| Has the client experienced physical, sexual or emotional abuse at any time in their life?  | <input type="text" value="Please Select"/> |   |  |
| <a href="#">Click here to view Safeguarding Adults policy</a>  |  |   |  |
| A risk to children   | <input type="text" value="Please Select"/> | A risk to children  | <input type="text" value="Please Select"/> |
| Responsibility for/regular contact with own or others children   | <input type="text" value="Please Select"/> | Responsibility for/regular contact with own or others children        | <input type="text" value="Please Select"/> |
| Concerns about responsibility for/contact with own or others children  | <input type="text" value="Please Select"/> | Concerns about responsibility for/contact with own or others children | <input type="text" value="Please Select"/> |
| If pregnant, expected date of birth  | [REDACTED]                                 |   |  |
| Check the box if the client/or child is named on a 'Subject to Child Protection Plan'  | <input type="checkbox"/>                   |   |  |
| <a href="#">Click here to view Safeguarding Children policy</a>  |  |   |  |
| Antisocial and offending behaviour   | <input type="text" value="Please Select"/> | Antisocial and offending behaviour                                    | <input type="text" value="Please Select"/> |
| Sex offending  | <input type="text" value="Please Select"/> | Sex offending   | <input type="text" value="Please Select"/> |
| <b>Record forensic history within Risk Information</b>   |  |   |  |



|  |               |                           |               |
|--|---------------|---------------------------|---------------|
| Physical health condition  | Please Select | Physical health condition | Please Select |
| <a href="#">All admissions to our inpatient wards should have the Infection Control Risk Assessment completed. Click here to go to the form.</a> |               |                           |               |
| Falls  | Please Select | Falls                     | Please Select |
| <a href="#">If significant or serious, complete Falls assessment</a>   |               |                           |               |
| Tissue viability   | Please Select | Tissue viability          | Please Select |
| Home safety issues   | Please Select | Home safety issues        | Please Select |
| Driving related issue  | Please Select | Driving related issue     | Please Select |
| <a href="#">Address any safety related issue within the Recovery Care Plan</a>   |               |                           |               |
| Does an Alert need to be recorded?   |               |                           |               |
| Save   |               | Clear                     |               |
| Cancel   |               |                           |               |

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Unknown Zone (Mixed) 100%

**Drop-down options:**

- 0 No apparent risk
- 1 Low risk
- 2 Significant risk
- 3 High risk

**Has the client experienced physical, sexual or emotional abuse at any time in their life? Drop down options:**

- None stated
- Not asked
- Yes

**Responsibility for/regular contact with own or others children drop-down options:**

- Not known
- No
- Yes

**Concerns about responsibility for/regular contact with own or others children drop-down options:**

- 0 No children/No concerns
- 1 Minor concerns
- 2 Significant concerns
- 3 High concerns

**14. DUTY OF CARE TO THOSE WHO PRESENT A RISK TO SELF AND OTHERS**

As a basic principle, all mental health professionals recognise that reducing the risk of self-harm, suicide and self-neglect is part of the practitioner’s fundamental duty to try to improve a service user’s quality of life and recovery. There is also a clear professional duty of care to a service user who presents a high risk of harm to others when this risk is due to a mental health problem – this duty may include tackling stigma and discrimination. There is also a duty of care to other service users, other professionals and wider society. In many cases, improving a service user’s quality of life may have wider benefits for others, such as reducing the risk to vulnerable groups of potential victims, including children. These goals are most likely to be achieved in the context of a good relationship between the service user and those providing their care.

## 15. PLANNING RISK MANAGEMENT

Risk assessment only has a purpose if it enables the care team and the service user to develop a plan of action in specific areas to manage the risks identified. This plan should be developed with the service user and their carer, and should be regularly reviewed.

## 16. RISK ASSESSMENT

Risk assessment is a process in which the practitioner documents relevant information and decides how the risk might become acute or triggered.<sup>22</sup> It identifies and describes predisposing, precipitating, perpetuating and protective factors, and also how these interact to produce risk. This assessment should be agreed with the service user and others involved in their care in advance, and should lead to an individualised risk management plan as part of the RCPlan.

The RiO Risk Information functionality provides a structured template for recording the assessment and management of clinical risk. It documents background and current risk factors, risk triggers and exacerbating and protective factors, risk sharing and summarises key actions to mitigate risk. It links directly with RiO alerts, Care Plan and Crisis/Relapse Plan functionalities where comprehensive risk management should be documented and kept updated.

The RiO Risk Information Functionality should be reviewed and revised every time there is a change in the perceived risk, at the client's, or carers, request or when any items from the Risk Screen functionality achieve a level of 'significant' or 'high'.

After documenting key actions to mitigate risk in the RiO Risk Information the following next steps should be carried out:

- Revise and update the Recovery Care Plan in dialogue with the client/carers.
- Consider the need to generate an Alert. Risk related alerts are:
  - Additional mobility/nutritional needs
  - Allergic reaction
  - Contagion/blood borne virus
  - Domestic Abuse (alleged perpetrator or victim)
  - Environmental risk
  - History of serious suicidal behaviour
  - Known to be violent
  - MAPPa eligible
  - Not for cardio-pulmonary resuscitation
  - Physical condition
  - Potential risk to worker
  - Risk from other member of household
  - Risk of leaving ward without consent
  - Risk of self harm
  - Safeguarding children concerns
  - Vulnerable adult

- Revise and update the Crisis/Relapse Plan within the Recovery Care Plan to include the clients 'risk signature'
- Link relevant Progress Notes to the Risk History functionality.
- Ensure significant historic risk incidents are captured in Risk History.
- Consider the need to share risk information within the Trust and with other agencies.
- Set a timescale within the RCPA approach to review the plan.

**Figure 3: The RiO Risk Information**

**Risk Information**

---

Client [REDACTED]

Date/time [REDACTED]

**?** What are the key historic risks/concerns (if any)? Review the client record, including historical Risk Incidents which can be accessed via the hyperlink below

[Risk Incidents \(view history or add incidents\)](#)

Summarise static historical risk factors that are unlikely to change over time such as previous suicide attempts and early life experiences (potential risks).

ABC ✓

**Forensic history.**

List relevant arrests and convictions both past and pending, including index offence, with dates.

ABC ✓

**?** What risks/concerns are there? Consider each concern and comment on likelihood, how soon expected and how severe the outcome if it does occur. Ensure that this reflects the information recorded in Risk Screening.

Nature of current risks or concerns

ABC  
✓

What triggers the risk? Consider acute risk factors or triggers such as alcohol, drugs, relationship difficulties, life events, mood etc. Factors currently exacerbating risk:

ABC  
✓

What mitigates the risk? Consider the protective factors such as relationships, occupation, appointments with CMHT etc. Factors currently protecting or alleviating against risk:

ABC  
✓

**?** What are the views of others? Consider and include, where appropriate, the knowledge and experience of the client and family/carers when assessing risk and protective factors and include this information in the appropriate sections above. If there is additional information from the client and/or family/carers that you have not incorporated, please include it below.

Client's/carer's assessment of risk where it differs from your assessment.

ABC  
✓

### Actions to be taken

No further action

Address in Recovery Care Plan

[Care Plan](#)

Record an Alert

[Alerts](#)

### Summary of Key Actions to Manage Risk

Summary of actions. Include discussions with other agencies/staff about managing risk.

ABC  
✓

[Link to crisis/relapse plan](#)

**List of information sources accessed in completing Risk Profile**

|                                |                          |
|--------------------------------|--------------------------|
| Client                         | <input type="checkbox"/> |
| Carer/Relative                 | <input type="checkbox"/> |
| Trust client record            | <input type="checkbox"/> |
| Case notes from other area     | <input type="checkbox"/> |
| Social Services (non MH teams) | <input type="checkbox"/> |
| GP                             | <input type="checkbox"/> |
| Police/Criminal report         | <input type="checkbox"/> |
| Forensic report                | <input type="checkbox"/> |

Save Clear Cancel

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Unknown Zone (Mixed) 100%

## 17. STRUCTURED RISK ASSESSMENT

Risk management in mental health care should be structured and consistent.<sup>1</sup> It should be explicit to the service user and should involve the service user's own priorities. It should also include structured clinical judgement. Decisions about care and security should not be based simply on a largely unstructured clinical approach, which could be subject to personal biases about the service user and may miss important factors such as the service user's strengths and resources or the views of the carer. These biases could lead to poor judgements where the risk is either overestimated or underestimated if key factors are missed. This is especially true if the judgements are made by an individual practitioner alone rather than by a clinical team working together. If it is not clear to the service user that their risk is being assessed, the principle of engagement is broken.

Figure 2: The risk management planning cycle



## 18. PROVIDING CARE PROPORTIONATE TO RISK

A fundamental principle of mental health care is that the level of security to which a service user is subjected should be as non-restrictive as possible and should be

proportionate to the degree of risk that they actually present at the time.<sup>20</sup> Risk assessment can be integral to deciding on the right level of intervention and support for a service user. When it is done properly – using the principles of involvement, working together and individualised support – risk management is empowering rather than disempowering for the service user<sup>23</sup> and can be a vital part of recovery.

## **19. EMBEDDING RISK MANAGEMENT IN EVERYDAY PRACTICE**

The information that informs a risk management plan can be based on special interviews or reports, but risk management is also based on routine practices in mental health care. These routine practices include enhanced observation and preventing absconding where this is appropriate.<sup>19</sup> Thinking about and recording risk management decisions is not an ‘add-on’ to practice, but should produce a structured and documented version of the clinical judgements that practitioners make everyday. This formal version of everyday practice should increase the confidence of practitioners when making decisions, especially if they are working collaboratively.

## **20. SAFEGUARDING CHILDREN AND ADULTS**

If in the course of a risk assessment any adult or child is thought to be at risk of abuse or neglect (including self-neglect) the Trust’s Safeguarding policies and procedures should be activated. Direct links to both policies are available via the Risk Screen in RiO. Full contact details for the Safeguarding Team are available on the Safeguarding Team web page on the Trust’s intranet.

To contact the Police about an urgent safeguarding issue or to request a Welfare Check contact the Southern Safeguarding Coordination Unit on 01823 363666.

## **21. WORKING WITH SERVICE USERS & CARERS - SHARING DECISION-MAKING**

Each step in the process of developing a risk management plan should be based on discussions between the service user and those involved in their care. The service user should be offered the opportunity to take a lead role in identifying the risks from their point of view, drawing up plans for dealing with difficult situations, and indicating the sort of support that they would prefer: service users and carers are often in the best position to comment on the robustness and practicality of the plan. The plan should include negotiated and individualised advance decisions on early warning signs of a relapse, as well as preferred early interventions at times of crisis.<sup>3,4</sup>

### **Collaborative work with carers**

Where there is a carer involved, they are a vital source of support for the service user and may also be a key person in helping to manage the risks identified.<sup>24</sup> Practitioners should be sensitive to the relationship between the service user and the carer, as there may be risks within this relationship and different points of view about the best actions to be taken. If the carer is at risk, they should be seen individually so that the risks can be explored and actions can be agreed. The carer should receive enough information in a comprehensible format to enable them to provide the necessary care.<sup>24</sup> The carer’s worries about the service user should

always be taken seriously, even if the care team is less concerned.<sup>2</sup> The carer should be offered an assessment and should be helped to develop a plan for meeting their own specific needs.

The Trust is committed to working in partnership with people who experience mental health problems, and with their families and carers. It recognises that providing effective treatment relies on a three-way partnership between people who experience mental health problems, their families and carers, and professionals.

A clear contact with the Trust must still be available for families / carers even if a Confidentiality Statement is in place that declines consent to share information with named individuals. **It is always acceptable for Trust staff to receive information without breaching confidentiality.** These issues of confidentiality and point of contact for incoming information should be discussed with families/carers in most cases. If there are barriers to sharing of risk information with family/carers that make it difficult to carry out care safely this should be reviewed with the client and the Service Manager's advice taken. For further advice see the Somerset Partnership Confidentiality and Information Sharing with Families and Carers – Best Practice Guidelines.

## 22. CONFIDENTIALITY AND DISCLOSURE

The Trust Confidentiality Policy states:

*There is a clear public interest in the maintenance of confidentiality, breaching confidentiality can harm the patient, third parties and damage the patient-professional relationship and the public perception of professionals. However, on occasions it is necessary to breach confidentiality where there is a greater public interest in doing so. This balancing test is sometimes referred to as the "Egdell test". A clear example of a permissible breach of confidentiality would be where a patient tells a staff member that a third party is at real risk of harm. In these circumstances it is good practice to try and persuade the person to agree to the disclosure of this information. Consideration should be given as to whether an interpreter or translator should be required in these circumstances. However, if they do not agree then it is good practice to inform the person of the extent of the disclosure that will be made by the staff member and the reasons why. The decision making process and the discussions with the person involved should be documented in the patient's electronic record. It is recommended that the staff member seeks advice from their supervisor and/or line manager before making a confidential disclosure and where necessary this decision should be the subject of a multi-disciplinary risk assessment. Should there be any doubt about the need to make a confidential disclosure then advice should be sought from the Caldicott Guardian. Staff should also refer to professional guidance i.e. GMC, NMC, GSCC, and other Allied Professional Bodies including UKIP. All such breaches in confidentiality must be reported on the DATIX system and will be reviewed and scrutinised by the Caldicott Group.*

*Information sharing between statutory/partner organisations directly involved in a service user's care, and for the purpose of providing that care, is essential to good practice. General consent from the service user for such information sharing of this sort, or agreed restrictions on such, should be recorded following a discussion with the service user and the provision of written information supporting this. The principle*

*of sharing information in the interest of public safety is endorsed by the Partnership Trust, as long as it can be shown to be only information that needs to be shared and only with those who have a clear need to know.*

*If there is doubt about sharing information with external bodies, written consent should be sought; if this is not appropriate, the duty to share must be discussed with the line manager and either the Caldicott Guardian, Director of Finance, Information and Performance or the Information Governance and Records Manager.*

The Trust has adopted a traffic light system within RiO to record discussions with the client around information sharing and confidentiality.

*In all cases, the Trust will abide by red confidentiality statements set in RiO **unless:***

- *The information is the subject of a Court Order*
- *The information is needed for the prevention or detection of crime*
- *There are child protection issues*

If someone other than the service user is at significant risk, advice must be sought from the police public protection team, multi-agency public protection arrangements (MAPPA) or local MARAC arrangements so that an appropriate public protection plan can be activated. The rationale for any disclosure without consent, e.g. to prevent harm, should be clearly documented. Practitioners should discuss any concerns about the need to share information with outside agencies with their line manager who has access to senior management or legal advice as necessary.

Where there is an identified public safety risk and the risk assessment shows that enactment of the identified risk behaviours will realistically cause significant to catastrophic harm then there is a duty to act and consider urgent disclosure to the police so that the risk can be contained if possible and that any identifiable individual at risk can be notified. Practitioners should seek the advice of their line manager, who has access to formal legal advice, in any case where there is doubt about a decision to share or not to share information with other agencies. Practitioners should refer to information sharing agreements between the Partnership Trust and other agencies (particularly MAPPA and Social Services) that give guidance on the sharing and protection of client identifiable information. Practitioners should also refer to their own professional codes of conduct.

For advice on information sharing with regard to a younger person, where the issue of parental consent is relevant, the decision should be discussed with the Safeguarding Team or a specialist in the CAMHS service.

For advice on information sharing around safeguarding children and safeguarding adults procedures, staff should refer to the relevant policies (ie: Safeguarding Children's Policy and Safeguarding Vulnerable Adults Policy).

## **23. AVOIDING EXCLUSION ON THE BASIS OF NEGATIVE RISK**

Social inclusion should be one of the goals of any risk management plan, and strategies to support the service user in achieving this should be identified. Service users are likely to be aware of their own risk and to want help, but may find it difficult to talk about this in case it increases stigma.<sup>9</sup> Any risks identified should not be



overstated or needlessly used to exclude the service user from services or contact with people; this contributes to myths about mental health problems, stigma and discrimination. Unnecessary exclusion can be avoided by carefully linking risk assessment to risk management. Regular reassessment can provide opportunities for information-sharing with the service user and their carer, and can establish a forum in which risk-related issues can be openly discussed. “A trusting relationship between the user and their care co-ordinator is the best foundation for successful risk management.”

## **24. DIVERSITY**

Clinical judgement is based on perceptions that can be biased without the practitioner being aware. Therefore all staff involved in risk assessment must be capable of demonstrating an appropriate level of cultural sensitivity and competence.<sup>3,4,25</sup> This competence applies to diversity in terms of race, faith, age, gender, disability and sexual orientation. Assumptions about any of these aspects may influence perceptions of risk. The practitioner should reflect on their assumptions about people from diverse groups within society and think about any judgements of risk that they are making about people from these groups. Some authorities have argued that assumptions about race can have an influence on judgements of risk.<sup>25</sup>

Assumptions about gender can also frame the way that risk is assessed in women and men. It is essential to stay open-minded about the potential for violence and self-harm or suicide – regardless of race and gender – and not to expect service users to conform to basic stereotypes.<sup>4,26</sup> Other social groups are sometimes stigmatised as ‘always’ difficult in some way (e.g. service users with a personality disorder diagnosis or substance use problem). Structured assessment approaches and an awareness of relevant research on the use of different instruments with different groups will help with this aim. Practitioners should draw upon their own knowledge of equality issues and on the equality and diversity resources within their organisation for guidance; this will help to set the context for fair and respectful judgements of risk. Reflective practice, clinical supervision and a team approach are also crucial.

## **25. RECOGNISING THE FLUIDITY OF RISK**

Risk can change – sometimes over very short timescales. By definition, dynamic factors fluctuate in their contribution to the overall risk. Given the fluidity of risk, only the tools based on structured professional judgement are useful in monitoring change and engagement with the service user and carer. So there should be an established procedure to formally review the assessment of risk at regular intervals. However these reviews should not be rigidly limited to these time points. It is important that the procedure has some flexibility so that, in particular circumstances, an earlier or more timely formal review can be undertaken. This also guards against a ‘tick box’ mentality in completing risk assessment forms. All practitioners working with the service user need to be familiar with previous risk assessments so that they can be alert to changes in the level of risk. Particular attention should be paid to the relationship between substance misuse and changes in the risk of harm to self or others.<sup>27</sup> It is crucial that service users and carers have access to someone whom they can contact in a crisis if the need arises, and that they are taken seriously if this occurs.

## **26. REGULAR REVIEW**

While remaining flexible, risk management within Recovery Care plans should include scheduled dates for reassessment, so that they are not simply amended as a reaction to a crisis or other events. These review requirements should be part of the risk management plan and not separate from it, and the service user and all those involved in their care should be involved in this review. Risk management plans should also include a clear statement of responsibility for carrying out specified tasks in the plan, as well as for reviewing them. From discussion with the service user, it is essential to anticipate what circumstances would trigger a review outside the normal timetable, as well as which times of year are particularly difficult. There should be scope for the service user or carer to request a review. In addition, risk management should be revisited before and during time periods that are recognised to be associated with increased risk, for instance: The first few days after an admission to a ward, prior to leave, on return from leave and around the time of discharge.<sup>19</sup>

## **27. RECOGNISING THE INDIVIDUALITY OF RISK**

Each service user behaves differently when they begin to need support. It is important for care teams to prioritise their relationship with the service user so that personal signs and triggers ('signatures') can be identified by those involved in their care as well as by the service user her or himself. These signs and triggers will often be very individual to each service user. When they have been noted and their relevance to risk has been understood, they should lead to intervention as early as possible and should never be ignored.<sup>2</sup> Key personalised risk factors or 'signatures' should be documented in the RiO Risk Information and in the Crisis/Relapse Plan parts of the Recovery Care Plan. They may be added as an Alert. Advanced decisions are an important component of developing individualised and collaborative care.

**Figure 4: Supplementary NICE guidance on the short-term management of violence<sup>3</sup>**

***Prediction***

Measures to reduce disturbed or violent behaviour need to be based on comprehensive risk assessment and risk management. Therefore mental health service providers should ensure that there is a full risk management strategy for all their services.

***Working with service users***

Service users identified to be at risk of disturbed or violent behaviour should be given the opportunity to have their needs and wishes recorded in the form of an advanced decision. This should fit within the context of their overall care and should clearly state what intervention(s) they would and would not wish to receive. This document should be subject to periodic review.

***Risk assessment***

Risk assessment should include a structured and sensitive interview with the service user and, where appropriate, with carers. Efforts should be made to ascertain the service user's own views about their trigger factors, early warning signs of disturbed or violent behaviour and other vulnerabilities, and the management of these. Sensitive and timely feedback should complete this process.

***Care plans***

Risk assessment should be used to establish whether a care plan should include specific interventions for the short-term management of disturbed or violent behaviour.

***Tools***

Actuarial tools and structured clinical judgement should be used in a consistent way to assist risk assessment, although no 'gold standard' tool can be recommended.

This guidance is available from:

[Violence and aggression: short-term management in mental health, health and community settings | Guidance and guidelines | NICE](#)

**28. FIRST CONTACT WITH SERVICES**

When the service user has a first crisis episode and has not had contact with mental health services before, the family's – and in particular the main carer's – contribution to information-gathering is critical. In this situation, the carer has the most knowledge about the service user and is a vital source of both information and support. But this will be a particularly difficult time for the carer as well as for the service user, and practitioners must acknowledge this when working with carers at this time.

## **29. WHAT SHOULD TRUSTS BE DOING TO MANAGE RISK?**

There are many practical steps that trusts should be considering in the area of risk management. These steps include:

- keeping the physical environment under regular review;
- conducting investigations as recommended by Department of Health guidance;
- learning from inquiries and reports by the Care Quality Commission; and
- appointing senior staff to oversee clinical risk management.

## **30. WHO SHOULD BE DOING RISK MANAGEMENT?**

Risk management is everyone's business – including the service user's. The carer and the practitioner with whom the service user works are in the best position to make the most important and relevant contribution to risk management planning, but all of those involved in providing care have a role to play. Anybody involved in tool-based risk assessment must know their own strengths in terms of their personal competencies and skills. Newly qualified staff should be allocated less complex cases and closely supervised. The more formal the risk assessment, the higher the degree of personal competency required.

## **31. SOURCES OF INFORMATION**

A variety of sources should be used for getting hold of information on which to base the assessment and management plan. These sources must include interviews with the service user and carer, but can also draw on reports, case notes and the relevant tools.

## **32. EFFECTIVE TEAM WORK AND PARTNERSHIPS**

The practitioner may sometimes be working alone, but in most situations the best risk assessments and the most effective decisions are made by a team of experienced practitioners in consultation with the service user and carer. Decisions and assessments should also be based on collaboration between health and social care agencies in hospitals and in the community.<sup>1,20</sup> In some cases they should be based on collaboration between general and specialist services. The judgements made in a risk assessment should be made in collaboration with others in the multi-disciplinary team and with the service user and carer. In instances where the risk seems high, the involvement of senior colleagues to advise and support may be helpful.

Teams should think about the way that they operate and communicate: effective decision-making is more likely in an atmosphere of openness and transparency, where all views are welcomed and responsibility is shared. Teams should consider the best way for them to resolve disagreements about a decision, to ensure that the best decisions are made and that team cohesion is preserved. Teams should also be alert to group processes such as the pressure to conform and the potential for groups to recommend more risky courses of action than an individual would. When working across agencies, a common understanding and language should be established for the issues that will be addressed.<sup>23</sup>

### **33. MEETINGS**

There should be a clear discussion about the risk management plan at any RCPA meeting, and the service user and their carer should be enabled to attend. The issue of risk needs to be discussed with sensitivity at this meeting and, since the service user or carer may feel inhibited in a large group, they should be given an opportunity to meet with key clinicians both before and after the main meeting. They should also be able to have meetings separately from each other.

### **34. TRAINING**

All practitioners involved in risk management will receive relevant training, and this will be updated at least every three years. This training does not have to be classroom-based but should include attention to:

- the indicators of risk;
- the importance of identifying high-risk periods;
- options for flexible and robust risk management;
- ways of maximising involvement;
- communication and therapeutic relationships; and
- relevant aspects of the Mental Health Act.

Service users and carers should be involved in delivering training to practitioners. The training should include an emphasis on an awareness of long-term clinical and social needs, as well as knowledge of the person's current mental condition and an awareness of how risk changes as the service user's level of care changes (e.g. following discharge or when on leave).<sup>14</sup>

### **35. RECORDING INFORMATION**

All significant risk-related decisions should be recorded in RiO in a timely and accurate manner. The most relevant sections are the progress notes, the Alert functionality, the Risk Screen, the Risk Information module and the Recovery Care Plan and Crisis/Relapse Plan (which should be shared with the client). It will be important also to, whenever it is not possible to follow an important principle of best practice, document the reason for this.

### **36. COMMUNICATION**

Once a risk management plan has been developed or reviewed as part of the RCPlan, it must become a live document and be communicated to the service user and all of those involved in providing their care: risk management has no purpose if it is not shared.

### **37. DECISION-MAKING IN THE REAL WORLD**

Decision-making by professionals involved in risk assessment and risk management is complex and is affected by many factors that are specific to the practitioner

making the decision, such as their personal values, their own attitude towards risk, their workload and the time that they have available to address the matters in hand. It is important for professionals to be aware of and reflect on the factors that influence their decision-making, to ensure that their values are enhancing the process rather than distorting it. Again, effective team working, individual supervision and good communication with others will all support these processes. Feedback from the service user on this aspect of practice is a useful part of reflective practice.

### **38. LEARNING FROM ADVERSE INCIDENTS**

Things can go wrong even when best practice has been used. If things do go wrong or do not go according to plan it is important to learn why, including identifying any mistakes that were made.<sup>29</sup> Learning from 'near misses' is vital to improving services,<sup>5</sup> although not all lessons learned will require changes in practice – they may not necessarily lead to better outcomes. The culture of an organization can make all the difference in ensuring that staff feel able to be honest about the decisions that they have taken, the basis on which they made their decisions, and how things might have been done differently and better: lessons can be learned and, where necessary, practices can be changed for the better. Training could also be improved as a result. It is important to remember that any decision is likely to be acceptable if it conformed to relevant guidelines, it was based on the best information available, it was documented and the relevant people were informed.<sup>11</sup>

Somerset Partnership has a database of Learning Points gathered from analysis of untoward events which is held by Corporate Governance.

### **39. LEARNING FROM GOOD PRACTICE**

Most of our learning in risk management is based on looking back at adverse incidents. It is vitally important, though, to acknowledge that dealing with risk and making decisions is part of everyday practice, and practitioners make the right decision most of the time. Every right decision helps to prevent an adverse incident, so organisations should set up systems for systematically learning from good practice as well. This should include sharing experiences among practitioners and encouraging multidisciplinary and peer review of clinical practice.<sup>30</sup>

### **FURTHER INFORMATION**

Tools useful in management of risk of harm are discussed and compared in the following document, which is available at:

[http://webarchive.nationalarchives.gov.uk/+/www.dh.gov.uk/prod\\_consum\\_dh/groups/dh\\_digitalassets/@dh/@en/documents/digitalasset/dh\\_076512.pdf](http://webarchive.nationalarchives.gov.uk/+/www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/@dh/@en/documents/digitalasset/dh_076512.pdf)

DOH June 2007

### **40. SUMMARY**

A checklist for clinicians is available in Appendix E.

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**CLINICAL RISK MANAGEMENT CLINICAL AUDIT STANDARDS**  
(Derived from Clinical Assessment and Management of Risk of Harm to Self and Others Policy,  
and the RCPA Policy)

Agreed by Clinical Audit Standards Group July 2010

|   |   |                   |                       |
|---|---|-------------------|-----------------------|
| Service area(s) to which standards apply: | ✓ | All Mental Health | CAMHS                 |
|   |   | Inpatient Adult   | Community Adult       |
|   |   | Inpatient Older   | Community Older       |
|   |   | Rehab & Recovery  | Drugs Service         |
|   |   | Eating Disorders  | Learning Disabilities |

|  |                                     |
|--|-------------------------------------|
| Standards and RCPA policy due for review | October 2013                        |
| Audit regularity                         | 18 months                           |
| Previous audits                          | <a href="#">2000 A132</a>           |
|  | <a href="#">2001 A133 (General)</a> |
|  | <a href="#">2001 A133 (Local)</a>   |
|  | <a href="#">2005 A203</a>           |
|  | <a href="#">2006 A203</a>           |
|  | <a href="#">2011 A482</a>           |

## CLINICAL RISK MANAGEMENT CLINICAL AUDIT STANDARDS

| Ref No             | Standard   | Compliance | Exceptions                                   | Definitions  |
|--------------------|--|------------|--|--|
| <b>142/<br/>58</b> | <p>All clients should have a RiO Risk Screening which is updated:</p> <ul style="list-style-type: none"> <li>• After every risk incident</li> <li>• When new risk information is received</li> <li>• At critical points in the care pathway (see definitions)</li> </ul> | 100%       | Those clients who have not yet been assessed | <p>Core Assessments - Risk Screening should be updated as a minimum at critical points in the care pathway:</p> <ul style="list-style-type: none"> <li>➤ Admission/assessment</li> <li>➤ Planned and actual leave</li> <li>➤ MDT care reviews/discussions</li> <li>➤ Discussion of client risk in clinical supervision</li> <li>➤ CPA reviews</li> <li>➤ 7-day follow-up contact</li> <li>➤ Discharge</li> </ul> |
| <b>59</b>          | All risk incidents should be recorded within progress notes and should be flagged to “add to risk history”, and the appropriate risk type(s) selected  | 100%       | None   | These incidents are events which happen during the current episode of care   |
| <b>60</b>          | All historic risk incidents should be recorded as Risk Incidents in Risk History, and the appropriate risk type(s) selected  | 100%       | None   | These incidents are events that occurred prior to the current episode of care. Historical incidents should be added to Risk History and dated retrospectively.   |

## CLINICAL RISK MANAGEMENT CLINICAL AUDIT STANDARDS

| Ref No    | Standard  | Compliance | Exceptions  | Definitions  |
|-----------|---|------------|---|--|
| <b>62</b> | <p>All clients with either a Long Term Risk or Acute Risk Screening factor assessed as Significant or High (score 2 or 3) should have full details recorded within the Core Assessments - Risk Information. This should include a minimum of the following fields:</p> <ul style="list-style-type: none"> <li>• Static historical factors</li> <li>• Forensic history (where relevant)</li> <li>• Nature of current risks or concerns</li> <li>• Current risk triggers/factors exacerbating risk</li> <li>• Factors currently protecting or alleviating against risk</li> <li>• The views of the family/carers.</li> <li>• Summary of Key actions to manage risk</li> </ul> | 100%       | The views of the client and family/carers where they concur with the professionals. | <p>Risk Screening factors are:</p> <ul style="list-style-type: none"> <li>• Violence/harm to others</li> <li>• Suicide</li> <li>• Self harm</li> <li>• Accidental self harm/neglect</li> <li>• Leaving without prior agreement (inpatient only)</li> <li>• Neglect/abuse/exploitation by others</li> <li>• Any previous experience of physical, sexual or emotional abuse.</li> <li>• A risk to children</li> <li>• Responsibility for own/others children</li> <li>• Antisocial and offending behaviour</li> <li>• Sex offending</li> <li>• Physical health condition</li> <li>• Falls</li> <li>• Tissue viability</li> <li>• Home safety issues</li> <li>• Driving related issues</li> </ul> |
| <b>63</b> | Where clients have an entry within the Core Assessment -Risk Information, either “No further Action” or “Address in the recovery care plan” should be ticked  | 100%       | None  |  |

## CLINICAL RISK MANAGEMENT CLINICAL AUDIT STANDARDS

| Ref No | Standard   | Compliance | Exceptions  | Definitions  |
|--------|--|------------|---|--|
| 64     | Where clients have an entry within the Core Assessment - Risk Information, and "Address in care plan" is ticked, there should be an appropriate entry in the care plan                             | 100%       | Where the information may cause serious harm, or where special safeguards for confidentiality are needed (e.g. safeguarding children or vulnerable adults) the intervention does not need to be recorded in a written care plan or letter that will be shared with the patient. This also applies where sharing information would lead to disclosure of third party information where there is no consent to do so. | For CPA Level 2 this should be recorded in the RiO Recovery Care Plan<br>For CPA Level 1 this can be recorded in either the RiO Recovery Care Plan or a Therapeutic letter (uploaded as "Plan of Care Letter") |
| 65     | All clients discharged from inpatient care with a risk screening factor assessed as Significant or High should have risk management item(s) in their care plan for at least 90 days post discharge | 100%       | None  | <i>(There is an increased risk of suicide within the first 90 days post discharge from an inpatient unit)</i>  |

## CLINICAL RISK MANAGEMENT CLINICAL AUDIT STANDARDS

| Ref No    | Standard   | Compliance | Exceptions | Definitions   |
|-----------|--|------------|------------|---|
| <b>66</b> | A risk related alert should be recorded where a corresponding risk has been identified | 100%       | None       | <p>Risk related alerts are:</p> <ul style="list-style-type: none"> <li>• Additional mobility/nutritional needs</li> <li>• Allergic reaction</li> <li>• Contagion/blood borne virus</li> <li>• Domestic Abuse (alleged perpetrator or victim)</li> <li>• Environmental risk</li> <li>• History of serious suicidal behaviour</li> </ul> <p>41. Known to be violent<br/>           42. MAPPA eligible<br/>           43. Not for cardio-pulmonary resuscitation<br/>           44. Physical condition<br/>           45. Potential risk to worker<br/>           46. Risk from other member of household<br/>           47. Physical condition<br/>           48. Potential risk to worker<br/>           49. Risk of leaving ward without consent<br/>           50. Risk of self harm<br/>           51. Safeguarding children concerns<br/>           52. Vulnerable adult</p> <p>Alerts should apply to active/current risks, and be removed when the risk has passed</p> |

## CLINICAL RISK MANAGEMENT CLINICAL AUDIT STANDARDS

| Ref No     | Standard   | Compliance | Exceptions | Definitions   |
|------------|--|------------|------------|---|
| <b>79</b>  | If the client has refused all contact, and they are considered to still need specialist mental health care services, the offer of care on a regular basis should continue, and support and liaison should be established with other parties e.g. GP, carer | 100%       | None       | For all patients discharged with the discharge reason 'Against Professional Advice' there should be correspondence with the patient in which the offer of care is made either in the form of a letter or care plan sent to the patient. The offer should also be documented in the progress notes. There should be correspondence with the GP or other parties confirming the offer of contact and, as a minimum, confirming that ongoing advice will be available from the Trust through a specified point of contact" |
| <b>519</b> | All clients on Level 2 CPA should have the "Other Information" section of the care plan completed including action to be taken in the event of a relapse and emergency contact numbers.  | 100%       | None       |   |

**SELF HARM CLINICAL AUDITS**  
 (Derived from Clinical Assessment and Management of Risk of Harm to Self and Others Policy,  
 and [NICE CLINICAL GUIDANCE CG16](#))

Updated by Clinical Audits Group 14/09/2009

|   |   |                             |                              |
|---|---|-----------------------------|------------------------------|
| <b>Service area(s) to which standards apply :</b> | √ | <b>All Mental Health</b>    | <b>CAMHS</b>                 |
|   |   | <b>Inpatient Adult</b>      | <b>Community Adult</b>       |
|   |   | <b>Inpatient Older</b>      | <b>Community Older</b>       |
|   |   | <b>Rehab &amp; Recovery</b> | <b>Drugs Service</b>         |
|   |   | <b>Eating Disorders</b>     | <b>Learning Disabilities</b> |

|  |                           |
|--|---------------------------|
| <b>Standards and policy due for review</b> | December 2012             |
| <b>Audit regularity</b>                    | Once every 3 years        |
| <b>Previous audits</b>                     | <a href="#">A373 2009</a> |
|  | <a href="#">A309 2008</a> |
|  |                           |



## SELF HARM CLINICAL AUDIT STANDARDS

| Ref No | Standard   | Compliance | Exceptions | Definitions   |
|--------|--|------------|------------|---|
| 221    | Staff show respect and understanding to people who self harm and present to an Emergency Department  | 100%       | None       | <p>People who self harm and present to an Emergency Department report they are:</p> <ul style="list-style-type: none"> <li>• Treated respectfully</li> <li>• Given full information about their care</li> <li>• Fully involved in decisions about their treatment/care</li> <li>• Provided with written information about relevant local services</li> </ul>                                    |
| 222    | Somerset Partnership Trust provides appropriate training for healthcare staff in Somerset General Hospitals who have contact with people who self harm | 100%       | None       | <p>Training to include:</p> <ul style="list-style-type: none"> <li>• The problems faced by people who self harm when they have contact with services</li> <li>• An exploration of some of the meanings and motives for self harm</li> <li>• Capacity and consent in relation to self harm</li> <li>• Assessment of people who self harm</li> <li>• The content of the NICE guideline</li> </ul> |
| 223    | All referrals to psychiatric services should be accompanied by an adequate initial assessment from the DGH or A&E.                                     | 100%       | None       | <p>Brief details to be recorded within progress notes and/or presenting problems, and should include adequate risk assessment, and willingness to engage.</p> <p>Adequate risk assessment = Adequate validated risk assessment</p>  |
| 224    | Healthcare Professionals offer full information about the treatment options available within the mental health system                                  | 100%       | None       | Trust leaflets available  |

## SELF HARM CLINICAL AUDIT STANDARDS

| Ref No | Standard   | Compliance | Exceptions                     | Definitions   |
|--------|--|------------|--------------------------------|---|
| 225    | Following referral to psychiatric services, a comprehensive assessment of psycho social needs for every person who self harms is conducted | 100%       | Patients who refuse to be seen | <p>The needs assessment includes:</p> <ul style="list-style-type: none"> <li>• Social situation (living arrangements, work, debt)</li> <li>• Personal relationships</li> <li>• Recent life events and current difficulties</li> <li>• Psychiatric history (including previous self harm, drug/alcohol use)</li> <li>• Mental state examination</li> <li>• Enduring psychological characteristics associated with self harm</li> <li>• Motivation for the act</li> </ul> <p>Decision about referral for further management should be based upon combined needs and risk assessment</p> |
| 226    | Following referral to psychiatric services, a comprehensive assessment of risk for every person who self harms is conducted                | 100%       | Patients who refuse to be seen | <p>Risk assessment includes:</p> <ul style="list-style-type: none"> <li>• Characteristics of the act of self harm (intent, medical seriousness, use of violent methods, evidence of planning, precautions taken to prevent rescue)</li> <li>• Characteristics of the person (hopelessness, forensic history, future suicide intent)</li> <li>• Circumstances of the person (social class, physical illness, recent bereavement, social isolation)</li> </ul> <p>Decision about referral for further management should be based upon a combined needs and risk assessment</p>          |

## SENIOR CLINICAL REVIEW GROUP – TERMS OF REFERENCE

### 1. MEMBERSHIP

As required and determined by the specific patient which can be from any area of service.

The following should be considered:

Medical Director (or nominated senior consultant colleague)  
Representatives from Specialist Services (eg Psychological Therapies, Personality Disorders, Forensic Liaison Team, Addiction Specialists)  
Representative from Named Patients Panel  
Representative from Senior Management Group (Chair)  
Representative from Placement Support Team  
Representative from Safeguarding Children and Safeguarding Vulnerable Adults Teams (if required)  
Administrative support (as appropriate)  
A range of other specialists would be asked to contribute as necessary

### 2. FREQUENCY OF MEETINGS

As required.

### 3. MINUTES

The minutes of each meeting will be drawn up as a permanent record and provisionally agreed by the Chair of the meeting. All members will receive a copy of the minutes. The minutes will be discussed and confirmed, or amended, as necessary.

### DUTIES

- Review 'stuck' cases in service areas
- Provide a senior clinical multi-disciplinary review of treatment
- Highlight areas of good practice and recommend areas for improvement based on above review.
- Suggest proposals for future care if appropriate

### 4. ACCOUNTABILITY AND REPORTING ARRANGEMENTS

Provide agreed summary of above review to the Director of Mental Health and Social Care, other relevant senior managers and ward/team managers. Any immediate concerns regarding management of risk or safeguarding will be forwarded to the relevant service manager and staff member for immediate actions. Funding regarding placements would need to be dealt with through the usual panel process.

## **5. EXPLANATION OF A 'STUCK' CASE**

A 'stuck' case might be defined as any or all of the following:

- A case where the diagnosis or treatment plan, or recovery plan, is unclear
- A case where various treatments/approaches/interventions have been tried but progress is slow
- A case where there are significant differences of opinion between professionals
- A case where the user or carer requests a 'second opinion' or broader look at the options.

## **6. HOW TO REQUEST A SENIOR CLINICAL REVIEW MEETING**

- Via Placement Panel
- Via regular review of Inpatient Wards
- Local/Care Co-ordinator/Clinical request

## TREATMENT REFUSAL/SELF DISCHARGE ALGORITHM

### To be read in conjunction with the Consent and Capacity to Consent to Examination and/or Treatment Policy

If an adult with capacity makes a voluntary and informed decision to refuse or withdraw consent to treatment (whether contemporaneously or in advance), this decision must be respected, except in certain circumstances as defined by the Mental Health Act 1983. If the patient withdraws consent, they must be given a clear explanation of the likely consequences of not having treatment and, where relevant, an explanation of the circumstances in which treatment may be given without their consent under the Mental Health Act 1983. A record of this discussion must be documented in the patient's electronic patient record.

If a voluntary (i.e. informal) patient refuses treatment such as medication, this wish must be respected if they are capable of making this decision. The only authority for treating a voluntary patient is either their valid consent or the Mental Capacity Act but only if the patient lacks capacity to make this decision and treatment would be in their best interest.

In some cases patients will explicitly communicate that they have made a decision to decline treatment or self-discharge from a hospital. Other people may appear to be declining treatment by not attending appointments and disengaging from services. For some people this will be a gradual process over a period of time. People with mental health difficulties are at higher risk than the general population of suicide and not engaging in treatment, in particularly disengagement from treatment and not attending one or more appointments, is an indicator of a potential increase in suicide risk. Every effort should be made to engage people with mental illness with services in order to fully assess risk of suicide and consideration should also be given to use of the Mental Health Act.

**If a patient age 18 and above refuses treatment, the following steps should be followed.**

- **Assess for mental capacity to make the decision about refusing treatment.**
- **Document the outcome in the electronic patient record.**

|  | Non urgent treatment   | Urgent/emergency treatment   |
|--|--|--|
| Adult with capacity to make decisions about treatment who is not detained under the Mental Health Act. | <p>Decision to be respected.</p> <ul style="list-style-type: none"> <li>• Ensure the patient has full information about the treatment and the consequences of refusing it, to enable them to made an informed decision;</li> <li>• Discuss with the patient why they do not want treatment;</li> <li>• Consider factors such as fear and stigma;</li> <li>• Discuss with the patient potential options to overcome barriers to treatment. Could the person be treated in a different environment, by a different team for example?</li> <li>• Discuss with line manager and multi-disciplinary team;</li> <li>• Inform other professionals involved with the patient's care including the GP;</li> <li>• Inform family members/carers if consent has been obtained to do this.</li> <li>• Document the patient's refusal, a statement about their mental capacity at the time of the refusal and steps taken above in the</li> </ul> | <ul style="list-style-type: none"> <li>• Decision to be respected even if this decision could result in death, however seek advice if the patient is refusing treatment for a condition which endangers self or others, such as serious mental illness or an infectious disease that presents a risk to public health.</li> <li>• If a person requires emergency treatment to save their life, and they are unable to give consent as a result of being physically or mentally incapacitated (for example, they are unconscious), treatment will be carried out in their best interests under the Mental Capacity Act. Once they have recovered, the reasons why treatment was necessary will be fully explained.</li> <li>• Make every effort to follow subsequent steps:</li> <li>• Ensure the patient has full information about the treatment and the consequences of refusing it, to enable them to made an informed decision;</li> <li>• Discuss with the patient why they do not want treatment;</li> </ul> |

|  |  |   |
|--|--|---|
|  | <p>patient's electronic patient record.</p> <ul style="list-style-type: none"> <li>Continue to review risk factors.</li> </ul>   | <ul style="list-style-type: none"> <li>Consider factors such as fear and stigma;</li> <li>Discuss with the patient potential options to overcome barriers to treatment. Could the person be treated in a different environment, by a different team for example?</li> <li>Discuss with line manager and multi-disciplinary team;</li> <li>Inform other professionals involved with the patient's care including the GP;</li> <li>Inform family members/carers if consent has been obtained to do this.</li> <li>Document the patient's refusal, a statement about their mental capacity at the time of the refusal and steps taken above in the patient's electronic patient record.</li> </ul> |
| <p>Adult patient assessed as not having capacity to make decisions and not subject to the Mental Health Act.</p> | <p>Make a best interest decision involving:</p> <ul style="list-style-type: none"> <li>next of kin/person with lasting power of attorney</li> <li>GP</li> <li>Professionals involved in the patient's care.</li> </ul> <p><b>Record best interest decision in care plan/case</b></p> | <ul style="list-style-type: none"> <li>When there are no family or carers available to consult about serious medical treatment then refer to the Independent Mental Capacity Advocate Service (IMCA).</li> <li>There are some circumstances where a decision should always be referred to the Court of</li> </ul>   |

|   |  |  |
|---|--|--|
|   | <b>notes.</b>  | Protection if the person cannot give their consent; this includes situations where there is serious concern about the person's capacity or best interests.   |
| Adult patient with fluctuating capacity, complex health needs or drug or alcohol misuse that is affecting capacity to make decisions. | <ul style="list-style-type: none"> <li>• Arrange a multi disciplinary meeting involving, next of kin/ advocate, GP and professionals involved in the person's care.</li> <li>• Continue to offer appropriate treatment such as substance misuse services.</li> <li>• Continue to review risk factors and mental and physical health conditions.</li> <li>• Consider use of the Mental Health Act where there is significant mental illness.</li> </ul> <p><b>Record outcome of MDT and any action plan in care plan/case notes</b></p> | <ul style="list-style-type: none"> <li>• Inform all relevant health and Social Care professionals of need for multi disciplinary decision making.</li> </ul> |

**For children and young people under the age of 18, please refer to the Consent and Capacity to Consent to Examination and/or Treatment Policy.**



# Assessing risk of harm to self and others

## | A checklist for clinicians

- If you are not trained to assess and manage risk of harm to self and others in relation to mental health then please refer to the relevant locality mental health services
- Complete a RiO risk screen
- When there are any significant risks then complete the Risk Information module and construct a Risk Management Plan as part of the Recovery Care Plan. Be sure to update the Crisis / Relapse part of the plan and consider adding alerts to RiO

| In constructing a Risk Management Plan consider:

- |                       |   |
|-----------------------|---|
| Information gathering | <ul style="list-style-type: none"> <li>▪ Have you gathered the right information to assess the risk adequately? Remember that past history is a strong predictor of future risk.</li> <li>▪ Have carers / family / others involved in care had the opportunity to express their concerns and been consulted and involved in the assessment of the risk and in the Risk Management Plan?</li> </ul>  |
| Risk Sharing          | <ul style="list-style-type: none"> <li>▪ Has the client been involved in constructing and implementing the Risk Management Plan?</li> </ul>   |
| Information Sharing   | <ul style="list-style-type: none"> <li>▪ Have you shared risk information with relevant professionals on a need to know basis, and with families and carers on a need to share basis, within the restrictions of client confidentiality?</li> <li>▪ Have you considered the need to share information urgently and the possible need to breach confidentiality (including police referral) when someone/the public is identified as being at significant risk of harm?</li> </ul> |
| Taking Action         | <ul style="list-style-type: none"> <li>▪ Have you considered the safeguarding of children and vulnerable adults who are at risk of abuse and neglect?</li> <li>▪ Have you considered assessment of capacity or use of the Mental Health Act?</li> </ul>   |
| Documenting Risk      | <ul style="list-style-type: none"> <li>▪ Have you documented the nature of the current risk and the way it has been assessed and managed so that future professionals will be able to learn from your practice and pick up from where you have left off?</li> </ul>   |