SOUTH ESSEX PARTNERSHIP NHS FOUNDATION TRUST

PROCEDURE FOR THE ASSESSMENT AND MANAGEMENT OF CLINICAL RISK

Controls Assurance Statement

The principles contained within this procedure and associated documents will ensure that all clinical staff involved in assessing and managing clinical risk do so systematically with patients safety in mind.

The therapeutic relationship between service user and professional and/or relative/carer is considered a fundamental element to effectively assess and manage clinical risk.

It is considered that staff, service users, relatives and/or carers will work in collaboration to ensure a thorough assessment of a person which will include any risk factors.

These guidelines should be read in conjunction with associated trust policies Serious Untoward Incidents (CP3), Accident & Incident Reporting (RM06), Care Programme Approach (CLP 30).

1.0   INTRODUCTION

1.1   These guidelines identify the principles of managing risk, which promotes open and honest communication with the development of a collaborative therapeutic relationship.

1.2   Communicating effectively with service users and carers is a vital part of the process of managing clinical assessment and risk. Effective communication starts from the beginning of a healthcare need being identified and continues throughout a patient's treatment. To enable dialogue and facilitate assessment throughout the process it is helpful if a patient and/or carer feels supported, empowered and enable to communicate and collaborate with Trust employees.

1.3   As stated in the policy it is not always possible to completely eliminate risk from an individuals life.

1.4   A persons care must be based upon individual assessment of needs which is considered in a collaborative and therapeutic manner. The development of the therapeutic relationship will be considered the most valuable tool in reaching decisions regarding care and treatment.

2.0   AIMS

2.1   These procedures in conjunction with existing policy documents Serious Untoward Incidents (CP3), Adverse Incident Reporting (RM06), Care Programme Approach (CLP 30) and Trust Policy on Being Open supports the philosophy of the Trust and the National Patients Safety Agency principles of *Being Open.*

The Trust aims to deliver high standards of healthcare to all patients and promote commitment from all healthcare organisations involving each individual working for the Trust.

3.0   COMMUNICATION

3.1   A key part of assessing risk is considering the needs of the service user and/or carer together with any past experiences.

The assessment for each service user needs to ensure past, present and future details as set out in the Trust Care Programme Approach policy, (CLP30).

4.0   MANAGING RISK ASSESSMENT

4.1   Service users, staff, relatives and/or carers will be encouraged to work in collaboration with each other to develop a working therapeutic relationship to enable a full holistic assessment.

4.2   Risk will be considered as part of the holistic assessment of a person taking into account any advance directive issues and/or personal safety plans.

4.3   The assessment may result in a decision that would develop a plan of care that includes elements of therapeutic risk taking. These plans must be considered carefully and agreed by the Multi Disciplinary Team (MDT) and have the potential for therapeutic gain. The plan must be clearly recorded including evidence of the considerations that went into the decision.

4.4   Risk Assessment and the management of risk is a fundamental principle within the Care Programme Approach framework see policy CLP30. This includes the management of handing over and discontinuation of care between professionals.

4.5   Clinical workloads of professionals will be monitored by Ward Managers and Team Leaders with issues of concern highlighted and actioned in individual staff supervision as per Trust Policy (CP26) Policy for Supervision for Staff.

4.6   Any assessment must be completed in a manner and environment that is conducive to the promotion of psychological exchange. The environment must be calm and secure encouraging all individuals concerned to contribute.

4.7   Staff will complete a systematic assessment of clinical risk for the care of the individual patient in conjunction with the individual and documented as detailed in section 5.

4.8   At least one audit per year will take place to review practice and procedure and will include monitoring of the following policies:

Trust wide Audit facilitated by Clinical Audit and lead by appropriate Audit Lead:e.g.

- Prevention and Management of Violence and Aggression

- Observation Policy
- Administration of Medication
- CPA
- Holding Powers (MHA) – this is monitored six monthly

National Audit facilitated by Clinical Audit: e.g.
- Management of Violence

Locally managed Audit facilitated by Team Leaders/Ward Managers e.g.
- Confidentiality
- Absent without Leave/Missing Patients- this is monitored through serious untoward incidents

5.0 ASSESSING RISK

5.1 Risk Assessment is an essential and ongoing part of patient care which must be clearly documented and reviewed regularly as per Care Programme Approach process, Trust Policy CLP 30.

5.2 Elements of Risk Include:

- Self harm - including accidental harm, alcohol, drug or substance misuse, deliberate self harm
- Adverse consequences of treatment and physical injury
- Risk of absconding from in-patient services or risk of moving out of catchment area without informing necessary agencies such as Health, Social Services, Housing, Probation.
- Suicide- including previous attempts, threats, opportunity, means, thoughts
- Violence to others - including access to potential victims, specific threats made, history of violence to family, staff or others, or specific others, degree of physical harm caused, history of sexual assault, risk to children.
- Other types of risk to other people – including risk to children, arson, risk to others other than violence, destruction of property.
- Self neglect – including inability to care for self, lack of support, exploitation by others and vulnerability to abuse such as financial, sexual, physical.
- Evidence of:

  o transitory behaviour or social restlessness e.g. few relationships, frequent changes of address and/or employment.
  o poor compliance to treatment and disengagement from psychiatric after care.
  o suicidal ideation, suicide tendencies or suicidal plans need to be discussed fully with the Multi Disciplinary Team (MDT) involved in care. Decisions taken surrounding care and treatment in light of these factors must be reviewed regularly as agreed by the MDT involved.
  o Actual or potential substance abuse/misuse
  o Recent severe stress, loss events or threat of loss, e.g. death in the family
  o Recent discontinuation of medication, change in medication or non-compliance

o Physical health risks, e.g. refusing to eat, allergies, frailty and mobility
o Threatening behaviour and delusions/hallucinations of a persecutory nature

5.3   Contributory Factors that may increase risk include:
- Failure to monitor service users
- Failure to remove dangerous objects
- Failure to use a locked ward
- Failure to supervise staff
- Failure to obtain past records
- Poor communication between staff /teams
- Failure to treat psychiatric disorders adequately
- Failure to discuss treatment options with service users
- Negligent discharge
- History of absconding / potential to abscond
- History of Self harm / Suicide

6.0   ASSESSMENT TOOLS

6.1   The Risk Assessment Tools as set out within Trust CPA Policy (CLP30) are the tools agreed to be used throughout the organisation. Any risk assessment tools prior to use have to be ratified by the CPA steering group.

In addition the following have been agreed:

- Older Peoples Services are authorised to use the –

◊ Waterlow Tool
◊ Falls Risk Assessment Tool
◊ Malnutrition Universal Scoring Tool (MUST)
◊ Transport Risk Assessment Tool

- Forensic Services are authorised to use the –

◊ HCR 20

- Learning Disabilities are authorised to use the –

◊ Learning Disabilities Clinical Risk Assessment Tool

- Psychology Department are authorised to use –

◊ Brief Risk Screening Tool for Adult Community Services and FERN

7.0   ENVIRONMENT

7.1   The following Trust Policies aim to ensure that there are audits in place to ensure regular systematic reviews of premises.

- PEAT
- Health and Safety audit
- Ligature audit

7.2 Potential risk factors regarding observations of in-patients see Trust Policy Engagement and Formal Observation Policy (CLP 8)

7.3 Relevant factors relating to the service users home circumstances and ward environment must be considered e.g. conditions, support network, social isolation, ward environment.

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

7.5 To identify high – risk areas in the ward, e.g. quiet rooms/areas, kitchen, bathrooms and taking steps to minimise these risks.

8.0 DOCUMENTATION/MONITORING

8.1 Following a comprehensive risk assessment the clinical decisions in respect of risk management will be detailed within an individual care plan.

8.2 Issues concerning risk will be fully documented as per CPA guidelines, (CLP30) including;
- How serious is the risk
- Is the risk specific or general
- How immediate is the risk
- How volatile is the risk
- What specific treatment and which management plan can best reduce the risk

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

8.3 Staff must be aware that the risk assessment process is ongoing and not a one off event. Reviews of risk assessment must take place at the regularity agreed by the MDT and relevant documents completed.

8.4 The Key Events Charts detailed within the CPA process must be completed and is considered a valuable reference tool.

This may be as per the minimum as set out in the CPA policy (CLP 30) or more regularly as need arises.

Need may arise due to a service users
- o behaviour
- o change in psychiatric condition
- o further information becoming available

9.0	**MINIMISING RISK**

9.1   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, Nursing and Midwifery Council.

9.2   In order to assess clinical risk all staff will follow an induction programme and will undertake other training where necessary which will include an introduction to Clinical Risk Management. The aim of this training is to ensure that staff undertaking assessment of service users should receive training in the recognition, assessment and management of risk of both suicide and violence. Following this, it will be a fundamental requirement of core practice for all clinical staff to have a 3 yearly update. This guidance below should be read in conjunction with the mandatory training policy HR21.

Core Practice	*UPDATE INTERVAL*	*STAFF CATEGORY*	*DELIVERY METHOD*
Clinical Risk	Three yearly	All clinical staff	direct

9.3   Risk Management Training includes the following aspects:

- indicators of risk
- high risk periods
- managing non compliance
- managing loss of contact
- communication between services, agencies, professionals, users and carers
- mental health act
- use of approved risk assessment tools and documentation
- Ethical Care, Prevention and Management of Violence and Aggression
- Awareness of Clinical policies including – Record Keeping, ECT policy and procedures, Observation Policy, Confidentiality, Mental Health Act (including AWOL), Administration of Medication, Discharge Protocols including CPA, Assessment /Admission Protocols

9.3   There will be clear lines of responsibility for administrative maintenance of medical records, including filing of reports and records of treatment.

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

9.5   There will be a clear understanding at the interface between health and social care with an agreed referral process between GP's, community health care workers/ Community Mental Health Teams as per service operational policies.

9.6   It is essential that care plans record the responsible agency and individual in the provision of agreed intervention (CLP 10, Named Nurse Policy and CPA Policy CLP 30).

9.7   There will be a handover of care led by the nurse in charge between shifts (inpatient services) based on the current care plan. This handover will include all relevant members of the ward multi disciplinary team (Named Nurse Policy, CLP 10 and Ward Handovers CLP20).

9.8   Clinical workloads of nurses will be monitored both in patient and community by the ward manager/team leader and issues of concern highlighted and actioned in individual staff supervision, Corporate Policy CP26, Supervision for Staff.

9.9   A comprehensive and effective assessment of those patients presenting increased risk of harm will receive highest priority for allocation of resources in accordance with (CPA Policy, CLP30).

9.10   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.

9.11   Qualified staff will make a systematic assessment of clinical risk in the care of the individual service user using approved tools and as outlined within this document.

9.12   Clinical risk minimisation training will be made available to all staff and is compulsory to all qualified clinical staff as part of mandatory / core practice as detailed within 9.2 of this document.

9.13   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.

10.0   DISCHARGE

10.1   Arrangements under the Care Programme Approach (CLP 30) need to be taken into account from the point of admission

10.2   All service users to be seen within 7 days of discharge from in-patient care

10.3   All service users, relatives and carers to be aware of who to contact in cases of crisis.

10.4   Arrangements for information sharing/ communication amongst teams/people working with the patient.

11.0	**REVIEWS AND RE-ASSESSMENTS**

11.1 Staff should be aware that the risk assessment process is ongoing and not a one off event. Reviews of risk assessment should take place on a daily basis and evaluated weekly at the MDT meeting.

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

11.13 Reassessments of service users risk should take place when further information e.g. from relatives /carers, patient notes or other professionals is forthcoming.

11.14 The nurse in charge must discuss at handover the patients mental state and symptoms, which may indicate a need to review the patients risk status and/or care plan.

12.0	**CLINICAL RISK MANAGEMENT GROUP**

12.1 The Clinical Risk Management Group will

- Review internal investigations and monitor action plans.

- Monitor clinical risk issues through monthly reporting of SUI's.

- Address Clinical Risk issues with relevant line managers who in turn will liaise with the Clinical Risk Management Group for guidance.

- Disseminate lessons learnt as set out within CPG3 (Serious Untoward Incident Procedures).

The Clinical Risk Management Group, is responsible for the monitoring of clinical risk issues. The Group has representation from across the Trust. 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.

13.0	**PROCEDURAL GUIDLEINES REFERENCE INFORMATION**

Clinical Policy No:	CLPG28
Implementation Date:	18.11.1997
Last Review Date:	19.09.2006
Amendment Date (s):	19.09.1998, 03.10.2001, 22.01.2003, 19.09.2006
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The Director responsible for monitoring this policy is

the Director of Integrated Governance and Executive Nurse