Livewell Southwest

Clinical and Social Risk Assessment and Management Policy

Version No. 2.3
Review: November 2019

Notice to staff using a paper copy of this guidance

The policies and procedures page of LSW intranet holds the most recent version of this document and staff must ensure that they are using the most recent guidance.

Author: **Clinical Risk Advisor**

Asset Number: **717**

Reader Information

Title	Clinical And Social Risk Assessment and Management Policy v2.3
Asset number	717
Rights of access	Public
Type of paper	Guidance Policy
Category	Clinical And Social Care
Document Purpose/summary	The guidance is to help support positive risk management principles and practice in a spirit of collaboration based on practitioner decision making and organisational support. To provide a practical guidance for practitioners in clinical and social care management and to encourage a supportive cultural background. The policy guidance outlines the core principles of best practice in managing risk, underpinned by the philosophy that care needs must be balanced against risk needs in the context of promoting recovery and safer outcomes. It clearly emphasises that positive risk management is a part of a clearly constructed plan developed by all key stakeholders and requires comprehensive documentation to enhance open, democratic and transparent culture that embraces reflective practice.
Author	Clinical Risk Advisor
Ratification date and group	2nd November 2016. Policy Ratification Group
Publication gate	8th November 2016
Review date and frequency of review	Three years after publication, or earlier if there is a change in evidence.
Disposal date	The PRG will retain an e-signed copy for the archive in accordance with the Retention and Disposal Schedule, all copies must be destroyed when replaced by a new version or withdrawn from circulation.
Job title	Professional Lead / Clinical Risk Team in conjunction with Specialist Staff.
Target audience	For all Staff
Circulation	Electronic: Livewell Southwest (LSW) intranet and website (if applicable) Written: Upon request to the PRG Secretary on ☏ 01752 435104. Please contact the author if you require this document in an alternative format.
Consultation Process	This policy was produced in consultation with the Mental Health and Learning Disability Services, Carer representatives, the Risk Management Team, Professional Leads, and specialist input from key services / professionals, Adult Social Care.
Equality analysis checklist completed	Yes
Supersedes Document	Clinical Risk and Social Care Assessment and Management Best Practice Guidance v2.1
References/sources of information	• Best Practice in Managing Risk (2007) Department of Health • Care Programme Approach Policy & Standards (2008) • Best Practice in Managing Risk Implementation Tool Kit

	(2007), CSIP • Threshold and Assessment Grid (TAG) • Disclosure of Health Records Policy (LSW) • New Ways of Working (2007), Department of Health • Good Leadership and Management are key to avoid failings in patient safety (2008), Health Care Commission • Serious Untoward Incident Protocol (Drug & Alcohol Services) (2006) • Livewell Southwest Serious Incident Requiring Investigation Policy – Latest Version • Report to the NE SHA – Independent Inquiry into the Health Care and Treatment of GT (2007), NHS North East • Quarterly Partnership Review Meeting feedback minutes and recommendations from workshops held throughout 2006 – 2008. • MAPPA Guidance, version 4 (2012). Published by Home Office/National Probation Service. Available online at https://www.justice.gov.uk/downloads/offenders/mappa/mappa-guidance-2012-part1.pdf • Pressure Ulceration (Prevention & Intervention) • Falls Prevention & Management Protocol for in-patient, community and community outpatient teams • Clinical Record & Note Keeping Policy
Associated documentation	• Equality Impact Assessment • Best Practice in Managing Risk (2007) DoH • Care Programme Approach Policy and Standards (2006) • Livewell Southwest 's Risk Management Meeting Guidance
Author Contact Details	By post: Local Care Centre Mount Gould Hospital, 200 Mount Gould Road, Plymouth, Devon. PL4 7PY. Tel: 0845 155 8085, Fax: 01752 272522 (LCC Reception).

Abbreviations:

STORM	Skills-based training on risk management for suicide prevention
HCR 20	Historical Clinical Risk Management-20
MAPPA	Multi Agency Public Protection Arrangements
MUST	Malnutrition Universal Screening Tool
VTE	Venous Thromboembolism Risk Assessment
CPA	Care Programme Approach
TAG	Threshold Assessment Grid (Risk Assessment)
CAMHS	Child and Adolescent Mental Health Services
LSMS	Local Security Management Specialist
RMM	Risk Management Meeting
CSIP	Care Services Improvement Partnership

Document review history

Version no.	Type of change	Date	Originator of change	Description of change
For previous review history please contact the PRG secretary.				
V1:0	Final document	24/11/2008	S Edmunds	Approved Document
v1:1	Update	08/11/2010	Author	Reviewed, no changes made.
V1:2	Review	Dec 2012	PRG	Review date extended, no other changes made.
V1:3	Review	Dec 2012	Author	Review date extended, no other changes made.
V2.0	Review	Aug 2013	Professional Lead	Final Changes made following consultation prior to ratification.
V2.1	Review	October 2015	Professional Lead & Clinical Risk Advisor	Changes made following consultation
V2.2	Review	July 2016	Clinical Risk Advisor	Major changes
V2.3	Amendments	October 2016	Clinical Risk Advisor	Amendments following PRG meeting September 2016

Clinical and Social Risk Assessment and Management Policy

1 Introduction

1.1 The aim of this document is -

1) To provide practical 'on the ground' guidance for clinicians in Clinical and Social Risk Assessment and management.
2) To encourage a positive and supportive culture within which the clinical practice and risk management issues occur.
3) To outline Livewell Southwest's policy on clinical risk management.

1.2 The core principles of the document are based on the DoH document 'Best Practice in Managing Risk' (June 2007) adapted here to be applicable to all local services and service users. This document has the full endorsement and support of clinicians and managers at all levels throughout Livewell Southwest and is seen as the basis of good clinical practice in clinical risk management.

1.3 The principles and guidance is applicable to all areas of health and social care, including Mental Health, Learning Disabilities, Child and Adolescent Mental Health, General Nursing including in-patient and Community Care, Health Visiting and Specialist Services.

1.4 The philosophy underpinning this document is that care needs must be balanced against risk needs in the context of promoting recovery. It emphasises:

- positive risk management
- collaboration with the service user and others involved in care
- coordinated working between all involved clinicians, services, service users and teams
- the organisation's role in risk management alongside individual clinicians

1.5 Definition of Clinical and Social Risk:

Clinical risk is an avoidable increase in the probability of harm occurring to a patient. Events or incidents occur in our daily practice that will, or could potentially, affect the quality of patient care. Sometimes this can lead to harm, sometimes harm is avoided (a near miss).

1.6 Definition of Clinical and Social Risk Assessment:

Arising from risks to and/or from a Service User. The identification of potentially harmful intentions or factors that jeopardise a person's safety or recovery or the safety of others, together with a consideration of strengths and protective factors. All individuals referred to services will have an assessment of clinical risks undertaken.

1.7 Positive Risk Management:

The employment of strategies that allows the Service User to live their life to their full potential while managing identified risks to reduce the likelihood of negative outcomes occurring and/or the severity of the consequences of that risk.

1.8 Defensible Risk:

Independence Choice and Risk (DoH, 2007) provides the following helpful definition of reasonable risk: “Balance and proportionality are vital considerations in encouraging responsible decision making. Reasonable risk is about striking a balance in empowering people who use services to make choices, ensuring that the person has all the information tailored to their specific needs, in the appropriate form, to make their best decision.”

2. Purpose Core Principles of Best Practice in Managing Risk

Key best practice points:

Overall

1) Best practice involves making decision based on knowledge about the individual service user and their social context, clinical judgement and research evidence.

Fundamental Principles

2) Positive risk management as part of a clear constructed plan is a required competence of all health & social care practitioners.
3) Risk management should be conducted in a spirit of collaboration and based on a relationship between service user, their carers and clinical staff that is as trusting as possible.
4) Risk management requires an organisational strategy that promotes a positive culture around risk management and supports the efforts of individual practitioners.

Core specifics for practice

5) Care plans should be developed by multidisciplinary and multi-agency teams in an open, democratic and transparent culture that embraces reflective practice.

2.1 All staff involved in risk management must engage in appropriate and up to date training that meets their learning needs. In Mental Health this will be incorporated within the Care Programme Approach Training Programme which is reviewed annually, and links to other training programmes, such as, STORM and the minimum requirement will be for staff to have attended the initial one day programme and then receive an update 3 yearly. Other risk assessments should be used as appropriate i.e. HCR 20. For those working outside Mental Health; Clinical and Social Care Risk training is advertised within Professional Training and Development.

2.2 Comprehensive documentation is essential component of positive risk management; this includes the rationale for decisions that are made regarding

risk management. This Rationale / discussion must be documented within the clinical record.

2.3 There is the option of Special Notes on SystmOne to record key aspects of risk management that staff within the organisation need to be aware of. High priority reminders can also be used to make staff aware of issues that could cause a risk. Guidance can be found in the SystmOne policy

3. Duties

The **Chief Executive** is ultimately responsible for the content of all policies, implementation and review.

3.1 Responsibility and Accountability of Clinical and Social Risk Management in Livewell Southwest

Livewell Southwest has a responsibility to ensure that the organisation has structures in place to support the practice of positive clinical and social risk management and expects directly employed health professionals to work within them.

3.2 Responsibilities of the organisation

- Good positive clinical and social risk management is endorsed by the Executive Team of Livewell Southwest.
- Ensure that training is available for all staff as needed.
- Ensure that structures and systems are in place to facilitate the delivery of excellent clinical risk management practices.
- Monitor, evaluate and audit the practices as required to inform and update this guidance and training.

3.3 Responsibilities of Team Managers and Locality Managers

- Managers should attend risk management meetings to support clinicians and practitioners in risk management decision making processes, as appropriate.
- Locality Managers / Deputies/ Service Managers/ Advanced Practitioners have a responsibility to support teams where complex decisions are being discussed and where there is a need to ensure an organisational viewpoint is considered, this will enable professionals to be fully supported in complex decisions.

3.4 Responsibilities of All Health & Social Care Professionals

- All individuals are required to follow these best practice guidelines in relation to clinical and social care risk management and planning / attending / recording and following up outcomes from risk management meetings.

- That any training needs are identified within the approved Livewell Southwest routes of Line Management, Caseload Management and Individual Performance Review.

4 Best Practice Guidance

4.1 Best Practice point 1

Best Practice involves making decision based on knowledge about the individual service user and their social context, clinical judgement and research evidence.

The practitioner, or team, is responsible for working with the individual to make decisions about risk by taking into account the needs of the individual service user, the safety of the wider community and the latest evidence about risk assessment. This evidence includes an understanding of risk factors, the effectiveness of interventions as well as evidence based risk management tools. Individuals' needs, assessed from their clinical and social care condition and social context, as well as their preferences, need to be taken into account.

Livewell Southwest, in line with the DoH guidance, Best Practice in Managing Risk (2007), advocates the use of expert knowledge and skills in combination with formal tools to guide risk management.

4.2 Best Practice point 2

Positive risk management as part of a clearly constructed plan is a required competence of all practitioners and should be the basis for effective risk management on a daily basis.

Positive risk management means being aware that, in the context of promoting recovery, risk can never be completely eliminated, and management plans inevitably have to include decisions that carry some risk. This should be explicit in the decision-making process and should be discussed openly with the service user and carer if appropriate.

Positive risk management has been emphasised due to a recognition that risk averse practice has become more prevalent and can not only inhibit recovery, but can also take up additional resources, paradoxically increasing risk across the system.

Positive risk management includes:

- working with the service user to identify what is likely to work,
- paying attention to the views of carers and others around the service user when deciding a plan of action,
- weighing up the potential benefits and harms, both short and long term, 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 i.e. recovery, 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.

Another way of thinking about good decision-making is to see it as supported decision-making. Independence, Choice and Risk has this to say:

"The governing principle behind good approaches to choice and risk is that people have the right to live their lives to the full as long as that does not stop others from doing the same. Fear of supporting people to take reasonable risks in their daily lives can prevent them from doing the 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. By taking account of the benefits in terms of independence, well-being and choice, it should be possible for a person to have a plan which enables them to manage identified risks and to live their lives in ways which best suit them." – MAPPA Guidance".

Livewell Southwest has a clear and unanimous voice in supporting staff in implementing a positive approach to risk. It is an expectation that all staff embeds these principles into their everyday practice and all staff can expect to be supported in doing so by all levels of Livewell Southwest Staff.

4.3 Best Practice in point 3

Risk management should be conducted in a spirit of collaboration and based on a relationship between service user, their carers and staff that is as trusting as possible.

Open involvement of the service user and carers in discussions around risk is a basic principle underlying quality practice. The emphasis should always be on an outcomes / supportive approach, building on recognition of the service user's strengths. The use of service user centred approach to encourage this can assist in this e.g. Service User Personal Safety Plan, Pain Diary etc. The inclusion of any advance directives and advance statement of wishes should be considered.

Full engagement is sometimes not possible but the potential for it should always be considered; if this is not the case the reason for this should be clearly documented.

The development of the risk management plan as part of the care plan should be carried out in an atmosphere of openness and transparency. If for some reason the service user is not involved this should be documented.

4.4 Best Practice point 4

Risk management requires an organisational strategy that promotes a positive culture around risk management and supports the efforts of individual practitioners.

Risk management is not just the responsibility of individual practitioners but the responsibility of the wider organisation. Livewell Southwest recognises that a balanced approach to safety and positive risk management is in the interests of individual service users, practitioners and the wider community.

Livewell Southwest has a responsibility to develop a culture in which positive risk management can flourish. Practitioners will be able to see that if risks have been managed and documented appropriately they will be supported if serious Incidents occur.

This includes the need to learn and share widely from Serious Incidents and build on good practice identified. These are integrated within the Serious Incident Requiring Investigation policy.

4.5 Best Practice point 5

Risk management tools should be used to complement Structured Professional Judgement rather than a replacement for it.

4.5.1 Structured Professional Judgement

Structured professional judgment is an approach that attempts to bridge the gap between actuarial and unstructured clinical and social care approaches to risk assessment (Douglas & Kropp, 2002; Hart, 1998).

Structured professional judgement is an approach to risk assessment and not a specific instrument.

The aim is to combine the evidence base for risk factors with individual patient/service user assessment.

Structured professional judgement assists but does not replace the opinion professionals make using a structured assessment, which is used in the formulation of a risk management plan which forms part of the care plan. This brings risk assessment and management into the domain of multidisciplinary teams.

Structured professional judgement is useful not only for supporting evidence-based practice, but also for increasing the transparency of decision making for the purposes of clinical governance, quality and standards.

4.5.2 Actuarial Risk Assessment Tools

A basic risk assessment tool should be used for all patients and service users being seen by services, Threshold Assessment Grid (TAG) or Initial Holistic Assessment.

In more complex cases or where initial screening indicates significant risk a more in-depth risk assessment should be undertaken e.g. CPA risk assessment within Mental Health, or within Physical Health the use of Waterlow, MUST, VTE, Health Needs Assessment.
For social care, community support needs assessment (CSNA), Risk Management Meetings, safeguarding enquiry/alert .

In the most complex and high risk cases specialised tools to address specific areas of risk should be used e.g. STORM for suicide/ Self Harm risk or HCR-20 violence risk assessment for service users within forensic services.

The flow diagram below describes the Livewell Southwest use of risk assessment tools in Mental Health (Also please refer to CPA Policy)
At every stage of this process regular review must take place in line with CPA Guidance.

New referral

↓

Initial risk assessment tool (e.g. TAG) as part of clinical assessment

↓

Clinical assessment & risk assessment indicates need for further risk assessment or for CPA

↓

CPA risk assessment tool completed including other assessment tools

↓

Clinical picture and CPA risk assessment indicate further risk management/ assessment strategies needed

↓

Risk assessment meeting/ clinical discussion with colleagues
(Please refer to Clinical Risk Management Meeting Guidance)

↓

Consider specialist tools and processes e.g. MAPPA.

Flow Diagram regarding risk assessment in Physical Health Care

New referral

↓

Initial Risk Assessment tool as part of Clinical/Holistic Assessment

↓

Clinical assessment & risk assessment indicates need for further risk assessment e.g. Waterlow / Must

↓

Appropriate assessment tool completed

↓

Clinical picture and risk assessment indicate further risk management /assessment strategies needed

↓

Risk assessment meeting/ clinical discussion with colleagues
(Please refer to Clinical Risk Management Meeting Guidance)

↓

Agree appropriate risk management strategy for patient / carers and family

4.6 Best Practice point 6

Risk management plan as part of the care plans should be developed by multidisciplinary and multi-agency teams in an open, democratic and transparent culture that embraces reflective practice.

Working together is a critical part of risk management and can help ensure:

- That key information is shared to ensure safety.
- That different perspectives can be brought together to make the best decisions.
- That responsibility is appropriately shared between team's practitioners and service users.

In low complexity, low risk cases practitioners working alone with service users can make effective risk management plan as part of the care plans. However in many situations the best risk assessments and most effective management plans are developed by teams working in consultation with service users and carers.

Clear channels of communication between practitioners and services are critical to effective risk management. Confidentiality remains central but where public protection concerns are raised MAPPA processes should be considered.

The process for sharing information and involving teams and other services again must be proportionate to the risks being considered. Depending on the nature of the situation and risk, different means of collaborative working may be appropriate. When decisions need to be made urgently more formal meetings may not be possible but comprehensive documentation of consultations remains essential.

The following are recommended ways of working with risk and should be recorded in the patient record:

- Informal discussions with colleagues
- Discussion with practitioners from other teams
- Discussion at full team meetings
- Formal risk management meetings
- Use of special Notes on SystmOne

Involvement of the service user and carer in these processes is essential but the degree and how they are involved must be judged individually and recorded accordingly.

4.7 Best Practice point 7

Comprehensive documentation is an essential component of positive risk management and should be seen as enhancing clinical/social care practice, not as a barrier to it.

Risk management documentation includes a variety of formats: formal risk

management meetings, completion of risk management tools and recording everyday clinical decisions about risk in clinical records. Comprehensive documentation is vital to ensure effective communication and the potential consequences of failures in this have been well catalogued following previous serious incidents. Particular danger points where communication can fail are at discharge from hospital and referral to another care provider, or when multiple agencies /teams are involved.

It is expected that in general risk management documents should include an understanding of the specific risks, the triggers to these and contingency plans to manage these. In the majority of cases this will simply involve the development of a risk management plan as part of the care plan.

If initial risk assessment indicates a higher degree of risk then appropriate and proportionate responses to managing this should be made. Initial discussion with other professionals (especially more senior staff) should be undertaken and a decision to move to more formal processes of risk management meetings and the involvement of further services should be considered.

All relevant risk related decisions should be recorded clearly within the clinical record. The service user and carer should be able to contribute to this documentation where appropriate. Where positive risk management is implemented, a clear rationale for the plan should be documented.

All clinical and social care issues discussions and meetings relating to risk management should also be documented. The process of documentation should not be a bureaucratic end to itself and should not be aimed solely at self-protection but should contribute to effective risk management and reflection as well as assisting the service in effectively supporting the service user.

Risk management documents should, where appropriate, be communicated with the service user and all those providing their care. The local policy on information sharing governs this process.

5 Monitoring Implementation of the Guidance in Practice

- A local review of Clinical and social care Risk Management practices should be used by individual teams to monitor compliance with this guidance.

- Recommendations from Serious Incidents Requiring Investigation will also guide practice and these guidelines.

All policies are required to be electronically signed by the Lead Director. Proof of the electronic signature is stored in the policies database.

The Lead Director approves this document and any attached appendices. For operational policies this will be the Locality Manager.

The Executive signature is subject to the understanding that the policy owner has followed the organisation process for policy Ratification.

Signed: Deputy Director of Professional Practice

Date: 3rd November 2016

Clinical and Social Care Risk Management Meeting Guidance

1 INTRODUCTION

Livewell Southwest, is committed to the effective management of risk through proactive, multi-disciplinary approach incorporating Care Programme Approach (CPA), Health – Risk Assessment and Management.

This guidance is Livewell Southwest's response to providing Risk Management and links in with and reinforces the organisation's commitment to effective and positive risk management.

1.1 RATIONALE – WHY have a risk meeting?

The purpose of a risk management meeting is to enhance the organisations mechanism of risk management and to provide a procedure and supportive framework to manage and co-ordinate risk and ownership of identified actions.

- The key to the process is to identify the **immediacy, severity, likelihood and nature** of risk
- Facilitate a process which may lead to minimising and managing risk with inpatients or those in the Community
- Ensures public/staff/user protection
- Develop defensible practice
- Encourage proactive rather than reactive risk management plan as part of the care plans for the benefit of the service user, carers, staff and the public
- Assist in the safe Discharge of Patients and service users where risks are present and need a multi-disciplinary/agency Management plan.
- Provide a system for the sharing of confidential information across agencies, within existing policies and protocols, for example: Caldecott NHS Code of Confidentiality 2003, Data Protection Act 1998, Information Sharing policy
- Recording of accurate information in relation to the discussion using the CPA review document within Mental Health & CAMHS or the template in the guidance attached, and, timely uploading onto SystmOne.

1.2 WHO, WHERE & WHEN?

This guidance applies to all clinical areas of Livewell Southwest and associated agencies, working in partnership with the organisation.

LSW supports individual staff and teams in their proactive risk management. LSW acknowledges that many patients and service users known to services have significant risk histories and are managed successfully using the individual clinician's structured professional judgement and team support.

2. When would a risk meeting be indicated? Not Exhaustive

- Evidence of early warning signs/increasing risk and/or patterns of behaviour, such as the use of or presence of weapons, or a known, named victim identified at risk. Deterioration of physical health or mental Health.
- Offending behaviour linked to dangerousness and/or increased contact with Police. For example; threats, possession of weapons or assault.
- Regular contact with Police not resulting in arrest – for example Section 136 of the Mental Health Act 1983.
- Regular reporting of risk related incidents.
- History of non-compliance with treatment/services and/or difficulty in engaging service users leading to increased levels of dangerousness, non- concordance with treatment or increased risk.
- The need for a service user in this category to be treated in line with legal sanctions outside of the organisation, such as Conditions of Bail, Restrictions Orders etc.
- The importance of issues surrounding Child Protection/Safeguarding Adults.
- Hospital Orders- for example Sections 37 & 37/41 of the Mental Health Act 1983 – moving into the local community.
- Threats involving staff, other service users and the organisation's property.
- Adverse incidents involving dangerous behaviour.
- History of admission to High Secure, Regional Secure and Low Secure services and how this may impact on current management.
- Those new to services from prison, with knowledge of index offence of dangerousness.
- Subject to CPA with complicating factors which cause greater concern / increase risks.
- Suicide/self- harm behaviour/self -neglect behaviours that affect clinical presentation, ability to engage with treatment and manage individual risks.
- Use of drugs/alcohol that affect clinical presentation, ability to engage with treatment and manage risks.
- Evidence of physical condition whose symptoms can exacerbate risk e.g. Dementia, acquired brain injury / stroke/Pressure ulcers/Mobility Issues etc.
- When there are disagreements within the clinical and social care team regarding severity of risk or proposed plan of care.

3. Who to invite?

The core group of individuals who should attend can include:-

- Care Co-Coordinators/Named Nurse/ District Nurse/and professionals (as appropriate)
- Patient/Service User/Relative if indicated, if not included there should be a communication plan of how to feedback
- Appropriate and relevant medical staff
- Appropriate and relevant team managers
- Appropriate and Relevant practitioners – e.g. psychologists
- Social Care representatives.
- Other agencies- for example, Housing, Harbour, Insight, care agencies,

residential/nursing home care staff, Voluntary or 3rd sector agencies etc.

- Locality manager or Deputy where organisational representation is required.
- Representatives from staff currently involved in care if outside the organisation- for example the service user is in a private bed or other residential accommodation or receives services from another care provider
- Tissue Viability

For more complex cases, the following individuals could be asked to attend:-

- Police, Probation Services
- Professional practice department –this may include the Clinical Risk Advisor, Health and Safety Manager, Professional Lead and LSMS.

However this is in the case where their professional judgement may be of benefit The attendance form this team does not constitute organisational representation. If there are concerns regarding the outcome of the RMM the relevant Locality Manager/Social Care Manager must be invited.

- GP
- Commissioners – if purpose of the meeting is to look at alternate treatment/cost options and/or possible placement.

4. Organising a Risk Meeting?

1. A discussion should be held with the Responsible Professional and care co-ordinator / Team Manager/ Named Nurse/ District Nurse to establish the purpose and remit of the risk meeting including who should be invited and why.
2. When a Risk Meeting has been convened the CPA Risk Assessment & Summary or other Risk Assessment Paperwork is completed reflecting current risks, this is to be uploaded onto SystmOne. ? who in social care
3. An agenda should be available; the purpose of this is that all attendees are clear about the purpose and their role at the meeting, including any preparation they need to do.
4. A Chairperson for the meeting must be identified – this should **not** be the individual patients care co-ordinator/Named Nurse – however care co-ordinators / Team manager/ Named Nurse could chair meetings for colleagues to develop their skills.
5. Minute Taker to be identified by the Chair prior to the meeting – this should be someone who is trained in using SystmOne, or someone who is familiar with IT systems.- How will it apply to adult social care
6. Requests for any further information required, such as Police checks, prison information, Probation/Court information, should be made prior to any risk meeting if possible through the agreed route.

Running a Risk Management Meeting?

- The meeting should run according to the agenda – for advice and support generating the agenda clinicians can approach Clinical Risk Advisor or Professional Lead.

- A confidentiality / Data and Information sharing statement must be shared and recorded in the minutes.

- All those in attendance at the meeting will be expected to contribute to the meeting, share information that is reasonable and proportionate, and co-operate in the formulation of a care plan.

- It is the responsibility of the chair to ensure the meetings proceed within time frames and outline and co-ordinate information so the action points and areas of responsibility can be identified.

- There will be a dedicated minute taker.

- A decision will be made at the meeting as to whether the individual will be informed of the meeting and process involved and who will take responsibility for sharing this information (if not in attendance).

- The chair will conclude the meeting with a summary of the action points and agreed Care/ management plan.

- A decision will be made at the conclusion of the meeting on whether to hold a review meeting. If agreed, a further date will be set as appropriate to reflect concerns. All attendees have a responsibility to attend review dates or send a nominated deputy and a new agenda should be devised (appendix 1).

6. Actions after the Risk Management Meeting?

The agenda (Appendix 1) will be stored on SystmOne as a record attachment, and circulated to those with no access to SystmOne within 7 working days; however this will be reflected depending on the urgency of the case. The discussion must be recorded on Risk Management Meeting Minutes Assessment within S1 (appendix 2) or alternatively within Mental Health CPA review document (make sure the risk management box is ticked) as is current practice, either way they must be stored on SystmOne.

Individuals are responsible for any action points with which they are assigned and completed within agreed timescales. If this is not possible the meeting chair and care co-ordinator/Named Nurse should be informed. The Chair of the meeting will retain overall responsibility for ensuring actions are completed.

Where appropriate, a Special Note may be created within the SystmOne system.

appendix 1

Risk Management Meeting AGENDA

Date:

Venue:

Time:

Purpose: ***reason for calling meeting to be recorded here***

Current Risks: Please detail

Item No	Item	Lead
1	**Welcome & Apologies** Apologies:	
2	Minutes of Previous Risk Management Meeting (if applicable -– Review Actions)	
3	Purpose of meeting	
4	Immediate Assessed Risks	
5	Discussion	
6	Formulation of Risk management plan as part of the care plan	
7	Identify who will be responsible for actions	
8	Date of next meeting if appropriate	

Prior to the meeting:

Would all invitees ensure they are aware of the individuals Risk History, Minutes of any previous RMM and the specific agenda items individuals are responsible for presenting / leading.

Who is invited:

Name / Base / Title	Purpose of attending meeting	Able to attend

Risk Management Meeting Minutes **appendix 2**

Name: Service Area:

NHS No:

Consultant :		**Care Co-ordinator or** **Named Nurse:**	

Attendees:

Apologies:

Purpose:
Risk Highlighted/Assessed:

Discussion:

Plan/Outcome:

Actions:	Owner:	Completion Date