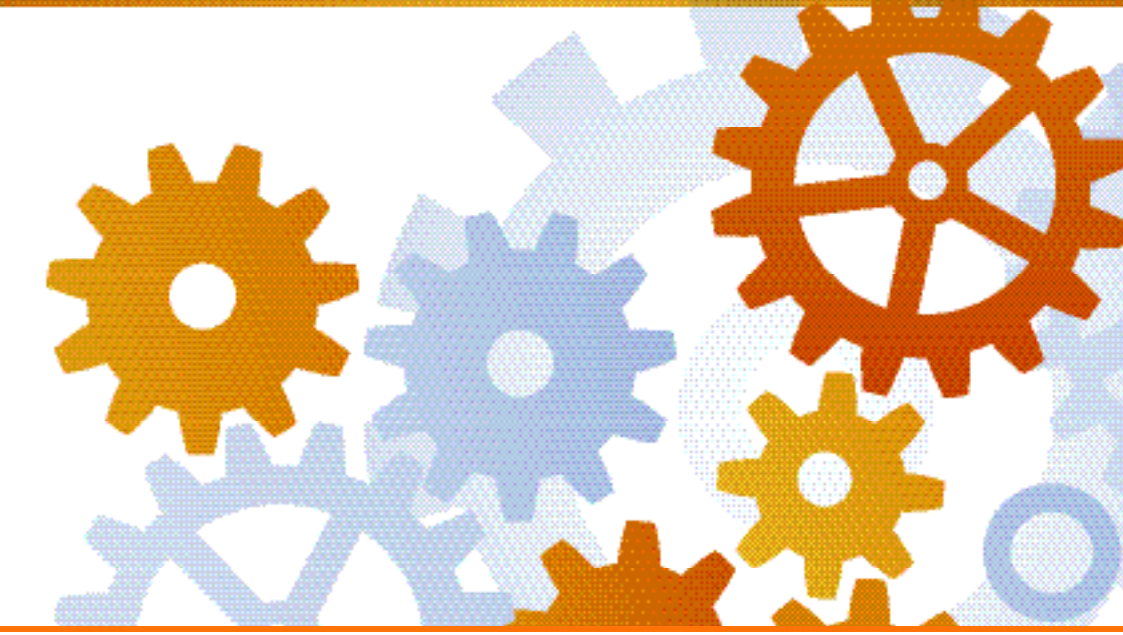
Guidance Document

Risk Management In Mental Health Services



Feidhmeannacht na Seirbhíse Sláinte
Health Service Executive

Clinical Indemnity Scheme

FOREWORD

Safety is central to the provision of quality mental health services. However adverse events do occur, sometimes with tragic personal consequences. Protecting patients and others from harm is a key priority and risk management is an essential component of providing such protection. Developments in recent years have served to support a more positive and proactive approach to risk in the planning and delivery of services. National mental health policy, *A Vision for Change* (2006), places the service user at the centre of mental health services and promotes a recovery approach to mental ill health. This invites the development of a stronger partnership approach between service users, carers and mental health professionals in negotiating all aspects of care, including the assessment and management of risk. In 2007 the Mental Health Commission produced the *Quality Framework, Mental Health Services in Ireland* in 2007 as a road map and enabler for mental health services in striving for high standards and good practices in the sector. Meanwhile the HSE developed an *Integrated Quality, Safety and Risk Management Framework* (2009) which is currently being implemented across all HSE services.

In the context of these developments the Director of PCCC established a working group under the chairmanship of David Gaskin, LHM Meath and Lead for mental health, to develop specific guidance for mental health services in the area of risk management. The group included a clinical director, director of nursing, risk advisers from within HSE mental health services and a number of external expert advisers including an academic, a service user representative, and clinical risk advisors (Clinical Indemnity Scheme).

This guidance document is intended for use by the staff of mental health services, other health service staff linking with mental health services, mental health service users and their families and carers. Its purpose is to embed risk management in all aspects of day to day practice by supporting services to adopt a more systematic approach to risk assessment and management thus reducing the potential for harm.

Martin Rogan,
HSE Assistant National Director, Mental Health.

Acknowledgements

The development of this guidance document was a collaborative effort between HSE and a number of external partners. Those partners are:

Debbie Dunne, Clinical Risk Advisor, and Dr Ailis Quinlan, Head of CIS, both of the Clinical Indemnity Scheme who responded so generously to our request for assistance with this guidance and brought their considerable knowledge and learning from the examination and investigation of adverse events to bear on the process.

Dr Margaret O Rourke, consultant Forensic Clinical Psychologist, Director of Behavioural Science, School of Medicine, University College Cork who provided invaluable external academic assistance.

Paddy McGowan, Expert By Experience, DCU, who has a long and distinguished history as a campaigner on mental health issues and as a peer advocate, for providing an erudite service user perspective on the many issues addressed in the guidance

Dr Fiona Keogh, Research Psychologist, who assisted in developing the guidance to an accessible and publishable standard.

Special thanks are due to all internal and external collaborators for their efforts, time and patience.

TABLE OF CONTENTS

CHAPTER 1

1.1 Introduction 5
1.2 Policy and Regulatory Framework 7
1.3 HSE Quality and Risk Management Standard 8
1.4 Risk Management in the HSE 9
1.5 Concept of Risk and Mental Health Service Provision 10
1.6 Duty of Care 11
1.7 Conclusion 12

CHAPTER 2

2.1 Integrated Risk Management 15
2.2 The Risk Management Process 15
2.3 Service Considerations 21
2.4 Existing Governance Structures/Processes 22

CHAPTER 3

3.1 Clinical Risk Assessment and Management in Mental Health Services 25
3.2 Clinical Risk Assessment and Management 26
3.3 Tools for Risk Assessment and Management 29

CHAPTER 4

4.1 Good Practice and Key Clinical Risks 33
4.2 Good Practice 33
4.3 Key Clinical Risks 39

REFERENCES 44

SUB GROUP MEMBERSHIP 47

APPENDICES

Appendix 1 Glossary of HSE Quality and Risk Terms and Definitions 48
Appendix 2 Incident Management 50



CHAPTER 1

1.1 Introduction

We are all concerned with delivering the best possible mental health service for service users and their carers. This means a service that is effective, involves service users and carers in decision making and is safe for all involved. Safe, effective mental health services take a modern approach to risk, where risk management is defined as *"the culture, processes and structures that are directed towards realising potential opportunities whilst managing adverse effects"* (AS/NZS 4360: 2004). This approach moves away from a one-dimensional view of risk in mental health as pertaining largely to threats arising from service users, and instead views risk as dynamic and multi-dimensional, and emphasises the potential gains as well as the hazards of risk taking. This document adopts this wider view, where the process of managing risk is not just focused on eliminating risk, but on realising potential benefits while reducing the likelihood of harms occurring as a result of taking risks.

This approach moves away from a one-dimensional view of risk in mental health....

This dynamic view of risk, which includes potential opportunities as well as minimising hazards, fits very well with the recovery approach to mental health services. National mental health policy *A Vision for Change* (DoH&C, 2006), recommended that mental health services adopt a recovery approach, and this policy is now being implemented by the HSE. Recovery in this context refers to the process of a person with a serious mental illness "reclaiming his or her right to a safe, dignified and personally meaningful and gratifying life in the community" (Davidson et al 2009). The emphasis is on self-determination and the role of the mental health services and mental health professionals is to support the individual to be successful in achieving *their* recovery. This approach to mental health is characterised by partnership between the service user and mental health professional in negotiating all aspects of care, including potential risks. It creates a context for the mental health

professional and the service user to understand and take responsibility for all possible consequences for certain treatment decisions, including benefits and risks.

The HSE has adopted the *Australian New Zealand Risk Management Standard* (AS/NZS 4360: 2004) as the common process by which to manage risk. The AS/NZS 4360:2004 is widely used in healthcare as it provides a flexible framework that can be applied to clinical and non-clinical risk.

The aim of this document is to provide guidance on risk management in the HSE, and support mental health services in adopting a systematic approach to risk assessment at all levels and across all disciplines, thus enabling risk management to be embedded in day to day practice. **Whilst it does address key issues, it does not claim to be exhaustive. This guidance is aimed at all those working in and accessing the HSE who have an interest in improving patient safety and quality of mental health services. This includes clinical staff, managers, risk advisors/managers, as well as service users, their relatives and carers. It is designed to be multi-purpose; it can be used by clinicians as a reference source for clinical risk management, it can be an information source on approaches to risk management for service users, it can guide the mental health service manager in working on a service-wide risk management process, it can be used by a multidisciplinary team in working with managers to develop a risk management process, or in discussing the care of an individual service user.**

The remainder of Chapter One provides information on the relevant policy and regulatory frameworks which provide direction on risk management activity and process. A key driver is the HSE Quality and Risk Standard which provides the defined HSE approach to quality and risk management across all services and functions. This chapter also considers the concept of risk in the context on mental health services.

Chapter Two outlines the main elements of the integrated risk management process and how risk management is everyone's concern and should be applied to all aspects of service provision across the organisation.

Chapter Three focuses on clinical risk assessment and management and outlines how the risk management process should be applied and how this process facilitates decision making and positive risk taking. The use of a range of evidence based tools to assist with this process is considered and links to various tools are provided.

Chapter Four provides practical guidance on communication, personal safety and staff training and addresses some of the key clinical risks in mental health practice such as vulnerability, violence and suicide.

1.2 Policy and Regulatory Framework

> *"Patient safety has become both a national and international imperative in recent years, with increased emphasis across the world on patient safety in policy reform, legislative changes and development of standards of care driven by quality improvement initiatives."*
>
> Report of the Commission on Patient Safety and Quality Assurance (DoH&C, 2008)

Contemporary health strategy and policy articulate the need for services to be quality and safety driven at all levels, demanding a strong and unambiguous focus on safe and effective care. Relevant strategy documents include *Quality and Fairness,* DoH&C (2001); *A Vision for Change,* DoH&C (2006); *Quality Framework, Mental Health Services in Ireland,* MHC (2007); and *Building a Culture of Patient Safety, Commission on Patient Safety and Quality Assurance* (DoH&C, 2008). The legislative requirements for provision of mental health services in Ireland clearly outline the need to have in place risk management systems and processes (Regulations for Approved Centres and the Rules of the Mental Health Commission).

1.3 HSE Quality and Risk Management Standard

The HSE is committed to the provision of safe, high quality health services. Improving and maintaining the safety and quality of services requires sustained commitment to continuous improvement from everyone involved in the health system. The HSE has issued a *Quality and Risk Standard*[1] that describes a framework for achieving high standards in clinical care through the implementation of an integrated quality and risk management system (HSE, 2007). The aim of the standard is to provide a common set of requirements that will apply across all service providers to ensure that health and social services are both safe and of an acceptable quality.

The Statement of Standard is: *Healthcare quality and risk are effectively managed through implementation of an integrated quality and risk management system that ensures continuous quality improvement.*

In providing for the establishment of an integrated quality, safety and risk management framework in which existing statutory and policy obligations can be met, the HSE *Quality and Risk Management Standard* describes how excellence in clinical governance can be achieved and maintained. The standard will drive improvements in patient safety and quality of care and assist in preparing services for the inspection regime of the Inspector of Mental Health Services.

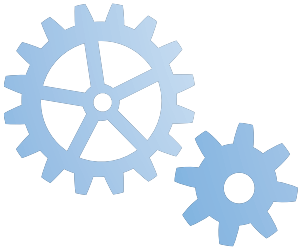
Whilst the HSE *Quality and Risk Standard* applies to all health services, there are additional legislative and regulatory requirements that are specific to mental health services. In particular the Mental Health Act 2001 mandates the Mental Health Commission which has both regulatory and advisory functions including the Inspectorate of Mental Health Services and the preparation and oversight of regulations and codes of practice for mental health services. *Quality Framework, Mental Health Services in Ireland* prepared by the Mental Health Commission (2006) should be read in conjunction with the HSE *Quality and Risk Standard,* with particular attention to Standard 7.

[1] HSE (2007) *Quality and Risk Standard Management Standard.* Office of Quality and Risk.

1.4 | Risk Management in the HSE

The HSE recognizes the interdependencies of risks, e.g. the relative safety of the service user and staff is dependent on the safety of the environment in which care is delivered[2]. For the HSE there is a number of categories of risk identified for risk management purposes[3] these include:

- Risks of injury (to patients, staff and the public)
- Risks to the service user experience
- Risks to the compliance with standards
- Risks to objectives and projects
- Risks to business continuity
- Risks to reputation
- Risk to finances
- Risk to the environment.



The HSE has adopted the *Australian New Zealand Risk Management Standard* (AS/NZS 4360: 2004) which describes a process for risk management. This process is outlined in Figure 1.1 below.

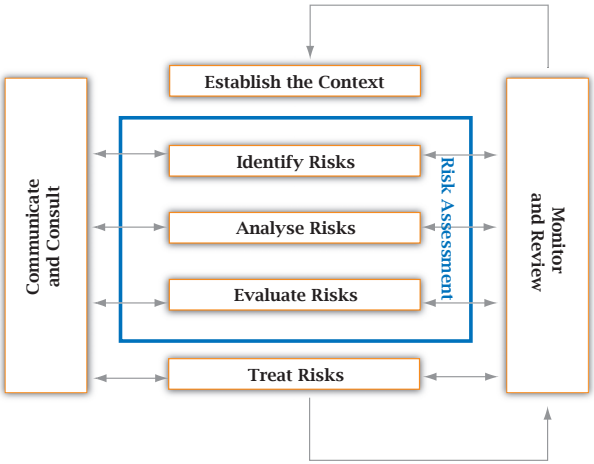


Figure 1.1: The Risk Management Process, (AS/NZ 4360:2004)

[2]Standard 4.1 of the *MHC Quality Framework* notes the importance of the physical environment "Stakeholders see the quality of the physical surroundings as having a strong impact on those using mental health services and on their recovery processes." (p.48).
[3]HSE (2007) *Risk Management in the HSE; An Information Handbook.* Office of Quality and Risk.

In the HSE risks of all kinds should be systematically identified, evaluated, assessed and managed in order of priority. The principal vehicle for identifying, communicating and tracking risk at all levels is the risk register, which allows a repository of risk information to be maintained (HSE, 2007). Guidance on conducting risk assessment[4] and developing the risk register has been prepared by the HSE and is available (HSE, 2008).[5]

1.5 Concept of Risk and Mental Health Service Provision

Part of the work of mental health professionals, whether in community or hospital based multidisciplinary teams, is to manage risk. Risk is often perceived as a wholly negative process. As a consequence of this negative perception *"individuals and organisations often take a 'fight or flight' approach to risk assessment and management. The former is characterized by over reaction, rigidity, excessive controls and the identification of risk where none may exist. The latter can involve avoidance, complacency or the denial and minimization of risk. Anxiety and other emotions can therefore exert a significant influence on risk assessment management and strategy practice and policy."*
(O'Rourke and Bailes, 2006).

This negative view is not a productive way of viewing risk. Whilst it can be linked with the concepts of harm or danger, risk also can be a chance to gain benefits in a situation where harm is possible (Gilmore, 2004). It is important to be clear about what we mean when we examine risk in relation to mental health issues.

Four areas of risk are relevant for consideration when dealing with people with mental health issues;

- **Vulnerability:** The service user can be at risk of or exposed to damage or harm through personal or external factors (e.g. naiveté, low insight, family, social/community pressures, in care, poverty, homelessness or other resource or capability deficits);

[4]HSE (2008) Risk Assessment Tool and Guidance (including guidance on application) Office of Quality and Risk. [5]HSE (2007) Developing a populating a Risk Register Best Practice Guidance. Office of Quality and Risk.

- **Self harm/suicide risk:** The service user can be at risk from self harm, intentional injury or killing oneself, action/behaviours destructive to one's own safety or health;
- **Mental Instability:** The service user can be a risk to self or others because of fluctuating and/or unpredictable mental health function especially in relation to command hallucinations and other "at risk" psychotic or disturbed phenomena;
- **Risk to others:** The service user can be at risk of causing harm or danger, or encouraging/involving others in the causing of harm or injury to others.

People who pose a risk to themselves or others may have other difficulties in their lives, such as substance misuse, legal or financial problems or housing difficulties. Consequently they require a spectrum of services and supports. This means that effective working between the different agencies responsible for the various aspects of care is essential. Risk assessment and management does not fall exclusively within the domain of any single profession or discipline. No agency can operate in isolation when working with people with mental health risk (O'Rourke and Hammond, 2005).

1.6 | Duty of Care

Risk assessment and management involves a professional duty of care on the part of those working in mental health services towards the individual service user, where health needs are balanced with issues of personal and public safety. Health professionals must balance the promotion of client decision making and autonomy with the demands of personal, professional and public accountability. Managing risk should not just focus on eliminating risk, it is about providing a process for ensuring the potential benefits identified are increased and the likelihood of harms occurring as a result of taking risks are reduced (Titterton, 2005).

As part of their everyday work, the mental health professional is required to comply with specific responsibilities under health and safety

legislation[6], such as taking reasonable care to protect his or her safety, health and welfare and the safety, health and welfare of others. However, the dynamic concept of risk requires that the range of partners in mental health services each play their part in effective risk management including the service user and to a lesser extent the carers and family members. This can be achieved most effectively through the type of partnership working embodied in the recovery approach, where these individual responsibilities can be teased out and negotiated. Service users may require additional support to understand and comply with their responsibilities in this regard, such as advice and support from an independent advocate. Effective risk assessment and management, which actively involves the service user in the process, can and should be empowering and health facilitating. Some interventions can present a risk to service users, such as some types of medication which may have unwanted side effects. So the concept of risk is much broader than often portrayed or acknowledged.

1.7 Conclusion

The HSE approach to risk management is based on the principle that people with mental illness (whatever the nature) should be treated in the same way as people with any other illness or medical condition. Care and treatment needs should be properly assessed and wherever possible provided with the full agreement and input of the service user and his/her significant others (family or carers). Common principles can be identified and used to form the basis for guidance; however the design of a risk management system will be influenced by and tailored locally to the specific services provided. Although risk will never be eliminated completely, it can be minimised by implementing good processes and procedures. The risk management process is dynamic so that learning should continuously feed back at two levels – the individual care plan and the organisational systems. Effective risk assessment and management, which actively involves the service user can and should be empowering and health promoting.

[6]The Safety, Health and Welfare at Work Act, 2005

Chapter 1 – Key Messages

1. The HSE has issued the *Quality and Risk Standard* (2007) which requires integrated quality and risk management systems that ensure continuous quality improvement.
2. Risk management is defined as "The culture, processes and structures that are directed towards realising potential opportunities whilst managing adverse effects"(AS/NZS 4360: 2004).
3. Mental health services must have risk management systems and processes in place.
4. All risks should be systematically identified, assessed and managed in accordance with risk management standard AS/NZS 4360: 2004.
5. The recovery approach should underpin the structure and delivery of mental health services including risk assessment and risk management.
6. A partnership approach between service users, carers, professionals and other stakeholders is essential when balancing risk, need and recovery.
7. Health professionals must balance individual risk, needs and autonomy with the demands of personal, professional and public safety and accountability.
8. Risk is dynamic, there is no such thing as zero risk, but it can be minimised and managed by implementing the procedures outlined in this guidance.



CHAPTER 2

2.1 Integrated Risk Management

> *"A safe, quality mental health service will flourish where a culture of quality improvement is encouraged by using quality and safety methods which adopts a whole-system approach."* (Mental Health Commission, 2007)

Integrated risk management implies that addressing risk is everyone's responsibility. Safe, effective clinical practice requires that the entire system is working well, not just the parts that are the direct responsibility of the clinician. Thus the systems and processes of a comprehensive risk management process need to be in place throughout the system and need to address **all** the risks to the organisation. This means that clinical risk processes, health and safety processes and other risk management processes work in tandem and in a supportive way – they are not separate.

Every mental health service needs to ensure that an integrated, service wide quality and risk management framework is in place to identify any risks that arise in relation to service users, staff and the organisation. The adoption of the HSE and the MHC requirements related to risk management (described in Chapter 1) will go a long way to ensuring that an integrated, service wide quality and risk management framework is in place to identify any risks that arise in relation to service users, staff and the organisation.

2.2 The Risk Management Process

The risk management process is based on the *Australian/New Zealand Risk Management Standard* (Australian/New Zealand 4360:2004). This standard is an internationally recognised risk management standard which provides a framework for the risk management process. This risk management process is outlined in Figure 2.1.

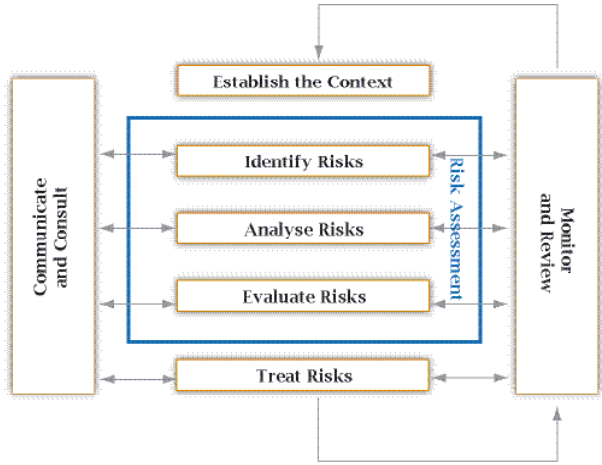


Figure 2.1: The Risk Management Process, (AS/NZ 4360:2004)

There are five steps involved in the risk management process and these are described in detail here.

Step 1: Establish the context of risk

The first part of the risk management process is to determine the overall context in which the other steps of the risk management process will occur. Identifying external and internal drivers helps to illuminate the context.

Examples of external drivers include;

- Service user expectations of high quality and safe services
- Service users advocacy groups
- Mental Health Commission
- Professional bodies
- Legislation e.g. Mental Health Act 2001, Safety Health and Welfare at Work Act 2005
- HIQA requirements
- CIS and MHC Incident reporting requirements
- Organisations that provide indemnity to the mental health services and

staff such as the State Claims Agency, Clinical Indemnity Scheme and Irish Public Bodies.

Example of internal drivers include;

- HSE Governance requirements
- HSE Quality and Risk Standard 2007
- Need to improve patient safety
- Need to improve the patient environment
- Need to learn from reported incidents and complaints occurring in the mental health service.

Step 2: Identifying the risk

There is a variety of sources and methods for identifying organisational risk. Quite often people focus on incident reporting, and although this is the cornerstone of risk management, there are other equally important sources of risk information, some of which are outlined in Figure 2.2. Some areas of risk may be perceived as being 'entirely clinical' or 'entirely management'. While it is certainly useful for local clinical and management teams to conduct initial work in identifying risks specific to their area of expertise, it is essential for an integrated system, that at some point clinical and management teams work together to develop a comprehensive, organisational risk register.

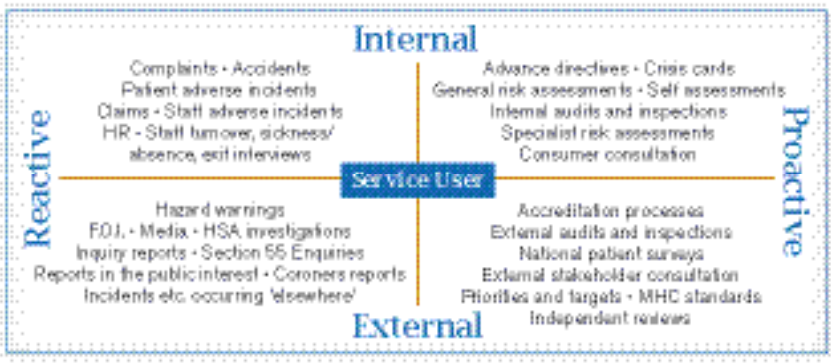


Figure 2.2: Sources of information for identifying risk

A formal risk identification process is needed within the services to identify:

- The extent and nature of risks,
- The circumstances under which risks arise,
- The causes and potential contributing factors.

Risk identification is the first stage of the entire risk management process. If this stage is not functioning adequately then the entire process is flawed. This will happen because the organisation has no way of knowing if the risk it is tackling is in fact the more serious risk to which it is exposed. Identifying, understanding and prioritising risks, enables informed decision making about policies and service delivery systems.

The specific issues to be addressed in relation to risk identification are;

- Systems need to be in place for reporting, grading and recording risks
- The training needs of the staff must be carefully considered and accommodated.
- The development of proactive risk identification techniques.

It is vital that communication and consultation with internal and external stakeholders as appropriate, takes place at each stage of the risk management process.

Step 3: Assess the risk

The assessment of risk involves both the analysis and evaluation of the identified risk. Risk analysis is about developing an understanding of the risks identified, therefore all risks are to be analysed in order to:

- Assess the extent of actual or potential impact
- Assess the likelihood of occurrence

In subjecting a risk to analysis it is essential that account is taken of the existing control measures. Putting a value on a risk and its implications is arguably subjective but nonetheless important for assessing the status of

a risk and monitoring whether the state of a risk has altered. The HSE have developed a risk assessment tool and guidance[7] for use by services for this purpose, the aim of which is to ensure consistency for risk assessment throughout all services.

Risk assessment guidance and tools may be accessed

HSE intranet
http://hsenet.hse.ie/HSE_Central/Office_of_the_CEO/Quality_and_Risk/ .

Internet access at:
http://www.hse.ie/eng/About_the_HSE/Whos_Who/Quality_and_Risk_Management.html

The purpose of risk evaluation is to make decisions based on the outcome of the risk analysis regarding which risks require treatment and the priorities of that treatment. Thus the risk assessment process is an aid to decision making regarding the prioritisation of the management of risks. This can involve a decision to accept the risk, or treat the risk by risk avoidance, risk transference or risk control.

Criteria used to make decisions regarding accepting or treating the risk should be consistent with the defined internal, external and risk management contexts and taking account of the service objectives and goals.

Step 4: Treating the risk

Risk assessment informs risk management and there should be a direct follow through from assessment to management. An action plan needs to be developed for all identified risks that require further treatment. This plan should specify the person responsible and the timeframe for action. If possible, risks should be eliminated. However, this is not always achievable in healthcare, therefore the plan must be to reduce the risk to as low a level as is reasonably practicable.

[7]HSE (2008) *Risk Assessment Tool and Guidance (including guidance on application)* Office of Quality and Risk

Step 5: Monitoring and reviewing the risks

Risk is not static it is dynamic and evolutionary therefore continuous monitoring and reviewing of the risk management control system is essential. Risk management needs to be on every agenda of every committee and needs to be constantly reviewed and evaluated. For example, multidisciplinary team meetings could have risk assessment as a standing item on their agendas, both for individual cases and for their overall work management. Similarly, risk management should be a item on the agenda of all mental health management team meetings. It is also important to assess whether the nature of the risk changes over time. Some of the areas assessed may include;

- Number of incidents reported
- Grades of incidents and risks identified
- Categories of risks
- Level of Root Cause Analysis activity across the service
- Status reports in relation to the update of safety statements and other quality improvement documents.

The risk register is an essential tool for the ongoing monitoring and management of identified risk issues. The complete information required to populate the risk register is detailed within the HSE document, *Developing and Populating a Risk Register Best Practice Guidance* (HSE, 2008). The risk register must contain details related to the risk such as the type of risk, its context, the risk rating, the agreed corrective measures/action plan, persons responsible and review dates.

The following are examples of sources of risk information that can be used to populate the risk register:

- Safety statements
- Results and recommendations of clinical audits
- Findings and recommendations from internal audit reports
- Findings and trends from incident analysis reports

- Findings and recommendations from inspection reports
- Non-compliance with standards
- Non-compliance with regulations, rules and codes of practice.

2.3 Service Considerations

Having a strategic framework for risk management allows for the development of appropriate structures and processes to manage risk within the mental health services. The HSE *Quality and Risk Standard* (2007) and Mental Health Commission (MHC) *Quality Framework* provide the direction as to how this is to be achieved i.e. by creating the necessary systems and processes that will reduce or eliminate risks to service users, staff and the organisation.

It is not sufficient to manage risk at the individual activity level or in isolated components of the organisation. Integrated risk management is a continuous, proactive, systematic process which allows mental health services to understand, manage and communicate risks. It contributes to strategic decision making and allows a service to achieve its overall service objective. Integrated risk management requires an ongoing identification and assessment of potential risk at every level throughout the service and then aggregating results to facilitate priority setting to improve decision making. Integrated risk management should become embedded in mental health services.

In order to achieve the highest standards of quality and safety in mental health services, the necessary systems and processes must be in place and these must be inclusive of all clinical and non-clinical risks. A service-wide perspective is needed, that includes multiple sources of information for analysis including audit, inspections, claims management, health and safety issues, complaints, internal audit, incident reports, incident reviews and risk management. Each service area needs to consider the following;

- Structures/groups that may already be in place within their service area and identify those groups that may require to be established;

- The development of the necessary processes required to proactively assess, identify and understand the risks inherent within the delivery of mental health services;

- The requirements necessary to ensure the systems and processes encourage all staff irrespective of discipline or rank to identify, report and analyse risks in their working practices and to incorporate controls to eliminate or reduce risk.

Near miss and incident reporting are often described as the cornerstone of quality and risk management systems (Wilson and Tingle,1999, Woloshynowych *et al.,* 2005). It is therefore essential to ensure that an effective incident reporting process is in place to facilitate the systematic identification and reporting of adverse events across mental health services. The information gained can be utilised at both a local and national level to identify trends and patterns to enable prioritisation of the development of safety improvement programmes. Information gained from incident reporting can contribute to the identification of gaps in the system that require attention. Further information on incident management is contained in Appendix 2 of this document.

2.4 Existing Governance Structures/Processes

There is a need for services to recognise that structures may already exist within their immediate service areas. The key is to ensure a service wide overview that is supported by a shared philosophy/principles and service wide commitment to manage risks and shared learning. A number of groups may already be in place which can be harnessed to support the governance requirements including;

- Service user groups
- Health and safety committee
- Policy and procedure groups
- Drugs and therapeutics committees
- Ethics committees
- Quality circles
- Clinical risk management steering groups

Chapter 2 – Key Messages

1. Risk management needs to be on every agenda of every committee and needs to be constantly reviewed and evaluated. Risk is not static it is dynamic.

2. Mental health services must develop a robust and proactive approach to the assessment, identification and understanding of the risks inherent within the delivery of mental health services. This should include the views of service users.

3. The risk management process should include all clinical and non-clinical risk and needs to be supported by an integrated communications plan for risk and quality management.

4. Staff must be encouraged and enabled to identify, report and analyse risks in their working practices and to incorporate controls to eliminate or reduce risk.

5. The risk register is the repository for risk information and should be used by all services – it is an essential tool for the ongoing monitoring and management of identified risk issues

6. The development of a safety improvement programme can be supported by sharing learning through groups such as quality circles, user groups and risk management groups.



CHAPTER 3

> *"The development of clinical risk-management and risk-assessment approaches within mental health settings is essential. Reducing exposure to litigation and financial risk addresses just one narrow aspect of the risk-management agenda. The recording and analysis of adverse events in clinical risk management must be seen in a wider context of service user safety, staff safety, quality service delivery and clinical governance."*
>
> (A Vision for Change, 2006).

3.1 Clinical Risk Assessment and Management in Mental Health Services

In the preceding chapters this guidance document has placed much emphasis on how recovery oriented mental health services, based on partnership working between service users and mental health professionals, provides a productive approach to clinical risk assessment and management. The relationship of mutual respect between the service user and mental health professional supports mental health professionals in their duty of care to service users, their colleagues and others, and recognises the responsibilities of the service user in working with mental health professionals to manage risk.

The assessment and management of risk is integral to mental health practice. Effective clinical risk management involves the implementation of operational procedures and supports which are based on agreed values and principles. These work to support the service user and enable a dynamic sensitivity to the individual's needs, vulnerabilities and evolving behaviours. The goal of these procedures is risk reduction and the provision of high quality, effective services (O'Rourke 2003, O'Rourke and Hammond 2005).

All mental health professionals have a role to play in both assessing and managing risk. The perspectives of all disciplines working with the service user should be taken into account when formulating both a risk assessment and risk management plan (Morgan, 2007). In accordance with the recovery approach, the overall assessment and treatment plan must be developed with the service user so that their perspective is an integral part of this plan.

3.2 Clinical Risk Assessment and Management

Risk assessment is defined as the overall process of risk identification, risk analysis and risk evaluation (AS/NZ 4360:2004) as outlined in Chapter Two. Risk assessment is a process, not an outcome, and allows clinicians to support their decision making by documenting and communicating the systematic assessment of the individual. The assessment of risk is an essential component of the risk management process. Good risk management is the same as good clinical practice and should be part of everyday clinical practice (O'Rourke 2003, Morgan 2007).

Clinical risk management is a four step process as follows:

1. Identification of risk
2. Analysis of risk
3. Evaluation of risk
4. Treating risks

Following all four steps in the clinical risk management process facilitates informed decision making and positive risk taking. These steps must be underpinned by communication and consultation together with ongoing monitoring and review.

Step 1: Identification of Risk

Safe assessment is dependent on the accumulation and communication of reliable information and consideration of valid risk factors. Multiple assessment methods and the use of different sources of information are important here.

Identification of risk is concerned with accumulating information about the individual, being mindful of the need for multiple assessment methods and the use of different sources of information, for example, obtaining collateral information from family members, friends, General Practitioner and other agencies as appropriate.

Identification of risk also involves identifying historical and current risk factors relating to the outcome of concern (e.g. self harm) and this is where evidence-based tools and guidelines can be utilised. These usually involve the synthesising of the information into a variety of profiles of mental illnesses, adverse social circumstances, and life events etc. The use of evidence based tools and guidelines can facilitate a structured organisational approach to risk assessment.

The reality of clinical practice is that risk tests and/or scales can help inform clinical judgement but not replace it, as ultimately it is people, not tests who should make decisions (see tools below in Table 3.1).

Risk is safely identified if all parameters of individual functioning are examined. Research has shown that the four essential parameters of risk are:

- History
- Clinical
- Disposition
- Context

Case information (history, mental state, substance misuse etc.) and the presence of risk factors (historical, current, and contextual) are considered here (O'Rourke, 2003; Doyle and Dolan, 2007).

Risk management therefore emphasises the need to assess the historical and current presentation, the clinically relevant behaviours, the personality features (both strengths and deficits) and the contextual factors, again both strengths and protective factors and also any issues which may increase risk. Risk assessment should be dynamic not static and should be seen as a continuous process which is mediated by changing conditions.

Step 2: Analysis of Risk

Risk analysis is defined as 'the systematic process to understand the nature of and deduce the level of risk (AS/NZS 4360:2004). Risk management emphasises prevention rather than prediction of risk, therefore all risk factors need to be considered in terms of the conditions under which the risk will increase and/or decrease. It is important that risk is analysed using multiple sources of information including the person's presentation current and historical, collateral reports (from family, partners, GP and other agencies as appropriate). Personality, behaviours (e.g., intoxication, addiction) and all contextual features should be included. Protective factors, (historical, current and contextual) should also be considered here.

Step 3: Evaluation of Risk

Evaluation of risk is similar to risk formulation and includes examining the nature, severity, imminence and likelihood of risk.

All risks should be systematically identified, analysed and then evaluated in order to determine both the case and risk management needs. This should be done by working in partnership with service users, carers, professionals and other stakeholders to balance risk, need and recovery. Risk must be evaluated in the context of the overall needs of the person and health professionals must balance individual risk, needs and autonomy with the demands of personal, professional and public safety and accountability.

Evaluation of risk should include any specific factors that would enhance or decrease the risk occurring, for example the presence or absence of alcohol addiction, the presence or absence of bereavement etc. The individual's risk assessment will inform their management plan. This will also provide a rationale for the clinical decision taken.

Step 4: Treating the Risks – Clinical Risk Management Plan

Using the information gathered from steps 1-3 the management plan is developed by the multidisciplinary team in partnership with the service user. This informs the ongoing active treatment, care and management of the service user. This plan will be continuously reviewed and modified as circumstances change.

3.3 Tools for Risk Assessment and Management

> *"The limitations and value of risk assessment instruments must be understood. Risk assessment should be seen as an assessment of a current situation, not itself a predictor of a particular event. Its critical function is to stratify people into a group (low, medium or high risk), which will help dictate the appropriate care and treatment and risk management strategy."*
>
> (Royal College of Psychiatrists Scoping Group on Rethinking Risk to Others, 2008).

There is a variety of tools available for clinical risk assessment in mental health services (see Table 3.1). These tests are more fully described in the UK, Department of Health Document *Best Practice in Managing Risk,* (DOH, UK, 2007). The publication also provides a guide for mental health professionals working with service users to assess risk. It provides a set of fundamental principles and good practice which underpin risk assessment for all mental health settings and provides a list of tools offering structure to risk management. The aim of this publication is to support services in adopting a systematic approach to risk assessment at all levels and across all disciplines within the mental health services, thus enabling risk management to be embedded in day to day practice, (DOH (UK) 2007). These tools are of relevance to the practice of clinical risk assessment in mental health services in Ireland.

It is important to acknowledge that risk assessment tools should support, rather than replace, professional judgement. The limitations and values of risk assessment tools must be understood. Accurate risk prediction may not be possible at an individual level; however the use of structured risk assessment when systematically applied by a clinical team with a tiered approach to risk assessment can enhance clinical judgement. This will contribute to effective safe service delivery.

Examples of tools for supporting best practice in risk assessment and Management:

Multiple risks: Provide a framework for examining all risks

CRMT:	Clinical Risk Management Tool/Working with Risk
FACE:	Functional Analysis of Care Environments
GRiST:	Galatean Risk Screening Tool
RAMAS:	Risk Assessment Management and Audit Systems
GIRAFFE:	Generic Integrated Risk Assessment for Forensic Environments
START:	Short-term Assessment of Risk and Treatability

Risk of violence or sexual violence, and antisocial or offending behaviour

HCR-20:	Historical Clinical Risk-20
	PCL-R: Psychopathy Checklist-Revised
PCL: SV:	Psychopathy Checklist: Screening Version
STATIC-99	
SVR-20:	Sexual Violence Risk-20
VRAG:	Violence Risk Appraisal Guide

Risk of suicide or self-harm

ASIST:	Applied Suicide Intervention Skills Training
BHS:	Beck Hopelessness Scale
	SADPERSONS
SIS:	Suicidal Intent Scale
SSI:	Scale for Suicide Ideation
STORM:	Skills-based Training on Risk Management

Further information and detail available in: Department of Health (2007) **"Best Practice in Managing Risk",** *Principles and evidence for best practice in the assessment and management of risk to self and others in mental health services* (UK)

http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_076511

Chapter 3 – Key Messages

1. Effective clinical risk management involves partnership to support the service user and enable a dynamic sensitivity to the service users needs, vulnerabilities and evolving behaviours.

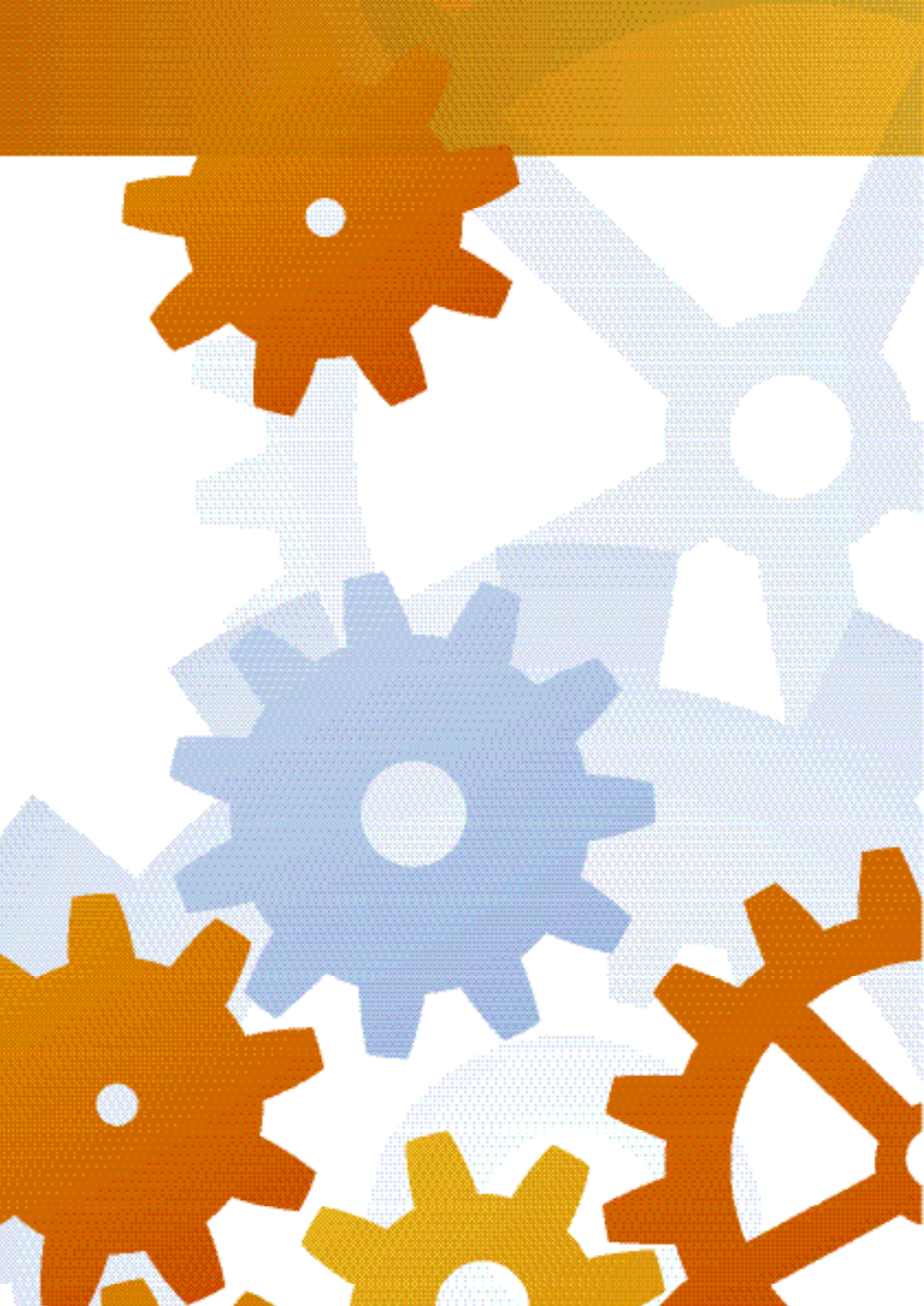
2. All mental health professionals have a role to play in both assessing and managing risk. Mutual respect between the service user and mental health professional supports staff in their duty of care to service users, the carers, colleagues and others.

3. Multiple assessment methods and the use of different sources of information are important.

4. Risk is safely identified if all parameters (Historical, Clinical, Dispositional and Contextual) & features of individual functioning are examined.

5. Risk assessment tools should support rather than replace professional judgement.

6. Having identified risk there is an absolute duty of care to manage it.



CHAPTER 4

4.1 Good Practice and Key Clinical Risks

Risk management is an essential part of a good clinical practice. This chapter provides practical guidance on communication, personal safety and staff training and addresses some of the key clinical risks in mental health practice such as vulnerability, suicide and violence. Key points from *Linking Safety and Service* (HSE, 2008; the strategy for managing work related aggression and violence within the Irish health service) are included in this chapter and it is recommended that the strategy should be read in conjunction with this section.

Although risk will never be eliminated completely, it can be minimised by ....

4.2 Good Practice

Although risk will never be eliminated completely, it can be minimised by ensuring that there is good communication, sufficient attention to staff and patient safety and appropriate training and support for staff and service users. These three issues are dealt with in more detail below. A list of *Best Practice Principles* is included (see Table 4.1).

4.2.1 Communication

Good communication is key to managing risk. All methods of communication are important to achieve effective risk management in care provision. Research and clinical practice have indicated that specific aspects of communication are important in order to achieve this, these include:

Listening to all concerned: full and clear picture is essential (rapport is a crucial element and time is required to build up a relationship of trust and respect).

Asking the questions: the quality of the assessment is dependent on asking appropriate questions.

Good written records: if information is not recorded it will not be remembered/discussed or acted on.

Regularly consult the records: monitoring and recording change. A strategy for Action Points, a communication chain and clear and shared goals are all important.

Confidentiality: any information sharing should be confidential on a 'need to know' basis and not in the public domain.

Regular Review: An active learning, changing process. (Remember: Risk is dynamic).

(Source: Start Safe Stay Safe, O'Rourke, 2003)

Missing information can lead to an underestimation of risk, and consequently a failure to act when action is required. The lesson from practice is that agencies working together really can make the difference. When forms are standardised and safe systems implemented, it is important to supply regular updates (O Rourke, 2003).

4.2.2 Service User and Staff Safety

Violence and aggression in mental health services is a complex issue with a wide variety of causes, behaviours and consequences. Aggressive behaviour is a concern for staff and service users alike. Service users can sometimes feel unsafe in inpatient settings, yet the purpose of the inpatient care is to provide a safe and therapeutic environment. The challenge for staff is to manage disruptive behaviour in a way that optimises patient and staff safety, while protecting patient's rights.

The legal obligation imposed upon employers by health and safety legislation requires that organisations put in place all reasonably practicable preventative and protective measures in order to create safe places and processes of work for their employees and others. Enshrined in this obligation is the requirement that employers conduct systematic risk assessments of workplace hazards which are likely to result in accident or injury. Such assessments must then inform the implementation of control measures deemed necessary to minimise associated risks.

The reader is referred to the HSE strategy for managing work related aggression and violence within the Irish Health Service -*'Linking Safety and Service, Together creating safer places of service' (HSE,2008)*[8]. The strategy employs four best practice approaches from organisational and health disciplines including;

- a contextual understanding of aggression and violence within healthcare;
- an integrated, balanced organisational response;
- a public health preventative approach, and
- a partnership ethos of working.

This strategy highlights a number of high priority risk reduction measures which should be implemented at the earliest opportunity. These include developing a response in relation to;

- Risks inherent in lone working and working alone;
- Risks associated with non-physical aggression and violence;
- Risks associated with physical aggression and violence;
- Risks associated with behavioural manifestations of medical conditions such as cognitive impairments, systemic illnesses and substance use/or withdrawal;
- Risks associated with the provision of training in physical interventions;
- Risks associated with the use of physical interventions in practice;
- Risks associated with the psychological impact of aggression and violence.

[8]*HSE,(2008) 'Linking Safety and Service, Together creating safer places of service.'*

Achieving an effective organisational response to the issue of work-related aggression and violence from both health and safety, and quality and risk perspectives will require a cohesive integrated approach. Health and safety priorities include establishing full compliance with risk assessments, while quality and risk priorities include addressing high risk issues which can achieve significant impact in the shorter term. It is critical however that these efforts are not simply integrated with each other, but also with the broader organisational strategy for managing aggression and violence. It is imperative therefore that a strong working liaison exists between those responsible for health and safety, quality and risk, and the implementation of the aggression and violence strategy (HSE, 2008).

4.2.3 Staff Training and Support

The training of all staff should include the management of risk. Training should be available at a number of levels to address the learning needs of different staff. Mental health services staff should be supported to exercise professional skills in terms of effective information sharing. Mental health staff should be enabled with the knowledge and skills to collaborate fully with service users, carers and with other agencies and disciplines in order to safeguard public safety and individual care. In addition, all staff should receive specialist training on the prevention and management of aggression and violence.

The benefits of an effective risk management strategy can only be gained through involving all staff. Planned, not piecemeal methods should be the strategy for good practice when addressing risk in mental health services. All staff, whether directly or indirectly involved, should be clear on what is expected of them, this may best be achieved by providing training for multidisciplinary teams as a unit.

Communication, service user and staff safety, and training are all areas which support the delivery of best practice in relation to risk management. The following list of principles provides a useful summary for this area (Table 4.1).

Best practice principles for assessment and management of risk to self and others. *Best Practice in Managing Risk, (DOH, 2007)*

1. Positive risk management as part of a carefully constructed plan is a required competence for all mental health practitioners.
2. Best practice involves making decisions based on knowledge of the research evidence, knowledge of the individual service user and their social context, knowledge of the service user's own experience and clinical judgement.
3. Risk Management should be conducted in a spirit of collaboration and based in a relationship between the service user and their carers that is as trusting as possible.
4. Risk management must be built on recognition of the service user's strengths and should emphasise recovery.
5. Risk management requires an organisational strategy as well as efforts by the individual practitioner.
6. Risk management involves developing flexible strategies aimed at preventing any negative event from occurring or, if this is not possible, minimising the harm caused.
7. Risk management should take into account that risk can be both general and specific, and that good management can reduce and prevent harm.
8. Knowledge and understanding of mental health legislation is an important component of risk management.
9. The risk management plan should include a summary of the risks identified, formulations of the situations in which identified risks may occur, and actions to be taken by practitioners and the service user in response to crisis.

10. Where suitable tools are available, risk management should be based on assessment using the structured clinical judgement approach.

11. Risk assessment is integral to deciding on the most appropriate level of risk management and the right kind of intervention for the service user.

12. All staff involved in risk management must be capable of demonstrating sensitivity and competence in relation to diversity in race, faith, age, gender, disability and sexual orientation.

13. Risk management must always be based on the capacity for the service user's risk level to change over time and recognition that each service user requires a consistent and individualised approach.

14. Risk management plans should be developed by multidisciplinary and multi agency teams operating in an open, democratic and transparent culture that embraces reflective practice.

15. All staff involved in risk management should receive relevant training which must be updated at least every three years.

16. A risk management plan is only as good as the time and effort put into communicating its findings to others.

4.3 Key Clinical Risks

As identified in Chapter One the four areas of risk which are relevant for consideration when managing people with mental health issues (O'Rourke and Hammond, 2005) are;

Vulnerability: The service user can be at risk of or exposed to damage or harm through personal or external factors (e.g. naiveté, low insight, family, social/community pressures, in care, poverty, and homelessness) or other resource or capability issues. There needs to be a greater awareness of risks of sexual vulnerability of mental health inpatients, to cover both patient's own behaviour and the advances of others;

Self harm/suicide risk: The service user can be at risk from self harm, intentional injury or killing oneself, action/behaviours destructive to one's own safety or health;

Mental instability: The service user can be a risk to self or others because of fluctuating and/or unpredictable mental health function especially in relation to command hallucinations and other "at risk" psychotic or disturbed phenomena;

Risk to others: The service user can be at risk of causing harm or danger to others or encouraging/involving others in the causing of harm or injury to others

4.3.1 Vulnerability and Mental Instability

The recovery process involves some exposure to risk. Growth takes place by encountering different circumstances and/or relationships and risk is part of these changes. Risk may be minimised by a professional awareness of vulnerability factors and impending mental instability.

Good clinical practice includes risk assessment and management which takes cognisance of vulnerability factors. Ultimately this leads to the minimising of risk to self and others. Mental instability can be managed more effectively by early recognition.

As well as following the steps of clinical risk assessment outlined in Chapter Three, the following parameters should be considered in assessing for indication of vulnerability or mental instability (this is not an exhaustive list):

Components	Examples
History	Poverty Homelessness Poor/lack of family support Experience of bullying, harassment or stigmatisation
Clinical	Non-compliance with medication Decline in hygiene, grooming Increase in use of alcohol and/or use of illicit drugs Evidence of more intense symptoms or ominous signs Demand/avoidance of services
Disposition	Cognitive, Emotional or Behavioural Skills Deficits. Behaviour indicating major mood changing for example - - over spending, elation - will making, funeral arrangement, depression
Context/ Environment	Has the person experienced any of the following: - change in living circumstances - loss of job, relationship - bereavement

As with suicide and violence and aggression prevention it is easier to judge the relative importance of the above signs if the mental health team/professional already know the patient. Although risk cannot be eliminated, it can be minimised by implementing good clinical practice inclusive of risk assessment and management which takes cognisance of vulnerability factors and addresses the incidence of mental instability.

4.3.2 Suicide and Self-harm Prevention

According to the National Parasuicide Register, over 11,000 cases of deliberate self-harm, some of which are the result of serious suicide attempts, present to Irish hospitals each year for assessment and treatment. A history of one or more acts of deliberate self harm is the strongest predictor of repeated suicidal behaviour, both fatal and non fatal (HSE, DoH&C, 2005).

Services should audit mental health facilities on a regular basis for environmental suicide risks and take remedial action where possible. Non-suicidal self harm accounts for a significant proportion (15.5%) of patient safety incidents reported to the Clinical Indemnity Scheme from mental health services during 2007.

As well as following the steps of clinical risk assessment outlined in Chapter 3, the following parameters should be considered in assessing suicidal risk (this is not an exhaustive list):

Components	Examples
History	a history of self-harm a previous suicide attempt a history of suicide in the family trauma sexual/physical victimisation
Clinical	a history of mental illness a serious medical illness alcohol abuse/elicit drug use a history of self-harm a history of low frustration tolerance social or self alienation.
Personality	Cognitive Emotional Behavioural Skills Deficits. Traits which are significant to cause individual or others to suffer e.g. consistently impulsive or emotionally labile, self-limiting and self-defeating beliefs and behaviours
Context/ Environment	Has the person experiences of any of the following: - Recent loss by death or separation, a job, a pet - A major life change or challenge (retirement, redundancy, children leaving home, financial troubles).

As with violence and aggression prevention, it is easier to judge the relative importance of the above signs if the mental health team/professional already know the patient. Although risk cannot be eliminated, it can be minimised by implementing good procedures for measuring and working with risk.

4.3.3 Assessing the Risk of Violence

Research findings (Alaszewski et al, 1998) suggest that most mentally ill people present a greater risk to themselves than to others.

Violence Risk Factors

Past behaviour does predict future behaviour but not absolutely. Dynamic components, such as changes in personality, environment, work status and personal relationships, have an important role to play also.

As well as following the steps of clinical risk assessment outlined in Chapter Three, the following parameters should be considered in assessing signs of risk of violence (this is not an exhaustive list):

Components	Examples
History	A history of violence A history of conduct disorder A history of non-adherence and/or treatment attrition (etc.)
Clinical	Command hallucinations are of particular risk The manic phase of a bi-polar disorder Impulse control disorders (including self-harming behaviours) Drug or alcohol use problems (etc.)
Disposition	Anger and emotional control problems Impulsivity Low frustration tolerance Anti-social cognitions, beliefs or behaviours (etc.)
Context/ Environment	Non-stable, non-supportive family environments Fractured family and/or personal relationships Age: e.g. Youth is highly associated with violent crime Gender: Males show higher rates of violence (etc.)

It is easier to judge the relative importance of the above signs if the mental health team/professional already know the patient. Although risk cannot be eliminated, it can be minimised by implementing good risk management process as outlined above.

The use of Structured Professional Judgement (SPJ) instruments ensure that important areas in the assessment of risk are not missed. This allows for structured risk assessment and provides a clear basis for risk management planning. Examples of such instruments include the HCR-20 – for assessment of violence risk and the S-RAMM for assessment of risk of suicide and self-harm.

Chapter 4 – Key Messages

1. Effective care requires that mental health professionals consider service users not as passive recipients of service but as actively involved, core contributors to the risk and care process (O'Rourke et al 2003).
2. Risk can be minimised by ensuring that there is good communication, sufficient attention to staff and patient safety, and appropriate training and support for staff and service users.
3. Best Practice Principles summarise the key principles for effective risk assessment and management.
4. Risk is safely identified if all parameters (Historical, Clinical, Dispositional and Contextual) and features of individual functioning are examined.
5. Risk assessment tools, particularly SPJ's, can support professional judgement.

References

1. Alaszewski,A., Harrison,L and Manthorpe, J. (eds) (1998) *Risk, Health and Welfare: Policies, Strategies and Practice.* Buckingham: Open University Press.
2. Australian/New Zealand Standard Risk Management (AS/NZS 4360:2004), 3rd Edition, Standards Australia International Ltd, Sydney and Standards New Zealand, Wellington, ISBN 0 7337 5904.
3. Davidson, L. et al. (2009) *Recovery in practice.* Oxford University Press.
4. Department of Health (2007) *Best Practice in Managing Risk, Principles and evidence for best practice in the assessment and management of risk to self and others in mental health services.* HMSO UK.
5. Department of Health and Children (2008) *Building a Culture of Patient Safety, Report of the Commission on Patient Safety and Quality Assurance.* Stationery Office, Dublin.
6. Department of Health and Children (2006) *A Vision for Change* Stationary Office, Dublin.
7. Department of Health and Children (2001) *Quality and Fairness:* A Health System for You Stationary Office, Dublin.
8. Department of Health and Children (2005) *Reach out: Irish National Strategy for Action on Suicide Prevention (2005 -2014).* Stationary Office, Dublin.
9. Doyle, M. and Dolan, M. (2007) Standardised Risk Assessment. *Psychiatry,* Vol 6, 10. P 409-414.
10. Gilmore, H. (2004) *Living alone with dementia: risk and the professional role.* Nursing Older People, 16(9).
11. Government Publications Office (2006) Mental Health Act 2001 (Approved Centre) Regulations 2006, S.I. No.551 of 2006.
12. HSE (2007) *Developing and Populating a Risk Register Best Practice Guidance.* Office of Quality and Risk.
13. HSE (2007) *Quality and Risk Management Standard.* Office of Quality and Risk.
14. HSE (2008) *Risk Assessment Tool and Guidance.* Office of Quality and Risk.
15. HSE(2008) 'Linking Safety and Service, Together creating safer places of service.'
16. HSE, Department of Health and Children (2005) *Reach Out –*

National Strategy for Action on Suicide Prevention 2005-2014 . Health Services Executive.

17. Mental Health Commission (2008) Code of Practice for Mental Health Services on Notification of Deaths and Incident Reporting : COP -S33-01-2008.
18. Mental Health Commission (2007) *Quality Framework for Mental Health Services in Ireland.* Mental Health Commission.
19. Morgan, J.F. (2007) *'Giving up the Culture of Blame' Risk assessment and risk management in psychiatric practice.* Briefing document for Royal College of Psychiatrists.
20. National Suicide Research Foundation (2007) Annual report: *National Registry of deliberate Self Harm Ireland. Accessed via:www.nsrf.ie Accessed on 15.09.008.*
21. National Office for Suicide Prevention (2007) Annual Report: *Reducing suicide required a collective, concerted effort from all groups in society. Accessed via: www.nosp.ie Accessed on 15.09.08.*
22. National Suicide Research Foundation (2007) *Inquested deaths in Ireland: A study of routine data and recording procedures.* Cork: National Suicide Research Foundation, ISBN 978-0-9557914-1-3.
23. O'Rourke, M. (2003) Start Safe, Stay SAFE. *The Handbook for Suicide Prevention, Violence Reduction and Risk Management.* RAMAS, London.
24. O'Rourke, M. and Bailes, G. (2006) *Risk Assessment and Management,* British Psychological Society Position Paper, UK.
25. O'Rourke, M., Hammond, S., Bucknall, M. and Ostling, M. (2003) *Multiagency Risk Management: Safeguarding Public Safety and Individual Care.* RAMAS, London.
26. O'Rourke M.M. & Hammond S.M. (2005) The Risk Assessment, Management and Audit System (RAMAS) Professional Manual: 2nd Edition. The RAMAS Foundation. London.
27. Royal College of Psychiatrists *(2008) Rethinking risk to others in mental health services: final report of a scoping group.* (June 2008) College Report CR 150.
28. Titterton, M. (2005) *Risk and Risk Taking in Health and Social Welfare.* Jessica Kingsley Publishers. London.
29. Wilson J & Tingle J. (1999) *Clinical Risk Modification-A Route to Clinical Governance.* Elsevier Health Sciences.
30. Woloshynowych, M., Rogers, S., Taylor-Adams, S. and Vincent, C. (2005) The investigation and analysis of critical incidents and adverse events in healthcare. *Health Technol Assess,* 9(19).

31. Webster, CD., Douglas, KS., Eazes, D., and Hart SD. (1997) *HCR-20: Assessing risk for Violence. Mental Health, Law and Policy Institute:* Simon Fraser University.

32. Bouch, JB., and Marshall, JJM. (2003) S-RAMM *(Suicide – Risk Assessment and Management Manual)* Dinas Powys, Vale of Glamorgan, Cognitive Centre Foundation.

HSE Office of Quality and Risk documents accessed September 2009.

HSEintranet

http://hsenet.hse.ie/HSE_Central/Office_of_the_CEO/Quality_and_Risk/ .

WWW Internet access

http://www.hse.ie/eng/About_the_HSE/Whos_Who/Quality_and_Risk_Management.html

Quality and Risk Documents

- SIMT 01 Part 1 Serious Incident Management Introduction
- SIMT 01 Part 2 Serious Incident Management Policy and Procedure
- OQR006 HSE Incident Management Policy and Procedure
- OQR008 HSE Toolkit of documentation to support incident management. PDF (size 655 KB)
- OQR009 HSE Quality and Risk Management Standard
- OQR010 HSE Developing and Populating a Risk Register BPG
- OQR011 Risk Management in the HSE; An Information Handbook
- OQR012 Risk Assessment Tool and Guidance (Including guidance on application)
- OQR023 HSE Integrated Risk Management Policy (Doc 2.4)
- OQR026 Quality and Risk Taxonomy Governance Group Report on Glossary of Quality and Risk Terms and Definitions
- OQR029 HSE Procedure for Developing Policies, Procedures, Protocols and Guidelines.pdf (size 547 KB)
- Towards Excellence in Clinical Governance – A Framework for Integrated Quality, Safety and Risk Management across HSE Service Providers. Framework Document, V. 1 Jan 2009
- Towards Excellence in Clinical Governance – A Framework for Integrated Quality, Safety and Risk Management across HSE Service Providers. Companion Guide, V. 1 Feb 2009

Membership of Mental Health Risk Management Sub Group

David Gaskin	Chair, Local Health Manager Meath and Lead Local Health Manager Mental Health – HSE Dublin North East
Colum Bracken	Director of Nursing Mental Health Services – HSE Dublin West, South West
Margaret Brennan	Quality and Risk Manager – HSE PCCC Directorate
Dr. Serena Condon	Clinical Director – St. Brendan's Hospital, Dublin
Debbie Dunne	Clinical Risk Advisor – Clinical Indemnity Scheme
Dr. Ailis Quinlan	Head of Clinical Indemnity Scheme
Dr. Fiona Keogh	Research Psychologist (co-opted to the group in Dec. 2008).
Tony Leahy	Specialist National Planning – HSE Mental Health Service
Una McCarthy	Clinical Risk Advisor Mental Health Services – HSE West (Mid West Area)
Paddy McGowan	Lecturer, Expert by Experience, Dublin City University
Dr. Margaret O'Rourke	Consultant Forensic Clinical Psychologist, Director of Behavioural Science – School of Medicine, University College, Cork
Sean Sammon	Risk Manager, PCCC – HSE West

Appendix 1

Glossary of HSE Quality and Risk Terms and Definitions

Corporate Governance	The system by which organisations direct and control their functions and relate to their stakeholders in order to manage their business, achieve their missions and objectives and meet the necessary standards of accountability, integrity and propriety (HSE, 2006).
Clinical Governance	A Framework through which organisations are accountable for continually improving the quality of their services and safeguarding high standards of care by creating an environment in which excellence will flourish (adapted Scally and Donaldson, 1998).
Risk	The chance of something happening that will have an impact on objectives (AS/NZS 4360:2004).
Risk Analysis	Systematic process to understand the nature of and to deduce the level of risk (AS/NZS 4360:2004).
Risk Criteria	Terms of reference by which the significance of risk is assessed (AS/NZ 4360:2004).
Risk Assessment	The overall process of risk identification, risk analysis and risk evaluation (AS/NZS 4360:2004).
Risk Matrix	A form of presentation, a single table, which enables easy comparison of the values placed on different risks (Health Care Standards Unit and Risk Management Working Group 2004).

Risk Management	**The culture, processes and structures that are directed towards realizing potential opportunities whilst managing adverse effects (AS/NZS 4360:2004).**
Risk Management Process	The systematic application of management policies, procedures and practices to the tasks of communicating, establishing the context, identifying analysing, evaluating, treating, monitoring and reviewing risk (AS/NZS 4360:2004).

Appendix 2

Incident Management

It is the policy of the HSE that all incidents shall be identified, reported, communicated and investigated (HSE, 2008). All persons/agencies providing services or advice, directly or indirectly, to or on behalf of, including agencies and services funded by the HSE must have in place compatible policies and procedures. The HSE Incident Management Policy and Procedure outlines five phases in incident management these include:

1. Identification
2. Immediate management
3. Reporting
4. Incident investigation
5. Closing the incident loop

For further information please refer to the full policy document with associated tool kit of documentation HSE intranet

(http://hsenet.hse.ie/HSE_Central/Office_of_the_CEO/Quality_and_Risk/Documents

Internet access via:

http://www.hse.ie/eng/About_the_HSE/Whos_Who/Quality_and_Risk_Management.html

For the management of Serious Incidents (SI), the HSE has issued policy and guidance (HSE, 2008). The management of serious incident document is designed to enable HSE employees and HSE funded agencies to understand how the HSE manages Serious Incidents in a timely and effective way. The CEO has established a Serious Incident Management Team (SIMT) led by a National Director. When the SIMT is notified through the line management structure that a SI has occurred they must take responsibility to ensure that the incident is managed appropriately. The Serious Incident Management Policy and Procedure is not intended to replace local incident management and reporting, rather it is there to be used in circumstances where a national or integrated

response is required to mange the issue. It is designed to allow the HSE as a whole organisation to learn from Serious Incidents.

Within the Mental Health services there are a number of adverse event reporting requirements to statutory agencies and external bodies such as the Mental Health Commission (MHC, which requires 6-monthly incident summary reports), The Health and Safety Authority, the Clinical Indemnity Scheme, Irish Public Bodies and other Public Liability and Clinical Liability Indemnifiers.

There is also a requirement for An Garda Síochána to complete a confidential Form 104 which is sent to the Central Statistics Office (CSO) after a coroner's inquest has taken place. This captures information relating to whether the death was accidental, suicidal, homicidal or undetermined. The data recorded on this form was recently analysed by the National Suicide Research Foundation following which a number of recommendations were made, notably that another system be developed to collect data on the medical and psychosocial characteristics of individuals whose deaths lead to inquests, such as introduction of national inquiries as is performed in other countries.

The National Registry of Deliberate Self harm was established by the National Suicide Research Foundation in 2002. This monitors presentations following deliberate self harm to A/E Departments in all general hospitals in Ireland.

The MHC has developed a Code of Practice for notification of deaths and incident reporting requirements to the MHC, which is applicable to approved centres, day hospitals, day centres and 24 hour staffed residences within mental health services.

The State Claims Agency introduced a national secure web based incident reporting system in 2003, called STARS Web for use by enterprises participating in the Clinical Indemnity Scheme for notification of clinical incidents. This system links public hospitals and other healthcare enterprises to a national database where they can access their own data on their reported incidents. The data from this system can be utilised to provide the incident data summary reports required by the Mental Health Commission.

There were 7812 clinical incidents reported to the Clinical Indemnity Scheme from public Mental Health Services in 2008. The breakdown of the top 5 event types reported is presented in Figure A.2. The highest (35.5%) event type reported relates to the category of violence, harassment and aggression

(V/H/A), followed by 30.6% of events relating to Slips Trips and Falls (STF). Self Harm events accounts for 11.7% of all events reported from Mental Health Services.

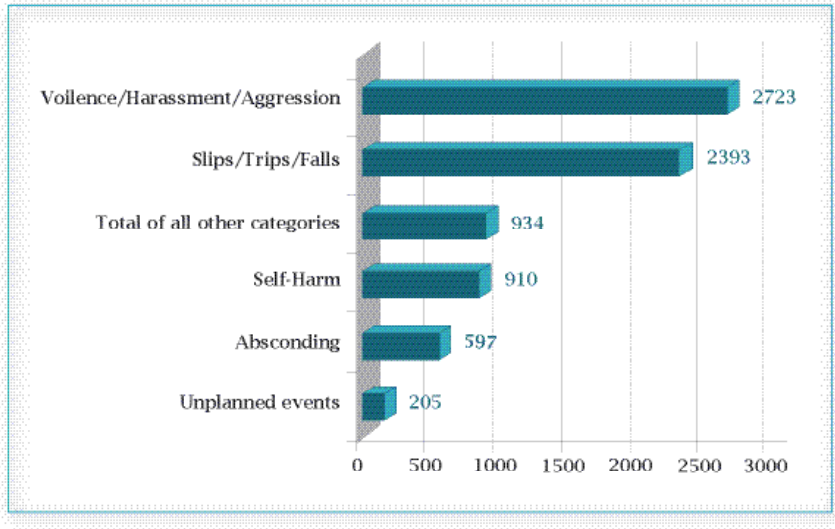


Figure A.2: Top 5 Events reported to the Clinical Indemnity Scheme from Mental Health Services in 2008.

Under the *Safety, Health and Welfare at Work (General Application) Regulations 1993 and 2007* the Health and Safety Authority require notification of certain workplace accidents and dangerous occurrences. These include incidents of violence and aggression, which are a significant issue within the mental health services.

As with other sectors, it is likely that there is significant under-reporting of incidents in mental health services – research by the NPSA (UK) suggests that reports from community based settings, reports about medication, clinical assessment and treatment may be underreported.



Feidhmeannacht na Seirbhíse Sláinte
Health Service Executive