SOUTH ESSEX PARTNERSHIP NHS TRUST

CLINICAL RISK ASSESSMENT AND MANAGEMENT

Controls Assurance Statement

This Policy is required in order to ensure that all staff assesses those factors, clinical, resource and environmental which are likely to affect our ability to clinically manage the patients in our care.

1.0 Policy Statement

1.1 The policy aims to outline the mental health service's approach to the minimisation and prevention of adverse events resulting from risks associated with clinical care.

1.2 The following factors are specific to Mental Health Services:

1.2.1 the risk of self harm
1.2.2 the risk of harm to or from others
1.2.3 adverse consequences of treatment and physical injury
1.2.4 risk of self-neglect.
1.2.5 risk of absconding from in-patient services.

1.3 Other factors may be considered as adverse incidents, which may or may not have an impact on clinical risk:

1.3.1 system failures
1.3.2 expedient action
1.3.3 communication breakdown
1.3.4 ill defined responsibilities
1.3.5 poor inter-agency working
1.3.6 cover up
1.3.7 non-availability of resources.

1.4 The following are contributory factors highlighted in connection with self-harm or suicide:

1.4.1 failure to monitor patients
1.4.2 failure to remove dangerous objects
1.4.3 failure to use a locked ward
1.4.4 failure to supervise staff
1.4.5 failure to obtain past records

1.4.6 poor communications between staff
1.4.7 failure to treat psychiatric disorders adequately
1.4.8 negligent discharge.
1.4.9 previous history of absconding or potential to abscond

2.0 Minimising Risk

2.1 In order to minimise risk; the following mental health standards will be implemented. These will include standards set by Clinical Negligence Scheme for Trusts, Royal College of Psychiatrists, United Kingdom Central Council for Nursing and Midwifery.

2.2 All staff will receive an induction program and will be briefed on appropriate procedures. Individuals will be required to sign to confirm that these areas have been covered in their induction.

2.2.1 clinical policies
2.2.2 record keeping policies
2.2.3 agreed clinical protocol for ECT.

2.3 Clear lines of responsibilities for administrative maintenance of medical records, including filing of reports and records of treatment.

2.4 CPA and Supervision Register will be adequately documented and systems will be in place to ensure easy 24-hour availability of information to all clinical staff (as per CLP30 - CPA).

2.5 There will be a clear understanding at the interface between health and social care. It is essential that care plans record the responsible agency and individual in the provision of agreed intervention.

2.6 There will be an agreed referral process between GPs, community health care workers/CMHTs as per Service Operational Policy.

2.7 There will be a handover of care led by the nurse in charge between shifts (inpatient service), based on the current care plan. This handover should include all relevant members of the Ward MDT.

2.8 Clinical workloads of nurses will be monitored both impatient and community by the Ward/Team Manager and issues of concern highlighted and actioned in individual staff supervision notes.

2.9 A comprehensive and effective assessment of those patients presenting increased risk of harm will receive highest priority for allocation of resources.

2.10 A safe environment with adequate facilities will be provided for assessment and management of clinical risk in the individual patient care. It is recommended that all clinical areas designate a room for this purpose.

2.11 Qualified staff will make a systematic assessment of clinical risk in the care of the individual patient (as outlined in Section 3).

2.12 Clinical risk minimisation training will be made available to all staff and is compulsory to all qualified clinical staff.

2.13 Staffing levels will be monitored by the nurse in charge on a daily basis to fulfil observation requirements as they arise, in line with the CLP8 Formal Observation Policy. Inadequacies will be notified to the Site Officer and/or Team Manager.

2.14 As a minimum, at least one audit per year will take place to review practice and procedure and will include monitoring of the following policies:

Control & Restraint
Management Violence
Confidentiality
Observation Policy
Holding Powers (MHA)
Administration of Medication
Discharge Protocols
Assessment and Admission protocols
Absent Without Leave/Missing Patients

3.0 Assessing Risk

All patients will be assessed for risk. A standard psychiatric assessment will be completed and will include the following: -

3.1 History

3.2 Previous violence or suicidal behaviour.

3.3 Evidence of transitory behaviour or social restlessness eg, few relationships, frequent changes of address and/or employment.

3.4 Evidence of poor compliance to treatment and disengagement from psychiatric after care.

3.5 Evidence of actual or potential substance abuse/misuse.

3.6 Identification of any precipitants and any changes in mental state or behaviour that occurred prior to violence or relapse.

3.7 Evidence of recent severe stress, loss events or threat of loss, e.g. death in the family.

3.8 Evidence of recent discontinuation of medication, a change in medication or noncompliance.

3.9 Evidence of physical health risks, eg, refusing to eat, allergies, frailty, and mobility.

3.10 Mental State

3.11 Evidence of threatening behaviour and delusions/hallucinations of a persecutory nature.

3.12 Emotions related to violence for example irritability, anger, hostility, and suspiciousness.

3.13 Specific threats made by patients.

3.14 Evidence of suicidal ideation, tendencies or plans need to be discussed fully with the Team, decisions taken on the care and treatment of the patient in light of these factors documented in the care plans and reviewed on a daily basis.

3.15 Evidence that a patient is considered to be an absconding risk in an in-patient area or a risk of moving out of the catchment area without informing the necessary agencies such as Health, Social Services, Housing or Probation.

4.0 Environment

4.1 Relevant factors relating to the clients' home circumstances and the Ward Environment must be considered, i.e.:

4.1.1 Home

4.1.2 Conditions of the home.

4.1.3 Adequacy of the support network.

4.1.4 Social isolation.

4.1.5 Ward Environment.

4.1.6 Potential risk factors to be identified, e.g. agreeing the most appropriate area for the client to be cared for while in hospital.

4.1.7 To identify high-risk areas in the ward, eg, smoking room, kitchen, bathrooms, taking steps to minimise associated risks.

5.0 Documentation/Monitoring

5.1 Following the comprehensive risk assessment the clinical decisions in respect of risk management will be detailed in the individual care plan.

5.2 The agreement of the care plan will be clearly identified and documented both in the medical and nursing record. The care plan should aim at answering the following questions:

5.2.1 How serious is the risk
5.2.2 Is the risk specific or general?
5.2.3 How immediate is the risk
5.2.4 How volatile is the risk
5.2.5 What specific treatment and which management plan can best reduce the risk.

N.B. It is absolutely imperative that staff at all times CLEARLY document their clinical and medical judgements/decisions in the patient's notes. This includes re-assessments.

6.0 Reviews and Re-assessments

6.1 Staff should be aware that the risk assessment process is ongoing and not a one-off. Reviews of risk assessment should take place on a daily basis and evaluated weekly at the patient's ward round.

6.2 In the event of a patient's behaviour or psychiatric condition changing, a re-assessment of risk should take place in order to assess if this changes the patient's clinical risk.

6.3 Reassessments of patient's risk should take place when further information eg, from relatives, patient's notes or other professionals, is forthcoming.

N.B. The Nurse in Charge must discuss at handover the patient's mental state and symptoms which may indicate a need to review the patient's risk status and/or Care Plan.

7.0 Clinical Risk Management Group

7.1 The Mental Health Directorate has a MDT Clinical Risk Management Group, which is responsible for the monitoring of clinical risk issues. The Group has representation from across the Mental Health Directorate. Clinical Risk issues should be addressed with the relevant Department Manager who in turn will liaise with the Chair of the Clinical Risk Management Group for action.

8.0 Policy Reference Information

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The Director Responsible for reviewing this Policy is:

the Director of Adult, Child and Adolescent Mental Health Services