POLICY TITLE: Clinical Risk Assessment and Risk Management

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Policy Owner:	Adrian Cree, Chief Medical Officer
Ratified by:	Colin Quick, Chief Quality Officer
Responsible Signatory:	Adrian Cree, Chief Medical Officer
Outcome:	This policy: • Aims to ensure that service users, staff and anyone visiting the registered premises are assured that all risks connected with the establishment, treatment and services identified, are assessed and managed appropriately
Cross Reference:	H02 Admission, Transfer and Discharge H04 Assessment, Diagnosis and Treatment - Healthcare H11 Consent H26 Prevention of Falls H34 Care Programme Approach and Care and Treatment Planning Wales H37 Prevention and Management of Disturbed/Violent Behaviour H37.2 Banned and Restricted Items H46 Arrangements for Visitors, including Visits by Children H47 Observation & Engagement H48 Suicide Prevention LE03 Data Protection LE06 Confidentiality OP04 Incident Management, Reporting and Investigation OP04.1 Assessment and Control of Ligature Points, Ligatures and other Self Harm Risks OP05 Mental Capacity OP06 Safeguarding Children OP06.1 Child Protection (Scotland) OP08 Safeguarding Adults OP08.1 Responding to Suspected Radicalisation OP08.2 MAPPA OP08.3 Adult Support and Protection (Scotland) OP28 Supervision Priory Health & Safety Manual

EQUALITY AND DIVERSITY STATEMENT

Priory Group is committed to the fair treatment of all in line with the Equality Act 2010. An equality impact assessment has been completed on this policy to ensure that it can be implemented consistently regardless of any protected characteristics and all will be treated with dignity and respect.

CLINICAL RISK ASSESSMENT AND MANAGEMENT

1 PURPOSE

1.1 The purpose of this policy is to provide clinicians with an overview of the Priory Healthcare arrangements for assessing, managing and reducing clinical risk.

1.2 The policy outlines the documentation required for assessing and managing clinical risk and the requirements to complete risk assessments and risk management plans.

1.3 The policy outlines the training associated with the arrangements for assessing, managing and reducing clinical risk.

2 INTRODUCTION

2.1 Risk assessment is the process of informing the management of risk and enables colleagues to meet their responsibility to, as far as possible, ensure the patient's safety and those with whom they have contact.

2.2 It is recognised that there are limitations. Risk can be reduced but cannot be eliminated. The potential for incidents and serious incidents always remains.

2.3 Risk is a dynamic process changing over time in response to a number of factors that include the patient's previous history, their current mental health, the environment, particularly stressful points of transition such as admission, transfer or discharge from the ward. As such it is important to update risk assessments after each significant change in the patient's presentation, this would include responding to any incidents or change in their mental state. By updating the risk assessment, we capture the changes in risk factors and can adapt our management of the patient to reduce the risk to themselves and others.

2.4 NICE guidance published in 2022 (NG225) identifies a number of changes to our approach to risk assessment:

- Do not use risk assessment tools and scales to predict future suicide or repetition of self-harm
- Do not use risk assessment tools and scales to determine who should and should not be offered treatment or who should be discharged.
- Do not use global risk stratification into low, medium or high risk to determine who should be offered treatment or who should be discharged
- Focus the assessment on the person's needs and how to support their immediate and lon-term psychological and physical safety.
- Mental health professionals should undertake a risk formulation as part of every psychosocial assessment.

2.5 Changes have been implemented to the risk assessment process to adhere to the above risk assessment principles applying them to all domains of risk in our CareNotes risk assessment tool. However, we continue to use dedicated tools for the assessment of sexual and physical violence that continue to use low medium high risk and are outside of the scope of the guidance offered in NG225. Examples of this is are the HCR 20 for violence risk and RSVP version 2 and SVR-20 Version 2 for assessment of sexual violence risk.

3 AIMS OF THE POLICY

3.1 To ensure that colleagues:

(a) Understand why clinical risk is assessed.
(b) Understand their responsibility for ensuring that all patients have a current risk assessment and risk management plan.
(c) Are able to complete a risk assessment, develop a formulation and devise a risk management plan.

(d) Know how to recognise and minimise the risk to patients, colleagues, visitors and the public.

4 PRINCIPLES

4.1 Risk assessment is the process of informing the management of risk and enables clinicians to meet their responsibility to, as far as possible, ensure the patient's safety and the safety of those with whom they have contact. The principal aim of this policy is to assist colleagues in ensuring as far as possible the safety and well-being of patients, colleagues, visitors and the public.

4.2 To ensure that effective clinical risk assessments and management plans are completed for all patients:
(a) At admission.
(b) During the course of their care and treatment (whether an inpatient or an outpatient).
(c) In response to any change in clinical presentation and/or any concerns that are identified/raised.
(d) In response to incidents which involve the patient.
(e) Before and after leave from the hospital.
(f) In the event that arrangements are being made for a child to visit an adult patient.
(g) Prior to transfer to another Priory service.
(h) Prior to discharge from Priory Healthcare.

4.3 The clinical risk assessment and management plans will reflect the patient's historical risk and the patient's current risk and will in turn influence the clinical and care interventions for example the level of supportive observations to be delivered or whether leave to the ward garden/courtyard, grounds, or the community is appropriate

4.4 The frequency, severity and pattern of any current and previous aspects of risk are considered when conducting the risk assessment and compiling the risk management plan.

4.5 A sufficient clinical risk assessment and risk management plan will assist in managing and minimising the identified risks.

4.6 The Priory Healthcare clinical risk assessment and management tools must be used for the completion of risk assessments for inpatients (located on the electronic clinical record (CareNotes) and in hard copy (paper) form (the Five Point Risk Assessment (H Form: 128)).

4.7 Risk assessments should not be undertaken in isolation i.e. as much as possible they must involve and take into account the views of the patient, the multi-disciplinary team (MDT), their carers for example their family and stakeholders for example community mental health teams (hereafter referred to as 'carers').

4.7.1 While it is important to complete a risk assessment **within** each MDT meeting, with representation from the various professionals and the patient and carers this is a **minimum** requirement for risk assessment. Outside of this requirement, it is expected that a risk assessment is completed by the senior member of the team as soon as practicable after an incident and definitely before the end of the current shift. The outcome of the risk assessment and any subsequent changes to the care plan (which may include observation levels) should be communicated to the next shift at handover. It is important that any actions generated from the risk assessment are updated in the keeping safe care plan.

4.8 Any changes concerning risk must be clearly communicated to relevant others during shift handovers, at ward round meetings and as required during the course of the patient's care.

5 RESPONSIBILITIES

5.1 The assessment and management of risk is the responsibility of the MDT working within Priory Healthcare. It is not a 'one off' activity but a continuous responsibility and process. Clinical risk assessment works best when everyone, including the patient and their carers, contributes to the process.

5.2 Communication and collaboration at all levels is essential to ensure effective risk assessment and management.

5.3 Induction, supervision, support and training for staff are essential in promoting effective practice. The provision of clinical supervision for all clinical staff enables the identification of specific training needs relating to risk assessment and management, which must be addressed as required by the supervisor in conjunction with their manager as required. (Refer to OP28 Supervision).

6 TRAINING

6.1 All MDT colleagues must be provided with a suitable induction to the service. This must refer to current patient risk and other factors which may influence that risk.

6.2 The Priory Academy modules which are immediately relevant to risk assessment and management and which are required to be undertaken by all MDT colleagues are:
(a) Admission and discharge procedures
(b) Clinical risk assessment.
(c) Observation and engagement.
(d) Suicide prevention/self-harm.
(e) Managing aggression.
(f) Safeguarding modules.
(g) Prevent (identifying potential radicalisation).

7 DEFINITIONS

7.1 **Risk:** Risk is the possibility that an event will occur with negative or harmful outcomes/impact for a particular patient or others with whom the patient comes into contact.

7.2 **Risk assessment:** The process of assessing the possibility of a harmful event occurring, and estimating the likely impact should the event take place. Risk assessment is an assessment of the patient taking into account their past and current presentations and formulating an understanding of that patient.

7.3 **Risk management:** The management strategies and interventions used by practitioners to control and minimise risk. Once the risk is identified, assessed and understood, care plans are developed for the patient, which reduce and manage the risk as much as possible through the delivery of specific interventions.

7.4 **Clinical risk management:** This is the development of a systematic, organised effort to eliminate or reduce the possibility of harm, damage or loss and/or minimise the impact/outcome. Effective efforts are underpinned by high quality communication about risk and clear care plans to address identified risk factors for the patient.

7.5 **Protective factor/mitigating action:** Any circumstance, event, factor or consideration with the capacity to prevent or reduce the severity or likelihood of harm to self or others.

7.6 **Categories of risk:** Requires immediate action, requires attention during stay, requires attention after discharge and not currently a known risk.

7.7 **Requires immediate action:**

This category is where having assessed the patients risk it is concluded that the current identified risk factors are not adequately care planned and the patient needs immediate care planning to manage the risk factors and support the patient.

7.8 **Requires attention during stay**:
This category is where having assessed the patients risk it is concluded that the patient has adequate care plans in place to support the patient and manage the risk. However, it is also recognized that it will take time for therapy, medication, supportive environment and other care planned interventions to further reduce that risk. The key difference to requires immediate action is that the risk assessors conclude that the risk is currently adequately care planned.

7.9 **Requires attention after discharge:**
This category is where risk factors that may not currently be of immediate concern or during the admission have been identified and will need addressing when the patient is ready for discharge. This could include arranging community support from NHS services or carer support on discharge.

7.10 **Not currently a known risk:**
This is where the patient has been assessed by the team and the conclusion is that the patient does not present a risk of one of the risk domains. A patient with no history of illicit drug abuse or prescribed drug misuse and no current behavior suggesting sourcing or using drugs liable to misuse might be considered Not currently a known risk of drug misuse or abuse.

7.11 It is important that for new admissions, where we are still gathering information on the patient and building our clinical picture of them in the ward environment, that caution is expressed in considering them not currently a known risk. Information gathering may be continuing on the patient and this might lead to a re-evaluation of the risk assessment.

7.11.1 If the patient is admitted out of clinical hours and the risk assessment is completed by the duty registered medical officer (RMO) or an on-call clinician, then the patient's team must review the risk assessment at the earliest opportunity on the next working day.

7.12 When referring to the above categories of risk these should be supported by a description that identifies the specific nature of the risk for example:
Example 1: 'X has a history, over three years ago, of cutting his arms when distressed but will when necessary, approach staff when he experiences distressing thoughts and with prompting will implement the coping strategies that he has put in place with his primary nurse' (requires attention during stay)
Example 2: 'Y is experiencing continual command hallucinations telling him to attack his father but is able to resist them by using his coping strategies including discussing with the clinical team when distressed by the hallucinations. However in a less supportive setting he is worried he may not be able to resist the command hallucinations' (Requires attention after discharge)
Example 3: 'Z intends to take her own life, she has a plan by which to do so and will carry out this plan as soon as possible if suitable risk management actions aren't taken'(requires immediate action)

7.13 The recency, severity, frequency, intent and pattern of any previously identified risk behaviours must be considered when conducting any risk assessment and compiling a risk management plan.

7.14 Consideration must be given to any potential or known risk indicators regarding children and young people who may be in contact with the service as a patient, visitor or relative of a patient. This may relate to previous and current safeguarding risks to children, or how the patient's mental illness may affect their parenting capacity.

7.15 Accurate history taking is essential when assessing risk and devising a risk management plan. In order to assess and manage a patient's risk, it may be essential to seek information from a variety of sources. It is not intended that practitioners need to access information from all of the areas outlined below, but to simply refer to areas thought to be of importance (practitioners must remain aware of patient confidentiality):
(a) Family/carer/partner/significant other.
(b) General Practitioner.
(c) Hospitals/Community Mental Health Teams (CMHTs).
(d) Probation Service.
(e) Local police.
(f) Local Authorities (Children's and Adult Service Departments).

8 WHAT NEEDS TO BE DETERMINED BY A RISK ASSESSMENT?

8.1 Key risk related information must be obtained from clinical documentation and from interviews with the patient and others. Past risk behaviours and risk history are a key indicator of current and future risk. It is essential to review past incidents and consider the nature of the incident, specifically and accurately. For example:
(a) What harm was caused?
(b) What were the background circumstances of the incident?
(c) Who experienced harm?
(d) What risk factors were present at the time?

8.2 It is also important to explore what was happening for the patient at the time. At the conclusion of the risk assessment, a clear identification of the risk(s) should be possible, as well as key factors including:

8.3 **Recency** – Where recent incidents have occurred the current risk must be seen as greater than if these were isolated historic incidents. It is vital to review the current situation in the context of the risk history.

8.4 **Immediacy** – It is important to try to establish how immediate the risk is. If there are no current risks, what would change to cause the potential risks to become an actual risk or, if recent risks are no longer current, what has changed to bring this about?

8.5 **Severity** – The more serious the potential consequences of an incident, the more robust the assessor should be in addressing it.

8.6 **Patterns** – The clinician undertaking the assessment should try to identify common patterns that lead to an incident occurring, including anything in the patient's relapse profile or risk history.

8.7 **Intent** – Rather than accepting the actual consequences of the patient's actions, which may not have resulted in actual harm, it is essential to explore his or her intent. For example:
(a) Although an overdose of medication was not lethal, the patient's intention in taking it may have been to end their life.
(b) An individual may have been prevented from harming someone else, or not inflicted significant harm in an assault. However, this should not be presumed to reveal the patient's actual intent, which should still be explored thoroughly. Current intent is one of the strongest indicators of future behavior.

8.8 **Frequency** – Understanding the number of incidents will assist in determining the level of risk.

8.9 **Plan** – The level of forethought and planning by the patient before a risk action is an indicator of both the intent and the broader elements of risk to be managed.

8.10 **Possible protective factors** – The patient should be involved wherever possible, in identifying what might help him/her and what has previously reduced the risk and why. Part of this process is an examination of what individual protective factors might influence any potential risk(s). These will be unique to the individual but may be long standing. Possible protective factors may include:

(a) Patient resilience.
(b) Good problem solving skills.
(c) Future plans/hope for the future.
(d) Strong religious faith or spiritual belief.
(e) A lack of impulsivity and/or the ability to control impulsivity.
(f) Belief that suicide and/or harm to others is wrong.
(g) Family responsibilities, for example, as a parent or carer.
(h) Strong relationship with spouse/partner.
(i) Strong social support.
(j) Relationships and integration within community.
(k) Economic security in older age.
(l) Early identification and appropriate treatment of mental health problems.

This is not an exhaustive list.

9 DEVELOPING A RISK ACTION PLAN

9.1 The risk action plan is part of the risk assessment process . The risk action plan is developed by considering all of the relevant information that has emerged through the process of assessment. The risk action plan should be used to establish the basis of the risk management plan and the interventions that will help to keep the patient safe. It should inform the keeping safe care plan, which should always be reviewed following an updated risk assessment, to ensure the needs of the patient and actions are in line with the most recent risk assessment. It can also involve the keeping well, keeping healthy and keeping connected care plans.

9.2

Box 1: After completion of a risk assessment the clinician should have as clear as possible an understanding of the following:	
Who	Is the patient(s) at risk?
What	Is the specific risk(s) - name each risk identified
When	Is the patient at risk, for example, now? In the future - what would change to increase or minimise the risk? If the patient was assessed as previously being at risk but is not now - **what has changed?**
Where	Would the patient be safe, for example, does the patient need to be in a more restrictive environment or seen more frequently?
Why	Is the patient currently vulnerable to these risks?
How	Collaborative is the patient likely to be with any risk management plan?
WHAT IS THE PLAN TO ADDRESS EACH CURRENT AND POTENTIAL RISK? Has it been documented? Has it been communicated?	

9.3 The starting point in beginning the care planning process is to consider how willing the patient is in collaborating with the clinician. Where possible the patient should co-create their care plans with the clinical team. In this case, the patient's perspective and objectives are taken into account and whether the patient will take responsibility for his or her safety. The MDT will implement the Keeping Safe care plan where responsibility for the individual's safety is assumed by the team in those cases where the patient is not prepared, or able to work with the MDT.

10 PATIENT INVOLVEMENT

10.1 As outlined the patient must, as far as possible, be involved in their own risk assessments and management plans. It is also expected that where possible the completed risk documentation will be shared and discussed with the patient. Recorded evidence that the patient has been involved in the risk assessment process is expected as much as is possible.

10.2 Consideration should be given to early warning signs of relapse. Such alerts should be noted on the risk assessment and associated care plan and a crisis/contingency plan should be formulated to highlight any potential risks of non-engagement and/or non-compliance.

10.3 There will be cases, where it will not be appropriate to share risk assessments and management plans with the patient. Possible reasons for this would be those instances where disclosure would compromise public protection/colleague safety or undermine the mental health of the patient. All decisions around non-disclosure should be taken by the MDT and before any CPA meeting/CTP for Wales and the reasons clearly recorded in the patient's health records.

10.4 Examples of the actions that can be taken to assist in keeping the patient safe include:

a) Increasing the level of supportive observations.
b) Agreeing with the patient that he/she will approach staff in the event that he/she feels at risk.
c) Identifying distraction techniques with the patient that will help soothe and calm.
d) The introduction of safety items for example bedding or clothing in the event of a crisis.
e) Using a diary or journal.
f) Use of medication as required.
g) Restricting leave from the ward.
h) Removing unsafe, often restricted, items in the event that the patient's assessed risk of harm has increased.

11 SAFEGUARDING AND PROTECTING ADULTS/CHILDREN

11.1 Local Authority Children & Family teams, Adult Services and Child and Adult protection teams are the lead agencies with regard to safeguarding and Child and Adult protection matters. Professionals must familiarise themselves with the child and adult safeguarding procedures for their locality together with Priory policies (refer to OP06 Safeguarding Children, OP06.1 Child Protection (Scotland), OP08 Safeguarding Adults, and OP08.3 Adult Support and Protection (Scotland)).

12 INPATIENT RISK ASSESSMENT PROCESS

12.1 **The MDT** - The MDT must complete a risk assessment for every inpatient. Good documentation and comprehensive records will demonstrate that the MDT has made a clinical judgement based on the current evidence available. It is important that the documentation captures the decision-making and rationale in relation to risk and due consideration has been given to any safeguarding factors.

12.2 A risk assessment should be completed by the MDT **before** any decisions are made in the MDT meeting. The risk assessment should have a consensus of agreement by the members of the MDT and any disagreement discussed. Risk assessment **informs** decision-making, it cannot occur after the decision making process.

12.3 Contributing to risk assessment and risk management is the responsibility of all clinical staff. The on-going risk management of patients requires frequent and timely reviews, relevant and the gathering of relevant information and robust communication.

12.4 When conducting risk assessments, clinicians need to seek information that they do not have. Clinicians should not shy away from asking difficult questions. There is no evidence that asking a patient whether they are having suicidal thoughts will put the thought into their mind if it were not there before. There is, however evidence to indicate that talking to

patients sensitively about suicide is extremely important in providing a safe space for them to explore and manage their feelings.

12.5 As a minimum, all patients in acute hospitals (services in acute hospitals include acute, PICU, CAMHS, Addiction, Eating Disorders and Personality Disorder Services) will have a Priory risk assessment in place. Patients in Forensic Services will have at least a monthly review of their risk assessment, but more often if indicated and patients in Rehabilitation and Recovery Services will have a risk assessment updated every three months as a minimum, but more regularly if indicated.

12.6 The first risk assessment must be completed after the patient has been assessed by the admitting nurse and doctor. If this occurs out of hours, this must be reviewed at the earliest opportunity on the next working day, by the patient's team. The first risk assessment should not conclude a patient is low risk until sufficient information is gathered and reviewed by the clinical team. Decisions relating to the patient in terms of observations, access to restricted items, or leave, need to take into account the higher risk until sufficient information on the patient and there has been a sufficient accumulation and consideration of observational intelligence. This should not lead to blanket restrictions and the least restrictive principle can still be followed for each patient. However, decisions should be based on a medium to high risk at the start of the admission until more information is available and the risk is re-evaluated.

12.5 Each ward needs to ensure that it has systems to communicate the current risk and any changes of risk of each patient to all staff. These systems will invariably include handover meetings, MDT ward rounds, safety huddles and ad-hoc meetings.

12.6 Risk levels and the monitoring of risk must be communicated at all shift changes, ward rounds, before and after therapy, and when there is changeover of any sort including from one member of staff to another when delivering observations. This will ensure that all relevant staff are aware of risk factors.

12.6.1 The risk assessment must reflect the patient's <u>current</u> level of risk, observation and risk management requirements.

12.7 The risk assessment and risk action plan is completed and reviewed and where necessary updated for all inpatients:

(a) At the time of admission.
(b) At each multi-disciplinary team review.
(c) As a minimum every seven days.
(d) Where consideration is being given to a significant intervention for example a first period of leave away from the hospital.
(e) Where necessary following leave for example in the event of an early return and/or where concerns have been raised while the patient has been on leave.
(f) In the event that new or previously unknown risks are identified.
(g) Where there is to be a visit from a child to an adult patient.
(h) During a CPA/CTP review meeting with the patient.
(i) In response to a serious incident or a cluster of low-level incidents.
(j) Where there is evidence that the patient may be researching the means to harm themselves or others for example discussing this with hospital staff, their peers or their family, or where there is evidence of the harmful use of the internet.
(k) Where there is a serious incident involving one patient which has the potential for other patients to copy or imitate the incident.
(l) Where the patient receives bad news for example a family bereavement.
(m) Prior to transfer or discharge from Priory Healthcare inpatient services. This must accord with Policy H02 Admission, Transfer and Discharge.

12.8 The patient is re-assessed immediately before periods of leave and on returning from leave The Five Point Risk Assessment (H Form 128) must be used for this purpose.

12.9 The Five Point Risk Assessment must be completed for any inpatient on **all** wards excluding brain injury services. Note that this includes private wards. The Fie Point Risk Assessment is completed for any patient having escorted/unescorted leave, for the first leave of the day. This includes all leave to therapy units, dining rooms and other buildings in the grounds. Each unit must have a local procedure, to ensure that patients who have unescorted leave that are attending dining rooms/therapy units etc. in the grounds, have arrived at the expected time. The procedure must refer to how colleagues are alerted in the event that a patient leaves a therapy group prematurely.

12.10 The risk assessment must be documented and reflect current information in respect of the patient's mental and physical health, also taking into account any historical risk factors, the risks associated with the environment, contact with certain individuals and particular items for example banned and restricted items and ligatures which the patient may have access to.

12.11 Consideration must be given to removing and returning restricted items during the course of the risk assessment process. Items that have been returned to the patient or removed from the patient must be identified and listed.

12.12 In the event of a risk assessment determining that risk is increasing for the patient, then consideration by colleagues must in the first instance, be to increase the level of supportive observations and identify, and where necessary, remove items (not only the listed restricted items) that have the potential to cause harm.

12.13 The risk assessment must reflect the patient's **current** risk, observation and risk management requirements.

12.14 All identified risks should be clearly tracked through to the Keeping Safe care plan with an action against each risk identified and these should clearly feed through to the care plans in place for that patient. Please refer to Section 13 for detail on completing Care Plans.

12.15 The completion of the risk assessment and associated Keeping Safe care plan for patients must reflect the overall view of the MDT and their approach and management of the patient concerning the level of observation.

12.16 For those patients under the CPA/CTP, risk assessment and management must be viewed as an integral part of the CPA/CTP process.

12.17 Observation and engagement is a key aspect of the risk assessment process These documented observations then become central to regular risk assessment reviews. The assessment of a patient's risk is based on the information collated by staff whilst observing and engaging with the patient. Changes in the patient's mood and behaviour must be recorded in CareNotes. The better the quality of the information, the more accurate the risk assessment will be.

12.18 The patient is monitored throughout their stay and care plans are adjusted to take account of changing circumstances.

12.19 Clinicians should be aware of, and make use of existing risk management forums in their working area. Risk management forum can be convened that involves representatives from the hospital senior management team and chaired by one of them (the Medical Director should always be involved) and clinicians (including the senior consultant psychiatrist from the relevant service line). The quality improvement lead, professional network leads and/or other stakeholders external to the hospital for example a local authority safeguarding lead, case manager/commissioner, etc. may also be invited if it is a particularly complex case. This is not an exhaustive list. This would include patients on Level 3 and 4 observations for more than a month or multiple episodes of Level 3 and 4 observations. The purpose is to

convene key stakeholders to agree an effective risk management plan and share clinical risk at a senior management level. Any such meetings should be minuted and a summary made in the patient's clinical record.

12.20 The use of the clinical risk assessment/management tools will be subject to audit by the hospital management team and the Healthcare Quality Team.

13 INPATIENT CARE PLANS

13.1 The inpatient care plans will be based, as required, on the outcome of the risk assessment and risk formulation. The care plan will identify the ways in which the patient will be assisted to maintain and improve their safety, health and well-being.

13.2 **A patient perspective** - The care plans must be written from the patient's perspective, for example, the patient's agreement to interventions should ideally be written using the first person and reflecting the way in which the patient perceives his or her situation for example 'I am thinking about killing myself because I see no hope for the future'. If this is not possible, this can be reflected in the problem statement of a care plan. For example 'William intends to kill himself and is unable to work with the staff team on a care plan to help keep him safe'.

13.3 Written style - The care plans must be understandable to colleagues and to the patient for example without jargon and/or technical terms and written in the language, style or method that makes sense to them.

13.4 Each care plan must include:
(a) A statement in relation to the patient's need (this includes risk areas identified).
(b) An objective to address the need.
(c) Interventions to achieve the objective.
(d) An evaluation date.

14 OUTPATIENTS

14.1 All GP letters must highlight any risks. Initial assessments must include a historical risk assessment as well as detailing current risks. Subsequent follow-up letters should detail changes to risks, including risks to themselves, others (if applicable), safeguarding, non-compliance with treatment or other relevant risks. The treatment plan in the letter must then cover any risks identified. It is important that the GP letter includes any identified risk areas that need to be managed in the community and what resources might help reduce the risk.

15 DAY UNITS/THERAPY UNITS

15.1 Patients attending the day/therapy unit are to have risk assessments undertaken by the member of the team allocated to carry out the assessment following referral to the unit, if the individual does not have a pre-existing risk assessment/management plan in place. If there is a pre-existing risk assessment/management plan, the opportunity should be taken to review it.

16 PATIENTS IN FORENSIC SERVICES

16.1 Priory Forensic sites care for mentally disordered offenders and others who require Forensic care. When risk assessing forensic patients a more comprehensive tool is used initially (for example START, HCR-20) which is specifically fitting to the patient group, however the standard Priory assessment tools can also be used. The use of other risk assessment tools provides a more in depth assessment and therefore added protection of all concerned whilst improving the care planning, treatment and management of patients. **It is essential that there is a current risk assessment and risk management plan to take into account**

the specific risk factors and circumstances related to the patient's current care and treatment on the ward.

16.2 Forensic service risk assessment and management is a multi-agency care process that takes a structured partnership approach to risk assessment, seeking input from all agencies involved in the patient's welfare. It can be integrated into standard care management and the care programme approach/CTP for Wales. Structured professional approaches to risk assessment (for example HCR-20) place particular emphasis on multi-disciplinary collaboration and guide risk management.

16.3 **Patient/Carer Involvement -** Copies of the completed risk assessment/management tool will be sent to all those invited to a patient's CPA /CTP meeting, including the patient and their carer after the meeting has finished. In exceptional cases and with the agreement of at least two practitioners (when it is considered detrimental to the patient and/or carer) this will not occur, and the reasons for this should be recorded on the risk management plan, and in the patient's Health Record. It is acknowledged that in some circumstances, the patient might not agree with or choose to partially accept the CPA/CTP for Wales plan; this may also be the case regarding the risk management plan.

16.4 Following a recent remand in custody, prison establishments may have a significant amount of risk information about an individual. Key contacts include staff working in hospital/medical wings, psychology and probation departments.

16.5 Similarly, any patient returning to prison from a Priory hospital must have any risk concerns communicated to the appropriate prison staff. Recent Home Office guidance requires an s.117 meeting prior to certain transfers back to custody

17 WORKING WITH CARERS, FAMILIES AND SIGNIFICANT OTHERS

17.1 Working constructively with carers and families is an essential part of the risk assessment and risk management process.[1] If families or friends are concerned that someone may be at risk it is important that they are able to voice their concerns and that these will be fully considered during the assessment process. It has been widely recognised in many serious inquiries that carer and family concerns were not given sufficient credibility nor warnings from them heeded by clinical teams. Similarly, it is essential to furnish the family and carers with advice on how assistance can be sought in the event of a crisis following hospital discharge or during periods of leave from the hospital.

17.2 It should be routine practice to establish as early as possible what information, if any, the patient is willing to share with relatives and/or carers.

17.3 Concerns about 'breaking confidentiality' can also pose a problem to clinicians when trying to support families. As stated earlier, maintaining patient confidentiality is paramount. However, supporting families by providing general advice does not break confidentiality, as is shown in the examples below:
Example 1: 'I can't speak to you about your daughter without her permission, but I can tell you if someone has a condition such as you've described, these are the symptoms to look out for…'
Example 2: 'If you're worried about someone experiencing this, or maybe beginning to experience this, then please call the team on this number...'

18 POSITIVE RISK MANAGEMENT

[1] It should be remembered that family members are often the main carers. If carers and/or family members have a role in any risk management plan, it is important that they have agreed to this and their role is clear to everyone, including the service user. This should be documented in the risk management plan and all relevant parties should have a copy of this plan.

18.1 Positive risk management can only take place in the context of a robust risk assessment and risk management plan, taking into account advance directives (where these are in place), an exploration of 'what if?' scenarios and contingency plans. It is reliant upon having developed, with the patient, a shared understanding of the potential risks to the patient of their own behaviours, and the drivers for these behaviours. It involves balancing the negative consequences of these risk behaviours, were they carried out, with the positive benefits of the use of agreed, adaptive coping mechanisms to combat them. Focussing on the strengths of the patient and their social network, it offers the opportunity for the patient to drive her/his own recovery with others' help.

18.2 Positive risk management should have been agreed within the MDT and the clinician(s) working directly with the patient should also be receiving consistent and regular supervision which allows the opportunity to discuss and reflect on potential decisions that can allow 'reality checks' on what is safe, what is possible and what actual risks are being addressed, and how. (See box 2).

18.3 The underlying principles of positive risk management is that clinical decisions should always be defensible rather than defensive, in the best interests of the patient and seeking to provide the least restrictive options in terms of their care. It has to be acknowledged that there are inherent risks in this, for example, granting someone leave from the ward when they have previously been expressing ideas of self-harm but are now providing assurances of how they can manage these and not act upon them.

Box 2: A checklist for teams and patients when working with positive risk management

1. Are you clear about the patient's experiences and understanding of risk?
2. Are you clear about the carer experiences and understanding of risk (primarily, are they happy that the particular risks to be taken and any responsibility that may be placed upon them?
3. Have you clearly defined potential risks and their context?
4. Has there been a clear articulation of the desired outcomes?
5. Has there been a clear identification of strengths and coping mechanisms?
6. Is everyone clear about the planned stages for risk-taking?
7. Has there been an estimate of potential pitfalls and estimated likelihood?
8. What potential safety nets are in place, including identification of early warning signs linked to a crisis and contingency plan?
9. Have you and the patient explored the 'what if' scenarios?
10. What was the outcome of previous attempt(s) at this course of action?
11. How was it managed, and what will now be done differently?
12. What needs to, and can, change?
13. How will progress be monitored?
14. Who agrees to the approach (and who disagrees?)
15. When will it be reviewed?

19 REFERENCES AND BIBLIOGRAPHY

19.1 Legislation

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20 ASSOCIATED FORMS

20.1

H Form 11A	Transfer and Discharge Information Checklist
H Form: 12	Avoidance of Falls Assessment
H Form: 64	Transport Risk Assessment for Wheelchairs
H Form: 128	Five Point Risk Assessment - Leave Signing In and Out Form
HG 12	Guidance for the completion of the 5-Point Risk Assessment - Leave signing in and out form
OP Form 24	Swallowing Difficulties Risk Assessment

21 APPENDICES

21.1 **Appendix 1** - Table 1: Clinical risk indicators for suicide and Table 2 Groups with the highest risk of suicide (Eales 2006)
Appendix 2 - Box 6: 20 essential things to find out from the assessment of self-harm and/or suicide
Appendix 3 - Table 3: Risk factors in aggression and/or violence
Appendix 4 - Box 8: 20 essential things to find out from the assessment of dangerousness to others

APPENDIX 1

Table 1: Clinical risk indicators for suicide	
Historical	**Cognitive**
Previous self-harm	Current suicidal thoughts/ideation
Family history of suicide	Severe psychic anxiety
Previous use of violent methods	Suicide plan
Physical	Belief of no control over self/events
Chronic physical illness/pain	Behaviour
Emotions	Disengaged from services
Hopelessness/helplessness	Poor adherence to psychiatric treatment
Diagnosis	Access/willingness to use lethal means
Depression	Social
Post-natal depression	Unemployed/retired
Alcohol and/or drug misuse	Separated/widowed/divorced
Psychosis	Family concerned about risk
Puerperal psychosis	Lack of social support
Emotionally unstable personality disorder	Reduced contact with family and home environment
Verbal	Other
Expressed intent	
Expressed plans	Discharged from hospital within last 14 days

Adapted from Morgan (2000)

Table 2: Groups with the highest risk of suicide (Eales 2006)	
Group	Increased risk against the general population
Mental health patients within four weeks following discharge from hospital	x 100 - 200
People with a history of self-harm	x 10 - 30
People misusing drugs	x 10 – 20
People misusing alcohol	x 5 – 20
Offenders serving non-custodial sentences	x 8 – 13
Current or ex mental health patients	x 10
Offenders serving a custodial sentence	x 9 - 10

APPENDIX 2

Box 6: 20 essential things to find out from the assessment of self-harm and/or suicide
1. Why now? 2. What were the precipitants? 3. What protective factors had prevented it until now? 4. What changed? 5. Were there specific mental health related issues for example depression, command hallucinations? 6. Was the patient influenced by anyone else's actions? 7. Was it premeditated, impulsive, or spontaneous? 8. If it was premeditated, how much planning was involved? 9. Did the patient provide any 'warnings' beforehand? 10. What stopped the attempt for example did the patient stop of her/his own volition or due to external causes? 11. Were the means used for example tablets, acquired for this specific attempt? 12. What was the patient's intention for example to die, escape from an intolerable situation? 13. What did the patient think might happen as a consequence of their attempt? 14. How did the patient think other people might have responded? 15. Was the attempt itself controlled or was there a loss of control? 16. What did the patient do after the attempt? 17. How was he found? 18. How does the patient feel now they have survived? 19. Would they make a further attempt? 20. How does the patient see their future? **THIS IS NOT AN EXHAUSTIVE LIST**

APPENDIX 3

Table 3: Risk factors in aggression and/or violence	
Historical	**Verbal**
Previous incidents of violence	Denial of previous dangerous acts
Previous use of weapons	Expressing intent to harm others
Previous dangerous impulsive acts	Increased volume of speech
Previous admissions to Forensic settings	Describing angry and/or uncontrollable feelings
Known patient trigger factors	Making threats
Physical	**Cognitive**
Increased physical arousal	Ruminating on angry feelings and events
Exaggerated reactions	Preoccupation with violent fantasy
Invasion of body space	Suspicious and/or perceives threat from others
Sexually inappropriate behaviour	**Specific symptoms**
Facial tension	Violent command hallucinations
Emotions	Paranoid delusions about others
Anger and/or hostility	Morbid jealousy
Frustration	Passivity
Suspicion	**Mental health diagnosis**
Other	Psychosis
Male gender, under 35 years of age	Patient disorder
Major life events	Dementia
Unstable living arrangements	Organic brain injury
Recent discontinuation of, or non-compliance with, medication	**Misuse of drugs and/or alcohol**
Non-attendance of appointments	**Autism/Asperger's syndrome plus complex needs**

APPENDIX 4

Box 8: 20 essential things to find out from the assessment of dangerousness to others

1. Why now?
2. What might trigger any violence?
3. What protective factors have prevented it until now?
4. What would change for those protective factors not to work?
5. Are there specific mental health related issues for example psychosis, command hallucinations?
6. Is the patient influenced by anyone else's actions for example peers, other Patients?
7. What does the patient intend for example to kill the victim, hurt them, 'get rid' of their own intolerable feelings?
8. If it is premeditated, how much planning is involved?
9. Would the patient provide any 'warnings' beforehand?
10. Does the patient habitually carry weapons or would they acquire something for this specific attempt?

If there has been violence:

1. Was it premeditated or impulsive or spontaneous?
2. What stopped the assault for example did the patient stop of her/his own volition or due to external causes?
3. Was the violence controlled or was there a loss of control?
4. Was there any element of sadism or torture?
5. What did the patient do after the assault?
6. How was he caught?
7. Did he admit to the violence?
8. How does the patient feel about the violence now?
9. Would he do anything similar again?
10. How does the patient see their future?

THIS IS NOT AN EXHAUSTIVE LIST