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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 Is the Child/Young person quiet, withdrawn or not making eye contact?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 others  No evidence of immediate vulnerability  Child/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 others  Rapid/Exaggerated changes in mood  Mental state likely to deteriorate without treatment  Child/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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