North Essex Partnership
University NHS Foundation Trust

CLINICAL RISK MANAGEMENT PROTOCOL

Incorporating Clinical Risk Assessment Tools Handbook

2013 edition

Compiled and issued by the Quality, Risk and Patient Safety department

INVESTOR IN PEOPLE

NORTH ESSEX PARTNERSHIP UNIVERSITY NHS FOUNDATION TRUST

POLICY DOCUMENT

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SECTION ONE

Clinical Risk Management Protocol

CLINICAL RISK MANAGEMENT PROTOCOL

1 INTRODUCTION

This protocol 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 patient safety. It is accompanied with a handbook that includes screening and specialist assessment tools suitable for different areas of practice: younger people, adults and older adults. The tools recognised by the Trust are published validated tools and all assessment tools have been ratified for use throughout the Trust. The tools are contained in a handbook that is accessible through the Trust Intranet. No unvalidated tools should be used as these are not recognised by the Trust. Please see section 10.3 of this protocol.

This Protocol applies to all Trust employees and to those on secondment to the Trust including all professional trainees and locums.

This Protocol provides a framework and guidance for professional practice, with the expressed aim of managing and minimising risk whilst providing care and treatment that is safe, sound, supportive, positive, service user centred and socially responsible.

The purpose of undertaking a risk assessment using a risk assessment tool in conjunction with professional judgment is to identify risk factors and immediacy of risk in a structured way that enables a risk management plan to be created that will guide care and treatment as part of the care pathway.

2 SCOPE OF PROTOCOL

2.1 This Protocol should be used in conjunction with the associated Trust policies, procedures and protocols, covering aspects of care pathways and risk management including CPA and non CPA care

2.2 The Protocol details the use of validated tools for age-specific and specialist services.

2.3 All staff involved in risks management must be capable of demonstrating sensitivity and competence in relation to diversity in race, faith, age, gender, disability and sexual orientation.

2.4 The policy endorses that working in partnership with service users, carers, families and colleagues to provide care and interventions that not only make a positive difference, but also do so in ways that respect and value diversity including age, race, culture, disability, gender, spirituality, sexuality. Please refer to the Equality & Diversity Policy).

3 DUTIES & RESONSIBILTIES

3.1 The Board

The Board has the responsibility to ensure that both the assessment and management of clinical risk is carried out effectively and to provide a suitable infrastructure to support this activity.

3.2 Area Directors and Operational Managers

Area Directors and Operational Managers must ensure the implementation and compliance within their respective locality and specialty.

3.3 Managers

It is the responsibility of professional leads / team managers/ward managers to ensure all members of their teams who have a responsibility for undertaking clinical risk assessment and management in relation to this protocol

- understand their responsibilities
- implement the Trust's standards
- undertake training in Risk Assessment / Management to have the competence to fulfil the Trust's required standard

3.4 Individual health and social care clinicians/practitioners

Individual health and social care clinicians/practitioners have a duty to implement this policy and procedure. This duty extends to the supervision of unregistered/support staff when tasks are delegated.

3.5 Quality Risk & Patient Safety Department

It is the responsibility of the Quality Risk and Patient Safety Department to ensure that any changes/revisions of this protocol are approved by Risk and Governance Executive and that the updated protocol is available on the Trust's intranet.

3.6 Policy Advisory Group

It is the responsibility of the Policy Advisory Group to review this protocol to ensure that it meets national and legal requirements.

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

4.1 **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.

4.2 **Risk Assessment** is the process of gathering information about a service user's mental state, behaviour, intentions, personal psychiatric history, including any history of physical, sexual or emotional abuse, and social situation, and forming a judgement about the likelihood or probability of an

adverse and / or harmful outcome based upon that information.

Approaches:

Formulation
The application of clinical knowledge in predicting risks, identifying cues and interviewing to bring together a formulation of **risk.**

Measurement
The use of an appropriate tool that helps predict accurately the likelihood of a risk occurring.

4.3 **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.

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

4.5 **Crisis Management**
A crisis plan setting out the action to be taken if the service user becomes ill or their mental health is deteriorating rapidly (this is based on risk assessments and on previous experience of what works for the individual service user.

Any early warning signs, relapse indicators, triggers, key events, other risk indicators are to be taken into account in a crisis and the nature of response to a crisis.

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

5.1 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 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. Risks should be balanced against potential benefits using professional judgement and experience within the framework for practice set by the Trust and by their professional bodies.

5.2 This Protocol applies to all service users and their relatives and carers. This Protocol also applies to service users with learning disabilities being treated for an episode of mental illness.

5.3 Caring for and treating someone living with mental health problems effectively and safely is not an exact science. Consequently, there is likely to remain some risk.

5.4 This means that some therapeutic risk-taking may be necessary and unavoidable if individual service users are to progress. Methodical assessment and active management of risks are key steps towards

minimising harm and maximising benefit.

5.5 Properly-managed risk-taking 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 service user, carers and all relevant colleagues;
- Clear and concise documentation relating to risks and shared appropriately.

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

6.1 Responsibility for managing clinical risk is one that is shared between the organisation, individual practitioners, service users and carers.
The Chief Executive on behalf of the Board will ensure that the following is provided:

- there is an agreed procedural framework for risk management that staff can work to;
- training in the assessment and management of risk;
- training in the use of systems and techniques that support risk assessment and management;
- safe environments from which services will be delivered;
- necessary agreed flexible strategies and protocols to govern practice;
- support staff in the assessment, management and minimisation of risk through supervision and support mechanisms;
- Ensure that adherence to relevant legislation and national guidance is audited and procedures are updated appropriately.

6.2 Clinical Staff and Practitioners

The Trust expects its staff in undertaking their duties with service users, relatives, carers and with the public to:

- 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
- Understand the concepts of risk and risk management in clinical practice, and the Trust's philosophy of care;
- Have a methodical and evidence-based approach to the assessment and management of risk, using agreed tools and methodologies only, following a structured clinical judgement approach;
- Understand risk as including environmental, psychological and physical

aspects;

- Identify, assess, positively manage and, where possible, minimise risk for all, whilst undertaking assessment.
- Formulate an initial risk assessment within 24 hours and review a risk assessment at least every 6 months and more frequently where risks are fluctuating. Inpatient risk assessment should be at least weekly.
- Risk assessment is a dynamic process and should be under continuous review. Risk management must always be based on awareness of the capacity for the service user's risk level to change over time and recognition that each service user requires a consistent and individualised approach.
- Be aware of Trust's guidance on capacity and consent for all service users, irrespective of age. If the person's capacity is in question, then undertake an assessment in line with Assessment of Mental Capacity Policy.
- Weigh the risk of harm to the service user or to others against the potential benefits in relation to service user empowerment and act accordingly.
- Take no action that contributes to or increases risk;
- Plan for contingencies dependent upon the risk assessment.
- Record information about risk and share that information with all who may need it. A risk management plan is only as good as the time and effort put in to communicating its findings to others;
- Adhere strictly to the guidance and direction given in this Protocol;

7 CLINICAL RISK MANAGEMENT AND THE CARE PROGRAMME APPROACH (CPA)

7.1 Clinical risk assessment and management is part of the CPA process, however the principles apply to those under 'non CPA'. All Service User Risks should be assessed. This involves identifying specific interventions based on an individual's support needs, taking into account safety and risk issues.

7.2 A CPA care plan is drawn up, preferably with the Service User / Carer to meet the service user's needs. This forms the recorded management plan and should include the following:

- A summary of all risks identified;
- Identify and document any unmet needs;
- Actions to be taken to manage risk by Practitioners, Service Users or Carers

8 TRUST STANDARDS FOR CLINICAL RISK ASSESSMENT & MANAGEMENT

8.1 Individual practitioners must always use their professional judgement about individual service users' 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 breakdown of established relationships and periods of significant contact with other agencies such as police, courts and housing agencies;
- Pre-determined indicators of relapse or risk (identified in previous risk assessments) are apparent;
- A service user looses contact with the service in an unplanned way;
- The care and / or treatment offered to a service user changes significantly, including transfer between services / Trusts particularly heightens risks moving from inpatient to community care setting

8.2 Risk assessment must also be reviewed when the practitioner delivering the majority of the care changes.

8.3 In addition to assessment of risk in response to the events detailed above clinical risk must be reassessed/reviewed routinely (but at intervals not greater than 6 months).

8.4 If a service user is admitted/transferred to an in-patient facility for assessment / treatment, the frequency of review should increase proportionately with the risks presented with that treatment episode. This review should involve the Multi-Disciplinary Team (MDT) and any other specialist or professional input as appropriate.

8.5 It is also important that risk assessments acknowledge the reduction of risk when this occurs and the factors which have helped the service user in reducing their risk. This will serve as useful information in the formulation of future risk management plans.

8.6 The Trust's minimum requirement for risk assessment is the completion of the screening tool and recording on the Risk Assessment Module on Remedy for all service users.

9 SAFEGUARDING

9.1 All practitioners should be aware of their responsibilities for Safeguarding and be able to fulfil their obligations required as detailed in the Trust's Safeguarding Policies which are located on the Trust Intranet (http://iconnect/policies/safeguarding-policies)

10 RISK ASSESSMENT TOOLS

10.1 Practitioners with responsibility for risk assessment may also use one of the recognised and agreed, validated risk assessment tools contained in the Handbook. This should be clearly documented in Remedy and the completed tool scanned into the service user's record.

10.2 The following tools are recognised for use in the Trust. Some tools require specialist knowledge training to implement / interpret correctly. It is the responsibility of the practitioner to ensure that only validated tools are used

and their training in the use of specific tools is up to date:

- 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
- Worthing Weighted Risk Indicator
- Assessment Tools for Risk of Violence – HCR20 and Hare's Psychopathy Checklists
- Short CANE (Camberwell Assessment of Need for the Elderly)
- Pressure Ulcers/Sores – Waterlow Pressure Sore Risk Assessment,
- Assessment of Manual Handling Needs
- Driving
- Risk of Sexual Violence (RSV)
- Transport Risk Assessment Checklist for Staff Using Private Cars to Transport Clients
- Structured Assessment of Violence Risk in Youth (SAVRY)
- Drug Use Screening Tool (DUST)
- Mother and Baby Assessment (from Mother and Baby Facilities Operational Policy)
- Falls Risk Assessment Screening Tool (from Prevention and Management of Falls Policy)
- Domestic Abuse, stalking, harassment and honour based violence (DASH) 2009 Risk Model for (MARAC – multi agency risk assessment committee)

10.3 Use of other specialist tools not included in the Handbook is prohibited, unless the tool has been approved by the Trust's Quality Risk and Patient Safety department. Any new tools should be submitted for recognition and inclusion by emailing the Associate Director of Quality, Risk and Patient safety including the rationale for changing or adding to the above list of validated tools in use in the Trust.

11 MANDATORY RECORD-KEEPING

11.1 The Trust's primary recording instrument is the electronic health record Remedy; which is accessible at all Trust sites via the Trust's network to those authorised professional staff, who must access and use the system to record service user details and all clinical activity.

11.2 To ensure we minimise risk to service users, Trust staff and the public, all clinical risk assessments and risk management plans for a service user must be recorded in full detail on the electronic system, providing 24 hour electronic access to the information for other Trust professional staff who may need access to the service user's risk assessment; this is particularly pertinent to out of regular working hours, weekends and crisis teams.

- The risk assessment module for each service user record within the electronic health record Remedy is located through the initial assessment/CPA screens and risks are logged in the risk repository in the master patient index.
- Each component of the risk assessment i.e. violence, neglect etc; has its own individual screen for professionals to complete and once completed

to “sign off” with date and time, providing accurate record of date and author of the entry and to prevent alteration or deletion in the future, preventing any confusion of when or who by the data was entered, or deletion of the details.

- Each risk component has supporting guidance notes visible on screen to facilitate professionals in completing the risk assessment in accordance with risk management policies and processes.
- Staff must ensure that clinical records are explicit as to which risk tool has been used and who carried out the risk assessment.

12 MANAGING CHALLENGING/ENDURING RISK

12.1 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, e.g. an identified unmet need or gap in service provision.

12.2 In managing difficult risk, it is the assessing practitioner's responsibility to:

- Inform his / her line manager as soon as possible;
- Take reasonable steps to minimise any risk to him / herself, or members of the public where this may be the case;
- Seek assistance and / or guidance from practitioner colleagues and the multi disciplinary team;
- 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;
- Ensure that the action taken is documented electronically and appropriately, shared with individuals and relevant agencies, in accordance with local agreements and practice guidance.
- Discuss caseload management in relation to risk regularly in mandatory supervision

12.3 It is imperative when a difficult-to-manage risk is identified that consideration be given to holding a professionals meeting. This may take the form of a Multi-Agency Public Protection Arrangement process (MAPPA) or child protection meeting.

12.4 The practitioner's line manager must:

- Inform the Associate Director for the area or service concerned where the risk identified and the action taken;
- Identify and attempt to resolve any equipment, skills, or staffing deficits that exacerbate the risk;
- 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.

13 CONFIDENTIALITY AND SHARING PROTOCOLS

13.1 The Trust's service users have the right to expect that information they disclose to Trust professionals will be kept confidential and not shared inappropriately. Service user information is recorded primarily for the benefit of the individual. The Trust has a leaflet available for service users and staff called "Your health records. How we look after them and who can see them"; this can be located on the Trust's I-connect site and is also available in hard copy from the Trust's Making Experiences Count team based at Trust Headquarters.

13.2 Disclosure is permitted for the following reasons, if it is deemed to be in the best interest of the service user, in the interest of public safety, or for safeguarding reasons. Trust staff have a responsibility to make themselves familiar with the following Trust documents which can all be located on the Trust's I-connect site and these will support staff in making the right decision when to disclose and when not to disclose service user information:

- Access to Health and Social Care Records Policy and Procedures
- The Unified Written Health and Social Care Record Policy
- Confidentiality and Information Sharing Protocol
- Information Sharing Protocol/Memorandum of Understanding agreed between Police, Probation Service, Social Services and Mental Health Trusts in Essex (MAPPA).

13.3 The safety of the public must always be considered, with particular reference to requests for information about a person who may be implicated in a serious criminal offence or about to commit an offence. For advice on requests, please do not hesitate to contact the Quality, Risk and Patient Safety department.

14 MANDATORY TRAINING

14.1. **All professional qualified practitioners** involved in risk management **must** undertake training in line with the Trust's Training Matrix.

14.2 Details of the mandatory CPA/Risk Training courses are available on the CPA page on i-connect.

15 REVIEWING & MONITORING OF PROTOCOL AND APPROVED TOOLS

15.1 Compliance Monitoring

Compliance with this protocol will be against the Trust's agreed minimum requirements/ standards as detailed in the auditable standards and monitoring arrangements.

16 THIS PROTOCOL SHOULD BE READ IN CONJUNCTION WITH THE FOLLOWING TRUST DOCUMENTS

Access to Health and Social Care Records Policy and Procedures

Appointments Policy Incorporating the Non-Attendance Procedure

Assessment of Mental Capacity Policy

Trust Auditable Standards and Monitoring Arrangements

Care Programme Approach (CPA) & Non CPA (Standard Care) Policy and procedure

Clinical Risk Assessment Tools Handbook

The Co-existence of Mental Health Needs and Substance Misuse (Dual Diagnosis) Care Pathway Liaison and Referral Protocol

Confidentiality and Information Sharing Protocol

Policy for Consent to Examination or Treatment

Discharge Policy

Getting it Write guidance

Guidelines for the Use of an Integrated Mental Health Information System (Remedy)

Incident Reporting Policy and Procedure

In-Patient Leave Procedure and Policy

In-Patient Observation Policy

Mandatory Training Matrix

Manual Handling Policy and Procedure

MAPPA Agreement

Operational Policy for the Mental Health Care Record and Information System (Remedy)

Patient Safety Environmental Standards

Physical Health Care Policy

Prevention and Management of Violence and Aggression at Work, Policy, Procedure and Guidelines

NEPFT Safeguarding Children Folder

NEPFT Safeguarding Adults Folder

Searching of Patients and Their Property Protocol (Including Visitors Property)

Transfer of Care Policy (including procedural guidance for transferring between inpatient units)

The Unified Written Health and Social Care Record Policy

The Use of Medicines Policy and Procedures Handbook

Your health records. How we look after them and who can see them

17 REFERENCES

Working Together, 1999

Every Child Matters, 2003

NHS Code of Practice – Confidentiality, 2003

No Secrets 2000

Independence, Choice and Risk: A guide to best practice in supported decision making. DH. 21 May 2007.

Best Practice and Managing Risk – Principles and evidence for best practice in the assessment and management of risk to self and others in mental health services. Document prepared for the National Mental Health Risk Management Programme. Department of Health June 2007. Forward by Louis Appleby.

NHS Confederation Briefing: Implementing National Policy on Violence and Abuse. 2008.

Refocusing the Care Programme Approach – Policy and Positive Practice Guidance. DH. March 2008.

SET (Southend, Essex and Thurrock) Safeguarding Adults Procedures Booklets

Appendix 1

RECORDING RISK ON REMEDY

The risk management module is where your risk assessment and risk management plan should be recorded. On the new system there will be only ever be on risk assessment on a service user. All clinicians/practitioners involved in someone's care will share the responsibility for updating the risk assessment.

All service users will be assessed against the following categories

- Suicide ideation/ intent
- Ideas of self-harm/ self-injurious behaviour
- Violent and aggressive behaviour
- Evidence of neglect/ vulnerability
- Safeguarding children and adults issues
- Physical health issues
- Hazards include allegations, assessment environments, pets etc.

Where assessing risk you will be required to ascertain the following

- Yes risk identified
- No risk identified
- Historic risk (previous risk not assessed as a risk in the current presentation)
- Insufficient information

A key part of the risk assessment process will be to identifying contingency plan and crisis plan. The contingency plan will include identifying early warning signs and relapse features. A crisis plan should detail the action to be taken either by the clinician, service user, carer or other agencies in the case of a crisis i.e. whether a service user may need an assessment under the Mental Health Act, emergency child care arrangements. Other factors in the crisis plan should indicate as to whether the service user should be assessed in their home environment or on Trust premises or other agency location.

For all except where a risk has been identified you will be required to describe the risk and the context in the box below. This will then be copied over into the risk management plan and then you will be required to detail the risk management plan against each aspect of the risk identified.

When updating a risk assessment you will have the opportunity to stipulate there is no change in a specific risk by ticking "no change". Therefore you will only need to add the new information against the risk you need to update.

Each risk assessment will update the risk repository. The risk repository will be the key place on the system where all identified risks are displayed to assist clinicians/ practitioners when undertaking a new assessment. When a risk has been updated the previous assessment of that category of risk will move to History of selected risks.

The risk repository also will give details on historical risks and significant life events such as anniversaries and significant events during their care such as serious self-harm.

SECTION TWO

Risk Assessment

Person Details

Name **DoB/Gender**

Address

Telephone **NHS NO:**

Risk Assessment

Suicide Ideation / Intent

Consider the following while completing this section:

- **Previous attempt on their life/use of violent methods and access to means**
- **Fluctuation of mood**
- **Sleep disturbance**
- **Family history of suicide**
- **Considered/planned intent**
- **Major psychiatric diagnoses i.e. psychosis - command Hallucinations**
- **Recent significant life events - bereavement/ loss of job, debt, Divorce/ separation (Both positive and negative)**
- **Trigger events - anniversaries, news stories, publicity**
- **Major physical illness/disability, pain management issues or recent diagnosis of life changing/ life limiting illness**
- **Expressing suicidal ideas/high levels of Distress/ anxiety**
- **Impulsivity and unpredictable behaviours**
- **Imminent or recent discharge from an institutions i.e. Prison, Hospital or armed forces**
- **Presence of social support network**
- **Misuse of drugs and/or alcohol**

Risk Status:

1- Yes, Risk identifies

2- Historical Risk

3- No Risk Identified

4- Insufficent Information

Risk Description:

Ideas of Self-Harm/ Self Injurious Behaviour

Consider the following while completing this section:

- **History and current Self-injurious behaviour (e.g. cutting, burning, overdose) - Seriousness and pattern of injuries**
- **Deliberate Self neglect**
- **Deliberate avoidance of prescribed treatments and medication**
- **Drugs and Alcohol misuse**
- **Changes in the pattern of self-injury e.g. changes to cutting sites, methods used, mental state - presence of other mental health conditions**
- **Culturally isolated situation**
- **Driving risks**
- **Resistance to eating and drinking**
- **Deliberate promiscuous behaviour**
- **Impulsive acts**

Risk Status:

1- Yes, Risk identifies

2- Historical Risk

3- No Risk Identified

4- Insufficent Information

Risk Description:

Violence and Aggressive Behaviour

Consider the following while completing this section:

- **Previous incidents of violence/forensic history**
- **Evidence of thought disorder/ hallucinations/ delusions**
- **Signs of anger and frustration**
- **Preoccupied with violent fantasy/ morbid jealousy**
- **Expressing intent to harm others**
- **Abuse/harassment/exploitation of others**
- **Psychological inability to understand situation (e.g. dementia)**
- **Elated moods**
- **Misuse of drugs and/or alcohol**
- **Denial of previous dangerous acts**
- **Sexually inappropriate behaviour**
- **History of Arson and other damage to property**
- **Identify known triggers**
- **Previous dangerous impulsive acts**
- **Access or possession of offensive weapons**
- **History of martial arts/ previous employments**
- **Persistent pain**
- **Behaviour associated with withdrawal symptoms**

Risk Status: 1- Yes, Risk identifies

2- Historical Risk

3- No Risk Identified

4- Insufficent Information

Risk Description:

Evidence of Neglect / Vulnerability

Consider the following while completing this section:

- **Previous history of neglect**
- **Poor diet and fluid intake**
- **Accommodation difficulties e.g.**
- **Facing eviction/repossession/**
- **homelessness**
- **Difficulty maintaining personal hygiene**
- **Limited social contacts**
- **Memory loss, disorientation and wandering**
- **Carers issues e.g. young carers**
- **Risk of falls**
- **Difficulty managing physical health/ medication, e.g. accidental overdose**
- **Learning disabilities**
- **Risk through exploitation by others**
- **New to the service/ in transition between services**
- **Recent discharge from an institution**
- **Poverty/ deprivation**
- **Accidental Fire Risk**
- **Issues regarding care environment**
- **Manic/ Sexually disinhibited behaviour**
- **Difficulty communicating needs/ Lacks insight**

Risk Status: 1- Yes, Risk identifies

2- Historical Risk

3- No Risk Identified

4- Insufficent Information

Risk Description:

Safeguarding Children

Consider the following while completing this section:

- **Service user directly or indirectly providing care for a child/ dependent**
- **Child being cared for by an adult with an addiction/ mental health issue**
- **Bullying/ abusive behaviour**
- **Service user lives in household with children or vulnerable adult**
- **Existing child protection plan/child in need plan/ safeguarding adult plan**
- **MARAC referral/ action plan**
- **DASH Risk assessment completed**
- **Open safeguarding (child/adult) investigation**
- **Contact with children/ adults through professional. Voluntary or recreational role**
- **Poor compliance with care or treatment**
- **Child's health or development may be impaired (behavioural, intellectual, physical/ educational/ sexual or social)**
- **Carers issues e.g. young or old carers**
- **Living in hazardous/ poor conditions/neighbourhoods**
- **Dependent upon others to meet basic needs**
- **Capacity issues**
- **Easily influenced**
- **Domestic abuse**
- **Deprivation of liberty**
- **Cultural issues**
- **Potential abuses of position of Trust**
- **Communications difficulties**
- **Impaired physical condition**
- **Abuse/ neglect- physical, emotional/psychological, sexual, discriminatory, institutional, financial**

Risk Status: 1- Yes, Risk identifies

2- Historical Risk

3- No Risk Identified

4- Insufficent Information

Risk Description:

Physical Health Issue

Consider the following while completing this section:

- **Impaired physical condition**
- **Communications difficulties**
- **History of MRSA, C.Difficile / Blood Bourne viruses**
- **Long term physical health condition such as Diabetes, cardio vascular disease.**
- **Skin issues - Potential for pressure ulcers**
- **Risk of Falls**
- **Impaired mobility**
- **Poor Diet and fluid intake**
- **High Risk Medication e.g. clozapine, warfarin, Lithium**
- **Poor concordance with Physical health Medication/ treatment**
- **Purging/ use of diuretics**
- **BMI < 15**
- **BMI > 30**

Suicide Ideation / Intent

Risk Status: 1- Yes, Risk identifies

2- Historical Risk

3- No Risk Identified

4- Insufficent Information

Risk Description:

Hazards

Consider the following while completing this section:

- **Aggressive animals**
- **Unsafe neighbourhood, e.g. crime, lighting, vehicular damage, isolation, parking issues**
- **service users ability to drive/ operate machinery due to medication/ mental state**
- **Home environment, e.g. infestation, infection risk, access difficulties, structural risks**
- **Risk of allegations**
- **Service user aggressive, intimidating or threatening behaviour**
- **Hostile relatives and neighbours**
- **Gender-specific situations to be highlighted**
- **Poor mobile phone reception**
- **Inadequate information on service user**

Risk Status: 1- Yes, Risk identifies

2- Historical Risk

3- No Risk Identified

4- Insufficent Information

Risk Description:

Risk Management Plan

Risk Plan:

Suicide Ideation/Intent:
Risk Description:

Management Strategy

Ideas of Self-Harm/Self Injurious Behaviour:
Risk Description:

Management Strategy

Violence and Aggressive Behaviour

Risk Description:

Management Strategy

Evidence of Neglect/Vulnerability:

Risk Description:

Management Strategy

Safeguarding Children:
Risk Description:

Management Strategy

Physical Health Issue:
Risk Description:

Management Strategy

Hazard:
Risk Description:

Management Strategy

Authorisation Details	
Carried Out By	**Date**
Manager	**Date**
Notify Authoriser?	
Do Not Use	**Outcome**
Notes	

SAINSBURY CENTRE FOR MENTAL HEALTH TOOL FOR CLINICAL RISK ASSESSMENT

CLINICAL RISK MANAGEMENT

Service user's name:	**Unit:**
Remedy 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 Responsible Clinician / 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

SUICIDEIde

	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**

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WORTHING WEIGHTED RISK INDICATOR

Service user's name:	**Unit:**
Remedy 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 service user made a previous attempt on their life?			12
2. Did they use a violent method i.e. drowning / hanging / shooting?			12
3. Does the service user use recreational drugs?			9
4. Does the service user use alcohol to excess?			9
5. Is the service user expressing suicidal thoughts?			5
6. Has the service user considered / planned how they would kill themselves?			5
7. Does the service user believe they have little or no control over their life?			5
8. Is the service user expressing a high level of distress (delusions / low esteem / hallucinations)?			5
9. Does the service user feel nothing has changed since the last attempt?			4
10. Does the service user live alone?			2
11. Is the service user separated / divorced / widowed?			2
12. Is the service user unemployed or retired?			2
13. Is the service user male?			1
14. Is the service user aged over 45?			1
15. Is the service user 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**

Service user's name:	Date of Assessment:		
VIOLENCE / AGGRESSION	**NO**	**YES**	**SCORE**
1. Has the service user identified specific individuals they intend to harm?			12
2. Has the service user used a weapon in the assault of another person?			9
3. Has the service user been previously admitted to a high security unit?			9
4. Has the service user been previously admitted to a low / medium secure unit?			7
5. Is there evidence of the service user being dangerously impulsive to others?			5
6. Is there a known history of assaults on others that required medical attention?			5
7. Has the service user threatened physical / psychological harm to others?			4
8. Has the service user expressed paranoid delusions featuring specific individuals?			4
9. Has the service user expressed but not demonstrated aggressive behaviour?			4
10. Is there evidence / reports of sexually inappropriate behaviour?			3
11. Has the service user previous convictions for violent / sexually inappropriate behaviour?			3
12. Are there known triggers to violent behaviour?			3
13. Does the service user use recreational drugs?			3
14. Does the service user use alcohol to excess?			3
15. Has the service user 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 service user failing to drink properly?			20
2. Is the service user failing to eat properly?			16
3. Is the service user without electric / gas for heat / light?			5
4. Is the service user unable to adequately manage existing physical health problems?			4
5. Has the service user debts that impact significantly on their life?			4
6. Does the service user regularly experience financial difficulty (basic needs food / warmth / shelter)?			4
7. Is the service user deprived of positive social contacts?			3
8. Is the service user living in inadequate accommodation?			3
9. Is the service user unable to adequately shop for themselves?			3
10. Is the service user unable to adequately communicate need?			3
11. Is there pressure reference eviction / repossession?			2
12. Has the service user a lack of sufficient / appropriate clothing?			2
13. Is the service user unable to adequately mange their personal hygiene?			2
14. Is the service user culturally isolated?			2
15. Is the service user'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**

Service user'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	

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 service user.

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 service user 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 service user. 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 service users 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 service users 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 service users 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 Associate Director of Quality, Risk and Patient Safety.

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.

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EDINBURGH POST NATAL DEPRESSION SCALE (EPDS)

Service user's name:	**Unit:**
Remedy 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	

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MOTHER AND BABY ASSESSMENT

Service User's Name:	**Unit:**
Remedy 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	**Verbal Contact:**	
	None	
	Appropriate	
	Inappropriate	
	Current risks identified:	
E	**Eye Contact:**	
	Total avoidance	
	Hostile	
	Menacing	
	Glancing	
	Appropriate	
	Current risks identified:	
F	**Skin Contact:**	
	Caresses baby	
	Minimal	
	Rough	
	Harmful	
	Current risks identified:	

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 service users 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, Associate Director of Quality, Risk and Patient Safety, 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 Quality, Risk and Patient Safety department on [I/S] ([I/S]).

NORTH ESSEX PARTNERSHIP UNIVERSITY NHS FOUNDATION TRUST

CAMBERWELL ASSESSMENT OF NEED FOR THE ELDERLY
(CANE)

(SHORT CANE)
Version I

SERVICE USER'S Name:	Unit:
Remedy 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:	

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SHORT CANE

Service User's Background Details

(Please fill in blanks, or circle whichever applies)

SERVICE USER'S NAME:			
UNIT:			
REMEDY 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 Service user (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:

SHO- 52 -RT CANE ASSESSME- 52 -NT

NORTH ESSEX PARTNERSHIP UNIVERSITY NHS FOUNDATION TRUST

SHORT CANE ASSESSMENT

Service User's name:			
Unit::		**Remedy 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)				

FALLS RISK ASSESSMENT SCREENING TOOL

Service user's Name			
Unit			
Remedy Number		NHS Number	
Date of Birth		Age	
Date of Assessment		Time of Assessment	

A PLEASE ASSESS SERVICE USER AND SCORE ALL THE FOLLOWING CRITERIA.
B See 'Guidelines for Falls Risk Assessment Screening Tool' on pages 3-5.

1 SEX	Score
Male	1
Female	2
2 AGE	Score
Below 60	0
60-75	1
75-80	2
81 and over	3
3 MENTAL STATE	Score
Unaltered	0
Agitated	1
Intermittent confusion	1
Disorientated time/place/person	1
Thought/perception disorder	1
Depressed	1
4 MEDICAL HISTORY	Score
Vertigo	1
Diabetes	1
Arthritis	1
Cardio Vascular	1
CVA/Stroke	2
Parkinson's/Other Neurological conditions	2
Osteoporosis	2
Multiple Conditions	3
Condition of Feet	
Oedematous	2
Decreased sensation	2
Neglected feet	2
Painful sores/wounds	3
5 FALLS HISTORY	Score
None	0
History of Falls	1
Fallen in last 48 hours	2
Sustained injury	3
6 ELIMINATION/CONTINENCE	Score
Independent and continent	0
Fully dependent and incontinent	1
Incontinent/in-appropriate urination, fully mobile	2
Continent with prompting/ assistance accessing toilet	2
Incontinent and gets up unaided unsafely	3

7 MEDICATION	Score
None	0
Diuretics/Laxatives	1
Hypnotics	1
Tranquilisers	1
Hypotensives	1
Analgesia	1
Anti-psychotics	1
Anti-depressants	1
Hypo-glycaemics	1
Parkinson's and other neurological drugs	1
Non-prescribed drugs	1
Multiple	3
8 MOBILITY	Score
Independent	0
Uses aids	1
Immobile	1
Wandersome (no risk)	1
Wandersome (with risk)	2
Mobile with 1 or 2 staff	2
Restricted, attempts to mobilise unaided	3
Poor transfers	3
9 GAIT	Score
Steady	0
Hesitant/Unsteady	3
Anxious re mobilising/fear of falling	3
10 SENSORY IMPAIRMENT	Score
No impairment	0
Hearing	1
Impaired comprehension	1
Sight	2
Balance	2
Diminished peripheral sensation	2
Multiple	3
11 OTHER FACTORS	Score
Inappropriate footwear	1
Inappropriate clothing	1
Impact of alcohol/drugs	1

Total Score		**Level of Risk** *(1-12 Low Risk; 13-19 Medium Risk; 20+ High Risk)*	

FALLS CHECKLIST (*Please circle that which is appropriate) **Page 2 of 5**

The numbers below correspond to sections on Page 1 of this Tool		*Identified Need			*Inter-vention		Action	Date
3	Mental state	Yes	No	Un-known	Yes	No		
4	Medical History	Yes	No	Un-known	Yes	No		
4	Osteoporosis	Yes	No	Un-known	Yes	No		
6	Elimination/ Continence	Yes	No	Un-known	Yes	No		
7	Medication	Yes	No	Un-known	Yes	No		
8	Mobility	Yes	No	Un-known	Yes	No		
8	Transfers	Yes	No	Un-known	Yes	No		
9	Gait	Yes	No	Un-known	Yes	No		
10	Sensory impairment	Yes	No	Un-known	Yes	No		
10	Balance	Yes	No	Un-known	Yes	No		
11	Footwear and clothing	Yes	No	Un-known	Yes	No		

Are cot sides to be used for this service user?	Yes / No
Is the service user nursed on a mattress on the floor?	Yes / No
Please explain how and why these decisions have been reached:	
Other	

ACTION TAKEN	DATE	COMMENTS
Refer to Chiropody		
Refer to Physiotherapy		
Refer to Occupational Therapy		
Recommend new footwear		
Risk management discussed		
Other		

Assessor's Signature		Date	
Assessor's Name (print)		Designation	
Consultant's Name (print)			

Assessments should be updated regularly, dependent upon service user's condition.

UPDATE/REVIEW OF ASSESSMENT

Changes to original Falls Risk Assessment			
Assessor's Signature		Date of Assessment	
Assessor's Name (print)		Designation	
Consultant's Name (print)			

GUIDELINES FOR FALLS RISK ASSESSMENT SCREENING TOOL Page 3 of 5

These guidelines have been compiled for the purpose of ensuring standardisation when using the Falls Risk Assessment Screening Tool.

All sections must be completed at any one assessment session in order for the service user's assessment results to be current.

The numbers below correspond to sections on Page 1 of this Tool	CATEGORY	GUIDELINES
3	**Mental State**	Altered, affecting ability to maintain safe environment
	Agitated	Anxious, distressed, restless
	Intermittent confusion	Variable levels of orientation to time, place or person
	Disordered thought/ perception	Altered state of mind, not based on reality e.g. hallucinating, deluded
	Depressed	Low in mood
4	**Medical history**	
	Osteoporosis	Warning signs : minor trauma fracture, height loss, Kyphosis (curvature of spine)
		Risk factors for osteoporosis :
		Lack of oestrogen – early menopause/early hysterectomy
		Long term steroid use
		Long term immobility
		Low body weight
6	**Elimination/Continence**	
	• Independent and continent • Continent with prompting/assistance to access toilet • Fully dependent and incontinent • Incontinent/inappropriate urination • Fully mobile	• Bladder and Bowel management • Independently manages own continence, eg fully continent, self-caring with catheter, self-caring with stoma etc • May express need to use toilet but requires physical assistance, may need directions to find toilet, may require prompting, etc • Requires all assistance with toileting (transfers, bladder and/or bowel care • Urinates in places other than toilet, commode, bedpan, urine bottle. Requires pads, assistance with catheter care, bowel care • Stoma care etc
7	**Medication**	
	Many different sorts of medication can potentially leave the service user susceptible to falls. **Drugs causing hypotension (low blood pressure)** Diuretics eg Bendroflumethiazide, Frusemide, Bumetanide, Coamilofruse, Amiloride, Spironolactone, Co-amilozide, Navispar Ace inhibitors eg Enalapril, Lisinopril, Perindopril Nitrates eg Isosorbide Dinitrate, Isosorbide Mononitrate Calcium antagonists eg Nifedipine, Amlodipine, Felodipine, Diltiazem Beta-blockers eg Atenolol, Propranolol, Metoprolol Tricyclic antidepressants eg Amitriptyline, Dosulepin **Drugs causing impaired balance or dizziness** Benzodiazepines eg Temazepam, Nitrazepam, Diazepam, Lorazepam Hypnotics eg Zopiclone, Zolpidem Opioid analgesics eg Co-codamol, Co-dydramol, Dihydrocodeine, Morphine Antipsychotics First and second generation can cause dizziness, hypertension and ataxia. SSRI and related antidepressants eg Fluoxetine, Paroxetine, Citalopram, Sertraline Anti-Parkinson drugs eg Co-careldopa, Co-beneldopa	

The numbers below correspond to sections on Page 1 of this Tool	CATEGORY	GUIDELINES
7	**Medication** *(continued)*	
	Drugs which cause dehydration Laxatives eg Senna, Lactulose, Bisacodyl **Medication bought over the counter (non prescribed)** Antihistamines eg Chlorpheniramine, Loratidine, Cetirizine, Acrivastine	
	THIS LIST IS NOT EXHAUSTIVE – ALWAYS CHECK BNF TO SEE IF OTHER MEDICATION MIGHT CONTRIBUTE TO FALLS.	
8	**Mobility**	
	Wander some (no risk) (with risk)	i.e. Service user excessively moving around environment Becoming unsteady, fatigued, hazards, outdoors etc.
	Poor transfers	Service user having difficulty safely transferring eg sit to stand from bed, chair, toilet etc
	Full	Walks independently
	Restricted	Distances walked are limited to below 15 metres
	Bedbound	Full nursing care or nursed in bed due to a medical condition
	Painful sores/ wounds	Any wound or sore.
9	**Gait**	
	Steady	Can service user 'walk and talk'? 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
	Anxious re: mobilising/ fear of falling	Mobility and function restricted by loss of confidence, may demonstrate hesitancy, freezing, over-reaching for furniture.
10	**Sensory Impairment**	
	Sight	Is their sight impaired? Do they wear glasses? Cannot recognise object across the room, difficulty reading newspaper/book, wears glasses, partially sighted, registered blind
	Hearing	Difficulty hearing conversational speech, hard of hearing, wears hearing aid, has hearing aid but does not wear
	Balance	Unable to stand without some kind of support Difficulty maintaining balance, sway on standing, if balance threatened may fall
	Muscle Weakness	Unilateral/bilateral
	Diminished peripheral sensation	eg Diabetic who is unable to feel when places feet on floor
	Impaired comprehension and/or communication	Expressive/receptive dysphasia, language barrier, altered spatial awareness

The numbers below correspond to sections on Page 1 of this Tool	CATEGORY	GUIDELINES
11	**Other Factors**	
	Inappropriate footwear	Ill fitting, inappropriate style, poor shoe condition,
	Poor foot condition	eg Long toe nails, bunions, calluses
	Impact of alcohol/drugs	Be aware of service user's alcohol consumption in relation to other factors eg medication and balance and use of recreational drugs

GENERAL CONSIDERATIONS

- Ensure that service user is aware of their own limitations or that family/carer is aware of the risks.
- Service user's glasses are within reach and used at all times
- Service user has hearing aid at all times
- Service user has appropriate footwear and/or splints as required.
- High risk service users are nursed in an area that can be monitored often.
- Is the service user on multiple medication? Can the doctor reduce medication?
- Is the service user pain free?
- Is the service user's route to the toilet, etc, free from obstacles?
- Is the lighting good?
- If the service user cannot be monitored frequently, are you happy that they are in a safe environment?

FIRST OF TWO PAGES

NORTH ESSEX PARTNERSHIP UNIVERSITY NHS FOUNDATION 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	MATT

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

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

INDIVIDUAL SERVICE USER ASSESSMENT OF MANUAL HANDLING NEEDS

PLEASE PHOTOCOPY THIS FORM DOUBLE-SIDED

Service user's name		**Ward/Unit**		Date of Birth	

Remedy No		**Weight**		**In Pain**	Yes / No / sometimes	**Co-operative**	Yes / No / sometimes

PLEASE ASSESS THE SERVICE USER AND CIRCLE AND/OR COMPLETE AS RELEVANT/APPROPRIATE -

BED	SIT/STAND	WALK	SHOWERING/BATHING	WHEELCHAIR	HOIST
Unaided	Unaided	Unaided	Unaided		N/A
Unaided but under supervision	Unaided but under supervision	Unaided but under supervision	Unaided but under supervision		Assistance 2 persons / 3 persons
Minimal assistance required	Manual handling aids Under supervision	Walking aids (excluding wheelchair) Under supervision	Under supervision Assistance required	Minimal assistance required	Type of sling Specialist slings – please specify
Assistance required 1 person/2 persons Hoist	Assistance required 1 person / 2 persons	Assistance required 1 person / 2 persons	Mechanical assistance, ie hoist	Assistance required 1 person / 2 persons	Colour of sling (indicates size)
Specialist bed required	Specify type of chair	Specify type of aid	*Safety straps to be used when using mechanical bath hoists*	Service user's own wheelchair?	Load capacity of hoist required

Additional Comments – Include special needs such as communication difficulties, sensory impairment, or other medical conditions.

Signature of Assessor: …… Print Name: …… Designation: …… Date: ……

To be re-assessed on …….. (date) for service users with complex needs this must be undertaken on a weekly basis. ***This assessment should be kept with the service user's health and social care records.***

SEE REVIEW SHEET OVERLEAF

INDIVIDUAL SERVICE USER ASSESSMENT OF MANUAL HANDLING NEEDS – RECORD OF REVIEW

ON REVIEW -
(1) If any CHANGES in the service user's condition occur, please complete A NEW ASSESSMENT SHEET.
(2) If NO CHANGES in the service user's condition/assessment are apparent, please COMPLETE THE RECORD BELOW-

Date of Review	*Print Name of Assessor*	*Signature of Assessor*	*Designation*	*Comments*

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'

To download a current version of the above booklet see website
http://www.dft.gov.uk/dvla/medical/ataglance.aspx

PLEASE NOTE –
The standards are reviewed every six months, following updated advice from the Secretary of State's Honorary Medical Advisory Panels.

DRIVING – PSYCHIATRIC

It is the responsibility of the doctor in charge of their care to advise the driver whether or not it is appropriate to continue to drive. It is the duty of the licence holder to notify the DVLA and failure to do so could have consequences for their insurance cover.

This advice must be formally documented in the notes.

NEUROLOGICAL DISORDERS	Loss of consciousness/loss of or altered awareness. Epilepsy Regulation may apply. EEG evidence may be required.
MILD ANXIETY/ DEPRESSION	No need to notify, can drive if OK and no medication side effects
SEVERE ANXIETY/ DEPRESSIVE ILLNESS	**DRIVING SHOULD CEASE.** Person must be stable on medication for 6 months with no side effects. Medical report may be required.
PSYCHOSIS, INCLUDING SCHIZOPHRENIA	Licence restored if free from symptoms, compliant with treatment and has insight for 3 months. Frequent mood swings (4 or more in 12 months) will require 6 months' stability.
DEMENTIA	**Early Dementia** - Annual review if sufficient skills are retained and progression is slow. Medical reports will be required.
ALCOHOL ABUSE	Licence refused or revoked for one year minimum
PERSONALITY DISORDER	Assessment as to affect on driving or road safety required.

The GMC has issued clear guidelines✶ applicable to such circumstances, which state:

"1 The DVLA is legally responsible for deciding if a person is medically unfit to drive. They need to know when driving licence holders have a condition, which may, now or in the future, affect their safety as a driver.

2 Therefore, where patients have such conditions, you should:

- Make sure that the patients understand that the condition may impair their ability to drive. If a patient is incapable of understanding this advice, for example because of dementia, you should inform the DVLA immediately.

- Explain to patients that they have a legal duty to inform the DVLA about the condition.

3 If the patients refuse to accept the diagnosis or the effect of the condition on their ability to drive, you can suggest that the patients seek a second medical opinion, and make appropriate arrangements for the patients to do so. You should advise patients not to drive until the second opinion has been obtained.

4 If patients continue to drive when they are not fit to do so, you should make every reasonable effort to persuade them to stop. This may include telling their next of kin, if they agree you may do so.

5 If you do not manage to persuade patients to stop driving, or you are given or find evidence that a patient is continuing to drive contrary to advice, you should disclose relevant medical information immediately, in confidence, to the medical adviser at DVLA *(details can be found on page 5 of the (DVLA) Booklet 'For Medical Practitioners – At a Glance Guide to the Current Medical Standards of Fitness to Drive').*

6 Before giving information to the DVLA you should inform the patient of your decision to do so. Once the DVLA has been informed, you should also write to the patient, to confirm that a disclosure has been made."

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RISK ASSESSMENT FOR TRANSPORTING SERVICE USERS

Service User's Name:	Unit:	
Remedy Number:	Date of Birth:	
Date of Assessment:	Time of Assessment:	
Is the service user -		
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 service user– *(Consider physical condition of service user 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 service user -	
Is the car driver -		
1	Covered to carry service users 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 service user safely in the car. Appropriate alternative arrangements, for example a Trust vehicle which can accommodate the needs of the service user – **Please specify** **-**		
Able to transport service user 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.

Second of Two Pages

RISK ASSESSMENT FOR TRANSPORTING SERVICE USERS (Continued)

Service User's Name .....

Date	OUTCOME OF RE-ASSESSMENT (Circle response as applicable)		PRINT Name of Assessor	Assessor's Signature
	Unchanged	Changed *(complete new form)*		
	Unchanged	Changed *(complete new form)*		
	Unchanged	Changed *(complete new form)*		
	Unchanged	Changed *(complete new form)*		
	Unchanged	Changed *(complete new form)*		
	Unchanged	Changed *(complete new form)*		
	Unchanged	Changed *(complete new form)*		
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	Unchanged	Changed *(Complete new form)*		
	Unchanged	Changed *(Complete new form)*		
	Unchanged	Changed *(Complete new form)*		

RISK ASSESSMENT TOOLS FOR USE WITHIN THE CHILD AND ADOLESCENT MENTAL HEALTH SERVICE (CAMHS)

CLINICAL RISK MANAGEMENT IN CAMHS

CAMHS adheres to CPA policy and all clinical data is recorded on Remedy. The CAMHS CPA Assessment and Risk Assessment should be used for generic assessment purposes. This is located within Remedy and also on the intranet. Care planning should be integral to the assessment process.

GUIDANCE ON CAPACITY AND CONSENT

Young People Under 16 Years of Age

There is no presumption of capacity for young people under 16 years of age. Where a young person has been assessed to be 'Gillick Competent' in respect of a specific decision, they can make decisions as an adult does – there will need to be documentary evidence of such an assessment. Guidance regarding assessments of Gillick Competence is contained in the NEPFT Safeguarding Children Folder.

Young People Aged 16 Years of Age and Above

The Mental Capacity Act (2005) presumes that everyone aged 16 years of age and over has capacity. Where clinicians/practitioners have concerns that a young person does not have capacity to make a specific decision or consent to a specific action being taken, they should assess capacity in respect of that specific decision (following the guidelines in the NEPFT Assessment of Mental Capacity (MCA) Policy which is available on the Trust intranet). Such assessments must be documented appropriately using MCA2.

SAVRY AND DUST

The following two tools (SAVRY and DUST) are risk screening tools suitable for aiding clinical judgement when working with children and adolescents to guide care and treatment planning.

A number of other tools are also being considered for future inclusion in the Handbook, including screening for eating disorders, deliberate self harm, forensic indicators and risk of violence in 5-11 year olds. Any new additions will be included in the intranet version of the Handbook.

STRUCTURED ASSESSMENT OF VIOLENCE RISK IN YOUTH (SAVRY)

The SAVRY is a screening tool designed to assist clinicians in assessing and making judgements about risk of violence in girls and boys between the ages of 12 and 18 years. It consists of 24 risk items (historical, social/contextual and individual/clinical) drawn from existing research and professional literature on adolescent development and on violence and aggression in youth.

The SAVRY may be used by professionals in a variety of disciplines who have expertise in conducting individual assessments in child/adolescent development and in youth violence.

Each CAMHS team should have a copy of the SAVRY Manual and Rating Forms.

For copyright reasons, it is not possible to reproduce this in the Handbook.

DRUG USE SCREENING TOOL (DUST)

This tool screens young people affected by drugs, alcohol and solvents. The DUST is designed to help make decisions about responses to young people's substance misuse. The age and maturity of the young person must be part of the overarching judgement made by the professional who is conducting this assessment.

You do not require a comprehensive knowledge of drugs and alcohol, but you may need advice from your local drug and alcohol team.

Access to training in the use of the tool, and to obtain the up-to-date version, please contact the Clinical Manager at Longview Adolescent Unit.

ASSESSMENT OF SIDE EFFECTS OF MEDICINES

Regular assessment and monitoring of medicines is essential to ensure optimal treatment for service users. It is necessary to consider both the positive and negative effects of medication and the consequences of these on the individual.

It is therefore important that all mental health workers are able to recognise side effects, use valid and reliable methods of assessing the symptoms and the severity and document these symptoms accordingly. All service users on antipsychotic medication must be assessed for the adverse effects of antipsychotic medication using formalised assessment tools. The choice of tool will be dependent upon the medication prescribed and the possible associated side effects such as movement disorder.

Efficacy of medicines is directly related to symptomatology but, because of the subjective nature of a service user's mental state over a period of time, measuring this may be difficult.

Non-compliance with medication is often due to adverse effects but by involving the service user in the recognition and management of them they can be overcome. All side effects should be assessed, not just extra-pyramidal; i.e. dry mouth, drowsiness, gastric discomfort, etc.

> *"Neuroleptics have a number of side effects; some of which can become irreversible, e.g. tardive dyskinsea. Weighing the possible benefits against these side effects is essential in drug use and dose determination for those prescribing them, and, most importantly, those receiving them. Nurses have a crucial role to play in assessing both the user's mental state and the benefits and side effects of medication. In this way they provide the prescribing doctor with information required to determine the minimum therapeutic dose in addition to providing information for users".*
>
> RCN, "Good Practice in the Administration of Depot Neuroleptics", (DoH, 1994)

The use of a self assessment score for measuring side-effects; such as the *"Liverpool University Side-Effect Rating Scale"*, (LUNSERS), can be of benefit when combined with appropriate education. Rating scales are an established method of increasing the objectivity of observations, but can be time consuming.

The Trust recognises the following scales -

1 **LUNSERS** (Liverpool University Neuroleptic Side Effect Rating Scale)

2 **AIMS** (Abnormal Involuntary Movement Scale)

3 **SESCAM** (Side Effects Scale/Checklist for Anti-psychotic Medication)

4 **Adapted West Wales Adverse Drug Reaction** (ADR) Profile

5 **GASS** (Glasgow Antipsychotic Side Effect Scale)

By combining objective assessment of both the positive and adverse effects of medication and involving the service user in this process, a collaborative informed judgement on the appropriateness and effectiveness of drug therapy can be made.

LUNSERS

(Liverpool University Neuroleptic Side Effect Rating Scale)

LUNSERS is a fully validated and reliable means of assessing neuroleptic side effects. It includes 41 known side effects of neuroleptics and 10 "red herring" items such as hair loss and chilblains which are not known side effects of neuroleptic medication. The "red herring" items are numbered -

3, 8, 11, 12, 25, 28, 30, 33, 42 and **45.**

These should be scored separately as this score may indicate individuals who over-score generally on the scale (a high score would be over 20, for example).

The scoring is as follows:

Not at all	=	0
Very little	=	1
A little	=	2
Quite a lot	=	3
Very much	=	4

The real neuroleptic side effect score is the sum for the remaining items (all items, excluding the "red herrings".

This scale can be used on a monthly or three-monthly basis using the total scores to monitor any changes in the side effect profile.

Further details can be obtained from Jennie Day or Richard Bentall at the address below -

Jenny Day (Research Pharmacist)
Richard Bentall (Professor of Clinical Psychology)

Department of Clinical Psychology
Whelan Building
University of Liverpool
P O Box 147
Liverpool
L69 3BX

LUNSERS Side Effects By Groups

Extrapyramidal Side Effects	
19	Muscle stiffness
29	Slowing of movements
34	Muscle spasms
40	Restlessness
43	Shakiness
48	Parts of the body moving of their own accord
37	Over-wet or drooling mouth
Possible range	**/28**

Anticholinergic Side Effects	
6	Dry mouth
10	Constipation
32	Difficulty passing water
38	Blurred vision
51	Passing a lot of water
Possible range	**/20**

Other Autonomic	
15	Dizziness
16	Feeling sick
20	Palpitations
27	Increased sweating
36	Diarrhoea
Possible range	**/20**

Allergic Reactions	
1	Rash
35	Sensitivity to sun
47	New or unusual skin marks
49	Itchy skin
Possible range	**/16**

Psychic Side Effects	
2	Difficulty staying awake during the day
4	Increased dreaming
9	Difficulty in concentrating
14	Tension
18	Tiredness
21	Difficulty in remembering things
23	Lack of emotions
26	Depression
31	Sleeping too much
41	Difficulty getting to sleep
Possible range	**/40**

Hormonal Side Effects	
7	Swollen/tender chest
13	Period problems (female only)
17	Increased sex drive
24	Difficulty achieving climax
46	Reduced sex drive
50	Periods less frequent
Possible range Females	**/24**
Possible range Males	**/16**

Miscellaneous	
5	Headaches
22	Losing weight
39	Putting on weight
44	Pins and needles
Possible range	**/16**

Red Herrings	
3	Runny nose
8	Chilblains
11	Hair loss
12	Urine darker than usual
25	Weak fingernails
28	Mouth ulcers
30	Greasy skin
33	Flushing of face
42	Neck muscles aching
45	Painful joints
Possible range	**/40**

POSSIBLE RANGE FOR TOTAL SCORES	
LUNSERS **side effect scores only**	
Females	/164
Males	/156
LUNSERS **all 51 items**	
Females	/204
Males	/196

LUNSERS Project – Service User Profile

Service User's Name				
Remedy Number		Date of Birth		Sex: M / F
Unit				

Key Worker's Name	
Psychiatrist's Name	

Current medication including dose and frequency

Other interventions

Date of last CPA/Outpatient visit		Date of next CPA/ Outpatient visit	

Hospitalisation history

Date assessment completed	
Assessor's signature	
Assessor's name (printed)	
Professional Designation	

LUNSERS

(Liverpool University Neuroleptic Side Effect Rating Scale)

Service User's Name				
Remedy Number		Date of Birth		Sex: M / F
Unit				

If not self assessment, name of person completing LUNSERS

……

Please indicate how much you have experienced each of the following symptoms **in the last month** by ticking the appropriate boxes

		Not at all	**Very little**	**A little**	**Quite a lot**	**Very Much**	**Level of distress – On a Scale of 1 to 10, 1 being 'not at all' and 10 being 'very much'**
1	Rash						
2	Difficulty staying awake during the day						
3	Runny nose						
4	Increased dreaming						
5	Headaches						
6	Dry mouth						
7	Swollen or tender chest						
8	Chilblains						
9	Difficulty in concentrating						
10	Constipation						
11	Hair loss						
12	Urine darker than usual						
13	Period problems						
14	Tension						

Questionnaire - Page One of Three

		Not at all	Very little	A little	Quite a lot	Very much	Level of distress – On a Scale of 1 to 10, 1 being 'not at all' and 10 being 'very much'
15	Dizziness						
16	Feeling sick						
17	Increased sex drive						
18	Tiredness						
19	Muscle stiffness						
20	Palpitations						
21	Difficulty in remembering things						
22	Losing weight						
23	Lack of emotions						
24	Difficulty in achieving climax						
25	Weak fingernails						
26	Depression						
27	Increased sweating						
28	Mouth ulcers						
29	Slowing of movements						
30	Greasy skin						
31	Sleeping too much						
32	Difficulty in passing water						
33	Flushing of face						
34	Muscle spasms						
35	Sensitivity to sun						
36	Diarrhoea						

Questionnaire - Page Two of Three

		Not at all	Very little	A little	Quite a lot	Very much	Level of distress – On a Scale of 1 to 10, 1 being 'not at all' and 10 being 'very much'
37	Over wet or drooling mouth						
38	Blurred vision						
39	Putting on weight						
40	Restlessness						
41	Difficulty getting to sleep						
42	Neck muscles aching						
43	Shakiness						
44	Pins and needles						
45	Painful joints						
46	Reduced sex drive						
47	New or unusual skin marks						
48	Parts of body moving of their own accord, eg foot moving up and down						
49	Itchy skin						
50	Periods less frequent						
51	Passing a lot of water						

Date assessment completed	
Assessor's signature	
Assessor's name (printed)	
Professional Designation	

Questionnaire - Page Three of Three

AIMS

(Abnormal Involuntary Movement Scale)
to Assess for Tardive Dyskinesia

AIMS is a 12-item scale designed to record in detail the occurrence of dyskinetic movements.

Examination Procedure

Either before or after completing the Examination Procedure, observe the service user unobtrusively, at rest (eg in the waiting room). The chair to be used in this examination should be a hard and firm one, without arms.

1 Ask the service user whether there is anything in his/her mouth (ie gum, candy, etc) and if there is, to remove it.

2 Ask the service user about the current condition of his/her teeth. Ask service user if he/she wears dentures. Do teeth or dentures bother service user now?

3 Ask service user whether he/she notices any movements in mouth, face, hands or feet. If yes, ask to describe and to what extent they currently bother service user or interfere with normal activities.

4 Have service user sit in chair with hands on knees, legs slightly apart and feet flat on the floor. (Look at entire body for movements while in this position).

5 Ask service user to sit with hands hanging unsupported. If male, between legs, if female and wearing a skirt/dress, hanging over knees. (Observe hands and other body areas.)

6 Ask service user to open mouth (observe tongue at rest within mouth). Do this twice.

7 Ask service user to protrude tongue. (Observe abnormalities of tongue movement.) Do this twice.

8 Ask service user to tap thumb, with each finger, as rapidly as possible for 10-15 seconds, separately with right hand, then with left hand. (Observe facial and leg movements.)

9 Flex and extend service user's left and right arms one at a time. Note any rigidity.

10 Ask service user to stand up. (Observe in profile. Observe all body areas again, hips included.)

11 Ask service user to extend both arms out-stretched in front with palms down. (Observe trunk, legs and mouth.)

12 Have service user walk a few paces, turn and walk back to chair. (Observe hands and gait.) Do this twice.

AIMS

(Abnormal Involuntary Movement Scale)
To Assess for Tardive Dyskinesia

Name of Service User: ……

Location: …….. Remedy Number: ……

Instructions:
Movement Ratings
Rate highest severity observed.
Rate movements that occur upon activation one less than those observed spontaneously.

Code:
0 = None
1 = Minimal
2 = Mild
3 = Moderate
4 = Severe

Please circle one

Facial and Oral Movements						
1	**Muscles of facial expression**, eg movements of forehead, eyebrows, periorbitol area, cheeks, include frowning, blinking, smiling, grimacing	0	1	2	3	4
2	**Lips and perioral area**, eg puckering, pouting, smacking	0	1	2	3	4
3	**Jaw**, eg biting, clenching, chewing, mouth opening, lateral movement	0	1	2	3	4
4	**Tongue**. Rate only increased movement both in and out of mouth. NOT inability to sustain movement	0	1	2	3	4
Extremity Movement						
5	**Upper (arm, wrist, hands, fingers).** Include choreic movements (ie rapid, objectively purposeless, irregular, spontaneous) athetoid movements (ie slow, irregular, complex, serpentine). Do NOT include tremor (ie repetitive, regular, rhythmic)	0	1	2	3	4
6	**Lower (legs, knees, ankles, toes)** eg lateral knee movement, foot tapping, heel dropping, foot squirming, inversion and eversion of foot	0	1	2	3	4
Trunk Movement						
7	**Neck, shoulders, hips**, eg rocking, twisting, squirming, pelvic gyrations	0	1	2	3	4
Global Judgement						
8	**Severity of abnormal movement**	0	1	2	3	4
9	**Incapacitation due to abnormal movements**	0	1	2	3	4
10	**Service user's awareness of abnormal movements**. Rate only service user's report	0	1	2	3	4
Dental Status						
11	**Current problems with teeth and/or dentures**	0	1	2	3	4
12	**Does service user usually wear dentures?**	0	1	2	3	4

Signature of Assessor: …… Designation: ……..

Name of Assessor: …….. Date of Assessment: ……

SESCAM

(Side Effects Scale/Checklist for Antipsychotic Medication)

Assessment Procedure

Observe service user in the following way and complete the rating scale/checklist. Ensure the service user has nothing in the mouth (eg chewing gum) and if dentures are worn, that there are no problems with fitting.

1 Ask the service user to sit down. Ensure you are an appropriate distance away, so that you can observe hands and feet as well as face. Observe facial and oral movements, also any resting tremor or restlessness of the feet or other parts of the body.

2 Ask service user to open the mouth and then protrude tongue. Observe any abnormal tongue movements inside the mouth and when protruding the tongue.

3 Ask the service user to stand up while you engage them in some conversation. Observe posture, trunk, including hip movements and any inability to stand still. Ask them to hold their arms out and observe any hand tremor.

4 Ask the service user to walk several paces, turn and walk back twice. Observe arm swing and gait.

5 Ask the questions relating to the service user's subjective assessment of side effects and the suitability of medication.

SESCAM

(Side Effects Scale/Checklist for Antipsychotic Medication)

Name of Service User:		Date:
Age:	Sex:	Service user number:
Location:		
Medication (include all antipsychotic medication and dosages):		

Severity Ratings

0 = Absent	Signs definitely absent during assessment period.
1 = Uncertain	Signs may be present but unsure whether they are drug-induced side effects or normal variation or behaviour resulting from abnormal mental or other cause.
2 = Mild	Signs just detectable and, in the case of spontaneous abnormal movements, present only occasionally.
3 = Moderate	Signs moderate or, in the case of abnormal movements, pronounced but present only occasionally, or mild but present most or all of the time.
4 = Severe	Signs pronounced and, in the case of spontaneous abnormal movements, present most or all of the time.

		Assessment					
		1st	2nd	3rd	4th	5th	6th
A	**Face/Mouth/Neck**						
1	Unchanging facial expression (*see additional definitions)						
2	Dribbling						
3	Involuntary movements of mouth, lips or tongue (*)						
4	Looks sleepy						
5	Other (please specify)						
B	**Extremities**						
	Upper (arms, hands fingers):						
6	Regular, resting or pill rolling tremor (*)						
7	Other (please specify)						
	Lower (legs, feet):						
8	Tapping of feet/ restlessness (jogging on the spot) (*)						
9	Other (please specify)						
C	**Trunk/posture/gait**						
10	Pelvic gyrations/or any writhing/rocking movements (*)						
11	Rigid, shuffling gait (*)						
12	Reduced arm swing (*)						
13	Slowness and reduced spontaneity						
14	Other (please specify)						

* ADDITIONAL DEFINITION OF ITEMS

1 **Unchanging facial expression:** Rigid looking face with little spontaneous movement.

3 **Involuntary movements of mouth/lips or tongue:** Side to side or worm-like rolling and twisting movements of the tongue, puckering, smacking, pouting of lips and mouth.

6 **Pill-rolling:** Circular movements of the thumb against index finger.

8 **Tapping of feet/restlessness:** Toe-tapping, pacing/jogging on the spot.

10 **Pelvic gyrations:** Circular or front to back movements of the pelvis.

11 **Shuffling gait:** Shuffling (dragging) of the feet while walking, knees may be bent.

12 **Reduced arm swing:** Arms are fixed or in an unusual position while walking.

SESCAM CHECKLIST

See additional definitions overleaf

Please ask service user the following questions and if "yes" tick box, if not apparent place "x" in box.

		Assessment					
Do you have any of the following (If "yes", please specify problem)		1st	2nd	3rd	4th	5th	6th
(a)	Dizziness						
(b)	Drowsiness						
(c)	Sexual problems						
(d)	Constipation						
(e)	Urinary problems						
(f)	Skin problems						
(g)	Excessive weight gain						
(h)	Blurred vision						
(i)	Feeling restless						
(j)	Lack get up and go						
(k)	Other						

Does the medication agree with you? Yes ☐ / No ☐

If no, why? (list reasons):

Do you think this is the right medication for you? Yes ☐ / No ☐

Signature of Assessor: …… Designation: ……

Name of Assessor: …….. Date of Assessment: ……

SESCAM
ADDITIONAL DEFINITION OF CHECKLIST ITEMS

(a) **Dizziness:** When and how often is this problem occurring?
(b) **Drowsiness:** When and how often is this problem occurring?
(c) **Sexual Problems:** Include erectile/ejaculatory difficulties, menstrual problems and general decreased libido.
(d) **Constipation:** How does this differ from normal pattern?
(e) **Urinary Problems:** Include retention or incontinence.
(f) **Skin Problems:** Include photosensitivity (sunburn) and any rashes.
(g) **Excessive Weight Gain:** State how much gained over what period.
(h) **Blurred Vision:** How often does this occur? When is it worse?
(i) **Feeling Restless:** How often does this occur? When is it worse?
(j) **Lack Get Up and Go:** In what way does this affect you?
(k) **Other:** Please specify and state how it affects you.

Adapted from SESCAM Bennett et al 1994 Middlesex University

ADAPTED WEST WALES
ADVERSE DRUG REACTION (ADR) PROFILE

This Profile should to be completed for, and wherever possible with, those service users whose physical health requires regular monitoring for the potential adverse effects of certain prescribed psychotropic medications.

Please complete all relevant details to establish a base-line of physical health information which may then be used to plan and influence related healthcare interventions.

If you have any questions relating to the document, support and guidance is available from Trust Nurse Consultants

PHYSICAL HEALTH MONITORING AND SIDE EFFECT PROFILE

Antipsychotic medications may exacerbate metabolic and cardiovascular (CV) risk factors. Consider these risks when starting therapy. Consensus Guidelines recommend follow-up monitoring of baseline values. Use this form to keep track of service user's metabolic and CV parameters for up to 1 year. (Continue to monitor for the duration of treatment).

Service user's name			
Age		Sex	
NHS number			
Unit			
Community/In-Patient (delete as applicable)			
Care Co-ordinator's name			
Consultant's name			
Name of clinician completing this form			
Current medication			
Medication change (dose/type)			
Known allergies			
Date of assessment		Next monitoring date	
Side effect tool to be used in addition			

1. **Complete baseline column at the time of the assessment**
2. **Subsequent shaded columns NOT TO BE COMPLETED**
3. **Unshaded columns to be completed at the designated intervals**

	Baseline .../.../...	4 weeks .../.../...	8 weeks .../.../...	12 weeks .../.../...	6 months .../.../...	9 months .../.../...	1 year .../.../...
Personal/family history							
Weight							
Waistline M<102cm F<88cm							
Blood Pressure <130/<85 mmHg							
Fasting plasma glucose 3.0-7.8 mmol/L							
Triglycerides <2.3 mmol/L							
Total Cholesterol <5.0 mmol/L							
HDL Cholesterol M 0.90-1.42 mmol/L F 1.16-1.70 mmol/L							
LDL Cholesterol <3.4 mmol/L							
ECG (QTc) M <440ms F <470ms							
Serum Prolactin (if on Prolactin antipsychotic) M <360 mu/L F <700 mu/L							
Urinalysis							
Drug Testing							

<u>Metabolic Syndrome is defined as the presence of any 3 of the following</u>: Waistline — Men: >102cm (40in); Women: >88cm (35in) Triglycerides — ≥1.7 mmol/L (150 mg/dL) HDL Cholesterol — Men: <1.0 mmol/L (40 mg/dL); Women: <1.3 mmol/L (50 mg/dL) Blood Pressure — ≥130/≥85 mm Hg Fasting plasma glucose — ≥6.1 mmol/L (110 mg/dL)	☐ If a service user gains ≥5% of initial body weight or shows worsening glycaemia or dyslipidaemia, consider switching to an atypical antipsychotic that is not associated with significant weight gain or diabetes.

Significant medical history
General Health – Service User/Care perspective
General Health – Assessing practitioner perspective

Changes & potential problems	**Yes/No Improving (I) Worsening (W)**	**Comments**	**Action**
Hand Tremor			
Tongue Tremor			
Feet shuffle			
Abnormal movements			
Posture			
Gait			
Standing			
Injection site			
Sleep			
Sedated			
Memory			
Concentration			
Energy			
Mood			
Irritable/Aggression			
Eyesight			

Changes & potential problems	**Yes/No Improving (I) Worsening (W)**	**Comments**	**Action**
Continence - Bowels			
Continence - Bladder			
Sexual health			
Reproductive health			
Chest Pain			
Short of breath			
Dry mouth / hyper-salivation			
Sore throat			
Alcohol use			
Smoking			
Other problems not listed			
Comments			

LIST EVERYTHING EATEN YESTERDAY AS A TYPICAL OR UNTYPICAL DAY	
Breakfast	
Lunch	
Supper	
Snacks including chocolate, crisps, biscuits etc.	
Tea /Coffee /Soft/ fizzy drinks	
NOTE CULTURAL, RELIGIOUS VARIATIONS	

Potential problem areas	**Yes/ No**	**Comments**	**Action**
Diet – pattern, amounts, range, variety, including appetite changes up or down.			
Fluids 1.5 - 2 L per day			
Indigestion / heartburn			
Related Px medication			

Health			
Dental / oral health			
Optical health (glasses, contact lenses etc)			
Podiatry			
Integumentary (sunscreen/ sun-glasses)			
Physical & Sensory Impairments			
Men's health (eg: wellman)			
Women's health (eg: smears)			

Medication – non-prescription			
Over the counter			
Complementary			
Illicit			

Potential problem areas	Yes/ No	Comments	Action
Medication – non-prescription *(continued)*			
Other			
Comments			

Health education, promotion, prevention			
Health education needs			
Socio-ethical-legal			
Other			

Problem/potential problem	Description/action
Hand tremor	Interference with activities of living. Parkinsonism
Tongue tremor	Fine tremor on protruding - ? tardive dyskinieasia - AIMS
Feet shuffle	Involuntary movements - ?akathisia.
Abnormal movements/ posture/gait	Chewing/sucking/jerking/restless/mannerisms/tics arms/legs stiff, dragging – AIMS
Dizziness	Any falls or stumbles. Light headed – check BP
Injection site	Pain, lumps, effects wearing off early.
Sleep / sedation	Sleep lasting less than 2hours. Yawns, drowsy, day-time sleep. Sleep apnoea. Snoring. Oxygen saturation.
Memory/ Concentration/ Lack of energy.	Interference with day to day life
Mood	Happy – unhappy/hopeful - less/helpful -less
Irritability /aggression	Hostility. Pain. Oxygen saturation.
Eye sight	Watching TV, reading, signs etc…
Bowels & Bladder	Continence, frequency, urgency, retention, constipation, pain, diarrhoea, blood, smell, UTI, prostate.
Reproductive health	Pregnancy, conception, potency, libido
Women's Health	Breasts, menstruation, menopause, parenting - same sex nurse.
Men's Health	Prostate, ejaculatory, erectile function, parenting – same sex nurse.
Chest pain	Associated with need to lie down, sweating, nausea = serious. ECG
Short of breath	As above.
Dry mouth	Suggest sucking sweet, gum or drinking water. Oral hygiene maintained. Check for ulcers.
Hyper-salivation	Social impact – implement management plan
Sore throat	Urgent bloods, risk of blood dyscrasia (esp: where carbamazepine co-prescribed).
Alcohol	Increase, changing pattern / effect.
Illicit drugs	What, quantity, frequency, source, administration etc.
Medication concordance	Timing, route, amount, spacing between, understandings etc.
Complementary medications/therapies	Purpose, effect, cross reference with prescribed medication / therapy.
Urinalysis	Routine urine analysis provides a baseline and may reveal potential areas for concern.
Allergies	Highlights information relevant to prescribing and treating.

Reference – Sue Jordan (2002) West Wales ADR Profile

GLASGOW ANTIPSYCHOTIC SIDE-EFFECT SCALE (GASS) *© Waddell & Taylor, 2007*

Name			
Age		**Sex**	Male / Female
Please list current medication and total daily doses below -			

A	This questionnaire is about how you have been recently. It is being used to determine if you are suffering from excessive side effects from your antipsychotic medication.
B	Please place a tick in the column which best indicates the degree to which you have experienced the following side effects.
C	**Also** tick the **end or last** box if you found that the side effect was distressing for you.

Over the past week:		*Never*	*Once*	*A few times*	*Every day*	*Tick this box if distressing*
1	I felt sleepy during the day					
2	I felt drugged or like a zombie					
3	I felt dizzy when I stood up and/or have fainted					
4	I have felt my heart beating irregularly or unusually fast					
5	My muscles have been tense or jerky					
6	My hands or arms have been shaky					
7	My legs have felt restless and/or I couldn't sit still					
8	I have been drooling					
9	My movements or walking have been slower than usual					
10	I have had uncontrollable movements of my face or body					
11	My vision has been blurry					
12	My mouth has been dry					
13	I have had difficulty passing urine					
14	I have felt like I am going to be sick or have vomited					
15	I have wet the bed					
16	I have been very thirsty and/or passing urine frequently					
17	The areas around my nipples have been sore and swollen					
18	I have noticed fluid coming from my nipples					
19	I have had problems enjoying sex					
20	**Men only:** I have had problems getting an erection					

Tick yes or no** for the **last three months	*No*	*Yes*	*Tick this box if distressing*
21. **Women only**: I have noticed a change in my periods			
22. **Men and women**: I have been gaining weight			

Staff Information

1 Allow the service user to fill in the questionnaire themselves. All questions relate to the previous week.

2 Scoring -

For questions 1-20 award –

1 point for the answer “once”
2 points for the answer “a few times” and
3 points for the answer “everyday”

Please note zero points are awarded for an answer of “never”.

For questions 21 and 22 award –

3 points for a “yes” answer and
0 points for a “no”

Total for all questions= _____

3 For male and female service users a score of:

0-21 absent/mild side effects

22-42 moderate side effects

43-63 severe side effects

4 Side effects covered include:

1-2 sedation and CNS side effects

3-4 cardiovascular side effects

5-10 extra pyramidal side effects

11-13 anticholinergic side effects

14 gastro-intestinal side effects

15 genitourinary side effects

16 screening question for diabetes mellitus

17-21 prolactinaemic side effects

22 weight gain

5 The column relating to the distress experienced with a particular side effect is not scored, but is intended to inform the clinician of the service user’s views and condition.

CLINICIAN'S NOTES