Essex County Council

North Essex Mental Health Partnership NHS Trust

CLINICAL RISK MANAGEMENT PROTOCOL

(Incorporating Clinical Risk Assessment Tools Handbook)

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Compiled and Issued by
The Risk Management Department

INVESTOR IN PEOPLE

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CLINICAL RISK MANAGEMENT PROTOCOL

INTRODUCTION

This updated Handbook is a guide to assist all practitioners in their practice and to support patient safety. It aims to identify and reduce clinical risk leading to safe practices and increased patients safety. It includes screening and specialist assessment tools suitable for different areas of practice: older people, adults and younger people. It is based on published, validated tools. This handbook is accessible through:

- Intranet
- Hard copy for each clinical team
- Individual copies for practitioners

BACKGROUND

All practitioners are under an obligation to ensure that their professional practice is designed to ensure patient safety. There have been a few well-publicised cases that have demonstrated the kind of criticism that can be made over errors of judgement. At the same time, paternalistic approaches are not in the patients' longer-term interests.

Clinical risk screening and assessment form an integral part of the Trust's Risk Management Strategy.

The following is an extract from page 7 of the Trust's Risk Management Strategy -

> "*Risk creates the need to decide about major changes to care, moving into and out of relationships, judging the competence of individuals to exercise choice and control in their lives. It also is crucial in assessing the degree of protection that an individual may require to live safety. Risk is also central in case of abuse, violence, self-harm and self-neglect."*
>
> *"Practitioners will make risk decisions every day and the Trust acknowledges the difficult balancing act between risk minimisation and the empowerment of the patient. There will also be difficulties in resolving the imbalance between promoting patient's rights and preserving the responsibilities of the practitioner to others."*

It becomes imperative therefore that the Trust supports staff to screen for and assess risk appropriately and as robustly as possible.

REVIEW

During January 2004, a consultative group consisting of senior representatives of professional groups reviewed the Clinical Risk Management Protocol and Handbook, resulting in some tools being discontinued and new tools being added.

In March 2004 a sample of staff were surveyed by the Trust concerning the risk assessment process. The response supported the use of screening and assessment tools and a number of suggestions were made that have been incorporated into the tools. This Handbook is the result of this collaboration.

USE OF THE TOOLS

- It is expected that all practitioners will use these tools for all patients
- The screening and assessment process must be clearly evident in the clinical notes
- Clinical risk screening and assessment form part of the Care Programme Approach (CPA) process
- This Handbook must be made accessible to all staff
- Clinical Risk Screening Tool is accessible from Carebase.

Director of Nursing
July 2004

SECTION ONE

CLINICAL RISK MANAGEMENT PROTOCOL

1 INTRODUCTION

1.1 North Essex Mental Health Partnership NHS Trust is committed to providing effective and safe health and social care services for people living with mental health problems. The safety and continued well-being of all service users, their relatives and carers, members of Trust staff and the general public is the highest priority for everybody working for the Trust. This integrated Clinical Risk Management Protocol with its associated guidance, risk assessment tools and audit programme has therefore been drafted for use throughout the Trust.

1.2 National targets for health improvement set by the Department of Health and the initiatives that support their achievement demand from mental health and social care providers a binding Protocol governing the organisation's approach to assessing and managing clinical risk. The National Service Frameworks for Mental Health and Older People, the NHS Plan and the report of the Confidential Inquiry into Suicides and Homicides by People with Mental Illness (Safety First, 2000) set out new requirements for mental health providers associated with managing risk. Particular focus has been placed on follow-up after discharge, access to care for people in crisis, assertive outreach, early intervention and health promotion.

1.3 This Protocol has been developed to support the Trust and individual practitioners in providing a comprehensive and systematic process for assessing and managing clinical risk. It includes:

- A definition of clinical risk, risk assessment, risk management and contingency planning.
- A clinical risk management philosophy, which includes positive risk management as part of good practice.
- The Trust's expectations and obligations: accountability for managing risk.
- Risk assessment, timescales and frequencies.
- Managing difficult risk.
- Use of the evidence-base and improving practice.
- Record-keeping.
- Confidentiality and information sharing.
- Clinical risk management and the Care Programme Approach.
- Evaluation, review and oversight of this Protocol.

Appendix 1. Safety First recommendations and Trust actions

1.4 This Protocol provides a framework and guidance for professional practice, with the expressed aim of controlling and minimising risk throughout all areas of the Trust's services, and providing care and treatment that is safe, sound, supportive, positive, service-user-centred and socially responsible.

1.5 This Protocol applies to all Trust employees and to those on secondment to the Trust including all professional trainees and locums. It should be used in conjunction with the associated Trust policies, procedures and protocols, covering aspects of risk. Trust staff are expected to use these policies where relevant to their practice and to involve themselves as required in reviewing and updating them.

1.6 This Protocol encompasses the findings, and includes protocols, tools, programmes and guidance to meet the recommendations, of Safety First, the report of the Confidential Inquiry into Suicides and Homicides by People with Mental Illness (2001). The 18 headline recommendations are in Appendix 1, and are referenced in the text.

1.7 This Protocol links expressly to the Trust's Serious Untoward Incident and Child Protection policies.

2 DEFINITION OF CLINICAL RISK, RISK ASSESSMENT, RISK MANAGEMENT AND CONTINGENCY PLANNING

2.1 **Clinical risk** is the likelihood or probability of an adverse and / or harmful outcome to an episode of mental illness or distress, or to a particular behaviour associated with that illness or distress.

2.2 **Risk assessment** is the process of gathering information about a service user's mental state, behaviour, intentions, personal psychiatric history and social situation and forming a judgement about the likelihood or probability of an adverse and / or harmful outcome based upon that information.

2.3 **Risk management** is the process of weighing the risk of an adverse and / or harmful outcome to any given situation or course of action against the possible therapeutic and social benefits that may accrue from it, and consequently planning and sanctioning activity or providing safeguards with the aim of minimising the risk and maximising the benefits.

2.4 **Contingency planning** is the process of considering what might go wrong and pre-planning strategies to minimise adverse and / or harmful outcomes.

3 CLINICAL RISK MANAGEMENT PHILOSOPHY: POSITIVE RISK MANAGEMENT AS PART OF BEST PRACTICE

3.1 The Trust is committed to a philosophy of care that values each individual service user and seeks to maximise his or her well-being and potential for self-fulfilment. This philosophy can only be realised if service users are enabled and encouraged to take an active role in the ordering of their own lives. Trust practitioners must encourage independence, self-reliance and competence in all service users (while avoiding a punitive approach), and balance risk against potential benefits using their professional judgement and experience and those of their colleagues within the framework for practice set by the Trust and by their professional bodies. Practitioners must appreciate that systems and practices that reward dependency and passivity rarely make a positive contribution to individual achievement. A balance should always be struck between valuing and respecting service users and helping them to achieve their full potential.

3.2 The Trust recognises that its philosophy means that some risk may be necessary and unavoidable if individual service users are to progress. Therapeutic risk-taking can be a valid tool. Methodical assessment and active management of that risk are key steps towards minimising risk and maximising benefit. The Care Programme Approach (CPA) is the framework within which this activity takes place for most service users (arrangements may be different for younger children and for older people with mental health problems).

3.3 Caring for and treating someone living with mental health problems effectively and safely is argued not to be an exact science. Consequently, the outcomes of care and treatment for any individual do not always meet expectations. There is likely to remain some risk, of;

- physical and / or psychological harm to the service user,
- physical and / or psychological harm to relatives, carers, dependants, caring professionals or members of the public;
- harm to children;
- deterioration in the service user's mental well-being.

Harm includes physical, emotional and sexual abuse, violence, exclusion, self-harm, exploitation, criminal activity, substance misuse, being victims of unacceptable behaviour and homelessness.

3.4 However, properly-managed risk, based on sound risk assessment, can enhance autonomy, empowerment, choice, participation and social inclusion for service users and their relatives and carers, whilst combating stigma. Thus, it is vital that all those caring for and treating people living with mental health problems

- identify and understand the risks for and from each individual;
- evaluate and manage those risks within an agreed framework to the highest professional standards;
- plan for contingencies and share that plan with all relevant colleagues (for example, through CPA and / or professionals' meetings).

3.5 This Protocol applies to all direct users of Trust services and to their relatives and carers.

4 THE TRUST'S EXPECTATIONS AND OBLIGATIONS: ACCOUNTABILITY FOR MANAGING RISK

4.1 Responsibility for managing clinical risk is one that is shared between the organisation, individual practitioners, service users and carers. To assist in this process the Trust will:

- provide an agreed procedural framework for staff to work within;
- provide training in the assessment and management of risk;
- provide training in the use of systems and techniques that support risk assessment and management;
- provide safe environments from which services will be delivered;
- develop the necessary agreed strategies and protocols to govern practice;
- support staff in the assessment, management and minimisation of risk;
- apply and ensure adherence to relevant legislation and government guidance.

4.2 In recognition of this shared responsibility, the Trust expects its staff in their dealings with service users, their relatives and carers and with the public to:

- understand the concepts of risk and risk management in clinical practice, and the Trust's philosophy of care;
- have a methodical, research-based approach to the assessment and management of risk, using agreed tools and methodologies;
- understand risk as including environmental, psychological and physical aspects;
- in a timely fashion identify, assess, positively manage and, where possible, minimise risk for all those for whose care and treatment they are responsible and their relatives and carers;
- weigh the risk of harm to the service user or to others against the potential benefits to be gained in each situation they encounter, and act accordingly;
- take no action that contributes to or increases risk;
- plan for contingencies;
- record information about risk and share that information with all who may need it;
- adhere strictly to the guidance and direction given in this Protocol;
- extend their vision of risk to include:
  - the service user
  - the service user's family, friends and carers
  - the public
  - children
  - Trust staff colleagues
  - workers in other agencies.

5 CLINICAL RISK ASSESSMENT

5.1 The purpose of undertaking a risk assessment, using a risk assessment tool in conjunction with professional judgement, is to identify risk factors and immediacy of risk, and to create a risk management plan that will guide care and treatment.

5.2 Individual practitioners must always use their professional judgement about individual clients' needs to decide finally whether, when and how clinical risk should be assessed. However, as general guidance, the Trust's view is that clinical risk must be assessed in situations where:

- a service user comes into the service for the first time in any treatment episode;
- a service user's mental or physical state changes (deteriorates) significantly;
- a service user's social situation changes (deteriorates) significantly, including homelessness or change of accommodation, unemployment, change of support network, divorce or rupture of established relationships, and episodes of significant contact with other agencies such as the police, the courts and housing agencies;
- pre-determined indicators of relapse or risk (identified in previous risk assessments) are apparent;
- a service user loses contact with the service in an unplanned way;
- the care and / or treatment offered to a service user changes significantly, including at discharge from inpatient care.

Risk assessment may also be advisable when:

- the practitioner(s) delivering the majority of care change(s).

5.3 In addition to assessment of risk in response to the events detailed above, clinical risk must be reassessed routinely (but at intervals not greater than 6 monthly). This process should be synchronised with the CPA (or other relevant) review process.

6 SAFEGUARDING CHILDREN

6.1 It is the responsibility of all professionals working in mental health to consider the impact of parental / carer mental illness on children (Working Together, 1999; Every Child Matters, 2003)

Where it is assessed or identified that a child may be at risk of significant harm, for whatever reason, professionals should follow the procedures outlines in the Essex Child Protection Committee Blue Book Guidance and the NEMHPT Safeguarding Children Folder and ensure that the effective communication of potential risks occurs – to colleagues within other agencies e.g. to Social Care Child Protection and/or where appropriate Police Child Protection Unit. The Service Manager, Safeguarding Children & Vulnerable Adults should be informed of all referrals and investigations of the abuse of children.

Full guidance on child protection and safeguarding children issues are enclosed in the Trust's **SAFEGUARDING CHILDREN** folder available in all clinical areas. Any query relating to child protection or safeguarding children should be referred to the Service Manager for Safeguarding Children at the Child and Adolescent Mental Health Service, 654 The Crescent, Colchester Business Park, Colchester, CO4 9YQ. Tel: [I/S] .

6.2 VULNERABLE ADULTS:

It is the responsibility of all professionals working in mental health to consider the possibility that a vulnerable adult may be the victim of abuse (No Secrets, 2000). All clients aged 18 and over of NEMHPT are defined as vulnerable adults.

Where it is assessed or identified that a vulnerable adult may be at risk of significant harm, for whatever reason, professionals should follow the procedures outlined in the Essex Vulnerable Adults Protection Committee Guidance booklets. Professionals must ensure that the effective communication and investigation of potential risk occurs and where appropriate colleagues within other agencies e.g. Police Vulnerable Adult Officers or CSCI are informed. The Service Manager, Safeguarding Children & Vulnerable Adults should be informed of all referrals and investigations of the abuse of vulnerable adults.

Any query relating to the protection of vulnerable adults form abuse should be referred to the Service Manager for Safeguarding Vulnerable Adults at the Child and Adolescent Mental Health Service, 654 The Crescent, Colchester Business Park, Colchester, CO4 9YQ. Tel: [I/S] .

6.3 SAFEGUARDING CHILDREN & VULNERABLE ADULTS TRAINING:

It is mandatory for all clinicians / practitioners working with clients to attend a one day course on Safeguarding Children.

Training on the abuse of vulnerable adults is as yet not a mandatory requirement for clinicians / practitioners but is strongly recommended.

NEMHPT provides training on both the Safeguarding of Children & Vulnerable Adults, through a variety of courses, further details are available from the Service Manager on [I/S] .

7 RISK ASSESSMENT TOOLS

7.1 Practitioners with responsibility for risk assessment must use one of the recognised and agreed, validated risk assessment tools contained in this Handbook. These tools are -

- (for clinical risk assessment/screening tool)
- North Essex Mental Health Partnership NHS Trust Risk Assessment Screening (Modified from the Sainsbury Centre for Mental Health tool)
- Sainsbury Centre for Mental Health Tool for Clinical Risk Assessment
- Beck Scales/Inventories – Hopelessness Scale, Depression Inventory, Suicide Ideation Scale, Suicide Intent Scale
- Edinburgh Post Natal Depression Scale
- Mother and Baby Assessment
- Worthing Weighted Risk Indicator
- Assessment Tools for Risk of Violence – HCR20 and Hare's Psychopathy Check Lists
- Short CANE (Camberwell Assessment of Need for the Elderly)
- Falls Risk Assessment
- Pressure Ulcers/Sores – Waterlow Pressure Sore Risk Assessment, Braden Pressure Ulcer Risk Assessment and The Norton Scale
- Assessment of Manual Handling Needs
- Driving
- Transport Risk Assessment Checklist for Staff Using Private Cars to Transport Clients
- Assessment and Risk Assessment Summary for Young People Under 17 Years (including Care and Risk Review for Young People Under 17 Years)
- Assessment and Risk Assessment Summary for Children Under 5 Years

Competent use of these tools requires the user to have had specific briefing or training, and some require the user to hold a licence. In all cases, practitioners should have an understanding of the relative usefulness and purpose of any tool that they use. All tools will be used to the highest professional standards.

7.2 Use of tools other than these is discouraged, unless the tool proposed has been approved by the Trust's Clinical Risk Management group.

7.3 It is recommended as best practice that risk assessments be discussed with and counter-signed (as having been so discussed) by a second practitioner.

8 RECORD-KEEPING

8.1 Practitioners must record and store clinical risk assessments and risk management plans in full; together with other significant clinical details, these must be easily-accessible to other professionals likely to be involved in the care of the service user in question. They must record them in a form that allows other practitioners who may not be familiar with the service user

readily to understand both the clinical risks posed and the associated management plan.

8.2 Where an electronic patient information system such as CareBase exists, clinical risk assessments and risk management plans must be recorded on that system. If there is no access to electronic systems, paper records of risk assessment and management plans must be easily-accessible and must follow the service user between teams, care co-ordinators and facilities as his / her care and treatment changes. This process must form an integral part of the CPA (or the relevant care planning processes used for younger children and for older people with mental health problems).

8.3 Each service user's overall risk management plan must be shared between disciplines and specialities in the Trust, following the requirements of CPA (or the relevant care planning processes used for younger children and for older people with mental health problems). Risks that are identified and their planned management should be recorded on the individual's CPA care-plan.

9 MANAGING DIFFICULT RISK

9.1 It is inevitable that assessment of clinical risk in people with mental illness or distress will sometimes uncover a level of risk that may be outside the capacity of the assessing practitioner and / or their colleagues to manage. (This situation reflects the concept of identifying unmet need in CPA: if the need that is unmet is in fact a difficult-to-manage risk, then the identifying practitioner must follow the guidance in this section of this Protocol.)

9.2 In this situation it is the assessing practitioner's responsibility to:

- inform his / her line manager as soon as possible;
- take steps to minimise any risk to him- or herself;
- seek assistance and / or guidance from practitioner colleagues;
- identify other agencies and individuals that may be able to manage and minimise the risk posed and inform them of the risk as a matter of urgency;
- identify other agencies and individuals that may themselves be at risk from the service user in question and inform them as a matter of urgency.

9.3 The practitioner's line manager must:

- inform the Service Manager for the Area or service concerned of the risk identified and the action taken;
- identify and attempt to resolve any material or staffing deficits that exacerbate the risk.

9.4 The Trust will:

- inform other agencies and individuals inside and outside North Essex of the situation if appropriate;
- mobilise the resources of the Trust and other agencies and individuals to manage and minimise the risk if possible. This may include authorising
- emergency treatment outside the Trust, authorizing the temporary employment of extra staff and / or involving the police or other emergency services.

9.5 The identification of a difficult-to-manage risk may also, in specialist services, be an indicator for a Multi Agency Public Protection Arrangement (MAPPA) process, a professionals' meeting or a child protection meeting.

10 USE OF THE EVIDENCE BASE AND IMPROVING PRACTICE

10.1 The Trust fully and unreservedly supports practitioners in the application of research and the use of an agreed evidence-base. It recognizes that the evidence-base is dynamic and continually evolving.

10.2 Trust practitioners have a duty to keep themselves up-to-date with research findings and the developing evidence-base that is relevant to their practice. This applies equally to research and evidence about risk assessment and management.

10.3 Practitioners also have a duty to practice reflectively, considering their practice against Trust standards and published best practice literature.

10.4 Equally, the Trust has a duty to incorporate relevant research and evidence into its guidance for practitioners, and to review and if necessary change its guidance regularly. The Trust's audit programme will reflect the need to evaluate and understand practice in risk assessment and management. Changes to practice, including the use of different risk assessment tools, suggested by service governance reviews or by practitioners will be considered and implemented (by incorporation in this Protocol) by the Trust as appropriate.

11 CONFIDENTIALITY AND INFORMATION-SHARING ABOUT INDIVIDUALS

11.1 Practitioners have a duty to keep personal information given to them by service users confidential. This duty is enshrined in professional codes of conduct and in legislation such as the Data Protection Act (1998). The Trust has a duty to facilitate that confidentiality through its systems, staffing, training and policies / protocols, and to ensure that its systems do not themselves make breaches of confidentiality more likely.

11.2 However, as we work towards greater integration of health and social services and an increase in working with partnership agencies, there is a growing need to share information in order to reduce and manage risk. Wherever possible (unless it is contra-indicated by the involvement and views of other agencies, such as those in the criminal justice system) the service user's explicit and valid consent should be obtained wherever disclosure of information is to be made, via an informed Consent to Share.

11.3 Practitioners and the Trust also have a duty of care to service users and the wider public, which in some instances can only be discharged by passing on information given by individual service users. When considering whether information should be shared the following core principles should be considered:

- The use of confidential information must be justified.
- Disclosure should only take place when absolutely necessary.
- Use the minimum that is required.
- Access should be on a strict need to know basis.
- Every one must understand their responsibilities.
- There should be an understanding of the law and the need to comply.

Disclosure of information should not be made when the benefits of disclosure have not been clearly established or when the benefits of disclosure will not have a reasonably direct and provable impact on reducing and managing risk.

11.4 Part of the process of assessing and managing risk for individual service users, their relatives and carers and other people with whom they are in contact is forming and acting on judgements about what information should be shared and with whom in order to minimise risk. Where permission to disclose is refused, this can be overruled in certain cases under Schedules 2 and 3 of the Data Protection Act and under the provisions of some other legislation. Occasions on which information must be shared in order to avoid an adverse and / or harmful outcome include:

- When there is a need to prevent or reduce the risk of serious crime such as to prevent danger to a person's life or to prevent a serious infringement of the law: if a service user makes threats against another individual, that individual must be told; if a service user makes threats against another agency, that agency must be told.
- In response to concern about the health and well being of a person, or public health or welfare concerns: if another agency or practitioner will be able to minimise risk where the Trust cannot, or is in a better position to do so in particular circumstances, that agency or practitioner must be fully informed.
- When there is a need to deliver an effective service within the grounds of a duty of care: when another agency or practitioner will have contact with a service user to continue care and treatment, that agency or practitioner must be fully informed.
- Under the power of certain tribunals and the court and as a requirement of certain legislation such as assessment under the Mental Health Act: when the Mental Health Act Commission, the General Medical Council, the Courts (through a court order), the DVLA or the police (in the case of a suspected serious crime) require, they must have the information given to them.
- Under the Children Act (1989), disclosure of information (aimed at protecting children) is a higher duty than confidentiality: practitioners' duty is clearly to contribute to the protection of children at the expense of service user confidentiality.
- Where an advance agreement has been made which specifies that the individual has given permission to disclose information in situations of necessity and when there is a likelihood that the individual may withdraw their agreement whilst under the influence of a disabling mental illness.

12 <u>CLINICAL RISK MANAGEMENT AND CPA</u>

12.1 CPA is the vehicle for care delivery to most users of Trust services and their carers. The four elements of CPA are:

- systematic arrangements for assessment of the health, social care and psychological needs of service users and their carers;
- formation of an agreed care plan that identifies the health and social care required, possibly from a variety of providers;
- appointment of a care co-ordinator to co-ordinate implementation and monitoring of the plan;
- regular multidisciplinary reviews and where necessary changes to the care plan.

12.2 Service users whose care is not explicitly subject to CPA should always benefit from application of those principles of CPA listed in 10.1 and 10.3 - 10.7, albeit under the guise of the Single Assessment Process for older

people with mental health problems or the relevant care planning processes used for younger children in CAMHS.

12.3 The assessment of health, social care and psychological need implicitly and necessarily includes assessment of risk to self and others. Section 2.1.7 of the Trust's CPA Policy states: "It is essential that consideration of risk should be undertaken for every service user." This Protocol governs the assessment and management of risk in the application of CPA, and is thus to be read and implemented in conjunction with the CPA Policy. The level of CPA to which a service user is allocated must (among other considerations) reflect the degree of risk identified. (Safety First recommendation 3.)

12.4 The agreed care plan must provide a framework of care and treatment to maximise individual service users' potential for mental health and social inclusion, and must include actions and interventions that minimise identified risk.

12.5 Contingency planning is integral to CPA. (Safety First recommendation 4.)

12.6 Service users and their carers should be fully and actively involved in the process of CPA.

12.7 The Trust will provide training in risk assessment and management in the context of CPA training.

12.8 The Trust will follow NIMHE recommendations for the use of suicide prevention audit tool kit and CPA application process.

13 EVALUATION, REVIEW AND OVERSIGHT OF THIS PROTOCOL

13.1 The Trust will regularly review this Protocol

- in the light of changed research findings and evidence
- in response to audit findings and reports;
- in light of practical experience including any major untoward incidents involving the assessment and management of clinical risk.
- Publication of new and relevant documentation/guidance.

There will also be an initial review 6 months after it is first implemented.

13.2 Oversight of the working, review and revision of this Protocol will rest with the Trust's Risk Management Group.

13.3 All Trust staff are expected to adhere to this Protocol. Staff will be trained in the use of the Protocol as part of the Trust's CPA training programme.

This Protocol should be read in conjunction with:

- MHS Code of Practice – Confidentiality
- Sharing Information Protocol
- Consent to Treatment Policy
- Do Not Attend, Cancellations of Service and NHS Modernisation
- CPA
- Carebase Policy
- Tissue Viability Policy
- Physical Care Policy and Guidance
- Manual Handling Policy
- Zero Tolerance Policy

Appendix 1

SAFETY FIRST RECOMMENDATIONS AND TRUST ACTIONS

1. A coherent research-based clinical risk management approach, with practice based on use of a single sound agreed risk assessment tool.
See Section 5 above

2. Staff training in the management of risk – both suicide and violence – every 3 years. ***See Section 10 above***

3. All patients with severe mental illness and a history of self-harm or violence receiving the most intensive level of care (i.e. Enhanced CPA).
See Trust CPA Policy

4. Individual care plans to specify action to be taken if patient is non-compliant or fails to attend. ***See Section 3 above and Trust CPA Policy***

5. Prompt access to services for people in crisis and for their families.
See Operational Policy for 24 hour Mental Health Assessment Service

6. Assertive outreach teams to prevent loss of contact with vulnerable and high-risk patients. ***See Operational Policy for Assertive Outreach Services***
Operational Policy for Intensive Outreach Services (Longview)

7. Atypical anti-psychotic medication being available for all patients with severe mental illness who are non-compliant with "typical" drugs because of side-effects. ***See Guidance***

8. A strategy for dual diagnosis covering training on the management of substance misuse, joint working with substance misuse services, and staff with specific responsibility to develop the local service.
See Dual Diagnosis Strategy

9 All likely ligature points in inpatient wards, including all non-collapsible curtain rails, being removed or covered.
See Trust Environmental Audit programme

10. Follow-up within 7 days of discharge from hospital for everyone with severe mental illness or a history of self-harm in the previous 3 months.
See Trust CPA Policy

11. Patients with a history of self-harm in the last 3 months receiving supplies of medication covering no more than 2 weeks. ***See local pharmacy protocols***

12. Local arrangements for information sharing with criminal justice agencies.
See local Multi Agency Public Protection Panels (MAPPPs) agreement

13. Post-incident multidisciplinary case review and information being given to families of involved patients. ***See Trust Serious Untoward Incident Policy***

14. Observation of inpatients, particularly after 5 p.m.
See Trust inpatient unit Operational Policies

15. Removal from inpatients of potential ligatures.
See Trust inpatient unit Operational Policies

16. A written policy on disengagement. ***See Trust DNA Policy***

17. A unified case notes system.
See Trust Health and Social Records Policy

18. Leave management. ***See Trust Leave Policy***

SECTION TWO

SPECIALIST TOOLS

- Risk Assessment Screening Tool
- Sainsbury Centre for Mental Health Tool for Clinical Risk Assessment
- Beck Scales/Inventories
    - (BHS) Beck Hopelessness Scale
    - (BDI-II) Beck Depression Inventory
    - (BSI/BSS) Beck Scale for Suicide Ideation
    - Suicide Intent Scale (SIS)
- Edinburgh Post Natal Depression Scale (EPDS)
- Mother and Baby Assessment
- Worthing Weighted Risk Indicator
- Assessment Tools for Risk of Violence
    - HCR 20 – Version 2
    - Hare's Psychopathy Check Lists
- Short Cane (Camberwell Assessment of Need for the Elderly)
- Falls Risk Assessment
- Pressure Ulcers/Sores
    - Waterlow Pressure Sore Risk Assessment
    - Braden Pressure Ulcer Risk Assessment
    - The Norton Scale
- Assessment of Manual Handling Needs
- Driving
- Transport Risk Assessment Checklist for Staff Using Private Cars to Transport Clients.
- Assessment and Risk Assessment Summary for Young People Under 17 Years (plus Care and Risk Review for Young People Under 17 Years)
- Assessment and Risk Assessment Summary for Children Under 5 Years

Date of Assessment …….. **FIRST OF TWO PAGES**

NORTH ESSEX MENTAL HEALTH PARTNERSHIP NHS TRUST

RISK ASSESSMENT SCREENING TOOL

RISK INDICATORS

This Screening Tool should be undertaken for all service users who come into contact with the Trust's services. It should be completed in conjunction with the Clinical Risk Management Protocol. If high risks are identified, a more detailed risk assessment and risk management plan should be developed and recorded in CPA2/B. For complex cases a detailed chronology should be highlighted in the CPA documentation.

Name _____ **CareBase Number** _____

Date of Birth _____ **Unit** _____

SUICIDE ***Consider the following***

Previous attempt on their life/use of violent methods
Considered/planned intent
Major psychiatric diagnoses
Recent significant life events (bereavement/loss of job)
Misuse of drugs and/or alcohol
Family history of suicide
Helplessness or hopelessness
Believe no control over their life
Major physical illness/disability
Expressing suicidal ideas / high levels of distress

Comments

`

AGGRESSION / VIOLENCE ***Consider the following***

Previous incidents of violence/forensic history
Evidence of thought disorder
Signs of anger and frustration
Preoccupied with violent fantasy
Expressing intent to harm others
Abuse/harassment/exploitation of others
Psychological inability to understand situation (e.g. dementia)
Misuse of drugs and / or alcohol
Denial of previous dangerous acts
Sexually inappropriate behaviour
Arson and other damage to property (deliberate only)
Known triggers
Previous dangerous impulsive acts

Comments

Date of Assessment …….. **SECOND OF TWO PAGES**

NEGLECT ***Consider the following***

Previous history of neglect
Poor diet and fluid intake
Adequate accommodation?
Facing eviction/repossession
Difficulty maintaining hygiene
Limited social contacts
Difficulty managing physical health
Denies problem perceived by others
General presentation
Difficulties with money

Comments

SELF HARM / VULNERABILITY ***Consider the following***

Self-injury (e.g. cutting, burning)
Stated abuse/exploitation by others (eg. financial)
Accidental fire risk
Difficulty communicating needs
Carer issues
Disengagement with Services/Treatment
Risk of absconsion
Other self-harm (e.g. eating disorder)
Culturally isolated situation
Harassment by others
Accidental overdose of prescribed medication
Risks of falls/wandering/mobility
Driving risks

Comments

Child Protection Issues (Include child's date of birth, school and GP) – *The welfare of the child is paramount*

The outcome of this assessment should inform the Risk Management Plan as part of the CPA documentation CPA 2/B and may indicate a need for a more detailed / specialised risk assessment.

Name of Assessor _____Signature _____

Professional designation_____

Comments should summarise main areas of risk and include behavioural indicators, client insight and any factors relating to compliance with treatment / medication or careplan .

SAINSBURY CENTRE FOR MENTAL HEALTH TOOL FOR CLINICAL RISK ASSESSMENT

CLINICAL RISK MANAGEMENT

Client's Name:	**Unit:**
CareBase Number:	**Date of Birth**:
Date of Assessment:	**Time of Assessment:**

This page is to be used as a summary of the comprehensive assessment and management plan, or as a brief update when a detailed version is not required.

SUMMARY OF RISK ASSESSMENT

Involvement of service user and / or carers in assessment:

Primary risks identified:

Other risks identified:

INITIAL RISK MANAGEMENT PLAN

Precautions:

To be discussed with:

Information needed:

Actions:

Assessor's Signature:	**Profession/Title:**
Assessor's Name:	

Review date:

DETAILED ASSESSMENT AND MANAGEMENT PLAN

1. This assessment and plan should form an integral part of a comprehensive mental health assessment and care planning process.
2. This is not an exhaustive list of risk factors: it gives an initial indication of the potential sources of risk and possible management response.
3. Accurate prediction of risk is difficult: the initial assessment will inevitably be based on incomplete and possibly inaccurate information.
4. This assessment should offer a guide to areas requiring further discussion and investigation and an initial plan of management within available resources.
5. If completed by one person, this assessment should be discussed with the RMO and / or multi-disciplinary team (and the service user and carers, where appropriate).

NETWORK OF SUPPORT AND COPIES SENT TO

Network of support		**Names** *(where relevant)*	**Copies sent**
Service user	☐	.....	☐
Carer(s)	☐	.....	☐
GP	☐	.....	☐
Psychiatrist	☐	.....	☐
CPN	☐	.....	☐
Ward key worker	☐	.....	☐
Social worker	☐	.....	☐
OT	☐	.....	☐
Psychologist	☐	.....	☐
Support worker(s)	☐	.....	☐
Non-statutory worker(s)	☐	.....	☐
Other *(please specify)*	☐	.....	☐
	☐	.....	☐

RISK INDICATORS

SUICIDE

	Yes	No	Don't Know		Yes	No	Don't Know
Previous attempt on their life	☐	☐	☐	Expressing high levels of distress	☐	☐	☐
Previous use of violent methods	☐	☐	☐	Helplessness or hopelessness	☐	☐	☐
Misuse of drugs and / or alcohol	☐	☐	☐	Family history of suicide	☐	☐	☐
Major psychiatric diagnoses	☐	☐	☐	Separated / widowed / divorced	☐	☐	☐
Expressing suicidal ideas	☐	☐	☐	Unemployed / retired	☐	☐	☐
Considered / planned intent	☐	☐	☐	Recent significant life events	☐	☐	☐
Believe no control over their life	☐	☐	☐	Major physical illness / disability	☐	☐	☐
Other *(please specify)*							

Comments

NEGLECT

	Yes	No	Don't Know		Yes	No	Don't Know
Previous history of neglect	☐	☐	☐	Lack of positive social contacts	☐	☐	☐
Failing to drink properly	☐	☐	☐	Unable to shop for self	☐	☐	☐
Failing to eat properly	☐	☐	☐	Insufficient / inappropriate clothing	☐	☐	☐
Difficulty managing physical health	☐	☐	☐	Difficulty maintaining hygiene	☐	☐	☐
Living in inadequate accommodation	☐	☐	☐	Experiencing financial difficulties	☐	☐	☐
Lacking basic amenities at home	☐	☐	☐	Difficulty communicating needs	☐	☐	☐
Facing eviction / repossession	☐	☐	☐	Denies problem perceived by others	☐	☐	☐
Other *(please specify)*							

Comments

AGGRESSION / VIOLENCE

	Yes	No	Don't Know		Yes	No	Don't Know
Previous incidents of violence	☐	☐	☐	Paranoid delusions about others	☐	☐	☐
Previous use of weapons	☐	☐	☐	Violent command hallucinations	☐	☐	☐
Misuse of drugs and / or alcohol	☐	☐	☐	Signs of anger and frustration	☐	☐	☐
Male, under 35 years old	☐	☐	☐	Sexually inappropriate behaviour	☐	☐	☐
Known personal trigger factors	☐	☐	☐	Preoccupied with violent fantasy	☐	☐	☐
Expressing intent to harm others	☐	☐	☐	Admissions to secure settings	☐	☐	☐
Previous dangerous impulsive acts	☐	☐	☐	Denial of previous dangerous acts	☐	☐	☐
Other *(please specify)*							

Comments

OTHER

	Yes	No	Don't Know		Yes	No	Don't Know
Self-injury (eg cutting, burning)	☐	☐	☐	Exploitation by others	☐	☐	☐
Other self-harm (eg eating disorder)	☐	☐	☐	Exploitation of others	☐	☐	☐
Stated abuse by others	☐	☐	☐	Culturally isolated situation	☐	☐	☐
Abuse of others	☐	☐	☐	Non-violent sexual offence	☐	☐	☐
Harassment by others	☐	☐	☐	Arson (deliberate only)	☐	☐	☐
Harassment of others	☐	☐	☐	Accidental fire risk	☐	☐	☐
Risk to child(ren)	☐	☐	☐	Other damage to property	☐	☐	☐
Other *(please specify, eg absconsion)*							

Comments

SITUATION CONTEXT OF RISK FACTORS

Including, for example: arousal in difficult settings; risks in community locations; friends / neighbours / carers; need for two workers; gender or ethnicity considerations.

HISTORICAL AND / OR CURRENT CONTEXT OF FACTORS

SUMMARY OF "POSITIVE" RESOURCES AND POTENTIAL

SUMMARY OF RISK ASSESSMENT

Including, for example: factors, context, gut reactions / intuition, potential for positive risk-taking.

RISK MANAGEMENT CONSIDERATIONS

Including, for example, who; what; how; when; expected outcome; positive potentials.

CPA registration

CPA	☐ Yes	☐ No	☐ Standard	☐ Enhanced
Section 117	☐ Yes	☐ No		
Other Section	☐ Yes	☐ No	Section:	
Supervised discharge	☐ Yes	☐ No		

Role of service user and / or carer in plan

Service user involved	☐ Yes	☐ No	Service user agreed to plan	☐ Yes ☐ No
Carer involved in plan	☐ Yes	☐ No	Carer agreed to plan	☐ Yes ☐ No

Comments

OPPORTUNITIES FOR RISK PREVENTION

Including risk mitigating / protective factors.

SHORT-TERM CRISIS MANAGEMENT OPTIONS

LONG-TERM RISK MANAGEMENT OPTIONS

POSTIVE RISK OPTIONS (and support needed)

RESPONSIBILITIES FOR ACTION (including timescale and / or dates)

Assessor's Signature:	**Profession/Title:**
Assessor's Name:	
Date	

Date of next review	**Location of next review**

BECK SCALES FOR THE ASSESSMENT OF DEPRESSION, HOPELESSNESS AND SUICIDE IDEATION

Beck Depression Inventory (BDI-II)
Beck Hopelessness Scale (BHS)
Beck Scale for Suicide Ideation (BSI/BSS)
Suicide Intent Scale (SIS)

These scales have been formulated by Beck and are recognised by the Trust in its policies. It is not possible to reproduce the scales themselves in this Handbook, but the information below should help in determining when they may be useful to use as part of your risk assessment of your client.

All these tools are based upon a cognitive approach to therapy. Emotional problems are characterised by negative thinking that focuses on particular themes. These negative thoughts affect the behaviour of the client in highly individualised ways.

Beck Depression Inventory (BDI-II) - Age Range 13-80

The Inventory identifies the degree of negativity towards self, performance difficulties and the degree of unhappiness and pessimism.

Current research shows a high degree of correlation with suicide ideation in generalised population, however, the Beck Hopelessness Scale (BHS) and the Beck Self Concept Test (BST) have been found to be better indicators of intent.

Beck Hopelessness Scale (BHS) - Age Range 13-80

This has been found to be the most sensitive indicator of suicide risk amongst the Beck battery of tests.

It assesses the level of pessimism or negative view of the future held by the client. It is a 20-item true/false, self-report questionnaire.

It is advocated for use with the Beck Self Concept Test (BST) to improve its reliability.

Beck Scale for Suicide Ideation (BSI/BSS) - Age Range from 17 years

This scale assesses the degree to which someone is presently thinking of suicide. This is a 21-item scale administered in a structured clinical interview. Two of the items are intended to function as an internal screening component. This component saves time and reduces the intrusiveness of the questionnaire for patients who are non-suicidal. Ratings are made on a 3-point scale. It evaluates the intensity of specific attitudes, plans and behaviours concerning suicide, such as the frequency and duration of suicidal thoughts, subjective feelings of control, the relative strengths of the wish to live and the wish to die, deterrents, and the availability of method.
A number of limitations are cited regarding good clinical practice with the BSI/BSS.

1 The BSI/BSS scores are best regarded as indicators of *suicide risk* rather than as predictors of eventual suicide in a given case.

2 The BSI/BSS systematically covers a broad spectrum of attitudes and behaviours that clinicians routinely consider in judging suicidal intention. The BSI/BSS measures suicide ideation: as such, it should not be used as the sole source of information in the assessment of suicide risk. Any endorsement of any BSI/BSS item may reflect the presence of suicide intention and should be investigated by the clinician.

3 The BSI/BSS is a self-report instrument and contains no mechanism to detect dissimulation or confusion. Suicidal patients may deliberately conceal their intentions from others and may distort their BSI/BSS responses.

4 The BSI/BSS was developed with adult psychiatric outpatients and in-patients; it should be used cautiously with other populations.

5 The BSI/BSS is not intended as a replacement for expert clinical evaluation. Because patients with suicidal ideation may act upon their thoughts, the clinician reviewing BSI/BSS data must be able to respond with a full range of appropriate interventions.

Suicide Intent Scale (SIS)

This is a 15-item questionnaire administered in a clinical interview. It assesses the severity of the individual's psychological intent to die at the time of the attempt, by investigating relevant aspects of the attempter's behaviour before, during and after the attempt. Items include the degree of isolation and likelihood of being discovered, final acts, conception of lethality and medical rescuability, attitudes towards living and dying, and purpose of the attempt.

This scale has been consistently validated as a measure of the seriousness of the intent to die.

For further information on the above scales and the correct documentation, please contact the Risk Manager.

EDINBURGH POST NATAL DEPRESSION SCALE (EPDS)

The aim of the EPDS is to assist primary care teams in detecting mothers with postnatal depression. Cox et al, who developed the scale, referred to published work demonstrating that 10-15% of mothers experience a marked depressive illness in the months following childbirth; at least half have not recovered by the end of the post-partum year, and the children of such depressed mothers may show behaviour disturbance at 3 years or cognitive defects at 4 years.

The EPDS is a simple, 10-item questionnaire intended to be capable of completion in 5 minutes. It is best administered during the second or third month post-partum; the mother should not be given the opportunity to discuss her answers with others, as this may influence results.

Scores for each item range from 0-3 according to severity.

The authors suggested a threshold of 12/13; women scoring above this are most likely to be suffering from a depressive illness and therefore should be assessed further to confirm whether or not clinical depression is present. A threshold of 10 was suggested for routine use by primary care workers.

In a recent study, Harris et al confirmed that the EPDS is a valuable screening tool which performs as well as the Montgomery-Asberg Depression Rating Scale and the Raskin 3 Area Scale and is superior to the Beck Depression Inventory.

EPDS Score Interpretation Guide

Response categories are scored 0, 1, 2 and 3 according to increased severity of the symptom.

Items marked with an asterisk are reverse scored (ie 3, 2, 1 and 0). The total score is calculated by adding together the scores for each of the 10 items.

NORTH ESSEX MENTAL HEALTH PARTNERSHIP NHS TRUST

EDINBURGH POST NATAL DEPRESSION SCALE (EPDS)

Client's Name:	**Unit:**
CareBase Number:	**Date of Birth**:
Date of Assessment:	**Time of Assessment:**
Assessor's Signature:	**Profession/Title:**
Assessor's Name:	

As you have recently had a baby, we would like to know how you are feeling now. Please UNDERLINE the answer which comes closest to how you have felt IN THE PAST WEEK, not just how you feel today.

Here is an example, already completed -

I have felt happy:

Yes, all the time

Yes, most of the time

No, not very often

No, not at all

This would mean **"I have felt happy most of the time"** during the past week. Please complete the other questions in the same way.

IN THE PAST WEEK -

1	**I have been able to laugh and see the funny side of things**	As much as I always could Not quite so much now Definitely not so much now Not at all	
2	**I have looked forward with enjoyment to things**	As much as I ever did Rather less than I used to Definitely less than I used to Hardly at all	
3*	**I have blamed myself unnecessarily when things went wrong**	Yes, most of the time Yes, some of the time Not very often No, never	
4	**I have been anxious or worried for no good reason**	No, not at all Hardly ever Yes, sometimes Yes, very often	
5*	**I have felt scared or panicky for no very good reason**	Yes, quite a lot Yes, sometimes No, not much No, not at all	
6*	**Things have been getting on top of me**	Yes, most of the time I haven't been able to cope at all Yes, sometimes I haven't been coping as well as usual No, most of the time I have coped quite well No, I have been coping as well as ever	
7*	**I have been so unhappy that I have had difficulty sleeping**	Yes, most of the time Yes, sometimes Not very often No, not at all	
8*	**I have felt sad or miserable**	Yes, most of the time Yes, quite often Not very often No, not at all	
9*	**I have been so unhappy that I have been crying**	Yes, most of the time Yes, quite often Only occasionally No, never	
10*	**The thought of harming myself has occurred to me**	Yes, quite often Sometimes Hardly ever Never	
		TOTAL SCORE	

NORTH ESSEX PARTNERSHIP NHS FOUNDATION TRUST

MOTHER AND BABY ASSESSMENT

Client's Name:	**Unit:**
CareBase Number:	**Date of Birth**:
Date of Assessment:	**Time of Assessment:**
Assessor's Signature:	**Profession/Title:**
Assessor's Name:	

A	**Physical Needs of Baby:**	
	Carried Out By:	*Please circle that which is applicable -* Mother / Health Professional
	Feeding	
	Changing	
	Bathing	
	Entertaining	
	Current risks identified:	
B	**Mother's Acknowledgement and Perception of Baby:**	
	If Acknowledgement:	
	Positive	
	Negative	
	Comment on checking:	
C	**Holding the Baby:** **Mother's Behaviour:**	
	Relaxed and safe	
	Anxious	
	Tense	
	Refusal	

	Too tight	
	Willing, but unsafe	
	Distant	
	Current risks identified:	
D	**<u>Verbal Contact</u>:**	
	None	
	Appropriate	
	Inappropriate	
	Current risks identified:	
E	**<u>Eye Contact</u>:**	
	Total avoidance	
	Hostile	
	Menacing	
	Glancing	
	Appropriate	
	Current risks identified:	
F	**<u>Skin Contact</u>:**	
	Caresses baby	
	Minimal	
	Rough	
	Harmful	
	Current risks identified:	

NORTH ESSEX MENTAL HEALTH PARTNERSHIP NHS TRUST

WORTHING WEIGHTED RISK INDICATOR

Client's Name:	**Unit:**
CareBase Number:	**Date of Birth:**
Date of Assessment:	**Time of Assessment:**
Assessor's Signature:	**Profession/Title:**
Assessor's Name:	

Notes:

1. The risk indicator must include consideration of the impact of the illness on children and other dependants. This is particularly important in considering a full risk assessment.

2. Scores must be totalled and graded against severity scale below each indicator.

SUICIDE INDICATOR	NO	YES	SCORE
1. Has the client made a previous attempt on their life?			12
2. Did they use a violent method i.e. drowning / hanging / shooting?			12
3. Does the client use recreational drugs?			9
4. Does the client use alcohol to excess?			9
5. Is the client expressing suicidal thoughts?			5
6. Has the client considered / planned how they would kill themselves?			5
7. Does the client believe they have little or no control over their life?			5
8. Is the client expressing a high level of distress (delusions / low esteem / hallucinations)?			5
9. Does the client feel nothing has changed since the last attempt?			4
10. Does the client live alone?			2
11. Is the client separated / divorced / widowed?			2
12. Is the client unemployed or retired?			2
13. Is the client male?			1
14. Is the client aged over 45?			1
15. Is the client in poor physical health?			1
3 6 9 12 15 18 21 24 27 29 31 34 39 42 45 48 51 54 56 57 61 63 66 69 72			
LOW	**MODERATE**	**SEVERE**	

Client's Name:	Date of Assessment:		
VIOLENCE / AGGRESSION	**NO**	**YES**	**SCORE**
1. Has the client identified specific individuals they intend to harm?			12
2. Has the client used a weapon in the assault of another person?			9
3. Has the client been previously admitted to a high security unit?			9
4. Has the client been previously admitted to a low / medium secure unit?			7
5. Is there evidence of the client being dangerously impulsive to others?			5
6. Is there a known history of assaults on others that required medical attention?			5
7. Has the client threatened physical / psychological harm to others?			4
8. Has the client expressed paranoid delusions featuring specific individuals?			4
9. Has the client expressed but not demonstrated aggressive behaviour?			4
10. Is there evidence / reports of sexually inappropriate behaviour?			3
11. Has the client previous convictions for violent / sexually inappropriate behaviour?			3
12. Are there known triggers to violent behaviour?			3
13. Does the client use recreational drugs?			3
14. Does the client use alcohol to excess?			3
15. Has the client refused to co-operate in treatment designed to reduce dangerousness ?*			1
3 6 9 12 15 18 21 24 27 29 31 34 39 42 45 48 51 54 57 61 63 66 69 72			
LOW	**MODERATE**		**SEVERE**

NEGLECT INDICATOR	**NO**	**YES**	**SCORE**
1. Is the client failing to drink properly?			20
2. Is the client failing to eat properly?			16
3. Is the client without electric / gas for heat / light?			5
4. Is the client unable to adequately manage existing physical health problems?			4
5. Has the client debts that impact significantly on their life?			4
6. Does the client regularly experience financial difficulty (basic needs food / warmth / shelter)?			4
7. Is the client deprived of positive social contacts?			3
8. Is the client living in inadequate accommodation?			3
9. Is the client unable to adequately shop for themselves?			3
10. Is the client unable to adequately communicate need?			3
11. Is there pressure reference eviction / repossession?			2
12. Has the client a lack of sufficient / appropriate clothing?			2
13. Is the client unable to adequately mange their personal hygiene?			2
14. Is the client culturally isolated?			2
15. Is the client's accommodation detrimental to their health?			2
3 6 9 12 15 18 21 24 27 29 31 34 39 42 45 48 51 57 61 63 66 69 72			
LOW	**MODERATE**		**SEVERE**

Client's Name:	Date of Assessment:

Transfer scores to table below and "tick" the appropriate "Low, Medium or High" box

	SCORE	LOW	MED	HIGH
Suicide				
Violence / Aggression				
Neglect				

- Dangerousness = "The potential for acts which are likely to cause serious physical or lasting psychological harm". (Butler, Committee, Cmnd 6244, 1974)

RISK ASSESSMENT

Risk of unintentional self harm, e.g. self neglect	
Risk of intentional self harm / suicidal ideation / suicide attempt	
Risk to safety of others including physical, sexual, emotional, financial	
Risk of abuse by others including physical, sexual, emotional, financial	
Previous history of severe mental illness	
Family history of severe mental illness / suicide or attempted suicide	
Other comments	

ASSESSMENT TOOLS FOR RISK OF VIOLENCE

HCR-20 – Version 2

The HCR-20 is one of the most widely recognized and used risk assessment tools in relation to assessing risk of violence. It was first developed by British Columbia Forensic Psychiatric Services in Canada in 1995 and represents the outcome of an up-to-date amalgamation of current research and thinking on violence and mental disorder.

It is a checklist of 20 items which are considered risk factors for violent behaviour including historical, clinical and risk management factors. Use should be restricted to clinicians who have received training and should be considered as PART of a comprehensive risk assessment process. It is recommended for use in forensic and semi-forensic inpatient and community settings.

Hare's Psychopathy Check Lists

PCL-R (Hare's Psychopathy Check List – Revised)
PCL-SV (Hare's Psychopathy Check List – Short Version)
PCL-YV (Hare's Psychopathy Check List – Youth Version)

The Hare Psychopathy checklists are psycho-diagnostic tools for assessing psychopathy in forensic populations. The PCL uses interview and collateral (e.g., file) information to score items measuring the interpersonal, affective, and social deviance/lifestyle components of psychopathy. It is widely regarded as being the "state of the art" instrument for the purpose of assessment of psychopathy and is known to be a strong predictor of recidivism, violence and response to therapeutic intervention. Since, in making a diagnosis of psychopathy, the potential for harm to patients is very great, the instrument should only be used by those who,

- Possess an advanced degree in the social, medical or behavioural sciences,
- Have experience with forensic populations,
- Limit the use of the instrument to populations with whom it has been validated,
- Have adequate training in its use.

The manuals and coding sheets for these tools are lengthy and therefore not reproduced in this handbook. Please contact Michelle Appleby for further information about the use of these tools.

INSTRUCTIONS FOR THE SHORT CANE

The Short CANE is a comprehensive, person-centred needs assessment tool that has been designed for use with the elderly. It is suitable for use in a variety of clinical and research settings. The CANE has a person-centred approach which allows views of the professional, user, and carer to be recorded and compared. The instrument uses the principle that identifying a need means identifying a problem plus an appropriate intervention which will help or alleviate the need. Therefore the CANE models clinical practice and relies on professional expertise for ratings to be completed accurately. Administrators need to have an adequate knowledge of clinical interviewing and decision-making. Administrators should also have good working knowledge of the concepts of need, met need, and unmet need. This knowledge can be gained with experience of full CANE assessments and reference to the manual.

There are 24 topics relating to the user and two (A & B) relating to the carer. There are four columns to document ratings so that one or more of the user (U), staff member (S), carer (C), or rater (clinician/researcher) (R) can each express their view. Note at the top of the column which person has been interviewed.

The Short CANE aims to assess whether there is currently a need in the specific area. A need is defined as a problem with a potential remedy or intervention. Use the prompts below each area on the record form to establish the user's current status with regards to the need area. If there has been a need then assess whether it was met appropriately. Score each interviewee independently, even though their perceptions of need in each area may differ from one another. The administrator should ask additional questions probing into the area until he/she can establish whether the person has a significant need that requires assistance and whether they are getting enough of the right type of help. Once this information has been gathered a rating of need can be made. Judgement of rating in this section should be based on normal clinical practice. The CANE is intended to be a framework for assessment grounded in good professional practise and expertise. Although Section 1 in each problem area is the main section of interest to CANE administrators, it often cannot be rated until adequate information has been collected about the area. When adequate information has been gathered the rater should clearly be able to make a clinical judgement as to whether the area is a met need, an unmet need, or is not a need for the person. Confusion with ratings can be avoided by not directly asking a closed question about whether there is a problem in a certain area (e.g., "Do you have any problems with the food here?") because the person can answer "No". This response may then be mistaken as a 'No Need' where in fact it is a 'Met Need' because the person is assisted by someone else.

- *No Need:* Score 0 there if there is no need in the area then go on to the next page. In this situation the user is coping well independently and does not need any further assistance. For example, the user has reported that they are successfully administering their own medication and do not have any problematic side effects. Or the staff member reports that the user appeared to be comfortable in his/her home environment and that no alterations to the building are needed or planned.

- *Met Need:* Score 1 if the need is met or if there is a minor need requiring no significant intervention. A need is met when there is a mild, moderate or serious problem which is receiving an intervention which is appropriate and potentially of benefit. This category is also used for problems which would normally not be of clinical significance and would not require a specific intervention. For example, the user is receiving an assessment for poor eyesight or a district nurse is overseeing the administration of medications each day.

- *Unmet Need:* Score 2 if the need is currently unmet. An unmet need is a serious problem requiring intervention or assessment, which is currently receiving no assistance or the *wrong* type or level of help. For example, if a staff member reported that the user was incontinent of large amounts of urine every night despite toileting twice during the night and the use of pads. Or a carer reported that the user had become very hard of hearing and had not received an assessment or suitable hearing aids.

- *Unknown:* Score 9 if the person does not know about the nature of the problems or about the assistance the person receives and go on to the next page. Such a score may mean that further information is needed to make a rating.

SHORT CANE SCORING

It is to be noted that scoring is a secondary aspect of the CANE as its primary purpose is to identify and assess individual unmet needs. The total CANE score is based on the rating of section 1 of each of the 24 problem areas. The two areas (A and B) relating to carer's needs are not added into this total score. Count total number of met needs (rated as a 1 in Section 1), out of a maximum 24. Count total number of unmet needs identified (rated as a 2 in Section 1) out of a maximum score 24. Count total number of needs identified (rated as a 1 or 2 in Section 1), out of a maximum 24. The 'Raters' (clinicians or researchers) ratings are made based on all the information gathered through the assessment. Raters ratings of section 1 are used as the basis for total CANE scores.

FOR YOUR INFORMATION

There is a more comprehensive version of CANE (Version IV) which is available by contacting the Trust's Risk Management department on [I/S] ([I/S]).

NORTH ESSEX MENTAL HEALTH PARTNERSHIP NHS TRUST

CAMBERWELL ASSESSMENT OF NEED FOR THE ELDERLY
(CANE)

(SHORT CANE)
Version I

CLIENT'S Name:	Unit:
CareBase Number:	Date of Birth:
Date of Assessment/Interview:	Time of Assessment/Interview:
Assessor's/Interviewer's Signature:	Profession/Title:
Assessor's/Interviewer's Name:	

STAFF'S Name and Grade:	Unit:
Date of Assessment/Interview:	Time of Assessment/Interview:
Assessor's/Interviewer's Signature:	Profession/Title:
Assessor's/Interviewer's Name:	

CARER'S Name and Relationship:	Unit:
Date of Assessment/Interview:	Time of Assessment/Interview:
Assessor's/Interviewer's Signature:	Profession/Title:
Assessor's/Interviewer's Name:	

NORTH ESSEX MENTAL HEALTH PARTNERSHIP NHS TRUST

SHORT CANE

Client's Background Details

(Please fill in blanks, or circle whichever applies)

CLIENT'S NAME:			
UNIT:			
CAREBASE NUMBER:		DATE OF THIS FORMS'COMPLETION:	
DATE OF BIRTH:		AGE (in years):	
SEX:	Male / Female		
ETHNICITY:	Asian / African / African-American / Black Caribbean / White / Other ……		
RELIGION:	Christian / Muslim / Hindu / Jewish / Other ……..		
FIRST LANGUAGE	English / Other ……..		
MARITAL STATUS:	Single / Married / Divorced / Separated / Widowed		
LIVING SITUATION:	Alone / With Partner / With Other Relatives / With Others		
LIVING ENVIRONMENT:	Flat / House / Sheltered / Residential / Nursing / Other ……		
PREVIOUS OCCUPATION (or partner's):			
EDUCATION:	(years)		
CURRENT STATUS:	In-patient / Day-Patient / Community Patient (Psychiatric / Geriatric / Other ……)		
MAIN DIAGNOSES (DSM-IV/ICD 10):			
CURRENT MEDICATION:			
DISEASE PREVENTION: (eg blood pressure/ smoking/sleep pattern/ exercise/health screening/ vaccination)			
DOES THE PERSON HAVE A CARER?	Yes / No		
IS THE PERSON A CARER?	Yes / No		

NOTES:

NORTH ESSEX MENTAL HEALTH PARTNERSHIP NHS TRUST

SHORT CANE ASSESSMENT

Client's Name:			
Unit::		**CareBase No:**	

BEFORE COMPLETION PLEASE REFER TO 'INSTRUCTIONS FOR THE SHORT CANE'

Please rate the topics below using the following ratings
0 = No Need 1 = Met Need 2 = Unmet Need 9 = Unknown

Date of Assessment ➔				
Interviewee: U = User C = Carer S = Staff R = Researcher	**U**	**C**	**S**	**R**
1 ACCOMMODATION - Does the person have an appropriate place to live?				
2 LOOKING AFTER THE HOME - Does the person look after their home?				
3 FOOD - Does the person get enough of the right type of food to eat?				
4 SELF CARE - How does the person look after their self-care?				
5 CARING FOR SOMEONE ELSE - Does the person care for another? Can they manage this caring?				
6 DAYTIME ACTIVITIES - How does the person occupy their day?				
7 MEMORY - Does the person have a problem with memory?				
8 EYESIGHT / HEARING - How is the person's eyesight and hearing?				
9 MOBILITY / FALLS - How does the person get around inside and outside their home?				
10 CONTINENCE - How is the person's continence?				
11 PHYSICAL HEALTH - How is the person's physical health?				
12 DRUGS - Does the person have problems with medication or drugs?				
13 PSYCHOTIC SYMPTOMS - Does the person ever hear or see things others don't?				
14 PSYCHOLOGICAL DISTRESS - Does the person have problems with mood or anxiety?				
15 INFORMATION (ON CONDITION & TREATMENT) Has the person had clear information about their condition?				
16 SAFETY TO SELF (DELIBERATE SELF-HARM) Is the person a danger to themselves?				
17 SAFETY TO SELF (INADVERTANT SELF-HARM) Does the person have accidents?				
18 SAFETY TO SELF (ABUSE/ NEGLECT) Is the person at risk from others?				
19 BEHAVIOUR - Is the person's behaviour problematic for others?				
20 ALCOHOL - Does the person have a drinking problem?				
21 COMPANY - Does the person have an adequate social life?				
22 INTIMATE RELATIONSHIPS - Does the person have an close emotional/physical relationship?				
23. MONEY/ BUDGETING - How does the person manage their money?				
24 BENEFITS - Is the person receiving the benefits he/she is entitled too?				
A. *Carer's Need for Information* - Has the carer been given all the information they needs about the person's condition and treatment?				
B. *Carer's Psychological Distress* - Is the carer currently psychologically distressed?				
Met Needs - Count the number of 1s in the column (1 to 24 only).				
Unmet Needs - Count the number of 2s in the column (1 to 24 only)				
Total Needs - Add number of met needs and unmet needs (1 to 24 only)				

NORTH ESSEX MENTAL HEALTH PARTNERSHIP NHS TRUST

FALLS RISK ASSESSMENT

Client's Name:	Unit:
CareBase Number:	Date of Birth:
Date of Assessment:	Time of Assessment:
Assessor's Signature:	Profession/Title:
Assessor's Name:	
Consultant's Name	

1 Ensure that patient is aware of their own limitations or that family/carer is aware of the risks.

2 Patient's glasses are within reach and used at all times

3 Patient has hearing aid at all times

4 Patient has appropriate footwear and/or splints as required.

5 High risk patients are nursed in an area that can be monitored often

6 Is the patient on multiple medication? Can the doctor reduce mediation?

7 Is the patient pain free?

8. Is the patient's route to the toilet, etc, free from obstacles?

9. Is the lighting good?

10. If the patient cannot be monitored frequently, are you happy that they are in a safe environment?

EXPLANATIONS

GAIT

STEADY	Independently walking with or without aid
HESITANT	Needs supervision for safety
POOR WEIGHTBEARING	Requires 1-2 nurses for all movements
UNSTEADY	Requires the support of 1 person for safety
NON-WEIGHTBEARING	Unilateral / bilateral

SENSORY DEFICIT

SIGHT	i.e. Do they wear glasses? Is their sight impaired?
BALANCE	Unable to stand without some kind of support
MUSCLE WEAKNESS	Unilateral / bilateral

MEDICATION

DIURETICS	e.g. Frusemide, Amiloride, Spironolactone, Co-amilozide, Navispar, Co-amilofruse
HYPNOTIC	e.g. Nitrazepam, Temazepam
TRANQUILLISERS	e.g. Diazepam

IF UNSURE OF A DRUG ASK A QUALIFIED NURSE OR A DOCTOR

MOBILITY

FULL	Walks independently
RESTRICTED	Distances walked are limited to below 15 metres
BEDBOUND	TLC or nursed in bed due to a medical condition
PAINFUL SORES/WOUNDS	Any wound or sore beneath the knee

Is a pressure mattress to be used for this patient:	Yes ___	No ____
Are cot sides to be used for this patient:	Yes ___	No ____
Please explain how and why these decisions have been reached:		

SEX	SCORE
Male	1
Female	2
AGE	SCORE
60-75	1
75-85	2
85 & over	3
MEDICAL HISTORY	SCORE
Diabetes	1
CVA / Stroke	2
Parkinsons	2
Arthritis	1
Osteoporosis	2
History of fractures	2
Confusion	3
Multiple Conditions	3
MEDICATION	SCORE
None	0
Diuretics	1
Hypnotics	1
Tranquilisers	1
Hypotensives	1
Multiple	3
CONDITION OF FEET	SCORE
Oedematous	2
Decreased sensation	2
Neglected feet	2
Painful sores / wounds	3

FALLS HISTORY	SCORE
None	0
In ward	1
At home	2
Both	3
Frequent Falls	3
(Please state where)	
MOBILITY	SCORE
Fully Independent	1
Bed bound	1
Uses aids	2
Restricted	3
Chair Bound	3
GAIT	SCORE
Steady	0
Hesitant	1
Poor transfer	3
Unsteady	3
Non-weight bearing	3
SENSORY DEFICIT	SCORE
No deficit	0
Hearing	1
Sight	2
Balance	2
Muscle weakness	2
Multiple	3

3-8 LOW RISK 9-12 MEDIUM RISK 13+ HIGH RISK TOTAL SCORE RISK CATEGORY	
ACTION TAKEN	DATE
Refer to Chiropody Refer to Physio Refer to OT Recommend new footwear Risk management discussed	

NORTH ESSEX MENTAL HEALTH PARTNERSHIP NHS TRUST

THE WATERLOW PRESSURE SORE RISK CALCULATOR

RING SCORES IN TABLE, ADD TOTAL. SEVERAL SCORES PER CATEGORY CAN BE USED

Build/Weight for Height	H	Skin Type Visual Risk Areas	H	Sex Age	H	Special Risks	H
Average	0	Healthy	0	Male	1	**Tissue Malnutrition**	H
Above Average	1	Tissue Paper	1	Female	2		
Obese	2	Dry	1	14 – 49	1	eg Terminal Cachexia	8
Below Average	3	Oedematous	1	50 – 64	2	Cardiac Failure	5
		Clammy (temp ↑)	1	65 – 74	3	Peripheral Vascular Disease	5
		Discoloured	2	75 – 80	4	Anaemia	2
		Broken/Spot	3	81+	5	Smoking	1
Continence	**H**	**Mobility**	**H**	**Appetite**	**H**	**Neurological Deficit**	**H**
Complete/Catheterised	0	Fully	0	Average	0	e.g. Diabetes, MS, CVA, Motor/ Sensory Paraplegia	4-6
Occasionally Incontinent	1	Restless/Fidgety	1	Poor	1		
Cath/Incontinent of Faeces	2	Apathetic	2	N.G. Tube/ Fluids Only	2		
Doubly Incontinent	3	Restricted	3	NBM/Anorexic	3		
		Inert/Traction	4				
		Chairbound	5				

	Major Surgery/ Trauma	H
	Orthopaedic – Below Waist, Spinal On Table> 2 Hours	5 5
	Medication	H
	Cytotoxics High Dose Steroids Anti-Inflammatory	4

SCORE	10+ AT RISK	15+ HIGH RISK	20+ VERY HIGH RISK

THE WATERLOW PRESSURE SORE RISK CALCULATOR FLOW CHART

BUILD / WEIGHT FOR HEIGHT	DATE										
AVERAGE	0										
ABOVE AVERAGE	1										
OBESE	2										
BELOW AVERAGE	3										
CONTINENCE											
COMPLETE / CATHETERISED	0										
OCCASION INCONTINENT	1										
CATH / INCONTINENT OF FAECES	2										
DOUBLE INCONTINENT	3										
RISK AREAS VISUAL SKIN TYPE											
HEALTH	0										
TISSUE PAPER	1										
DRY	1										
OEDEMATOUS	1										
CLAMMY	1										
DISCOLOURED	2										
BROKEN / SPOT	3										
MOBILITY											
FULLY	0										
RESTLESS / FIDGETY	1										
APATHETIC	2										
RESTRICTED	3										
INERT / TRACTION	4										
CHAIRBOUND	5										

NAME	**HOSPITAL NUMBER**

SPECIAL RISK	DATE										
TISSUE MALNUTRITION											
eg TERMINAL CAHEXIA	8										
CARDIAC FAILURE	5										
PERIPHERAL VASCULAR DISEASE	5										
ANAEMIA	2										
SMOKING	1										
NEUROLOGICAL DEFECIT											
eg DIABETES, CVA	4										
MS, PARAPLEGIA	to										
MOTOR / SENSORY	6										
MAJOR SURGERY / TRAUMA											
ORTHOPAEDIC – BELOW											
WAIST, SPINAL	5										
ON TABLE > 2 HRS	5										
MEDICATION											
STEROIDS, CYTOTOXICS,											
ANTI – INFLAMMATORY.	4										
SEX											
AGE											
MALE	1										
FEMALE	2										
14 – 49	1										
50 – 64	2										
65 – 74	3										
75 – 80	4										
81 +	5										
APPETITE											
AVERAGE	0										
POOR	1										
N G TUBE / FLUIDS ONLY	2										
NBM / ANOREXIC	3										

DATE	**SCORE**	**MAT**

10 + AT RISK
15 + HIGH RISK
20 + VERY HIGH RISK

RING SCORES IN TABLE, ADD TOTAL - SEVERAL SCORES PER CATEGORY CAN BE USED

GUIDELINES FOR COMPLETING

'BRADEN'

PRESSURE ULCER RISK ASSESSMENT SCALE AND PROGRESS CHART

(This form can be used for up to four assessments)

- Use new line for each assessment. Date and time each entry, record score in each box and total. Also indicate in your professional opinion the level of risk, ie low, medium or high

- Assess the patient's condition at that point in time, not how they were prior to admission.

- If pressure-relieving equipment is required, use equipment flow chart and request (via equipment library) quoting the 'Braden' risk assessment score and the level of risk.

ON ADMISSION OR TRANSFER TO WARD

- All patients to be assessed using the 'Braden' Pressure Ulcer Risk Assessment Scale.

- **If not at risk** – Re-assess weekly ***OR*** at any major change in the patient's condition.

- **If at risk** – Reassess ***daily*** for at least the next ***three days*** after admission, then reassess weekly or following any major change of condition.

- **If at risk** – Briefly provide the following information, using the lower half of the form. Space limited – keep the information brief.

- **Skin Assessment** – Complete a visual assessment of the patient's skin, particularly the pressure points and record any pressure ulcers (grade and site) or tissue damage, ***however minor***.

- **Action Taken** – Particularly turning/positional changes and time intervals, eg 1, 2 hourly, etc.

- **Equipment Required** – Record any pressure reducing (static), pressure relieving (dynamic) and manual handling equipment required.

- **Equipment Requested** – Date and time, also requested from where.

- **Equipment Received** – Date and time

- **Outcome** – The aim is to reduce the risk of pressure damage. Therefore, when reassessing, has this been achieved? If not – why?

'BRADEN' PRESSURE ULCER RISK ASSESSMENT

- Assess all patients admitted or transferred to ward.
- Always assess potential risk to pressure ulcers on admission or as soon as possible after admission. If at risk, reassess daily for 3 days after admission, then reassess weekly or following any significant change in patient's condition.
- Assess the patient, as they appear at that point in time not how they were prior to admission or what you expect them to be in the future.
- *"Risk assessment tools should only be used as an 'aid memoir' and should not replace clinical judgement"*
- All patients must have a skin integrity assessment on admission or transfer to ward and a record of any pressure ulcers (grade and site) must be made.

SENSORY PERCEPTION

Defined as – *The patient's ability to respond meaningfully to pressure related discomfort*

- The ability to feel discomfort is probably the most important factor when trying to prevent pressure ulcers. The healthy person relies on 'spontaneous body movement' to prevent tissue damage. If we are unable to feel this discomfort spontaneous body movement does not occur or is significantly reduced. Therefore greatly increasing the chances of tissue damage.
- Generally, it is obvious if certain groups of patients experience a lack of feeling, eg spinal injury, stroke, advanced MS, neurological disorders, etc. In other groups of patients poor sensation may be less obvious, eg diabetic patients with peripheral neuropathy, minor strokes, sedated patients, recent major surgery, advanced disease, spinal anaesthetic, cord compression, vascular surgery, some elderly patients also experience reduced peripheral loss of sensation.

MOISTURE

Defined as – *Degree at which the skin is exposed to moisture*

- Usually straight forward includes urine and faecal incontinence as well as sweating which can also expose the skin to moisture.

ACTIVITY

Defined as – *The degree of physical activity*

- Again assess the patient's activity as they are at that time.
- Score 1 (bed fast) if the patient has just been admitted and the likelihood is that they will remain on a trolley or bed rest for the main part of the day, even though they may normally be independent.

MOBILITY

Defined as – *The patient's ability to change and control body position*

- Score 1 (completely immobile) if the patient makes no attempt to change his/her position while in bed or chair.
- Score 4 (no limitation) if the patient is on bed rest but is totally independent while confined to bed.

NUTRITION

Defined as – *Usual food intake*

- Score 1 if the patient is 'nil by mouth' and on IV fluids for 1-5 days.

FRICTION AND SHEAR

Measures the amount of friction and sheer force the patient is exposed to. Friction and shear are two of the three forces that may cause tissue damage (the third force is direct pressure).

- Score 1 if the patient is frequently sliding in the bed or chair but cannot reposition self. Even though the nurse/carer is able to reposition him/her. NB You are measuring the patient's ability to correct a patient's own position not the nurse/carer's ability.

'BRADEN' PRESSURE ULCER RISK ASSESSMENT SCALE

- **FIRST ASSESSMENT** to be completed as soon as possible after admission. **IF AT RISK** – reassess daily for at least the first **3 DAYS** after **ADMISSION,** then reassess weekly **OR** following any significant change in the patient's condition.
- Also complete a visual assessment of the patient's skin, particularly the pressure points.

SENSORY PERCEPTION Ability to respond meaningfully to pressure related discomfort	**Completely Limited – Score 1**	**Very Limited – Score 2**	**Slightly Limited – Score 3**	**No Impairment – Score 4**
	Unresponsive (does not moan, flinch or grasp) to painful stimuli, due to diminished level of consciousness or sedation OR Limited ability to feel pain over most body surfaces	Responds only to painful stimuli. Cannot communicate discomfort except by moaning or restlessness OR Has a sensory impairment, which limits the ability to feel pain or discomfort over ½ the body.	Responds to verbal commands but cannot always communicate discomfort or needs to be turned. OR Has some sensory impairment which limits ability to feel pain or discomfort in 1 or 2 extremities.	Responds to verbal commands. Has no sensory deficit, which would affect ability to feel pain or discomfort.
MOISTURE Degree at which the skin is exposed to moisture	**Constantly Moist – Score 1**	**Very Moist - Score 2**	**Occasionally Moist – Score 3**	**Rarely Moist – Score 4**
	Skin is kept moist almost constantly by perspiration, urine, etc. Dampness is detected every time the patient is moved or turned.	Skin is often but not always moist. Linen must be changed at least once per shift.	Skin is occasionally moist, requiring an extra linen change approximately once per day.	Skin is usually dry. Linen only requires changing at routine intervals.
ACTIVITY Degree of physical activity	**Bed fast - Score 1**	**Chair fast – Score 2**	**Walks Occasionally – Score 3**	**Walks Frequently – Score 4**
	Confined to bed	Ability to walk severely limited or non-existent. Cannot bear own weight and/ or must be assisted into chair or wheelchair.	Walks occasionally during day, but very short distances, with or without assistance. Spends majority of each shift in bed or chair.	Walks outside the room at least twice and inside room at least once every 2 hours during waking hours.
MOBILITY Ability to change and control body position	**Completely Immobile – Score 1**	**Very Limited – Score 2**	**Slightly Limited – Score 3**	**No Limitations – Score 4**
	Does not make even slight changes in body position without assistance	Makes occasional slight changes in body position but unable to make frequent or significant changes independently	Makes frequent though slight changes in body position, independently.	Makes major and frequent changes in position without assistance
NUTRITION Usual food intake pattern	**Very Poor – Score 1**	**Probably Inadequate – Score 2**	**Adequate - Score 3**	**Excellent – Score 4**
	Never eats a complete meal. Rarely eats more than 1/3 of any food offered. Eats 2 servings of protein (meat or dairy products) per day. Fluid taken poorly. Does not take a liquid diet supplement OR Is NBM and/or maintained on clear liquids or IV's for more than 5 days	Rarely eats a complete meal and generally eats only ½ of any food offered. Protein includes only 3 servings of meat or dairy products per day. Occasionally will take a dietary supplement OR Receives less than the optimum amount of liquid diet or tube feed.	Eats almost half of most meals. Eats a total of 4 servings of protein (meat or dairy products) each day. Occasionally, will refuse a meal, but will usually take a dietary supplement if offered OR Is on tube feeding or TPN which probably meets most of nutritional needs.	Eats most of every meal never refuses a meal. Usually eats a total of 4 or more servings of meat and dairy products. Occasionally eats between meals. Does not require supplements.
FRICTION AND SHEAR	**Problem - Score 1**	**Potential Problem – Score 2**	**No Apparent Problem – Score 3**	
	Required moderate to maximum assistance in moving. Complete lifting without sliding is impossible. Frequently slides down bed or chair, requiring frequent repositioning with maximum assistance. Spasticity, contractures or agitation leads to almost constant friction.	Moves freely or requires minimum assistance. During a move skin probably slides to some extent against the sheets, chair or other devices. Maintains relevant good position in chair or bed most of the time but occasionally slides down.	Moves in bed and chair independently and has sufficient muscle strength to lift up completely during movement. Maintains good position in bed or chair at all times.	

FOR GUIDELINES SEE OVER PAGE

ONE PAGE ONLY

NORTH ESSEX MENTAL HEALTH PARTNERSHIP NHS TRUST

'BRADEN' PRESSURE ULCER RISK ASSESSMENT SCALE AND PROGRESS CHART

Patient's name			
Ward/Unit		**Carebase No**	

- ***FIRST ASSESSMENT*** to be completed as soon as possible after admission.
- ***IF AT RISK*** – *Reassess daily for at least the first **3 DAYS** after **ADMISSION**, then reassess weekly **OR** following any major change in the patient's condition.*

Assessment Date and Time →		Record Score ↓	Record Score ↓	Record Score ↓	Record Score ↓
SENSORY PERCEPTION					
Completely limited	1				
Very limited	2				
Slightly limited	3				
No impairment	4				
MOISTURE					
Constantly moist	1				
Very moist	2				
Occasionally moist	3				
Rarely moist	4				
ACTIVITY					
Bed fast	1				
Chair fast	2				
Walks occasionally	3				
Walks frequently	4				
MOBILITY					
Completely immobile	1				
Very limited	2				
Slightly limited	3				
No limitation	4				
NUTRITION					
Very poor	1				
Probably inadequate	2				
Adequate	3				
Excellent	4				
FRICTION & SHEAR					
Problem	1				
Potential problem	2				
No apparent problem	3				
TOTAL 16 or less = at Risk Low (L) Medium (M) High (H) →		Total = Tick ✓ L, M, H	Total = Tick ✓ L, M, H	Total = Tick ✓ L, M, H	Total = Tick ✓ L, M, H

PATIENTS AT 'RISK' **– Brief information on the following (more detailed information to be included in the nursing notes.**

Skin Assessment – A visual inspection of the patient's skin must be completed as soon as possible after admission. Record any pressure ulcers (grade and site), ***however minor.***				
Action Taken Including turning regime				
Equipment Required (pressure relieving, manual handling, etc)				
Equipment Requested Date and time				
Equipment Received Date and time				
Outcome				
Assessor's Signature, printed name and grade				

ONE PAGE ONLY

NORTH ESSEX MENTAL HEALTH PARTNERSHIP NHS TRUST

THE NORTON SCALE

Patient's name			
Ward/Unit		**CareBase No**	

Instructions for use –

1 Assess the patient's condition and score accordingly (1-4) under each heading (A-E).

2 Total the scores together.

3 A total of 14 and below indicates a patient is at risk and preventative measures should be taken. **The lower the total, the higher the risk.**

4 Assess the patient regularly.

Patients with scores of 14 or below are considered to run the greatest risk of developing pressure ulcers.

Patients with scores of 14-18 are not considered to be at risk, but they will require reassessment immediately any change in their conditions is observed.

Scores of 18-20 indicate patients at minimal risk.

(Source - Marsden 2001 page 691)

(A) Physical Condition		(B) Mental Condition		(C) Activity		(D) Mobility		(E) Incontinent	
Good	4	Alert	4	Ambulant	4	Full	4	Not	4
Fair	3	Apathetic	3	Walk/Help	3	Slightly Limited	3	Occasionally	3
Poor	2	Confused	2	Chairbound	2	Very Limited	2	Usually/Urine	2
Very Bad	1	Stuporous	1	Bedfast	1	Immobile	1	Doubly	1

Source: Norton *et al.* 1985

Assessed by	
Name	Grade
Date	Time

ONE PAGE ONLY

NORTH ESSEX MENTAL HEALTH PARTNERSHIP NHS TRUST

ASSESSMENT OF MANUAL HANDLING NEEDS

(This assessment should be conducted in line with the Trust's Manual Handling Policy)

Client's Name: …… Ward and Unit: ……

Weight: …….. Co-operative: Yes / No In Pain: Yes / No

ASSESSMENT FOR MANOEUVRING A CLIENT IN THE FOLLOWING SITUATIONS *(Please circle as appropriate)*

BED	SIT/STAND	WALK	BATH	WHEELCHAIR IF REQUIRED
Unaided	Unaided	Unaided	Unaided	Unaided
Unaided but under supervision	Unaided but under supervision	Unaided but under supervision	Unaided but under supervision	Unaided but under supervision
Minimal assistance required	Walking aids Under supervision Assistance required	Walking aids Under supervision Assistance required	Assistance required (excluding manual lifting)	Minimal assistance required
Assistance required 1 person 2 persons Hoist	Assistance required 1 person 2 persons	Assistance required 1 person 2 persons Wheelchair	Mechanical assistance, ie hoist	Assistance required 1 person 2 persons Mechanical assistance
Additional comments:				

Signature: …… Designation: …… Date: …….

To be re-assessed on ……. (date) or sooner if there is any significant change in the client's health.

This assessment should be kept with the client's notes.

DRIVING

Refer to Current Driver and Vehicle Licensing Agency (DVLA) Booklet
'For Medical Practitioners –
At a Glance Guide to the Current Medical Standards of Fitness to Drive'
(NB Standards are reviewed every six months)

'To download a current version of the above booklet see website
http://www.dvla.gov.uk/at_a_glance/content.htm

Extract from the current above publication -

'This booklet is published by the Department for Transport. It describes the law relating to medical aspects of driver licensing. In particular, it advises members of the medical profession on the medical standards which need to be met by individuals to hold licences to drive various categories of vehicle. The Department has prepared the document on the advice of its Advisory Panels of medical specialists.'

'The document provides the basis on which members of the medical profession advise individuals on whether any particular condition could affect their driving entitlement. It is the responsibility of the individual to report the condition to the DVLA in Swansea. DVLA will then conduct an assessment to see if the individual's driving entitlement may continue or whether it should be changed in any way. (For example, entitlement could be permitted for a shorter period only, typically three years, after which a further medical assessment would be carried out by DVLA).'

For your information, the contents of the current booklet (February 2004 edition) include -

Introduction to the Booklet

Summary of Amendments Since the Last Edition

Chapter 1	Neurological Disorders
Chapter 2	Cardiovascular Disorders
Chapter 3	Diabetes Mellitus
Chapter 4	Psychiatric Disorders
Chapter 5	Drug and Alcohol Misuse and Dependency
Chapter 6	Visual Disorders
Chapter 7	Renal Disorders, Respiratory Disorders, Sleep Disorders
Chapter 8	Miscellaneous Conditions, Elderly Drivers
Annex 1	Driving Assessment for Disabled Drivers
Annex 2	Disabled Drivers' Assessment Centres
Annex 3	Withdrawal of Anti-Epileptic Medication
	Epilepsy Regulations
	Index of Medical Conditions

PLEASE NOTE –
'The standards are reviewed every six months, following updated advice from the Secretary of State's Honorary Medical Advisory Panels. The next revision is scheduled for Autumn 2004.'

DRIVING – PSYCHIATRIC

NEUROSIS	No need to notify, can drive if OK and no medication side effects
PSYCHOSIS	Licence restored if free from symptoms and has insight for up to 12 months
DEMENTIA	**Early Dementia** OK if no significant disorientation in time and space, plus retention of insight and judgement Annual review
	Otherwise - Usually driving permitted if ability to cope with general day to day living, ie insight and judgement retained
ALCOHOL ABUSE	Licence refused or revoked for one year minimum If severe (eg Korsakoff's, severe Cirrhosis) → revoked

- Inform the patient that they may not be fit to drive and advise them to inform the DVLA and their insurance company.

If you deem them as unable to comprehend then you must inform their relative/carer and consider whether the public interest necessitates your writing to the DVLA.

This is one of the circumstances under which confidentiality can be breached. However this is a medical decision and this should be referred to the relevant doctor.

DRIVING - GENERAL

GROUP 1 (Most of us!)	Until 70 years of age, then 3 yearly with medical form
GROUP 2 (PSV, HGV, etc)	Until 45 years of age, then 5 yearly until 65 then annually
CHRONIC NEUROLOGICAL eg Parkinsons	Medical assessment ? Short licences
CEREBROVASCULAR	One month off then licence if clinical recovery
TRANSIENT GLOBAL AMNESIA	Provided no epilepsy, HI or no other cause OK
ANGINA, HEART FAILURE ARRYTHMIAS	Stop if occurs while driving Start when symptoms controlled
HYPERTENSION ECG ABNORMALITY	OK if no other symptoms
MI **PACEMAKER INSERTION**	Stop for one month Restart if OK
DIABETES - NIDDM IDDM	Subject to satisfactory control and no other relevant disabilities
DIABETES - Diet controlled	No need to notify

NORTH ESSEX MENTAL HEALTH PARTNERSHIP NHS TRUST

TRANSPORT RISK ASSESSMENT CHECKLIST FOR STAFF USING PRIVATE CARS TO TRANSPORT CLIENTS

Client's Name:		Unit:
CareBase Number:		Date of Birth:
Date of Assessment:		Time of Assessment:
Is the client -		
1	Able to safely get in and out of the front/back seat of the vehicle	Yes / No
	Does the vehicle offer two or four door access to the client– *(Consider physical condition of client and any behavioural risks that are of concern)*	Two / Four
	Level of assistance required: Independent / Independent with Supervision / Assistance of One / Assistance of Two	
2	Considered fit enough to travel? *If unsure, seek medical advice or make alternative arrangements*	Yes / No
3	Likely to carry out any of the following risk behaviours –	
	(a) Attempt to leave the car at inappropriate times and places?	Yes / No
	(b) Interfere with the car controls?	Yes / No
	(c) Require high levels of attention from the driver?	Yes / No
	(d) Display signs of verbal or physical aggression?	Yes / No
	If 'Yes' is answered to any of the above behaviours, further consultation with the team is required.	
4	Able to cope (physical mobility and psychologically) and remain safe, if the car broke down?	Yes / No
Escort		
1	***Please complete*** - The appropriate level of escort availability has been assessed and the outcome is that the client -	
Is the car driver -		
1	Covered to carry clients by their personal car insurance (including written confirmation)?	Yes / No
2	Able to contact appropriate agencies in an emergency situation, for example car breakdown? (ie using mobile phone and having phone numbers to hand)	Yes / No
3	Able to fit and secure down necessary objects (eg mobility aids or medical devices) in the car?	Not Applicable/ Yes / No
OUTCOME OF ASSESSMENT		
Unable to transport client safely in the car. Appropriate alternative arrangements, for example a Trust vehicle which can accommodate the needs of the client – **Please specify** -		
Able to transport client safely in the car under the following conditions - *(These may include having an escort, using child locks, sitting service user in back seat of vehicle, using a swivel seat.)*		
Assessor's Signature:		Profession/Title:
Assessor's Name:		

This assessment should be regularly reviewed and the outcome could be rescinded at any time in the assessor's judgement.

TRANSPORT RISK ASSESSMENT CHECKLIST FOR STAFF USING PRIVATE CARS TO TRANSPORT CLIENTS (Continued)

Client's Name ………………………………………………………………

Date	**OUTCOME OF RE-ASSESSMENT** (Circle response as applicable)		PRINT **Name of Assessor**	**Assessor's Signature**
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FIRST OF NINE PAGES

Essex County Council

North Essex NHS
Mental Health Partnership
NHS Trust

ASSESSMENT & RISK ASSESSMENT SUMMARY FOR YOUNG PEOPLE UNDER 17 YEARS (APRIL 2004)

Patient's Name			
CareBase (CB) Number		Date of Birth	
Address and Contact Number			

Date Form Completed	

This tool is designed as an **Aid** to risk assessment and does not replace your clinical judgement. It should be used both as a prompt and a record of contact for the case notes.

PERMISSION TO SHARE INFORMATION WITH PARENTS/ OTHER SERVICES	No		Yes	

Referrer			
Name	Job Title	Location	Contact Number

OTHER INVOLVED PROFESSIONALS (tick where applicable)			
GP		School	
Referrer		Other NHS providers professionals	
Social Care Services		Police	
Other (please specify			

STATED REASON FOR REFERRAL AND SERVICE REQUESTED BY REFERRER

TYPE OF REFERRAL (tick where applicable)			
Individual		Whole family	
Siblings/More than one child		Parents only	

LEGAL STATUS ON REFERRAL (tick where applicable)			
Not special status		Other order	
Wardship		Seeking asylum	
Children Act Order		Court Order	

WHO HAS LEGAL RESPONSIBILITY (tick where applicable)			
Parents married/cohabiting		Foster carers	
Parents separated/divorced		Two adoptive parents	
One parent, widowed		Other relatives	
One parent		Local Authority	
One birth, one adoptive			

TYPE OF SCHOOL (Please detail)

FAMILY COMPOSITION (Please use a genogram)

HISTORY (Not restricted to risk)

Relevant family, medical, psychiatric or psychotherapeutic, school history, major life events, trauma, etc

PRESENTING PROBLEMS AND THEIR DURATION AS PERCEIVED BY THE CLINICIAN (including current mental state)

Current Medication

HISTORY OF RISK TO THE CHILD FROM OTHER PEOPLE (Please refer to Safeguarding Children Folder)				
	✷N/A	Mild	Moderate	Severe
Risk of physical abuse				
Risk of neglect				
Risk of sexual abuse (including prostitution)				
Risk of emotional abuse				
Risk of being bullied				

IS THE CHILD ON THE CHILD PROECTION REGISTER	No		Yes	
If YES, in which category				

HISTORY OF RISK TO SELF OR OTHERS FROM CHILD				
	✷N/A	Mild	Moderate	Severe
Drug abuse				
Alcohol abuse				
Eating disorder				
Self-neglect/self-harm				
Offering self for abuse/prostitution				
Suicide attempts				
Significant damage to property				
Fire setting or arson				
Absconding				
Threatening behaviours				
Harming animals				
Physical violence to others (including other children/ adults)				
Sexual harm to other child				
Using objects to inflict harm to other (including weapons)				

✷ N/A relates to the time at assessment

Additional comments

PROTECTIVE FACTORS – 'TURNING POINTS'

Motivation to change
Ability to learn from experiences
Positive response to treatment opportunities
Stabilising relationships
Education/Work opportunities
Avoidance of risk-taking peers/adults
Effective use of time
Availability of treatment

FORMULATION

CHILDREN'S GLOBAL ASSESSMENT SCALE SCORE (C-GAS score)

CURRENT LEVEL OF RISK (Please tick one box for each category)

	✸N/A	Mild	Moderate	Severe
Harm from others				
Suicide				
Self Harm (including eating disorders)				
Harm to others				
Legal/Forensic/Risk of imprisonment				
Psychiatric breakdown				

✸ N/A relates to the time at assessment

SUMMARY OF RISK ASSESSMENT
(Also highlight areas where information is not known and recommended follow-up action including availability of treatment)

CARE PLAN AND RISK MANAGEMENT
(State briefly treatment offered by other agencies where necessary)

OUTCOME OF ASSESSMENT (Please tick the box that applies in each category - there are other outcomes possible)

Ongoing treatment offered	☐	YES	If YES please go to 'Treatment type'
	☐	NO	If NO please go to 'Reasons for not undertaking ongoing treatment'

TREATMENT TYPE			
Brief treatment (6 appts only)	☐	Standard – once a week	☐
Group	☐	Standard – less than once a week	☐
Individual – intensive (2 per week)	☐	Intermittent (6 appts maximum in 12 months)	☐
Individual – intensive (3 per week)	☐	Family	☐
Individual – intensive (4 per week)	☐	Couples	☐
(Individual – intensive (5 per week)	☐	Referral to Adolescent Unit	☐
Referral to specialist services	☐	Referral to Adult Services	☐
Referral to other agency	☐	Referral to Child and Family Consultation Service	☐
Referral to private therapy/ voluntary services	☐		

REASONS FOR NOT UNDERTAKING ONGOING TREATMENT		
Mutual agreement	☐	
Treatment declined by patient	☐	
Treatment declined by parent (s)	☐	
Treatment judged not indicated by therapist	☐	
Funding for treatment refused	☐	
Other, please specify	☐	

CARE PLAN REVIEW
Care Plan Review Date (If other than termly Care Plan review)

SIGNATURES			
Completed by (name)		Case Consultant/ Manager (name)	
Professional status		Signature	
Signature		Date	

NB Where possible, a risk assessment should be completed by two clinicians

Essex County Council

North Essex NHS
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NHS Trust

CARE & RISK REVIEW FOR YOUNG PEOPLE UNDER 17 YEARS (APRIL 2004)

CareBase Number	

CHILD AND FAMILY CONSULTATION SERVICE / ADOLESCENT / OTHER
(Please circle as appropriate)

AUTUMN/SPRING/SUMMER TERM
(Please circle as appropriate)

Date form completed	

PERMISSION TO CONTACT PARENTS/OTHER SERVICES WITHHELD	No		Yes	

ATTENDANCE

CURRENT ISSUES INCLUDING ANY CONCERNS

PROGRESS OF TREATMENT

CURRENT LEVEL OF RISK (Please tick one box for each category)

	✸N/A	Mild	Moderate	Severe
Harm from others				
Suicide				
Self Harm (including eating disorders)				
Harm to others				
Legal/Forensic/Risk of imprisonment				
Psychiatric breakdown				

✸ N/A relates to the time at assessment

CHILDREN'S GLOBAL ASSESSMENT SCALE SCORE (C-GAS Score)

Additional Comments

CareBase Number …….. **THIRD OF THREE PAGES**

The following information is required for case notes. If any categories apply, please tick.

OUTCOME OF REVIEW			
Client/Person with parental responsibility given care plan copy		Day Centre involved	
Child Risk Assessment Requested		Sheltered work involved	
Social Worker involved		Non NHS residential accommodation	
Domicile care involved		Other	

STATUS			
Continue		Deceased	
Discharge		Move out of area	
Lost to Service		Other – including intermittent holding	

SIGNATURES			
Completed by (name) Care Co-ordinator's Name:		Case Consultant (name)	
Professional status		Signature	
Signature		Date	

Essex County Council

North Essex NHS
Mental Health Partnership
NHS Trust

ASSESSMENT & RISK ASSESSMENT SUMMARY FOR CHILDREN UNDER 5 YEARS (APRIL 2004)

Patient's Name			
CareBase (CB) Number		Date of Birth	

Date Form Completed	

Date of first contact with psychotherapist/psychiatrist/psychologist/social worker/nurse specialist

PERMISSION TO CONTACT THE GP WITHHELD	No		Yes	

Referrer			
Name	Job Title	Location	Contact Number

OTHER INVOLVED PROFESSIONALS (tick where applicable)			
GP		Nursery School/Other day care	
Referrer		Paediatric department	
Social Services		Health Visitor	
Other (please specify)		Police	

STATED REASON FOR REFERRAL AND SERVICE REQUESTED BY REFERRER

TYPE OF REFERRAL (tick where applicable)			
Individual		Whole family	
Siblings/More than one child		Parents only	

LEGAL STATUS ON REFERRAL (tick where applicable)			
Not special status		Other order	
Wardship		Seeking asylum	
Children Act Order's		Court Order	

Patient Name			
CareBase (CB) Number		Date of Birth	

WHO HAS LEGAL RESPONSIBILITY (tick where applicable)			
Parents married/cohabiting		Foster carers	
Parents separated/divorced		Two adoptive parents	
One parent, widowed		Other relatives	
One parent		Local Authority	
One birth, one adoptive			

DAY CARE	
None – too young	
Pre-school/nursery	
Childminder/day care	
Day care by relative	

FAMILY COMPOSITION (Please use a genogram)

Patient Name			
CareBase (CB) Number		Date of Birth	

PRESENTING PROBLEMS AND THEIR DURATION AS PERCEIVED BY THE CLINICIAN

HISTORY (Not restricted to risk)
Relevant family, developmental history, medical, psychiatric or psychotherapeutic history, quality of family relationships especially the parent-infant relationship.

FORMULATION

Patient Name			
CareBase (CB) Number		Date of Birth	

FORMULATION (continued)

INSERT AN ADDITONAL PAGE IF NECESSARY

PARENT INFANT RELATIONSHIP - CHILDREN'S GLOBAL ASSESSMENT SCALE SCORE (PIR – CGAS Score)

HISTORY OF RISK TO THE CHILD FROM OTHER PEOPLE

	✷N/A	Mild	Moderate	Severe
Risk of physical abuse				
Risk of neglect				
Risk of sexual abuse				
Risk of emotional abuse				
Risk to well-being and/or development from home environment (not included in the above categories) eg violent family relationships, post-natal depression, traumatic contact arrangements, etc				

IS THE CHILD ON THE CHILD PROECTION REGISTER	No		Yes	

If YES, in which category

HISTORY OF RISK TO SELF OR OTHERS FROM CHILD

	✷N/A	Mild	Moderate	Severe
Feeding difficulties				
Failure to thrive				
Hurting self, eg head banging, biting self				
Risk-taking behaviour eg climbing on window sills, etc				
Significant damage to property				
Using dangerous equipment, eg knives, matches				
Running away from home or parent				
Threatening behaviours				
Harming animals				
Physical violence to other child eg biting, drowning, etc				
Sexual harm to other child				

✷ N/A relates to the time at assessment

Patient Name			
CareBase (CB) Number		Date of Birth	

CURRENT LEVEL OF RISK (Please tick one box for each category)				
	✸N/A	Mild	Moderate	Severe
Harm from others				
Risk-taking dangerous behaviour				
Self Harm				
Harm to others				
Risk of breakdown of relationships/placement				
Extreme emotional reactions which impede development and relationships				

✸ N/A relates to the time at assessment

SUMMARY OF RISK ASSESSMENT
(Also highlight areas where information is not known and recommended follow-up action)

CARE PLAN AND RISK MANAGEMENT
(State briefly treatment offered at CFCS and by other agencies where necessary)

Patient Name			
CareBase (CB) Number		Date of Birth	

OUTCOME OF ASSESSMENT (Please tick the box that applies in each category) there are other outcomes possible)

Ongoing treatment offered		YES	If YES please go to 'Treatment type'
		NO	If NO please go to 'Reasons for not undertaking ongoing treatment'

TREATMENT TYPE			
Brief treatment (6 appts only)		Standard – once a week	
Group		Standard – less than once a week	
Individual – intensive (2 per week)		Intermittent (6 appts maximum in 12 months)	
Individual – intensive (3 per week)		Family	
Individual – intensive (4 per week)		Couples	
(Individual – intensive (5 per week)			

REASONS FOR NOT UNDERTAKING ONGOING TREATMENT			
Mutual agreement		Referral to Adolescent department	
Treatment declined by patient		Referral to Adult department	
Treatment declined by parent(s)		Referral to Child and Family department	
Treatment judged not indicated by therapist		Referral to Portman Clinic	
Funding for treatment refused		Referral to other agency	
Other – please specify		Referral to private therapy	

CARE PLAN REVIEW
Care Plan Review Date (If other than termly Care Plan review)

SIGNATURES			
Completed by (name)		Case Consultant/ Manager (name)	
Professional status		Signature	
Signature		Date	

NB Where possible, a risk assessment should be completed by two clinicians

CLINICIAN'S NOTES