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NHS
Gloucestershire Health and Care
NHS Foundation Trust

CLINICAL POLICY
Assessing and Managing Clinical Risk and Safety

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This Risk Assessment policy is currently under review to align with forthcoming changes that will remove the need to score risk levels. While the new policy will reflect this updated approach, the principles of risk formulation and care planning around identified needs remain essential good practice. Please continue to adhere to the current policy, which supports these core practices, until the updated policy is fully rolled out. Thank you for your ongoing commitment to these standards during this period of transition.

Policy Number	CLP249
Version:	V14.8
Purpose:	This policy has been written to provide a clear framework for risk assessment and risk management within the Trust. It outlines how these principles will be applied within the Trust, and will act as a benchmark for monitoring practice against standards
Consultation:	Clinical Policy Consultation Group
Approved by:	Clinical Policy Group
Date approved:	February 2018
Authors:	Matthew Edwards, Ruth Wethey, Jessica Blakeman, Rob Newman
Date issued:	February 2018
Review date:	CURRENTLY UNDER REVIEW
Audience:	All staff within the Trust
Dissemination:	This policy will be available on the Trust intranet under Clinical Policies
Impact Assessments:	This Policy has been subjected to an Equality Impact Assessment. This concluded that this policy will not create any adverse effect or discrimination on any individual or particular group and will not negatively impact upon the quality of services provided by the Trust

Version History

Version	Date Issued	Reason for Change
V7.4	Sept 2011	Amendments to cover DASH service

V8	May 13	Format change
V9	Oct 2013	Full review
V10	March 2015	Amendments to cover service development of Mental Health Intermediate care Services Gloucestershire – Agreed at Governance Committee
V11	Oct 2015	Amendments to Crisis and Contingency planning guidance
V12	June 2016	Amendments to risk assessment and screening templates for PMHS/ICT Herefordshire and Gloucestershire
V13	June 2017	Amendments to reflect current risk template within RiO
V14	Feb 2018	Amendments to reflect organisational learning
V14.1	July 2019	Format Update
V14.2	August 20	Review date extended at the request of the Head of Nursing
V14.3	Jan 2021	Review date extended by the policy group 05.01.2021
V14.4	March 2021	Review date extended as agreed by Alison Curson and James Wright
V14.5	08/11/2022	Review date extended – Policy confirmed as fit for purpose and extended whilst work is under way to complete a bench marking exercise using Nice Guidance NG225
V14.6	14/06/2023	Extension of 1 year to review date agreed by the Quality Assurance Group and Clinical Policy Group, amended to remove references to Hereford and 2G
V14.7	10/05/2024	Extension to review date – Policy confirmed as sufficient to meet the needs of existing practice by Associate Director of Patient Safety, Quality and Clinical Compliance
V14.8	10/12/2024	Extension to Policy of 12 months with statement added to top of the Policy

SUMMARY

Risk assessment is an integral part of the assessment, support and treatment of each service user when in contact with the Trust. This is not something that happens only once, or only at set times in a service user's journey towards recovery, but is an on-going fluid process.

It is not possible to eliminate all risk, but through the use of risk assessment it is possible for the service user and their care team to understand and try to manage any identified risks.

Risk assessment should be structured, evidenced based and consistent across all the care settings within the Trust.

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1. INTRODUCTION

Risk assessment is an integral part of the assessment, support and treatment of each service user when in contact with the Trust. This is not something that happens only once, or only at set times in a service user's journey towards recovery, but is an on-going fluid process.

It is not possible to eliminate all risk, but through the use of risk assessment it is possible for the service user and their care team to understand and try to manage any identified risks.

Risk assessment should be structured, evidenced based and consistent across all the care settings within the Trust.

Best practise involves making decisions based on knowledge of the research evidence, knowledge of the individual service user, their social context, knowledge of the services users own experience and clinical judgment'.

Risk assessment and management is often developed with and or in conjunction with other agencies or providers. Where a service user is supported by care providers external to the Trust, or a service user's care is primarily managed and delivered by another service, the Trust still retains a responsibility to consider risk. Where a risk management plan is required, but the responsibility for delivering key elements lie outside of the Trust, this should still be documented and monitored.

2. PURPOSE

This policy has been written to provide a clear framework for risk assessment and risk management within the Trust. It outlines how these principles will be applied within the Trust, and will act as a benchmark for monitoring practice against standards.

This policy has been written to ensure that the Trust maintains a robust and effective process of assessing and managing risk. A number of key publications have been drawn on to help develop this document which have focused on developing safe and supportive clinical services to reduce specific risks around suicide, homicide and sudden deaths these include:

The National confidential enquiry into suicide and homicide by people with mental illness "Avoidable Deaths" (2013)

Best Practice in Managing Risk (2007)

Quality of Risk Assessment Prior to Suicide and Homicide: A Pilot Study (2013)

Self-harm and attempted suicide within inpatient psychiatric services: A review of the literature (2012)

National Patient Safety Agency (2004).

3. SCOPE

This policy applies to all Trust staff, who have a duty to abide by and promote the use of this policy.

4. DUTIES

General Roles, Responsibilities and Accountability

Gloucestershire Health and Care NHS Foundation Trust (GHC) aims to take all reasonable steps to ensure the safety and independence of its patients and service users to make their own decisions about their care and treatment.

In addition, **GHC** will ensure that:

- All employees have access to up to date evidence based policy documents.
- Appropriate training and updates are provided.
- Access to appropriate equipment that complies with safety and maintenance requirements is provided.

Managers and Heads of Service will ensure that:

- All staff are aware of, and have access to policy documents.
- All staff access training and development as appropriate to individual employee needs.
- All staff participate in the appraisal process, including the review of competencies.

Employees (including bank, agency and locum staff) must ensure that they:

- Practice within their level of competency and within the scope of their professional bodies where appropriate.
- Read and adhere to GHC policy
- Identify any areas for skill update or training required.
- Participate in the appraisal process.
- Ensure that all care and consent complies with the Mental Capacity Act (2005) – see section on MCA Compliance below.

5. MENTAL CAPACITY ACT COMPLIANCE

Where parts of this document relate to decisions about providing any form of care treatment or accommodation, staff using the document must do the following: -

- Establish if the person able to consent to the care, treatment or accommodation that is proposed? (Consider the 5 principles of the Mental Capacity Act 2005 as outlined in section 1 of the Act. In particular principles 1,2 and 3) Mental Capacity Act 2005 (legislation.gov.uk).
- Where there are concerns that the person may not have mental capacity to make a specific decision, complete and record a formal mental capacity assessment.
- Where it has been evidenced that a person lacks the mental capacity to make a specific decision, complete and record a formal best interest decision making process using the best interest checklist as outlined in section 4 of the Mental Capacity Act 2005 Mental Capacity Act 2005 (legislation.gov.uk).
- Establish if there is an attorney under a relevant and registered Lasting Power of Attorney or a deputy appointed by the Court of Protection to make specific decisions on behalf of the person (N.B. they will be the decision maker where a relevant best interest decision is required. The validity of an LPA or a court order can be checked with the Office of the Public Guardian) Office of the Public Guardian - GOV.UK (www.gov.uk).
- If a person lacks mental capacity, it is important to establish if there is a valid and applicable Advance Decision before medical treatment is given. The Advance Decision is legally binding if it complies with the MCA, is valid and applies to the specific situation. If these principles are met it takes precedence over decisions made in the persons best interests by other people. To be legally binding the person must have been over 18 when it was signed and had capacity to make, understand and communicate the decision. It must specifically state which medical treatments, and in which circumstances the person refuses and only these must be considered. If a patient is detained under the Mental Health Act 1983 treatment can be given for a psychiatric disorder.

6. POLICY DETAIL

OVER-ARCHING PRINCIPLES

Everyone referred to the Trust must be assessed for risk excluding self-referrals to IAPT group psychological / educational courses. Where a service user does not appear to have any significant risk, it should still be recorded that risk has been considered; this is to ensure that it is evident

that an assessment has taken place and has not been forgotten.

It is not possible to eliminate all risk; the purpose of risk assessment it is to enable the care team and the service user to understand and try to minimise the risks. Wherever possible this should be done using positive risk management.

Risk assessment and management is more than the consideration of solely violence or suicide but covers a range of areas, such as: -

harm to self; harm from others; harm to others; accidents; other risk behaviours / events

These may have been caused deliberately or unintentionally. They can be planned or spontaneous; a risk through inaction or neglect; caused by a lack of awareness, understanding, or environmental risks.

In line with national guidance, the Trust uses structured clinical (or professional) judgement, in assessing risk. This approach involves the practitioner making a judgement about risk on the basis of combining:

an assessment of clearly defined factors derived from research

staff clinical experience and knowledge of the service user

the service user's own view of their experience when documenting this information within a risk assessment it is essential to define whether the information is based upon ***clinical opinion*** *or upon* ***factual occurrence(s) that can be evidenced as such****.*

family/carer experience if available

Risk assessments are an aid and should be used with clinical judgment. Once an assessment has been completed, wherever possible positive risk taking strategies should be adopted.

All risk incidents should be recorded in a clear, accurate and timely fashion within the Health and Social Care notes.

Risk assessment and risk management should be carried out in collaboration with the service user and any other relevant individuals unless there is a clear documented reason why they are not involved. It is a 'live' dynamic process, changing and being updated throughout the service user's journey. Discussion with the service user and others involved is key to ensure an accurate assessment of the situation including any contextual factors which are crucial to the understanding of the service users past or present behaviour. Where this is disagreement about factors or context this should be noted in the service users record.

Risk assessments should not be completed in isolation, but should form part of the overall initial assessment, and then the day to day support treatment and management of the service user.

All risk assessment and management plans, regardless of specialism, should fit into a common recognisable framework, whilst supporting differences in the needs of the service user being assessed and the different parts of the service.

All risk assessment and management plans within the Trust should use the same common

definitions of risk.

The level and the intensity of assessment will vary according to clinical need and the type of service the service user is being assessed by.

DEFINING RISK

For the purposes of this policy, risk assessment is the process of recognising, understanding, and responding to potential events or behaviours that may be harmful or have a negative outcome.

Risk assessment needs to take into account a wide range of information about the service user, including: - history of violence, losses, environment, self-harm, employment, caring roles, self-neglect, housing issues, reliance on carers and others, development, family and support networks, relationships and relationship difficulties, health and wellbeing, health conditions, chronic conditions and pain[5]; and their more general social contacts.

When completing a risk assessment there are a number of different factors that can affect the probability of a risk occurring these are: -

Unchangeable factors *(Sometimes known as static factors) These are social or cultural factors such as upbringing, cultural group or events that have happened in the past and are unchangeable, for example a history of child abuse or suicide attempts.*

Changeable factors *(Sometimes known as dynamic factors) are those that change over time, e.g. mental state, misuse of alcohol. They can be aspects of the individual's health and wellbeing or aspects of their environment and social network, such as the attitudes of their carers or social deprivation.*

Acute / Trigger Factors *Change rapidly and may be short lived, allow assessment of immediate risk.*

Protective Factors *are factors in a person's life that promote mental health and wellbeing, reducing risk.*

It is useful to consider common risk factors for assessing violence and suicide based on actuarial and other data. These are subject to frequent change and the Trust will publish updated versions as and when required. This policy contains common risk factors listed in appendices 4-7 for the following areas: -

Violence in adults;

Suicide and self-harm for adults;

Neglect for older adults;

Suicide and self-harm for young people

Overall risk is defined by the sum of recorded risk factors. These actuarial factors for Risk change over time in accordance with current evidence based research. Clinicians need to be aware that this will happen and this policy allows for changes to actuarials to be made.

When reviewing historical or current incidents, it is important that these are described accurately and that the origin of where this information is derived from is included (where known). If information regarding an incident is unclear – this should be discussed with the service user When describing any form of assault or violent outburst, the Trust's approved method is the Assaulting Rating Scale (ARS)[2]. This defines incidents using a scale from 1-7 which are described below. Whilst this describes the physical effects, it does not take into account the psychological effect of an incident which should also be considered.

ARS Level Description
Threat of assault but no physical contact
Physical contact but no physical injury
Mild Soreness / surface abrasion s/ scratches / small bruises
Major Soreness / cuts / large bruises
Severe lacerations/ fractures/ head injury
Loss of limb / permanent physical disability
Death

Risks are uncertain, but through risk assessment one aims to: –

Clarify what the areas of concern are:

e.g. harm to self; harm from others; harm to others; accidents; or other risk behaviours / events such as absconding.

Consider whether these concerns are: -

planned or spontaneous; a risk through inaction or neglect; caused by a lack of awareness or a lack of understanding; or environmental

Determine what the level of risk is by considering –

What the probability of them occurring is
Whether this is a short, medium or long term risk
If there are any protective or mitigating factors, including cooperation / and adherence to treatment plans
If they did occur what the probable consequences might be

Develop strategies and plans to manage and reduce the likelihood or consequence of harm.

In determining whether the service user has a High, Medium or Low level of risk; short and long term risk factors should be considered. Recent studies have highlighted the 'low risk paradox', whereby Service Users who commit homicide or die by suicide often have a history of high risk factors, yet at the time of discharge from the services, are considered as low risk (NCISH, 2013). The distinction needs to be clear between long standing risk and high imminent risk.

The following matrix is designed to support clinicians in making a judgement about the level of risk.

Trust Risk Matrix			Probability			
			Unlikely	**Possible**	**Likely**	**Almost certain**
			there are many protective factors & or high adherence to treatment	there are good protective factors & or good adherence to treatment	limited protective factors to mitigate or reduce the risk with partial compliance to treatment	There are few, if any, protective factors, and low adherence/ cooperation with treatment
Consequence	**Negligible**	• physical injury to self / others that requires no treatment including first aid-*(ARS 1)* • minimal psychological impact requiring no support • low vulnerability requiring no intervention	**Low**	**Low**	**Low**	**Low**
	Minor	• slight physical injury to self / others that may require first aid (*ARS 2-3)* • emotional distress requiring minimal intervention • increased vulnerability but managed by low level intervention	**Low**	**Low**	**Medium**	**Medium**
	Moderate	• physical injury to self / others requiring medical treatment; (ARS 4) • psychological distress / formal intervention • vulnerability requiring increased intervention	**Low**	**Medium**	**Medium**	**High**
	Major	• significant physical harm to self / others (*ARS 5 or higher)* • significant psychological distress needing specialist intervention • Vulnerability requiring high levels of intervention	**Medium**	**Medium**	**High**	**High**

STANDARDS FOR ASSESSMENT

All new referrals will have a risk assessment completed during the initial/core assessment.

This should be completed and recorded in the Service User's Health and Social Care Notes by a registered practitioner who is specifically required to complete core assessments and risk assessments as part of their job description.

All new referrals to Integrated Urgent care (NHS 111) Mental Health Acute Response Service (MHARS), Mental Health Intermediate Care Teams (ICT) (Primary Mental Health service) and IAPT service (Gloucestershire) will have a Risk Screen completed. For referrals to Mental Health Acute Response Service (MHARS), IAPT services within the ICT for Gloucestershire risk screening will be undertaken by band 4 practitioners or above (Appendix 10). For all Service Users where overall risk is LOW, no further risk assessment is required at that stage. Where risks are identified as being Medium or High, then a completion of a FULL risk assessment will be undertaken by a practitioner band 5 or above (Appendix 11).

Exception: Online direct psycho-educational course bookings do not receive risk screening or assessment.

At each of the following key events a Risk Review will be completed and risk documentation updated, if it requires updating:

CPA; Cluster /Care review

Transition between Wards /Teams /Care Co-ordinators /Lead Professionals

Admission to and from hospital

At each MDT if the service user is an inpatient

Discharge from services

At any other time, if there is any significant changes or any factors that cause concern.

A Band 4 practitioner / Student Nurse can assist with drafting a risk review; this must be checked and validated by their practice supervisor (as defined in the Assessment and Care Management Policy).

Risk Assessment Process

When completing a Risk Assessment, the practitioner should first review any existing Risk Assessment, Risk progress notes and/or Risk incidents recorded in the Health and Social Care Notes. This provides information about what risks have occurred in the past, when they occurred, and if there are any patterns or known triggers. Where any tick boxes have been checked and there is no commentary to explain the use of the tick box, attempts should be made to obtain information to give rationale/contextual information for its use.

The Risk Assessment will cover the following areas and include a risk rating of High, Medium or Low identified for each area:

Harm to self, including suicide
Harm from others

Harm to others
Accidents
Other risk behaviours.

The summary of the Risk Assessment should include the rationale for risk level and any actions being taken with information under these headings:

Reason for assessment / review purpose

People present or involved *in this risk assessment including any other agencies involved and whether the assessment is led by Trust staff (e.g. could include the service users' carers, clinicians and other agencies)*

Risk(s) being reviewed *(List the risks identified rather than just the broad headings i.e. deliberate self-harm, self-neglect and suicide rather than just 'Harm to self')*

Who is affected by the risk(s) *(Include what is known e.g. is there a risk to the general public, females or one particular person?)*

Current situation / change since last assessment / review

Formulation of risks *stating the risk level (Low/Medium) and risk duration (Short/Medium/Long term e.g. if justifying a course of action that increases short term risk for longer term gain) considering the probability and consequences of the risk occurring. Include actuarials and clinical factors and protective factors. The information included should indicate the source and/or origin of information (where known) and whether it is based upon a factual occurrence or is a clinical opinion.*

Risk management and contingency plan *(including any positive risk taking strategies, observation levels)*

These headings allow clinicians to record in as much detail as required by the assessment of risk by using their clinical judgment. *(See Appendices 11 and 12 for IAPTus and Appendix 12 for RiO).*

Where possible, risk assessment and risk review should be undertaken by more than one person, ideally with Multi-Disciplinary Team (MDT) involvement or CPA/Cluster Care review. Certain situations mean that risk screening is initially completed with service users/carers and then reviewed with the team at the earliest opportunity.

All risk incidents must be recorded in the Risk Incident section of the Health and Social Care Notes to form a chronology of risk. Each risk incident should include the incident date, an incident heading and reference the date when the progress notes detailing the event was completed.

As part of each CPA or Cluster Care review the Care Coordinator/ Lead Professional should review the Risk Incident section of the Health and Social Care notes and ensure that it is up to date.

Specific Risk Issues for Inpatient Care

A service user is usually admitted to an inpatient area, as part of the management and

treatment plan, as a result of increased risk to themselves or others in the community. With the change in care setting, the nature of the risk changes. When completing a risk assessment in an inpatient setting it is important to recognise how these factors changed. Where a service user has been identified as being high or medium risk prior to admission this should only be reduced following a discussion with the MDT.

Where a service user has been identified as being medium risk or higher through the risk assessment process, this information should be communicated to the MDT as soon as practically possible.

When risks are discussed a contemporaneous entry should be made in the health and social care notes to document that this has taken place. A risk assessment will then be undertaken as detailed above.

Where a service user has been identified as having a medium level of risk whilst as an inpatient, the identified level can only be reduced following a documented discussion involving at least two qualified members of staff.

Where a service user has been identified as having a high level of risk whilst as an inpatient, the identified level can only be reduced following a documented discussion involving the MDT.

Specialist Risk Assessment

Following an initial Risk assessment, it may be appropriate to conduct a specialist risk assessment.

These assessments are conducted by a consultant, a clinical specialist or a clinician with extra training, who has been trained to assess a particular risk area, for example, using the Historical, Clinical, Risk Management tool (HCR-20). In addition, a specialist risk assessment may be completed by clinicians such as Speech and Language Therapists and Physiotherapists who also carry out assessments related to risk.

These will be recorded in the appropriate section of the Health and Social Care notes and added to the risk history section.

MANAGING RISK

Positive Risk Management

(Adapted from Best Practice in Managing Risk DoH 2007, page 10)

Positive risk management means being aware that risk can never be completely eliminated, and aware that the best management plans have to include decisions that carry some risk. This should be explicit in the decision-making process and should be discussed openly with the service user. A key feature is developing positive relationships between the care team, the service user receiving support and treatment and others involved or affected.

Positive risk management includes:

working with the service user to identify what is likely to work;

paying attention to the views of carers and others around the service user when deciding a plan of action;

weighing up the potential benefits and harms of choosing one action over another;

being willing to take a decision that involves an element of risk because the potential positive benefits outweigh the risk;

being clear to all involved about the potential benefits and the potential risks;

developing plans and actions that support the positive potentials and priorities stated by the service user, and minimise the risks to the service user or others;

ensuring that the service user, carer and others who might be affected are fully informed of the decision, the reasons for it and the associated plans;

using available resources and support to achieve a balance between a focus on achieving the desired outcomes and minimising the potential harmful outcome.

Crisis and Contingency Plans

Everyone receiving care should have as part of their care plan, information about recognising any signs of relapse and what to do in an emergency. This should be recorded in the 'crisis, relapse and contingency' (My safety plan) section of the service user's Health and Social Care notes.

This should include –

any early warning signs or relapse indicators
who to contact in an emergency
who the service user is most responsive (including for children who has parental responsibility) to and how to contact them
any strategies that have worked previously
any agreed strategies, interventions or advanced decisions including changes to medication, admission etc.
who will care for dependants
who can be involved, their contact details.

The type of Crisis and Contingency plan used will vary depending on where the service user is currently receiving support within the Trust. Essentially the following guidance will be followed in relation to this:

All service users supported in Primary Care services will receive a care plan or care plan letter which will include a Crisis and Contingency planning section.

All service users supported within secondary care will have a Crisis and Contingency form completed and saved within the My Safety planning section of the electronic patient record. Completion of this will form the basis of a personalised Crisis and Contingency plan which will be included as part of the service users current care plans and recorded within the appropriate section of the care record.

Risk Management Care Plans

The Trust operates integrated care planning; where a service user Risk Assessment is rated as a **High Risk** there must be a dedicated Risk Management Care Plan with appropriate

Interventions detailed within the Care Planning section of the Service User's Health and Social Care Notes.

Wherever possible the service user and any other relevant individuals should be involved in developing the risk management care plan. Where they are not involved, the reason should be clearly documented.

Everyone involved in or affected by the care plan, should receive a copy. Detailed guidance on sharing confidential information can be found in the Trust assessment, care coordination and care planning (CPA) policy.

Where the Risk Assessment rating is a **low or medium risk**, and it is appropriate, risk issues can be covered as a single intervention within the Care Planning section of the Service User's Health and Social Care Notes.

Where a service users' risk has been reassessed and it has been rated as moving from Low/Medium to High, consideration should be made as to whether this will have an impact on the current Crisis and Contingency plan. The Risk Management Care Plan should also be revisited to verify if there is a need for this to be adjusted in line with the current assessment.

The care plan should include how the risks are to be managed; and who will be involved.

If the service user is an inpatient, the care plan must also include the observation level and any other arrangements i.e. leaving the ward.

Dealing with Differences of Opinion Around a Risk Management Plan

Whilst not always associated with secondary risks, disagreements around a risk management plan do occur and it is important to ensure that these are addressed consistently for the benefit of the service user.

If the service user disagrees with the risk management plan or the accuracy of information used to inform and direct the plan this should be explored in detail to ensure that information being used for this risk management plan is indeed accurate and it is a true reflection of risks associated with the service user.

As part of multi-disciplinary working, no one person has the right to veto a decision. However, where a significant minority of the group disagree with the proposed risk, further steps should be taken to ensure there is an agreement around the plan.

The formal role of the Responsible Clinician is fully recognised and the explicit commitment of consultants working in community and inpatient areas to this multi-disciplinary approach to risk taking is vital to ensuring agreement is reached.

If an individual or group disagrees strongly, their objections should be clearly recorded and discussed in an attempt to see whether a compromise can be reached. Such discussion may centre on either the goals or methods of intervention and those arguing against the majority view must present their arguments in the context of possible effects on the client. Consideration of any possible secondary risk factors must also be considered underlying any disagreements around the implementation of an agreed plan.

The possible risk involved in taking no action at all must also be an important consideration.

If agreement cannot be reached, the dissenting views must be clearly recorded in the Health and Social Care notes and the person or people concerned must be committed to support the actions agreed until the next review date. At the agreed review date, information raised in the light of the disagreement in relation to the success of the plan should be considered.

Once the decision is taken at such a meeting, it becomes the collective responsibility of the Clinical Team. Key people to take action must be identified and as long as they implement the decision faithfully and take reasonable care, they should not be held individually responsible in the event of an accident occurring.

Principles of Working with Other Agencies

Other agencies may play a crucial role in support and meeting a service user's needs. Disclosure must always occur if other agencies or the public are deemed to be at risk. Safeguarding Children or Adults Procedures may be used at any stage of the risk assessment/ management process and may be of use in the development of a management plan. Multi Agency Public Protection Panels (MAPPA) may also apply.

Principles of Working Within Diversity

Assumptions around age, gender, sexual orientation, religion, marital status, race, culture or ethnicity may affect judgement around risk and determine a subsequent risk management plan. It is important that those developing plans within the principles described consider all of these factors. It is a process of personal reflection coupled with consideration of available research relating to stereotypes.

7. DEFINITIONS

A detailed definition of risk and key terms of High, Medium and Low is provided above.

A full list of abbreviations and terms are provided in Appendix 1.

8. PROCESS FOR MONITORING COMPLIANCE

Are the systems or processes in this document monitored in line with national, regional, trust or local requirements?	YES

Monitoring Requirements and Methodology	Frequency	Further Actions
A programme for regular auditing and monitoring will be carried out, as agreed by the Governance Committee this will include the following: All teams audited against core standards and practises outlined in this policy at least twice a year as part of the Assessment and Care Management Policy. Focused audits exploring specific standards and aspects of this policy as applied in practice. These include: • Audit of duties of staff groups in relation to the policy • Audit of compliance and concordance with training plan maintained by the Trust		The Governance Committee will receive copies of any reports and audits relating to standards and practises in this policy.

• The tools and procedures followed • Documentation regarding discussion and provision of information to patient • Audit of the quality of content of Risk Assessments; Risk progress notes and Risk Incidents		
Recording of Risk - This policy describes the recording of Risk within the Trusts Health and Social Care notes. The majority of Service Users records will be recorded using the Trust's Electronic Patient Record systems e.g. RiO, IAPTus. Staff are required to record Risk Assessments, Risk Incidents, Risk Progress Notes, Risk Management Plans, Crisis and Contingency Plans in all electronic patient record systems according to the latest training guidance and system updates.		

9. INCIDENT AND NEAR MISS REPORTING AND REGULATION 20 DUTY OF CANDOUR REQUIREMENTS

To support monitoring and learning from harm, staff should utilise the Trust's Incident Reporting System, DATIX. For further guidance, staff and managers should reference the Incident Reporting Policy. For moderate and severe harm, or deaths, related to patient safety incidents, Regulation 20 Duty of Candour must be considered and guidance for staff can be found in the Duty of Candour Policy and Intranet resources. Professional Duty of Candour and the overarching principle of 'being open' should apply to all incidents.

10. TRAINING

Training and information for staff will be given initially on induction to the Trust. Line Managers should ensure all appropriate staff members are aware of the local implementation of the policy.

11. REFERENCES

Best Practice in Managing Risk, Department of Health (2007)

Patient Assault: a comparison of reporting measures, Lanza M Campbell R, (1991) Quality Assurance no 5

Self-harm The short-term physical and psychological management and secondary prevention of self-harm in primary and secondary care, CG16, National Institute of Clinical Excellence (2004)

The National Patient Safety Agency (2004): Psychiatric Bulletin (2004), 28, 193-195
"Hidden data provide new insights into life at the end…" , Bazalgette, L. Bradley, W. Ousbey, J. Demos (2011)

Gloucestershire Suicide Prevention Strategy (2010-2015)

Quality of Risk Assessment Prior to Suicide and Homicide: A Pilot Study, The National Confidential Inquiry into Suicide and Homicide by People with Mental Illness (NCISH) (2013)

Self-harm and attempted suicide within inpatient psychiatric services: A review of the literature, International Journal of Mental Health Nursing (2012), 21, 4, 301-309

12. ASSOCIATED DOCUMENTS

Further Reading

Living with risk Mental health service user involvement in risk assessment and management. Langan, J. Lindow, V. Joseph Rowntree Foundation/The Policy Press (2004)

The risks of risk assessment Undrill G *Advances in Psychiatric Treatment (2007),*

Independence, choice and risk: a guide to best practice in supported decision making Department of Health (2007)

'Giving up the Culture of Blame' Risk assessment and risk management in psychiatric practice. Morgan J Royal College of Psychiatrists (2007)

Avoidable Deaths - National confidential inquiry into suicide and homicide by people with mental illness (2006)

Appendix 1 - Abbreviations and Terms

Band	A system used by the NHS to group staff from different backgrounds and professions according to their role, experience and qualification. A typical nurse will be a Band 5.
Care Coordinator	A named professional who 'coordinates' the care of a specific service usually done through a care plan
CPA	Care Programme Approach. A nationally set framework to manage is planned and delivered, within mental health services. It is also used for Learning Disability services.
CJLS	Criminal Justice Liaison Service. A dedicated team of mental health specialists who work with people in contact with the Courts.
Clustering	Part of PBR. Within Payment by Results, there are 22 groups of treatments that a service user can receive. The most appropriate group for a service user is worked out by completing a HoNOS PBR assessment
CQC	Care Quality Commission. A Government approved body that d licences health and social care organisations.
HCR-20	Historical, Clinical, Risk Management-20 (HCR-20) is an assessment tool that helps mental health professionals estimate a service user's probability of violence
HoNOS	Health of the Nation Outcome Scales. An assessment carried out by staff to identify the needs of a service user and to monitor improvement during treatment.
IAPT	Improving Access to Psychological Therapies
IAPTus	A national approved electronic health record system used by the IAPT Services
Liaison Service	Staff who assess and advise people with mental health problems or have specific needs arising from a learning disability in Adult Acute Hospital
MAPPA	Multi Agency Public Protection Arrangements
MDT	Multi-Disciplinary Team – a meeting where the different professional work and plan together
MHARS	Mental Health Acute Response Service
MHICT	Mental Health Intermediate Care Team

NICE	National Institute of Clinical Excellence
PbR	Payment by results. A national system used to match funding to the needs of the patient.
RiO	A national approved electronic health record system used by Adult MH Services CYPS, and Learning Disability Services
PMHS	Primary Mental Health Service
CRHT	Crisis Resolution and Home Treatment Team
WRAP	Wellness Recovery Action Plan

Appendix 2 - Risk Factors for Violence – Working Age Adults

(Taken from Best Practice in Managing Risk (2007) Department of Health)

Demographic factors

Male
Young age
Socially disadvantaged neighbourhoods
Lack of social support
Employment problems
Criminal peer group

Background history

Childhood maltreatment
History of violence
First violent at young age
History of childhood conduct disorder
History of non-violent criminality

Clinical history

Psychopathy
Substance abuse
Personality disorder
Schizophrenia
Executive dysfunction
Non-compliance with treatment

Psychological and psychosocial factors

Anger
Impulsivity
Suspiciousness
Morbid jealousy
Criminal/violent attitudes
Command hallucinations
Lack of insight

Current 'context'

Threats of violence
Interpersonal discord/instability
Availability of weapons

Based on.

The MacArthur Violence Risk Assessment Study, *Update of the Executive Summary*, September 2005. Available from: macarthur.virginia.edu/risk.html

Farrington, D., 'Predicting adult official and self-reported violence'. In Pinard, G. and Pagani, L. (eds) *Clinical Assessment of Dangerousness. Empirical Contributions*, Cambridge University Press, Cambridge, 2001

Appendix 3 - Risk Factors for Suicide – Working Age Adults

*(Adapted from Gloucestershire Suicide Prevention Strategy 2010, unless there is marked * in which case taken form Best Practice in Managing Risk (2007) Department of Health)*

Clinical factors:

Previous suicide attempt (this is strongest predictor);
Previous history of deliberate self-harm;
Mental illness (depression, bi-polar disorder, personality disorder, schizophrenia);
Substance misuse;
Mental health patients shortly before, or shortly after discharge from in-patient care;
Physical illness, especially chronic conditions and/or those associated with pain and functional impairment (e.g. multiple sclerosis, malignancy, pain syndromes[5]) *
A family history of suicide/mental disorder
Have experienced a number of stressful events;
Psychological factors - Hopelessness, Impulsiveness, Low self-esteem*

Socio-demographic factors:

Male*
Social isolation (gay men, lesbians, bisexuals and transgender communities, students, older people, living in rural location)
Homelessness; poor socio-economic backgrounds
Loss; (recent / or adversary of bereavements; relationship breakdown; widowed)
Unmarried, cohabitation,
Sudden death of loved one;
Occupational group; (doctors, farmers, vets, dentists and pharmacists)
Service veteran;
Being unemployed, retired or insecurely employed;
Breakdown or low levels of social support (prisoners, immigrants and refugees)

Adverse events such as

Financial concerns,
Conflict,
Abuse, (physical and/or sexual abuse)
Legal problems
Interpersonal losses

Resilience –

Poor emotional health in childhood and/or abuse;
Impaired problem-solving skills

Young people –

Parental separation and divorce; parents with a mental illness; caring for parents with a physical illness; impaired parent/child relationships (high expressed emotions, parental expectations and control);

Current 'context'*

Suicidal ideation*
Suicide plans*
Ease of access to a lethal method
Lethality of means*

Appendix 4 - Risk Factors / Indicators for Neglect – Older Adults

(taken from National Committee for the prevention of Elder Abuse (USA) 2008)

Signs of neglect observed in the home

Absence of necessities including food, water, heat
Inadequate living environment evidenced by lack of utilities, sufficient space, and ventilation
Animal or insect infestations
Signs of medication mismanagement, including empty or unmarked bottles or outdated prescriptions
Housing is unsafe as a result of disrepair, faulty wiring, inadequate sanitation, substandard cleanliness, or architectural barriers

Physical indicators

Poor personal hygiene including soiled clothing, dirty nails and skin, matted or lice infested hair, odours, and the presence of faeces or urine
Unclothed, or improperly clothed for weather
Decubiti (bedsores)
Skin rashes
Dehydration, evidenced by low urinary output, dry fragile skin, dry sore mouth, apathy, lack of energy, and mental confusion
Untreated medical or mental conditions including infections, soiled bandages, and unattended fractures
Absence of needed dentures, eyeglasses, hearing aids, walkers, wheelchairs, braces, or commodes
Exacerbation of chronic diseases despite a care plan
Worsening dementia

Behavioural indicators

Observed in the caregiver/abuser
Expresses anger, frustration, or exhaustion
Isolates the elder from the outside world, friends, or relatives
Obviously lacks care giving skills
Is unreasonably critical and/or dissatisfied with social and health care providers and changes providers frequently
Refuses to apply for economic aid or services for the elder and resists outside help

Observed in the victim

Exhibits emotional distress such as crying, depression, or despair
Has nightmares or difficulty sleeping
Has had a sudden loss of appetite that is unrelated to a medical condition
Is confused and disoriented (this may be the result of malnutrition)
Is emotionally numb, withdrawn, or detached
Exhibits regressive behaviour
Exhibits self-destructive behaviour
Exhibits fear toward the caregiver
Expresses unrealistic expectations about their care (e.g. claiming that their care is adequate When it is not or insisting that the situation will improve)

Appendix 5

RISK FACTORS TO BE CONSIDERED FOR ALL CYPS SELF HARM/SH ASSESSMENTS – CHILDREN AND YOUNG PEOPLE

Demographic and Historical Factors	**No evidence seen**	**Low**	**Med**	**High**
Gender				
Age				
Ethnicity				
Family/relationship crisis				
Recent change of living arrangements				
Problems at school/work				
Social isolation				
Coping style/personal resources				
Medical history				
Family/peer history of suicide				
Parental mental health and/or substance misuse problems				
History of antisocial behaviour				
History of abuse, severe victimisation and/or exploitation from others (inc. child protection concerns)				
Previous attempts/acts of Self Harm				
Risk Management Factors	**No evidence seen**	**Low**	**Med**	**High**
Current mental state and psychiatric history				
Change in clinical features				
Recent actual or threatened loss				
Current concerns expressed by significant others				
Current substance misuse				
Failure to comply with medication and/or care plan				
Suicide Plan e.g. method, availability, time/place, lethality, final arrangements,				
Unplanned disengagement with support services				
Reoccurrence of circumstances associated with risk				

Appendix 6

ADDITIONAL CHILDHOOD CLINICAL ACTUARIAL RISK FACTORS TO BE CONSIDERED AS PART OF THE RISK ASSESSMENT PROCESS - CHILDREN AND YOUNG PEOPLE

A CYPS risk assessment should consider the following childhood actuarial risk factors when completing the final summary section within the overall RiO Risk Summary screen.

Evidence of such risk factors may help to inform the subsequent clinical risk decision making process.

Family/relationship crisis
Recent change in living arrangements
Current vulnerability status including teenage mothers, homelessness, runaways, asylum seekers and refugees
Persistent problems at school/work
History of maltreatment/abuse/exploitation/victimisation (including significant harassment and bullying) either from home/ school/ community/ cyberbullying from a range of social networking media)
Social/peer isolation
Maladaptive coping style/personal resources
Family history of suicide
Peer history of suicide or unexpected death (especially concerning recent events)
Recent actual or threatened loss
Parental mental health and /or substance misuse problems
Current substance misuse problems (including use of solvents)
History of intentional harm to animals (if known)
History of parental/carer maltreatment of animals (if known)
History of risk taking behaviours (e.g. persistent antisocial behaviour, previous attempts/acts of Self Harm)
Chronic physical health issues
Experiencing a series of stressful life events

Appendix 7

RISK INDICATORS FOR SELF HARM

D - Demographic, B - Background history, C - Clinical History, CC – Current 'context'

D	Aged 14-35
D	Female
CC	Emotional distress
C	Anxiety
C	Depression
B	Young people living within a residential care setting (12-24 yrs)
C	Substance misuse
C	Eating disorder
C	Diagnosis of BPD
B	Previous Hx
B	Victims of domestic/sexual abuse past, present
CC	Suicidal intents
CC	Loss, separation or receiving bad news
B	Relationship problems
D	Unemployed

Based on: Literature used/Best Practice in Managing Risk (2007) DoH, Royal College of Psychiatry, improving the lives of people with mental illness (2012). Fox & Hawton (2004), Klonsky (2007), Dickson et al (2009).

Appendix 8

RISK FACTORS FOR SELF NEGLECT

This assessment needs to consider both the individual's ability and willingness to care for themselves adequately. This is a difficult area of risk to assess, one which may depend on an assessment of the individual's physical, cognitive and psychological levels of function.

"*Determining the competence is crucial to determining the passive or active nature of self-neglect" Baumhover 1996*

The individual may be in a position where they have to be responsible for the care of another, whether spouse or children. If this is the case, then the assessor should take into account the needs of all involved, and the identified patient/clients ability to care for themselves and others safety within the specified situation.

Historical factors of self neglect

Previous self-neglect
If the patient/client has experienced difficulties in self-care in the past, this may indicate greater risk of self neglect in future.

General health status
Physical health problems such as arthritis, a stroke or other illness may affect the individual's ability to perform activities of daily living effectively. Conditions such as depression or anxiety can affect the individual's levels of motivation and cognitive difficulties may mean the individual is less able to understand and complete activities of daily living safely.

Some conditions may present specific difficulties such as reduced mobility, poor co-ordination, or impaired understanding.

Alcohol/drug abuse is associated with reduced self-care and compliance with medication and treatment. The individual's levels of motivation and initiative may be impaired.

Current status factors of Self Neglect

Presenting levels of function
What is the individual able to do for themselves? Are they demonstrating adequate problem solving skills or ability to carry out activities of daily living safely?
They should also consider an individual's ability to communicate their thoughts, feelings and needs as well as their ability to understand what is being communicated to them.

Current mental state
If there is evidence of reduced levels of cognition, then the individual is at greater risk of being unable to care for themselves adequately. With reference to the CPA core assessment, assessors need to consider the following components of mental state:
Appearance and behaviour
Speech
Thought
Mood

Insight
Memory
Concentration
Sleep
Appetite

Levels of insight
If the individual is able to recognise their limitations and accept appropriate levels of support then the risk of self-neglect is lowered.

Risk management factors of self neglect

Lives alone – the risk is higher when the individual lives alone.

Appropriate informal support, family/other – whether living alone or with others, if the individual receives support and encouragement from family and friends, then the risk is lowered. If they are not supported or perceive themselves to be under pressure from their family, then the risks are higher.

Formal support – whether living alone or with others, the risk is lowered if help and assistance is accepted. This may be from Social Services or other agencies.

Compliance with treatment/interventions – the risk of self-neglect is lowered if they are able to comply with treatment and medication regimes.

Suitability of environment – the risks are increased if the environment does not meet the physical needs of the individual. Risks are increased if the individual has problems in moving around their home, staying warm, or having access to facilities such as shops or a laundry.

Clinician's assessment of self neglect
Give your own subjective overall assessment of the risk of self-neglect - a lack of adequate self-care and/or access to appropriate facilities which would ensure the individual's safety and care of themselves in activities of daily living.

Information taken from Baumhover, L and Beall, S *Abuse, Neglect and Exploitation of Older Persons* London, Jessica Kingsley

Appendix 9

ACTUARIAL INDICATORS FOR INCREASED RISK OF ABSCONDING

Previous absconding behaviour (the most important factor in prediction).
Under 40 years old.
Male.
Detained.
Psychosis.
MHA detention.
Unemployed.
Dependency on alcohol / illicit substances.
Negative feelings, stress and/or anger about admission.
Early days of admission (especially first 3 weeks).
Warmer months.
Weekend.
Boredom / frustration.
Following bad news.
Homesickness.
Concerns regarding safety of accommodation.
Domestic concerns – including animals
Between mid-day and 11pm.
Shift handover times.

Taken from: **Absconding from psychiatric hospitals: a literature review** Report from the Conflict and Containment Reduction Research Programme Duncan Stewart, Institute of Psychiatry, Len Bowers Institute of Psychiatry, Nov 2010.

List compiled by Chris Betteridge 16/07/13.

Appendix 10

TEMPLATE: IAPTUS RISK INFORMATION – RISK SCREENING MHICT GLOS

Risk Screening - 2gether

Common Fields

Stage: **Referral Received**

Date: 13/11/2015

Risk to Self

	Yes	No Evidence	Not Assessed
Does your patient have any thoughts of harming themselves?	●	●	●
Has your patient ever self-harmed in the past?	●	●	●
Is there a history of self-harm in your patient's family?	●	●	●
Has your patient considered acting on these thoughts?	●	●	●
Has your patient attempted suicide in the past?	●	●	●
Is there a history of suicide in your patient's family?	●	●	●
Is there any evidence of self neglect?	●	●	●

Record further information here:
Test Risk Screening

	Yes	No	Not Assessed
Would there be anyone or anything stopping your patient from posing a risk to themselves?	●	●	●

Record further information here:
Test Risk Screening

What is the likelihood of your patient attempting to harm themselves at the moment?

0 1 2 3 4 5 6 7 8 9 10

What support does your patient currently have around them?
Test Risk Screening

Risk from others

	Yes	No Evidence	Not Assessed
Is your patient currently at risk/do they feel threatened by others around them? (E.g. violence, abuse, exploitation)	●	●	●

Record further information here:
Test Risk Screening

Risk to others

	Yes	No Evidence	Not Assessed
Does your patient currently pose a risk to others or perceive others to be at risk from them? (E.g. physical violence, threats of violence, verbally violent, sexually inappropriate, neglect of others, driving. Do they pose a safeguarding risk to others?)	●	●	●

Record further information here:
Test Risk Screening

Risk of accidents

	Yes	No Evidence	Not Assessed
Is your patient at risk of accidents? (E.g. wandering, falls, unsafe use of medication)	○	●	●

Record further information here:
Test Risk Screening

Other Risk behaviours

	Yes	No Evidence	Not Assessed
Does your patient present with other risk behaviours? (E.g. hoarding tablets, dangerous driving)	●	●	●

Record further information here:
Test Risk Screening

Risk tips:

Take self out if situation

Talk to someone

Calm self down by ...

Discuss problem with .... when calm

Speak to GP if concerned

Use Samaritans if needed (National no: 116 123; Glos: 01452 306333; Hfd: 01432 269000)

Use Out of hours GP if needed (Glos: 0300 4120220; Hfd: 0330 123 9309)

	0	1	2	3	4	5	6	7	8	9	10
How likely is your patient to use these numbers / tips?	●	●	●	●	●	●	●	●	●	●	●

The above indicators are intended to screen for risk factors at the time of the assessment; please take into account other relevant information and the extent to which information is available to you.

Screening Results

	Low	Medium	High
Overall Risk Rating:	●	●	●

If medium or high risk - remember to complete a Risk Assessment

If low risk – Remember to complete a risk management plan within the patient's treatment plan and to update the Risk Rating on the patient's boarding card

Print

Appendix 11

TEMPLATE: IAPTUS RISK INFORMATION – RISK ASSESSMENT MHICT GLOS

Reason for assessment / Review purpose
test test
People present or involved
test test
Risk(s) being reviewed under the categories: Risk to Self; Risk from Others; Risk to Others; Risk of Accidents; Other Risk Behaviours;
state risk duration (Short/Medium/Long term) and the risk level (Low/Medium/High) considering the probability and consequence of risk occurring.
test test
Who is affected by the risk(s) (if appropriate)
test test
Current situation / Change since last assessment/review
test test
Any factors increasing risk (include actuarial and clinical factors, current triggers, protective factors and if these change when entering or leaving an inpatient setting)
test test
Any factors reducing risk (including actuarial, clinical factors, protective factors)
test test
Any other agencies involved in risk assessment and management and whether the assessment is reliant led by trust staff
test test
Formulation
test test
Risk management and contingency plan (including any positive risk taking strategies, observation levels)
test test

Assessment Result

Remember to update Risk Rating on the patient's boarding card
Overall Risk Rating:

- (•) Low
- ( ) Medium
- ( ) High

Referrals made?

- Yes
- No

Date Referral made:

23/11/16

Multiagency Referral: (select as appropriate)

- Advocacy
- Local Authority Safeguarding Team
- MAPPA
- MARAC
- Other Organisation
- Police
- PREVENT
- Social Care

Print

Appendix 12

STRUCTURED ASSESSMENT TEMPLATE FROM RIO

Risk of Suicide	
Tick one or more of the check boxes below when applicable - REMEMBER check boxes are only prompts, any other relevant info can be documented in "Brief Supporting Information"	
Act with suicidal intent □	Suicidal ideation □
Brief Supporting Information -Remove information which is no longer relevant, it will be in the previous risk assessment *(if create new was selected)*:	
RISK RATING: Low/Medium/High	

Risk of Harm to Self	
Tick one or more of the check boxes below when applicable - REMEMBER check boxes are only prompts, any other relevant info can be documented in "Brief Supporting Information"	
Self-injury or harm □	Self-neglect □
Brief Supporting Information -Remove information which is no longer relevant, it will be in the previous risk assessment *(if create new was selected)*:	
RISK RATING: Low/Medium/High	

Risk of Harm from Others
Tick one or more of the check boxes below when applicable - REMEMBER check boxes are only prompts, any other relevant info can be documented in "Brief Supporting Information"
Child Protection Plan (CPP) indicator: Has never been subject to a CPP/ Has previously been subject to a CPP/ Is currently subject to a CPP/ Not Known

Domestic Abuse: Disclosed / Not disclosed / Not assessed at this time	
Risk caused by medication/services/treatment □	Risk of emotional/psychological abuse including bullying □
Risk of financial abuse □	Risk of neglect □
Risk of physical harm □	Risk of unlawful restrictions (locks on doors, physical restraints etc.) □
Risk of sexual abuse/exploitation □	Vulnerability □
Brief Supporting Information -Remove information which is no longer relevant, it will be in the previous risk assessment *(if create new was selected)*:	
RISK RATING: Low/Medium/High	

Risk of Harm to Others	
Tick one or more of the check boxes below when applicable - REMEMBER check boxes are only prompts, any other relevant info can be documented in "Brief Supporting Information"	
Exploitation of others (e.g. financial, emotional) □	Fire setting □
Hostage taking □	MAPPA □
Probation service involvement □	Risk to children □
Risk to vulnerable adults □	Sexual Assault (including touching/exposure) □
Schedule 1 or Sex Offenders Act 2003 □	Access to Weapons □
Stalking □	Violence/aggression/abuse to family □
Violence/aggression/abuse to general public □	Violence/aggression/abuse to other clients □
Violence/aggression/abuse to staff □	
Brief Supporting Information -Remove information which is no longer relevant, it will be in the previous risk assessment *(if create new was selected)*:	
Victims to be notified of Leave/Discharge? Yes/ No/ Not applicable	

RISK RATING: Low/Medium/High

Risk of Accidents	
Tick one or more of the check boxes below when applicable - REMEMBER check boxes are only prompts, any other relevant info can be documented in "Brief Supporting Information"	
Accidental harm outside the home (e.g. wandering) □	Driving/Road safety □
Falls □	Fire □
Unsafe use of medication □	
Brief Supporting Information -Remove information which is no longer relevant, it will be in the previous risk assessment *(if create new was selected)*:	
RISK RATING: Low/Medium/High	

Other Risk Behaviours and Issues	
Tick one or more of the check boxes below when applicable - REMEMBER check boxes are only prompts, any other relevant info can be documented in "Brief Supporting Information"	
Absconding/Escape □	Correspondence □
Damage to property □	Incidents involving the police □
Phone Calls □	Social Media □
Theft □	Visitors □
Substance/Alcohol □	
Brief Supporting Information -Remove information which is no longer relevant, it will be in the previous risk assessment *(if create new was selected)*:	
RISK RATING: Low/Medium/High	

Summary & Any Further Details
Summary and any further details: **REASON FOR ASSESSMENT / REVIEW PURPOSE** **PEOPLE PRESENT OR INVOLVED** *in this risk assessment including any other agencies involved and whether the assessment is led by Trust staff (e.g. could include the service users carers, clinicians and other agencies)* **RISK(S) BEING REVIEWED** *(List the risks identified rather than just the broad headings i.e. deliberate self-harm, self-neglect and suicide rather than just 'Harm to self')* **WHO IS AFFECTED BY THE RISK(S)** *(Include what is known e.g. is there a risk to the general public, females or one particular person?)* **CURRENT SITUATION / CHANGE SINCE LAST ASSESSMENT / REVIEW** **FORMULATION OF RISKS** *stating the risk level (Low/Medium) and risk duration (Short/Medium/Long term e.g. if justifying a course of action that increases short term risk for longer term gain) considering the probability and consequences of the risk occurring.* **RISK MANAGEMENT AND CONTINGENCY PLAN** *(including any positive risk taking strategies, observation levels)*
OVERALL RISK RATING: Low/Medium/High