ASSESSMENT AND MANAGEMENT OF CLINICAL RISK

1. BACKGROUND

PiC recognises that, whilst the majority of people suffering from mental disorder do not constitute a major risk to themselves or others, a patient group who require assessment and treatment in conditions of security may pose significantly higher risks both in the short and long-term.

PiC recognises the duty of care to patients / residents, staff and the public by providing a safe physical environment, appropriate staffing levels and skill mix together with procedures to recognise and manage risk factors in individual cases.

Patients may only be admitted to a PiC hospital within the registration framework. Therefore patients can only be admitted under the category of mental disorders for which the hospital is registered.

The assessment and management of risk is in an essential and fundamental part of the treatment and care provided by PiC. Accurate risk assessments and effective risk management are important components of the care pathway, ensuring that patient care is delivered in the appropriate environment and that their transition through the levels of security occurs at the appropriate pace, serving the best interest of the patient, whilst ensuring the protection of the public.

The Department of Health in England published a document titled Best Practice in Managing Risk in June 2007, which defines 16 best practice principles for effective risk assessment and management. The PiC Clinical Risk Policy has been designed to meet these best practice points.

This policy details how PiC meets each of the sixteen best practice principles set out by the Department of Health.

2. SCOPE

This policy applies to all PiC hospitals / units.

This policy should be implemented within the context of the PiC Values:

- Valuing people – respecting our staff, patients, their families and communities
- Caring safely – for ourselves, our patients, our customers and communities
- Working together with everyone
- Uncompromising integrity, respect and honesty
- Taking quality to the highest level

3. INTRODUCTION

By definition patients placed in conditions of security pose a greater risk to themselves and others than the general psychiatric population. Many of our patients have committed serious offences in the past and may themselves be vulnerable to varying forms of abuse. This policy considers the assessment of risk and its management to be a dynamic process starting at the point of referral to a PiC service, occurring throughout a patient / resident's stay and continuing after discharge.

Risk does not rest just in the individual but in the interaction between the individual and their environment in its widest sense. This policy also draws upon the work of the National Patient Safety Agency (NPSA), and the "Seven Steps to Patient Safety" which clearly identifies the responsibility of all staff to "Build a Safety Culture". This can be viewed at: http://www.npsa.nhs.uk/patientsafety/improvingpatientsafety/7steps/

There is no such thing as a "risk assessment" in isolation. What is assessed is a particular type of risk, over a particular period of time, and in a particular environment. The risk assessment should facilitate a management plan as to how this risk can hopefully be modified by specific interventions. These plans are then implemented and evaluated.

4. STATEMENTS OF PRINCIPLE

The assessment and management of risk is a shared responsibility that equally values the contribution of all disciplines, clinical and operational. Risk management in all its aspects is an ongoing and evolving process.

This process clearly works well where the patient is well known and risk assessment and management is being carried out as part of ward / house review meetings, discharge planning meetings and at CPA reviews.

Clinical risk assessment is not a one off activity; it informs all work with the patient / resident; from the point that they are first assessed with a view to admission, to the communications that are had with the Community Team when the patient / resident is discharged.

All Senior Managers have a responsibility to provide training in both the theory and practice of clinical risk assessment and management and to develop a culture of 'risk awareness'. This again builds on the work of the NPSA, and the "Seven Steps to Patient Safety" which clearly identifies training and leadership as essential elements of managing safety".

Those participating in risk assessments should have sufficient experience and skill to carry them out. Newly qualified practitioners in any discipline should not conduct unsupervised risk assessments.

Formulation of risk is where the assessor documents the interplaying factors that might lead to a harmful occurrence, and those factors which might mediate the likelihood of harm occurring or not.

In circumstances where the RC decides that it is not appropriate to share a risk with the patient (for example management plans to prevent the risk of Hostage taking) the 'Access to Health Records Act' (1990) applies.

Good risk assessment and management allows the coordinated planning of risk reduction interventions in conjunction with other therapeutic care, to ensure the patient progresses through their care pathway without unnecessary delays.

5. GOVERNANCE

PiC maintains close links with national and international researchers in the risk domain. This policy and risk assessment tools are regularly assessed by the Clinical Governance Group to ensure the most effective tools are used in the assessment and management of risk. These assess a patient's strengths as well as their vulnerabilities and provide an equal balance in the consideration of both protective factors and risk factors to assist the MDT and the patient in developing an appropriate care pathway to achieve recovery.

PiC has implemented the Short Terms Assessment of Risk and Treatability (START) and HCR-20 for all patient groups. START considers 20 dynamic items of a patient's functioning, each weighed equally in terms of strength and vulnerability. The HCR-20 is also a structured clinical judgement tool that focuses on the risk of long term violence and recidivism.

The Wales Applied Risk Research Network (WARRN) is a network that aims to improve training and standards in risk assessment and risk management across all sectors in Wales. It was established in collaboration with Welsh Government in response to a series of homicide enquiries. WARRN risk assessment is now used in all Health Boards in Wales covering mental health, forensic services and CAMHS services along with their associated Local Authorities.

WARRN is an organisation that supports Health and Social Care professionals to improve their knowledge, skills, and implementation of risk assessment, risk formulation and risk management. It achieves this by:

- Providing skills-based training to ensure a robust and consistent approach to risk assessment and risk management across a range of areas (e.g. violence, suicide, sexual harm).
- Training in effective techniques for risk management planning.
- Increasing staff confidence in asking 'difficult questions' in relation to risk.
- Ensuring an emphasis on utilising a formulation based approach to risk assessment and risk management.
- Training on diversity and process issues and how these can inadvertently impact on clinical judgment about risk.
- Assistance for staff to use a common language, common documentation, and common risk pathways for patients within the service.
- Promoting a multi-disciplinary approach to risk assessment with an emphasis on communication, dissemination, and the sharing of risk management plans both within organisations and across agencies.

- Dissemination of good practice in relation to the skills and techniques underpinning risk assessment and risk formulation.
- Providing 'Train the Trainer' courses that allow nominated individuals to cascade training throughout their organisation.

WARRN risk assessment is designed to be a straightforward and simple approach to risk assessment that can be used for all patients, irrespective of the presence or absence of risks or the type of risk (e.g. suicide, violence, neglect, exploitation). If risks are identified using WARRN they can be investigated and documented using the WARRN approach and risk management plans designed while Structured Professional Judgment risk tools (e.g. HCR-20, Risk of Suicide Protocol) are worked upon and developed.

The emphasis of WARRN is for all staff to have good skills in risk assessment and risk management and to be able to appropriately document and communicate risk-related information. WARRN's philosophy is that all staff need to have the skills to be able to identify risk and develop effective risk management strategies and that this task should not be the sole domain of 'expert' risk assessors.

Risk management is a standing agenda item for clinical governance groups at all levels of the organisation.

Each hospital has an identified person / Group to coordinate the implementation of new risk tools, including the training of staff and education of patients. This person / group also has responsibility for monitoring local standards of risk assessment through regular audit.

Risk management is part of the care programme approach (CPA) and should be closely aligned with it. The CPA meeting will ensure that plans are drawn up to meet all the patient's needs including those relating to risk. This will be recorded by the MDT in the CPA document, creating a record of management plans addressing elements of risks to both self and others.

The MDT will utilise the Mental Health Act appropriately when managing the patient. At times, this may require intervening without the patient's consent. The use of the Mental Health Act does not remove the need for discussion with the patient and all efforts are to be made to maximise the patient's autonomy as much as possible within the restrictions. A good knowledge of the Mental Health Act, its associated code of practice and associated memorandum is essential to good risk management in mental health.

Each risk tool has an identified member of the MDT who is responsible for completing this. However this only occurs after discussion in a Risk Planning Meeting attended by all members of the MDT.

6. WORKING WITH SERVICE USERS AND CARERS

Patient participation requires a degree of preparation involving patient education, staff training and innovation in relation to the way risk is communicated. MDT's will take

this into consideration when working with patients on risk assessments and management plans.

The MDT will focus on social inclusion being one of the goals of the risk management planning process and support the patient in achieving this.

The MDT will work closely with the patient during the risk assessment process to identify strengths and what is likely to work. Close attention must be paid to the views of carers and others around the patient when deciding a plan of action

Accurate and effective risk assessment and management can help to decrease stigma by improving the patients' understanding of risk and its function in their recovery. The MDT will avoid unnecessary exclusion by carefully linking risk assessment to risk management.

When the MDT identifies vulnerability in a patient a strategy will be developed to support the patient, building on their positive skills. The emphasis will be on the recovery approach and on the next stage in developing the patient's ability to cope when feeling vulnerable or having difficult demands placed on them.

Through regular reassessment the MDT provides opportunities for information sharing with the patient, their carer and can establish a forum in which risk assessment can be openly discussed.

MDT's should be aware that clinical judgement is based on perceptions that can be biased without the practitioner being aware. Staff training ensures that all staff involved in risk assessments are capable of demonstrating an appropriate level of cultural sensitivity and competence. This competence applies to diversity in terms of race, faith, age, gender, disability and sexual orientation.

7. MDT WORKING

Risk factors may be static (e.g. age of first offence) or changeable (dynamic) (e.g. current compliance with medication). Interventions to reduce risk or adverse outcomes need to be focused on the dynamic factors.

The MDT will utilise a consensus model of decision making when applying clinical judgement.

Positive risk management means that risk can never be completely eliminated and that management plans inevitably have to include decisions carrying some risks. The MDT needs to be mindful of the fact that taking a decision involving an element of risk may be a necessary part of the patient's risk management, because the potential positive benefits may outweigh the risk.
The MDT must ensure that the patient, carer and others who might be affected are fully informed of risk based decisions, the reasons for them and the associated plans.

The MDT will weigh up the potential benefits and harm of choosing one action plan over another and will develop plans that support the positive potentials and priorities

identified by the patient, whilst minimising the risk to the patient or others.

The MDT will use all available resources and support to achieve a balance between a focus on achieving the desired outcomes whilst minimising the potential harmful outcomes.

8. THE RISK ASSESSMENT PATHWAY

Risk management planning by the MDT follows the risk management planning cycle. This involves risk assessment leading to risk formulation, developing risk scenarios, each with a specific risk management plan. These plans identify the monitoring, treatment and supervision requirements to minimise the risk of each specific risk scenario. This process will continually be reviewed and updated by the MDT throughout the patients' care pathway.

The MDT gather information on each patient from the point of referral to ensure that there is a rapid collation of information from multiple domains, including medical, social, psychological, occupational functioning and nursing to develop an accurate knowledge of the individual patient and their social context.

The MDT uses a recovery ethos and My Shared Care Pathway to ensure that the patient is at the centre of their care and that the focus is on gaining knowledge of the patients' own experience.

MDT's will use the HCR-20, START and WARRN risk tools to allow for the consideration of a broad range of risk domains and for scenario planning in the short, medium and long term.

Patients may have a WARRN and START assessment completed during the pre-admission assessment if thought useful and this would be reviewed within the first 7 days of admission. This will be reviewed again at MDT and CPA meetings, prior to facilitating leave and at other times through the care pathway dependent on individual patient need. Where a START assessment is not completed pre-admission this will be completed within 7 days of admission.

All patients will have a completed HCR-20 within the first 12 weeks of admission. This will be reviewed as a minimum every 6 months. This is a structured clinical judgement tool that focuses on the risk of violence.

9. RISK COMMUNICATION

MDT's will clearly communicate, and where necessary educate, to ensure that care teams and patients have a clear understanding of what risk they are assessing and why there are carrying out a risk assessment.

Risk communication is an essential component of risk management. The MDT will utilise the CPA meeting to communicate current risk assessment and risk management plans to the patient and representatives of the funders and locality team.

At the point of transfer to the patient's local services, a CPA meeting will be used to handover the patient's detailed risk assessment and management plans to facilitate a safe and effective transfer process.

Section 117 of the Mental Health Act 1983 gives Health Authorities and Social Service Departments a responsibility to have comprehensive after-care plans that meets patient needs. All Section 117 after-care plans must include risk assessment and management plans aimed at reducing the likelihood of potential risks being translated into an adverse outcome following the patient being discharged to the community.

The Ministry of Justice has its own set of risk assessment questions for restricted patients which it requires answering before granting leave, conditional or absolute discharge. Copies of these documents are supplied to the RCs, who are responsible for completing them.

The MDT will prepare risk management plans if a patient is being transferred or returned to prison or transferred to another hospital. In addition the MDT should not assume that the patient, returned to court without a recommendation for a medical disposal, will automatically be sent to prison and a risk management plan to cover the patient's potential release from court into the community should be drawn up.