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‘Please read the policies in conjunction with any updates provided by National Guidance, which we are actively seeking to incorporate into policies through the Clinical Ethics Advisory Group and where necessary other relevant Oversight Groups’
**DOCUMENT HISTORY**

(Procedural document version numbering convention will follow the following format. Whole numbers for approved versions, e.g. 1.0, 2.0, 3.0 etc. With decimals being used to represent the current working draft version, e.g. 1.1, 1.2, 1.3, 1.4 etc. For example, when writing a procedural document for the first time – the initial draft will be version 0.1)

<table>
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</table>

NB This policy relates to the Isle of Wight NHS Trust hereafter referred to as the Trust
## Contents

<p>| | |</p>
<table>
<thead>
<tr>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>1.</td>
<td>Executive Summary</td>
</tr>
<tr>
<td>2.</td>
<td>Introduction</td>
</tr>
<tr>
<td>3.</td>
<td>Definitions</td>
</tr>
<tr>
<td>4.</td>
<td>Scope</td>
</tr>
<tr>
<td>5.</td>
<td>Purpose</td>
</tr>
<tr>
<td>6.</td>
<td>Roles &amp; Responsibilities</td>
</tr>
<tr>
<td>7.</td>
<td>Policy Detail / Course of Action</td>
</tr>
<tr>
<td>8.</td>
<td>Process of Risk Assessment and Risk Management</td>
</tr>
<tr>
<td>9.</td>
<td>Gathering Information</td>
</tr>
<tr>
<td>10.</td>
<td>Identifying Situations and Circumstances Known Present Increased Risk (Critical Indicators)</td>
</tr>
<tr>
<td>11.</td>
<td>Categories of Risk</td>
</tr>
<tr>
<td>12.</td>
<td>Using Structured Clinical Judgement and Recording the Risk Assessment and Management Plan</td>
</tr>
<tr>
<td>13.</td>
<td>Consultation</td>
</tr>
<tr>
<td>14.</td>
<td>Training</td>
</tr>
<tr>
<td>15.</td>
<td>Monitoring Compliance and Effectiveness</td>
</tr>
<tr>
<td>16.</td>
<td>Links to other Organisational Documents</td>
</tr>
<tr>
<td>17.</td>
<td>References</td>
</tr>
<tr>
<td>18.</td>
<td>Legislation</td>
</tr>
<tr>
<td>19.</td>
<td>Appendices</td>
</tr>
</tbody>
</table>
1 Executive Summary

The Isle of Wight NHS Trust (referred to in this document as the Trust) is committed to the safety and well-being of service users, staff and all people visiting or working within the Trust.

Clinical Risk Assessment and Management is part of the Trust's overall risk management strategy and is fundamental to maintaining safety. This policy defines the overarching standards to be employed within all local services relating to the risk assessment and management of individual service users. It should be used by all staff involved in the assessment and management of clinical risk in Mental Health & Learning Disability Services.

The policy applies to all Mental Health & Learning Disability services in the Trust. Procedures are designed to support structured clinical judgment (defined below), the approach to clinical risk assessment and management that is favoured both by the Department of Health (DH) (Best Practice in Managing Risk, March 2009) and the Trust, where appropriate excerpts from this document are taken below.

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.

2 Introduction

Safety is at the heart of the Trust's approach to clinical risk assessment and management. This policy and its procedures aim to give a framework to staff in Mental Health & Learning Disability Services so that they can provide the safest possible services to our service users.

It is intended that the policy supports staff, service users and carers so that risk assessment and management becomes a meaningful process that integrates well with and adds value to the wider care plan. In order to achieve this we adopt the underlying principle that "modern risk assessment should be structured, evidence based and as consistent as possible across settings and across service providers" (Best Practice in Managing Risk, Department of Health, March 2009 – see below).

Essentially clinical risk assessment and management is fundamental so that:

- Risks to the wellbeing of service users, staff and others are assessed and identified
- Indicators of possible adverse outcomes e.g. non-compliance with treatment or non-attendance at appointments are addressed
- Risks to service users, staff and others are regularly reviewed
- Risks to service users, staff and others are communicated appropriately
- Shortfalls in services are identified and addressed

And ultimately
- Service users, staff and others are safeguarded.

2.1 Our 10 Underpinning Values

When approaching clinical risk assessment and management the Trust endorses the DoH's underlying principles:

1) ‘Best practice involves making decisions based on knowledge of the research evidence, knowledge of the individual service user and their social context, knowledge of the service user’s own experience, and clinical judgement.'
2) Positive risk management as part of a carefully constructed plan is a required competence for all mental health/learning disability practitioners.

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

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

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

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

7) Risk management must always be based on awareness of the capacity for the service user’s risk level to change over time, and recognition that each service user requires a consistent and individualised approach. (Best Practice in Managing Risk March 2009)

In addition, our Trust holds the following values which are fundamental to how we provide our services:

8) Any intrusion into people’s lives, or constraints imposed on their right to self-determination, must be both within the law, mindful of their human rights and at the minimum level necessary in order to maximise privacy and dignity whilst keeping them safe.

9) Carers must be treated with respect, taking into account their relationship with the service user; their special knowledge of the situation and their actual and potential contribution to the service user’s well-being should be fully acknowledged and utilised.

10) It must be recognised that all staff working within high risk situations may be subject to stress and have the right to receive appropriate support and supervision.

Mental Capacity Act 2007:

In applying this policy you must also comply with the principles of the Mental Capacity Act 2007:

1. Always assume a person has capacity unless you have established that they lack capacity.
2. Do everything you can to help the person make a decision for themselves.
3. An unwise decision does not prove that the person lack capacity.
4. Anything you do or any decision made for or to the person must be in their best interest.
5. Always consider whether the outcome can be achieved in a way that interferes less with the person’s wishes.

Whenever there is a doubt about the person’s capacity you must assess their capacity and if they do lack capacity you must act in their best interests. Further guidance can be found in the Trusts’ MCA Policy and in the MCA Code of Practice.

3 Definitions

Clinical Risk Assessment and Management is defined by the Trust as a continuous and dynamic process for judging risk and subsequently making appropriate management plans considering the risks identified. Throughout this policy The Care Programme Approach (2008) will be referred to as CPA.
4 Scope

This Policy applies to all clinical staff working within the Isle of Wight NHS Trust Mental Health and Learning Disabilities Clinical Division.

5 Purpose

The Isle of Wight NHS Trust policy “Clinical Risk Assessment and Management in Mental Health & Learning Disability Services” sets out the framework for the management of risk in all clinical areas. This guidance is aimed to further extend staff awareness of the complexity and detail involved in risk assessment and risk management within services.

Essentially the assessment and management of risk must be an integral element of the CPA and the Single Assessment Processes, Models of Care within substance misuse services and any other care planning process.

The guidance is not intended as a substitute for specific training of staff in this area of work. Training on the assessment and management of risk remains a priority area for the Isle of Wight Mental Health & Learning Disability Services.

Risk and risk taking are intrinsic to practice in Mental Health/Learning Disability Trusts. Properly managed they are a means of encouraging autonomy, choice and participation for users of mental health services and combating their stigmatisation and social exclusion. It is the policy of the Isle of Wight Trust that all mental health professionals will undertake or contribute to the assessment and management of clinical risk.

NB: For convenience the term “mental health professional” may be used, but this should be taken as referring to all clinical staff working with service users in Mental Health & Learning Disability Services.

6 Roles and Responsibilities

6.1 Executive Lead

The Chief Operating Officer is the executive lead for the Trust Board for Clinical Risk Management.

6.2 Clinical Director, Head of Operations, Head of Nursing and Service Managers for the MH&LD Business Unit

The Clinical Director, Head of Operations and Operation Managers are responsible for ensuring that all teams operate the Clinical Risk Assessment and Management Policy in a way that delivers optimum care for patients.

6.3 All Clinical staff

All clinical staff working in Mental Health and Learning Disabilities services for the Trust have a duty to be aware of the risks for every patient they are caring for and for sharing those risks accordingly with relevant individuals. It is essential that all identified risks are recorded within the individuals risk assessment and associated care plan. An Alert on the Electronic Patient Record System (EPRS) should be added and any previous Alerts reviewed and updated.
All Clinical Team Leaders/Ward Managers/Service Managers are responsible for ensuring staff who report to them are familiar with this policy. All operational staff are expected to comply with this policy.

Each of the above are responsible for:

- The implementation and evaluation of risk assessment and management procedures within this document.
- The supervision of staff in the use of procedures and risk assessment tools.
- Contributing to the audit and research programmes which will inform the continual process to improve practice
- Attending 3 yearly classroom based clinical risk training and completing yearly on-line mandatory training

6.4 All Administrative staff

All administrative staff working in Mental Health and Learning Disabilities services have a duty to escalate any concerns raised during their contact with patients, to the relevant clinical staff within their team. If any administrative staff become aware of any risks they should add an Alert on the Electronic Patient Record System (EPRS) and inform relevant clinical staff.

7 Policy detail/Course of Action

7.1 Principles of risk assessment and management – Key Standards.

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

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

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

- The risk management plan should include a summary of all risks identified, formulations of the situations in which identified risks may occur, and actions to be taken by practitioners, the service user and carers in response to crisis.

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

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

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

- All staff involved in risk management should receive relevant training, which should be updated at least every 3 years.

- A risk management plan is only as good as the time and effort put into communicating its findings to others.
7.2 In addition, our Trust has set the following standards which are integral to how we approach risk:

The process of risk assessment should essentially be helpful – both to service users and carers by providing considered plans delivered by safe services, and to staff through informing clinical decision making and promoting a considered, organised and structured approach to risk.

7.3 Patients deemed no longer subject to CPA will no longer require a Core Assessment and this will be closed at the point of discharge. The discharge summary letter will provide the patient, Carers/family and GP with the care plan for the person when they leave hospital.

7.4 The National Confidential Inquiry into Suicide and Homicide by people with mental illness – October 2016 highlights “The first three months after hospital discharge continue to be a period of high suicide risk. In England the number of deaths rose to 200 in 2014 after a fall in the previous year. Risk is highest in the first two weeks post-discharge: in a previous study we have shown that these deaths are associated with preceding admissions lasting less than 7 days and lack of care planning.” Locally it has been agreed that good practice indicates that the majority of patients being discharged from in-patient wards should be followed up by the Home Treatment Team and it must be clearly documented the rationale for anyone not being followed up by them.

7.5 Robust discharge planning between the Home Treatment Team and the Community Teams needs to take place bearing in mind the risks identified in The National Confidential Inquiry (October 2016). There must be a minimum of weekly visits by the Community Team for a minimum of 3 months post discharge from the Home Treatment Team.

7.6 Individual care plans must clearly document and reflect any risks prior to stepping down to the Community Team and how these risks will be addressed and the level of contact must be recorded in the care plan.

The assessment should:

- Inform and guide the process of care with the service user at the centre.
- Be dynamic and ongoing with reviews triggered by needs and/or some events.
- Be recorded in a clear accessible form, and be communicated appropriately.
- Be integral to the wider clinical assessment and care planning process for each service user. It should be fully compatible with the Care Programme Approach (CPA) 2008 and other care planning processes.
- Be carried out by suitably trained and competent staff
- Ensure that the risk management plan is guided by the risk assessment.
- Be linked to Trust audit and research programmes

8 The Process of Risk Assessment and Risk Management

The Trust endorses the use of “structured clinical judgment” as an approach to assessing risk. This approach is endorsed by the Department of Health and the Royal College of Psychiatrists (RCP) and is felt as the safest strategy to address clinical risk. It essentially involves the use of clinical judgment that is guided by a standardised format, potentially complemented by the use of clinical risk assessment tools.
9 Gathering Information

The quality of the risk assessment depends on the information available. The amount and accuracy of the information available may vary considerably according to the circumstances and setting where the initial assessment is carried out. For example, the information available to make an informed risk assessment on an unknown patient newly admitted to a hospital ward in the middle of the night may greatly contrast with the extent of information known about a patient already subject to the CPA (or equivalent processes). The three main sources of information available to staff are:

- Clinical interview and observation
- Information from informants (these may be relatives or carers and people from any agency involved in the person’s care)
- Documentary evidence available in care records

Therefore, in certain circumstances, staff will not have full information and will have to make the best possible assessment based upon what information is available. As more information comes to light, and with the person better known, the risk assessment and care plan should be reviewed and updated. Anyone assessed as posing a risk of harm to self or others should not suffer discrimination because of that assessment.

The behaviour may be assessed as potentially harmful or dangerous and may legitimately restrict certain services options. It may also entitle the person assessed to special provision because of those needs. When considering information about history of harm to self or others, there are four components which should be considered:

- Severity
- Recency
- Frequency
- Pattern

Attention must be paid not only to actual past harm committed by the person but also to the potential of likely harm and acts of harm which were intended but prevented. These must be given proper consideration and weight so as to avoid the tendency to minimise the potential of harm.

10 Identifying Situations and Circumstances Known to Present Increased Risk (Critical Indicators)

There are certain general circumstances that may increase a level of risk, such as violence being more likely when drug or alcohol abuse co-exist with major mental illness or when a patient has multiple psychiatric diagnoses.

Research has also shown that certain factors including sociodemographic data, past history, and situational factors can particularly be associated with increased likelihood of violence and suicide.

As well as general circumstances it is also often possible to identify circumstances in which, based on past experience, it is likely that a particular person will present an increased risk. For example:

- When a person stops medication and has previously been aggressive during an acute phase of an illness.
- When a person who has been suicidal in one particular situation, such as the ending of a close relationship, is faced with another similar situation.
• When a person who has previously offended under the influence of drugs and alcohol starts drinking again, or enters an environment where drugs or alcohol are available.

• When there is an apparent improvement in health though history suggests that this maybe short lived and requires careful monitoring over a longer period of time.

• Where a service user with a learning disability previously inclined to challenging behaviour after bereavement suffers a further loss.

Environmental conditions or events which have been associated with dangerous behaviour or risks in the past should be considered including taking into account the risks of fires in service user’s homes, particularly those with a history of self-harm by burning and smokers.

Situational factors can include loss of employment, financial difficulties, the ending of a relationship and sexual exploitation. Evidence of perpetration of, or risk of being subject to, domestic violence should be included in risk assessment.

Personal triggers are factors internal to the person which have been historically identified as related to risk e.g. deterioration in mental state, stress reactions, loneliness or other emotional states. These should also be considered.

The person may demonstrate warning signs of risk behaviours. They are observable behaviours which have been noted to be present when harm is about to happen. For example, pacing, swearing, threats of self-harm, stalking, refusal to eat and refusal of medication.

Wherever possible, staff should consider both general factors and information relevant to the individual based on their history. Staff must use their professional judgment to decide on the weight to give each factor. Wherever possible this should be done in a multi-disciplinary setting in order to capture the most complete picture of risk.

11 Categories of Risk

There are three categories to be considered here:

11.1 Risk of Harm to Self

This can be considered under separate headings: Suicide, deliberate self-harm, accidental self-harm, neglect and risk of harm to a service user if a required admission to hospital cannot be arranged.

Suicide - Two elements are important in assessing the risk of suicide:

• Knowledge of general risk factors for suicide
• Skills in making direct enquiries about suicidal intent

The period around inpatient discharge is a time of particular high risk of suicide, emphasising the need for proper assessment prior to discharge and effective follow up afterward.

Recent research evidence suggests that a breakdown in the continuity of care by either carers or professionals significantly increases the risk of suicide post discharge. This could include key personnel being on leave or leaving or a change of consultant since the admission.

The most obvious warning sign is a direct statement of intent. This should never be ignored, although it needs to be considered within the context of the individual service user.

Those who are suicidal can fluctuate between a wish to live and a wish to die. More than half of those under the care of Mental Health Services who commit suicide have had contact with a member of staff within 7 days of the event. With skilled questioning on the basis of a strong therapeutic relationship, staff can be well placed to elicit signs of high suicidal intent. However an expression of lack of suicidal intent
does not necessarily indicate lack of risk. It may be that the service user is trying to avoid accessing services so that they can commit an act of self-harm or suicide, or their intent may be fluctuating.

A care plan to manage the risk must urgently be put in place when risk of suicide is expressed. The care co-coordinator and the Consultant Psychiatrist (where there is one) may need to be informed and this will trigger a review of the risk assessment and care plan. Consideration should be given as to whether the use of The Mental Health Act 1983 (MHA) is appropriate.

**Deliberate Self Harm**

People who have committed non-fatal acts of self-harm are at an increased risk of committing suicide at a later date. The highest risk is in the first three years, especially the first six months following an overdose.

Factors associated with a higher risk of repetition of deliberate self-harm include:
- Substance misuse problems
- Diagnosis of personality disorder
- Previous psychiatric inpatient treatment

For those in longer term care, deliberate self-harm can be a feature of frustration and boredom. For those with limited verbal skills, this pattern of behaviour may be adopted by people who cannot otherwise express their distress. The factors may be prevalent in services for adults with learning disabilities. Deliberate self-harm is also a common pattern of behaviour amongst adolescents and such incidents should always be carefully assessed.

**Self-Neglect**

Assessment of risk of self-neglect may include assessment of:
- Hygiene
- Diet
- Infestation
- Household safety
- Warmth

A failure to eat or drink adequately may be acute, severe and life threatening. On the other hand, it may result in slow deterioration in health and nutritional status and not be recognised initially by professionals or carers. This is a complex area for assessment. Professionals have to balance an acknowledgement of relative standards and the service user’s right to be protected from unnecessary interference against the need for accurate assessment of a person’s circumstances and responsibility for intervention where severe self-neglect is likely.

Also included under this heading are risks of:
- Losing contact with services
- Relapse due to not taking medication

Active follow up in the community may be necessary and a contingency/crisis plan should be in place when a service user who is considered high risk does not keep an appointment or is not at home when visited. Wherever possible interventions should be with the consent of the service user however when the situation may be life threatening then consideration needs to be given to the use of the Mental Health Act 1983 (MHA).

11.2 **Risk to Others**

Predicting dangerous or violent behaviour is an inexact science. The most reliable long term predictor of violent behaviour is previous violent behaviour, hence the importance of full, accurate and up to date information, communication and recording.

This should include any incidents of harm to others (including history of offending) and any history of carrying instruments that have potential to cause harm, including knives. Victims are more likely to be
family members or those trying to deliver care and support. In assessing risk of violence, consideration should be given to the risk for family and carers and in addition the need to protect any particularly vulnerable adults or children in the household. Carers are often particularly at risk of violence from the person they care for and staff should be sensitive to this.

**Assessing the Risks of Violence -**

- Identifying situations or circumstances in which, based on previous experience, the service user is likely to become violent. Trying to see the behaviour from a service user’s point of view can be very revealing in terms of risk assessment.

- Liaison may occur with the probation and police service if they are currently involved with the service user or have had previous involvement in order to exchange appropriate information and to develop a jointly agreed risk management plan. (Multi-agency public protection panels should be used where appropriate).

- Attention must be paid not only to actual past harm committed by the person, but also to the potential for harm. Acts that were intended to harm or could have harmed but which were prevented, must be given proper consideration and weight so as to avoid the tendency to minimise the potential risk of harm.

- The assessment should aim to identify not only the nature of the risk of violence but also identify who is at risk.

**Risks to Staff -**

Managers within the Trust must comply with the legislative requirements set out in the Health and Safety procedures relevant to their Departments. In particular this requires managers to undertake health and safety risk assessments to identify hazards and evaluate risks to staff.

Physical and verbal violence towards staff requires immediate management action. Trust managers are responsible for the development, implementation, monitoring and review of safe working practices and procedures in all environments where staff have contact with service users. This is particularly important where staff are working alone in the person’s home or in community settings such as locality bases. Each team should review its safe working procedures annually or more often if the need arises.

Staff also have responsibilities and need to ensure they consider the risks that may occur during the course of their work. In order to do this they need to check on current risk status before interviewing a service user and take all appropriate steps to ensure their own safety during any encounter.

**Risk to staff in other Provider Agencies**

It is essential that with any referral to a care provider within the Trust or outside the Trust, consideration should be given to the provision of an unambiguous, accessible and up to date risk assessment and management plan, with the new provider’s responsibilities clear and agreed by them.

Service users must be consulted, understand the reasons for sharing the information and agree to this action. If service users refuse to share the information then it may not be possible to commission a particular service. There are some particularly dangerous situations when information needs to be shared without consent. Professionals should adhere to the principles and guidance offered by their professional body that clarifies the circumstances in which confidential information may be shared with other agencies in the public interest.

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

Assessment of adult service users must include asking if there are children in the household. This is of particular importance when the adult is a lone parent or the main carer of children. Where possible the mental health professional involved in the case should meet the children and observe their physical condition and behaviour.
Concerns should always be discussed with the parent, however where doubts remain the line manager must always be informed and advice should be sought from the Trust’s Safeguarding Children Lead.

If a referral to Children’s Social Care is required, there should be two separate but integrated care plans - one, focusing on the needs of the child managed by the children's service and another focusing on the needs of the adult managed by the Trust services. The respective care co-ordinators should work in close liaison and attend care planning and review meetings for both child and adult as necessary.

The welfare of a child is paramount (Children Act - 2004), timely communication and the sharing of information is a key factor in ensuring that children are protected from harm. Confidentiality of the parent or service user may be overridden in these circumstances.

The team manager must be informed about concerns in the response by children's social care to a referral. If the team manager cannot resolve the concerns through discussions with the other agency it must be escalated to the Trust Safeguarding Children Lead. In all cases a further referral must be made if new concerns arise.

Consultant Psychiatrists must always be informed and directly involved in clinical decisions for service users who express delusional beliefs or suicidal ideation that may involve and pose a risk to children. Where the service user is an inpatient this will include any decision regarding discharge, leave, CPA reviews or contact arrangements with children. These decisions must not be delegated to a junior doctor.

The above cases are likely to be the small minority. Therefore, Care Coordinators must have a low threshold for acting in cases where there may be a significant risk to children. All such cases must be discussed in the multi-disciplinary team meeting to ensure a group decision is taken about how to manage risks and plan actions. When a consultant psychiatrist is not present at the meeting the discussion must include whether it is necessary for the consultant to be alerted to the case to make a decision about whether there is a need for direct consultant involvement and / or oversight of the case.

If urgent action is required to safeguard a child, before the routine team meeting, the clinician must seek advice from the manager or senior clinician immediately and make a referral to Children’s Social Care. If in any doubt advice should be sought from the Trust Safeguarding Children Lead, although this should never cause a delay to safeguard a child.

When considering the risk presented by mental illness or substance misuse from someone who is also a parent, or is significantly involved in the care of children, it is important to consider specifically the risks that the children may encounter as a result of the parent’s potentially impaired parenting abilities.

The following are examples of specific risks to children:

- Severe postnatal depression and puerperal psychosis carry particular risks for babies and young children.

- Adults with moderate to severe learning disabilities may lack the knowledge and skills to provide adequate parental care.

- Continuous or frequent intoxication due to alcohol or drug misuse can lead to dangerously low levels of parental care and supervision.

- Psychosis can result in physical or emotional neglect or abuse of children. The risk is high if an adult has delusional beliefs which involve a child.

- Severe obsessive compulsive disorder can place children under intolerable pressure to comply with rituals and routines resulting in impaired social development and schooling.

- Suicidal thinking that includes a child in a suicide pact.
• Children should not be expected to be the main carers for adults to the detriment of their own needs for care and development.

11.3 Risk of Abuse or Exploitation by Others – Safeguarding Adults
All staff, agencies and service providers must work within the law and must not support or condone abuse to vulnerable adults. Where abuse is occurring or believed to be occurring then staff must pass their concerns on to a responsible person. The Safeguarding Adults from Abuse procedures must be followed where there is concern that abuse of a vulnerable adult may have occurred. In all cases where there is actual or risk of potential abuse or exploitation, staff should consult the Safeguarding Adults Multi-Agency Policy, Guidance and Toolkit – Hampshire, Isle of Wight, Portsmouth and Southampton – May 2015.

12 Using Structured Clinical Judgment and Recording the Risk Assessment and Management Plan

The nature of the risk assessment will be dependent upon how well known the service user is to the professionals completing the assessment. A risk assessment that takes place within an initial interview in Accident and Emergency or when someone is admitted as an emergency in the middle of the night will be different from a risk assessment that is part of the ongoing management of a long term case.

In a similar manner a service user who is only seen in outpatient clinic and is assessed as low risk and is not subject to CPA will not need a complex care plan or complex risk assessment. The care plan for these service users’ will be the outpatient clinic letter which will highlight to the service user, carer and GP what the care plan consists of, including a risk assessment and contingency plan.

The risk status of a service user is a key item of information and must be recorded in the appropriate place on the PARIS Electronic Patient Record (EPR). Using the Trust’s risk assessment forms not only guides a professional’s judgment but also serves as a record of the risks assessed and the subsequent plan. The assessment must be completed on the electronic care record CPA assessment or within the outpatient clinic letter.

The Care Co-ordinator is normally responsible for ensuring the appropriate risk assessment is completed (during an in-patient admission the role may be delegated to the named nurse). A full CPA assessment is required for service users who meet the eligibility criteria for CPA.

For standard care or equivalent substance misuse services this may be an individual worker/lead clinician.

For people under CPA this will be the designated Care Co-ordinator or named nurse in discussion and agreement with the multi-disciplinary team where appropriate.

When a risk assessment has to be completed at the time of an emergency, such as an unplanned admission to hospital, the person/s responsible will be the most senior professional/s involved in the emergency. This is likely to be the admitting doctor and the most senior nurse present.

All professionals involved in emergency/crisis admissions should jointly participate in the completion of the risk assessment and sign the record. Risk assessments made during emergencies should clearly state the review date and consideration should be given to an early review. When necessary, in high-risk situations, this may need to be within 24 hours.

Assessing risk and the attendant management plan will have a slightly different focus dependent upon whether the service user has a mental illness, a substance misuse problem or a learning disability.

12.1 Use of the tools
The descriptions of the risk assessment tools that follow are to be considered just that; tools to assist in the process of risk assessment. They are not only a format to record risk, but act as a structure to guide
the clinician in their thinking, so that the risk assessment can be as comprehensive as possible. The document is intended to be live – that is, not something that is completed once the risks have been assessed but a tool that structures the consideration of the risks with the information presented.

By prompting the clinician to consider details that are relevant to risk assessment that may be overlooked, e.g. history of substance using behaviour, it supports the clinicians in considering a variety of possibilities. Clinicians are then better placed to make more sophisticated and meaningful management plans. This is the essence of structured clinical judgement.

The Threshold Assessment Grid (TAG)
This form on PARIS (EPR) is to be used for new mental health service users at first presentation to services.

The person or persons conducting the assessment for new service users in the Single Point of Access Team will complete this assessment.

If high risk has been recorded by the assessor, this must be discussed in the multi-disciplinary meeting, an agreed management plan needs to be implemented and a further comprehensive assessment must take place as soon as possible.

If risk is assessed as low and the person does not require specialist mental health services but social/family factors cause some concern the immediate management plan may be giving information on community agencies such as CAB, Relate and various other appropriate agencies and referring back to the GP.

Paris CPA Assessment
This must be completed for all service users who come into secondary care and meet the criteria for CPA and a management plan must be clearly identified and implemented.

Addenbrooke's Cognitive Examination- Revised (ACE-R) is a brief neuropsychological assessment of cognitive functions and a development on the Mini–mental state examination, which it incorporates. The test is widely used for determining mild cognitive impairment and dementia. The test includes measures of language, memory, visuospatial skills, and orientation.

This must be completed for all service users who come into secondary care with the possibility of cognitive impairment.

Other Specialist Tools
For specialist settings, or for individuals with particular areas of risk, many tools have been developed to assist in the risk assessment process. A selection of such tools have been made available by the Department of Health (see “Best practice guidance” June 2009).

12.2 Formulating a Care Plan to Manage the Risk
In order to be effective a risk assessment must be communicated and acted upon.

Risk management is about evaluating the risks identified in the risk assessment process, taking into account the possible beneficial and harmful outcomes, and subsequently planning and implementing appropriate strategies to reduce these identified risks. Really the aim should be to identify the vulnerabilities and strengths of the service user which contribute to the risk equation, and develop/reduce these proportionately; the risks should alter accordingly. This is an integral part of CPA, standard care and Models of Care Substance Misuse and the care plan produced needs to clearly specify how needs are to be met and the risks managed.
It should ideally be planned in collaboration with the service user and carer (where appropriate), and copies of the written plan should be provided to the service user and carer (if the service user consents).

Using the information gained from the risk assessment and the assessment of need, the care plan is formulated and recorded by the Care Co-ordinator/Lead Clinician. This may be undertaken in a multidisciplinary forum for service users monitored on CPA and in a clinical interview/meeting for those maintained on standard care or equivalent substance abuse services.

For CPA levels of care planning it may be appropriate for all members of the multidisciplinary team, providers of services, involved external agencies and the GP to be provided with a copy of the care plan.

This may contain a variety of strategies and agreements, which could include the following:

- The services that are to be provided by each agency within a given timescale.
- Any care responsibilities that the relative or carer has agreed to take on.
- How any assessed risk of harm will be managed and by whom.
- The likely warning signs or triggers that may suggest an increase in risk.
- The time period a risk situation will be allowed to continue before a new review occurs.
- Details of who to contact in a crisis and how to do so.
- Details of the GPs involvement.
- Support that may be made available for the relative or carer.
- Contingencies in the event of default by the service user or any service provider.
- Details of the service users care co-ordinator/lead clinician and how they may be contacted.

The service user should be asked to sign the care plan to signify agreement with the plan. If the service user has any objections these should be recorded. It is not necessary for the plan to be signed at the CPA meeting as this may present administrative difficulties however good practice would suggest the plan is sent to the service user for signature as soon as possible, say, within a maximum of two weeks.

The Care Co-ordinator/Lead Clinician will normally be responsible for co-ordinating interventions as necessary, and ensuring that the care plan is adhered to. During periods of in-patient care the named nurse will undertake this duty, however it is important the Care Co-ordinator/Lead Clinician remains in contact with the service user and is aware of events and plans being made during the in-patient admission.

In situations of high risk a backup for the Care Co-ordinator/Lead Clinician/named nurse should be identified as a contact point in the absence of the Care Co-ordinator/Lead Clinician/named nurse.

12.3 Monitoring and Reviewing the Situation - Risk Review
A review should also use structured clinical judgment, following the guidance above. Using the PARIS Electronic Patient Record (EPR) practitioners can update the current risk assessment and management plan, ending any risks that have been mitigated and adding any new ones.

For those service users under CPA the Care Co-Ordinator is responsible for completing this risk review and updating the assessment and management plan. For those not subject to CPA the Lead Clinician will be the responsible person.
As a minimum all risk assessments should be reviewed annually.

Where staff involved in a service users care plan consider that a change in mental state has occurred and risk has increased, the Care Co-ordinator/Lead Clinician and the Consultant Psychiatrist or Responsible Clinician (RC) should be informed as soon as possible so that action can be taken to reassess the individual’s needs.

The Care Co-ordinator is also responsible for ensuring the information on the increased risk is appropriately shared with other involved team members, providers of services and carers.

In urgent situations the Care Co-ordinator/Lead Clinician, or during in-patient admissions the named nurse, may need to take immediate decisions without a formal review of the care plan and in these circumstances this should be communicated to the multi-disciplinary team and a formal review arranged as soon as possible. Changes in risk should also lead to a review of the level of care currently provided and CPA may be considered if not already in place.

12.4 Support to Staff

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

- All MH & LD staff, Students, Agency and Bank staff must have regular training on the management of violence and aggression
- All staff involved in risk assessment and management should receive regular supervision as set out in the IOW NHS Trust Clinical Supervision Policy.
- High-risk cases should only be allocated to suitably experienced staff.
- Staff should alert their line managers to all cases that are assessed as high risk by the multidisciplinary team.
- Risk status should be considered when cases are prioritised for allocation.
- Careful workload management should ensure staff have sufficient time for the work required in such cases and this needs to be discussed in caseload management supervision regularly.
- Staff should be clear about line management accountability and to whom they should report any clinical concerns. In the case of any situation which is identified as high unmanaged risk this must always be reported immediately.
- Staff should be made aware of internal and external staff support systems.

12.5 Carers

Staff should make every effort to work in partnership with carers in assessing and managing risk. Carers can often contribute very sensitive information about risk factors for the person they care for, and they are also often in a position to be managing most of the risks presented on a daily basis.

Confidentiality rules should not be used as an automatic barrier to communicating with carers. Staff should explain to service users both the importance of confidentiality rules but also the advantages of permission being given for carers to be given clinical and risk information so that they are fully equipped to help ensure the safety of the person they care for (and also of themselves). Carers should be treated as key potential allies in the risk management plan, once identified they should always be offered a carer’s assessment.
13 Consultation

This document was disseminated for consultation throughout the Mental Health and Learning Disability Clinical Risk Management Group and the Mental Health and Learning Disability Clinical Business Unit Quality Group.

14 Training

- The Department of Health have an expectation that all clinical staff in Mental Health & Learning Disability Services receive training in the recognition, assessment and management of risk at least three yearly (NPSA, 2009)

- All clinical staff will attend 1 day classroom based training in Clinical Risk Assessment and Management at a minimum of 3 yearly intervals as recommended by the National Confidential Inquiry into Suicide and Homicide by people with Mental Illness and Department of Health on a mandatory basis.

- All clinical staff will also complete yearly online Clinical Risk Assessment & Management training as a mandatory requirement.

15 Monitoring Compliance and Effectiveness

Compliance with this policy will be monitored in the following ways:

- Quarterly Clinical Documentation audits will be presented at the MH and LD Clinical Business Unit Quality Meeting.

- Standards of Risk Assessment and Management will be monitored within caseload management and clinical supervision.

- Compliance with the mandatory training component will be monitored by Team Managers and the MH Clinical Risk Management Group.

16 Links to other Organisational Documents

- MH & LD Care Programme Approach (CPA) & Standard Care Policy (Nov 17)
- MH & LD Guidelines for Managing Patients who disengage from Services (June 18)
- MH & LD In-patient Supportive Observation Policy (Sept 20)
- MH & LD Services Seclusion Policy (May 19)
- IOW NHS Trust Lone Worker Policy (Dec 17)
- IOW NHS Trust Missing Patients Policy (Aug 20)
- IOW NHS Trust Safeguarding Children Supervision Policy (Sept 19)
- Safeguarding Adults Multi-Agency Policy, Guidance and Toolkit – Hampshire, Isle of Wight, Portsmouth and Southampton (Dec 16)
- IOW NHS Trust Safeguarding Children and Young People Policy (June 19)
- Isle of Wight Health and Social Care System Discharge Policy (Sep 16)
- IOW Trust Safeguarding Adults Policy (Sept 20)
- Adult Observation Chart Policy (Incorporating National Early Warning Score – NEWS) (May 19)
- IOW NHS Trust Clinical Supervision Policy (March 20)

17 References

- Safety of Client/Patients with Mental Health Needs, The Essence of Care: Department of Health, (Feb 2001)
• Avoidable mortality in England and Wales: Office for National Statistics (Apr 2015)
• Refocussing the Care Programme Approach - Policy and Positive Practice Guidance: Department of Health (Mar 2008)
• Best Practice in Managing Risk: Department of Health: (Mar 2009)
• National Confidential Inquiry into Suicide and Homicide by People with Mental Illness: (Oct 2016)
• Working together to safeguard children - A guide to inter-agency working to safeguard and promote the welfare of children: (Mar 2015)

18 Legislation

• A revised code of practice for the Mental Health Act 1983 provides guidance for Professionals; (Jan 2015)
• The Mental Health Act: 2007
• The Mental Capacity Act – Office of the Public Guardian (2005, updated Oct 14)
• The EU’s General Data Protection Regulation (GDPR) will apply from 25 May 2018
• The Health and Safety at Work Act (1974)
• NHS and Community Care Act (1990)
• The Care Act (2014)
• The Children Act (2004)

19 Appendices

• Appendix A - Financial and Resourcing Impact Assessment on Policy Implementation
• Appendix B – Equality Impact Assessment (EIA) Screening Tool
Appendix A

Financial and Resourcing Impact Assessment on Policy Implementation

NB this form must be completed where the introduction of this policy will have either a positive or negative impact on resources. Therefore this form should not be completed where the resources are already deployed and the introduction of this policy will have no further resourcing impact.

<table>
<thead>
<tr>
<th>Document title</th>
<th>Clinical Risk Assessment and Management in Mental &amp; Learning Disability Services Policy</th>
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<td>Within Current Budgets</td>
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<td>Training Staff</td>
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<tr>
<td>Equipment &amp; Provision of resources</td>
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Summary of Impact: Release of 2 staff one day per month to deliver training to all clinical staff within the MH & LD Business Unit.

Risk Management Issues: Being able to release staff to provide the training and attend it.

Benefits / Savings to the organisation: In house training provides “Lessons Learnt” from local SIRI Reviews, sharing good practice and standardisation of clinical practice throughout the Business Unit clinical services.

Equality Impact Assessment

- Has this been appropriately carried out? YES
- Are there any reported equality issues? NO

If “YES” please specify:

Use additional sheets if necessary.

Please include all associated costs where an impact on implementing this policy has been considered. A checklist is included for guidance but is not comprehensive so please ensure you have thought through the impact on staffing, training and equipment carefully and that ALL aspects are covered.

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### Equipment and Provision of Resources

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<tr>
<td>IT Hardware / software / licences</td>
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<tr>
<td>Medical equipment</td>
<td></td>
<td></td>
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<tr>
<td>Stationery / publicity</td>
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<tr>
<td>Travel costs</td>
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<td>Utilities e.g. telephones</td>
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<tr>
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<tr>
<td>Marketing – booklets/posters/handouts, etc.</td>
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**Totals:**

- Capital implications £5,000 with life expectancy of more than one year.

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<td>Signature of appropriate Executive or Associate Director:</td>
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Equality Impact Assessment

This Equality Analysis is a written record that demonstrates that you have shown *due regard* to the need to *eliminate unlawful discrimination*, *advance equality of opportunity* and *foster good relations* with respect to the characteristics protected by the Equality Act 2010.

<table>
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<td>Responsible department</td>
<td>MH&amp;LD</td>
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<tr>
<td>EIA Author</td>
<td>Su Tomkins</td>
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<td>Intended equality outcomes:</td>
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Who was involved in the consultation of this document?

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<td>MH&amp;LD Document Control Group</td>
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<tr>
<td>13/06/2022</td>
<td>Dr Firas Alayash – Consultant Psychiatrist – Lead Reviewer</td>
</tr>
<tr>
<td>13/06/2022</td>
<td>Melanie Smith – Nurse Practitioner – Lead Reviewer</td>
</tr>
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</table>

Please describe the positive and any potential negative impact of the policy on service users or staff.

**In the case of negative impact, please indicate any actions to mitigate against this by completing stage 2.**

Supporting Information can be found by following the link: [www.legislation.gov.uk/ukpga/2010/15/contents](http://www.legislation.gov.uk/ukpga/2010/15/contents)

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<td>Pregnancy &amp; maternity</td>
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Stage 2: Full impact assessment

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