# ADULT MENTAL HEALTH SERVICES

## CLINICAL RISK ASSESSMENT & MANAGEMENT POLICY AND PROCEDURE AMH

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EXECUTIVE SUMMARY:

This policy provides a system for ensuring that a thorough and consistently high standard is applied to the assessment of clinical risk in Solent NHS Trust in order that the risks identified can be managed effectively, fairly and safely, in line with the overarching Trust Risk Management Strategy & Policy

Key policy issues:

Safety of service users, carers, and the public in relation to suicide, self-harm, neglect, vulnerability, violence and rehabilitation in a clinical recovery model

Engagement and collaboration with service users and carers

Positive risk-taking, sound risk management to and facilitate recovery

Undertaking, documenting, and communicating suitable and sufficient risk assessment and care management plans to service users, carers and relatives (as appropriate)
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1. INTRODUCTION & PURPOSE

1.1 Purpose

1.1.1 Solent NHS Trust (referred to in this document as Solent) is committed to the safety and wellbeing of service users, staff and all people visiting or working within the Trust.

1.1.2 Clinical risk assessment and management is part of the Trust’s overall risk management strategy and is fundamental to maintaining safety.

1.1.3 This policy defines the overarching standards to be employed within all local services relating to the risk assessment and management of individual service users. It should be used by all staff involved in the assessment and management of clinical risk.

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

1.1.5 This policy aims to promote the safety of service users, carers and the public in relation to a range of clinical risks to self and others (including, self-harm, suicide, neglect, vulnerability and violence) whilst maximising the service user’s independence, social inclusion, and recovery.

1.1.6 This policy provides staff with guidance and a set of principles and risk tools to support the provision of up-to-date, high quality clinical risk assessment.

1.1.7 This policy aims to promote the safety of service users, carers and the public in relation to a range of clinical settings where risks to service users and others (including, accidents (eg falls), self-harm, suicide, neglect, vulnerability and violence) whilst maximising the service user’s independence, rehabilitation, social inclusion, and recovery.

1.1.8 The Trust endorses positive risk management and will support any risk-related decision if it is:

- Considered – carefully, collaboratively, based upon the best information available and conforming with relevant guidelines/best evidence
- Recorded – in accordance with the tool/structured prompt and record system in place and that identified risks are reflected in overall treatment/care/risk management plans
- Communicated – the relevant people are involved/informed in a timely way.

1.1.9 This policy details expected standards of practice derived from:

- Re-focusing the care programme approach: Policy and positive practice guidance, DH, 2008,
- 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, DH, June 2007.
- Re-focusing the care programme approach: Policy and positive practice guidance, DH, 2008.
• It also takes in to account a range of other relevant guidance (See Reference, Bibliography and Cross-references).
• Rabone & Anor v Pennine Care NHS Trust [2012]

1.1.10 This policy aims to ensure risk assessments and management plans are based on a holistic view of the person as an individual and not on stereotypes, and accounts for the diverse nature of our service users and the different contexts in which risk is assessed.

1.2 Definitions

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

1.2.2 Risk relates to an event happening with potentially harmful or beneficial outcomes for self/and or others and covers a number of aspects (DH, June 2007).

• How likely it is the event will occur.
• How soon it is expected to occur.
• How severe/beneficial the outcome will be if it does occur.

Note: A beneficial outcome may for example be increased independence.

1.2.3 Risk assessment is an estimate of each of these aspects based on the gathering of historical and current information through the processes of reviewing case notes, engagement, communication, investigation, and observation: and identification of specific risk factors of relevance to the individual and the circumstances in which they may occur.

1.2.4 A risk factor is any circumstance, condition, or characteristic thought to have a relationship to the potential to harm oneself or others.

1.2.5 A protective factor is any circumstance, event, factor or other consideration thought to prevent or reduce the severity or likelihood of harm to self or others.

1.2.6 Risk formulation is a narrative account of how identified risk and protective factors combine to increase and decrease risk.

1.2.7 Risk management involves developing strategies aimed at preventing identified potential adverse events from occurring, and/or minimising the harm caused.

1.2.8 Positive risk management means recognising that the risk of negative outcomes can never be completely eliminated and that management plans inevitably have to include decisions that carry some risk. Positive risk management requires balancing both the service user’s quality of life and plans for recovery, and the safety needs of the service user, their carers, their family and the public.

1.2.9 Positive risk-taking is the weighing up of potential benefits and harms of exercising one choice of action over another, identifying the potential risks involved, and developing plans that reflect positive potentials and choices of the individual.
1.2.10 Risk ‘tools’ refer to both published, standardised, empirically based, assessments and to ‘bespoke’ assessments, based on clinical and empirically based knowledge.

1.2.11 The structured clinical (or professional) judgement involves making a judgement about risk based on combining:

Assessment of presence of risk and protective factors derived from research

- Clinical experience and knowledge
- Knowledge of the service user
- The service user and carer’s own view and experience

1.3 Principles

1.3.1 Risk is an everyday component of the life of any individual and it is not possible to remove all risk from the experience of service users or staff, but healthcare staff have a duty to protect patients as far as is ‘reasonably practical’ (NPSA, 2007) and must avoid any unnecessary risk.

1.3.2 Risk management is not just the responsibility of individuals and this policy is part of the Trust’s wider risk management strategy to support individuals and teams in their assessment and management of clinical risk. It is an on-going/dynamic process.

1.3.3 Risk assessment and management should be based on physical, procedural and relational security (DH, March 2010).

Note: Relational security is the knowledge and understanding staff have of a service user and of the physical and social environment and the translation of that information into appropriate responses and care.

1.3.4 Risk assessment and management are an integral part of a service user’s care and should be undertaken in the wider context of a holistic and recovery approach to care planning.

1.3.5 Risk assessments and risk management plans should involve:

- Engagement and the building of a trusting relationship with the service user and care
- Collaboration with the service user and carer
- Discussion and consultation with all members of the multidisciplinary team, private services, and other agencies involved in the service user’s care
- Structured clinical (or professional) judgement supported by the best evidence and information available in order that the best decision is made at the time
- A stepped approach and use of agreed risk tools for each care group and service area reflecting the level of detail or speciality required.

1.3.6 Risk tools provide a means to systematically identify potential risk and protective factors. These should be used more as an aid to formulation and risk management planning than a means of prediction.

1.3.7 All risk assessments and formulations (as set out in appendix 1), management plans, and discussions should be clearly documented and communicated to all involved and relevant parties, including the service user, carer, and other agencies if appropriate.
1.3.8 All qualified and appropriately trained staff should be proactive in information sharing with other agencies if where to do so enhances the safety of the service user and/or the safety of the public, even if the service user withholds consent.

1.3.9 Risk is best managed through a positive risk management and risk-taking approach (Department of Health, 2007).

1.3.10 Risk assessment and management plans should be developed and reviewed in line with local Care Programme Approach policy, and whenever new relevant information becomes available or there is a change in the service user’s clinical presentation or circumstances including:
   a. New assessment of a new or previously known service user
   b. Escalation of risk, or social factors impacting on risk (i.e. housing issues)
   c. Review at CPA or review of or change in circumstances
   d. Discharge from the ward, CRHT or a community team

1.3.11 Staff should demonstrate sensitivity and competencies in relation to the protected characteristics (Equality Act 2010) including ethnicity, religion and belief, age, sex, gender reassignment, marriage and civil partnership, pregnancy and maternity, disability and sexual orientation.

1.3.12 All clinical staff should demonstrate an effective level of competence in the assessment and management of risk.

1.3.13 Auditing risk assessment and management practice and standards are an essential part of maintaining an effective, efficient and fair service.

2. SCOPE & DEFINITIONS

2.1 This policy applies to all service users and carers regardless of context.

2.2 An awareness of this policy and the importance and principles of good clinical risk assessment and management is relevant for all health and social care staff working in Solent NHS Trust, this policy however is aimed at Adult Mental Health services.

2.3 The standards of practice and training set out in this policy, however, specifically applies to all clinical practitioners working in the Trust who are required to assess and manage clinical risks whilst carrying out their duties, including temporary or bank staff.

3. POLICY STATEMENT

3.1 This policy cannot cover all eventualities and practitioners are expected to exercise their clinical judgement, experience and discretion in applying this policy and managing risk. When the optimum course of action cannot be taken, the optimum plan should be documented, along with reasons for not taking it, and details of the alternative plan.

3.2 In view of the historical stereotypical risk bias associated with BME people and some religious groups, for example heightened risk of violence in BME groups, and potential stereotypical views regarding older people being of lower risk of violence in view of age or associated frailty,
risk assessments and management plans will be based on a holistic view of the person and not on stereotypes.

3.3 All service users will at the point of first contact or assessment have a risk assessment and formulation documented in the relevant part of the electronic records system. This should include taking into account any known historical risk factors and an initial management plan if indicated. Other risk assessments may be indicated through this assessment i.e. HCR-20 and this is to be raised at the MDT for allocation with an available trained assessor. Service users who pose high risk/s and/or require complex management will have a multidisciplinary/multi-agency formulation and risk management plan.

3.4 Comprehensive risk assessment and management plans can be completed by a single practitioner but where there is multidisciplinary (MDT) or multiagency input into the assessment or plan, this must be documented. Where a MDT risk assessment and management plan is indicated, this must reflect input from all involved and relevant parties. All risk assessments will be completed within the timescales agreed for the service area and reviewed in line with key CPA milestones.

3.5 The risk assessment must be undertaken in collaboration with the service user, carer or family where appropriate, and when this has not been possible, the rationale for not doing so must be clearly documented.

3.6 When risks are identified risk management plans must include, but not limited to, accessing support during crisis and out of hour’s periods.

3.7 The risk assessment and management plan must be signed (or the author/s clearly documented if electronically held), dated, and involvement of the service user and carer/s/other agencies recorded.

3.8 The risk assessment and management plan must be communicated to all relevant parties in accordance with the Data Protection, Security and Confidentiality Policy, Trust Guidance on Managing Confidentiality, and the Department of Health, Information Sharing and Mental Health – Guidance to Support Information Sharing by Mental Health Trusts (September 2009). Particular consideration must be given to any identified risk/s to a named person and carers.

3.9 The risk assessment and management plan must be stored on the electronic CPA system through Clinical Record System.

3.10 All new staff will be made aware of this policy during their Trust and local induction and all clinical staff will be trained in the principles, standards, and use of risk tools relevant to their care group and/or service area. Staff are expected to attend Trust Risk training requiring staff to update their training every 3 years provided by the Trust.

3.11 The standards for clinical risk assessment and management practice against which practice will be audited at least yearly.

4. ROLES AND RESPONSIBILITIES

4.1 All staff

4.1.1 An awareness of the importance of clinical risk assessment and management is the responsibility of all staff and everyone should make it their business to be at all times aware
that service users will potentially present a range of risk behaviours, using common sense and acting accordingly if necessary, and ensuring they report any issues or incidents of relevance to their line manager.

4.2 Chief Executive

4.2.1 The Chief Executive has overall responsibility for all aspects of Risk Management and internal control within the Trust and overall responsibility to ensure systems and resources are in place to ensure effective clinical risk assessment and management processes, as outlined in this policy, and a culture of organisational support, openness, fairness, and learning.

4.3 Chief Nurse

4.3.1 The Chief Nurse has responsibility for the strategic development of risk management and implementation of organisational risk management, of which clinical risk is a major part

4.4 Chief Operating Officer (Portsmouth)

4.4.1 Overall management of clinical risk assessment and management is the responsibility of the COO, including the implementation of the policy, training, and monitoring.

4.4.2 The COO also has responsibility for organisational learning and continuous improvement in clinical risk management, through ensuring the learning arising from the Trust-wide Integrated Action Plans

4.5 Quality and Standards Lead

4.5.1 The Quality and Standards Lead will be responsible for reviewing the policy and procedure in liaison with professional groups and Head of Patient Safety, in line with the trust polices on policy approval document

4.6 Clinical Director and Operations Director

4.6.1 Responsible for ensuring implementation of this policy, high quality service provision, provision of training and ensuring learning is applied following adverse incidents.

4.7 Service Managers and Modern Matrons

4.7.1 Responsible for ensuring the appropriate risk tools and documentation are accessible and used. Responsible for ensuring systems are in place to resolve disagreements or conflicts regarding risk assessment and risk management plans within or between teams.

4.8 Service Line Clinical Governance Groups

4.8.1 Responsible for ensuring up-to-date knowledge of relevant national and local policy developments and best practice regarding clinical risk management in their field. Key areas are:

4.8.2 Contribute to the development of standards and training, in line with developments in national and local policy, guidance and research.
4.8.3 Ensure all clinical staff access appropriate supervision and training, and continuously improve their practice.

4.8.4 Having clear and robust governance and management structures to assist and ensure effective risk management at divisional level

4.8.5 Having local groups in place and managing their risks associated with their services and activities, which report to the Service Line Governance Group

4.8.6 Responsible for ensuring up-to-date knowledge of relevant national and local policy developments and best practice regarding clinical risk management are in place within their services.

4.8.7 Ensure that contribution to the development of standards and training, in line with developments in national and local policy, guidance and research.

4.8.8 Ensure all clinical staff access appropriate supervision and training, and continuously improve their practice.

4.8.9 Identification and management of risks, through local risk registers

4.8.10 Monitor the risks, incidents, claims and complaint within their division, ensuring that action plans are developed and progressed.

4.8.11 Having and utilising processes for escalation of risks to the Corporate Risk Register and Executive Directors

4.9 Team Leaders

4.9.1 Responsible for ensuring all staff are aware of the principles and procedures detailed in this policy and monitor whether staff have received the appropriate training.

4.9.2 Responsibility for ensuring all staff have regular supervision as per Trust Policy, are properly supported, and receive annual appraisals and a Personal Development Plan.

4.9.3 Responsibility for ensuring Team members are confident and competent in undertaking clinical risk management, and address any developmental needs.

4.9.4 Responsible for monitoring/auditing whether the appropriate ‘tools’ and documentation are used and identify action plan where required.

4.9.5 Team leaders have responsibility for ensuring multi-disciplinary discussion and input into risk assessment and management where this is appropriate.

4.10 Clinical Staff

4.10.1 All clinical staff have a legal and a professional ‘duty of care’ which requires that they exercise a reasonable standard of care while doing something (or possibly omitting to do something) that could foreseeably harm others.
4.10.2 All qualified clinical staff with a responsibility for carrying out formal risk assessment and management plans are accountable for their actions or omissions within the sphere of their professional practice.

4.10.3 Clinical staff has a responsibility to attend training and supervision arranged, and must seek advice if unsure about their own or other people’s decision/s regarding risk assessment and management.

4.10.4 Clinical staff has a responsibility to inform their manager if they have not had training or supervision.

4.11 Care Co-ordinators

4.11.1 In addition to the clinical staff duties above, responsible for monitoring agreed risk management plan, and joint working across service areas/agencies when relevant.

4.12 Consultant Psychiatrists

4.12.1 As a requirement of the NPSA 2009 Rapid Response Report, Consultant Psychiatrists must be directly involved in all clinical decision making in relation to service users who are identified as posing a risk to a child.

4.13 Risk Champions

4.13.1 The role of the risk champion is to facilitate reflection around the area of risk they have been assigned and received further training, in order to assist MDT’s in assessing and managing risks raised, effectively.

4.13.2 There will be champions around risks for Suicide and Risk to Others. Those assisting with reflection on the risk of Suicide will have a good understanding of the underpinning theory explored in the training. The champions for Risk to Others will be those staff trained in the use of the HCR-20.

4.13.3 For those trained in the use of the HCR-20 there will be an identified lead within the service to support and provide supervision where indicated.

5. PROCEDURE

5.1 The process of undertaking an assessment of risk and management plan should reflect the principles outlined in Section 2 of this policy.

5.2 The risk assessment and management plan should take account of the legislation arising from the Mental Capacity Act (2005), the Mental Health Act (2007) and their principles, and the Deprivation of Liberty principles

5.3 First or renewed contact with services

5.3.1 Every service user will have either risk assessment and documented formulation using Trust agreed tools and Trust documentation, specific to the care group or service area. This will be undertaken by a suitably qualified or trained practitioner and used to identify potential risk and protective factors and enable an initial formulation and management plan.
5.4 Mental Health Act Assessments

5.4.1 The assessment of risk to self and others is a key component of the Mental Health Act (MHA) assessment.

5.5 Those who require further assessment

5.5.1 Service users with identified high risk behaviours requiring further assessment to ensure effective management, will have a Multi-disciplinary (MDT)/Multi-agency (or equivalent inpatient MDT review) review of their risks (building on the comprehensive screening assessment) and MDT/Multiagency input regarding the risk management plan. This will include all service users admitted into acute/ rehabilitation or secure and forensic inpatient care, and Recovery Teams.

5.6 Routine or on-going Management of Severe Mental Disorder

5.6.1 Service users under CPA or the equivalent must have a review of their risk/s and management plan at each key CPA milestone.

5.6.2 Risk assessments must be reviewed whenever there is a change in the service user’s clinical presentation/circumstances, admission to and discharge from inpatient unit, or transfer to another team/Trust.

5.7 A & E Liaison & Urgent Response

5.7.1 Service users seen by the A&E Liaison Team who are not known to services will have an assessment of risk within the assessment. Those known to services will have their current risk assessment reviewed and updated.

5.8 Crisis & Resolution Home Treatment Team (CRHTT)

5.8.1 The CRHT will complete or update a risk assessment for all service users, whether referred from the community or inpatient services.

5.9 Acute Inpatient care for Adults

5.9.1 An initial assessment will have been completed by CRHTT as part of the gatekeeping procedure prior to admission. This may not be completed if admission is through 136 suite or where CRHTT have not had direct contact with person admitted. In these cases the assessment will need to be completed by the inpatient services.

5.9.2 A comprehensive risk assessment appropriate to acute inpatient care is contained within the acute care admission documentation and provides for a 72 hour initial mental health and risk management plan. It must be completed on admission collaboratively by the nurse in charge and doctor and where possible the service user. In exceptional circumstances, in which the doctor is delayed, the admitting nurse will discuss and agree the 72 hour plan with another senior nurse. Within 72 hours of admission, the Primary Nurse/OT will fully complete a risk and mental health care plan. This and the 72 hour initial plan must be discussed and reviewed with the wider MDT within 72 hours, building on the initial formulation and plan, and paying particular attention to issues of capacity in relation to specific decisions, therapeutic engagement and observation, risk of absconding, leave, substance misuse, risk to self,
transition from the community to inpatient setting, and vice versa. A person’s risk should be reviewed at every MDT Clinical Review.

5.9.3 The risk and mental care plan will be reviewed daily and at the daily MDT meeting, and whenever there is a change in clinical presentation or circumstances known to impact of the person’s risk.

5.9.4 The risk assessment and management plan will be reviewed and updated by ward staff upon discharge from inpatient services.

5.10 Forensic Risk Case Only

5.10.1 In addition to the risk assessment (including detailed analysis of offending behaviour), those identified with a forensic risk receive a comprehensive forensic risk assessment (HCR-20) at the earliest opportunity from identification. The findings of such an assessment will be a significant contribution towards the design of the service user’s care pathway.

5.10.2 Where a forensic risk has been identified (please see Appendix 2 for flow chart) there will be a referral to an appropriately trained HCR-20 assessor via an MDT review and discussion. The assessor would normally be the risk champion for the specified team/area. The HCR-20 should include all relevant care professionals involved in the individuals care. It should be noted that adequate time should be built into the HCR-20 job plan or workload plan in order to facilitate the completion of such assessments.

5.11 Dual Diagnosis

5.11.1 An exploration of the possible association between substance/alcohol misuse and increased risk of aggressive/anti-social behaviour, overdose, and or suicide/self-harm, must be integral to any clinical risk assessment (DH, 2006). Consideration should be given to the severity of the substance/alcohol misuse and the combination used (DH, 2006).

5.12 Forensic issues in Risk Management

5.12.1 Some users represent a particular high level of risk of harm to others and if judged appropriate should be referred to the Secure & Forensic Service for an opinion.

5.13 Positive Risk Taking:

5.13.1 What is Positive Risk Taking?

i) Positive risk-taking is weighing up the potential benefits and harms of exercising one choice of action over another. This means identifying the potential risks involved, and developing plans and actions that reflect the positive potentials and stated priorities of the service user. It involves using available resources and support to achieve desired outcomes and to minimise potential harmful outcomes.

ii) Positive risk-taking is not negligent ignorance of the potential risks. Nobody, especially users or providers of a specific service or activity will benefit from allowing risks to play out their course though to serious undesired outcomes. So, in practice it is usually a carefully thought-out strategy for managing a specific situation or set of circumstances.
iii) From the experiences of mental health services, positive risk-taking may be characterised by:

- Real empowering of people through collaborative working and a clear understanding of responsibilities that service users and services can reasonably hold in specific situations.
- Supporting people to access opportunities for personal change and growth.
- Establishing trusting working relationships, whereby service users can learn from their experiences based on taking chances just like anyone else.
- Understanding the consequences of different courses of action and making decisions based on a range of choices available and supported by adequate and accurate information.

iv) Working positively and constructively with risk depends on a full appreciation of the service user’s strengths. It is very much based in the here and now, but will be clearly influenced by knowledge of what has worked or not worked in the past and why. The influence of historical information lies in the deeper context of what happened, rather than the simple stigma of the events themselves. It is the knowledge that support is available if things begin to go wrong as they occasionally do for us all. It can occasionally be distinguished between its short and long-term differences, whereby short-term heightened risk may need to be tolerated and managed for longer term positive gains. It can be about explicit setting of boundaries to contain situations that are developing into potentially dangerous circumstances for all involved. It can be about taking the risk of withdrawing services that are inappropriate to needs, or have created a dependency on contact that serves no therapeutic value.

v) As a concept, it needs to be appreciated and understood from the different perspectives of the service user, informal supports, and services – how they define or interpret a risk and its potential benefits will not always be congruent or compatible.

5.13.2 Why Take Risks?

i) Risk is something we frequently initiate personally in all aspects of our lives, in order that we may develop and make changes for ourselves. We take risks with the intention of achieving positive gains, because we see a stronger potential for opportunity than for failure. Sometimes risk-taking is driven by forces or events beyond our personal control or conscious thoughts, by circumstances that we have no choice but to react to in whatever way we can.

ii) In our daily lives we take risks in order to achieve or experience specific desires, such as to be informed, exercise choices, make decisions, hold some control over direction or our own destiny, or to experience degrees of power. We also take risks to collaborate with others positively, make constructive use of opportunities, experience autonomy, and learn from experience and to grow and change.

<table>
<thead>
<tr>
<th>PRINCIPLES FOR WORKING WITH RISK</th>
</tr>
</thead>
<tbody>
<tr>
<td>Risk is a normal everyday experience.</td>
</tr>
<tr>
<td>Risk is dynamic; constantly change in response to changing circumstances.</td>
</tr>
<tr>
<td>Assessment of risk is enhanced by accessing multiple sources of information, but frequently you will be working with incomplete and possibly inaccurate information.</td>
</tr>
<tr>
<td>Identification of risk carries a duty to do something about it – that is, risk management.</td>
</tr>
<tr>
<td>Risk-taking is an integral component of good risk management</td>
</tr>
<tr>
<td>Decision-making can be enhanced through positive collaborations.</td>
</tr>
</tbody>
</table>
- Risk can be minimised, but not eliminated.
- Organisations carry a responsibility to meet reasonable expectations for encouraging a fair blame culture, while not condoning poor practice.

5.13.3 Taking Positive Risks:

i) First, through a focus on strengths, giving a more positive base on which to build potential plans to support beneficial risk-taking. This considers the strengths and abilities of the service user, of their wider network and social systems, and of the wide-ranging services potentially available (statutory and voluntary sectors, and most importantly non-mental health resources).

ii) By a willingness on behalf of all people involved in a specific activity to think and work in this way. It can present significant challenges to the more traditional ways of working, and requires people who relish such challenges, the pursuit of new ideas, and who respond to permission for the expression of imagination. People who pay lip-service to innovation never push the limits of what is routine and comfortably known. If parts of the wider network are not signed up, confidence in being able to sustain positive risk-taking becomes undermined, as the fears associated with a blame culture are more likely to permeate people’s thinking and threaten the implementation of creative ideas.

iii) Through high-quality supervision and support, which are essential for discussing and refining ideas, as well as providing a reality check to prevent idealism overwhelming realism.

iv) Through the development of appropriate crisis and contingency plans for the fears and possibilities of failure. These will aid prevention of some harmful outcomes and the minimisation of others. Risk-taking should be pursued in a context of promoting safety, not negligence.

v) By risk-taking becoming part of the culture of ideas and training. Risk-taking should not be seen as a one-off experiment, but rather as a natural line of thinking. Whole-team training will be essential if the approach is to be fully understood and practised by all team members as a routine part of its culture.

vi) With adequate resources to enable creative work to take precedence over what usually “just happens”. Resources are never open-ended, but true innovation needs organisational support to sustain its development and positive impact.

vii) By limiting the duration of the decision – that is, working to shorter timescales and with smaller goals broken down. This has a strong analogy with weather forecasting, whereby the predictions are more accurate for the next few hours than they would be for the next few days.

viii) By having team and service mechanisms in place to check on progress, providing an ability to quickly change previous decision when needed, including intervening in a more restrictive way when needed.

ix) Through clear definitions of individual and collective accountability and responsibility. Individual practitioners can reasonably be expected to be accountable to the standards of conduct set out by their professional body, and for the roles they play in the local implementation of guidance and legislation. However, there are also collective responsibilities
for information sharing, decision-making and care planning, belonging more with the team than the individual in isolation.

x) Through the organisation exercising its responsibilities to ensure adequate support, and setting the tone for a culture to develop that will enable all the above points to happen.

### GUIDELINES FOR POSITIVE RISK-TAKING

- Consider the clinical risk management policy and procedures
- Service User experience and understanding of risk.
- Carer experience and understanding of risk
- Clear definition of risk-taking in context.
- Clear articulation of the desired outcomes.
- Identification of Strengths.
- Planned stages for risk-taking.
- Awareness of potential pitfalls (and estimated likelihood)
- Potential safety nets (including early warning signs, crisis and contingency plans) IN collaboration with the service user and carers to manage the identified risks and include a Contingency/Crisis Plan
- Outcome of previous attempt(s) at this course of action
- Identify situations and circumstances known to present increased risk
- How was it managed, and what will now be done differently?
- What needs to, and can, change?
- How will progress be monitored?
- Who agrees to the approach?
- When will it be reviewed?
- Make an assessment of the risk and record the assessment formulation and plan in the patient records.

#### 5.14 Information sharing and the police national computer (PNC)

5.14.1 Where there is a benefit to a service user in sharing information with other agencies, such as the police, third sector agencies and probation, all reasonable efforts must be made to obtain the consent of the service user to do so. In circumstances where the service user withholding consent, or obtaining consent is not possible, the healthcare team must then consider the risk to the service user and the wider public of not sharing the information. Issues considered and outcomes of this consideration must be documented and professionals should seek advice from the Trust’s Caldicott Guardian, the vulnerable person’s officer (the appointed investigating officer), and the Trust police liaison officer, where appropriate.

5.14.2 The PNC has the facility to record core information about service users about whom the mental health services have significant concerns if they go absent without leave (AWOL), and can accommodate instructions on what actions to take should the service user be stopped in such ‘identified circumstances’ and a check made against their identity. The service user does not have to have any previous criminal record for this facility to be utilised.
5.15 **Patient Information Management System (PIMS) Alert**

5.15.1 If a service user presents particularly high or specific risks to self or others that need to be flagged up to colleagues and clinicians, details should be relayed to appropriate colleagues and agencies and documented in the Progress Notes under heading of Risk.

5.16 **What to do in the event of a dispute or conflict of opinion regarding the risk assessment and management**

5.16.1 When a marked difference in professional/clinical opinion exists it is vital that such differences are identified, explored, understood and resolved. A meeting arranged by the Team Leader, Service Manager, or Head of Service (depending on where the difference exists) should be arranged to this end. If resolution does not seem possible it should be escalated to the appropriate clinical lead. When a marked difference between service user/carer and the team exists every effort must be made to meet with the service user/carer to discuss, explore, understand, and resolve the differences.

5.17 **Safeguarding Children & Risk Assessment**

5.17.1 In May 2009, the National Patient Safety Agency (NPSA) issued a Rapid Response asking all Mental Health Organisations to ensure that the potential risks to children are properly assessed, and all clinical risk assessments must evidence consideration of whether the service user has or may have contact with children, their own or others, and again whenever the service user’s circumstances change. A referral to children’s social care services must be made under local safeguarding procedures as soon as a potential risk becomes apparent. A referral must be made if a service user expresses delusional beliefs involving their child and or the service user might harm their child as part of a suicide plan. Subsequent to assessing that a service user may pose a risk to children, a consultant psychiatrist must be directly involved in all clinical decision making.

5.17.2 Additionally, the Trusts’ Child Protection Lead must be notified of any services users with an identified risk to a child, whether or not that child is already known to social services.

5.18 **Safeguarding Vulnerable Adults**

5.18.1 In the event of an adult service user being identified at risk or the victim of abuse (physical, financial, sexual), local procedures for safeguarding vulnerable adults must be followed.

5.18.2 The ‘**Safeguarding Adults: The role of Health service practitioners (DH14 Mar 2011)**’ seeks to support empowerment that involves risk management.

5.18.3 Empowerment involves a proactive approach to seeking consent, maximising the person’s involvement in decisions about their care, safety and protection. It is not possible, nor arguably desirable, to eliminate risk. Empowerment in safeguarding involves risk management that is based on understanding the person, understanding the autonomy of the person and how they view the risks they face. There may be risks the person welcomes because it enhances their quality of life; risks the person is prepared to tolerate and risks they want to eliminate.
5.18.4 **Empowering approaches to safeguarding adults**: An adult’s legal right to consent marks the fundamental difference between approaches in safeguarding adults and safeguarding children.

‘Case law – powers and limitations of the Local Authority in safeguarding adults’
‘...whatever the extent of a local authority’s positive obligations under Article 5, its duties, and more important its powers, are limited. In essence, its duties are threefold: a duty in appropriate circumstances to investigate; a duty in appropriate circumstances to provide supporting services; and a duty in appropriate circumstances to refer the matter to the court. But, and this is a key message, whatever the positive obligations of a local authority under Article 5 may be, they do not clothe it with any power to regulate, control, compel, restrain, confine or coerce. A local authority which seeks to do so must either point to specific statutory authority for what it is doing...or obtain the appropriate sanction of the court....’

Para 96, Re A (Adult) and Re C (Child); A Local Authority v A (2010) EWHC 978 (Fam), Lord Justice Munby

*NB Though this statement referred to Local Authorities, the implications are relevant for the roles of public bodies and their role to assist and support rather than to control.*

5.19 **Staff Support and Safety**

5.19.1 It is essential that staff member’s own personal safety needs and need for support are met. Consideration should be given to how risks to staff safety are to be managed (e.g. gender/ethnicity of staff, where they are seeing service users, call assist arrangements etc).

5.19.2 Staff should be reminded of their rights and responsibilities to be treated with dignity and respect across all of the protected characteristics and reminded of the Trust ‘Dignity and Work’ Policy for Employees.

5.19.3 Managers are reminded of their obligations under health and safety legislation and the lone working policy.

5.19.4 Support for management of risk decisions will be obtained through discussion through the individuals MDT and through individual one to one supervision. Other forums such as Risk Panels may also be available as an opportunity for practitioners to bring cases to a senior practitioner panel as a way to reflect on plans and assessment and offer additional suggestions where appropriate.

5.20 **Mental Capacity and Risk**

5.20.1 Provision should be made for service users who are deemed not to have capacity or have limited cognitive ability (e.g. ensure an appropriate professional and/or advocate works with clinical team to gather information and develop formulation with, or on behalf of, the service user). Where an appropriate professional is not within the team, the team leader must seek the assistance from another service/team.

5.21 **Communicating and documenting the findings of a risk assessment**

5.21.1 All professionals working in mental health services are bound by law and professional codes of conduct to a duty of confidentiality to their service users. They also have a duty of confidentiality to carers. However, there will be a few situations where permission is not
required to share confidential information: where it is required by law e.g. a court order or where disclosure is in the public interest e.g. to protect a member of the public from harm and in particular in the context of a named potential victim.

5.21.2 The completed risk assessment and management plan must be shared with and communicated to the service user and carer whenever possible and where required provided in an alternative format such as Braille or large print.

5.21.3 Reports describing the findings of clinical risk assessments must be stored in the patient electronic record under the appropriate section (in Clinical Records System). For reports received in paper format of clinical risk assessments as well as reports in which a clinical risk assessment is just a part (e.g., a Care Programme Approach [CPA] report or a Mental Health Review Tribunal [MHRT] report), should be stored in the relevant parts of the Patient electronic record, clearly identified through the document referencing when stored.

5.21.4 The person undertaking or leading on a risk assessment is responsible for ensuring that the findings and recommended actions are clearly documented, signed and dated, and communicated to all relevant parties.

- Any communication about significant risk, including reviews, should inform the care plan and contain the following elements:
- A statement about the risk or risks to be managed (e.g., violence)
- A statement about the risk and protective factors most relevant to this possible outcome
- A risk formulation (please see appendix 2)
- A risk management plan, which will include a statement about treatment options relevant to managing relevant risk factors, supervision options and monitoring
- Crisis and contingency planning

5.22 Training, supervision and qualifications for undertaking risk assessments

5.22.1 All new staff will be made aware of this policy during their induction and all clinical staff will be trained in the principles, standards and use of risk tools relevant to their care group and/or service area. Formal training will be attended by staff member every 3 years. On-going training will take place through supervised and reflective practice.

5.22.2 Risk assessment and risk management must be addressed during routine supervision process, team reflective practice, and appraisal, drawing on the lessons from incidents and serious untoward incidents.

6. DEVELOPMENT, CONSULTATION AND RATIFICATION

6.1 This policy was reviewed by the Solent Policy Group. A wide range of professionals and managers were consulted via the Clinical and Service Directors and members of the Integrated Teams.

6.2 Service User and Carer Groups were consulted in the course of originally developing this policy. The policy was formal approved and ratified as specified on the front cover

6.3 As indicated in section 1.1.2, this policy is substantially underpinned by the Department of Health Best Practice in Managing Risk national guidance on clinical risk assessment and management. This document was subject to a national and international review process, including close scrutiny by a panel of service user and carer representatives.
7. **EQUALITY & HUMAN RIGHTS IMPACT ASSESSMENT**

7.1 In accordance with the Race Equalities Scheme, Disability Equality Scheme, Single Equality Scheme and Gender Equality Scheme (2007 -2010) equality and diversity issues must be considered in the development of documents. All public bodies have a statutory duty under the Race Relation (Amendment) Act 2000 to “set out arrangements to assess and consult on how their documents and functions impact on race equality”.

7.2 Impact Assessment was conducted and no negative impact was highlighted.

8. **MONITORING COMPLIANCE**

8.1 Monitoring of the effectiveness of this Policy and how it is operating, including the quality of clinical risk assessment and management practice and training, will be audited against the standards outlined in this policy and will be routinely audited as part of the Trust-wide audit cycle. Audit reports will be disseminated for information and action.

8.2 Clinical risk assessments and management practice will also be audited across the six equality strands.

8.3 As part of the Policy review the policy sponsor and author will ensure, through consultation, the correct roles and responsibilities for staff and forums / committees are identified within the document.

8.4 Line managers and supervisors will monitor staff training needs and attendance, initially via the induction process and thereafter annual as part of the personal development review (PDR) process. Where training needs or non-attendance are identified line managers will ensure staff members are booked to attend as necessary. Monitoring of essential training non-attendance will be undertaken as detailed in the essential training policy.

9. **DISSEMINATION AND IMPLEMENTATION OF POLICY**

9.1 There will be a planned dissemination and implementation. This policy will be circulated to all staff by means of the bulletin, disseminated through team meetings, and will be placed on the intranet. New staff will be made aware of all the Trusts policies as part of their Induction. Copies of the policy will be available in a range of formats upon request by line managers for those with limited access to a personal computer or visual or sensory impairments.

10. **DOCUMENT CONTROL INCLUDING ARCHIVE ARRANGEMENTS**

10.1 The Governance support team will maintain a central database of procedural documents and will be responsible for uploading these to the trust website. The Governance support team will maintain an archive of any previous versions.
11. REFERENCE DOCUMENTS


12. BIBLIOGRAPHY


Department of Health, *Information Sharing and Mental Heath – Guidance to Support Information Sharing by Mental Health Trusts* (September 2009)


Department of Health, *Reference guide to consent for examination or treatment* July 2009

National Patient Safety Agency, National Reporting and Learning Services, *Seven Steps to Patient Safety in Mental Health* (November 2008)


NPSA (2006), ‘Avoidable Deaths’ Five year report of the national confidential inquiry into suicide and homicide by people with mental illness. The University of Manchester (December 2009)
NPSA (2009), *National confidential inquiry into suicide and homicide by people with mental illness. Annual report*, The University of Manchester (July 2009)


13. **GLOSSARY**

**CRHTT**
Crisis Home Treatment Team

**HCR-20**
Historical-Clinical-Risk Management-20; a tool that is for use by practitioners who have had relevant training in its use.

**High risk**
This service user presents a risk of committing an act that is either planned or spontaneous, which is very likely to cause serious harm. There are few, if any, protective factors to mitigate or reduce that risk.

**Medium risk**
This service user is capable of causing serious harm, but in the most probable future scenarios, there are sufficient protective factors to moderate that risk. The service user evidences the capacity to engage and occasionally, to contribute helpfully, to planned risk management strategies and may respond to treatment. This patient may become a high risk in the absence of the protective factors identified in this assessment.

**Low risk**
This service user may have caused, attempted or threatened serious harm in the past but a repeat of such behaviour is not thought likely between now and the next scheduled risk assessment. He is likely to cooperate well and contribute helpfully to risk management planning and he may respond to treatment. In all probable future scenarios in which risk might become an issue, a sufficient number of protective factors (e.g., rule adherence, good response to treatment, trusting relationships with staff) to support ongoing desistance from harmful behaviour can be identified.

**Risk Formulation**
A summary of the risks in the context of historical and current factors including triggers and signs of escalation of risk and dynamic factors which may impact on the risk posed and management plan.

14. **CROSS REFERENCE**

This policy should be read in conjunction with:
- Care Programme Approach (CPA) Policy
- Data Protection, Security and Confidentiality Policy
- Trust Guidance on Managing Confidentiality
- Essential Training Policy
- Observation Policy
- Safeguarding and Child Protection Policy
- Safeguarding Adults Policy
- Management, Reporting, Recording and Investigation of Incidents Policy
- Prevention and Management of Violence and Aggression Policy
- SIRI Policy
- Lone Working Policy
15. **REVIEW**

15.1 This document may be reviewed at any time at the request of either at staff side or management, but will automatically be reviewed 3 years from initial approval and thereafter on a triennial basis unless organisational changes, legislation, guidance or non-compliance prompt an earlier review.
16. APPENDICES

Appendix 1  
Suicide Assessment and Treatment Pathway

This pathway should be used in conjunction with the Supporting Guidance Document.

**A1. Lead Questions**
- Have you ever felt life isn’t worth living?
- Are you thinking of suicide?
- Have you ever thought that you would do something to harm yourself?

**A2.** So that I understand you clearly, do you wish to kill yourself?

**A3. Specific Questions**
- Why are you thinking about suicide?
- How recently/often have you thought that?
- What exactly would you do? Do you have a plan?
- What has stopped you from carrying this out so far?
- Have you known someone who has completed suicide?
- Have you tried to kill yourself before?
- Have you been drinking alcohol today? Have you been misuse drugs today?

**F1. Features**
- Fleeting thoughts which are easily dismissed.
- No plan
- Mild or no symptoms of mental illness
- No alcohol or drug problems/intoxication
- No self harming behaviour

**F2. Features**
- Fleeting suicidal thoughts
- No specific plans or immediate intent but may have considered methods
- Significant mental illness
- Significant alcohol or drug problem/intoxication
- Unstable psychological situation with impending crisis
- Infrequent dangerous or self-harming behaviour

**F3 Features**
- Frequent of fixed suicidal thoughts
- No specific plans or immediate intent but may have considered methods
- Significant alcohol or drug problem/intoxication
- Significant mental illness
- Unstable psychological situation with impending crisis
- Frequent dangerous or self-harming behaviour

**F4. Features**
- Definite suicidal intent with specific plan and access to means of lethality
- Significant mental illness
- Significant alcohol or drug problem/intoxication
- Unstable psychological situation with impending crisis
- Escalating and more frequent dangerous/Russian roulette or self-harming behaviour

**Low risk**
- Consider engaging family and friends, community support
- Diffuse emotional distress as far as possible
- If indication or evidence of mental illness, arrange for assessment by appropriate professional

**Medium Risk**
- Diffuse emotional distress as far as possible
- Secure safety
- Arrange full mental health and psychological assessment. Timescale appropriate to level of risk.
- Engage family and friends, community and professional support
- Identify suicide prevention strategies appropriate to person
- Encourage/allow verbal/emotional expression of distress
- Utilise problem solving techniques
- Distraction
- Promote hopefulness and build upon self confidence by engaging in future orientated conversation/discussion
- Explore previous coping strategies.

**Medium/High Risk**
- Diffuse emotional distress as far as possible
- Secure safety
- Remove/restrict lethal means
- Arrange full mental and psychological assessment. Timescale appropriate to level of risk
- Engage family and friend’s community and professional support
- After crisis, identify suicide prevention strategies
- Encourage/allow verbal/emotional expression of distress
- Utilise problem solving techniques
- Promote hopefulness and build upon self confidence by engaging in future orientated conversation
- Explore previous coping strategies
- Self-monitoring/relapse prevention strategies
- Reflect on impact of suicide on family, friends etc
- If person fails to engage with arranged support, initiate pro-active follow up as per local policy

**High Risk**
- Diffuse emotional distress as far as possible
- Immediate action to secure safety
- Remove/restrict lethal means
- Arrange immediate full mental health and psychological assessment
- Engage family and friends, community and professional support
- After crisis, identify suicide prevention strategies
- Ensure personal safety
- Do not leave person until measures to ensure immediate safety are in place
- Encourage/allow verbal/emotional expression of distress
- Use problem solving techniques
- Promote hopefulness and build upon self confidence by engaging in future orientated conversation
- Reflect upon impact of suicide on family/friends etc
- Explore previous coping strategies
- Self monitoring/ relapse prevention strategies

**Actions**

**Provide appropriate information:**
- Leaflets
- Z Cards
- Element website

**Review suicide risk category**

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AMH CLINICAL RISK ASSESSMENT & MANAGEMENT POLICY AND PROCEDURE

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This pathway is intended as guidance only and staff should use their professional judgement when making decisions.

**At all levels of risk**
Ensure compliance with Child Protection Guidance

**At all levels of risk**
Record suicide risk, action taken, those involved and review risk in further if change in clinical presentation

**If not in contact with Mental Health services consider referral to:**
- General Practitioner
- Accident and Emergency (Psychiatric Assessment Team)
- Community Mental Health Teams
- Outpatients (Psychiatry)
- Addiction Team

In consultation with the person, inform GP and key support agencies regarding outcome of assessment irrespective of level of risk.
Appendix 2  Risk Formulation Format

Risk Formulation:
In order to support a clearer approach to recording, it is proposed the risk summary (final free
text box on the risk summary form) should be formatted as below.

Risk Overview:
To include a brief description of current risks (including physical health risks).

Historical Overview:
To briefly describe any historical risks that are not covered in risk overview. Historical
elements will be in the boxes above also to help keep it brief.

Dynamic Factors:
To include the signs and triggers that would indicate a possible escalation in risk. These should
be both clinical factors and situational factors (housing, relationships etc.). Substance misuse
should also be included here.

Protective Factors:
To include any factors that help reduce/mitigate an escalation in risk.

Plan:
Bullet points for individuals plan, related to factors outlined above. EG if there is a physical
health risk but there is a care plan in place the bullet point can say, Physical Risk as per care
plan.

The above only needs to be brief as you should have the more detailed info in the sections
above the summary box. (To be reviewed in the event of Electronic patient Records system
changing).
FLOWCHART - REFERRAL OF PATIENTS WITH A HISTORY OF VIOLENCE in A2i or CRHT

Referral of patients with a history of violence/current violent behaviours (including those on MAPPAs)

Are there presenting axis 1 disorders (depression/anxiety/psychosis) or DSH, ie likely to meet Secondary Care AMH criteria?
If unclear, clarify with referrer before appointing patient.

If so, obtain maximum information regarding offending and risk (GP and Probation)

No significant mental health problem

Do not accept referral/ DISCHARGE

Post -sentencing or post release from prison – pass to Criminal Justice Team

Assess (If appropriate, with input from a senior mental health professional)

If person has a treatable mental health problem with low or manageable risk to others, provide treatment.
The only treatment for anger is for patients with BPD who self-harm and are accepted for DBT, when anger can be an additional target behaviour.

If significant risk to others (eg psychosis and significant risk of violence) contact Dr. Moreton/Dr. Ormsby at Ravenswood, or if unsure take to Risk Panel.

If threatening staff or aggressive, terminate interview.

If patient makes a threat to harm others, contact police and potential victim.
Appendix: 4

Equality Impact Assessment

Step 1 – Scoping; identify the policies aims

<table>
<thead>
<tr>
<th>Question</th>
<th>Answer</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. What are the main aims and objectives of the document?</td>
<td>To provide guidance and parameters for which risk assessments in Adult Mental Health services are undertaken and carried out.</td>
</tr>
<tr>
<td>2. Who will be affected by it?</td>
<td>Service Users within AMH services and staff assessing risk.</td>
</tr>
<tr>
<td>3. What are the existing performance indicators/measures for this? What are the outcomes you want to achieve?</td>
<td>Current assurance/monitoring through audit. Outcome to maintain standards in assessment and management in a recovery focused approach.</td>
</tr>
<tr>
<td>4. What information do you already have on the equality impact of this document?</td>
<td>Previous assessment</td>
</tr>
<tr>
<td>5. Are there demographic changes or trends locally to be considered?</td>
<td>No</td>
</tr>
<tr>
<td>6. What other information do you need?</td>
<td>None</td>
</tr>
</tbody>
</table>

Step 2 - Assessing the Impact; consider the data and research

<table>
<thead>
<tr>
<th>Question</th>
<th>Yes</th>
<th>No</th>
<th>Answer (Evidence)</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Could the document unlawfully against any group?</td>
<td>x</td>
<td></td>
<td></td>
</tr>
<tr>
<td>2. Can any group benefit or be excluded?</td>
<td>x</td>
<td></td>
<td></td>
</tr>
<tr>
<td>3. Can any group be denied fair &amp; equal access to or treatment as a result of this document?</td>
<td>x</td>
<td></td>
<td></td>
</tr>
<tr>
<td>4. Can this actively promote good relations with and between different groups?</td>
<td>x</td>
<td></td>
<td>Emphasis of document is around collaborative plans and assessment with service user and staff.</td>
</tr>
<tr>
<td>5. Have you carried out any consultation internally/externally with relevant individual groups?</td>
<td>x</td>
<td></td>
<td>Through Governance group only as this is a review.</td>
</tr>
<tr>
<td>6. Have you used a variety of different methods of consultation/involvement Mental Capacity Act implications</td>
<td>x</td>
<td></td>
<td>See above</td>
</tr>
<tr>
<td>7. Will this document require a decision to be made by or about a service user? (Refer to the Mental Capacity Act document for further information)</td>
<td>x</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

If there is no negative impact – end the Impact Assessment here.

Step 3 - Recommendations and Action Plans

<table>
<thead>
<tr>
<th>Question</th>
<th>Answer</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Is the impact low, medium or high?</td>
<td></td>
</tr>
</tbody>
</table>
2. What action/modification needs to be taken to minimise or eliminate the negative impact?

3. Are there likely to be different outcomes with any modifications? Explain these?

<table>
<thead>
<tr>
<th>Step 4 - Implementation, Monitoring and Review</th>
<th>Answer</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. What are the implementation and monitoring arrangements, including timescales?</td>
<td></td>
</tr>
<tr>
<td>2. Who within the Department/Team will be responsible for monitoring and regular review of the document?</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Step 5 - Publishing the Results</th>
<th>Answer</th>
</tr>
</thead>
<tbody>
<tr>
<td>How will the results of this assessment be published and where? (It is essential that there is documented evidence of why decisions were made).</td>
<td></td>
</tr>
</tbody>
</table>

**Retain a copy and also include as an appendix to the document**