Pennine Care NHS
NHS Foundation Trust

Policy Document Control Page

Title

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Addition to include Risk assessment prior to activities and leave

Originator

Originated By: Matt Walsh

Designation: Patient Safety Lead

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Equality Relevance Assessment Undertaken by: Matt Walsh

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Policy to be uploaded to the Trust's External Website? YES

Review

Review Date: 27/05/2018

Responsibility of: Matt Walsh

Designation: Patient Safety Lead

This policy is to be disseminated to all relevant staff.

This policy must be posted on the Intranet.

Date Posted: 6th June 2016

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1. INTRODUCTION:

Pennine Care NHS Foundation Trust is committed to providing the highest standard of care for people with mental health problems, learning disabilities and substance misuse problems. In line with this aim, the Trust recognises the importance of clinical risk assessment for all service users, and effective risk management for those who may present an increased risk to themselves or other people.

Clinical risk assessment and the management of that assessed risk is a dynamic and continual process based on a formulaic approach. The judgement of the professional is integral to good risk formulation and in the production of a risk management plan with service users.

Even with the best risk assessment practice, suicides and violent incidents will still occur. However evidence suggests that some deaths may be preventable.[1] It is important that professionals use their knowledge and skills to undertake a thorough assessment of risk, in which a clear, reasoned judgement is developed and documented, which can demonstrate that the best possible practice has been followed.

At the time of the policy review it is acknowledged by the Trust that some parts of the service are using an electronic patient record and some parts are not. The assessment and management of risk must not be compromised by any part of the service due to a difference in patient recording within the Trust.

2. AIM OF THE POLICY

The purpose of this policy is to set out good clinical risk assessment and management practice, which should be followed for all mental health, substance misuse and learning disability service users. It should be read in conjunction with the current Pennine Care CPA Policy (v.11; February 2016).

The policy also takes into consideration the requirements set out by the Department of Health in the National Service Framework for Mental Health, The Standards for Better Health, the NHS Litigation Authority Risk Management Standards and Effective Care Co-ordination in Mental Health Services: Modernising the Care Programme Approach.

3. SCOPE OF THE POLICY

3.1. The principles of good clinical risk assessment and management described in this policy is relevant to all health & social care staff working in Pennine Care. All staff should be aware of these standards of good practice. However the standards of practice and training set out in this policy specifically relate to practitioners who have responsibility for assessing and managing individual

[1] Avoidable Deaths. (2008) National Confidential Inquiry. DH

service user risk. (e.g.: care coordinator, primary nurse, key worker, access and liaison staff, assessment officer, doctors).

3.2. This policy applies to all service users who receive a specialist mental health, learning disability or drug and alcohol services from Pennine Care. This also includes service users undergoing initial assessment on referral to Pennine Care Services.

3.3. Staff working within community (physical health) provision will have recourse to specific clinical risk assessments (e.g. wound care) but would not be expected to complete an overarching assessment of risk.

4. ROLES & RESPONSIBILITIES

4.1. Pennine Care recognises that it cannot realistically expect or achieve risk elimination. However, the Trust expects that all efforts will be made to achieve *risk minimisation*[2]*.*

4.2 It will be the responsibility of the Chief Executive to ensure arrangements and resources are in place for the provision of clinical risk management processes within the Trust as outlined within this policy. Overall management of clinical risk management will be the responsibility of the Executive Director of Nursing including the implementation of the policy, appropriate training and performance management.

4.3 The Patient Safety Lead and the Trust's Risk Manager are responsible for coordinating risk management activity (clinical and non-clinical) within the Trust. This will incorporate the development and review of central governance structures, updating the Risk Management Strategy and review of Serious Untoward Incidents

4.4 Lead Managers, Team Supervisors, Health and Social Care Staff are responsible for the implementation of the policy and in particular, for the recognition and management of a potential service user clinical risk. In addition, Lead Managers are responsible for:

- Ensuring that appropriate training is made available to all professional groups, as outlined in the CPA policy and Trust's Training Needs Analysis.

- Ensuring that all appropriate Health and Social Care staff as identified in the training needs analysis have attended Risk Assessment and Management Training and every three years attend or complete a clinical risk assessment up date as outlined in the Training Needs Analysis. The Training Needs Analysis is the responsibility of the OL&D service in conjunction with Lead Managers. It is the responsibility of all staff in contact with service users to be aware of risk issues and to report these concerns on to the relevant professional or line manager for action.

[2] Pennine Care CPA Policy February 2016 v.11

4.5 It is the responsibility of care coordinators, doctors, primary nurses, key workers and assessment officers, to ensure that they undertake and/or contribute to formal risk assessments for service users, and to ensure that they have undertaken the approved training in order to do so.

4.8 The scope of accountability for the individual practitioner is summarized as:

- *Each individual is accountable for their own actions within the sphere of their professional competence*
- *Training and qualification attaches certain reasonable expectations of competence to practicing professionals*
- *Practitioners must be able to demonstrate reasonable attempts to gain relevant information take action or challenge the actions and decisions of others.*

4.9 In order to support practitioners in exercising their individual and professional accountability the Trust (through managers) is responsible for providing:

- Systems that effectively trigger risk issues for discussion and risk management decisions. Service managers are responsible for ensuring that processes are in place to identify high-risk service users on the team caseload e.g. :
    - The Trust's CPA policy (v.11) clearly sets out the criteria for a service user to be considered for CPA+; this is when the clinical lead for the patient's care is sufficiently concerned that the risk of dangerousness arising from the mental disorder warrants screening by a multi-disciplinary group (including support from the Patient Safety Lead; Violence and Aggression Manager; Trust's Security Manager). The overarching aim of CPA+ is to work in partnership with the service user by taking a multi-disciplinary approach to care planning with regular review with an end-goal of reducing the risk of harm to others.
    - Regular opportunities for practitioners to discuss risk assessment and management plans with the multi-disciplinary team and/or their line manager via clinical **supervision**. Ensuring that *high-risk* service users are discussed as appropriate to risks presented as a minimum at least monthly.
    - Opportunities for staff to attend approved risk assessment/management training at least every **three years**[3]
    - Relevant inter-agency agreement to ensure high quality communication and coordination across services.

[3] Appleby, L. (2001) *Safety First*: Five-Year Report of the National Confidential Inquiry into Suicide & Homicide by People with Mental Illness

5. THE CARE PROGRAMME APPROACH & RISK ASSESSMENT

5.1. The assessment and management of clinical risk is an integral part of the Care Programme Approach (CPA). A primary aim of the Pennine Care CPA Policy is:

"to facilitate the identification of risk in order to manage it effectively"[4].

Of particular importance is:

- The assessment of risk
- The documentation of risk
- The communication of risk
- The adoption of appropriate risk management strategies based on the assessment.

The Trust Approved Risk Assessment (TARA) documentation was developed by clinical content groups across Pennine Care Mental Health Services alongside the National Programme for Information Technology.

5.2. The Trust approved risk assessment has been incorporated into the processes for the patient assessment and CPA. The Trust Approved Risk Assessment is also a stand alone document for those service users who have not been allocated to CPA. Each service user will have a completed Risk Assessment covering the
following areas:

- *Risk of suicide and/or harm to self*
- *Risk of self-neglect*
- *Vulnerability to exploitation or abuse by others*
- *Risk of harm to others (including children)*

Drug and Alcohol Use is incorporated into the four domains

5.3. It is expected that each service user undergoes a review of risk at regular intervals. Each assessment must be clearly recorded chronologically in the clinical record and must clearly indicate that a review has taken place, even where no changes were made. The Care Coordinator or allocated key worker is responsible for ensuring regular review of risk and risk management plans.

5.4. In addition to regular CPA review, there are key points or events that indicate the need to conduct or review the risk assessment. These are:

- *First contact with the specialist mental health service/DAS/LDS*
- *Significant change in circumstances of the service user*
- *Care plan reviews (planned or unplanned)*
- *Hospital admission, leave and discharge*

[4] Pennine Care CPA Policy v.11 2016 .

- *Referral or transfer to other parts of the specialist mental health service*
- *Discharge or transfer out of the specialist mental health service*

Any serious or untoward incident that changes significantly the practitioners evaluation of the risk (e.g. serious suicide attempt when there had previously been no indication or prior expression of intent).

- Any transition Point –this includes care coordinator change within the same team (Nat CPA Training Package), change within Borough (e.g. Early Intervention Team to CMHT) and transfer within Trust (e.g. Oldham to Stockport) but also Prison to Mental Health care and vice versa

Risk assessment will be incorporated into the initial screening and assessment of the service user. It will involve the consideration and identification of a range of evidence based risk indicators. Where possible it should draw upon a wide range of available information including the opinions and views of others including relatives and carers.
Where appropriate, risk assessment should be multi-disciplinary, ensuring that risk is owned and shared at ward, team and service level.

It is important and vital that as much information is gathered in the screening stage as possible. This may involve liaising with other agencies or health care providers who may hold vital information crucial to an accurate assessment of risk; team managers should facilitate this when liaising with other health care providers or utilise specialist teams (e.g. Criminal Justice Mental Health Teams) who can access information across a range of agencies. Support may also be given from central services (e.g. Security Manager or Patient Safety Lead).

6. TRUST RISK ASSESSMENT & DOCUMENTATION

6.1. Pennine Care has an approved Trust Risk Assessment Tool (TARA) as the standard tool for assessment of risk which should be used for all service users. This is fully integrated into the Trust CPA process, and is the risk assessment component of the Trust CPA documentation. The Trust approved document for risk assessment can be found on the Trust Intranet site for Trust approved documents under CPA and initial assessment.

6.2. The Trust Approved Risk Assessment is intended to provide a thorough risk assessment of all areas of potential risk. However in some circumstances, groups of clinicians may wish to use an additional risk assessment for specific purposes. All supplementary risk assessment tools should be approved for use by the appropriate committee or strategy group (e.g. Violence Reduction/ Suicide Prevention and Self Harm Group).

6.3. The Risk assessment consists of four domains, which ensures a systematic approach is taken to identify key risk factors from all relevant sources

including the service user, relatives, family and carers, and by examining any written information available, e.g. patient records.
Each risk domain, e.g. risk to self, risk to others, self-neglect and exploitation/vulnerability, are further systematically assessed. The next stage is the formulation of risk. This is designed to communicate succinctly the conclusions of the risk assessment and what factors would exacerbate and minimise identified risks. The focus is on risk management which will be included within the service users care plan CPA Well Being Care Plan. The Trust has also specialist training, e.g. High Risk Clinical Formulation Training and HCR20 training for service users entering or exiting forensic settings.

6.4. On completion of the Risk Assessment where in any of the domains the assessor has ticked a yes the assessor must provide further detail and assessment for that domain and complete the narrative section of the risk assessment tool for that domain.

The Risk Assessment contains further prompts to explore specific issues which may indicate the presence of risk. These risk indicators are based on evidence collected from research and are generally accepted as potential predictors of risk. However they should be considered only as prompts to assist the assessor to explore these issues with the patient and to help the assessor to formulate a clinical judgment about possible risk.

6.4.1 **Suicide & Self Harm:**

Details of past history of suicide attempts or self harm should be recorded. The date and method of each attempt should be recorded.
A family history of suicide is a strong indicator or risk within a person who presents other risk factors.
Where a potential risk of self harm or suicide is identified, from the indicator check list the assessor will check if there were any specific factors which indicate the level of intent to carry out a future act of self harm or a past act. The assessor should make brief (bullet points) of any relevant points, i.e.:

- Potential lethal method – attempted hanging
- Attempted to conceal – discovered
- Denying or trivialising serious attempt
- Procuring the means – purchased rope
- Detailed plan / tested out
- Recently made a will
- Written suicide note
- Sold or given away possessions
- Expression of Hopelessness – best psychological predictor of completing suicide (STORM research)
- Fleeting or Fixed Thoughts
- Choice of preferred method

- Alcohol or Drug use
- Presence of mental illness
- If being seen after attempt – then check for guilt or regret that is associated at either attempt or survival. Guilt and or regret of attempt can not be relied upon to mitigate the risk and can in fact increase the risk of further attempts unless there are other substantial factors to reduce the risk of further attempts. This mix of emotions can give rise to an increase in stress and possibly the use of alcohol.

The assessor will need to explore other potential risk factors specific to the individual. The assessment should include any issues which have not been highlighted in the Risk Assessment check list.
This will be very specific to the individual person, but should cover all potential areas of stress in the person's life. This should also include the individual's ability to identify and participate with alternative coping strategies.
Ambivalence and ambiguity should be explored, also the extent to which the patients risk may change over time i.e. diurnal variation or when anniversaries or other significant life events occur. The assessor should consider when current support mechanisms might change in the future. Other issues to consider include:

- Relationship problems
- Debts / accommodation or other stressors
- Delusions – content and nature
- Recent contact with the Police
- Self Harm – Suicide Continuum – morbid coping or suicidal intent – the Question "Was death intended? "needs to be assessed

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6.4.2. **Risk to Others / Risk of Violence**

This domain prompts the assessor to explore the potential risk to others in more detail, and to check out further specific issues. Working through the risk will help the assessors to identify areas for further assessment, and the context of the risk for the individual patient. This will depend on the individual person however the assessor should consider the following

- Checking out or testing plans
- Purchasing or attempting to purchase the means
- Delusions, passivity or paranoia
- Complex personality presentations
- Hallucinations which the person attributes to others in the vicinity
- Impulsivity
- Use of Non Prescribed Drugs & Psychoactive Substances
- Risk of accidental harm to others i.e. drink driving
- Risk of harm to children or dependants

Details of past history of violence or harm to others should be recorded including the date, method and severity of each violent incident.

6.4.3. Serious Self Neglect

The assessor should explore other potential risk factors specific to the individual that cover all potential areas of the person's ability to care for themselves. Additional individual factors might include:

- Ability to manage finances / budget
- Ability to manage acute or chronic physical health needs.
- Changes to support systems and transition points in care.

Details of past history of Serious Self Neglect should be recorded in line with the Care Act 2014 inclusion of self-neglect as a specific category of adult safeguarding, more details on the Trust's responsibilities and strategy for Safeguarding please see policy XXX

6.4.4. Vulnerability and Risk of Exploitation

The assessor must record any potential areas of vulnerability past and present or risk of exploitation. Also areas of risk around accidents including risk of falls. The Trust is committed to Safeguarding processes and expects all of it's clinical staff to be mindful of adult safeguarding within this domain. The Care Act 2014 placed NHS Trust's on a statutory footing in sharing responsibility for adult safeguarding including awareness, reporting and investigation .

6.5. Drug and Alcohol Misuse

Drug and Alcohol misuse is an indicator within all 4 specific domains Detailed exploration of the impact of substance misuse on the individual needs to be completed where identified within the domain. Substance misuse is a significant factor in all domains of risk, and therefore requires careful review. If a substance misuse problem is identified, the care plan should include risk management and the support provided to the service user with this problem. In line with the Inquiry into Southern Healthcare by Mazars consideration must be given to the physical health needs and support for people with drug and alcohol problems.

6.6. RISK FORMULATION

Having completed the full risk assessment, a risk formulation should be completed. The purpose of the formulation is to ensure clear communication of the risks identified in the assessment.

Having concluded what the current risk is, the assessor is asked to document any issues which might further increase the risk, based on the information gathered through the assessment. Within this section, the assessor should consider how risks might change in the future, and include any known prodromal signs of risk, or relapse signature for the individual if this is known. The formulation of the risk must include contextual factors known to increase the risk (e.g. risk of violence in the context of restraint) and be a concise paragraph explaining how the risk is increased but also how it can be decreased. Nominal expressions such as 'taking medication v. not taking medication' should be avoided.
The assessor should also record any factors which are known to protect and support the individual, as it will be important to continue to monitor that these protective factors remain in place. The views of the service user and their relatives should be central and heard in the care plan and how they can access support. Wherever possible care plans should be written in the first person (e.g. 'my medication needs are …' as opposed to 'John needs medication …'

6.7. The risk formulation should lead to the development of a Risk Management Plan, which should be recorded within the CPA documentation well being/ care plan. All risks which are identified should be included within the care plan with details of what actions will be taken to manage or minimise the risk and the method by which the action will be monitored and reviewed.
The plan must include contact details of services and how to access them in times of crisis both in core working ours and out of hours/weekends for both the service user and the carer. A review date must be documented. The Trust is also introducing a 'safety plan' to be completed in partnership with a person or patient presenting at A&E; this identified antecedents to the suicidal thoughts and what protective factors and people can be called upon to prevent the crisis from developing.

6.8. The assessment documentation will provide an ongoing record of significant risk incidents. This information will be input onto the electronic clinical information system to ensure that basic risk history information is immediately available to all staff that may come into contact with the patient, i.e. if the patient attends A&E.

6.9 Whenever a significant risk event occurs i.e. suicide attempt or assault, this should be added to the risk assessment and risk chronology sheet on the electronic version.

6.10 **Review & Evaluation**

Review of the risk assessment and management plan will be ongoing and continuous by the care team. However it is also necessary for the team to complete formal reviews and document when this is done.

The frequency of formal reviews will depend on the individual patient, but the following minimum standards should be followed.

- Inpatient services users – minimum weekly
- Community clients – at time of CPA review minimum 12 monthly
- Before and after transfer between services i.e. Acute to PICU
- Prior to review / change of observation levels which must be documented
- Prior to leave or discharge from an inpatient ward where risk must have been discussed and assessed in the preceding MDT meeting before leave or discharge is approved.
- Involvement in any prescribed therapeutic activities. Please see Risk assessment Policy CO21
- Following any significant changes to the patient's presentation or mental health.
- Transition within the care provision e.g. change of care coordinator, transfer of care

The guiding principle for review and evaluation of the risk assessment is that if any changes are required in any parts of the documentation or if any new information needs to be added. The information needs to be recorded within the appropriate domain and updated electronically
If no changes are needed to any part of the risk assessment the practitioner should evidence they have reviewed the risk, document no change, time, date on each domain. This will provide evidence that the review has taken place and that there is no change to the current risk assessment and risk management plan.

7. ASSESSMENT OF RISK AND IDENTIFYING RISK FACTORS

Whilst it is not possible to provide an exact formula to assess risk, practitioners are effectively assessing risk on a continual basis. Effective risk assessment combines careful assessment of an individual, the context(s) in which their risk behaviour occurs, and epidemiological factors derived from research. Reasoned clinical judgement and decision making is arrived at by weighing each of these areas in turn.
Pennine Care recognises that assessment tools and frameworks can assist practitioners in the systematic assessment of risk, and also promote consistency and shared understanding of risk across services.
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7.1. ASSESSMENT OF RISK OF SUICIDE & SELF-HARM

7.1.1. When assessing suicide risk it is useful to remember that suicide is most often an end point in a series of events and assessment requires careful questioning about stressors, particularly in the previous 6- 12 months. Additionally the following areas need to be examined in detail.

- Risk Factors;
- History;
- Ideation/Mental State;
- Intent;

- Planning; and
- Formulation.

7.1.2. The following are risk factors which research consistently demonstrates to be correlates of high risk for suicide.

RISK FACTORS (HARM TO SELF)		
VARIABLES	**HIGHER RISK**	**LOWER RISK**
Age	Older but younger males (**15 – 35 have higher rates of completion)**	Younger
Sex	Male	Female
Marital Status	Separated, Divorced, Widowed	Married
Living arrangements	Living alone	Others at home
Employment Status	Unemployed, retired	Employed
Physical health	Poor, especially terminal, painful, debilitating illness	Good
Mental health	Mental illness, especially depression, schizophrenia and chronic sleep disorders	Good
Ethnicity	**Being a member of an ethnic minority and non indigenous**	**Being a member Indigenous ethnic majority**
Substance Misuse	Substance misuse (incl alcohol & drug misuse)	None
Sexual Orientation	Gay Males	Heterosexual

Once again, it should be stressed that the level of importance of each of the risk factors will differ, depending on the individual circumstances of the service user. Clinicians will have to use their professional judgement and their knowledge of the client to assess the risk for suicide or self harm. The recent report by the National Confidential Inquiry into Suicide and Homicide (July 2015) offers new guidance in relation to the evidence that recent trends have provided:

•The rise in suicide among male mental health patients appears to be greater than in the general population - suicide prevention in middle aged males should be seen as a suicide prevention priority.

•It is in the safety of crisis resolution/home treatment that current bed pressures are being felt – the safe use of these services should be monitored;

providers and commissioners (England) should review their acute care services.
•Opiates are now the most common substance used in overdose – clinicians should be aware of the potential risks from opiate-containing painkillers and patients' access to these drugs.
•Families and carers are a vital but under-used resource in mental health care – with the agreement of service users, closer working with families would have safety benefits.
•Good physical health care may help reduce risk in mental health patients – patients' physical and mental health care needs should be addressed by mental health teams together with patients' GPs.
•Sudden death among younger in-patients continues to occur, with no fall – these deaths should always be investigated; physical health should be assessed on admission and polypharmacy avoided

(National Confidential Inquiry into Suicide and Homicide; (2012) – University of Manchester.
www.bbmh.manchester.ac.uk/cmhs

7.1.3. **Frequency** An accurate history of past self-harm incidents and suicide attempts is vital for the risk assessment process. The recency, severity, frequency and pattern of these attempts should be examined. For example, when considering the severity of an attempt, the person alone in a house who has taken steps to avoid interruption, has attempted to hang themselves and has been rescued only by chance, may be a higher suicide risk than the person who has taken an overdose they know is not lethal and presented themselves at the A&E department.
However it is important to recognise that an attempt may have had serious intent, but because it was not immediately fatal the person has time to change their mind and seek help.

7.1.4. Similarly, when considering the pattern of self harm or suicide attempts, a suicide attempt may be typically made by one person at the ending of a relationship. If that pattern is now repeating itself and a relationship is now ending, this indicates a higher risk. Anniversaries of recent traumas and losses may also increase risk, usually temporarily, particularly if it leads to a sense of entrapment and hopelessness. The service user's view of anticipated events may also increase risk as they approach. It is also important to remember that substance misuse, particularly of alcohol, greatly increases risk. Cocaine use is also associated with increased risk of suicide due to extreme mood swings, depression and agitation during withdrawal.

7.1.5. **Ideation and Mental State:** An examination of the person's ideas on suicide can help assess the risk. Consider whether the person sees suicide as a solution to his or her problems. Does the person think or fantasise about suicide? How frequently does the person think about suicide and how does he or she respond to these thoughts? The greater the prominence and rigidity of these thoughts in the persons life, the higher the risk of suicide. Fleeting thoughts quickly rejected represent low risk, while persistent, intrusive and

painful thoughts indicate high risk even in the absence of planning. Consider constraints on action (religious beliefs, family obligations).

7.1.6. **Intent*:** As with the intention of harming others, a statement from the service user that they intend to kill themselves is the strongest indicator of risk and should never be dismissed. Intent, whether declared or not, is the strongest indicator of future behaviour.

7.1.7. **Planning***: If the person admits to suicidal ideas, has he or she taken it a stage further to commence planning how to do it? How likely in the assessor's judgement is the plan to succeed? Plans to avoid detection are of particular significance. For example, if a person has continual thoughts of suicide, has the person determined that he or she will shoot him or herself when the rest of the family are away, and does the person have the means to do so, for example by owning a shotgun? If so, this would indicate a very high risk. Thoughts of suicide without any plan or without access to the means to do so carry a lower risk.

7.1.8. ***however, all practitioners should be reminded of the need to exercise professional judgement. Simply because there does not appear to be an expression of intent or a plan does NOT mean that the risk of the person completing suicide is absent. Circumstances and mood can change very quickly, impulsivity and rate increasing factors (alcohol, relationship break down) are all areas to explore. It is vital to understand the antecedents that arose for the person to drive the person into suicidal thinking. Services must explore these antecedents and seek in partnership with the service user, carers/families and/or other agencies to reduce the risk of suicidal thinking by addressing antecedents.

7.1.9. Once again a formulation should be made, including an appreciation of all the risk factors described above and their interaction in increasing risk. It should aim to answer the following questions:

- How serious is the risk?
- Is the risk specific or general?
- How immediate is the risk?
- What has changed in the last 48 hours, why now? What has changed to risk vulnerability and protective factors that have prompted the person to consider or have attempted harm to self?
- Is the risk liable to diminish fairly quickly?
- Are circumstances likely to arise that will increase the risk?
- What specific treatment and which management plan can best reduce the risk?
- Have antecedents and solutions been explored in partnership with the service user, their carer/family or other agency.

It is important to mention that service user's responses should not always be taken at face value - e.g. service users might categorically deny feeling suicidal when this is far from the case. Remember that it may be difficult to determine whether suicidal feelings are present in the face of plausible denial

by the service user. For further information see Self Harm Guidelines; it is vital that practitioners record their professional judgement and seek support from their clinical lead (manager or Consultant Psychiatrist – if available) to share and agree the decision making.

7.2. ASSESSMENT OF RISK OF HARM TO OTHERS

7.2.1. The assessment and clinical management of risk is an integral part of mental health practice. Research has provided evidence of a number of demographic factors that are associated with risk to others. Not all risk factors are of equal weight; in particular, factors such as age and sex are more unreliable in predicting risk of harm to other people.

It is not possible to provide an exact formula to assess risk. Staff must assess risk based upon reasoned judgement and their in-depth knowledge of the service user. Nevertheless, certain risk factors can be usefully used in assessment to draw attention to the possibility of increased risk.

7.2.2. The following are risk factors which research consistently demonstrates to be correlates of high risk for harm to others.

RISK FACTORS (HARM TO OTHERS)		
VARIABLES	**HIGHER RISK**	**LOWER RISK**
Age	Younger	Older
Sex	Male	Female
Living arrangements	Unstable, changeable	Stable
Employment Status	Unstable, changeable	Stable
Educational Attainment	Low	High
Mental health diagnosis	Clinical depression; Schizophrenia Paranoid Psychosis Personality Disorder	All other diagnoses
Substance Misuse	Substance misuse (incl alcohol & drug misuse)	None
Behaviour	Presence of Conduct Behaviours	None
Criminal Convictions	History of Property Offences	None
Development issues	Separation from Parents/Primary Care Givers before 16 yrs of age	None

7.2.3. When assessing the risk of harm to others, the following areas must be considered:

- Risk Factors;

- History;
- Ideation/Mental State;
- Intent;
- Planning; and
- Formulation.

7.2.4. **An accurate history of violent incidents is perhaps the most important Information to obtain in making an assessment of risk. Practitioners should seek support from the Risk Department where longitudinal risk information from previously reported incidents will be held for all known Pennine Care service users; this information can be gathered very quickly by the risk department and can be a vital source of the nature and degree of previous harm to others incidents. This information must be used to assess the risk of harm to others. Reported incidents are often more reliable to understand in their context than from letters or other reports that may lack specificity of detail.**

This information can also but often more laboriously be obtained from records and referral letters, as well as by asking service users themselves, carers and other family members. It is important to obtain past psychiatric/clinical records from other hospitals, districts, or social services departments/ liaison with police / probation services where appropriate and a full history of criminal offences should also be sought. If a referral letter indicates or the service user indicates that they have a forensic history then support should be sought from the Criminal Justice Mental Health Team or the Trust's Security Manager; this will enable swifter liaison and sharing of information from statutory criminal justice agencies (police, prison, probation).
Obtaining evidence for any of the following is also important:

- poor compliance with treatment or disengagement with aftercare;
- precipitants (such as drug and alcohol use) and any changes in mental state or behaviour which may have occurred prior to violence and/or relapse;
- recent severe stress, particularly of loss events or the threat of loss;
- recent discontinuation of medication;
- recent threatening behaviour including threats of violence/verbal threats;
- a history of intimidation (including stalking and harassment).
- Any referrals indicating a history of the service user being the subject of discussion at mult-agency risk-sharing information panels such as Multi-Agency Public Protection Arrangement (MAPPA) or Multi-Agency Risk Assessment Conference (MARAC) must trigger the assessing professional to liaise with the criminal justice mental health team in their Borough; this is a key indicator that the service user may have a history of harm to others.

7.2.5. Information about a history of harm to others has four components: recency, severity, frequency and pattern.

Recency: The more recent an event or incidents of harm to others, the higher the current risk. An assault upon a stranger committed today, indicates higher risk for the present than a similar incident last year, or five years ago.

Severity: The severity of injuries sustained in previous violent incidents is important to note. In particular past violent incidents which resulted in serious injury may indicate an increased risk of future violence, and also increased risk of serious injury. If known the severity of previous violence should be documented:

- an assault which results in no detectable injury;
- an assault resulting in minor physical injuries such as bruising, abrasions or minor lacerations;
- an assault resulting in major physical injuries including large lacerations, fractures, loss of consciousness, or any assault requiring subsequent medical investigation or treatment.
- Sexual assault

Frequency***:*** The more *frequent* the events or incidents of harm to others, the higher the current risk. Persistent and repeated assaults on others are very strong indicators of high risk.

Pattern: Is there a common pattern to the type of incident or the contexts in which it occurs?

7.2.6. Ideation and Mental State is an important aspect of risk assessment. It is important to assess what the person is thinking or feeling now and in particular look for evidence of the following:

- Evidence of any threat/control override symptoms: that is, firmly held beliefs of persecution by others (persecutory delusions) of mind or body being controlled or interfered with by external forces (delusions of passivity);
- Emotions related to violence e.g. irritability, anger, hostility, suspiciousness;
- Specific threats made by the service user; and
- Command hallucinations, e.g. voices telling service user to attack a particular person.

7.2.7. A statement from an individual that they intend to harm another person is the clearest indication of risk and **should never be ignored**. Intent, whether implied or not, is the strongest and most powerful predictor of future behaviour**.** Think Safeguarding for Adults and Children who is actually at risk from the person; refer and alert as appropriate in line with risk assessment tools and professional judgement.

7.2.8. Planning**:** If the person admits that they have thoughts of harming themselves or others, it is important to establish whether they have considered exactly how they might do so. This can be extracted from their own statements or other objective evidence. The presence of a plan as to how they would harm another person indicates yet higher risk. If the person also has access to the

means for carrying out that plan the degree of risk rises still higher**.** A person with paranoid delusions about their neighbours, and has considered exactly which weapon they would use to attack them, and has access to this weapon, poses a greater risk than the person who has vague ideas and no clear plan.

7.2.9. Formulation: Following the assessment a formulation should be made which should, so far as possible, specify factors likely to increase risk or dangerous behaviour and those likely to decrease it. It should include an appreciation of all the risk factors described above, in particular, how their interaction *might increase* risk. The formulation should aim to answer the following questions:

- How serious is the risk?
- Is the risk specific or general?
- How immediate is the risk?
- How volatile is the risk?
- Are circumstances likely to arise that will increase it? and
- What specific treatment and management plan can best reduce the risk?

7.3. ASSESSMENT OF RISK OF SELF NEGLECT

Self-neglect is a common problem for people with severe and enduring mental illness. It is also particularly important to consider this area of risk for people with substance misuse problems and also for elderly service users. Assessing the risk of self-neglect is not a straightforward process, except in the most severe situations. It is made more complex by differences in relative standards. The areas that should be covered by the assessment process are:

- Hygiene;
- Diet;
- Infestation;
- Household Safety;
- Warmth.
- Managing self medication / physical health needs

7.4. ASSESSMENT OF VULNERABILITY & ABUSE

All Pennine Care staff have a responsibility to report any concerns regarding abuse and exploitation of any vulnerable adultor children. There is also an expectation that staff who are responsible for assessing and managing risk will consider the potential risks that the service user may present to children or vulnerable adults whom they may have contact with. This should be considered within the risk assessment, and appropriate action taken. For further guidance and information, please see Pennine Care Safeguarding Adults Policy, and Pennine Care Child Safeguarding Policy. The Trust is fully engaged with the Prevent Strategy and this is mandatory training for all clinical staff working with vulnerable services users.

7.5. **Reliability of Information**

Information acquired from the service user and others for the purpose of assessing risk is usually reliable, but not always. Information from known reliable sources can be given more weight than information from unknown or unreliable sources. The sources of information must be detailed within the Risk Assessment. Regardless of the source of information, every effort must be made by assessors to follow up, clarify and confirm uncorroborated information, or information of doubtful accuracy (unknown or unclear) information prior to placing greater emphasis upon it.

8. THE CLINICAL RISK MANAGEMENT PLAN

8.1. It is important that teams give careful consideration to managing the risk behaviours identified during the assessment. When the risk assessment has been completed the risk management of the risk identified should be incorporated into the individuals care plan well being plan how the risk will be managed. The following questions should be considered when formulating a risk management plan.

- How serious is the risk?
- Is the risk specific or general?
- How immediate is the risk?
- How volatile is the risk?
- What factors cause or contribute to the risk?
- What specific treatment and interventions can best reduce the risk? and
- What plan of management is needed to reduce the risk?

8.2. Some helpful general Risk Management Strategies that should be followed are:

- The need to be alert and vigilant to hazard.
- The need to be aware of the service user's history.
- Consider who might be harmed, why and how.
- Evaluate whether current arrangements adequately address the risk and decide whether further measures need to be taken.
- The need for all team members (or other agencies/professionals) to be aware of the results of the risk assessment.
- Record in writing exactly what risks are thought to be present, what action has to be taken and by whom and what level of risk is being accepted for an individual, bearing in mind the practical constraints, resources available and the rights of the individual to be treated in the least restrictive manner compatible with minimal risk.
- Ensure that a regular review system is established so that levels of risk can be revised in the light of more recent information.
- Follow up within 7 days of all patients discharged from inpatient mental health services.
- Referral to an intensive crisis team (if appropriate).
- Optimum use of medication and other therapies

- Availability of appropriate support (e.g. family, carers, professionals, community workers, advocates, accommodation needs, day care needs, probation service etc.)

Lone working arrangements and placing risk markers on patients records.

Consider the 3 'A' check:

1. Is the planned support **AVAILABLE** when the person needs it.
2. Is the support **ACCEPTABLE** to the person – will they use it
3. And is the support **APPROPRIATE** to the risk –

If there is a non statutory agency/family carer involved – do they know when to escalate the risk back to the service if the person changes and becomes more acute in their risk presentation – do they know who to contact and how?

- Access to self-help groups for family members and carers.
- The involvement of all agencies (e.g. the service user's GP) associated with the service user in the consultation and formulation of the management plan.
- The use of legal processes and the Mental Health Act./Mental Capacity Act
- The appropriate level of observation for inpatient services users.
- The use of police or security officers.
- Frequency of home visits.
- Previous successful methods used to reduce risk.

It is the responsibility of the care coordinator or key worker to ensure that all persons are engaged in communication in relation to the sharing of changes to risk.

9. COMMUNICATION OF RISK INFORMATION

9.1. Effective communication of risk information is a fundamental part of the risk assessment process. However, there are particular points in the psychiatric care process and transfer points that commonly trigger communication failures. These failures can have serious consequences for service users, health and social care workers and the general public. It is essential that service users have their risks reviewed and communicated to other teams or agencies; almost all independent Inquiries into fatal consequences for members of the public identify communication of risk as a repeating key theme.

9.2. It is the responsibility of staff to ensure that they disclose information to other agencies, as appropriate and on a 'need to know' basis, so they could understand what the risks are and how they can best be managed. All relevant information should be recorded in the service user's case notes and made immediately known to all staff involved in working with the service user, then fully discussed at the next available meeting.
Sharing risk information with other agencies (i.e. Health, Social Services, and Primary care, Police, Probation, Housing and Prisons) in specified circumstances is important in order to:

- encourage a co-ordinated approach to dealing with mental disorder;
- facilitate the exchange of relevant information in the public interest;
- prevent serious injury or damage to the health of a person or people; and
- allow joint working practices to develop.

9.3. Occasionally, members of the public who are at specific risk may also need to be informed (i.e. those at risk of violence such as severe injury or rape). In these circumstances the public interest overrides professional confidentiality. Issues relating to disclosure of information should be discussed with the multi-disciplinary team and, where necessary, through existing line management structures and with the Trust Information Governance Manager. (See Information Sharing Policy)

9.4. The CPA care plan as formulated by the Care Co-coordinator/key worker provides the ideal means of communication between the agencies. It contains not just the plan, but the names and contact numbers of those involved plus information about risk and what to do if the service user goes into crisis. Copies of the care plan must be sent to all individuals and agencies involved, as appropriate. This is especially important where risks have been identified. The distribution of the care plan should be discussed with the service user and their consent sought, as part of the care planning process. However, where significant risks are identified and the service user is unwilling to give consent, their lack of consent may be overridden. This should be recorded in the appropriate documentation/notes.

9.5. If the service user withholds consent for the care plan to be circulated, a judgment must be made about the consequences of not doing so and a decision made regarding those who it will be given to.

9.6. This should be done on

- a *need to know* basis i.e. to prevent potential danger or harm befalling the user or others

Or

- If the need to protect the public or the service user outweighs the duty of confidence. (See the trust **Confidentiality Policy**)

When it is felt to be potentially injurious to share the risk assessment/management plan with the user the reasons for withholding it should be recorded in the appropriate documentation/notes.

9.7. Effective record keeping is an essential component of providing appropriate, consistent and quality care. In order to achieve this, each ward/department should have a comprehensive system for the completion, use, storage and retrieval of health records, in paper or electronic forms. Staff should also ensure that health records are maintained and secured in a manner, which complies with the requirements of the Trust's Caldicott Guardian and the Data Protection Act. Further information is provided in the Trust's Policy for Information Sharing, and Policy for Information Security.

10. TRAINING

10.1 The importance of providing a formal system of Clinical Risk Assessment training is highlighted in several key documents.

Safety First (2001)

. "All staff in contact with patients at risk of suicide should receive training in the recognition, assessment and management of risk, of both suicide and violence, at intervals of no more than three years".

National Service Framework for Mental Health -standard on suicide prevention.

"training for staff in specialist mental health services and risk assessment management is a priority, and (should be) updated at least every three years."

The Pennine Care Training Needs Analysis (TNA) identifies staff groups who are required to undertake Clinical Risk Assessment training Please see TNA. Staff identified in the TNA should attend updates every 3 years. A programme of Clinical Risk Assessment training is coordinated by the Learning and Development Department. Training dates and booking arrangements are circulated to all senior managers for dissemination to staff teams and available for all staff to view on the Trusts intranet OL&D training calendar. It is the responsibility of line managers to ensure that staff have received appropriate risk assessment training and updates. The TNA is subject to review and change.

10.2 Clinical Risk Assessment training covers the following key risk areas:

- Indicators of risk
- Completing risk assessments formulation and risk management plans
- Managing long term risks
- Communication
- Care Programme Approach (CPA)
- Loss of contact
- High risk periods
- Managing non-compliance
- Learning from incidents
- Medicines management
- Safeguarding Adults

There are also specific risk assessment and management training programmes for Suicide Prevention and Self Harm (STORM – Adults and Younger Persons versions; telephone assessment and intervention training) and the Management of Violence and Aggression address violence risk assessment and management.

The Trust has learned lessons from previous serious incidents and is now offering Higher Clinical Risk Formulation training. This training is provided by the Violence Reduction team within OL&D and is reviewed within the Violence Reduction Strategy Group.

10.3 The importance of risk assessment within the context of the Mental Health Act is reinforced in Mental Health Law training. This is provided by the Learning and Development Department; there is specific training provided for stakeholder groups (e.g. Approved Mental Health Professionals and s.12 Approved Doctors).

Employees have a responsibility to ensure they access the required training as identified in the Training Needs Analysis (TNA).

11. MONITORING

The provision of Clinical Risk Assessment Training is under continuous review to ensure that the content of training is up to date, and effectiveness is evaluated and improved. The Core and Essential Skills Group for Pennine Care will oversee this evaluation process and recommend future strategic development of Risk Assessment training within the Trust.

Serious Untoward Incident Review meetings are conducted weekly at the Patient Safety Improvement Group which will monitor and scrutinise completed risk assessments and risk management plans included in the Team Investigation Reports. Lessons learnt will be forwarded to the Divisional Governance Meetings, and other relevant groups (e.g Tier 4 Group) and Core and Essential Skills Group.

The Patient Safety Lead will report themes arising from Serious Untoward Incidents review and subsequent reports to the Divisional Integrated Governance Groups and the Learning and Development department. Aggregated learning from serious incidents will be shared via 7 minute briefings across all Divisional Business Units and via the Continuous Learning Forums.

12. REFERENCES

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Department of Health (2001) *Safety First: Five-Year Report of the National Confidential Inquiry into Suicide and Homicide by People with Mental Illness.*
Department of Health (2000) *Effective Care Co-ordination in Mental Health Services: Modernising the Care Programme Approach – A Policy Booklet.*
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Morgan C (2001) *Assessing and Managing Risk.* The Sainsbury Centre for Mental Health Health, Pavilion.
National Health Service Litigation Authority (2005) *Clinical Negligence Scheme for Trusts –Mental Health & Learning Disability Clinical Risk Management Standards.*

O’ Rourke, M & Bird, L (2001). Risk Management in Mental Health. The Mental Health Foundation.
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The University of Manchester. 1996. Learning Materials on Mental Health Risk Assessment.

Related Policies

Pennine Care Safeguarding Adults Policy
Pennine Care Child Protection Policy
Pennine Care CPA Policy
Pennine Care Violence Reduction Policy