‘Working with Risk’ Policy for use of the clinical tool

‘Working with Risk’ – CLP021
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Why we need this Policy

This policy applies to all Mental Health and Learning Disability Services within NHFT with the exception of the ‘Wellbeing and Changing Minds Teams’ which are services for Improved Access to Psychological Therapies (IAPT) within Primary Care. These teams use an alternative electronic tool for clinical risk assessment and management which is designed for use within IAPT services.

This policy will be used by all clinical staff employed within NHFT and working within those aforementioned services, who are involved in the assessment and management of clinical risks related to the presentation or clinical condition of service users within those services.

This policy outlines the process (including NHFT approved tools) for assessing and managing clinical risks for people who access services and who by the nature of their condition, symptoms, experiences, behaviour or lifestyle may place them at risk of suicide or self harm; violence or aggression (including homicide); abuse or neglect (including self neglect).

This policy should be read in conjunction with the following associated documents:

- Working with risk Practitioners Manual (Morgan, 2007)
- Working with risk Trainers Manual (Morgan, 2007)
- Additional Guidance (Appendix 4)
- Best Practice in Managing Risk, Department of Health, 2007

The concept of risk has always been central to mental health, learning disability and drug and alcohol services (from here on referred to as services), equally within health and social care sectors. However, it has been attributed more significance since the early 1990’s, largely due to the greater frequency of reporting high profile incidents.

The concept of risk is most frequently associated with dangers and losses. Whilst these will always be real consequences of illness and disability, we must also attempt to redress the balance by considering the potential benefits of positive risk-taking (Morgan, 2004). All parts of the services are
managing risk as an integral part of their work, and are taking risks both in a calculated way and reactively to situations and crises that emerge. The Trust recognises that inevitable resource limitations also result in the need for risk-taking on occasions; and just as resources cannot be provided to meet all circumstances, so risk cannot be eliminated. However, it is a reasonable expectation that all staff working in the identified services above work in coproduced way with service users and carers to achieve the goal of risk minimisation.

The governing principle behind good approaches to choice and risk is that people have the right to live their lives to the full as long as that does not stop others from doing the same. Fear of supporting people to take reasonable risks in their daily lives can prevent them from doing things that most people take for granted. The Trust expects that all health and social care staff involved in the clinical assessment of service users, in whatever capacity, are trained in risk assessment and risk management skills. Such skills form the foundation of core professional competences to support comprehensive clinical decision-making and deliver evidence-based practice.

What the Policy is trying to do

To demonstrate effective clinical risk assessment which is a key standard for the Trust (NHS Litigation Authority, 2012), and is crucial to the delivery of high quality services across mental health and learning disability. ‘16 Best Practice’ Points (Appendix 5) have been developed and published by the Department of Health (DH) (DH, 2007), and are identified as fundamental to clinical risk assessment and management practice by organisations, care teams and individual practitioners. These points are underpinned by the principles of positive risk management; collaboration and co-production with the service user and others involved in care; the importance of recognising and building on the service user’s strengths; and the organisation’s role in risk management alongside the individual practitioners. The Working with Risk tools (Morgan, 2007) are identified as one of a number which support the implementation of best practice in risk management. This Working with Risk Policy and the associated documents form an integral part of the wider NHFT Risk Management Strategy and Policy (Policy no: CRM001), and the Trust has chosen to use the ‘working with risk’ tools across all mental health, learning disability and drug and alcohol services. Within this context the Trust recognises and promotes the place for appropriate and reasoned positive risk-taking as one element of risk management underpinned by good risk assessment as a framework of good practice (refer to practitioner and trainer manuals for further guidance).

This policy and associated documents, will act as a resource for practitioners and teams by reflecting, informing and guiding practice. It aims to set out good clinical risk assessment, risk management and risk-taking practice to be followed for all service users. There are no research instruments, scales or scores that will enable anyone to say with accuracy that one service user is at risk and another is not. However, there is a considerable body of evidence that indicates which factors are associated with elevated risk and how formulation of risk can be made on the basis of assessment information (additional guidance, Appendix 4). This policy and its associated documents aim to support practitioners to make informed judgements about clinical risk.

This policy also sets out how NHFT will support its practitioners and teams when they encounter adverse incidents while working within the parameters of this policy and associated documents.
Which stakeholders have been involved in the review of this Policy

Assistant Director of Mental Health, Learning Disability and Specialty Services
SG – Carer
CTM and KS – Service Users
Directorate Management Team for Mental Health, Learning Disability and Specialty Services

Any required definitions/explanations

NHFT - Northamptonshire Healthcare NHS Foundation Trust

The following definitions taken from Morgan (2007) are used throughout this document:

- **Risk**
  
is the *likelihood* of an event happening with potentially harmful or beneficial outcomes for self and others. (Possible behaviours include suicide, self-harm, neglect, aggression and violence, vulnerability, abuse or over-protection; with an additional range of other positive or negative service user experiences).

- **Risk Assessment**
  
is the *gathering of information* through processes of communication, investigation, observation and persistence; and *analysis* of the potential outcomes of identified behaviours. Identifying specific *risk factors* of relevance to an individual, and the circumstances in which they may occur. This process requires linking the *context* of historical information to current circumstances, to anticipate possible future change.

- **Risk Management**
  
is the statement of *plans* and the allocation of *responsibilities* for translating *collective decisions* into *real actions*. It is the activity of exercising a duty of care where risks (positive and negative) are identified. It entails a broad range of responses linked closely to the wider process of care planning. The activities may involve preventative, responsive and supportive measures to diminish the potential negative consequences of risk and to promote potential benefits of taking appropriate risks. These will occasionally involve more restrictive measures and crisis responses where the identified risks have an increased potential for harmful outcomes. It should also clearly identify the dates for reviewing the assessment and the management plans.

- **Positive Risk-taking**
  
[From: Morgan, 2004]: is weighing up the potential benefits and harms of exercising one choice of action over another. Identifying the potential risks involved, and developing plans and actions that reflect the positive potentials and stated priorities of the service user. It involves using available resources and support to achieve the desired outcomes, and to minimise the potential harmful outcomes. It requires an agreement of the goals to be achieved, or a clear explanation of any differences of opinion regarding the goals or courses
of action. (Further information regarding characteristics of Positive Risk-taking is provided in appendix 6).

- **Individual Qualified Clinicians**

  All professionally qualified and/or registered clinical staff across mental health and learning disability services, engaged in the delivery of care to users of those services. This includes the following disciplines (this is not an exhaustive list):

  - Medical
  - Nursing
  - Occupational therapy
  - Clinical Psychology
  - Social Work

**Key duties**

- **Organisational**

  A copy of this policy will be held on the Trust Intranet. The Trust holds responsibilities for enabling the messages articulated through this policy through:

  - Full support for properly taken *risk decisions*, with an expectation that all possible and reasonable attempts have been made to minimise harmful outcomes, and that good practice, policy and associated guidance has been followed within the resources and information available to support the decisions
  - Provision of Clinical Risk Assessment Training as part of the Trust Statutory and Mandatory Training policy no: HR025 in order to ensure appropriate training and support in risk decision-making for multidisciplinary practitioners and teams
  - Helping everyone to learn from adverse incidents, and disseminating examples of good practice in taking risk decisions through relevant review groups identified within the Risk Management Strategy and Policy no: CRM001.
  - Continuing to work to develop systems for accessing and communicating quality information and data
  - Encouraging wider use of “professionals meetings” where senior experienced people in the organisation can be approached for advice and guidance based on their specific knowledge and role expertise, when requested by any team across any part of the services.

- **Chief Executive**

  Is responsible for ensuring arrangements and resources are in place for the provision of clinical risk assessment processes within the Trust as outlined within this policy

- **Deputy Directors**

  Are responsible for ensuring the overall standard of clinical risk assessment (including the implementation and review of the policy), appropriate training and performance management.
• **Heads of Services, Professional and Clinical Leads**  
  Are responsible for ensuring:  
  • That mandatory clinical risk assessment training is available to all professional groups.  
  • The implementation and dissemination of the policy, and that this is maintained across services  

• **Clinical Team Managers Modern Matrons and Senior Professionals**  
  Are responsible for ensuring:  
  • That all staff within their remit are engaged in recognised practice development and training initiatives related to clinical risk assessment and management practice.  
  • Promotion of and facilitation of multi-disciplinary processes for risk decision making, i.e. within team meetings; handovers; ward rounds etc.  

• **Individual Qualified Clinicians**  
  Are responsible for:  
  • Personally reading this policy in conjunction with its associated documents of which every team has access to a copy of, and understand their individual and collective roles in the provision of safe and effective care for service users  
  • Reflecting on aspects of working with risk on a regular basis through clinical/professional supervision and Individual Performance and Development Reviews.  
  • Attending clinical risk training relevant to their needs, and update this in accordance with the HR025 - Trust Mandatory Training Policy.  
  • Accepting responsibility for the professional standards of conduct set out by their professional body, and for the care co-ordination role within the local implementation of CPA guidance and legislation.  
  • Working collaboratively with other professionals within their team, across the Trust and other agencies with respect to information sharing, decision-making and care planning.  
  • Working collaboratively with service users and carers throughout the clinical risk assessment process, using legislative guidance such as the CLP023 - Mental Capacity Act (2005) to support this as necessary.  
  • Making thorough assessments of risk and to clearly document reasoned judgements.  
  • Recording all clinical risk assessments and management plans within the clinical record in accordance with IGP101 - Information Governance Policy and Management Framework and IGP117 – Health Records Keeping Standards policy.  
  • Ensuring that all people accessing services are treated fairly in keeping with equality and diversity guidance, and anti-discrimination law. To this end all services will ensure that demographic information relating to service users protected characteristics will be collected and kept up to date in order to identify any developing trends and act accordingly.  

• **All staff**  
  Are expected to conduct their work in a manner which supports the fundamental principles of clinical risk assessment, aimed at maintaining the safety of service users and others in the delivery of healthcare.
Policy detail

- **Working with Risk**

  Clinical risk assessment in practice requires the gathering of information from as many sources as possible in a spirit of collaboration and co-production with the service user and their carers, based on knowledge of the research evidence, the service users experience and social context, and clinical judgement. The process should be led by the care co-ordinator or lead professional, but there is also an expectation that any professional involved with the care and treatment of the patient who is made aware of risk related information should complete a risk assessment.

  Working with Risk 1 & 2 should be completed on SystmOne. Appendix 11 explains the interface between Working with Risk 1 & 2 and SystmOne. Working with Risk 3 is on SystmOne as a questionnaire.

  The risk assessment should take account of the following (see appendices for further guidance):

- **Risk factors**

  These can be static (unchangeable e.g. history of self harm) or dynamic (change over time e.g. misuse of alcohol)

- **History**

  Considering the recency; severity; frequency and pattern of risk incidents or behaviour.

- **Ideation/Mental State**

  Of the service user – what are they thinking or feeling at this moment e.g. is there evidence of symptoms indicating external control such as delusions or command hallucinations; are there emotions expressed related to violence or suicide; is there evidence of specific threats made by the service user to harm others or themselves.

- **Intent**

  A statement of intention from the service user is a clear indication of risk and should not be ignored.

- **Planning**

  If the person has thoughts to harm these should be explored to establish whether they have considered how they will do this; presence of a plan indicates a higher degree of risk – if they also have the means to carry out their plans the risk increases.

- **Protective factors**
Consideration should also be given to any factors with the capacity to prevent or reduce the likelihood of risk. Care should also be taken to equally consider any threats to these factors. These factors can make a significant contribution to the risk management plan.

- **Risk Formulation**

Taking into account all of the above information the aim is to identify factors likely to increase or decrease risk (as far as is possible) and should seek to determine how serious the risk is; whether it is specific or general; how immediate and volatile the risk is; what circumstances may increase the risk and therefore what specific treatment and management plan can best reduce the risk. The risk management plan should also specify who will be responsible for implementing each of the actions; this can include service users and their carers.

- **Review**

This should be planned in advance with the involvement and in co-production with service users and their carers, and not be completed only in response to crisis. Efforts should be made to anticipate circumstances which may trigger a review such as anniversaries. Review should also be considered at other periods recognised to increase risk such as prior to leave and discharge. **The period of review is down to clinical/professional judgement, but as a maximum is 6 months.**

The Trust holds reasonable expectations that its staff will work to the processes and guidelines of good practice outlined in this policy; its appendices and associated documents. The Trust will support the judgements made by its practitioners through shared corporate accountability even when things will occasionally go wrong, provided reasonable good practice has been adhered to within the resources and information available to support the decisions. The Trust expects the whole picture of risk to be reviewed by clinicians, with individual service users at least annually.

The Trust authorises the use of the ‘Working with Risk’ tools across all mental health and learning disability services. The following outlines the Trusts expectations of clinical practitioners with regards to the ‘Working with Risk’ tools, and identifies tools authorised for use in addition to or in association with these tools.

- **Working with risk 1 - current situation (Appendix 1).**

This is the baseline risk screening tool that should be completed with everyone who comes into contact with mental health and learning disability services (or other services as indicated in paragraph 2). This will usually include the first point of direct (face-to-face) contact, but may occasionally be completed on the information only available from referral, past notes, other sources of information.

This level of assessment and management plan should be completed within the first 24 hours of acceptance onto in-patient or residential units, or within the first 24 working hours of planned contact with the service user in community services. For **one-off and brief periods of contact**, this format will be completed immediately or soon after the point of contact.
It is a requirement of good practice that in-patient staff complete a copy of ‘Working with Risk 1’ as a part of the weekly Multi-disciplinary Team ward round. The MDT should also use the ‘Working with Risk 1’ as part of the decision making process when considering leave and discharge plans from the unit. Completion of a new form will not ordinarily be needed in each case of a half hour leave from the unit; however, consideration of any changes to the current situation should be clearly documented in the clinical record and a new ‘Working with Risk 1’ completed if required.

All clinical teams should aim to complete ‘Working with Risk 1’ in collaboration with other professionals or as a team. This helps to support clinical decision making and competency development for clinical staff.

Where the need for more detail is indicated, subsequent updated versions of the form may be completed as frequently as needed and where risks are rapidly changing.

It will be updated or reviewed as frequently as needed. The timing of when this is updated should be planned in advance, but can also be triggered whenever a significant change in a person’s risk presentation or circumstance and/or significant new risk information comes to light.

Examples of the circumstances which would prompt review include: discharge or leave from an inpatient unit or service (including 24 hour 7 day follow up appointment); transfer between services or pathways; change of care co-ordinator or lead professional; suicide attempt; non-compliance with treatment; loss of contact with service; any significant changes to behaviour; social/personal circumstances, personal relationships or mental state; change to legal status; significant change to treatment plan; CPA review (this is not an exhaustive list). The period of review is down to clinical/professional judgement, but as a maximum is 6 months.

A new form should be completed for each review, and information detailed on the form should relate to the period assessed since the last review.

Where a number of ‘Working with Risk 1’s have been completed ‘Working with Risk 2’ (below) should be used to then collect the detailed history from these assessments to help identify patterns, trends and triggers to risk behaviours and therefore a wider long term risk management plan.

- **Working with risk 2 - detailed review (Appendix 2).**

This document provides a format for more detailed analysis and reflection on risk information. It is to be used in addition to ‘Working with Risk 1 ~ Current Situation’ to record more detail, and as part of the wider review of care. It should dovetail with other more comprehensive needs assessments and care plans, and should be completed as part of the Multi-disciplinary or Professional team decision making process, and in collaboration with service users and carers.
This document would not be expected to be reviewed as frequently as ‘Working with Risk 1’, which should be used to document any of the changes to risk information between planned review dates. ‘Working with risk 2’ is used for updating the chronology of risk events and risk related strengths and can provide a picture of changing risk behaviour over time; helping to identify triggers, and relapse indicators in order to plan the most appropriate risk management strategies. The period of review is down to clinical/professional judgement, but as a maximum is 12 months.

This tool is an expected feature of recorded information for all people accepted into services under the CPA framework it should therefore be completed in tandem with the CPA process (refer to Care Programme Approach policy - CLP010), and care co-ordinators/lead professionals (or equivalent roles in other services) should be responsible for ensuring that this document is updated for people already known to services while they are inpatients. This requires appropriate involvement of community staff in inpatient reviews and pre-discharge meetings.

As an alternative to ‘Working with Risk 2’, Forensic Services will continue to use their evidence-based tools (i.e. HCR20 (Webster et al, 1997)) as the next level beyond the ‘Working with Risk 1’ baseline screening tool. Learning Disability services will also continue to use the John Aldridge Risk Assessment tool (Aldridge, 2005), as an alternative to this tool, where clinically indicated for service users not subject to CPA (see appendix 10 – ‘Patient Centred Safety Planning for guidance on the use of this tool). However, both services can still choose to use ‘Working with Risk 2’ where clinically relevant or useful. Other specialist risk assessments used within NHFT Mental Health and Learning Disability Services are listed below with the associated guidance/policy/protocol:

STORM suicide and self-injury assessment tools (University of Manchester, 2006). These tools are specifically designed for the management and prevention of suicide and self-harm. Staff must attend STORM training in order to practice and understand how to use these tools. Training is available within NHFT from validated STORM trainers and can be accessed by all staff, but is also mandatory for all clinical staff of band 5 and above who work with service users at risk of suicide and self harm (refer to Statutory and Mandatory training policy HR025) The tools are available to use on Systm1, (please refer to Systm1 user guide).

Kings College Medical Risk Assessment for Eating Disorders (Treasure, 2009) this risk assessment takes the form of recommended clinical guidance and investigations, the results of which should be recorded in the clinical record. A link to access this guidance on the internet is included in the reference section.

Dual Diagnosis Brief Assessment Tool – for assessment of substance misuse in service users with mental ill health (refer to CLP029 Policy for Dual Diagnosis for further guidance).

All the tools listed above will continue to be used alongside the ‘Working with Risk’ tools where clinically indicated. Their use and subsequent review is therefore optional and based on professional judgement. Specialist risk assessments are also indicated for the prevention of falls, patients moving and handling, pressure area care, Infection Control, prevention of malnutrition and prevention of VTE. Clinical staff should refer to policies: CLP062 - Policy for the Prevention of Falls in NHFT; HSC010 - Moving and Handling Policy; CLPg 033 - NHFT Guidelines for the prevention and management of pressure ulcers in all care settings; CLP068 - Nutrition and Hydration policy; Policy for Primary Thromboprophylaxis for patients...
admitted to NHFT – MMP016; ICP005 - Healthcare Associated Infections and Risk and CLPr002.

- **Working with risk 3 - positive risk-taking (Appendix 3).**

This format is to be used at the relevant point when considering the possibility that taking a risk could lead to a positive outcome. It guides through specific questions to be asked in supporting reasoned decisions for taking risk in a defined set of circumstances. It is a tool to support Multi-disciplinary decision-making, not a standard administrative requirement. The period of review is down to clinical/professional judgement, and can be prompted by an individual practitioner, clinical team or by a service user.

- **Development and Approval of New Clinical Risk Tools**

Where a need for a new or revised clinical risk tool is identified, it will be the responsibility of service managers and modern matrons to ensure they are approved reflecting the corporate procedure for approving or reviewing records. For further guidance refer to NHFT procedure for authorizing new clinical records within IGP117 - Health Records Keeping Standards.

- **Confidentiality**

The disclosure of information between agencies is a sensitive and complex professional and legal issue. All considerations around the exchange of information should only be made with reference to the Trust’s Information Governance Policy and Management Framework IGP101.. The Department of Health (2009) Information Sharing and Mental Health guidance document also provides support for professionals.

In cases where there is a significant risk; individuals/agencies concerned must be informed. This may apply even where consent has not been obtained from the service user. However it must be documented in the clinical records a) why consent cannot be obtained and b) the details of the risk that warrant not obtaining consent. On rare occasions, members of the public (which includes other service users) who are at specific risk may also need to be informed (i.e. those at risk of violence such as severe injury or rape). Where the public interest overrides professional confidentiality then information may be disclosed without consent. Issues relating to disclosure of information should be discussed within the multidisciplinary team and, where necessary, through the Caldicott Guardian and existing line management structures. Staff may, on occasions, require advice from their professional organisation. If requested, other agencies should be helped to develop procedures whereby information that is passed on remains confidential and protected.

- **Safeguarding**

In 2009 a rapid response report from the National Patient Safety Agency alerted Mental Health Organisations to the risk of harm to children by parents who have mental health...
needs. This raised attention to the very serious risks that may arise if their illness incorporates delusional beliefs about the child, and/or the potential to harm the child as part of a suicide plan.

The report therefore advises staff to assess the risks where a parent with mental illness is likely to have or resume contact with a child.

All staff working within adult mental health services, including crisis intervention and the drug and alcohol teams must ensure that they take appropriate action to protect children and young people connected to adult service users from harm.

Staff are encouraged to read the rapid response report for further detail. The report can be accessed via the NHS Patient Safety website, full details are provided in the reference section of this policy.

- **Quality assurance**

  As a core element of clinical practice, clinical risk assessment and management should be an integral part of reflective practice within clinical supervision and Multi-disciplinary Professional team meetings.

  Clinical audits of Clinical Risk Assessment and Management standards should be undertaken regularly by clinical teams as part of the Trust’s Quality monitoring schedule and used to inform additional training and development needs locally.

  An initial baseline audit will be completed by the Nursing and Quality Team using a sample from across Mental Health and Learning Disability Services and then repeated after 6 months to determine effectiveness of the revised policy.

**Training requirements associated with this Policy**

- **Mandatory Training**

  Training required to fulfil this policy will be provided in accordance with the Trust’s Training Needs Analysis. Management of training will be in accordance with the Trust’s Statutory and Mandatory Training Policy HR025.

- **Specific Training not covered by Mandatory Training**

  Ad hoc training sessions based on an individual’s training needs as defined within their annual appraisal or job description or following clinical or serious incident reviews.
How this Policy will be monitored for compliance and effectiveness

The table below outlines the Trust’s monitoring arrangements for this document. The Trust reserves the right to commission additional work or change the monitoring arrangements to meet organisational needs.

<table>
<thead>
<tr>
<th>Aspect of compliance or effectiveness being monitored</th>
<th>Method of monitoring</th>
<th>Individual responsible for the monitoring</th>
<th>Monitoring frequency</th>
<th>Group or committee who receive the findings or report</th>
<th>Group or committee or individual responsible for completing any actions</th>
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<tr>
<td>Duties -</td>
<td>Audit of caseloads (10% - a minimum of 4 and maximum of 30)</td>
<td>Head of Quality</td>
<td>Annually</td>
<td>Clinical Excellence and Audit Committee</td>
<td>Head of Quality</td>
</tr>
<tr>
<td>- All Qualified Clinicians completing clinical risk assessments in accordance with this policy</td>
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<tr>
<td>Tools and Processes authorised for use within the organisation</td>
<td>Clinical Audit of caseloads (10% - a minimum of 4 and maximum of 30)</td>
<td>Head of Quality</td>
<td>Annually</td>
<td>Clinical Excellence and Audit Committee</td>
<td>Head of Quality</td>
</tr>
<tr>
<td>How clinical risk assessments are reviewed including timescales.</td>
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<tr>
<td>Training –</td>
<td>Compliance with training will be monitored in line with NHFT Statutory and Mandatory Training Policy (HR025).</td>
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<tr>
<td>- All staff receive training as identified within the Trust’s training needs analysis.</td>
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</table>

Where a lack of compliance is found, the identified group, committee or individual will identify required actions, allocate responsible leads, target completion dates and ensure an assurance report is represented showing how any gaps have been addressed.

For further information

Deputy Director of Mental Health, Learning Disability and Specialty Services.
Equality considerations

The Trust has a duty under the Equality Act and the Public Sector Equality Duty to assess the impact of Policy changes for different groups within the community. In particular, the Trust is required to assess the impact (both positive and negative) for a number of ‘protected characteristics’ including:

- Age;
- Disability;
- Gender reassignment;
- Marriage and civil partnership;
- Race;
- Religion or belief;
- Sexual orientation;
- Pregnancy and maternity; and
- Other excluded groups and/or those with multiple and social deprivation (for example carers, transient communities, ex-offenders, asylum seekers, sex-workers and homeless people).

The author has considered the impact on these groups of the adoption of this Policy and no negative impacts have been identified. It is unlikely that the implementation of this policy could result in unlawful discrimination. The Trust is committed to ensure that the demographic information for service users regarding their protected characteristics is updated and will consider any developing trends related to protected characteristics.

Reference Guide


**BIBLIOGRAPHY**


**Document control details**

| Author: | Assistant Director of Mental Health, Learning Disability and Specialty Services  
| SG – Carer  
| CTM and KS – Service Users  
| Directorate Management Team for Mental Health, Learning Disability and Specialty Services |
| Approved by and date: | Trust Policy Board – 10 December 2019 |
| Responsible Committee: | Mental Health Directorate Management Team – 5 December 2019 |
| Any other linked Policies: | CLP010 – Care Programme Approach Policy  
| CLP020 – The Mental Health Act 1983  
| CLP023 - Mental Capacity Act (2005) Policy  
| CLP027 – National Recommendations Policy  
| CLP047 - Policy for Safeguarding children  
| CLP055 - Policy for Safeguarding Vulnerable Adults  
| CLP062 - Policy for the Prevention of Falls in NHFT  
| CRM001 - Risk Management Strategy  
| CRM002 - Policy for the Management of Incidents,  
<p>| HR025 – Core Skills Training Policy |</p>
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<th>Version No.</th>
<th>Date Ratified/Amended</th>
<th>Date of Implementation</th>
<th>Next Review Date</th>
<th>Reason for Change (eg. full rewrite, amendment to reflect new legislation, updated flowchart, minor amendments, etc.)</th>
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<td>05/12/2016</td>
<td>05/12/2016</td>
<td>05/12/2019</td>
<td>New governance of trust policies template.</td>
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<td>31/01/2019</td>
<td>31/01/2019</td>
<td>05/12/2019</td>
<td>Addition of Appendix 11</td>
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<td>3.0</td>
<td>10/12/2019</td>
<td>11/12/2019</td>
<td>10/12/2022</td>
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APPENDIX 1 - Working with Risk 1 – Current Situation

Purpose: This is a baseline screening tool that should be completed with everyone who comes into contact with mental health and learning disability services (this includes one off and brief periods of contact). A new document will need to be completed if there is a change in risk presentation/behaviour.

Please assess the situation since the last risk review. Historical risks should be entered into the significant known history box.

Name: _____________________________ Date of birth: _____________________________
Address: ___________________________ Postcode: _________________________________
NHS Number: *** Systm1 Number: _______________________________
Date of Assessment: ________________ Next Review Date: __________________________

Risk from others:
Yes [ ] No [ ] Unknown [ ]

Please explore: exploitation (financial, sexual, psychological), domestic violence, abuse (financial, sexual, psychological, physical), contact with services (poor engagement, bad experience), bullying (including cyberbullying)

Details of identified risk:

Risk to self:
Yes [ ] No [ ] Unknown [ ]

Please explore: suicide (thoughts, feelings, intent, levels of hopelessness/worthlessness, current plan, triggers, suicide pacts), drug use (illicit, overuse of prescribed), alcohol consumption, self harm (how recent, methods used, immediate risk, current feelings), self neglect, social isolation.

Details of identified risk:

Risk to others:
Yes [ ] No [ ] Unknown [ ]

Please explore: aggression (verbal, physical), violence (psychological, physical, sexual, towards people, animals, property), criminality, abuse (verbal, physical, sexual, psychological).

Details of identified risk:
Risk of neglect:  
Yes  No  Unknown  

Please consider: health, personal, degree of substance misuse, neglect (from others or to self), unmet needs or lack of service provision

Details of identified risk:

Risk to children:  
Yes  No  Unknown  

Please consider: neglect, physical/psychological/sexual abuse, is there a current safe guarding plan in place? Delusions regarding children, murder/suicide pacts including children

Details of identified risk:

Risk of physical complications:  
Yes  No  Unknown  

Please consider: medical issues (diabetes, epilepsy, heart disease etc), sensory issues, nutrition/hydration, pressure ulcers, VTE’s, infections (UTI/chest), swallowing/eating needs, incontinence, fractures, medication side effects, self neglect, overactivity

Details of identified risk:

Risk of wandering / falls:  
Yes  No  Unknown  

Please consider: footwear, footcare, mobility aids, diagnosis/cognitive impairment, dissociation, epilepsy, frailty, impact of medication, absconsion risks.

Details of identified risk:

Memory and cognitive impairment:  
Yes  No  Unknown  

Please consider: forgetfulness, agitation, frustration, diagnosis (medical/organic), dissociation, epilepsy, impact on self, family/friends.

Details of identified risk:
Challenges to service:  
Yes ☐  No ☐  Unknown ☐

Please consider: inappropriate demands, poor service response, threats, suicide pacts, social networking, relationships with others, poor engagement, media interest, conflicting reports of engagement or presentation between professionals/carers/patients.

Details of identified risk:

Protective factors:  
Yes ☐  No ☐  Unknown ☐

Please consider: positive resources, managed self harm, service users strengths/previous coping mechanisms, social support, what has worked well before, agreed plans (WRAP/Recovery Star/Personal safety plan) positive relationships with staff/family/carers/friends.

Details of identified risk:

Significant known history
Please summarise previous risk history this may include: suicide attempts, self harm, violence/aggression, criminality, abuse, drug/alcohol issues (the list is not exhaustive).
A detailed history should be written within Risk 2

Initial assessment of risk
Please summarise the risk factors identified above and consider: the situations in which risks may occur (or increase/decrease), estimates of potential, impressions/feelings needing further investigation, context and areas for positive risktaking/protective factors (consider completing a Risk 3).

Initial risk management plan
Please consider (based on the above information) what the risks are and the severity and likelihood of each, who is to do what, further areas of information needed. You must cover all areas where a “yes” has been identified and which has been identified in the ‘initial assessment of risk’, where unknown has been identified please indicate the plan required to clarify the risks.

Are the identified risks evidenced in the service users overall plan of care?  
Yes ☐  No ☐
Information sources available at this assessment

How was the assessment made?
(e.g. interview with service user and/or carer, observations, service notes/discussion, multiple sources)

Involvement and/or agreement of person and/or carer in process

Please consider: the service user/carers understanding of the risk, do they think it’s a risk? Do the service user/carer agree with the risk management plan?

Service user signature (optional)

If the service user cannot sign at this time, please document why.

Carer signature (optional)

Completed by:

Discussed with (profession):
APPENDIX 2 - Working with Risk 2 – Detailed Review

Purpose: This document provides a format for more detailed analysis and reflection on the risk information collected. It should be used in addition to Working with Risk 1 to record more in depth information, and should dovetail with other more comprehensive needs assessments and plans of care. The form must be completed for CPA Reviews and as part of a 117 process. It is considered good practice to use Risk 2 for service users who do not have a CPA status.

<table>
<thead>
<tr>
<th>Name:</th>
<th>Date of Birth:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Address:</td>
<td>Postcode:</td>
</tr>
<tr>
<td>NHS Number: ***</td>
<td>Systm1 Number:</td>
</tr>
<tr>
<td>Date of Assessment:</td>
<td>Next Review Date:</td>
</tr>
</tbody>
</table>

Network of Support
Service User
Carer(s)
General practitioner
Psychiatrist
Community psychiatric nurse
Ward link nurse/named nurse
Social worker/care worker
Occupational therapist
Psychologist
Support worker
Voluntary agency worker(s)
Others (please specify)

Confidentiality of information is vitally important to protect the rights of the individual. However, information is shared with the relevant people who work together to offer support. The sharing of information is discussed with the service user beforehand and their views are taken into account. These views will only be breached in the rare circumstances of serious risks identified to self and/or others.

Sources of information available:

**Service user current assessment of risks** (summarise their perspective/thoughts and understanding of the risk using their own words where possible)

**Carer(s)/important other(s) current assessment of risks** (summarise their perspective/thoughts and understanding of the risk using their own words where possible)
Potential for positive risk-taking (reactive or proactive plans, please consider what has been tried before, what was the outcome?)

Known chronology of risk incidents (please add the information gathered from previous Risk 1’s to this section)

(Please consider: specific dates, category/description of risk, detailed context/situation, service user’s account, carer(s) account, corrections to previously inaccurate information)

Strengths
(Please consider – service user abilities, capabilities, interests, personal qualities, protective factors and sources of support which could enhance the service users capacity to maintain safety and well being etc specifically linked to working with risk)
**Summary of assessment** (since last review)
(Please consider: situations which can contribute to an increase in risk eg. Context, environment, situations etc, intuitions which need further investigation, estimates of intent/likelihood, identify any early warning signs, environmental factors, identify any patterns or trends to risk behaviours.)

<table>
<thead>
<tr>
<th>Further need for specialised risk/other assessments</th>
<th>Yes</th>
<th>No</th>
<th>Action taken</th>
</tr>
</thead>
<tbody>
<tr>
<td>Please consider: STORM; MUST; NEWS; VTE; Falls; Fluid Balance; Waterlow; Medication side effects; High Dose Antisphychotics; Cognitive assessment; Mental Health Assessment tools (e.g. BPRS, Becks, Behaviour Assessment etc) Forensic Assessment tools (e.g. HCR-20). Also see additional tools listed in Working with Risk policy</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
Risk management plan
(Please consider: who, what, how, when, expected outcome, positive potentials etc. Considering for example, risk minimisation, early warning signs, crisis responses, long term management, positive risk taking (check Working with Risk 3), levels of observation etc. Please consider linking this plan to any recovery tools eg. WRAP/keeping me healthy and safe/Recovery Star which the service user may be using)

<table>
<thead>
<tr>
<th>Actions to be taken</th>
<th>Individual responsibilities and shared decision-making</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Role of service user and/or carer

Service user involved?  Yes / No  Carer involved?  Yes / No
Service user agreed?    Yes / No  Carer agreed?  Yes / No
Comments:

Date and place of next review: ....../....  ......................................................
Completed by: ..............................................................
Printed name (for collective responsibility)
Signature: ..............................................................  Base: ..............................................................
Service user signature (optional): If the service user cannot sign at this time, please document why.
........................................................................................................
APPENDIX 3 - Working with Risk 3 – Positive Risk-taking

Purpose: This format is to be used at the relevant point when considering the possibility that taking a risk could lead to a positive outcome eg. Planning for leave/discharge etc. It is a tool to support multi disciplinary decision making. A copy of this document should be given to the service user and if appropriate the carers.

<table>
<thead>
<tr>
<th>Name:</th>
<th>Date of birth:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Address:</td>
<td>Postcode:</td>
</tr>
<tr>
<td>NHS Number: ***</td>
<td>Systm1 Number:</td>
</tr>
<tr>
<td>Date of Assessment:</td>
<td>Next Review Date:</td>
</tr>
</tbody>
</table>

What are the reasons for considering taking risks?
*(including is it reactive or proactive?)*

What are the service user’s experiences and understanding of risk?

What are the carer’s experiences and understanding of risk?

What actions are you defining as being ‘positive risk-taking’ for (a) the service user and/or (b) the service practitioners?

- Define the actions/behaviours you determine to be risky:

- Define the risk that is being taken:

- Define the intended outcomes of the course of action:
What strengths can be identified (to support the risks being taken)?

What are the planned stages (for risk-taking)?

What may be the pitfalls (including estimates of likelihood)?

What are the early warning signs?

What safety nets (including crisis and contingency plans) can be identified?

What happened the last time this course of action was followed?

- How was it managed?

- What needs to and can change?

Outline the reasons and formulation why positive risk-taking is the course of action in this situation:

How will progress be monitored?
Who agrees to this approach?

How and when reviewed: …………………………………………………………………………. ……./……./…….

Signature (for collective accountability): ………………………………………………………………………….

Service user signature (optional):

If the service user cannot sign at this time, please document why.

………………………………………………………………………………...
### Appendix 4 - ADDITIONAL GUIDANCE

- [From: Morgan, 2007]

<table>
<thead>
<tr>
<th>SUICIDE</th>
<th>NEGLECT</th>
<th>AGGRESSION VIOLENCE</th>
</tr>
</thead>
<tbody>
<tr>
<td>Attempts on their life</td>
<td>Periods of neglect</td>
<td>Incidents of violence</td>
</tr>
<tr>
<td>Expressing high levels of distress</td>
<td>Lack of positive social contacts</td>
<td>Paranoid delusions about others</td>
</tr>
<tr>
<td>Use of violent methods</td>
<td>Failing to drink properly</td>
<td>Use of weapons</td>
</tr>
<tr>
<td>Helplessness or hopelessness</td>
<td>Unable to shop for self</td>
<td>Violent command hallucinations</td>
</tr>
<tr>
<td>Misuse of drugs and/or alcohol</td>
<td>Failing to eat properly</td>
<td>Misuse of drugs and/or</td>
</tr>
<tr>
<td>Family history of suicide</td>
<td>Insufficient/inappropriate clothing</td>
<td></td>
</tr>
<tr>
<td>alcohol</td>
<td></td>
<td>Signs of anger and</td>
</tr>
<tr>
<td>Major psychiatric diagnoses frustration</td>
<td></td>
<td>Sexually inappropriate behaviour</td>
</tr>
<tr>
<td>Separated/widowed/divorced</td>
<td></td>
<td>Known personal trigger</td>
</tr>
<tr>
<td>Expressing suicidal ideas</td>
<td>Difficulty managing physical health</td>
<td></td>
</tr>
<tr>
<td>factors</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Unemployed/retired</td>
<td>Difficulty maintaining hygiene</td>
<td></td>
</tr>
<tr>
<td>Considered/planned intent</td>
<td>Living in inadequate accommodation</td>
<td></td>
</tr>
<tr>
<td>Significant life events</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Believe no control over their life</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

While not all parts of the list will be relevant for any one individual, it is important that practitioners give consideration to all areas, as a part of the cognitive process of making an assessment more specific and individualised. To illustrate examples of every factor would be space and time consuming. You have a degree of discretion how you interpret each factor, but there is an expectation that people use their colleagues to check out any personal ambiguities, and to support consistency of interpretations and use of the tools.
<table>
<thead>
<tr>
<th>RISK ASSOCIATED WITH DISABILITY</th>
<th>PHYSICAL MEDICAL RISKS</th>
<th>SOCIAL RISKS</th>
</tr>
</thead>
<tbody>
<tr>
<td>Sensory impairments</td>
<td>Physical impairments</td>
<td>Loss of housing</td>
</tr>
<tr>
<td>Intellectual impairments</td>
<td>Medical conditions</td>
<td>Loss of income</td>
</tr>
<tr>
<td>Physical suitability of home</td>
<td>Self managing medication</td>
<td>Loss of employment status</td>
</tr>
<tr>
<td>Mobility inside the home</td>
<td>Monitoring medication side-effects</td>
<td>Loss of family contact</td>
</tr>
<tr>
<td>Mobility outside the home</td>
<td>Risks of withdrawal</td>
<td>Loss of friendships</td>
</tr>
<tr>
<td>Risk of falls</td>
<td>Self-injury (e.g. cutting, burning)</td>
<td>Loss of leisure opportunities</td>
</tr>
<tr>
<td>Risk of wandering</td>
<td>Other self-harm (e.g. eating disorder)</td>
<td>Stigma of mental illness</td>
</tr>
<tr>
<td>Risk of accidental injury</td>
<td>Risks from smoking (e.g. health, fire)</td>
<td>Stigma associated with ‘risk’</td>
</tr>
<tr>
<td>Communication difficulties</td>
<td>Manual handling risks</td>
<td>Living alone (with no support)</td>
</tr>
<tr>
<td>Expressing sexuality</td>
<td>Incontinence</td>
<td>Culturally isolated situation</td>
</tr>
<tr>
<td>Consequences of impulsivity</td>
<td>Loss of sex drive</td>
<td></td>
</tr>
<tr>
<td>Inappropiate demands on services</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Driving</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>RISKS FOR SERVICE USERS</th>
<th>RISKS FOR CARERS</th>
<th>OTHER RISKS</th>
</tr>
</thead>
<tbody>
<tr>
<td>Conflict with carers/friends</td>
<td>Conflict with service user</td>
<td>Exploitation by others</td>
</tr>
<tr>
<td>Conflict with services</td>
<td>Conflict with services</td>
<td>Exploitation of others</td>
</tr>
<tr>
<td>More often the victim rather than the perpetrator</td>
<td>Social isolation</td>
<td>Stated abuse by others (e.g. physical, sexual)</td>
</tr>
<tr>
<td>Loss of rights &amp; liberties</td>
<td>Guilt</td>
<td>Abuse of others</td>
</tr>
<tr>
<td>Not being listened to</td>
<td>Associated psychological stress</td>
<td>Harassment by others (e.g. racial, physical)</td>
</tr>
<tr>
<td>Abused by staff (and other service users)</td>
<td>Not being listened to</td>
<td>Harassment of others</td>
</tr>
<tr>
<td>Medication side-effects</td>
<td>(Many of the other losses and factors across these checklists)</td>
<td>Risks to child(ren)</td>
</tr>
<tr>
<td>[Experiencing many of the other factors across these checklists]</td>
<td></td>
<td>Religious or spiritual persecution</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>SUBSTANCE MISUSE RISKS</th>
<th>POSITIVE RISK-TAKING</th>
</tr>
</thead>
<tbody>
<tr>
<td>Problematic or hazardous use</td>
<td>To be considered in all the other categories/factors (where applicable)</td>
</tr>
<tr>
<td>Tolerances</td>
<td></td>
</tr>
<tr>
<td>Withdrawal symptoms</td>
<td></td>
</tr>
<tr>
<td>Dependence (physical)</td>
<td></td>
</tr>
<tr>
<td>Dependence (psychological)</td>
<td></td>
</tr>
<tr>
<td>Addiction</td>
<td></td>
</tr>
<tr>
<td>Personal reasons for using</td>
<td></td>
</tr>
<tr>
<td>Levels of use (inc. timescale)</td>
<td></td>
</tr>
<tr>
<td>Methods of using (e.g. site of injecting)</td>
<td></td>
</tr>
<tr>
<td>Impact on physical health</td>
<td></td>
</tr>
<tr>
<td>Impact on emotional health</td>
<td></td>
</tr>
<tr>
<td>Associated criminal activity</td>
<td></td>
</tr>
</tbody>
</table>
**ADDITIONAL SUPPORTIVE TOOLS & GUIDANCE**

**RISK ASSESSMENT**

**What are we assessing?** (Adapted from Morgan, 1998 ~Assessing & Managing Risk Practitioner Handbook published by Pavilion & Sainsbury Centre for Mental Health)

The following table establishes a broad framework for the function of risk assessment reminding us to look beyond just the factors that may be pertinent to the individual person alone. In a broader context of assessment our very presence as part of the process ensures we are part of the risk, as is the environment in which we all function.

<table>
<thead>
<tr>
<th>Individual risk:</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Information relevant to service users:</td>
</tr>
<tr>
<td>- all the factors outlined in relation to individual behaviours and cognitions, including psychiatric history and current mental state, personality and past risk behaviours</td>
</tr>
<tr>
<td>- information about victims (where relevant)</td>
</tr>
<tr>
<td>- appreciation of personal strengths, talents and protective factors</td>
</tr>
<tr>
<td>• Information relating to workers themselves:</td>
</tr>
<tr>
<td>- abilities and experience for working with risk (not just a quality associated with professional grading)</td>
</tr>
<tr>
<td>- expertise through training, confidence and high quality support and supervision</td>
</tr>
<tr>
<td>- an appreciation of individual staff strengths and talents</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Situational risk:</th>
</tr>
</thead>
<tbody>
<tr>
<td>• The context in which all previous incidents have occurred</td>
</tr>
<tr>
<td>• The environment:</td>
</tr>
<tr>
<td>- physical layout of the home, office, ward (e.g. positioning of furniture, clear exit routes, presence of likely weapons)</td>
</tr>
<tr>
<td>- effects of emotional arousal (e.g. long waiting times, lack of information about the situation, temperature extremes, overcrowding, service needs taking priority over service user needs)</td>
</tr>
<tr>
<td>- the wider community (e.g. threats from others, visiting out of normal hours, remote locations, estates with known reputations, signs of carrying medication)</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Systems risks:</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Inter-agency coordination (e.g. CPA/Care Management)</td>
</tr>
<tr>
<td>• Lines of communication (e.g. inter-agency agreements on confidentiality)</td>
</tr>
<tr>
<td>• Caseload sizes and priorities</td>
</tr>
<tr>
<td>• Professionally relevant operational policies and procedures</td>
</tr>
<tr>
<td>• Links with wider agencies (e.g. primary care, voluntary sector services)</td>
</tr>
</tbody>
</table>
Considering risk levels

It is not possible to provide an exact formula to assess risk. Staff must assess risk based upon reasoned judgment and their in-depth knowledge of the service user. Nevertheless, certain risk factors can be usefully used in assessment to draw attention to the possibility of increased risk. The risk factors identified by research only focus on harm to others and to self:

### RISK FACTORS (HARM TO OTHERS)

<table>
<thead>
<tr>
<th>VARIABLES</th>
<th>HIGHER RISK</th>
<th>LOWER RISK</th>
</tr>
</thead>
<tbody>
<tr>
<td>Age</td>
<td>Younger</td>
<td>Older</td>
</tr>
<tr>
<td>Sex</td>
<td>Male</td>
<td>Female</td>
</tr>
<tr>
<td>Living arrangements</td>
<td>Unstable, changeable</td>
<td>Stable</td>
</tr>
<tr>
<td>Employment Status</td>
<td>Unstable, changeable</td>
<td>Stable</td>
</tr>
<tr>
<td>Educational Attainment</td>
<td>Low</td>
<td>High</td>
</tr>
<tr>
<td>Mental health diagnosis</td>
<td>Clinical depression; Schizophrenia</td>
<td>All other diagnoses</td>
</tr>
<tr>
<td></td>
<td>Paranoid Psychosis</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Personality Disorder</td>
<td></td>
</tr>
<tr>
<td>Substance Misuse</td>
<td>Alcoholism, illegal drug misuse</td>
<td>None</td>
</tr>
</tbody>
</table>

### RISK FACTORS (HARM TO SELF)

<table>
<thead>
<tr>
<th>VARIABLES</th>
<th>HIGHER RISK</th>
<th>LOWER RISK</th>
</tr>
</thead>
<tbody>
<tr>
<td>Age</td>
<td>Older</td>
<td>Younger</td>
</tr>
<tr>
<td>Sex</td>
<td>Male</td>
<td>Female</td>
</tr>
<tr>
<td>Marital Status</td>
<td>Separated, Divorced, Widowed</td>
<td>Married</td>
</tr>
<tr>
<td>Living arrangements</td>
<td>Living alone</td>
<td>Others at home</td>
</tr>
<tr>
<td>Employment Status</td>
<td>Unemployed, retired</td>
<td>Employed</td>
</tr>
<tr>
<td>Physical health</td>
<td>Poor, especially terminal, painful, debilitating illness</td>
<td>Good</td>
</tr>
<tr>
<td>Mental health</td>
<td>Mental illness, especially depression, schizophrenia and chronic sleep disorders</td>
<td>Good</td>
</tr>
<tr>
<td>Substance Misuse</td>
<td>Alcohol, illegal drug misuse</td>
<td>None</td>
</tr>
</tbody>
</table>
Risk Factors for Aggression and Violence (from Morgan, 1998)

The following is a structure for considering the wide range of risk factors potentially associated with the assessment of aggression and violence (based on Lipsedge, 1995 ~ Clinical Risk Management in Psychiatry. *Quality in Health Care* 4 122-128). Note: the quality of assessment is not related to the ability to tick off more items on a list, it is about individualising the circumstances and context while being aware of what the research suggests is most commonly identified across study groups.

| Antecedents                  | a previous history of violence  
|                             | personality development (see separate list below) |
| Diagnosis                   | schizophrenia, specifically with paranoid features  
|                             | morbid jealousy and erotomania  
|                             | drug &/or alcohol misuse |
| Social                      | loss of family support  
|                             | deterioration in personal relationships |
| Clinical                    | declared intentions and attitudes towards previous and potential victims  
|                             | threats of violence  
|                             | presence of active symptoms, including delusions (especially regarding poisoning and sexual matters), passivity experiences, command hallucinations, jealousy, depression, and outbursts of anger  
|                             | signs and symptoms of relapse |
| Management                  | loss of contact with mental health services  
|                             | poor adherence with medication |

Personality Factors

- cultural/sub-cultural values in relation to the use of aggression and violence
- parental attitudes and child-rearing behaviours
- repeated exposure to aggression and violence
- failure to learn delay in the gratification of wants
- failure to develop alternative strategies other than the use of aggression and violence
- taking offence easily
- impulsive behaviours
- inability to cope with stress and frustration
- unresolved conflicts from previous rejections
- anxiety about losing control
- hostile response to authority
- inferiority complex
- continual denial of actual aggressive behaviours
- lack of remorse
- obsession with bizarre events or sadistic fantasies

- current mental state
- state of emotional arousal
- degree of hostility
- overt or covert expression of an intention to harm others
- recent behaviour
- past dangerous behaviour
- social tensions
- uncooperative with treatment

Potential Physical Warning Signs:

- clenched fists
- walking briskly/pacing
- throwing objects
- exaggerated responses to annoyance
- pressured and/or loud speech
- rigid muscle tension
- verbal threats
- invading personal space
- disinhibition

Note: any significant change from the normal for a specific individual should be considered seriously. The accuracy of any one of the above as a predictor is questionable and should be clearly considered within the context of the situation.

Assessment in practice

The following are pointers to the broad considerations you need to take account of when actively assessing the risks you have identified:

- Risk Factors ~ see boxes & checklists above
- History:
  - Recency: the more recent an event or incident the higher the current risk. An assault upon a stranger committed today, indicates higher risk for the present than a similar incident last year, or five years ago
  - Severity: the more severe an incident, the higher the current risk
  - Frequency: the more frequent the events or incidents the higher the current risk... persistent and repeated assaults on others are very strong indicators of high risk
  - Pattern: is there a common pattern to the type of incident or the contexts in which it occurs?
- Ideation/Mental State:
  - What is the person thinking or feeling now? It is important to assess the service user’s mental state and in particular look for evidence of the following:
a) Evidence of any threat/control override symptoms (i.e. firmly held beliefs of persecution by others ~ persecutory delusions... or mind or body being controlled or interfered with by external forces ~ delusions of passivity
b) Emotions related to violence (e.g. irritability, anger, hostility, suspiciousness)
c) Specific threats made by the service user
d) Command hallucinations (e.g. voices telling service user to attack a particular person)

- Intent:
  - a statement from an individual that they intend to harm another person is the clearest indication of risk and should never be ignored (N.B. Intent... whether implied or not is the strongest and most powerful predictor of future behaviour)

- Planning:
  - if the person admits that they have thoughts of harming themselves or others, it is important to establish whether they have considered exactly how they might do so
  - this can be extracted from their own statements or other objective evidence
  - the presence of a plan as to how they harm another person indicates yet higher risk
  - if the person also has access to the means for carrying out that plan the degree of risk rises still higher
  - a person with paranoid delusions about their neighbours, who has considered exactly how they might deal with them using his kitchen knife, poses a greater risk than the person who has more vague ideas and no clear plan

- Formulation:
  - following the assessment a formulation should be made which should, so far as possible, specify factors likely to increase risk or dangerous behaviour and those likely to decrease it
  - it should include an appreciation of all the risk factors described above, in particular, how their interaction might increase risk
  - the formulation should aim to answer the following questions:
    a) how serious is the risk?
    b) is the risk specific or general?
    c) how immediate is the risk?
    d) how volatile is the risk?
    e) are circumstances likely to arise that will increase it?
    f) what specific treatment and management plan can best reduce the risk?

Morgan (1998) offers the following additional considerations when developing your formulation of the identified risks:
- categories of risk (e.g. self-neglect, exploitation, self harm)
- named victim of potential/real risks (i.e. more often the service user themselves)
- known previous victims (including any information about why they were actual/potential victims)
- potential situation (i.e. context in which it may occur)
- other people (i.e. who may influence the level of risk)
- thought processes (e.g. command hallucinations, or acting on specific delusional beliefs)
- behaviour patterns (e.g. harmful or hazardous use of drugs &/or alcohol)
- experiences (e.g. medication side-effects influencing non-compliance)
- early warning signs (e.g. changing patterns of behaviour or usual routines)
- people to be informed (i.e. others with significant roles in the care plan)
- potential crisis responses (i.e. individualised to the person, availability & accessibility of local crisis response services)
- levels of risk (e.g. high, medium, low, no risk... can be difficult to quantify with accuracy)
- potential timescales:
  - imminent danger (N.B. can be in minutes or hours, and possibly sustained for a period of days)
  - planned intent may be immediate, or a risk over days/weeks
  - may depend on the sustainability of the underpinning risk factors
  - some assessments of medium, low or no risk may be stated with reasonable confidence across a period of months, providing the factors sustaining this prediction are made explicit

From: Lincolnshire Partnership Foundation Trust Risk Policy, 2007

**Reviewing Clinical Risk Assessment**

It will be the responsibility of the nominated practitioner or Care Co-ordinator who has responsibility for the care of the service user to consider the frequency of reviewing the clinical risk assessment. This judgement will be based on the context of the service user’s clinical presentation and their response to treatment. It is likely that a review of the clinical risk assessment will take place in the following circumstances:

- Admission, discharge or leave from a service (including in-patient units)
- At the point of referral and transfer between services
- Change of nominated practitioner or care co-ordinator
- Significant life event (e.g. suicide attempt, non-compliance with treatment, loss of contact with service)
- Deteriorating mental health &/or change of legal status
- Significant changes in treatment plan (e.g. medication change)
- Increased hostility towards others &/or property
- Reviewing progress (e.g. review of CPA care plan)
The review of the service user’s clinical risk assessment may be conducted at any time and anyone involved with the service user can request a review. In the event of any dispute concerning the clinical risks identified by any practitioner the matter must be brought to the attention of the clinical team leader &/or Consultant Psychiatrist for resolution and an incident report completed to describe the details which require resolution.

Good clinical decision-making must be based on a complete review of the clinical risks and benefits. Obtaining favourable clinical outcomes and reducing the likelihood of harm needs careful judgement around a variety of clinical factors and requires the clinician to balance the clinical risk against any potential benefit.

**Cultural Issues**

In the assessment and management of clinical risk care should be taken to consider specific cultural issues:

- Effective communication (e.g. is translation required?)
- Different concepts of mental illness
- Use of language (e.g. beware of using jargon)
- Reluctance or shame about disclosure
- Tolerance of perceived threat, and means of managing the risk
- Involvement of family members in the assessing and managing of risk
- Appropriate consideration given to cultural beliefs

Whenever appropriate, and with the agreement of the service user, it is desirable to involve someone from the person’s culture in the clinical assessment and care plan of the service user. Awareness of cultural issues is important for effective planning and positive outcomes. It must be noted that cultural issues may manifest in unfamiliar behaviour which could be misinterpreted as aggression or other unfamiliar behaviour which may be misinterpreted.
APPENDIX 5 - BEST PRACTICE POINTS FOR EFFECTIVE RISK MANAGEMENT
(Department of Health, 2007)

**Introduction**
1. Best practice involves making decisions based on knowledge of the research evidence, knowledge of the individual service user and their social context, knowledge of the service user’s own experience, and clinical judgement.

**Fundamentals**
2. Positive risk management as part of a carefully constructed plan is a required competence for all mental health practitioners.
3. Risk management should be conducted in a spirit of collaboration and based on a relationship between the service user and their carers that is as trusting as possible.
4. Risk management must be built on a recognition of the service user’s strengths and should emphasise recovery.
5. Risk management requires an organisational strategy as well as efforts by the individual practitioner.

**Basic ideas in risk management**
6. Risk management involves developing flexible strategies aimed at preventing any negative event from occurring or, if this is not possible, minimising the harm caused.
7. Risk management should take into account that risk can be both general and specific, and that good management can reduce and prevent harm.
8. Knowledge and understanding of mental health legislation is an important component of risk management.
9. The risk management plan should include a summary of all risks identified, formulations of the situations in which identified risks may occur, and actions to be taken by practitioners and the service user in response to crisis.
10. Where suitable tools are available, risk management should be based on assessment using the *structured clinical judgement approach*.
11. Risk assessment is integral to deciding on the most appropriate level of risk management and the right kind of intervention for a service user.

**Working with service users and carers**
12. All staff involved in risk management must be capable of demonstrating sensitivity and competence in relation to diversity in race, faith, age, gender, disability and sexual orientation.
13. Risk management must always be based on awareness of the capacity for the service user’s risk level to change over time, and a recognition that each service user requires a consistent and individualised approach.

**Individual practice and team working**
14. Risk management plans should be developed by multidisciplinary and multi agency teams operating in an open, democratic and transparent culture that embraces reflective practice.
15. All staff involved in risk management should receive relevant training, which should be updated at least every three years.
16. A risk management plan is only as good as the time and effort put into communicating its findings to others.
How do these principles relate to ‘working with risk’?

Service users should expect that their clinical risk will be appropriately assessed and managed to aid their recovery (Repper and Perkins, 2003) within a framework which ensures a thorough and consistent high standard of assessment (Barker, 1997). Risk Assessment and Risk Management are distinct activities in health and social care practice that are part of the realities of life, not solely administrative requirements. A number of practical considerations will guide practice [Adapted from O’Rourke and Bird, 2000]:

1. Risk is dynamic, constantly changing in response to altered circumstances
2. Risk can be minimised, but not eliminated
3. Assessment is enhanced by multiple sources of information, but frequently you will be working with incomplete and possibly inaccurate information
4. Identification of risk carries a duty to do something about it (i.e. risk management)
5. Assessment information and clinical decision-making can be improved by engaging multidisciplinary, multi-agency collaboration, through discussions and joint care planning (including involvement of the service user and carers themselves, as much as possible)
6. Defensible decisions are also constructive decisions when they are based on clear reasoning
7. Risk-taking can engage positive collaboration with beneficial outcomes
8. Confidentiality is a right, but may be breached in exceptional circumstances when people are deemed to be at serious risk of harm
9. Organisations should adopt reasonable expectations of minimising the blame culture; not condoning poor practice, but with sensitivity to the experiences of the victims (e.g. service users, carers or practitioners)

The best form of risk assessment and risk management plan is one undertaken with the service user and/or relevant carers. The process of assessing and managing risk frequently fails to deliver its best intentions by becoming driven less by social and clinical considerations, and more by administrative concerns. The human activity of working with someone becomes secondary to the need to get the form filled in. We quickly lose sight of the primary purpose of the tools – to guide and support good practice – submerging practice into the priority for completing the documentation.

We need to capture the immediate picture in the here and now; we need to routinely check and review the wider picture; and we frequently take therapeutic risks in order to help people develop, exercise their own choices, achieve their own goals, and move on. We also need good quality prompts that enable the service user to reflect on and engage in conversations of their personal perspectives on risk and/or safety. Each of these activities will benefit from tools offering specific guidance. ‘When’ and ‘how’ each of the tools is used is often an issue for individual or team professional judgement.
APPENDIX 6 - Characteristics of Positive Risk Taking

**Positive risk-taking** may be characterised by:

- *Real* empowering of people through **collaborative** working (or a clear explanation why this is not happening), and a clear understanding of **responsibilities** and **consequences** for actions that service users and services can each reasonably hold, in specifically defined situations.
- Supporting people to **access opportunities** for personal change and growth.
- Establishing **trusting** working relationships, whereby service users can **learn** from their experiences, based on taking chances just like anyone else.
- Support rather than restriction being offered at times when an apparently ‘unwise’ decision is being made; providing the analysis of the circumstances does not strongly suggest that harm will result.
- Understanding the consequences of different courses of action; making **decisions** based on a range of choices available, and supported by adequate and accurate information.
- Working positively and constructively with risk depends on a full appreciation of the service user’s **strengths**.
- It is very much based in the ‘**here and now**’, but will be clearly influenced by knowledge of what has worked or not worked in the past, and why. The influence of **historical** information lies in the deeper **context** of what happened rather than the simple **stigma** of the events themselves.
- It is the knowledge that **support** is available for the service user if things begin to go wrong, as they occasionally do for us all.
- It can occasionally be distinguished between its short-term and long-term **differences**. Whereby short-term heightened **risk** may need to be tolerated and managed for longer-term positive gains.
- It can be about explicit setting of **boundaries**, to contain situations that are developing into potentially dangerous circumstances for all involved.
- It can be about taking the risk of **withdrawing** services that are inappropriate to needs, or have created a **dependency** on contact which serves no therapeutic value.
- As a concept, it needs to be appreciated and understood from the **different perspectives** of the service user, informal supports, and services – how they define or interpret a risk and its potential benefits will not always be congruent or compatible.
APPENDIX 7 - RISK MANAGEMENT STRATEGIES

Risk within a wider Context of Care

- Risk management (inc. positive risk-taking) takes place within the wider context of a duty of care to service users and to others (carers, other practitioners, public ~ where specific knowledge indicates they may be subject to specified risks), for providing a service that meets needs and ensures personal safety as far as is reasonably possible.
- This duty applies equally to people of all ages, ethnic origins, cultural and spiritual beliefs, gender and sexual identity.
- It includes consideration of how to achieve shared accountability by all relevant people involved for decisions and actions, and a shared understanding of the associated risks.
- Good practice in risk management requires application of strategies at different stages:
  - Risk prevention (engaging trust, transparent assessment, education, working with service user priorities, risk-taking, responsive support, etc.).
  - Risk reaction (de-escalation, rapid/crisis response, Mental Health Act assessment, rapid tranquillisation, etc.).
  - Risk learning (immediate support to all affected, support through inquiry procedures, disseminating findings inc. positive practice identified, etc.).
- A positive approach to ‘working with risk’ will help to demonstrate how, at an individual personal level, practitioners are promoting the values of recovery and social inclusion.
- Recognition that different people have different tolerances & thresholds for risk, based largely on past experiences. It is okay for anyone to feel afraid in specific circumstances, and to use these feelings as a means of informing the need for further information or a cautious approach.
- It is important to use clinical supervision to explore feelings and impressions regarding risk.
- Risk management occurs within a wider Trust policy context, and all staff/teams are responsible for making themselves aware of associated policies that support or interact with this policy.
- Responsibility for the co-ordination of the risk assessment and management process lies with the identified care coordinator (see CPA and Practice Guidance Policy) or equivalent lead professional for service users not subject to CPA. In in-patient settings the responsibility lies with the Primary Nurse in liaison with the care coordinator/lead professional (flexibility of responsibilities based on negotiation and the best person to undertake specific tasks is encouraged for efficiency and best outcomes). These responsibilities also include co-ordination of contributions from all relevant members of multidisciplinary teams & multi-agency working arrangements for service user care.
APPENDIX 8 - Multidisciplinary Team-Working & Multi-Agency Working

Multidisciplinary assessment, a shared care plan and good inter-agency communication are important aspects of risk management. Ad hoc and unsystematic risk assessment and management leads to a greater potential for incidents to happen. Good multidisciplinary team-working requires a shift of thinking to a culture where individual staff members hold cases on behalf of the team. Mechanisms for ensuring this takes place effectively should be developed in all teams and relevant settings where care is provided.

Wherever possible, risk decision-making should be conducted within a multidisciplinary setting. All professionals involved in the decision-making process should have access to the relevant risk information. Where this is not possible, individual professionals should assure themselves that the information upon which they base their decisions is as up-to-date, accurate and complete as possible. Ideally, individuals and teams should not make decisions based on incomplete, inaccurate or out-of-date information, but at times this will be inevitable. Any and all decisions made, especially in areas where a specific risk has been identified, must be clearly documented in the service users’ notes.

Communication

Effective communication of risk information is a crucial part of the risk assessment and management process and must always seek to involve service users. Failures of adequate and accurate communication can have serious consequences for service users, mental health workers and the general public. These consequences have been well documented through incident inquiries. The danger points are generally related to transitions in care. Therefore, referrals from one team to another, one provider Trust to another, or from one relevant service to another should contain information about past history of harm to self or others and a current assessment of all relevant risks (including the wider contextual details, not just numbers of incidents). It is the responsibility of the identified care co-ordinator to manage the transfer of appropriate information to the receiving team or service; and this should be undertaken in consultation with the Consultant Psychiatrist (where appropriate) who will be communicating with their professional counterpart in the receiving service.

Where a long period of waiting may be anticipated following referral, it is the responsibility of the referring practitioner to ensure appropriate crisis and contingency plans have been agreed with the service user to provide a safety net should risks change during the waiting period, this is particularly important where the service user is not in receipt of services during the waiting period. Such contingency plans may include, for example, advice to see their GP or out of hours service in the event of worsening symptoms.
Defensible Decisions

The decision-making involved in the assessment of risk and its management is generally effective in avoiding harmful situations from arising; but it is not infallible. If harm occurs to a service user or others because of their actions, any practitioners or teams involved in the assessment and management of risk might need to defend the decisions they made and their reasoning for those decisions.

A defensible decision is one where:

- All reasonable steps have been taken to avoid harm
- Reliable assessment methods have been used
- Information has been collected and thoroughly evaluated
- Decisions are recorded and subsequently carried out
- Policies and procedures have been followed
- Practitioners and their managers adopt an investigative approach and are proactive

Organisation Support

Encouraging all staff to access appropriate support and advice from senior managers, as part of a proactive approach to decision-making, not just as a response to investigations. The Trust ‘Policy for the management of incidents’ outlines the approach to supporting all staff through difficult events when they occur. No gain arises out of reacting in ways that make the practitioner feel more anxious and unnecessarily guilty about the outcome. We recognise that where practitioners are left feeling unsupported at times of highest need it has a major negative impact on perceptions and morale much wider across the organisation. The ‘Working with Risk 3 ~ Positive Risk Taking’ document is fully supported as a mechanism for aiding collective decision-making about challenging plans, and as a means of evidencing why a particular plan of action is being followed.

The Critical Incident Support Team is an additional resource that should be accessed by any practitioner across all services at times when they feel traumatised by negative outcomes from events in their work.
Appendix 9 - Preventing Suicides in Mental Health Services

The National Patient Safety Agency (NPSA) has published a toolkit for in-patient mental health services to audit practice in relation to preventing suicide. The toolkit has been designed with current mental healthcare guidance in mind, and in particular promotes the following practice with regard to risk assessments:

- Risk assessments should be completed by the Multi-disciplinary Team.
- All staff should be vigilant to remove objects of potential harm such as plastic bags, phone chargers and for those at high risk of overdose, medicines.
- Risk should be assessed prior to granting leave for patients whose level of observation/engagement has increased since the last risk assessment.
- Care plans should reflect the risk assessment in terms of observation/engagement and leave.
- Prior to discharge, in-patient and community teams should update the risk assessment, as part of a joint CPA review. This risk assessment should also provide evidence of patient involvement.
Appendix 10 - PERSON-CENTRED SAFETY PLANNING
John Aldridge, 2010

Introduction

In recent years, Risk Assessment has become an integral part of providing services for people who have learning disabilities. I have deliberately chosen the term Safety Planning for a number of reasons:

I have designed the Safety Planning sections as a ‘module’ that can be used as part of any person-centred assessment or care planning process. We might particularly want to use it as part of the following:

- Behaviour assessment and management
- Mental health assessment, care planning and CPA
- Holistic assessment and care planning
- Life planning and health action planning
- Personal safety assessment and Health & Safety at Work

Why is safety planning an issue for people who have learning disabilities?

Vulnerability and people with learning disabilities

Although we need to be careful not to portray all people who have learning disabilities as vulnerable and therefore to ‘protect them for their own good’ we do need to recognise that having a learning disability does increase the person’s vulnerability (especially if they have severe or profound disabilities).

Some of the characteristics of vulnerable people are:

- Intellectual impairment: someone who doesn’t recognise a situation as abuse and doesn’t realise that what is happening is wrong
- Mental illness: someone whose thoughts and emotions are temporarily disturbed and who may not be able to make rational decisions
- Physical impairment: someone who physically can’t protect themselves, run away or retaliate
- Communication impairment: someone who can’t tell others what has happened, or mobilise protection because of communication difficulties
- Devaluation: someone about whom the abuser (and perhaps society as a whole) might say (or think), “they don’t matter so much, anyway”
- Social isolation: someone who lives apart from the mainstream of society
- Someone who has a very small social network of people who might help to protect them.
- Disempowerment: someone who is subject to:
  - The legitimate power of another person (e.g. use of Mental Health Act)
  - The implicit power of another person (e.g. a person needing support and care).

The NPSA (2004) identifies five areas or risk for people with learning disabilities:
• Inappropriate or unsafe use of physical interventions (control and restraint)
• Vulnerability in general hospitals, poorer standards of care and treatment
• Swallowing difficulties and dysphagia
• Lack of accessible information, impairing peoples’ ability to make informed decisions
• Illness or disease (physical and mental) being misdiagnosed or un-diagnosed (diagnostic overshadowing)

Threat and people with learning disabilities

A small number of people who have learning disabilities may pose a threat to themselves or others because of aggressive, destructive or offending behaviour.

We need to recognise this and help them to address safety in a person-centred way, rather than demonising and ‘managing’ them.

A balanced view

It is important to remember that a person may be both vulnerable and a threat. It is not an either/or thing. Emerson et al (1988) point out that people whose behaviour is a challenge are most likely to ‘lose out’ on community services and have fewer options for supportive services. As we can see from the NPSA report, people who live in environments where Control and Restraint are used are also vulnerable to being hurt or even killed by inappropriate and unskilled use of C&R.

The matrix below shows four possible combinations of vulnerability and threat. It may be worth using this matrix to help you decide on the safety issues for people you work with. Which category describes them best? Where would they place themselves on the threat / vulnerability scale? Where would other people place them?
<table>
<thead>
<tr>
<th>VULNERABILITY</th>
<th>THREAT</th>
<th>LOW VULNERABILITY + HIGH THREAT</th>
<th>HIGH VULNERABILITY + HIGH THREAT</th>
</tr>
</thead>
<tbody>
<tr>
<td>1 2 3 4 5 6 7 8 9 10</td>
<td></td>
<td>A very small number of people with learning disabilities whose behaviour is dangerous.</td>
<td>Typically, people with learning disabilities who also have a mental illness, or whose behaviour is challenging</td>
</tr>
<tr>
<td>LOW VULNERABILITY + LOW THREAT</td>
<td></td>
<td>Arguably, however, all people whose behaviour needs to be controlled are vulnerable to abuse.</td>
<td>People in secure settings and those whose behaviour is controlled using physical interventions.</td>
</tr>
<tr>
<td>1 2 3 4 5 6 7 8 9 10</td>
<td></td>
<td>Probably the majority of people with learning disabilities, for whom safety is not a major issue of their lives</td>
<td>Most probably people with severe and profound disabilities, who are likely to have physical, sensory and communication difficulties</td>
</tr>
</tbody>
</table>
The Threat – Vulnerability matrix

We can extend this idea to take in People and The Environment and this gives us the matrix below. Again, you might like to use this with the person to decide on the nature of risks that relate to them.

<table>
<thead>
<tr>
<th>THREAT</th>
<th>PERSON</th>
<th>ENVIRONMENT AND POSSESSIONS</th>
</tr>
</thead>
<tbody>
<tr>
<td>Threat posed by the individual to self and others</td>
<td>o Aggression and violence to others</td>
<td>o Damage to property, buildings, public environment</td>
</tr>
<tr>
<td></td>
<td>o Abuse and exploitation of others</td>
<td>o Theft of others’ property</td>
</tr>
<tr>
<td></td>
<td>o Deliberate self-harm</td>
<td>o Damage to own possessions</td>
</tr>
<tr>
<td></td>
<td>o Sexual offending</td>
<td></td>
</tr>
<tr>
<td></td>
<td>o Promiscuity</td>
<td></td>
</tr>
<tr>
<td>Threat posed by the individual to the environment and possessions</td>
<td>o Damage to property, buildings, public environment</td>
<td></td>
</tr>
<tr>
<td></td>
<td>o Theft of others’ property</td>
<td></td>
</tr>
<tr>
<td></td>
<td>o Damage to own possessions</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>VULNERABILITY</th>
<th>Vulnerability of the individual from others</th>
<th>Vulnerability of the individual from the environment (which incorporates their systems of support)</th>
</tr>
</thead>
<tbody>
<tr>
<td>o Aggression and violence by others</td>
<td>o Aggression and violence by others</td>
<td>o Environmental hazards</td>
</tr>
<tr>
<td>o Abuse and exploitation by others</td>
<td>o Abuse and exploitation by others</td>
<td>o Damage by others to possessions &amp; property</td>
</tr>
<tr>
<td>o Irrational decision-making</td>
<td>o Irrational decision-making</td>
<td>o Theft of property</td>
</tr>
<tr>
<td>o Sexual vulnerability</td>
<td>o Sexual vulnerability</td>
<td>o Unsafe or inappropriate living &amp; care arrangements</td>
</tr>
<tr>
<td>o Financial vulnerability</td>
<td>o Financial vulnerability</td>
<td></td>
</tr>
<tr>
<td>o Non-consensual care &amp; treatment</td>
<td>o Non-consensual care &amp; treatment</td>
<td></td>
</tr>
<tr>
<td>o Ineffective or inappropriate care &amp; treatment</td>
<td>o Ineffective or inappropriate care &amp; treatment</td>
<td></td>
</tr>
<tr>
<td>o Vulnerability of the individual posed by the nature of their condition (e.g. dysphagia due to cerebral palsy)</td>
<td>o Vulnerability of the individual posed by the nature of their condition (e.g. dysphagia due to cerebral palsy)</td>
<td></td>
</tr>
</tbody>
</table>

Who needs to feel safe?

Protective Behaviours is an approach that believes “We all have the right to feel safe all of the time” (PBUK, on line). This is seems a simple statement, but it contains a number of important elements:

- **All means all**: There are no exceptions to this belief. Everybody, including people whose behaviour is challenging, or who have committed offences, have the right to feel safe.
- **Feeling safe is a right**: The ability to feel safe is not something that needs to be earned by ‘good behaviour’ or by ‘being normal’. It is a basic moral and human right, underpinned by the Human Rights Act (1998). The right to feel safe does not go out the window when a person enters a secure environment.
- **Feeling safe**: We might ask, “Why do we not have the right to be safe?”. The problem with this is that it could be used as a reason to restrict peoples’ freedom in order to make them safe ‘for their own good’. Sometimes we ‘risk on purpose’ but usually we feel reasonably safe and
confident in doing so because the three key elements of Choice, Time Limit and Control are present. Feeling safe is broadly about feeling happy, comfortable and confident. We could argue that there is a dignity in risk.

- **All of the time**: Again, there are no exceptions. We are not saying that people have the right to feel safe some of the time. There are no ‘special circumstances’ in which it is acceptable for people not to feel safe (such as when being restrained). If it is necessary to use physical interventions with people, **everyone** has the right to feel safe in that.

When we are thinking about risk and safety in learning disability services, we need to balance the needs of three groups of people. These three groups of people need to ‘feel safe’.

1. **People with learning disabilities**. Person Centred Care puts the service user at the centre of decision-making and the care process. If the person feels vulnerable, it is important that services respond appropriately and help them to feel safe. Equally, if we are working with a person who is seen as posing a threat to others, they still have the right and a need to feel safe. There is a growing awareness that the use of physical interventions is a frightening and unsafe experience for service users. Therefore, when we carry out safety planning, it is imperative that we look at things from the service-user’s viewpoint.

2. **Other service users, family members and the general public**. These people have a right to feel safe and we have a duty of care to them to protect their safety. We also need to recognise that, although family members do not have the power of veto over decisions about their adult children, they do expect us to be responsible and not to take unnecessary risks. We might also need to think about whether they are at risk from the person with a learning disability.

3. **Service professionals**. It is also important to realise that there are a number of ways in which we need to feel safe.
   - If we are working with people whose behaviour is challenging we may need to take action that ensures our own safety if we are attacked.
   - We need to feel safe in the decisions that we make. We need to feel confident that things are not going to go wrong, that people will not be harmed and that we will not be held accountable for neglect of our duty of care. This is one of the main reasons why professionals are often very cautious about taking risks.

So, we need to balance the views, needs and wishes of these three groups when planning for safety. It is quite likely that people might have conflicting ideas that need to be worked through. Safety planning may involve a compromise in the positive sense, in that the needs of all parties are recognised and incorporated into any strategies, so that everyone feels confident. At the end of the day, the question that everyone asks themself is “do I feel happy about this?”.
Kinsella (2000) offers a structure that we might use to balance happiness and safety.

**Happiness**

- **Happiness low + safety low**
  - Nobody feels safe or happy
  - Never use these strategies

- **Happiness high + safety low**
  - Only use these strategies if the person or another is in real danger
  - We need to be careful that we do not unnecessarily put our need to feel safe in front of the service-user’s needs

- **Happiness high + safety high**
  - Everyone feels safe and happy
  - These strategies should always be used

**Safety**

- **Safety high + happiness low**
  - Only use these strategies if the person or another is in real danger

- **Safety high + happiness high**
  - People may wish to ‘risk on purpose’
  - Only use these strategies if the person and everyone else agrees that the risk is worth taking and it does not leave the person or others in real danger
  - There may be some difficulty in getting everyone ‘signed up’ to agreeing that the risk is worth taking
Balancing Safety and Happiness (adapted from Kinsella (2000))

What is risk?

Safety planning is about risk. Many professionals treat risk as simply the idea that “something might go wrong” and don’t look beyond that – they are ‘risk averse’.

A good definition of risk is, as “the likelihood of an adverse event or outcome” (New Zealand Ministry of Health 1998)

This reminds us that there are two dimensions:

- The ‘adverse’ event’ (what might go wrong?)
- The likelihood of it happening (how probable is it?)

For instance, if I go for a ride on my motorbike I might have an accident. If I think no further than that I’d never ride my motorbike again. I also need to think how likely it is that I will have an accident (I haven’t had one in the last 40 years of riding). This more balanced view might make me more optimistic about going for a ride.

Morgan (2000) also defines risk as “The likelihood of an event happening with potentially harmful or beneficial outcomes for self and/or others”. This definition reminds us that:

- as well as having possible negative outcomes (I might have an accident)
- events also have potential positive outcomes (I can go for a ride on my motorbike).
- Also, the outcomes may affect ‘self and/or others’ – there are several ‘stakeholders’ involved.

So, what is Safety Planning about?

There are a number of problems with Risk Assessment and Risk Management as they are used traditionally.

- They tend to be used in bureaucratic and service-led ways that run contrary to the precepts and beliefs of person-centred planning.
- Traditional approaches to risk management view things entirely from the organisation’s point of view and often fail to recognise the need to take risks if people are to develop and grow as individuals.
- The aim of much risk management is to eliminate risk. We can reduce risk but it is arguably impossible and unethical to attempt to completely eliminate it.

The New Zealand Ministry of Health 1998) comment that “Risk management aims to minimise the likelihood of adverse events occurring within the context of the overall management of an individual, to achieve the best possible outcome and deliver safe, appropriate, effective care” (my emphasis).

The key factors that any safety plan needs to balance are:

- **The best possible outcome for everybody.** It is not acceptable for one person to suffer merely because it meets other peoples’ safety needs.
- **Be safe and effective.** Clearly, a safety plan that fails to promote peoples’ safety is of no use to anyone.
• **Be appropriate.** Let’s not use a ‘sledge hammer to crack a walnut’. We need to acknowledge and work with the belief that people have a need and a right to take risks and to use a sense of proportion.

If we recognise the dignity of risk, it humanises and enables service users, rather than demonising and disabling them. But there is a wealth of difference between ‘taking a risk’ and being neglectful or foolhardy. Taking a risk implies that we have weighed up the positive and negative issues, the possible outcomes and likelihood of them happening.

A transparent team approach that involves all the stakeholders is more likely to result in a strategy in which most people are happy for most of the time.

<table>
<thead>
<tr>
<th>RISK MANAGEMENT</th>
<th>SAFETY PLANNING</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Looks at things entirely from the organisation’s viewpoint</td>
<td>• Involves the service user and significant others in assessment and decision making</td>
</tr>
<tr>
<td>• Tends to focus on the service user as a threat</td>
<td>• Considers both threat and vulnerability</td>
</tr>
<tr>
<td>• Aims to eliminate risk</td>
<td>• Aims to minimise risk</td>
</tr>
<tr>
<td>• Does things to the service user</td>
<td>• Does things with the service user</td>
</tr>
<tr>
<td>• Uses a prescriptive approach</td>
<td>• Uses a democratic approach</td>
</tr>
<tr>
<td>• Tends to be reactive</td>
<td>• Attempts to be proactive</td>
</tr>
<tr>
<td>• Runs contrary to Person Centred processes</td>
<td>• Consistent with Person Centred processes</td>
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</tbody>
</table>

**The three elements of effective safety planning**

To be effective, safety planning needs to use three mutually supportive elements. These are effective training and skill, effective method and effective teamwork.

If any of these are absent, the whole strategy collapses and becomes ineffective.

• **Effective training and skill:** Support staff need to be trained in approaches that help to enable service users, while promoting their safety. If physical interventions are used, staff need to be properly trained in their use. Training and skill also extends to service users, who may need help to express their safety needs, as well as perhaps becoming more emotionally literate, having more coping strategies at their disposal so that they don’t need to behave in unsafe ways.

• **Effective method:** we need to use person centred processes throughout and to actually use appropriate structures and systems. If staff are using physical interventions, they need to use them appropriately and correctly. The process of developing a safety plan needs to be transparent and democratic, so that people are encouraged to put their point of view (which might differ from others’).
• Effective teamwork. All support staff, service users and family members need to be ‘singing from the same hymn sheet’. It only takes one dissenter to jeopardise the effectiveness of a whole plan and the efforts of everyone else involved. The process of developing a safety plan needs to be a team process, with all stakeholders involved. In that way, if people are given a chance to have their say, they are less likely later on to work to their own private agenda.

So, how do we assess risk?

Safety planning needs to begin with an assessment of risk, but this is rather more complicated than merely thinking about “how likely is it that something may go wrong?”

• Risk assessment is an estimation of likelihood. Civil and constructional engineers can carry out precise risk assessments because they are able to calculate the strength of materials and the stresses under which they will be placed. A new bridge should not fall down if the engineer has carried out their calculations accurately. But risk assessment in human services is something more of an art than a science because we cannot precisely measure all of the influencing factors and we are not necessarily in control of these. If a person has a history of ‘risk behaviours’ we can use this to estimate the likelihood of them behaving this way in the future. If they are intending to do something new, such as going to the shops on their own, we might have to use educated guesswork to decide how risky that might be.

• We need to think about the circumstances and the context of the risk. Peoples’ safety may alter depending on how well they feel, how well supported they are, who is supporting them, how other people behave, whether they are at home or at work and so on. Prinns (1986) comments that “It is wiser to think of dangerous situations rather than dangerous people”.

• Risk assessments are, by their very nature, time-limited. Because the circumstances and the person may change, we need to revisit any risk assessment regularly. Safety planning should be reviewed frequently.

• Safety planning is a team effort and there is no reason why a person centred process should not be used. It is very important that everyone (including the person who has a learning disability) is involved in the whole process.

• Anything we do with people needs their consent (unless they are Sectioned under the Mental Health Act) or needs to be in their Best Interests (in keeping with the Mental Capacity Act. Recent judgements in the ‘Bournewood Case’ given by the European Court of Human Rights suggest that we would be acting illegally if we did anything involved in a person’s care without either attempting to gain consent or by using Best Interests. A plea that ‘it is necessary in order to protect people’ is not acceptable if the care contravenes the person’s human rights.

There is a problem with trying to measure risks using scoring systems, but we still need some way of deciding how big a risk is. The risk assessment matrix on the following page offers a tool that helps us to decide how serious the risk is, and how likely it is that a negative outcome will result.
Likelihood and Outcome are the two axes on a nominal ten-point scale. The matrix simply ‘multiplies’ the seriousness of the outcome by the likelihood of it happening, but I have avoided using a numerical score.

The risk levels are banded, using a ‘traffic light system’, to denote the overall level of risk.
- Condition Green (risks that are minor or unlikely to happen) are unlikely to require the full weight of safety planning. If a safety issue is in this category, I recommend that you don’t go any further.
- Condition Amber At this level of risk, it is appropriate to write a simple Safety Action Plan.
- Condition Red. Risks at this level are serious and require a full Safety Plan.
- Condition Double Red. Risks at this level are extremely serious and will require an urgent Safety Plan.

Use a team approach and involve all stakeholders
Don’t be afraid of debate, but it is important that you reach a consensus eventually.

The ‘Ten Steps’ to Safety Planning
The ‘Ten Steps’ approach will take you through the stages of developing a person-centred Safety Plan. To begin with, you may find it cumbersome and long-winded but it does prompt you to explore the safety issue in a balanced and person centred way. Once you get use to using this tool, you will find that you become quicker and more confident.

Use the flowchart on the following pages to help you decide how much of the full process you need to use.

TEN STEPS TO SAFETY PLANNING

PART A: ASSESSING RISK
Involves accurately describing and understanding the nature of the risk
- Vulnerability / threat
- Person / environment

- STEP 1 Describe the risk and identify the level of risk
  - Who or what is at risk? What is the ‘untoward event’ that people are concerned about? Try to be as precise as possible.
  - Who or what poses the threat?
  - What does the service user think or feel about the risk?
  - What do we know about the history of the risk? Has it happened before?
  - Decide on the level of risk, using a team process

IF THE LEVEL OF RISK IS ‘GREEN’, YOU PROBABLY DO NOT NEED TO TAKE FURTHER ACTION

IF THE LEVEL OF RISK IS HIGHER THAN ‘GREEN’, PROCEED WITH THE REMAINING STEPS
• **STEP 2** Inform and involve all the stakeholders

In practice, it is difficult to separate steps 1 and 2 and you will most likely work through these in parallel.
- Try to involve the service user as much as possible, or if this is not possible, at least keep them fully informed
- Gain consent from the service user (or use a rigorous Best Interests checklist)
- If appropriate, involve and inform the service user’s family and/or advocate
- Involve and inform the whole multidisciplinary team (consistent with completing the safety plan quickly)

• **STEP 3** Describe the setting conditions / context of the risk

- In what situations does the risk tend to occur?
- Who might be involved?
- Are there any patterns or trends that people have noticed?

• **STEP 4** Describe the triggers / antagonising factors

- What increases the likelihood of the risk happening?
- Are there any things that make it worse and make things escalate?

• **STEP 5** Describe the helpful / protagonising factors

- What decreases the likelihood of the risk happening?
- What helps to ease the situation and prevent things getting worse?

• **STEP 6** Identify the advantages and disadvantages of taking the risk

- What does the service user stand to gain by taking the risk?
- What do others stand to gain by not taking the risk?
- What does the service user stand to lose if we take no risk at all?

NB There is a need to balance the individual’s / others’ safety against the needs and right of the individual to enjoy autonomy and a reasonable quality of life.

**PART B: REDUCING THE RISK**

• **STEP 7** Identify whether the aim will be to:

Do you want to:
- Reduce the likelihood of the risk? or/and
- Reduce the severity of the risk?

If we want to retain an acceptable quality of life for everyone, it will probably be undesirable and unrealistic to try to reduce the likelihood to zero. It is generally a good idea to try to shift the risk into the Green band if possible, though in some cases the strategy may be one of ‘damage limitation’.
- **STEP 8** Explore the options for reducing likelihood or severity of the risk
  - What kinds of things might people do to reduce the risk?
  - Think creatively about the approaches and strategies that people (including the service user) might use
  - Think about what you could do, rather than what you are doing now
  - Be prepared to think ‘outside the box’
  - Be prepared to accept some level of risk

- **STEP 9** Identify and agree on the least restrictive effective alternative from your list
  - Use the principles of the ‘least restrictive alternative’. Try to choose an option that gives the greatest freedom to the individual, while protecting everyone’s safety.
  - Consider what the service user thinks and whether they consent to the plan. This is particularly important if the safety plan is about protecting the service user – they might want to take a risk.
  - Try to balance the needs of everyone involved, perhaps by making positive compromises

<table>
<thead>
<tr>
<th>NEGATIVE FOR SERVICE USER</th>
<th>POSITIVE FOR OTHERS</th>
</tr>
</thead>
<tbody>
<tr>
<td>(Try to avoid this option)</td>
<td></td>
</tr>
<tr>
<td>- Can you justify putting other peoples’ needs above the service user’s?</td>
<td></td>
</tr>
<tr>
<td>- Are you trying to use a sledgehammer to crack a walnut?</td>
<td></td>
</tr>
<tr>
<td>- Does this unnecessarily infringe the service user’s legal and human rights?</td>
<td></td>
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<tr>
<td>- Is there a better compromise?</td>
<td></td>
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</tbody>
</table>

<table>
<thead>
<tr>
<th>NEGATIVE FOR EVERYBODY</th>
<th>POSITIVE FOR EVERYBODY</th>
</tr>
</thead>
<tbody>
<tr>
<td>(Never use this option)</td>
<td>(Try to use this option where possible)</td>
</tr>
<tr>
<td>- Nobody feels safe or happy</td>
<td></td>
</tr>
<tr>
<td>- Avoid using this option merely because it keeps everyone merely safe – there is likely to be a more positive option</td>
<td></td>
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<table>
<thead>
<tr>
<th>POSITIVE FOR EVERYBODY</th>
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<tbody>
<tr>
<td>(Try to avoid this option)</td>
<td></td>
</tr>
<tr>
<td>- Does this safely balance everyone’s needs?</td>
<td></td>
</tr>
<tr>
<td>- Is everyone happy and in agreement?</td>
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<tbody>
<tr>
<td>(Try to use this option where possible)</td>
<td></td>
</tr>
<tr>
<td>- Can you justify putting the service user’s needs above those of others?</td>
<td></td>
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<tr>
<td>- Does this compromise your duty of care to other people?</td>
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</table>

**An options matrix**
• **STEP 10**  Develop a Safety Plan. This should contain:
  o The client’s name
  o A description of the risk and level of risk
  o The date of the risk reduction plan
  o The Aim of the risk reduction plan
  o The **Strategy** : A clear description of the exact strategy that will be taken to reduce the level of risk
    ▪ who will be involved
    ▪ what exactly people will do
    ▪ when these actions will be taken
    ▪ where the risk reduction plan applies
  o The **Safety Net** : A clear description of exactly what you will do if the untoward event happens or is immediately imminent
  o How to monitor and record the risk
  o The review and evaluation date
  o The signature of the key worker responsible for the Safety Plan
APPENDIX 11 – Interface between Working with Risk 1 & 2 and SystmOne

The Risk Screening Tool on SystmOne is based on Working with Risk 1 and 2.

Once saved, the Risk Screening Tools can be viewed in the Risk Node under All Risks.
Accessing the risk node allows the user to view all risks. The risk node shows a chronological history of risk (i.e. all the Risk Screening Tools which have been completed). Accessing the node can provide a picture of changing risk behaviour over time and subsequently assist in identifying triggers, relapse indicators and help to plan appropriate risk management strategies.

When completing a risk assessment, the relevant tabs are completed:

![Risk Assessment Form](image)

The relevant boxes should be ticked allowing for a text box to be activated which can be used to record the risk, the patient’s view of the risk and the carer’s view of the risk.

![Risk Assessment Table](image)

Complete the ‘Risk History and Initial Summary’ tab at the first point of contact/upon admission.
The ‘Risk Review Summary’ tab is used when the risk assessment needs to be reviewed.

Users should avoid duplicating/copying previous risk assessments when adding new information to a risk assessment (information should relate to the period since the last review). Duplicated risk assessments are lengthy and it is difficult to see what led to the risk assessment being completed or
reviewed; it is also difficult to see a changing picture of risk in the risk node when there are duplicated risk assessments.

Working with Risk 3 is available on SystmOne as a Questionnaire.