Harm Minimisation (clinical risk assessment and management) Policy: redacted version

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Contents

1 Introduction

The prime purpose (mission) of our Trust is to minimise the impact of mental illness and learning disability. In order to do this we have to both keep people safe and help them to find their own route to recovery and wellbeing. This involves working to minimise the risks of sometimes multiple and conflicting potential harms to both service users and other people. This is not always easy and this policy has been written to help you work through this process with your teams and the service users you work with.

There are a number of frameworks that underpin how we assess risk and minimize harm. These include:

- How trauma can have an impact on the people we work with and ourselves.
- How the recovery and wellbeing approach underpins our support for people to live lives that are fulfilling and meaningful but also supports us to think about how best to ensure their safety
- The ways that services have the potential to both help and exacerbate (or even create) harm for people we work with.
- The Human Rights of the people involved.

This has to be balanced with a clear understanding of how we work together to step in and work proactively when someone is not able to keep themselves safe. This can often lead to dilemmas for staff. It is therefore important to include perspectives of the person, people who care about them and the whole multidisciplinary team in conversations. It is essential to consider the Human Rights Act (1998) in these discussions and to clearly document the decision making process and who was involved.

The Trust Board recognises that risk assessment and management, including positive risk taking, is an integral part of good clinical practice. For this to be most effective, it should be part of the culture of the Trust. The Board is committed to ensuring that responsibility for implementation is accepted at all levels in the organisation.

2 Why we need this policy

Policy aims:

- To provide clinical teams with the support and guidance that will enable them to make well considered decisions with service users (and families and carers where appropriate) about the risk of potential harm/s for them and others.

- To ensure that clinical teams understand the need to demonstrate the rationale and clinical judgement by which decisions were arrived at and how the potential risk of each harm was balanced in that decision making.

- To convey the Trust's appreciation of the challenges faced by service users, families, and clinical teams in situations where issues of potential or actual harms are immediate and need active intervention or are ongoing over a long period of time.

3 Scope

3.1 Who this policy applies to

- This policy applies to all employees of the Trust where competency in the practice of clinical risk assessment, formulation and management is required to fulfil their role. There are mandatory training requirements for this group of employees.

- Other employees of the Trust who have regular contact with service users, their families and carers will need to have an awareness of how risks of harm can be worked with in the care or services they provide.

- Other practitioners who work with service users, their families and carers through partnership agreements, interagency integrated working arrangements, service level agreements, honorary contracts and educational placements should be guided by the principles and standards in this policy.

3.2 Roles and responsibilities

Role	Responsibility
Chief Executive and Trust Board	• Promoting a culture whereby the interrelationship between trauma informed care, personal recovery and wellbeing, and balancing risks of harm in support of that recovery are understood • Ensuring there are effective arrangements for staff to be trained, supervised and supported in the way they assess risk of harm, intervene to manage the risk and demonstrate that process in the clinical record
Director of Nursing and Governance	• Developing, monitoring and reviewing this policy and practice standards • Providing appropriate mandatory foundation training and education to support the standards
Senior Clinical Directors	• Identifying, developing and authorising the most appropriate clinical risk assessment tools and risk management processes in their clinical areas via the

	Service Development Groups (SDGs)
Director of Therapies, Medical Director, Director of Nursing, Chief Operating Officer	• Implementing and monitoring the adherence to this policy in their areas of responsibility • Ensuring that systems and processes are in place and monitored to meet the requirements outlined in this policy • Providing appropriate specialist training and education to support the policy standards including the use of agreed assessment tools • Ensuring that all appropriate employees undertake relevant training with updates as required • Implementing the systems and processes that are in place to monitor compliance with the policy
All employees where competency in clinical risk assessment, formulation and management is required in their role	• Implementing the policy's standards and procedures • Maintaining their individual competence in clinical risk assessment, management and undertaking training as required by their roles
Patient Safety and Clinical Effectiveness Groups	• Ensuring that the services delivered are safe, effective and reflect current approaches to clinical effectiveness, safety and patient experience

4 How to approach clinical risk assessment and harm minimisation

4.1 How to assess the risk of harm/s

4.1.1 The purpose of assessing risk

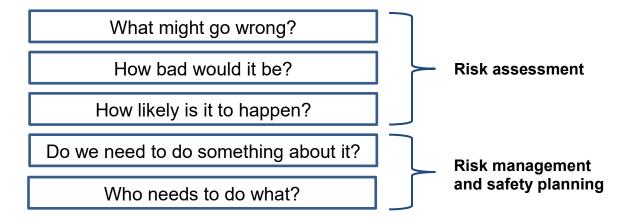> **The purpose of any risk assessment is to support the service user in their recovery and support their wellbeing through minimising the risk of harm to themselves or others. The most effective risk assessments are those that are co-produced and reviewed with service users. We do this most effectively when we have taken time to build trusting and safe relationships both with service users and within teams. This enables**

each person to talk about how they see the balance between potential harm and potential recovery in each situation and how their wellbeing will be affected. Harm does not happen in isolation 'in' an individual. It is created systemically and we can only work effectively to reduce it when compassion, psychological and social safety are evident throughout that system.

4.1.2 How we assess risk

In order to assess the risk of harm and think about how to minimise that harm whilst also supporting someone's wellbeing and recovery, we need to consider these questions:

What might go wrong?	
How bad would it be?	**Risk assessment**
How likely is it to happen?	
Do we need to do something about it?	**Risk management and safety planning**
Who needs to do what?	

Consideration needs to be given as to how the risk assessment is actually completed, a range of methods are available for example face to face, digital or telephone; the service user and the clinician need to be certain that the chosen method of completion is based on risk and need, ensures that all information is accurately shared and that it fully allows for a review of the potential harms.

To respond to these questions we need to understand:

- The context for these potential harms e.g. the environment in which someone lives, their relationships.

- Our own beliefs and how these might impact on what we think is the 'right' thing to do.

- The history of how these harms have been present before/ how they were managed etc.

- What is important to the person and what is of value to them in their life.

- Considering and, wherever possible discussing, the different options available and the pro and cons of each potential decision that might be made and ensuring these are recorded.

- The likely consequences of each decision (positive and negative) and acknowledge that these consequences might be for people other than the service user).

Considering the points above will help you understand *why* the risk of harm exists for this person at this point in time and should increase the likelihood that any intervention will be effective both short and long term.

There are **four broad areas** of potential harm to consider.

These are:

- **Harm to self** can include self-harm, attempts to end own life, self-neglect or indirect / accidental harm to self.

- **Harm from others** can include being subject to physical harm, emotional and psychological harm, sexual harm or exploitation of any type. It can also include harm from services and interventions (both intentional and unintentional.

- H**arm to others**, including physical, emotional or sexual harm, exploitation or neglect of those in their care.

  - **Whenever a child or vulnerable adult is at risk, consideration of a Safeguarding referral <u>must</u> be made.** All considerations must be documented within the care record. Please refer to the Safeguarding Adults Procedure or the Safeguarding Children Policy for further guidance.

- **Other harms** should always include consideration of risk to a person's physical health, as we know that people who experience mental health problems are much more likely to die prematurely from preventable physical health problems than the general population. Staff should refer to the Physical Health and Wellbeing Policy and associated documents. We must also consider relational risks such as the breakdown in either care or support arrangements as well as loss of trust in others or services.

4.1.3 Other considerations

- We know that clinicians typically underestimate the breadth of potential harm compared to the harms a service user might perceive (Sykes, Brabban, & Reilly, 2015) so it is important to think carefully with the service user about these. Harder to define harm may include loss of freedom, privacy, control, self-determination, hope, dignity, confidence, or aspiration. It may also include the loss of opportunity to learn from difficult experiences.

- Both short-term and long term harms, especially the harder to define harms, may only become apparent in the long-term.

- Harm may arise as a result of our interventions, especially if they are not compatible with the person's aspirations and life goals. An example would be adverse effects from medication which may impede the person's ability to live a full and meaningful life. Just as importantly, restrictive interventions such as restraint can be both traumatising and retraumatising. Not returning phone calls or turning up when we said we would can create or perpetuate an experience of rejection.

  - In some cases the decisions the service user wishes to take will develop into an advanced decision making process and we will work with the service user to develop and adhere to advance decisions and statements. (Advance decisions to refuse treatment and statements made in advance Ref CLIN-0011-v6).

When there is a real and immediate risk to human life we must take action. We need to be clear that our response is proportionate and related to these immediate risks, not disproportionately trying to protect the right to life at some point in the future. Our responses should be developed through collective conversations with the person themselves if at all possible. It is important to include multidisciplinary contributions and other support outside the team if needed.

When a team focuses on harm alone, it can lead to a disproportionate response; it is vital to consider the rights that the person has under the Human Rights Act. The two absolute rights that are most relevant are **the right to life and the right to not be tortured or treated in an inhuman or degrading way**. We should hold in mind the right to life does not 'outweigh' the right to be free of inhuman or degrading treatment. A team may need to access extra expert help if decisions were touching on this balance.

If you need further support please contact the Equality, Diversity and Human Rights team on 0191 3336267 or tewv.eandd@nhs.net

4.2 Working together to understand the risks of harm/s

> **Collaborative working is essential to minimise the risk of harm. Staff cannot control all situations where there is a risk of harm and pretending we can is dangerous. We all take risks every day as part of the life we choose and we should not try to remove every risk of harm from someone's life. Whether a risk is worth taking is a complex decision.**

An important principle to consider is that service users have the right to make individual decisions or choices about their own recovery and how to minimise harm to ensure their wellbeing. This includes the right to make decisions that we may not agree with and we should be trying, wherever possible, to reach a shared understanding with service users when judging potential risks of harm and how these should be managed. This involves shared decision making and supporting service users in their own decisions (not ours) to take positive risks when it is safe and appropriate for them to do so. By fully involving service users in risk assessment and management, we minimise the risk of unintended harms being caused.

The Decision Making and Recording Support Tool below can be a helpful framework to make sure that each person who is involved in the decision, including the service user, can have the space to think about the potential impacts. It is particularly useful to use a framework like this when emotions are running high or there is a divide in the approach that is being advocated.

4.2.1 The Decision Making and Recording Tool

POSSIBLE INTERVENTION:	……………………………………………………………………...............			
	Potential Short Term Benefits	**Potential Long Term Benefits**	**Potential Short Term Harms**	**Potential Long Term Harms**
Potential Benefits and Harms of carrying out this intervention:				
Potential benefits and harms of NOT carrying out this intervention:				

Alongside this tool, the principles of the Human Rights Act can be useful to ensure we have come to a balanced and proportionate decision.

Principles to consider:

Facts: What is the experience of the individual? Are they being heard?

Analysis of rights at stake: What are the human rights at stake? Can the rights be restricted? What is the justification for restricting the right? Is the restriction proportionate?

Identify share responsibilities: What could be changed to make it more rights respecting? Who has responsibilities for making changes?

What will be done: be clear about actions, timescales, responsibility, and levels of agreement?

Review Actions: How can the actions taken be recorded and reviewed and has the individual been involved?

4.2.2 Formulation

> **An individualised formulation, produced with and shared with the service user, provides a detailed understanding of potential factors that contribute towards the risk of harms occurring and makes it more likely that effective decision are made about what would be most likely to help.**

A risk formulation provides a framework underpinned by an evidence based theory to help explain the ways in which risks of harms might have developed and remain. It then helps us think together about what is most helpful to do. The key steps in a risk formulation involve professionals working with the service user to:

- Identify, using appropriate clinical risk assessment tools and carefully structured clinical judgment, the most important harms that the service user is experiencing or may experience and the risk of each of those harms occurring. The level of risk will not be the same for each harm or stable over time/ situation.

- Be clear on the factors that are protective in relation to each potential harm. No factors are completely protective or stable.

- The context to the harms is important. There are no inherently 'risky' situations/ factors, they all interplay to create a very individual picture for each person at different points in time.

- Explain how those factors interact with one another to create a risk of harm.

- Describe this formulation in words (a narrative), carefully separating out if necessary where factors in one area (e.g. harm to others) are different from factors in any other area (e.g. harm to self).

Static factors: Factors which do not change. These include historical indicators for example a history of suicide attempts, violence or childhood abuse. Although these factors will always be present, their relevance will vary across individuals and over time.

Dynamic factors: Factors which change over time. Examples of these are: attitude and beliefs, alcohol or substance misuse, and social deprivation.

4.3 Interventions to reduce the risk of harm/s

4.3.1 'Positive risk taking'

> **The Trust supports us working with service users to do things that may carry some risks if this is well (and collaboratively) thought through and supportive of the person's recovery and wellbeing. The Trust also recognises that negative events can still happen even with good quality assessment and safety/care plans.**

One of the most difficult conversations we will be involved in is how to balance protecting someone from harm whilst also enabling them to do things that help them live life to the full. Because this balance can be very complicated and because sometimes the outcome is harmful even when care has been good, it is vital to document the decision making process as well as the final decision. Writing it down ensures that everyone takes time to understand the nuance and has agreed to detail, as well as providing a retrospective record.

It is important to appreciate that something that reduces one harm might increase the risk of another. For example service users tell us that some of the ways we try to support them can also lead to loss of confidence or autonomy, can harm their identity, or lead to loss of hope. Where this has occurred (or might), it is important that this is recognised and documented.

That might lead to a conversation about ''positive risk taking'. The helpful part of this concept is to make us stop and think whether we are preventing someone from doing things that enhance their life but make us nervous. The unhelpful part is where we try to encourage people to do things that they don't want to or are not ready for. We need to balance ensuring the safety of the individual against over-intrusive interventions. This should not be used though to deny people access to the care that they need. This table might be useful to reflect on when a team starts to talk about 'positive risk taking' to ensure that the focus of the conversation remains on the person's own wellbeing and not the service's priorities (Flaherty-Jones & Dexter-Smith, 2019).

Positive risk taking is…	Positive risk taking isn't…
Doing something that you have chosen.	Being made to do something you don't want to do.
Doing something, no matter how small it might seem to you or other people, that feels a bit out of your comfort zone.	Doing something just because it frightens you/ only choosing 'big' things to take on.
Doing what you think is important.	Doing something that someone else thinks is important for you.
Doing something that is very clearly linked to what you want to be	Doing something that has no clear relationship with your personal goals

different.	for growth.
Involving other people – change can be daunting and we all need help.	Being coerced to do something risky while everyone else washes their hands of the situation.

4.4 Documenting and communicating the decisions that have been made

All service users will have their individual identified risks formulated into safety plans and care plans. This will be on the Trust's care record system in accordance with Trust procedures and practice. The agreed Safety/Care Plans will clearly identify which practitioner or service, relative or carer (where appropriate) is responsible for which agreed intervention, including how and when the intervention will be delivered and reviewed. There are also alerts on the electronic patient record system that highlight areas of risk.

Developing and sharing the formulation and safety/care plans with the service user, involved clinical practitioners and significant others involved in the care of the service user significantly lowers the risk. Some aspects of this may need to be sensitively approached e.g. if there is a trauma history. What is shared needs to be necessary and justifiable.

During multidisciplinary/ multi agency reviews it is the lead practitioner's responsibility to ensure that the necessary elements of the assessment, formulation and clinical management (safety) plans are communicated. However, each professional is responsible for assessing and communicating risks that they have noted during their own work and ensuring this is integrated into the safety plan.

We expect that, in most cases, the family and carers will have been involved in discussions while developing the formulation about risk of harms. It is also important to consider what formal information needs to be shared with carers and families through this process. In most cases this will be in agreement with the service user, but in exceptional circumstances the duty to share will override the duty to maintain confidentiality (the Caldicott Principle '*The duty to share information can be as important as the duty to protect service user confidentiality*' is actively supported by the Trust). This must be reviewed on an individual basis by the multi-disciplinary team, considering and documenting the wishes of the service user and the reason why it is believed confidentiality should be breached. Wherever possible that reason should be shared with the service user. Further information can be found in the Trust Patient and Carer Leaflet Common Sense Confidentiality

4.5 Timely reviews

> **The factors affecting risk levels are often dynamic and so risk levels fluctuate. Therefore, assessing the risk of harm and managing those risks to minimise that risk of harm is a continuous, proactive process to be collaboratively undertaken by all involved in the person's care.**

Service users should expect that the risks of clinically related harms will be assessed, formulated and reviewed by competent staff and that this will take place as often as

necessary so that the identified risks can be managed effectively. Risk assessments should be undertaken as clinical need indicates and, as a minimum, with every formal review. Minimum standards for the frequency of review of risk assessments in the community will, at the very least, be annual but should take place whenever the situation changes. In inpatient services it would be envisaged that these reviews would be more frequent and related to the changing needs of patients.

4.6 Support and training

> **All clinical practitioners will have access to training on how to reduce the risk of harm/s. Staff should be reviewing their work with service users on a regular basis within a supervisory setting.**

The Trust is committed to providing basic training in harm minimisation and risk formulation as part of the mandatory training programme. The principles of harm minimisation are also incorporated into other training requirements, including the Positive Approaches Training and Safeguarding.

Core mandatory training will be available to all staff. In addition, SDGs will determine, through their Training Needs Analysis, the precise training needs for staff in their clinical areas.

A key responsibility of staff is to ensure that they regularly discuss risks and harm minimisation within clinical supervision. A record of any supervisory discussion regarding the clinical risk management of a service user should be recorded in the contemporaneous clinical record of that service user (guidance can be found in the Trust Clinical Supervision Policy). All those involved in responding to risk of harm will have knowledge of the legal frameworks that they are working within and where to turn to resolve uncertainties (See section 10).

5   Specific circumstances to consider

5.1 Suicide risk mitigation

Good clinical risk assessment and management has a well-documented role in the prevention of suicide. All clinical practitioners should ensure they are familiar with contemporary information about risk factors associated with suicide for the communities they work with.

[Text redacted]

Recovery-focused practice in Mental Health Services emphasises the need for clinicians to work collaboratively with service-users to identify goals and aspirations, in a way that fosters hope and optimism and recognises an individual's desire to be listened to and respected. Although service-users may present to services at times of crisis and perceived hopelessness, it is important that all staff respond in a manner which promotes the possibility of recovery from the trauma of acute mental ill health

and personal despair. The core values of recovery practices are compatible with addressing the needs of people at risk of suicide. (National Action Alliance for Suicide Prevention: Suicide Attempt Survivors Task Force, 2014) (Specific diagnoses

The principles of the Harm Minimisation framework apply to all people regardless of diagnosis, and we need to take an approach based on the individual. It is important not to be blinded by any labels (diagnosis or other) and instead to retain an individualised understanding of the person we are working with. Our role is to seek to understand the person's distress and work collaboratively with them to find ways to minimize that distress so that the harmful behaviours are able to reduce. The Trust recognises that for some people, deliberate self-harm and/or suicidal thinking is present for long periods of time. Their lifetime risk of death or injury is higher than for other groups and the situations are often complex. Therefore decision making should be inclusive and thoughtful and revisited regularly.

When someone presents with a wide variety of suicidal and self-harm behaviours, these behaviours, thoughts, and feelings need to be separately assessed and described following detailed discussion with the person and clinical record searches. It is important that clinicians understand and document the actual and intended lethality of different behaviours.

[Text redacted]

The guidance that was previously in use, specifically aimed at people who had been diagnosed with 'borderline personality disorder' should no longer be used[1] including the version that had been developed in CYPS. Instead teams should make use of individual formulations, evidence bases relevant to the person's specific situation, and the Decision Support Tool.

More information about the potential harms from diagnosis is available in the appendices.

5.2 Management of behaviour that challenges

A significant clinical risk in mental health and learning disability services is the potential for violent, aggressive and/or behaviour that challenges (NICE, 2015). All clinical practitioners should ensure they are familiar with and knowledgeable about the content and principles of the Trust Person-Centred Behaviour Support Policy as part of their clinical risk assessment and management knowledge and skills. In each specialty there are clinicians with extensive clinical experience who can support teams to think about formulation of risk and potential interventions in these situations.

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[1] Protocol for the reduction of harm associated with suicidal behaviour, deliberate self harm and its treatment (for people with a diagnosis of borderline personality disorder and related conditions), 2014

5.3 Supportive observation and engagement

It is important that staff balance the distressing effect and potential long term harm of being on high level of observations and engagement (e.g. loss of skills, loss of autonomy) against the risk of immediate harm (e.g. serious self-harm or violence). As this will change over time, this balance will need to be continually assessed

Supportive observation and engagement, over and above the lowest level of observations and engagement, is a therapeutic intervention aimed at reducing factors which contribute to increased risk and promoting recovery. It should focus on engaging the person therapeutically and enabling them to address their difficulties constructively.

It is important that staff balance the distressing effect and potential long term harm of being on high level of observations and engagement (e.g. loss of skills, loss of autonomy) against the risk of immediate harm (e.g. serious self-harm or violence). As this will change over time, this balance will need to be continually assessed.

Agency and irregular bank staff should not be used to undertake observation/engagement of service users who are at/ present high risk of harm unless it is clear that they have the relevant skills and knowledge. Before delegating an observation to any member of staff, the Nurse-in-Charge must ensure that the staff member is clear about the reasons why the service user is on supportive observations, the details of the service users safety/care plan(s) and what is expected of them. Full details can be found in the Observation and Engagement - Supportive Observations and Engagement Procedure

It is important that staff clearly articulate and record their decision making so that colleagues working in the next shift/day are able to make decisions as the situation changes.

5.4 Admission, leave and discharge from hospital or transitions between places of care/ home

5.4.1 Admission

The first few days of admission should be recognised as a period of high risk. Careful risk assessment, formulation and safety planning is therefore needed at this time. This should include discussions with service users, family and carers, particularly when people have experienced recent illness onset or previous suicide attempts. Knowledge of recent life events or anniversaries experienced around admission should be incorporated into risk assessments. This should be documented in the safety summary of the care record [Text redacted]

As per the supportive Observation and Engagement Procedure, families and carers can, in certain circumstances, take responsibility for the observation of service users, but this will need to dealt with on an individual basis and the decision making process clearly documented in the clinical record. It is also very important that there is very

clear guidance for the family/ carer about what is expected of them and discussion about whether this is feasible.

Careful planning and consideration is required prior to agreeing to and going on leave from the ward. The current status of leave and the intervention plan should form part of the leave intervention section of the Safety Plan. Immediately prior to leave being taken, the person's mental state should be examined to ensure there are no concerns regarding leave taking place and recorded in the electronic record at the earliest opportunity. (For clarity, the term 'leave' in this context refers to both Leave of Absence from Hospital (for detained patients, and requiring a valid section 17 form) and time off the ward for an informal patient).

5.4.2 Discharge

[Text redacted]

Careful planning is therefore always required whenever anyone is discharged from hospital. Everyone should receive a follow up within 72 hours of discharge from hospital.

Crisis and crisis resolution home treatment (CRHT) teams have an important role to play in helping to reduce the risk of harms during this period. An integral role of the CRHT team is to facilitate discharge from acute Inpatient wards for service-users who continue to experience distress, but no longer require continued hospitalisation. Intensive Home Treatment (IHT)/ community support may be beneficial, including joint working with community intervention teams and other relevant teams along with the provision of a follow up within 72 hours in line with national guidance. CRHT's have a responsibility to attend ward report out meetings and attend formulations/discharge meetings where appropriate. CRHT's should have regular links with respective wards to identify patients that no longer require continued hospitalisation but may benefit from IHT. Clear communication between inpatient teams, IHT services/community teams is essential so each service can establish a clear role in the interventions that will be provided.

At the pre-discharge (Care Programme Review) meeting a review will take place that will include comprehensive care plan discussion and a new safety/care plan will be agreed in collaboration with the service user (and including their family and carers where appropriate). This must include adherence to the standards described in the National Confidential Inquiry into Suicide and Homicide by People with Mental Illness (NCISH) (2017): Safer services: A toolkit for specialist mental health services and primary care (see the link below)

http://www.champspublichealth.com/sites/default/files/media_library/Safer%20services%20A%20Toolkit.pdf.

The safety plan which includes management of risks will be communicated to all involved practitioners, the service user, and wherever appropriate, the family and/or carers.

The safety summary and safety plan must take into account the community living and support arrangements of the service user upon discharge or when granting any leave leading up to discharge. The assessment must include risks of harm to children if the service user may have or resume contact with children, especially if children have been implicated in any delusional or suicidal thinking.

5.5 When teams and organisations contribute to harm

We work with people at the times when they are experiencing periods of deep distress and are vulnerable. So we need to be particularly careful to make sure the way we relate to other people is helpful and therapeutic.

The appendix contains a useful brief guide on how to run meetings where service users and carers are present in a way which reduces the risk of inadvertently causing harm (based on research in the Trust which showed the small things we can do to reduce the likelihood that we cause harm in meetings). This will be covered in further detail in the staff training.

6 Interdependencies with other policies and procedures

Human Rights Equality & Diversity Policy

The Care Programme Approach and Standard Care

Observation and Engagement - Supportive Observations and Engagement Procedure

Person-Centred Behaviour Support Policy

Information Governance Policy

Confidentiality and sharing information policy

Safeguarding Children Supervision Procedure

Clinical Supervision Policy

Minimum Standards for Clinical Record Keeping

Rapid Tranquilisation Policy

Health and Safety Policy

Individuals who decline treatment and or disengage with services

Advance decisions to refuse treatment and statements made in advance

Staff Development Policy

Did Not Attend (DNA)/ Was Not Brought (WNB) Policy

Admissions Transfer and Discharge Policy

Safeguarding Adults Procedure

Safeguarding Children Policy

7 How this policy will be implemented

- This policy will be published on the Trust's intranet and external website.

- Line managers will disseminate this policy to all Trust employees through a line management briefing.

- The Staff Development Policy defines the requirements of all staff regarding Mandatory Training. The Education & Training Department (HR/OD) produces monthly Mandatory Training reports for Directors/Heads of Service.

- The training required to effectively implement any specific model and tool identified for use by services and/or professions, will be provided by those services and professions where required.

- The content, format and frequency of that training will be based upon the model and tool and the requirements of the service or professional group.

- Those services providing specific model/tool training will be responsible for monitoring that training and its implementation and provide updates to their relevant governance groups.

8 How this policy will be monitored and audited

The Director of Nursing and Governance and Medical Director, together with representatives from other professional groups, operational service areas and the educational staff will monitor the implementation of the policy by:

- Clinical audit of clinical risk documentation in the clinical record

- Attendance at and feedback from training programmes

- Lessons learned from incident and investigations reviews

- Reports to the Patient Safety Group, Quality Assurance Committee and other Trust meetings.

The use of documentation and record keeping processes will be audited against Professional Codes and Trust Minimum Standards for Clinical Record Keeping.

Service users must be informed, in general terms, how their information may be used, who will have access to it and the organisations it may be disclosed to. That is, they must be made aware that the information they give may be recorded or shared in order to provide them with care, and may be used to support local clinical audit and other work to monitor the quality of care provided. (Trust Information Governance Policy) Full guidance regarding confidentiality and sharing of information can be found in the Trust Confidentiality and sharing information policy.

9 Key legal and governance frameworks underpinning approaches to risk

Duty of care – organisations must maintain an appropriate standard of care in their work and not be negligent. Individuals who have mental capacity to make a decision, and choose voluntarily to live within a level of risk, are entitled to do so. In this case the law considers the person to have consented to the risk and there is thus no breach of duty of care and the organisation or individual cannot be considered negligent.

Human rights – all public authorities and bodies have a duty not to act incompatibly with the European Convention of Human Rights. A balance needs to be struck between risk and the preservation of rights.

Health and safety – There is a legal duty on all employers to ensure, as far as reasonably practicable, the health, safety and welfare of their employees as well as the health and safety of those who use services. Health and Safety legislation should not block reasonable activity.

Mental capacity – this is concerned with a person's ability to make decisions for themselves and the principle enshrined in the Mental Capacity Act, 2005 is that they must be assumed to have capacity unless it is established that they do not. People with capacity may make unwise decisions. For those who lack capacity, decisions made on their behalf must be made in their best interests and with the least restriction.

Fluctuating mental states and neurological conditions such as but not restricted to dementia – The choices and wishes of people with fluctuating mental states and dementia must be respected and their risk agreements monitored and reviewed regularly. In these circumstances it is important to engage with families and carers.

Safeguarding – For people who are considered to be vulnerable there is a need to consider the factors of empowerment and safety, choice and risk. Practitioners need to consider when the need for protection overrides decisions to promote choice and empowerment.

The Mental Health Act 1983 (MHA) – There are five guiding principles which should be considered when making all decisions in relation to care, support or treatment provided under the Act:

1. Least restrictive option and maximising independence
2. Empowerment and involvement

3. Respect and dignity
4. Purpose and effectiveness
5. Efficiency and equity

10 References and bibliography

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11 Document control

Date of approval:	07 April 2021	
Next review date:	07 April 2024	
This document replaces:	Harm Minimisation Policy CLIN-0017-v8.1 (redacted)	
This document was approved by:	Name of committee/group	Date
	Senior Leadership Group	07 April 2021
This document was ratified by:	Name of committee/group	Date
	Senior Leadership Group	07 April 2021
An equality analysis was completed on this document on:	EA is pending – SLG is aware	
Document type	Public (text redacted)	
FOI Clause (Private documents only)	For external publication. Sections redacted in line with National Patient Safety Alert.	

Change record

Version	Date	Amendment details	Status
8	15 Jul 2020	We have updated the policy to reflect: • Human rights legislation • Experts by Experience feedback regarding impact of harms • Removed diagnostic driven decision making and removed the protocol related to BPD in both AMH and CYPS services • Made the process of risk assessment more clear • Linked to new observation and engagement policy • Included appendices to enable us to add in	Withdrawn

		good practice without amending whole policy	
8.1	01 Sep 2020	Integrated feedback from service users and expert by experience re people who have long term high risk of self harm and suicide.	Withdrawn
8.2	07 April 2021	Updates to policy:- • Policy name changed to "Harm Minimisation (Clinical Risk Assessment and Management) Policy" • Section 1 - Introduction - added prime purpose • Section 4.5 Timely reviews - clarified minimum standards for frequency of review • Section 5.4.1 Admission - direction for use of safety summary in care record; reference to Supportive Observation and Engagement procedure; added leave planning and consideration requirements • Section 5.4.2 Discharge - communication of safety plan and what it must take into account • Appendix 2 – Redacted text	Ratified

12 Equality Analysis Screening Form

Forthcoming

13 APPENDICES

These Appendices are designed to offer space for thoughtful reflection and sharing learning across the trust. We hope that you will find them useful. If you have any other good practice, frameworks, or stories that you think would be useful to share with others, please send them to the recovery team and we will update the appendices over time.

13.1 Our learning about how meetings that involve a service user, can cause harm, and how to reduce the risk of that happening

- Make sure the room is confidential that there is a sign indicating not to be disturbed.
- Use a small preferably round table – you are aiming for safe and intimate not big and exposing.
- Don't have the staff sitting in there waiting for the service user to be 'brought in'. Try to arrive together.
- Keep the group small and relevant. Only people who have something to contribute should be there and the service user should have been involved in the discussion about the purpose of the meeting and who will be there. Make sure staff are briefed on what is expected of them before and during the session (especially that they are there to contribute not to 'watch').
- Make sure everyone has a drink (all the same – not that staff have tea and the patient has water unless that is their preference).
- At the start of the meeting make sure everyone is introduced and their role made clear.
- Make sure all the chairs are the same. The service user sitting on a small chair can feel vulnerable but sitting on a higher chair though can feel like being in court.

13.2 Making sense of what is happening

There are a number of ways in which we can work with service users to understand what they are experiencing. Psychological formulation and psychiatric diagnoses are the two most common in secondary care. Both have a role but it is important to talk with the person about how they make sense of their experience and what helps them. Both frameworks have inherent risks of causing harm and have been the subject to varying degrees of conceptual and philosophical arguments about their validity. It is important to understand the individual's understanding of this before 'imposing' either as valuable.

Much of the literature about what helps people to recover and live a fulfilling life identifies 'finding meaning' as an important factor. People describe part of the healing process as coming to some understanding around why they became unwell or experienced distress. This is a very individual process. For some a diagnosis may play a crucial part in that understanding. Others may understand their experiences as the impact of trauma, adversity, early relationships and attachment. And some will find a spiritual understanding. These examples are by no means exhaustive. What is clear is that people should have real choice about how they understand their experiences.

Psychological formulations and the potential for harm

Although psychological formulations can be thought of as just another meeting that is necessary for a person's care, it is important that we don't lose sight of their potential to cause specific harm. They hold power in the meaning and 'truth' that they can be used to create and the impact that this can then have on the way the person is understood, their identity and their opportunities. Psychological formulation should always be co-produced in order to reduce the risk of these and other harms.

We bring theories and frameworks which help us make sure the 'narrative' makes sense, holds us to account, asks us questions, and identifies gaps. In essence they reduce the chance of us prioritising our own view of the world. These narratives are just hypotheses. If we don't include the service user's perspective then they remain abstract academic theories. The service user doesn't always have to be in the meeting – that might not be appropriate and they might not want to be there. But there are many ways of including them. If they do have a different perspective then both views should be encapsulated.

As soon as notes are created they take on a certainty that can be hard for a person to shake. We have to work extra hard to convey the hypothetical nature of the formulation whilst also being clear on the plan. A very important role of psychology is to help the team to safely work through their responses to a situation/ and think about why they are struggling so that this doesn't impact negatively on a person's care. It is important that teams can have space to meet without a service user being present. But this is supervision and should be recorded as such.

Psychiatric diagnoses and the potential for harm

There is significant debate e.g. on social media about psychiatric diagnoses. Knowing the level of exposure to / engagement with that debate might help you understand whether the person finds a diagnosis helpful or harmful in making sense of their experiences.

Some of the harms of diagnosis that people voice include:

- Some diagnoses are stigmatising and lead to negative judgements and discrimination in the media and by the public, and family and friends. For example, a diagnosis of schizophrenia is often associated with violence and unpredictability towards others.
- Some diagnoses carry multiple judgements and discrimination within mental health services, for example people diagnosed with Borderline Personality Disorder are often seen as attention seeking and manipulative.
- Even if a diagnosis is welcomed by an individual we must use the language with care so that it doesn't dominate or become the person's identity. People describe becoming seen for example as 'A schizophrenic' or 'A PD' which clouds the other parts of themselves and leads to invalidating stereotypes preventing each person from being understood. Diagnoses are descriptions of experiences, not of people.
- Diagnosis can prevent clinicians thinking about the person's individual needs and has been used to deny access to care in circumstances where the person's needs could well have been met by services.
- A diagnosis that doesn't make sense to the person, or feeling 'wrongly diagnosed' can be very invalidating and feel like services are not 'seeing' the person and valuing their viewpoint.
- A Mental Health diagnosis can prevent people getting help for physical health problems because of diagnostic overshadowing.
- Diagnosis can invalidate what a person has been through and can suggest the problem is in some flaw within *them* rather than being a reaction to what has happened to them. For example diagnosing depression in someone who has lived in extreme poverty.
- Diagnosis can therefore be used to individualise distress and prevent us as a society facing global problems of poverty, violence, sexual abuse, racism etc.
- Diagnosis can be experienced as victim blaming. For example a sexual violence survivor being told that their distress can be understood as a problem with their personality.

There are times when the person does now want or agree with the diagnosis that the clinician is using to guide the treatment or in order to adhere to professional/ NICE guidelines. This situation requires extreme care about how the diagnosis is used and recorded in the notes; a discussion should be had with the service user about the purpose of any diagnosis being recorded.

An example from someone who did access our service:

Systemic Trauma is experienced within our society through discrimination and oppression. For a young black man repeatedly experiencing white women crossing the road away from him, their sense of self may begin to change. Many years of oppression and racism, the trauma of knowing a friend killed through gang violence and a fear of 'the authorities' prevents this young man from accessing early help for his distress and instead he turn to substances to cope. Identifying the set of symptoms he then experiences as psychosis is helpful in ensuring he has the best evidenced based treatment. But it is also possible to see how a life of oppression and trauma being summarized into a psychiatric diagnosis could appear to have reduced the social harms he's lived through to being a problem within him.

- Another consideration to pay attention to is that in the current system, diagnosis may be required in order for a person to access benefits, housing or the right treatment pathway for example. We need to find a way of using diagnoses to support people to access help, but make deliberate efforts to offer it as just one explanation for people's distress while we help people come to an understanding that makes sense to them.