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**Draft version 1**

**RISK ASSESSMENT AND CARE PLAN FOR CHILDREN AND YOUNG PEOPLE WITH A MENTAL HEALTH CONCERN**

**This tool should be used whilst the Child/Young Person is awaiting a mental health assessment by CAMHS — All questions must be answered.**

One or more yes response indicates following red risk level

1. Does the Child/Young Person have any immediate plans to harm self or others? Yes No
2. Is the Child/Young Person obviously disturbed, threatening, agitated or displaying unpredictable behaviour? Yes No
3. Is the Child/Young person quiet, withdrawn or not making eye contact? Yes No
4. Does the Child/Young person appear to be experiencing delusions or hallucinations? Yes No
5. Is there a risk that the Child/Young Person might abscond before being seen by CAMHS? Yes No

**IF THE CHILD/YOUNG PERSON IS DEEMED HIGH RISK AND MAY NEED DE-ESCALATION/INTERVENTION WHILST HERE PLEASE INFORM THE SECURITY TEAM OF THE CHILD/YOUNG PERSONS LOCATION.**

Has the Child/Young person been asked whether they have any items in their belongings which could be used to harm self

or others? (i.e. ligature, cutting, overdose).

Yes has been asked — items declared.

Yes had been asked — no items to declare.

Not been asked — specify why (agitation etc.)

Is the Child/Young person fit for mental health assessment? (Not intoxicated/sedated). Yes No

Does the Child/Young Person need to see a Doctor? Yes No

Has the Child/Young Person been referred to CAMHS? Yes No

**Observation level required (Please Circle) RED GREEN**

To make a referral: Contact SWYPFT CAMHS team via switchboard

Are there any safeguarding concerns? Yes: No: Referral Made? Datix No:

Background, Observations and Behaviours:

Is there any history of mental health issues? (Previous self harm, suicide attempt etc.)

Why is the Child/Young Person Presenting now?

Date: Time:

Family Members:

Present:

Professionals:

Child/Young Person Description: (Height, build, skin colour, clothing, hair colour and style:

**Actions to be taken according to level of risk identified**

**Name of Person completing Assessment: Date:**

**Designation: Signature:**

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| **Risk Level** | **Risk Factors** | **Actions** |
| **GREEN*** The Child/Young Person who are identified as green risk must have their risk re­assessed and documented if any of the following applies:
* There is a change in the Child/Young Person's behaviour or mood
* Every 24 hours whilst they remain in hospital
* On the advice of the CAMHS Team.
 | Mental Health issues but no immediate plans to harm self or othersNo evidence of immediate vulnerabilityChild/Young Person consenting to stay to be seen/reviewed as needed | * Refer to CAMHS team
* Implement the Mental Health Care Plan
* Reassess and document risk if:
* There is a change in the Child/Young Person’s behavior or mood
* Every 24 hours
* On the advice of the CAMHS
* Within 30 minutes of transfer to ward

Implement 30 minute safety observations and document on Mental Health Safety Observation Record |
| **RED*** The Child/Young Person who are identified as red risk must have their risk re­assessed and documented if any of the following applies:
* There is a change in the Child/Young Person's behaviour or mood
* Every 12 hours whilst they remain in hospital
* On the advice of the CAMHS Team.
 | Child/Young Person has ongoing thoughts of deliberately self harming self or othersRapid/Exaggerated changes in moodMental state likely to deteriorate without treatmentChild/Young Person is vulnerable | * Urgent escalation to CAMHS Team
* Complete all green actions first
* Consider detention under Mental Health Act
* Nurse in an appropriate place which meets their needs
* Start 1:1 continual visual observations
* Reassess and document risk if:
* There is a change in the Child/Young Person’s behavior or mood
* Minimum of every 12 hours whilst they remain in hospital
* On the advice of the CAMHS Team
* Immediately following transfer to Ward

Escalate for further staffing to assist in 1:1 observation if required |

**All staff involved in the care of this child must complete the signature identification list below.**

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| **Date** | **Print name** | **Initial**  | **Signature** | **Job Description** |
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| **Name: Ward:****Hospital Number:****D.O.B:** | **Date Time:****Name of Health Professional(s) undertaking risk assessment:****Signature of Health Professional(s):** |

**CODE Y = YES N = NO**

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| **Date:** |   |   |   |   |   |   |   |   |   |
| **TIME: (24 Hour clock)** |   |   |   |   |   |   |   |   |   |
| **RISK LEVEL(Circle risk level)** | **RED** GREEN | **RED** GREEN | **RED** GREEN | **RED** GREEN | **RED** GREEN | **RED** GREEN | **RED** GREEN | **RED** GREEN | **RED** GREEN |
| **Level of observations****30 = 30 minutes****C = Continual** |   |   |   |   |   |   |   |   |   |
| **Ensure level of risk is discussed at patient safety huddle** |   |   |   |   |   |   |   |   |   |
| **Ensure all items of potential harm are removed from the Child/Young Person and immediate surroundings** |   |   |   |   |   |   |   |   |   |
| **Do not allow the Child/Young Person to self-medicate** |   |   |   |   |   |   |   |   |   |
| **Ensure prescribed medication is administered** |   |   |   |   |   |   |   |   |   |
| **Encourage family/carer involvement as appropriate** |   |   |   |   |   |   |   |   |   |
| **Observe and report mood** |   |   |   |   |   |   |   |   |   |
| **Observe and report level of agitation** |   |   |   |   |   |   |   |   |   |
| **Observe and record any triggers to behaviour** |   |   |   |   |   |   |   |   |   |
| **State location of Child/Young Person's****bed****C= Cubicle****B= Bay** |   |   |   |   |   |   |   |   |   |
| **Reassess bed location following risk assessment** |   |   |   |   |   |   |   |   |   |
| **Provide reassurance and explanations** |   |   |   |   |   |   |   |   |   |
| **Maintain safety of Child/Young Person and others** |   |   |   |   |   |   |   |   |   |
| **Staff initials** |   |   |   |   |   |   |   |   |   |
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**V = Variance recorded on EPR under Safeguarding Progress Note**

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| **Name: Ward:****Hospital Number:****D.O.B:** | **Date Time:****Name of Health Professional(s) undertaking risk assessment:****Signature of Health Professional(s):** |

**SAFETY OBSERVATION RECORD**

**CODING TO BE USED**

**Y = Yes N = No N/A = Not Applicable**

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| **Time of Check (30 Min Intervals)** | **30****min** | **30****min** | **30****min** | **30****min** | **30****min** | **30****min** | **30****min** | **30****min** | **30****min** | **30****min** | **30****min** | **30****min** | **30****min** | **30****min** | **30****min** | **30****min** | **30****min** | **30****min** | **30****min** | **30****min** | **30****min** | **30****min** | **30****min** | **30****min** |
| **Time Recorded:** |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| **Is Child/Young Person in allocated location?** |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |
| **Is Child/Young Person settled?** |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |
| **Has Child/Young Person expressed any concerns / DSH tendencies?** |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |
| **Is the Child/Young Person's environment safe?**e.g. Do sharps bin need moving? Does equipment need moving to prevent Child/Young Person DSH (02 Tubing)Have all ligature risks been considered? |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |
| **Staff Initials** |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |

**My Plan (COPY TO BE KEPT IN YOUNG PERSONS ROOM)**

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| First Name: Ward:Hospital Number:Date Time:Signature of Parent/Carer/Young Person: | **Name of BTHFT Health Professional(s) undertaking risk assessment:****Signature of Health Professional(s):****Name of CAMHS Professional(s) undertaking risk assessment:****Signature of Health Professional(s):** |
| Regular Medications(and times to be given)  |  |
| Rescue Medication  |  |
| **Document Level of Supervision Required**Can the patient go off the ward?(if yes who is permitted to accompany them) |  |
| Visitors/Support Staff contact details of staff including organisation |  |
| Daily Routine |  |
| What ongoing support will be required following discharge? |  |
| Use of phone/Ipad/TV |  |
| Individual coping strategies (What is important to me?) |  |

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