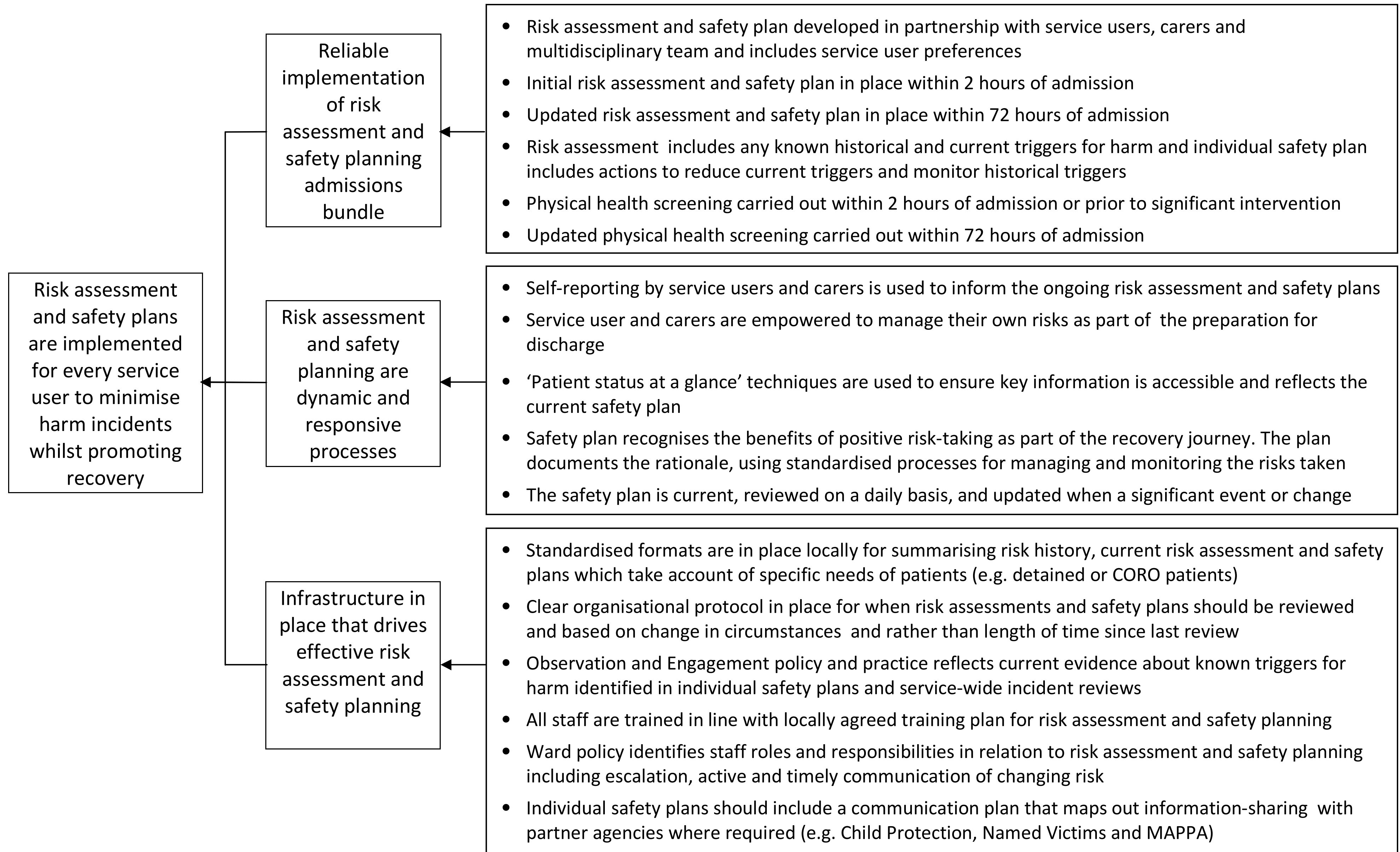
SCOTTISH PATIENT SAFETY PROGRAMME
EVERY PERSON EVERY TIME
MENTAL HEALTH

Risk Assessment & Safety Planning Driver Diagram Phase Two

The Scottish Patient Safety Programme is co-ordinated by Healthcare Improvement Scotland


Risk assessment and safety plans are implemented for every service user to minimise harm incidents whilst promoting recovery
Reliable implementation of risk assessment and safety planning admissions bundle
Risk assessment and safety plan developed in partnership with service users, carers and multidisciplinary team and includes service user preferences
Initial risk assessment and safety plan in place within 2 hours of admission
Updated risk assessment and safety plan in place within 72 hours of admission
Risk assessment includes any known historical and current triggers for harm and individual safety plan includes actions to reduce current triggers and monitor historical triggers
Physical health screening carried out within 2 hours of admission or prior to significant intervention
Updated physical health screening carried out within 72 hours of admission
Risk assessment and safety planning are dynamic and responsive processes
Self-reporting by service users and carers is used to inform the ongoing risk assessment and safety plans
Service user and carers are empowered to manage their own risks as part of the preparation for discharge
'Patient status at a glance' techniques are used to ensure key information is accessible and reflects the current safety plan
Safety plan recognises the benefits of positive risk-taking as part of the recovery journey. The plan documents the rationale, using standardised processes for managing and monitoring the risks taken
The safety plan is current, reviewed on a daily basis, and updated when a significant event or change
Infrastructure in place that drives effective risk assessment and safety planning
Standardised formats are in place locally for summarising risk history, current risk assessment and safety plans which take account of specific needs of patients (e.g. detained or CORO patients)
Clear organisational protocol in place for when risk assessments and safety plans should be reviewed and based on change in circumstances and rather than length of time since last review
Observation and Engagement policy and practice reflects current evidence about known triggers for harm identified in individual safety plans and service-wide incident reviews
All staff are trained in line with locally agreed training plan for risk assessment and safety planning
Ward policy identifies staff roles and responsibilities in relation to risk assessment and safety planning including escalation, active and timely communication of changing risk
Individual safety plans should include a communication plan that maps out information-sharing with partner agencies where required (e.g. Child Protection, Named Victims and MAPPA)

Risk assessment and safety planning admissions bundle

Secondary Drivers	Change ideas for PDSA testing
Risk assessment and safety plan developed in partnership with service users, carers and multidisciplinary team and includes service user preferences	• Use stamps to frame the rationale that include explicit identification of different stakeholders consulted, and different information sources used for the safety plan • Use tick boxes to record completion of stages of safety planning • Using a graded safety plan system as agreed by the multi-disciplinary team • Joint assessments at handover points e.g. A&E/Inpatient Unit; Crisis Team/Inpatient Unit • For repeat admissions, service user-owned records form the basis of discussions • Every day ask every service user whether they feel safe and act on response • Copy of safety plan provided to service users and carers • Process in place to review safety plan on return from pass which includes service user, carer and community staff input • Involve patient/carer in daily goal setting • Include patient/carer on multi-disciplinary rounds • Nurse/doctor do intake assessment together rather than sequentially • Safety plan refers to increased observation/engagement required in periods of increased risk
Initial risk assessment and safety plan in place within 2 hours of admission	• Features that should be incorporated in the safety plan should include legal status, observation status, time out of ward status, missing person plan and emergency treatment/as required psychotropic advice
Updated risk assessment and safety plan in place within 72 hours of admission	• Features that should be incorporated include all aspects of risk, based on observed behaviour over past 72 hours and collateral information including both historical dynamic factors to produce a more thorough assessment of patient’s needs
Risk assessment includes any known historical and current triggers for harm and individual safety plan includes actions to reduce current triggers and monitor historical triggers	• Protocol developed in consultation with staff, service users and carers • Specific discussions should be held around the removal of potential ligature points and other suicide methods from high risk patients

Physical health screening carried out within 2 hours of admission or prior to significant intervention	• Appropriate guidance developed around initial investigations (eg bloods, urine analysis, drug screening, x-rays etc) • Use of a checklist or proforma
Updated physical health screening carried out within 72 hours of admission	• Use of checklist to ensure that all requirements for physical checks are completed, following advice from consultant and medical team and arrangements made for any additional investigations.

Risk assessment and safety planning are dynamic and responsive processes

Secondary Drivers	Change ideas for PDSA testing
Self-reporting by service users and carers is used to inform the ongoing risk assessment and safety plans	• Discussions held and results recorded in a structured format • Carers routinely contacted for feedback • Use of Emotional Touchpoints
Service user and carers are empowered to manage their own risks as part of the preparation for discharge	• Consider use of patient held records where appropriate • Safety plans are developed collaboratively and signed by service users
'Patient status at a glance' techniques are used to ensure key information is accessible and reflects the current safety plan	• See Releasing Time to Care (RTC) 'Patient Status at a Glance' module for ideas
Safety plan recognises the benefits of positive risk-taking as part of the recovery journey. The plan documents the rationale, using standardised processes for managing and monitoring the risks taken	• Process in place to review risk assessment and safety plan on return from pass/ other time out, which includes service user, carer and community staff feedback • All feedback should be formally documented to inform those making risk-management decisions
The safety plan should be current, reviewed on a daily basis, and updated when a significant event or change occurs	• Clear guidance for roles and responsibilities, timing and recording mechanism for daily updates

Infrastructure in place that drives effective risk assessment and safety planning

Secondary Drivers	Change ideas for PDSA testing
Standardised formats are in place locally for summarising risk history, current risk assessment and safety plans which take account of specific needs of patients (eg detained patients or Compulsion Order and Restriction Order (CORO))	• Training staff to use locally agreed tool • Appropriate team-working and supervision to ensure that the tool is effectively used on an ongoing basis • Audit of quality of information entered into tool • Allocate named person for updating an individual's safety plan • Improve access to senior clinicians – particularly out of hours
Clear organisational protocol in place for when risk assessments and safety plans should be reviewed and based on change in circumstances and rather than length of time since last review	• Protocol clarifies roles of multidisciplinary team – responsibility for updating, how to access senior clinicians out of hours • Audit to ensure that significant events/changes in circumstances result in an update to safety plan
Observation and Engagement policy and practice reflects current evidence about known triggers for harm identified in individual safety plans and service-wide incident reviews	• See RTC 'Safe and Supportive Observation' module for ideas
All staff are trained in line with locally agreed training plan for risk assessment and safety planning	• Junior doctors work jointly with senior nursing staff • Existing suicide risk assessment training e.g. Assist training/storm training • Development of local training in risk assessment and safety planning • Ensure all staff have access to training in de-escalation techniques
Ward policy identifies staff roles and responsibilities in relation to risk assessment and safety planning including escalation, active and timely communication of changing risk	• Protocol clarifies roles of multidisciplinary team – responsibility for updating, how to access senior clinicians out of hours
The safety plan should include a communication plan that maps out information-sharing with partner agencies where required (e.g. Child Protection, Named Victims and Multi Agency Public Protection Arrangement (MAPPA)	

Secondary Driver	Phase 2 Potential Process Measure	Comments
Risk assessment and safety plan developed in partnership with service users, carers and multidisciplinary team and includes service user preferences	% of individuals where risk assessment and safety plan developed by MDT in partnership with service users and carers	Could measure using random audit of case-notes
Initial risk assessment and safety plan in place within 2 hours of admission	% of initial risk assessment and safety plan in place within 2 hours of admission	Could measure using random audit of case-notes
Updated risk assessment and safety plan in place within 72 hours of admission	% of updated risk assessment and safety plans in place within 72 hours of admission	Could measure using random audit of case-notes
Risk assessment includes any known historical and current triggers for harm and individual safety plan includes actions to reduce current triggers and monitor historical triggers	% of individuals whose risk assessment includes known triggers for harm and whose safety plan includes actions to reduce that harm	Could measure using random audit of case-notes
Physical health screening carried out within 2 hours of admission or prior to significant intervention	% of physical health screening carried out within 2 hours of admission	Could measure using random audit of case-notes
Updated physical health screening carried out within 72 hours of admission	% of updated physical health screening carried out within 72 hours of admission	Could measure using random audit of case-notes
Service user and carers are empowered to manage their own risks as part of the preparation for discharge	% of safety plans developed collaboratively and signed by service users	Could measure using random audit of case-notes
Safety plan recognises the benefits of positive risk-taking as part of the recovery journey. The plan documents the rationale, using standardised processes for managing and monitoring the risks taken	% of individuals whose safety plan evidences the use of positive risk taking to enhance recovery	Could measure using random audit of case-notes
The safety plan is current, reviewed on a daily basis, and updated when a significant event or change occurs	% of individuals safety plans which show evidence of feedback from service users and their carers following periods of time off ward/leave of absence	Could measure using random audit of case-notes