Cheshire and Wirral Partnership NHS
NHS Foundation Trust

Document level: Trustwide (TW)
Code: CP5
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Clinical risk assessment policy

Lead executive	Medical Director Compliance, Quality & Assurance
Author and contact number	Medical Director - 01244 397434

Type of document	Policy
Target audience	All clinical staff working in mental health, learning disability, CAMHS, and drug and alcohol services.
Document purpose	To provide a framework, including principles of best practice and positive risk taking, for all staff with a duty to assess and manage clinical risk, to ensure a thorough and consistent high standard of assessment to aid service user's recovery.

Document consultation	Clinical risk assessment rapid improvement task and finish group	
Approving meeting	Patient Safety & Effectiveness Sub Committee	10-Dec-12
Ratification	Document Quality Group (DQG)	10-Dec-12
Original issue date	Nov-07	
Implementation date	Dec-12	

CWP documents to be read in conjunction with	HR6	Trust-wide learning and development requirements including the training needs analysis (TNA)
	CP42	Care Programme Approach Policy
	FR1	Integrated governance Strategy
	CP35	Physical health pathway and policy
	CP14	Prevention and management of slips, trips and falls

Training requirements	There is specific training requirements for this document and is in accordance with CWP Training Needs Analysis.

Financial resource implications	No

Equality Impact Assessment (EIA)

Initial assessment	Yes/No	Comments
Does this document affect one group less or more favourably than another on the basis of:		
• Race	No	
• Ethnic origins (including gypsies and travellers)	No	
• Nationality	No	
• Gender	No	
• Culture	No	
• Religion or belief	No	
• Sexual orientation including lesbian, gay and bisexual people	No	
• Age	No	
• Disability - learning disabilities, physical disability, sensory impairment and mental health problems	No	
Is there any evidence that some groups are affected differently?	No	
If you have identified potential discrimination, are there any exceptions valid, legal and/or justifiable?		
N/A		
Is the impact of the document likely to be negative?	No	

• If so can the impact be avoided?	N/A	
• What alternatives are there to achieving the document without the impact? • Can we reduce the impact by taking different action?	N/A N/A	
Where an adverse or negative impact on equality group(s) has been identified during the initial screening process a full EIA assessment should be conducted.		

If you have identified a potential discriminatory impact of this procedural document, please refer it to the human resource department together with any suggestions as to the action required to avoid / reduce this impact.

For advice in respect of answering the above questions, please contact the human resource department.

Was a full impact assessment required?	No	
What is the level of impact?	Low	

Document change history

Changes made with rationale and impact on practice
1. Change to be 4 stages of CARSO 2. CARSO Flowchart wording updated

External references

References
1. Barker, P.J. (1997). Assessment in Psychiatric and Mental Health Nursing, Stanley Thomas, Cheltenham. 2. Department of Health (2007, (1)) Independence, choice and risk: a guide to best practice in supported decision making, Department of Health, London. 3. Department of Health (2007, (2)) Best Practice in Managing Risk, Department of Health, London. 4. Department of Health (2008) Refocusing the Care Programme Approach; Principles and Positive Practice Guidance, Department of Health, London 5. Monahan J. (1981). The clinical prediction of violence. Sage publications, Beverley Hills, CA. 6. National Institute for Mental Health in England, (2003). Case for Change. Department of Health, London. 7. Rapp, C.A. (1998). The Strengths Model. Case management with people suffering from severe and persistent mental illness. Oxford University Press, New York 8. Repper, J. and Perkins, R. (2003). Social inclusion and recovery, 'a model for mental health practice', Bailliere Tindall, London. 9. Simpson, A., Miller, C. and Bowers, L. (2003). Case Management Models and the Care programme Approach. How to make the CPA effective and credible. Journal of Psychiatric Mental Health Nursing, 10, pp. 472-483. 10. Webster, C. (1995). The HCR-20 Scheme. The assessment of dangerousness and risk. Simon Fraser, University of British Columbia, CA.

Monitoring compliance with the processes outlined within this document

Please state how this document will be monitored. If the document is linked to the NHSLA accreditation process, please complete the monitoring section below.				NHSLA Standards 6.3 - Clinical Risk Assessment		
Minimum requirement to be monitored NB the standards in bold below are assessed at level 2/3 NHSLA accreditation	Process for monitoring e.g. audit	Responsible individual / group	Frequency of monitoring	Responsible individual / group for review of results	Responsible individual / group / for development of action plan	Responsible individual / group for monitoring of action plan and Implementation
Duties	Duties will be reviewed as part of the update of the policy and will take account of changing roles, organisational structure and tasks	Medical Director	When changes to the policy are made due to guidance or organisational change	PSESC	Medical Director	PSESC
How the organisation trains staff in line with the training needs analysis	**Report**	**L&D Manager as part of Mandatory training reports.**	**Four times a year**	**WODSC**	**WODSC**	**WODSC**
Tools and processes authorised for use within the organisation, including timescales for use	**Report**	**Research & Effectiveness manager to ensure list of risk assessment tools are kept up to date.**	**Four times a year**	**PSESC**	**PSESC**	**PSESC**
How clinical risk assessments are reviewed including timescales (pilot)	Audit/ Inpatient Safety Metrics	Clinical Audit Team & Clinical Governance Department	At least once per year	PSESC	PSESC	PSESC
How the organisation monitors compliance with all of the above	As above	As above	As above	As above	As above	As above

Patient Safety & Effectiveness Sub Committee (PSESC)
Workforce & Organisational Development Sub Committee (WODSC)

Content

1. Introduction

The management of clinical risk is a key Trust responsibility, and is an ongoing process involving and identifying the potential for harm to service users, staff and the public. Whilst risk can never be eliminated, the role of the organisation is to ensure service users' risks are assessed and managed to safeguard their health and well-being. This policy relates to the use of clinical risk assessments of mental health, as defined below.

Fear of supporting people to take reasonable risks in their daily lives can prevent them from doing things that most people take for granted. What needs to be considered is the consequence of an action and the likelihood of any harm from it (Department of Health, 2007 (1)).

The Trust expects that all health and social care staff involved in the management and delivery of clinical assessment of service users, in what ever capacity, are trained how to undertake clinical assessments of risk, to develop and promote risk management plans relevant to those findings and to communicate their findings and recommendations to all relevant people. Such skills form the foundation of core professional competences to support comprehensive clinical decision making and deliver evidence based practice.

By involving service users and/ or their carers, practitioners can develop a culture of support and learning which concentrates on positive risk taking and the recovery of the service user (NIMHE, 2003).

2. Definition

Clinical risk is defined as:

The potential for the occurrence of harm with respect to self harm or attempted suicide, violence, serious neglect of self or dependents, abuse and exploitation of or by others (including sexual abuse, emotional and child abuse) (Webster, 1995).

It is the possibility of beneficial as well as harmful outcomes in a dynamic social environment where continuous change and uncertainty are present.

Clinical risk assessment and management is *the systematic process of collecting detailed clinical information about the service user's clinical history and current clinical presentation to allow for a professional judgement to be made identifying whether the service user is at risk of harming themselves or others.*

Department of Health guidance (2008) indicates that all service users should receive an assessment, which includes the assessment of clinical risk.

Clinical risk assessment supports the process of making a clinical judgement to determine the level of potential risk (Monahan, 1981) posed by or to the service user to themselves or others, including practitioners across services.

3. Purpose

This policy is based on the belief that service users should expect that their clinical risk will be appropriately assessed and managed to aid their recovery (Repper and Perkins 2003) within a framework which ensures a thorough and consistent high standard of assessment (Barker, 1997).

This will be achieved through following principles of best practice (Department of Health, 2007).

3.1 Principles of best practice (Department of Health, 2007(2))

- Best practice involves making decisions based on knowledge of the research evidence, knowledge of the individual service user and their social context, knowledge of the service user's own experience, and clinical judgement;
- Positive risk management as part of a carefully constructed plan is a required competence for all mental health practitioners;

- Risk management should be conducted in a spirit of collaboration and based on a relationship between the service user and their carers that is as trusting as possible;
- Risk management must be built on recognition of the service user's strengths and should emphasise recovery;
- Risk management requires an organisational strategy as well as efforts by the individual practitioner;
- Risk management involves developing flexible strategies aimed at preventing any negative event from occurring or, if this is not possible, minimising the harm caused;
- Risk management should take into account that risk can be both general and specific, and that good management can reduce and prevent harm;
- Knowledge and understanding of mental health legislation is an important component of risk management;
- The risk management plan should include a summary of all relevant risks identified, formulations of the situations in which identified risks may occur, and actions to be taken by practitioners and the service user in response to crisis;
- Risk assessment is integral to deciding on the most appropriate level of risk management and the right kind of intervention for a service user;
- All staff involved in risk management must be capable of demonstrating sensitivity and competence in relation to diversity in race, faith, age, gender, disability and sexual orientation;
- Risk management must always be based on awareness of the capacity for the service user's risk level to change over time, and recognition that each service user requires a consistent and individualised approach;
- Risk management plans should be developed by multidisciplinary and multi agency teams operating in an open, democratic and transparent culture that embraces reflective practice;
- A risk management plan is only as good as the time and effort put into communicating its findings to others.

3.2 Principles of positive risk management

These principles include, but are not limited to:

- 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.

4. Tools and processes authorised for use within the organisation, including timescales for use

Staff should only use clinical risk assessment tools that have been approved for use within the Trust.

To ensure that this process of assessment is followed, the following approved risk assessment tools detailed in Table 1 should be used.

Table 1: Examples of clinical risk assessment tools approved for use in each clinical service unit within the organisation

Clinical risk assessment tool	Clinical service unit
CARSO	Adult Mental Health (including Primary Care Mental Health)
CARSO	Drug & Alcohol Services CAMHS
Learning Disability Standard Risk Assessment Tool	Learning Disability Services
A suite of physical healthcare assessments to include : FRAT, MUST/STAMP, Waterlow, GCS, Braden etc.	All Clinical Services as appropriate (refer to physical healthcare policy)

Staff must ensure that any identified risks as a result of clinical assessment tools are adequately recorded and used to inform the treatment/care plan.

The management of clinical risk should be a process which includes the service user and / or their carers. It is important to work together in identifying potential clinical risks and implementing an agreed management plan to limit risks and use the service user's own strengths to promote their recovery.

Assessment needs to be individual to the person's own context for behaviour patterns or situational responses. Specific previous history of risk behaviours needs to be described as accurately and as fully as possible. Clinical staff should make use of information that is reasonably available to them and this will vary from service to service and setting to setting. Risk behaviours should be considered in the context of recency, frequency, severity and patterns of behaviour.

The up-to-date full list of all approved clinical risk assessment tools can be found at: http://nww.cwp.nhs.uk/academicunit/assessmenttools/Pages/risk_assessment.aspx

This updated list will be communicated to staff via Trust communications bulletins issued via CWP Essential.

For all new clinical risk assessment tools
The following process must be undertaken to ensure approval:

- If an assessment tool is being considered for use within the Trust, the service must contact Research and Effectiveness Manager for advice and guidance with regard to utility, validity, reliability, training, copyright and access issues;
- Individuals must complete the approval form at the attached link http://nww.cwp.nhs.uk/academicunit/assessmenttools/Lists/Register%20a%20tool%20to%20be%20approved/NewForm.aspx and submit to Patient Safety & Effectiveness Sub Committee (PSESC) to be included on the next meeting agenda;
- The individual/service representative must attend the PSESC meeting to present the tool and answer any queries from the Sub Committee members;
- If the tool is approved, the list of assessment tools for use within the Trust is updated and staff informed via CWP Essential.

Staff must ensure that any identified risks as a result of clinical assessment tools are adequately recorded and used to inform the treatment/care plan.

The management of clinical risk should be a process which includes the service user and / or their carers. It is important to work together in identifying potential clinical risks and implementing an agreed management plan to limit risks and use the service user's own strengths to promote their recovery.

Assessment needs to be individual to the person's own context for behaviour patterns or situational responses. Specific previous history of risk behaviours needs to be described as accurately and as fully as possible. Clinical staff should make use of information that is reasonably available to them and this will vary from service to service and setting to setting. Risk behaviours should be considered in the context of recency, frequency, severity and patterns of behaviour.

Clinical risk assessment relating to mental health must be carried out **on first assessment appointment** and findings entered onto the service user's electronic health record. Where key information remains unknown or uncorroborated, this should be noted. Where a risk is identified, a full clinical assessment of risk must be completed **within 5 working days**. An initial risk management plan, reflecting risks must be instigated. Where no clinical risk is identified, either to the service user or to others including children, no further detailed risk assessment will be necessary unless the clinical presentation of the service user changes.

The clinical risk assessment will be carried out by a suitably qualified mental health practitioner or competent practitioner.

Where a service user has been admitted to an inpatient unit within the Trust, a number of physical and mental health risk assessments will be conducted as outlined within the Admission and Physical Health Policy. These risk assessments will be conducted and appropriate management plans developed within 72 hours of admission.

For falls assessments conducted within the community, please refer to the Policy for the management of slips, trips and falls. For CCWC patients please refer to the Physical Health policy which identifies the timeframes for assessments to be conducted.

Clinical assessments of risk and risk management plans
Following completion of the clinical assessment of risk, a care plan which includes risk management needs to be developed. This is the documented evidence to show what action is to be taken to both reduce the level of clinical risk and/ or take positive risks, including what action needs taking in the event of a crisis or emergency arising. Such a plan should identify the responsibilities of the service user and/ or their carers in contributing to the recovery process.

5. How clinical risk assessments are reviewed including timescales

Where no clinical risk is identified, either to the service user or to others including children, no further detailed risk assessment will be necessary unless the clinical presentation of the service user changes and as such the clinical risk assessment would be reviewed..

Care planning documentation including a risk management plan as part of the care plan, for those subject to CPA, must be completed within 4 weeks of acceptance into service. For those subject to standard care a letter must be sent to the GP within 10 working days.

Should a service user's risks/ needs change, an up to date assessment must be carried out and documented. The care plan must also be updated to reflect new risks/ needs. The updated plan must be communicated to the service user, carer (if the service user has given consent), GP and other professionals involved in the service user's care.

Where a service user has been admitted to an inpatient unit within the Trust, a number of physical and mental health risk assessments will be conducted and reviewed as outlined within the Admission and Physical Health Policy.

For falls assessments conducted within the community, please refer to the Policy for the management of slips, trips and falls for guidance regarding review. For CCWC patients please refer to the Physical Health policy which identifies the timeframes for assessments to be conducted.

Where a service user's only contact with the Trust is within an outpatient clinic, a full Mental State Examination undertaken by a member of medical staff that includes the assessment of clinical risk should be recorded clearly and explicitly in the healthcare record. This will constitute an appropriate clinical risk assessment having been undertaken.

Guidance for the use of **CARSO** is outlined in appendix 2.

Guidance for the **use of the Learning Disability Standard Risk Assessment Tool** is outlined in appendix 3.

5.1 Scope of clinical risk assessment

No clinical risk assessment or management plan will completely eradicate clinical risks. The intention is to reduce the risks as far as is practical and support risk taking to aid recovery so that service users can live autonomously and safely in their communities during their recovery period until such time they are discharged from service.

Clinical risk can manifest in many forms. It is dynamic and changes continuously and is therefore not a steady state of mind. Predicting risk (Webster, 1995) is not an exact science but is more accurate when the service user's clinical history is known. For further guidance see appendix 1.

5.2 Positive risk taking

In all instances where positive risk taking may benefit the recovery of the service user, a care plan outlining the positive risk-taking actions will be discussed and agreed with the service user.

Principles of positive risk taking are outlined in part 3.2

5.3 Process for ensuring a continual, systematic approach to clinical risk assessments is followed throughout the organisation, including assignment of management responsibility for different levels of clinical risk in the organisation

It will be the responsibility of the lead professional or care co-ordinator to ensure a continual and systematic approach to clinical risk assessment and management. This judgment will be based on the context of the service user's clinical presentation and their response to treatment.

A review of the service user's clinical risk assessment may be conducted at any time and anyone involved with the service user can request a review. In the event of any dispute concerning the clinical risks identified, the matter must be brought to the attention of the clinical line manager for resolution.

Where service users have enduring and chronic mental health problems which results in a period of extended care beyond three months, it will be a requirement for the lead professional or CPA Care Co-ordinator to undertake clinical risk assessment review at annual intervals as a minimum in accordance Care Programme Approach (CPA) Policy, or more frequently if the service user's circumstances change.

Specifically, a review of the clinical risk assessment will take place on contact with the service user following the circumstances listed below:

- Admission, discharge or leave from service;
- At a point of referral and transfer between services;
- Change of nominated practitioner responsible for service user care i.e. care coordinator;
- Significant event, i.e. suicide attempt, non-compliance with treatment, loss of contact with service;
- Mental health deterioration/ change in mental state;
- Change in legal status of the service user;
- Change in treatment plan, medication etc;
- Increased hostility to others;
- CPA or other reviews.

Any change to the clinical risk assessment must be reflected in the care plan.

All service users will have their clinical risk assessment reviewed prior to discharge / transfer or leave from service, the outcomes of which must contribute to the discharge / leave decision. Where a clinical risk continues to exist this must be clearly documented in the care plan and arrangements put in place to minimise this risk.

Good practice dictates that a review of inpatient risk occurs prior to each approved leave. This is recorded electronically to enable supporting community teams to have up to date information.

6. How the organisation trains staff, in line with the training needs analysis

All clinical staff as appropriate must complete the Clinical Risk assessment training as outlined within the Trust's Training needs analysis derailed within mandatory employee learning policy.

7. Duties and Responsibilities

7.1 Chief Executive

As accountable officer, the Chief Executive must ensure that responsibility regarding clinical risk assessments for service users accessing mental health, drug and alcohol, CAMHS, and learning disability services is delegated to an appropriate executive lead, as outlined in the executive portfolios.

7.2 Medical Director – Compliance, Quality & Assurance

The Medical Director – Compliance, Quality & Assurance, is responsible for ensuring there is an appropriate and effective clinical governance system in place with regard to clinical risk assessments and their use within the Trust, through ensuring review, update and implementation of this policy.

7.3 Clinical Directors

Clinical Directors are responsible for approving clinical service unit specific clinical risk assessment tools through their local clinical service unit governance structures, upon receipt of assurance that they are part of approved pathways of clinical care. They are responsible for ensuring that those approved tools identified as having a cost or copyright implication should be appropriately resourced.

7.4 Ward Managers/ Line Managers

Ward Managers and Line Managers are responsible for:

- Ensuring clinical risk assessments are carried out for all service users on first contact with the service;
- Ensuring that the outcome of the risk assessment is documented in the health record;
- Ensuring that the clinical risk assessment is reviewed as appropriate in response to changes relating to the service user;
- Ensuring that staff are enabled and complete mandatory training requirements to ensure that staff are competent in clinical risk assessment and management of clinical risk, including the use of approved clinical risk assessment tools.

7.5 Clinical staff

Clinical staff are responsible for completing mandatory training requirements related to this policy, as per the Trust's training needs analysis. They should only use the tools authorised for use within the Trust.

7.6 Qualified Practitioner / Lead Professional / Care Programme Approach Co-ordinator

This may be a doctor, nurse, social worker, psychologist or occupational therapist. They are responsible for:

- Completing the clinical risk assessment on first contact with the service;
- Developing a risk management plan in response to the risk assessment;
- Undertaking a full clinical risk assessment if risk are identified following initial clinical risk assessment;
- Reviewing the risk assessment in response to a change relating to the service user;

- Communicating the updated risk assessment to the relevant professionals;
- Informing their Line Manager if a dispute arises in relation to a judgment made about the clinical risk assessment;
- Ensuring the clinical risk assessment is reviewed on discharge or transfer from the service.
- Completing mandatory training requirements relating to clinical risk assessment training.

7.7 Learning and Development Manager

- The learning and development manager is responsible for reporting on training in relation to clinical risk assessment in accordance with the Trust Training Needs Analysis. Reporting is at least 4 times per year to the Workforce and Organisational Development Sub Committee (WODSC).

7.8 Research & Effectiveness Manager

The Research and Effectiveness Manager is responsible for:

- Providing advice and guidance with regard to utility, validity, reliability, training, copyright and access issues related to clinical risk assessment tools;
- Maintaining a register of all assessment tools clinical risk assessment tools;
- Complete a report once per year to PSESC detailing those tools / processes authorised for use within the organisation.

7.9 Clinical audit team / clinical governance department

- Clinical audit team / clinical governance department responsible for auditing the review of clinical risk assessments and reporting this to the PSESC.

7.10 Patient Safety and Effectiveness Sub Committee (PSESC)

- The PSESC is responsible for approving this policy, its ongoing review (including review of duties) and receiving reports on the monitoring of this policy, through receipt of reports, work plans and action plans as detailed in this policy. It is also responsible for approving the generic clinical risk assessment tools for use in each clinical service unit, as per Table 1, and receiving the a report once per year detailing those tools/ processes authorised for use within the organisation. The PSESC also receives audit results from reviews of clinical risk assessments.

7.11 Workforce and Organisational Development Sub Committee (WODSC)

- WODSC is responsible for receiving a report four times per year from the Learning & Development Manager on compliance with mandatory training requirements, including training associated with this policy.

8. Acknowledgements

Lincolnshire Partnership NHS Foundation Trust
Clinical Risk Assessment and Management November 2009

West London Mental Health Trust
Clinical Risk Policy November 2010

Worcester Partnership NHS Trust
Clinical Risk Assessment Policy 2010

Appendix 1 - Factors to consider when undertaking a clinical risk assessment

Recency of risk (how recent)
Both previous and most recent incidents must be considered when assessing risk, the more recent the incident, the greater the potential risk.

Frequency of risk
The more frequent the incident, the greater the potential risk 'frequency' of risk can help to inform early warning signs, trigger factors and patterns.

Severity of risk
The seriousness of an incident should be considered within the context that it occurred e.g.

- Known trigger factors, patterns and past behaviour;
- Use of alcohol – resulting in a change in behaviour;
- Is there active symptoms of an organic/ functional illness;
- Evidence / expression / thoughts of planned intent to 'harm / injure' self / others;
- 'Discovery avoidance';
- Provisions made for events after death;
- Method and previous methods (weapons, objects, instruments etc);
- Indication of the individual's thinking in relation to the risk;
- Recent significant life events;
- Physical illness, disability and chronic pain;
- Cognitive or memory impairment of either a deteriorating and or fluctuating nature.

Suicide risk

- Previous attempts on their life;
- Previous use of violent methods;
- Major psychiatric diagnosis;
- Major physical illness / disability;
- Is there suicidal thinking / ideation / intent;
- Is there evidence of depressive features;
- Does the client have the means to attempt suicide;
- Has 'discovery avoidance' been considered;
- Are there provisions for events post-death;
- Is client refusing to eat/ drink/ take medication;
- Is alcohol use combined with suicide method;
- Family history of suicide;
- Is service user socially withdrawn or isolated;
- Recent significant life events;
- Does the client use of alcohol / drugs to excess;
- Separated / widowed / divorced;
- Unemployed / retired;
- Is the person experiencing chronic pain;
- Is there evidence of depressive features;
- Harassment, bullying or exploitation.

Aggression and violence

- Previous incidents of violence;
- Previous use of weapons;
- Evidence of weapons on person / at the person's home;
- Known personal trigger factors;
- Expressing intent to harm others;
- Previous dangerous impulsive acts;
- Presence of forensic history;

- Admissions to secure settings;
- Denial of previous dangerous acts;
- Paranoid delusions about others;
- Violent command hallucinations;
- Signs of anger and frustration;
- Sexually disinhibited and inappropriate behaviour;
- Preoccupation with violent fantasy;
- Misuse of drugs and / or alcohol;
- Arson (deliberate fire setting only);
- Other factors.

Self neglect and vulnerability

- Previous history of neglect;
- Failing to eat/ drink properly;
- Failing to engage/ comply with treatment;
- Difficulty managing physical health or hygiene;
- Difficulty communicating needs;
- Unable to shop for self;
- Insufficient/ inappropriate clothing;
- Does the service user have continence issues?
- Living in inadequate accommodation;
- Lacking basic amenities;
- Pressure of eviction/ repossession;
- Experiencing financial difficulties;
- Denies problems perceived by others;
- Is service user confused or disoriented;
- Is the client's memory impaired?
- Is the client prone to wandering?
- Is client prone to accidental injury?
- Lives alone;
- Lacks social contacts;
- Stated abuse / harassment by others;
- Stated exploitation by others;
- History of adult protection issues;
- Known cognitive impairment.

Other risks

- Culturally isolated situation;
- Risks to and from children. For example; service users who may be a direct risk to children or the potential detrimental effect from parental mental illness, or the effect that contact with children may have on service users mental health;
- Accidental fire risk;
- Other damage to property;
- Sexual offence (e.g. exposure);
- Sexual safety and vulnerability;
- Degree of learning disability, communication difficulties, epilepsy, diagnosed condition or syndromes;
- History of childhood abuse or neglect.

Appendix 2 - Guidance notes for Clinical Assessment of Risks to Self & Others (CARSO)

(Adapted with permission from CARDS, a tool developed by PriSM (Section of Community Psychiatry), Health Services Research Department, Institute of Psychiatry, London).

Guidance is also available on the electronic patient record.

What is CARSO?
The Clinical Assessment of Risks to Self and Others is a clinical decision support tool to aid practitioners in their assessment and management of the risk of both intentional and unintentional harm to self and harm to others in adults of working age using mental health services. It is intended to support and not replace clinical judgement.

CARSO comprises of a single-page form called CARSO Summarised View of Risk, located in the Risk/Alerts section/tab on the electronic patient record.

For information about frequently asked questions please go to the electronic patient record.

What is the purpose of the assessment?
The goal of this assessment is to inform the care planning process, to improve quality of care and to meet requirements for good clinical practice. It is not intended to assign a numerical value to the level of risk.

Who can complete this assessment?
Mental health practitioners who work in mental health services and who have been locally identified as competent to undertake full initial assessments can complete the assessment. It can also be used as a resource (e.g. for training, for education or for actual use) in other settings and by other agencies. Some assessments will involve more than one mental health practitioner.

Who should be assessed?
CARSO is designed for use with individuals seen by adult mental health services, including community, in-patient and psychiatric intensive care services.

When is the CARSO completed and reviewed?
The CARSO is suitable for use when an individual enters the service either by referral or transfer. The CARSO should be reviewed / re-planned for all patients who have previously received a risk assessment, or whenever there is new clinical cause for concern (e.g. on admission to hospital or other intensive treatment service, prior to hospital discharge, on carer report of concern, prior to CPA review).

How do I complete the assessment?
A CARSO summarised view of risk form is completed considering all the factors in appendix 1:

- Update the care plan on local care plan forms, circulate appropriately, and ensure that the completed CARSO is placed in the clinical notes.

CARSO Assessment Guidelines (for risk of harm to others)
Purpose: These guidelines provide headings you may wish to consider in structuring your clinical assessment. They are not intended to be prescriptive.

History

- Any history of harm to others e.g. violence? Is there any forensic history not involving violence?
- Are there patterns to previous harm to others (e.g. similar antecedents, known triggers)?
- Who was the victim? Why did it happen? Was the individual provoked? In what way?
- Was drug/alcohol use involved? Is this still present?
- Were the police involved? Did it lead to a criminal conviction?

- Has there been experience of violence in childhood?
- Have there been periods of disengagement or social instability?

Current thinking and behaviour

- Are there symptoms which appear (for this person) to be related to their risk of harming others?
- If so, are they becoming more severe?
- Does the individual perceive him/herself to be a risk to others?
- Are violent thoughts or plans being expressed?
- Is behaviour hostile or threatening or impulsive?

Contextual issues

- Are support networks to reduce risk currently operating?
- Is harm to others including violence & aggression common amongst this person's peer group?
- Have there been frequent moves between accommodation, or periods of homelessness?
- Are potential or threatened victims available (including children)?
- What stressors exist in the immediate environment?
- What would characterise a typical high risk or low risk situation for this person?

Service user's view of risk

- What does the service user feel has helped in the past
- Is he/she worried about the possibility of harming someone?
- Is he/she aware of triggers that may provoke them to intentional or unintentionally harm others?

Protective factors

- What is currently making harm to others less likely to occur? What has worked in the past?
- Is there or has there been an effective therapeutic alliance?
- What strengths, skills, beliefs or attributes can be built on?

Service aspects

- Is the service viewed as oppressive?
- Do the assessor and person being assessed have shared goals and expectations?
- Is treatment being given against the person's will?
- What interventions have worked in the past? E.g. has a move to a different environment helped?

Carer's view of risk

- Do carers think there is a problem?
- What is their report of past harm to others including violence? Who to, in what way, how severe was it?
- What has helped in the past?
- Is the situation deteriorating?

Document all new clinical assessment information in the clinical records.

CARSO Assessment Guidelines (for risk of harm to self)

Purpose: These guidelines provide headings you may wish to consider in structuring your clinical assessment. They are not intended to be prescriptive.

History

- Any history of suicidal behaviour or DSH? (Whether or not medical help sought);
- Any history of unintentional harm to self? E.g. self-neglect / environmental dangers;

- Are there patterns to previous suicidal behaviour and / or DSH (similar antecedents / triggers) / or to unintentional self-harm?
- For previous incidents particularly most recent: Why did it happen? Was the person feeling depressed? Angry? Problems with physical health? Provoked in any way?
- Was drug (street / prescribed / over the counter) or alcohol misuse involved? Still present?
- Circumstances surrounding harm to self incident? Efforts made to conceal it? What was the person hoping to achieve (e.g. certain death /temporary relief from emotional distress)?
- Was help sought? e.g. 999 / A&E / Crisis Team / Samaritans / NHS Direct / EDT involved? At what stage in the incident – e.g. during? After, who contacted them?
- Has there been experience of suicidal behaviour (or violence & / or abuse) in childhood or in current family / social situation (e.g. loss of relative/partner through suicide)?
- Have there been periods of disengagement or social instability e.g. homelessness?

Current thinking and behaviour

- Are there symptoms which appear (for this person) to be related to risk of harm to self (consider re self –neglect and unintentional self-harm as well suicidality and / or DSH)?
- If so, are they becoming more severe?
- Does the individual perceive him/herself to be a risk to themselves in any way?
- Are suicidal or self-destructive thoughts or plans being expressed?
- Is their behaviour currently or increasingly dangerous to their physical or psychological safety?
- Any specific plans for suicide or DSH? How far have these been carried out?
- What measures have been taken or will be to prevent detection?
- How does the service user see the future? Is hopelessness evident?
- Does s/he currently wish to be dead?
- Is impulsive behaviour currently a problem or risk for the person?

Contextual issues

- What if any support networks to reduce risk currently operating?
- Is suicide and/or self-harm common amongst this person's peer/ethnic / occupation group / life situation e.g. recently divorced or estranged men / prisoners / their gender etc?
- Have there been frequent moves between accommodation, and periods of homelessness?
- Are there any potential or threatened victims the person might harm, prior to, during, or as a consequence of, their own suicide? (e.g. children / ex- or current partners / elderly and / or dependent relatives) Would this be harm be motivated by hostility, or instead by a pact to take others with them? How would they plan their method for carrying this out?
- Are there any potential victims whose safety might be inadvertently at risk if the person were to attempt to kill or harm themselves? (e.g. children / dependent or vulnerable adults / general public);
- What stressors exist in the person's immediate environment?
- What would characterise a typical high or low risk situation for this person?

Service user's view of risk

- What does the service user feel has helped in the past?
- Is he/she worried about the possibility of deliberately or accidentally harming themselves or of killing him/herself?
- Is he/she worried about the possibility of harming someone else (either a known or anonymous person) either deliberately or accidentally?
- Is he/she aware of triggers that provoke self-harming and/or suicidal behaviour?
- What would make suicide (or self-harm) more likely to occur? E.g. some forthcoming event/ a 'final straw';
- What would make suicide (or self-harm) less likely to occur?

Protective factors

- What is currently making suicide (or self-harm) less likely to occur? What has helped in the past?
- Is there, or has there been, an effective therapeutic alliance?
- What strengths, skills, beliefs or attributes can be built on?

Service aspects

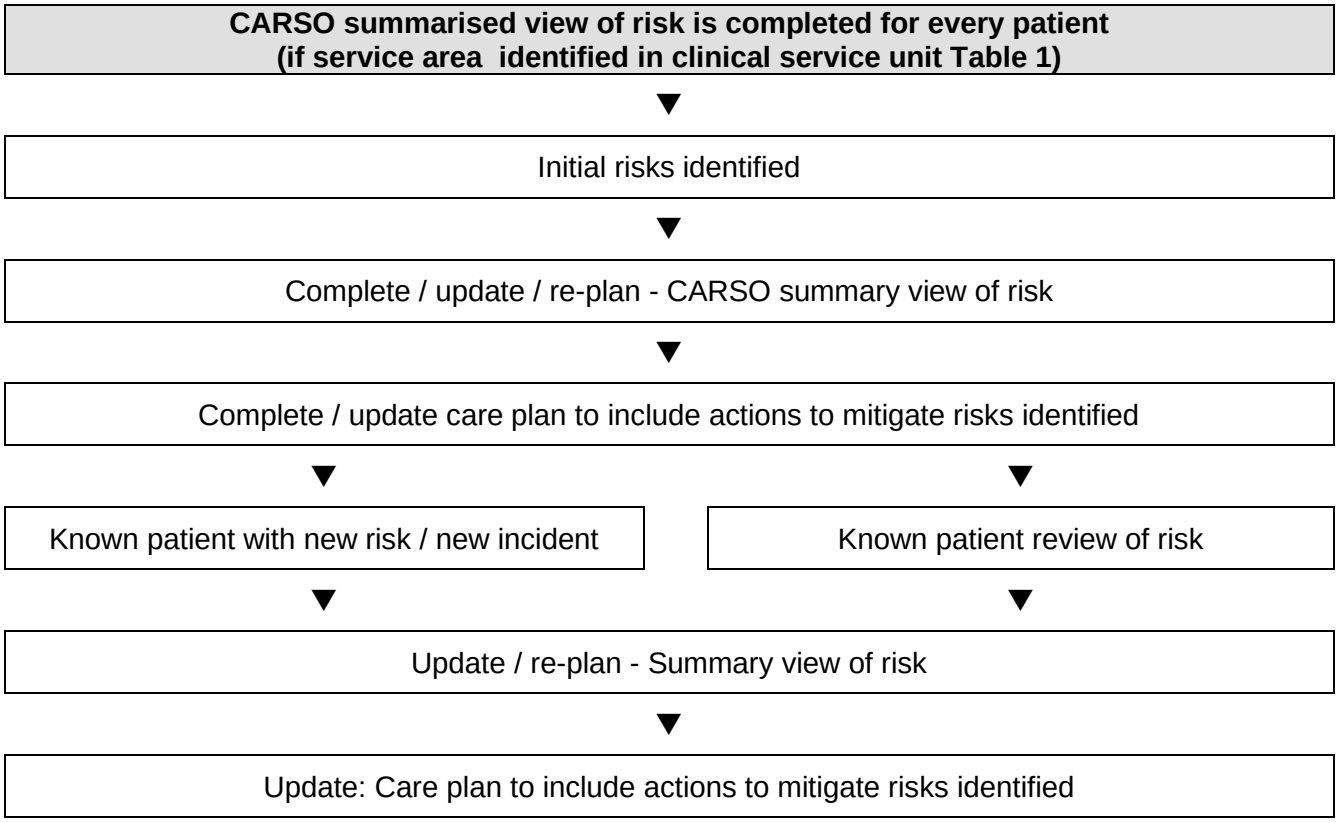
- Is the service viewed as oppressive, uncaring and / or punitive?
- Do the assessor and person being assessed have shared goals and expectations?
- Is any treatment being given against the person's will?
- What interventions and support have worked in the past? E.g. has a move to a different environment helped?

Carer's/Significant Others' view of risk

- Do carers / family / partners / friends think there is a problem?
- What is their report of past DSH and/or past suicide attempts? When? In what way? Where? How severe and life-threatening was it?
- What has helped in the past?
- Is the situation deteriorating?

Document all new clinical assessment information in the clinical records.

CARSO flowchart



Appendix 3 - Learning disability (LD) risk assessments

- All service users who are referred to the learning disabilities service will have a risk assessment completed as part of the initial assessment;
- Following acceptance to service the decision will be made to either place the service user on CPA or Standard Care;
- For those on Standard Care, a LD Standard Risk Assessment will be completed and reviewed at least annually. This risk assessment covers all risk categories allowing for comments to be written where required. If, when completing this risk assessment, it is found that there are greater risk concerns then staff should take back to the team and think about the need for a more in depth risk assessment, and consider completing the LD CPA Risk Assessment;
- For those on CPA, the LD CPA Risk Assessment will be completed and reviewed at each CPA review. This is a full risk assessment that details both current and historical risks together with how these risks may present and who they may affect. The risk assessment also contains a risk management plan and highlights responses to risk that have proved successful in the past or have reduced risk levels;
- If the service user presents with a specific high risk i.e. Arson then the staff will have the option of completing a LD level 4 Risk Assessment which is used for individual risks and is reviewed at each CPA review. This risk assessment requires research into historical risk before completing the form.

The learning disabilities service will also use the HCR20 and SVR20 for those service users who require forensic risk assessment.