## Executive Summary
This policy will be used by all clinical staff in the Trust and local authority staff working in the Trust who are involved in the identification and management of risks related to the presentation or clinical condition of all Service Users.

## Executive Lead
Medical Director

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Policy

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## Ratified by
Risk Management Group

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## Date of Equality Impact Assessment
08/06/2017

## Board Objective Reference
Objective 6

## CQC Regulation Reference
Regulation 17

## Risk Register Reference
N/A

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## Document Status
This is a controlled document. Whilst this document may be printed, the electronic version posted on the Trust intranet is the controlled copy.
Clinical Risk Policy

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1. Introduction

This policy aims to ensure that the Trust provides a structured approach to the identification, assessment, formulation and management of clinical risk and that all staff are aware of the principles of safe and effective clinical risk management and understand their duties and responsibilities.

The policy sets out the expected clinical risk practices for clinical services offered by the Trust to Service Users. It aims to ensure risks are considered and managed in the best interests of the Service User, to empower people to make choices, and to ensure both Service Users and staff can make informed decisions about risks.

1.1. Guiding Principles

"Safety is at the centre of all good healthcare. This is particularly important in mental health, but it is also more sensitive and challenging. Patient autonomy has to be considered alongside public safety. A good therapeutic relationship must include both sympathetic support and objective assessment of risk" (Department of Health June (2007) Best Practice in Managing Risk).

This policy supports the principles of recovery and empowerment through a process which encourages Service Users to make positive decisions about their lives and to manage choice and risk transparently. It recognises that risk is an inevitable consequence of people making decisions about their own lives and that positive risk management, as part of a carefully constructed plan, will help manage those risks more effectively.

"What needs to be considered is the consequence of an action and the likelihood of any harm from it. By taking account of the benefits in terms of independence, well-being, and choice, it should be possible for a person to have a support plan which enables them to manage identified risks." (Department of Health, Independence, Choice and Risk (2007)

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 this does not stop others doing the same. The Mental Capacity Act (2005) is based on the principle that every adult has the capacity to make all decisions affecting their life unless, and in specific circumstances, there is evidence that this capacity is lacking. Best practice guidance recognises that:

"Over defensive practice is bad practice. Avoiding all possible risks is not good for the Service User or society in the long term, and can be counterproductive, creating more problems than it solves". Best Practice in Managing Risk (Department of Health (2007), p.8.

1.2. Structured Professional Judgement
In accordance with DoH Best Practice, the Trust is committed to a structured professional judgement approach to risk management, which involves the following:

- Consideration of historical information in combination with current dynamic risk factors;
- Use of evidence based guidelines that promote systemisation and consistency;
- Evidence-based risk formulations and formulation-based management and treatment interventions; and
- Recognising risk assessment as a continuous process, mediated by changing conditions and sensitive to change as a result of treatment and management.

The policy describes a structured professional judgement approach that makes use of systematic procedures, standardised assessment tools and guidelines when necessary, to ensure the best information available is gathered and efficient methods of evaluating the information are employed. Structured formulations and risk management plans can then be developed, which consider the potential harms and benefits of the available options.

The policy complements and does not replace other risk management processes such as the Management of Violence and Aggression, Suicide Prevention, Multi Agency Public Protection Arrangements (MAPPA), the safeguarding vulnerable children/adult procedures, or the Care Programme Approach (CPA), which are core components of many services provided by the Trust.

2. Definitions

- **Risk:** An event or action related to clinical care and treatment with an uncertain outcome that will have beneficial or harmful consequences for either the individual concerned or others they come into contact with. The probability of any particular outcome can often only be estimated.
- **Clinical Risk Assessment:** Arising from risks to and/or from a Service User. The identification of potentially harmful intentions or factors that jeopardise a person’s safety or recovery or the safety of others, together with a consideration of strengths and protective factors. All individuals referred to Trust services will have an assessment of clinical risks undertaken.
- **Risk Formulation:** This is the key stage for analysing risk assessment information in order to explain and understand the risk. The risk formulation should be the reference point to concisely describe and communicate current risks and provide the basis for management interventions.
- **Positive Risk Management:** The employment of strategies that allows the Service User to live their life to their full potential while managing identified risks to reduce the likelihood of negative outcomes occurring and/or the severity of the consequences of that risk.
- **Reasonable Risk:** Independence Choice and Risk (DoH, 2007) provides the following helpful definition: “Balance and proportionality are vital considerations in encouraging responsible decision making. Reasonable risk is about striking a balance in empowering people who use services to make choices, ensuring that the person has all the information tailored to their specific needs, in the appropriate form, to make their best decision.”

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3. Duties

3.1. Risk Management Committee (RMC):

RMC are responsible for:
- Approval of this policy.
- Approval of risk management tools, procedures and guidelines as required.
- Prepare a Chair’s report for Quality Governance Committee.

3.2. Workforce Development Committee (WDC):

WDC are responsible for:
- Via the receipt of an Education proposal form, approve the training required for trust staff within the Trust Training Needs Analysis (TNA); and
- Monitor training compliance against the TNA, including numbers who did not attend.

3.3. Chief Executive

Overall responsibility to ensure that this policy is implemented and adhered to across the entire Trust.

3.4. Executive Directors

3.4.1 Medical Director

- Overall responsibility for the safe and effective management of clinical risk in the Trust.
- Responsible for monitoring and review of this policy.

3.4.2 Director of Operations & Nursing will ensure that:

- This policy is applied within all clinical directorates and areas delegating responsibility to appropriate deputies within the Trust.

3.5. Clinical Governance Team

Clinical Governance Team are responsible for:

- Co-ordinating Trust audits of compliance with the policy.
- Monitoring approval and registration of risk tools and guidelines and reviewing availability for use on PARIS, including version history.
- Referring procedures, tools and guidance to appropriate group/committee for approval where appropriate (e.g. professional advisory group).
- Liaise with the Deputy Risk and Performance Manager to ensure that arrangements are in place to update new tools and archive existing tools in the Integrated Governance shared N:Drive.
- Disseminating trends, themes and lessons learned in relation to clinical risks throughout the Trust.

3.6. **Post-Incident Review (PIR) Panel:**

- Review reports of serious incidents in the Trust.
- Ensure the quality of such reports and monitor action plans to address identified clinical risks.
- Instigate further investigations into serious incidents as appropriate.

3.7. **Heads of Operation will ensure that:**

- Employees are aware of and understand the requirements of the policy.
- Ensure that risk assessments take account of the risk to staff, Service Users, carers and the environment and ensure that appropriate systems are in place to protect the safety of individuals.
- Local arrangements are in place for monitoring and managing clinical risk.
- Local governance arrangements are in place to review and approve clinical risk procedures, tools and guidelines.
- Adding appropriate identified clinical risks to the Risk Register.

3.8. **Line Managers will ensure that:**

- This policy is implemented and compliance is monitored through clinical and management supervision.
- Implement audit tool to assess this compliance.

3.9. **Care Co-ordinators, Responsible Clinicians & Leads Professionals**

- Responsible for clinical risk assessment, formulation and management in accordance with Trust CPA policy.

3.9.1 All staff who work directly with people at risk are responsible for:

- Complying with the requirements of this policy.
- Participating in clinical risk training as specified in the Trust Training Needs Analysis (TNA).
- Updating such training in accordance with Trust TNA.
- Acting on information they receive regarding risk and reporting to respective care co-ordinator or clinician responsible for the Service User.
- Seeking advice, support and supervision in relation to risk as required
- Contributing to and/or undertaking clinical risk assessments.
- Reporting incidents on Trust systems including PARIS and DATIX.
3.9.2 Professionally Registered Staff

- Responsible and accountable for ensuring that appropriate clinical risk management practices are used in the care of those Service Users for whom they are responsible.

- Responsible for ensuring that practice in relation to clinical risk is consistent with professional codes of conduct and should ensure that they include ongoing learning on risk to self and others in their continuing professional development.

4. Processes and Procedures

**Figure 1 - Clinical Risk Management Cycle**

4.1. Process for Assessing and Managing Clinical Risk

This policy describes a “5-step” structured professional judgement approach to risk management based on *Best Practice Guidance* (DoH (2007) to assist in assessing, formulating, communicating and managing clinical risk; consistent with the principles of positive risk management (See Figure 1 above).

The approach is consistent with the stages of the Care Programme Approach, and is aimed at being *preventative* rather than predictive, ensuring risk assessments are closely linked to risk formulation and preventative interventions. Even where outcomes...
are unclear and where there may be uncertainty about diagnosis and needs, it is important that management plans to prevent harm are in place.

The approach combines an understanding and consideration of both static factors such as past history and demographic considerations, with dynamic factors, such as mood, mental state and current presentation that are subject to change or fluctuation. This approach will be applicable across different services and will be integral to the implementation of the Trust's CPA policy. It will apply to Service Users on CPA and those receiving standard care, and is also relevant to carers.

**4.2. Step 1 – Gathering information and assessment of strengths and needs**

At referral/presentation to services, all Service Users should expect a comprehensive and holistic assessment of strengths, needs and risks in accordance with CPA policy.

It is acknowledged that in time limited and/or urgent situations staff need to make judgements about risk with limited information. Screening of risks should be part of the initial assessment. Wherever possible, staff will need to review available documentation, interview the person being assessed and relevant others involved to gather information regarding history, referral details, current presentation and social circumstances.

Self-report by the service user is very important, but should not be relied upon alone, particularly if risk to children is being considered. The accuracy of information and the amount of emphasis that should be placed on the information available will need to be considered and documented in clinical records.

**4.3. Step 2 – Assess task and protective factors**

The effective management of a Service User’s problems and needs will contribute to reducing risks. In addition, it is important that specific risks to self and others are identified and assessed. These risks would include, but not be restricted to:

- Self-harm & suicide
- Violence to others
- Exploitation
- Self-neglect
- Physical health risks
- Falls
- Safeguarding children and vulnerable adults
- Abscond, escape and AWOL
- Alcohol/substance misuse

While there are no research instruments, scales or scores, that will enable anyone to say with complete accuracy that one Service User is at risk and another is not, there is a considerable body of evidence that indicates which factors are associated with
risk and how formulations and judgements about risk can be made on the basis of assessment information.

Risk assessment tools and guidelines (e.g. Standard Tool for the Assessment of Risk (STAR); HCR-20) aim to structure risk judgements and formulations and support clinical decision-making and management plans. They are one method for collecting information in a structured way and do not replace clinical judgement.

The Trust acknowledge that in some emergency and/or time limited situations, decisions about risk need to be made where there is only limited information and where the use of a tool or guideline would not be appropriate.

The source of information and any limitations in the information used to assess risk must be documented clearly.

Tools and guidelines approved and routinely used in the Trust are included in Appendix 1.

Staff may employ procedures, tools and guidelines as long as the following requirements are in place:

- The procedures, tools and guidance have been approved by the Directorate management team, authorised by the respective line manager and registered with the Trust (see Registration Tool, Appendix 2).
- Used in accordance with the code of professional conduct, best practice and this policy
- Staff have received the necessary training and ongoing supervision to use.
- There is a clear rational for use and the limitations of the tool are made clear.

New risk tools and guidelines must be approved by Directorate management teams and registered with the Trust Clinical Governance Team using the registration form in Appendix 2.

Where there is any doubt as to the suitability of a tool or guideline, the decision to approve will be referred by the Clinical Governance Team to the appropriate Trust committee or group (e.g. Risk Management Strategy Group, Clinical Risk Training Group). The register of risk tools and guidelines will be reported to the Risk Management Strategy Group on a quarterly basis.

### 4.4. Step 3 – Risk Formulation

At the formulation stage the aim is to summarise the risk assessment information collected in order to generate an *understanding* of the risks presented by the Service User. Information from assessments of strengths, needs and risks should be considered to concisely describe and explain the risk(s) in terms of the:

- History and nature of previous risk(s) (including type, severity and frequency of past/recent risk(s). A *summary* to explain what might have led to previous risk behaviour is required here.
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- Nature of current risks (imminence and likelihood of harmful outcome and recent changes in risks).

- Protective factors and/or personal strengths - These are any characteristics of a person, his/her environment or situation which reduces risk. Examples would include personal coping strategies, motivation for treatment, constructive activity, family, social and professional support.

- Warning signs for the future (early risk signs, factors which will trigger, increase, maintain and/or protect against or prevent risk behaviour).

The risk formulation should be the reference point to concisely explain and communicate current risks and provide the basis for management interventions and plans. The formulation of risks should wherever possible be a collaborative process that is shared with the Service User.

4.5. Step 4 – Risk Management

Positive risk management plans will consider the relative benefits and costs to the Service User and others they might come into contact with, and available options or actions in order to develop a plan which is collaborative and defensible.

Significant risks should be highlighted in risk management plans. Practical solutions to help Service Users to minimise risk should be actively considered. When considering how to manage risks it should be identified if they are imminent, and also:

- Level of severity
- Factors which reduce or increase risk
- Existing levels of support
- Whether the use of legal powers is appropriate
- The identification of protective factors

With the agreement of the Service User the identified risks and management plan should be shared with the relevant agencies. If the Service User refuses permission consideration should be given as to whether confidentiality can be breached in the interests of public safety on a need to know basis. Information sharing protocols should be followed under these circumstances. (Refer to Section 8 and the Trust safeguarding and confidentiality policies).

Crisis and Contingency Plan including relapse indicators, Advance Decisions, patterns of past behaviour and to whom the Service User is most responsive should be drawn up for those on CPA. Plans may include staff but should also consider the role of informal support networks.

Risks to lone workers need to be stated where applicable.
Risk assessment will inform the development of risk management plans which sit alongside CPA plans. Named individuals (or roles) are to be assigned with specific responsibility/accountability for actions to be taken. Agreement should be sought with all involved. Having everyone signed up to the plan, including the Service User and family or carers, is important whenever possible. A review date for the risk management plan should be set, and plans are to be recorded and stored in electronic systems and linked to CPA planning where this applies.

4.6. Minimum standards for good practice

Risk management decisions and plans are likely to be effective and defensible when:

- Staff conform to the relevant Trust policies, procedures and guidelines
- The best information available is used and the systematic methods of evaluating the information are employed (e.g. assessment procedures, tools and guidelines);
- Service Users and carers (having regard to the Service Users’ wishes) are involved;
- There is a team approach to development that is multi-disciplinary and/or multi-agency;
- Decisions are documented appropriately and in a timely way. Risk assessments should be documented as soon as is practicable but within 24 hours of assessment; and finalised within 48 hours;
- Where there are concerns, the appropriate people have been informed and included in the decision making process;
- All reasonable steps have been taken to manage the risk;
- Contingency/crisis plans are developed with the Service User and (if appropriate) their family/carer, and
- Verbal or written advance statement/decision details are recorded within the care plan indicating where copies of the advance statement/decision are to be found.

Guidance developed by the Trust Professional Advisory Group is also available to support positive risk decision making (see Appendix 3)

4.7. On-going Assessment of Clinical Risk

The level of risk can change very quickly and without warning in response to a variety of different risk factors. Therefore, risk assessments need to be an on-going part of clinical practice.

Reviews may be convened at key points in care based on level of risk identified, expected changes in risk, prior to change of members of the care team, and whenever circumstances or presentation changes or planned interventions have continued for a set period. In addition, there will be specific times during the care pathway when a formal documented risk assessment and/or review will be required. For example:
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- Referral;
- On admission to inpatient care;
- Following serious incidents;
- As part of clinical team/CPA review;
- Following any changes in security status or situation;
- Transfer to different service;
- Prior to leave from the ward; and
- Prior to discharge.

The findings from reviews are to be considered with the Service User and members of their care team including family/carers when appropriate.

4.8. Confidentiality and Sharing of Risk Information

Service Users, their families and carers expect information about them to be treated as confidential and as a consequence information will not be disclosed without consent, unless there are exceptional circumstances.

The Trust have systems and processes in place which place a high value on maintaining the confidentiality of individual Service Users (see Confidentiality policy) whilst at same time providing open access to information about services, the delivery of care and performance.

There are some circumstances where the disclosure of confidential information is allowed without the permission of the Service User:

- Where a child is believed to be at risk of harm (Childrens Act, 1989);
- Where there is evidence of risk of harm either to the individual or somebody else;
- For the prevention, detection and prosecution of serious crime;
- When instructed by a Court; and
- In certain circumstances under the Mental Health Act (1983).

5. 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 Learning and Development Policy. This will include:

- Clinical risk awareness at induction
- Directorate based training - customised to, directorate priorities, service user needs and staff training needs
- Specialised risk training as appropriate (e.g. HCR-20; SAVRY)

All staff who work directly with people at risk can expect training sufficient to enable them to practice safely and effectively. Staff should ensure that they are familiar with the core risks of harm to self and others.
### 6. Monitoring

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

<table>
<thead>
<tr>
<th>Minimum Requirement</th>
<th>Frequency</th>
<th>Process for monitoring</th>
<th>Evidence</th>
<th>Responsible Individual(s)</th>
<th>Response Committee(s)</th>
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<tbody>
<tr>
<td>Report for training attendance</td>
<td>Bi-monthly</td>
<td>Audits</td>
<td>Minutes</td>
<td>Training Lead</td>
<td>Workforce Education Governance Committee</td>
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<tr>
<td>Monitoring completion of risk assessments</td>
<td>Monthly</td>
<td>Audits</td>
<td>Electronic clinical record</td>
<td>Clinical Line Managers</td>
<td>Directorate governance groups</td>
</tr>
<tr>
<td>Monitoring completion of risk assessments</td>
<td>Annual</td>
<td>Audits</td>
<td>Risk Assessments</td>
<td>Clinical Line Managers</td>
<td>Clinical Audit Team</td>
</tr>
<tr>
<td>Team management reviews</td>
<td>As required in response to SUIs</td>
<td>Audits</td>
<td>Electronic clinical record</td>
<td>Clinical Line Managers</td>
<td>Directorate management Teams Trust Clinical Governance</td>
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<tr>
<td>Management and clinical supervision</td>
<td>Bi-monthly</td>
<td>Audits</td>
<td>Electronic clinical record</td>
<td>Clinical Line Managers</td>
<td>Directorate governance groups</td>
</tr>
<tr>
<td>Post incident reviews</td>
<td>Monthly</td>
<td>Audits</td>
<td>PIR reports</td>
<td>Heads of Service</td>
<td>PIR Panel</td>
</tr>
<tr>
<td>Monitor mental health &amp; CQUIN indicators</td>
<td>Monthly</td>
<td>Audits</td>
<td>Trust and Network Board reports</td>
<td>Deputy Director Clinical Governance</td>
<td>Trust Board Network Board</td>
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<tr>
<td>Monitor register of risk tools and guidelines</td>
<td>Quarterly</td>
<td>Audits</td>
<td>Clinical Governance report</td>
<td>Deputy Director Clinical Governance</td>
<td>Risk Management Strategy Group</td>
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<tr>
<td>PIR thematic reviews</td>
<td>Annual</td>
<td>Audits</td>
<td>Thematic review report &amp; Lessons learned newsletter</td>
<td>Deputy Director Clinical Governance</td>
<td>Clinical Governance Team</td>
</tr>
</tbody>
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7. Resource/Implementation Issues

This policy was consulted on via a specialist multi-disciplinary group and via the Integrated Governance Department’s Electronic document Management System cascade (Sharepoint) to all Trust nominated policy leads in accordance with the Trust Policy on Policies.

8. Risk Issues

It is recognised by the Trust that there are real benefits in terms of quality and effectiveness in developing new tools and processes that reflect local service priorities, needs and risks. This should always be in accordance with the process outlined in Section 5.3 above. For any advice please contact the Clinical Governance Team on (0161) 772 3611.

9. Requirements, Supporting Documents and References

9.1. Requirements

<table>
<thead>
<tr>
<th>Board Objective Ref:</th>
<th>Objective 2</th>
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<tbody>
<tr>
<td>CQC Ref:</td>
<td>Regulation 17</td>
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</tbody>
</table>

9.2. Supporting Documents

- CPA Policy
- Safeguarding Vulnerable Adults Policy
- Safeguarding children Policy
- Mental Health Act Policy Suite
- Policy for the Management of Violence and Aggression
- Consent Policy
- Confidentiality Policy
- Observation Policy
- AWOL Policy
- Professional Advisory Group Guidance
• Dual Diagnosis Policy

9.3. References

• Department of Health (2012) Suicide Prevention Strategy
• Department of Health (2005); Independence, Choice and Risk: a guide to best practice in supported decision making.
• Department of Health (2007); Best practice in Managing Risk: Principles and evidence in the assessment and management of risk to self and others in mental health services.
• The Mental Health Act (1983) (as amended) and its code of Practice
• The Mental Capacity Act (2005) and its Code of Practice
• The Human rights Act (1998) and the European Convention on Human Rights
• The Violence, crime and Victims Act (2004)

10. Review

This document will be reviewed in five years or sooner in the light of organisational, legislative or other changes.
## 11. Appendix 1 – Approved Trust Tools/Guidance for Assessment of Clinical Risk

<table>
<thead>
<tr>
<th>Tool</th>
<th>Use</th>
<th>Service</th>
</tr>
</thead>
<tbody>
<tr>
<td>Standardised Tool for Assessment of Risk (STAR:V2)</td>
<td>Assesses multiple risks</td>
<td>All parts of the Trust (except Adult Forensic Service).</td>
</tr>
<tr>
<td>Historical Clinical and Risk Management - 20 items</td>
<td>Guideline to assess risk of violence</td>
<td>Used routinely in Adult Forensic Service; Medium and Low Secure Services and used selectively in other areas in the Trust.</td>
</tr>
<tr>
<td>(HCR-20: Webster et al. 1997)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>(SAVRY: Borum et al., 2002).</td>
<td></td>
<td></td>
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<tr>
<td>Short Term Assessment of Risk and Treatability</td>
<td>Assesses multiple risks and used as part of Forensic Nursing Assessment</td>
<td>Adult Forensic Services and in MODAL team</td>
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<tr>
<td>(START: Webster et al., 2004).</td>
<td></td>
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<tr>
<td>Estimate of Suicide Risk (ESR-20: Polvi et al., 1997)</td>
<td>Assesses risk of self-harm and suicide</td>
<td>Adult Forensic Service</td>
</tr>
<tr>
<td>Falls Risk Assessment (FRA) and Falls Risk</td>
<td>Used to assess risk of falling</td>
<td>Used routinely in later life services but available for all services.</td>
</tr>
<tr>
<td>Assessment-Elderly (FRAE)</td>
<td></td>
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<tr>
<td>Security Needs Assessment Profile (SNAP: Collins et al., 2005)</td>
<td>Provides a model for decision making regarding physical, procedural and relational security needs</td>
<td>Adult Forensic Service</td>
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<tr>
<td>Beck Triad - Beck Depression Inventory (BDI-2),</td>
<td>These three self-report scales assess</td>
<td>For use in all services and recommended that they are used concurrently during assessment</td>
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<tr>
<td>Beck Hopelessness Scale (BHS) and the Beck</td>
<td>depression, hopelessness, self-harm/suicide.</td>
<td></td>
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<tr>
<td>Suicide Scale (BSS)</td>
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<tr>
<td>Primary Care Risk Assessment Measure</td>
<td>Screen for risk to self and others</td>
<td>Primary Care Mental Health Services</td>
</tr>
<tr>
<td>Alcohol &amp; Drug Directorate Risk Maps</td>
<td>Screen for risk to self and others</td>
<td>Alcohol and Drug Services</td>
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### Clinical Risk Assessment Tools & Guidelines

#### REGISTRATION FORM

<table>
<thead>
<tr>
<th>Title:</th>
<th>Title of the risk assessment tool/guideline</th>
</tr>
</thead>
<tbody>
<tr>
<td>Author:</td>
<td>Individual and organisation</td>
</tr>
<tr>
<td>Trust and/or Directorate Lead:</td>
<td>Please provide contact details of a Lead in the Directorate or organisation with responsibility for the use/maintenance of this tool/guideline</td>
</tr>
<tr>
<td>Registration date:</td>
<td>Date approved for use in Trust</td>
</tr>
<tr>
<td>Review date:</td>
<td>5 years after review date</td>
</tr>
<tr>
<td>Target population:</td>
<td>List Service User groups that the tool is appropriate to use with</td>
</tr>
<tr>
<td>Risks assessed:</td>
<td>List specific areas of risk targeted by the tool</td>
</tr>
<tr>
<td>For use by:</td>
<td>List services and staff groups approved to use tool</td>
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<td>Training needed:</td>
<td>List any training needed prior to using the tool</td>
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<td>Training provided:</td>
<td>List training provided to meet requirements above</td>
</tr>
<tr>
<td>Copyright information:</td>
<td>List any Trust licences, and restrictions on copying and distributing the assessment tool (if externally produced). List any intellectual property protections (if internally produced).</td>
</tr>
<tr>
<td>Evidence base:</td>
<td>List references to research validating the assessment tool</td>
</tr>
<tr>
<td>Further information:</td>
<td>Provide further guidance on how the tool should be used, what should be done with the information collected, etc.</td>
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**13. Appendix 2 – Guidance for Supporting Positive Risk Taking (PRT) and Effective Team Decision Making**

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**Why do we need this guidance?**

1. Recovery for service users almost always involves practitioners supporting them in Positive Risk Taking (PRT) during care planning and care delivery.

2. Individual practitioners are often reluctant to be seen to have supported PRT (feeling vulnerable to criticism later if anything ‘goes wrong’). Therefore, there is a need for guidelines to support multi-professional involvement in the decision-making process, to ensure the best decision is made and to prevent fear of castigation.

3. Care of people with mental health and/or alcohol/drug problems involves many professionals, often with differing explanatory frameworks for service user needs and conditions. This can result in occasional differences of professional opinion on appropriate care planning and risk-taking. This guidance is aimed at supporting collaborative and consensual decision-making processes.

**Basic principles:**

- Service user’s views and well-being should be at the heart of the decision-making process however, the protection of others, including children and vulnerable adults, should also be considered.
- Risk management does not only involve the prevention of harm, but also the enabling of individuals to make progress in life through decisions and actions that carry degrees of risk.
- Decision-making regarding PRT should be collaborative and consensual, involving all stakeholders and staff involved in the service user's care.

**Guidance for Positive Risk Taking:**

1. Discuss aspects of PRT within the care plan with the service user and/or carer (if possible and appropriate).

2. Wherever practical arrange a Multi-Disciplinary Team (MDT) discussion for shared-decision-making.

   (If time constraints prevent this, individual practitioners should make all efforts to discuss the issue with other staff.)

**At the Meeting:**

3. Encourage openness about the fears and concerns of both staff and service users/carers.
4. Generate a clear formulation of the 'problem' that takes into account both staff and service users/carers understanding and experience.

Useful Questions to ask might include:

- What has been tried before and what was learned from this?
- Is the service user's understanding of the risk different to that of the carers or practitioners?
- What are the anticipated benefits/desired outcomes of the proposed PRT intervention?
- What are the main risks of the proposed PRT intervention and how likely are these?
- What are the service user's strengths (personal qualities, resources, motivation etc) that support pursuit of the proposed PRT intervention?

5. Generate appropriate options taking into account service user's/carer's views and share the decisions made.

6. Identify indicators that show when the PRT intervention is not working, and agree a contingency plan which can be implemented quickly should the PRT intervention be unsuccessful.

7. If there is very high risk of serious harm (e.g. self-harm/suicide/violence and aggression to others) associated with the PRT intervention, or where there are differences of opinion within the professional team, consider holding a professionals meeting (including invited experts from elsewhere within the Trust) to review the proposed PRT intervention.

8. Generate and document a clear rationale for the decision on PARIS (noting when the discussion took place, and who was present).

9. Identify the criteria by which you will measure the success of the PRT intervention.

10. Update the Salford Tool for the Assessment of Risk (STAR) or other appropriate risk documentation and the care plan.

After the Meeting:

11. Share the decision with relevant team members/other agencies and discuss the outcome with the service user/carer (providing copies of the PRT and contingency plan as appropriate).

12. Schedule regular reviews of the progress of PRT outcomes, reflect and share learning.


Professional Advisory Group, April (2011)