Adult Social Care and Health

RISK ASSESSMENT & MANAGEMENT POLICY AND OPERATIONAL GUIDANCE

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Policy and Procedures to support people that self-neglect or demonstrate hoarding behaviour November 2018	http://www.kent.gov.uk/ under Adult Safeguarding Legislation and Guidance
Multi–Agency Safeguarding Adults Policy, Protocols and Guidance for Kent and Medway. October 2019	http://www.kent.gov.uk/
Care and Support Statutory Guidance 2014	https://www.gov.uk/government/publications/care-act-statutory-guidance/care-and-support-statutory-guidance
Mental Capacity Act 2005 and Deprivation of Liberty Safeguards Policy and Practice Guidance 2017	Knet, ASCH Policy page/TriEx

Summary of changes November 2021

Removed all references to **"**Vulnerable Adult Policy" as this policy no longer exits.
General refresh.

Summary of changes August 2020

This policy is no longer just for staff who carry out needs assessment, but for all staff in the Adult Social Care and Health directorate.
Focus on guidance on how to undertake a risk assessment and importance of monitoring and reviewing risk management plans.
Some staff groups will have their own risk assessment forms but all should follow the principles contained within this document.

Contents

Section A: Policy

A1. Aim

The aim of this document is to provide the tools and guidance staff need to feel confident when exercising their roles and responsibilities regarding supporting people to live they life they want to live.

The Adult Social Care and Health directorate is committed to supporting:

- Individuals to make informed choices to meet their needs
- Practitioners, together with individuals and their support network if relevant and appropriate, to address any risks to these choices in line with the directorate's responsibilities for safeguarding vulnerable adults.

A2. Scope

2.1 This policy and guidance applies to all staff within Adult Social Care including agency staff, temporary, contracted staff, and all commissioned organisations.

2.2 This document provides guidance to staff who become aware of a person (aged 16 + if supported by the Young People's team) who:

- appears to be at risk and is not receiving or chooses not to engage with adult social care
- appears to be at risk and is receiving support from adult social care
- wants to undertake what is potentially a risky activity and needs help to work through a plan to live their life in a supportive environment
- is deemed to be a vulnerable adult

2.3 It does not replace the risk management processes contained within the Multi-Agency Safeguarding Adults for Kent and Medway policy but aims to provide a consistent approach to risk.

2.4 **LD and OPPD Service Provision staff**
Service provision staff carry out specific Health and Safety Risk assessments on activities people want to undertake and have their own forms to do so. They must still work to the principles written in this policy which:

- support people to take positive risk towards greater independence
- consider supporting someone to take risks as a necessary part of a social care worker's responsibility to promote wellbeing.

2.5 This guidance should be read as a supporting document to:

- The Policy and Procedures to support people that self-neglect or demonstrate hoarding behaviour

- Multi–Agency Safeguarding Adults Policy, Protocols and Guidance for Kent and Medway
- The Mental Capacity Act 2005 and Deprivation of Liberty Safeguards Policy and Practice Guidance
- The Adult Social Care and Health Assessment, Care and Support Planning and Case Recording with Care policies.

A3. Statutory guidance

3.1 **Care Act 2014**

Under the Care Act 2014, the general duty of a local authority is to promote an individual's well-being.
"Well-being" means that individual's well-being relates to any of the following:

> "(a) personal dignity (including treatment of the individual with respect)
> (b) physical and mental health and emotional well-being
> (c) protection from abuse and neglect
> (d) control by the individual over day-to-day life (including over care and support, or support, provided to the individual and the way in which it is provided)
> (e) participation in work, education, training or recreation
> (f) social and economic well-being
> (g) domestic, family and personal relationships
> (h) suitability of living accommodation
> (i) the individual's contribution to society"

This means supporting people to understand and weigh up the risks and benefits of different options when exercising choice and control and does not mean preventing them making their own choices and/ or having control over their lives.
It also means that practitioners must balance choice and risk with their duty to protect people from abuse and neglect.

3.2 **Health and Safety**

a) General statement

Adult social care has a duty to protect the health and safety of its staff and other people with whom they are involved as far as is reasonably practicable.

Positive risk management does not change Health and Safety policy and guidance; a risk assessment will determine whether the risk(s) can be managed. Any control measures identified will help to protect people from harm as they pursue their activities. There will be occasions when the level of risk is so great that adult social care will not be able to support the activity. In

such situations, staff must clearly document and communicate the reasons for their decision to all involved.

b) Moving and Handling

If the risk involves any Moving and Handling issues, refer to the Moving and Handling Policy (found on Knet Adult Social Care Policy page under the "Health and Safety"" category) as there is specific legislation which relates to risks posed by moving and handling activities.

3.3 **Mental Capacity Act**

A positive approach to risk underpins the legal requirements in the MCA, as highlighted by the five statutory principles. The MCA aims to protect people who lack capacity to make particular decisions, but also to maximise their ability to make decisions or to participate in decision making, as far as they are able to do so. The 5 MCA principles are:

- A person must be assumed to have capacity to make decisions unless it is proved otherwise
- A person must be supported in making their own decisions before anyone concludes that they cannot
- A person must retain the right to make what appear as eccentric or unwise decisions
- Anything done for or on behalf of people without capacity must be in their best interests
- Anything done for or on behalf of people without capacity should be the least restrictive option.

A practitioner's first priority is to maximise a person's decision-making capacity, by taking all practicable steps to support the person to make the decision for themselves. This includes providing information in a manner that is likely to maximize the person's understanding and so to assist them to make the relevant decision.

For further details, including further duties, please consult the MCA policy and the Deprivation of Liberty Safeguard (DOLS) policy.

3.4 **Safeguarding/ Neglect/ Vulnerable Adults**

Risk assessment and risk management are essential aspects of the Adult Safeguarding process and need to be considered at every stage.
They will also be used when working with vulnerable adults who appear to be at risk of harm to themselves and/or others and positive risk management will play a large part in supporting the vulnerable adult to move towards independence.

For further guidance, to be found within the Adult safeguarding page on Kent.gov.uk, please read:

- The Multi-Agency Safeguarding Adults Policy, Protocols and Guidance for Kent and Medway
- The Policy and Procedures to support people that self-neglect or demonstrate hoarding behaviour
- The Kent and Medway Safeguarding Adults Board: A Quick Guide to Identifying and Responding to Self-Neglect and Hoarding

3.5 Duty of Care

In the context of social care, a duty of care is an obligation placed on an individual requiring that they exercise a reasonable standard of care while doing something that could foreseeably harm others. The standard of conduct and behaviour expected of people in their professional role is higher than for other people because of the professional training they have received and the level of responsibility they assume.

A4. Definitions

Defensible decisions (as opposed to defensive decisions**)** are decisions based on clear reasoning, with due regard to appropriate legislation, policies and procedures. They demonstrate clear and precise record keeping and, where possible, signed consent. What makes them “defensible” is that they could be judged as sound decisions, taken with the full involvement of the person and, if appropriate, by their network of support together with other involved professionals and agencies. The decisions will have been made after consideration of all the relevant information. It can also be evidenced to be decisions which would have been made by a body of co-professionals who work in a similar grade, have similar training and experience, and work in a similar specialism.

Defensive decisions (as opposed to defensible decisions) are decisions based not necessarily on what is the best option for a person but on what is the best option to protect the decision makers should something go wrong. Fear of litigation and accountability has developed defensive decision making into an art.

Mitigation actions are specific actions**,** project, activity, or process taken to reduce or eliminate long-term risk to people and property from hazards and their impacts. Implementing mitigation actions helps achieve the person’s outcomes specified in their care and support plan.

Positive r**isk management** is a carefully thought-out strategy for managing a specific situation or set of circumstances involving risk.

Positive risk taking: Part of the process of measuring risk involves balancing the positive benefits that are likely to follow from taking risks against the negative effects of attempting to avoid risks altogether (Skills for Care. Learning to live with risk .2011). The question is: “What are the risks for this person of not doing the activity they want to do?”.

Risk is an inevitable consequence of people making capacitated decisions about their lives. It can be described as the likelihood of an event happening with potentially harmful of beneficial outcomes for self and others. It is a combination of the chance that something might happen, and the consequence associated with the event.

Risk assessment is an examination of the proposed activity to identify the measures that need to be taken to minimize the risk of potential harm happening.

A5. Guiding Principles

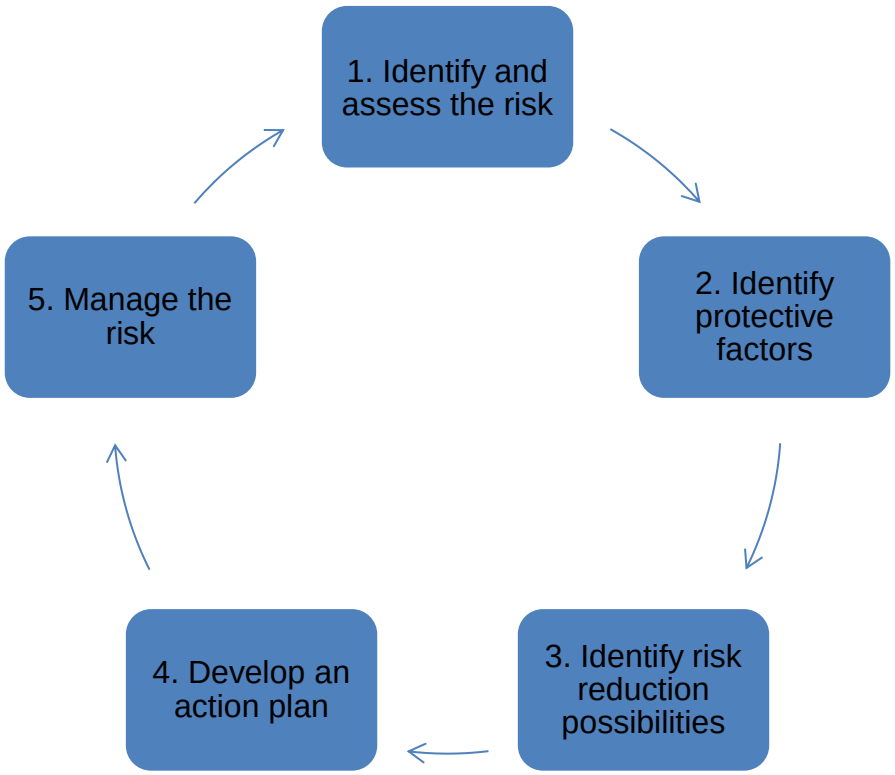
‘People have the right to live their lives to the full as long as that doesn’t stop others from doing the same.’ *Independence, choice and risk: a guide to best practice in supported decision making. 2007*

1. Risk is **dynamic** – it is constantly changing in response to altered circumstances.
2. Risk can never be eliminated, but it can be assessed and **may be reduced.**
3. Assessment will be enhanced if you are able to **access several sources of information,** but frequently you will be working with incomplete and possibly inaccurate information.
4. **Intuition** (instinct or gut reaction) is a **valuable tool** but it is not a final assessment. It acts as a means for telling us something is not quite what it seems, and its value lies in the response you make in order to access more information to back up or refute your assumptions.
5. **Identifying risks carries a duty to do something about them** (i.e. risk management) proportionate to the presenting situation.

6. Risk assessment, management and decision-making can be improved when **good team-working and multi-agency collaboration** are achieved. Involve the person as much as possible.
7. **Risk-taking can engage positive collaboration** with beneficial outcomes.
8. **Confidentiality** is a right but may be breached in exceptional circumstances when people are deemed to be at serious risk of harm.
9. Staff engaged in supporting **risk taking**, **evidenced by accurate records** are acting under KCC Adult Social Care and Health Directorate's instructions.

A6. The stages of Positive Risk Management

The chart below shows five stages of Positive Risk Management. It reflects an ongoing process of assessment and review.



Section B: Practice Guidance

The practice guidance aims to provide a framework for staff to follow when assessing and planning to manage risk. It relies on practitioners' professional judgement to decide which elements need to be given greater weight and attention in line with the complexity of issues facing the person, their network and the organisation/s supporting the person.

B1. Decision about when to carry out a formal risk assessment

Risk is considered in all assessments undertaken by practitioners, as stated in the assessment policy.
Where the presenting risks are considered low, the assessor will apply a proportionate approach to assessment and may not need to work through a detailed risk assessment. The level of risk assessment should be '*suitable and sufficient'* in relation to the particular circumstances for that person.

The assessor should work with the person to identify and manage any risks to their safety and wellbeing by providing information, advice, and guidance so that the person can make informed decisions. This will help ensure that the person understands any possible risks or implications linked to their decisions. The risks, advice and decisions taken must be documented on file by the assessor.

Practitioners will carry out a formal risk assessment whenever the presenting risks (such as undertaking an activity or not undertaking an activity) may lead to possible serious consequences for the person or others.
Examples of this may include:

- When a person is proposing to undertake a potentially risky activity and will need support to do it
- When a person with fluctuating capacity to decide where to live still wants to carry on living at home and everyone around them is anxious and believes they should go into a residential home
- When a person with a learning disability/ sensory impairment / on the Autistic Spectrum wants to travel independently and will either need focused support or we need to reassure their family/ support network that we are taking their concerns into account
- When someone's physical and mental health is declining due to self-neglect/ hoarding etc.…
- When working with someone on a multi-agency basis
- When a person is proposing to undertake an activity that poses a risk to another

Benefits for the practitioner in undertaking a formal risk assessment:

It will help you to:

- clarify your thinking
- define risks
- focus on mitigating risks
- alleviate the person's, their family and other professionals' fear and concerns
- communicate the risk management clearly
- evidence your professional judgement and rationale behind decisions
- engage other professionals and to do the right thing by the person you are supporting.
- feel confident that your practice aligns with the Mental Capacity Act (MCA) in that the person (P) should have every support in participating in a decision and understanding risk is a key factor.

B2. Using intuition/ gut feeling and exercising caution when doing so

The key principle is for practitioners to be open about the influences affecting their judgements and decisions.

An understanding of intuition/ gut feeling

Intuition/ gut feeling can be described as something you get from your professional or personal history, from experience; subtle cues when something is either 'not quite right' or 'a chance worth trying'.

Difficulties associated with its use

Intuition can be easily dismissed by those who take the view that only objective statements of fact can be communicated. It can be misinterpreted as being fact.

It could lead a practitioner in a wrong direction through their own personal biases or give practitioners a form of validation for not pursuing more rigorous searches and analysis of information.

Practitioners should be aware of how their personal prejudices may influence these feelings, so that gut reaction may occasionally be nothing more than a personal subjective viewpoint, and even a negative influence.

Practitioners need to safeguard against unintentional blind-spots – where they process new information in ways that only serves to reinforce their pre- determined gut reaction.

Ways it can be used and documented

When using intuition, it should never be left as a final statement without a clear indication of what you intend to do with it.

It should also be investigated as soon as possible through other sources of stronger evidence and discussed with colleagues and line -manager.

Practitioners should document what their gut feelings are, but more importantly what they intend to do with it. They should use less emotive terms such as ‘my concerns are...’ or ‘my impressions…’ alongside clearly identified factual information.

B3. Undertaking a formal risk assessment

Recording of the assessment will be done using the **Positive Risk Assessment form**. Best practice means that the practitioner, the person being supported and whoever else is involved, should all sign the document and be given a copy of the risk assessment.

Practitioners should start by thinking about who should be involved in the risk assessment: specialist / members of informal or formal support and whether the assessment needs to be a joint assessment and if so, who is best placed to be the lead in this particular set of circumstances.

If the practitioner is unable to find a way to engage the individual, attempts should be made to establish whom the person has shown likelihood to engage with best in the past and make contact. Practitioners can only work with the information they have available to them, so will need to record the sources of information on which they are basing their assessments and subsequent judgements. Practitioners need to be cautious about accepting a source’s accuracy until they can corroborate it.

Practitioners need to consider their use of language and create opportunities for both people and their support network to speak independently and freely.

As a simple rule of thumb, when looking at an activity that involves degrees of risk, focus attention on the following questions:

- What are the feelings and wishes of the individual?
- Who is at risk? And what is at risk?
- Are there urgent actions I need to take? (emergency services/ medical interventions etc.)
- Will the individual benefit from this activity?
- Does the risk relate to any information from the person's risk history?
- In what ways is this activity in the best interests of the individual?
- Can a similar activity be found that has more acceptable degrees of risk?
- How can the risk be minimized?

Step 1. Identify and assess the risk (see appendix 1 which provides useful questions a practitioner may work through depending on the complexity of the issues faced)

Practitioners need to be clear about defining the risk that is being taken or the actions/ behaviours that they determine to be risky and explore who or what is at risk at the time of the assessment. They then should explore the impact and likelihood of the risk(s).

Practitioners should also find out whether the risk places the council in an unlawful position (such as the possibility that someone is being deprived of their liberty) by discussing the individual and their circumstances with their line manager in the first instance.

Shared agreement about risk will not always be possible but it is important that everyone involved in reaching decisions about risk reaches a shared understanding of the viewpoints of all those who are affected by decisions involving risk.
(Department of Health 2010, p9)

Step 2. Identify protective factors (see appendix 2 which provides useful examples to think through)

Practitioners should explore the strengths/ protection factors surrounding the individual. Protective factors can be described as attributes or conditions that can occur at individual, family, community or wider societal level.

Step 3. Explore risk reduction possibilities (see appendix 3 which provides useful questions to work through)

Explore all the possible options put forward by all interested parties and think about the pros and cons of each option. Could some of these options be considered for now/ on a short-term basis? On a longer-term basis? Highlight the fact the preferred option may not be available now because of lack of resources and feed this back to your line-manager and/or commissioner.

Step 4. Support the person to develop an action plan (see appendix 4 which provides useful questions to work through)

Practitioners should support the person and their network to develop an action plan (or write the action plan if the person cannot or will not engage despite practitioners' best efforts) that manages the identified risks.

The plan should offer real solutions to minimise the risk and provide contingency actions.

The plan should confirm the specific responsibilities of everyone involved so that the responsibility for the risk taking is a shared one and the plan should be agreed by everyone who has a part to play in it.

Step 5. Management of the risk(s) and review of the risks (see appendix 5 which provides useful questions to work through)

a) Management of the risk(s)

Practitioners need to implement the action plan and have clear monitoring and reviewing systems in place. Practitioners are responsible for ensuring the accurate documentation and sharing of risk assessment information with all relevant partners.

In the event of any post- implementation disagreement where the practitioner is unable to achieve a quick resolution with the person themselves and interested parties, then the practitioner must discuss ways forward with their line manager.

Sometimes low-key monitoring is the only form of assistance that is acceptable to the person. This could involve community- based voluntary organisations providing specific services such as visiting, befriending or members of the person's social network.

b) Review of the risk(s)

The review meeting is an opportunity to:

- focus on solutions by using a collaborative approach to come up with ways to manage the ongoing risk(s)
- take stock of the current situation
- revisit the original risk assessment
- assess whether the nature of the risks/ strengths have changed and account for that in the revised plan
- look at the known or potential rates of improvement or deterioration in the individual and their environment
- check on the capabilities/ willingness/ strengths of the person and their support network
- evaluate the effectiveness of all the actions that were put in place in the plan
- be creative and come up with new mitigation actions to minimize risk
- ensure all the relevant stakeholders are engaged in the process of supporting the person
- update/ write a new risk management plan
- celebrate any achievements and set new goals.

A further review meeting date may need to be set until there is agreement the situation has become stable and the risk of harm has been reduced to an agreed acceptable level.

The frequency of reviews will be decided by the practitioner based on the specific circumstances of the case they are working with.

B5. OPPD Risk Enablement Panels

Where the risk issues associated with the support option(s) chosen by the person are considered too complex and challenging and the team manager or supervisor is unable to negotiate an agreement with the person, the case will be escalated for consideration by a Risk Enablement panel.
Recording will be done using the Adult Social Care and Health Risk Enablement Panel meeting form (on Knet).

B 5.1 The purpose of the Panel will be to:

- Consider the person's views and wishes
- Evaluate relevant information to inform the most effective action plan
- Seek positive solutions and outcomes for the person by resolving disagreements about how to address complex and challenging risk decisions

- Provide support to practitioner staff by ensuring that complex and challenging decisions are given appropriate support from senior managers
- Provide guidance and direction to staff
- Involve and include relevant professional expertise, in order to discuss and share the burden of decision-making
- Consider each case and clearly record its discussions, decisions and the reasoning used in reaching those decisions. It is also responsible for ensuring that the information is placed in the person's case file.
- To demonstrate that the Directorate has fulfilled its duty of care around the support of the person, carer and staff. (In some cases, it may be necessary to consider risks to other members of the household or neighbours).

Important: *the panel does not make decisions.*

The decision(s) to be made rests with the decision maker. If the person has capacity to make the specific decision that needs to be made, then they are the decision maker and they make it themselves. If they do not have the capacity to make the decision, then the decision rests with either the person who has LPA (the LPA relevant to the decision to be made) or the legal representative or the social care practitioner, who will have organised a bests interests meeting to explore what is in the best interests of the person concerned.

B 5.2 Chairing / timing and attendance

The panel will be chaired by a service manager and be considered quorate when there is a minimum of a team manager and a Safeguarding coordinator on the panel. The Panel can be single or multi-agency in line with the presenting risks and associated decisions.

The panel will be convened as and when necessary following a referral, reflecting the need to respond in a flexible and timely manner to all referrals. To facilitate this, it will be considered good practice to have at least one our ring fenced monthly for cases to be 'booked' into panel.

B 5.3 Action plan following the Risk Enablement Panel

A “SMART” action plan will be produced that includes:

- agreement of any trigger points that will determine the need for an urgent review meeting.
- communication plan (with the person and other key people)
- contingency plans and escalation process
- monitoring and review arrangements
- name of the person who will lead the case

B 6. LD Alliance Risk Enablement Panels

Risk enablement panels provide a forum for collaborative positive risk management working across all agencies within the Kent Learning Disability Alliance including the Young Peoples teams. The main areas of work include:

- people who present a significant risk to themselves and others that is currently difficult to manage.

- The risk issues associated with the support option(s) chosen by the person are considered too complex and challenging and the service manager is unable to negotiate an agreement with the person

B 6.1 The purpose of the panel will be to:

- Consider the person’s views and wishes
- Evaluate relevant information to inform the most effective action plan
- Seek positive solutions and outcomes for the person by resolving disagreements about how to address complex and challenging risk decisions
- Provide support to practitioner staff by ensuring that complex and challenging decisions are given appropriate support from senior managers
- Provide guidance and direction to staff
- Involve and include relevant professional expertise, in order to discuss and share the burden of decision-making
- Consider each case and clearly record its discussions, decisions and the reasoning used in reaching those decisions. It is also responsible for ensuring that the information is placed in the person’s case file.
- To demonstrate that the Directorate has fulfilled its duty of care around the support of the person, carer and staff. (In some cases, it may be necessary to consider risks to other members of the household or neighbours).

B 6.2 Chairing Timing and attendance

The core Local Management Team for each of the area teams consists of representatives from all Learning Disability professions:

- Service Manager – chair
- Community matron
- Clinical Lead Physiotherapy
- Clinical Lead speech and language
- Clinical Lead occupational Therapy
- Care management senior practitioner
- MHLD psychology
- MHLD Psychiatry
- MHLD Nursing
- KMPT Forensic Outreach

In addition to regular invites include:

- Police Community Support officer
- Housing
- KCC commissioning
- Professional presenting the case
- Probation Service
- Fire officer
- Service Provider
- Acute Liaison LD nurse

Risk Management Forums are booked bi -monthly in advance but can be convened more urgently if needed

B 6.3 Accountability

The risk Management Forum provides advice and support on risk management actions for people already involved in a case**, but does not manage the risk**

The staff member raising the case at the risk forum is responsible for completing the risk assessment, client discussion form, submitting the case and supporting documents to the service manager 4 weeks prior to the risk forum

The staff member raising the case is responsible for amendments to the risk assessment and any follow up actions

B 6.4 Action Plan following the Risk Management Forum

A **SMART** action plan will be produced that includes:

- Contingency and escalation plans
- Communication plan (with the person and other key people)
- Agreement of any trigger points that will determine the need for an urgent review meeting
- Name of the person who will lead the case
- Monitoring and review arrangements

C. Monitoring of the policy

C1. Required outcomes

This policy seeks to ensure that:

- All staff working in Kent County Council Adult Social Care and Health Directorate who carry out formal “risk assessments” are fully aware of their roles and responsibilities.
- This in turn will ensure that the people of Kent who need our services can feel confident that staff supporting them have been given the relevant information to do so.

C2. Review of the policy

- A member of the policy team will review the policy two years from the launch of this policy.
- They will check that all contents are still relevant, engage with key stakeholders to look at practice issues, incorporate recommendations and rewrite or amend contents as appropriate.
- The amended policy will be presented to DMT for approval if the amendments warrant this step.

Appendix 1. Risk assessment. Step 1.

Identify the risk

Practitioners should start by thinking through some of the following initial questions:

- What information is available at the time of assessment?
- Is there a need to get more information? From whom?
- What is the risk? (be very clear about defining the risk that is being taken)
- Define the actions/ behaviours you determine to be risky?
- What is the risk to self? To others? From others? From physical conditions? From mental health difficulties? From memory and cognitive impairment?
- What is the context of the problem/ situation requiring a risk decision?
- Who is at risk? How could they be affected?
- What is at risk?
- What can happen and in which situations? How could it happen?
- Does the risk relate to any information from the person known history?
- Consider significant behaviours, cognitions and personality factors from a detailed history

- **What are the feelings and wishes of the individual?**
- What is the person's / carer'(s) 'own current assessment of risks?
- Am I clear about the person's own understanding and experiences of risk?
- What is going on for the person in their life now?
- In what ways is this activity in the best interest of the individual?
- What are the positive outcomes to be achieved through taking the specific risk (short and/or long-term)?

- Consider the likelihood of risk (degree of intent; immediacy/ frequency of its occurrence or re-occurrence; timing: do different times of day or different days elevates or reduces the risk?)
- Consider the severity of risks (i.e. the impact it could have if it occurred)
- Do we have a known chronology of former risk incidents and ways which were helpful to manage them?
- What's the worst that could happen? For whom?
- What's the best that could happen? For whom?
- What could happen if we don't support the person to take the risk?

Appendix 2. Risk assessment. Step 2

Identify protective factors/ strengths

- What strengths does the person bring to support the risk?
    - Personal factors: such as high self-esteem, good coping and /or problem-solving skills, personal resilience, knowledge, skills and values, social and emotional competence, self-control, sense of optimism, positive attitude to help seeking, positive sense of identity and cultural heritage; what the person can or could do etc.

- What strengths does the informal support network bring to support the risk?
    - concrete or emotional support in times of need through family connections (whatever the concept of family means to them)? Can the person rely on friends/ neighbours?

- Does the person have any community presence: work/ volunteering/ education/ membership of community group?

- What strengths does the formal support network bring or could bring to support the risk?
    - access to professional support/ specialist practitioners/ risk champions/ multi-agency approach etc.
    - a practitioner who has found meaningful ways to engage with the person
    - access to health services (physical and mental health)
    - availability of resources (human or material resources)

- What are the potential safety nets? Think of early warnings, crisis and contingency plans

- Are the person's living conditions adequate? Think: do they have access to food? clothing? heat? clean drinking water?

- Can the person access and use working equipment/ phone/ internet?

Appendix 3. Risk assessment: Step 3

Explore risk reduction possibilities

- How can the risk be reduced to minimize its impact?
- What are alternative options? Can a similar activity be found that has more acceptable degrees of risk?
- Reasons why the alternative options are not the best options.
- What early warning signs and safety net can be identified?
- What happened last time this course of action was followed? How was it managed? Can we replicate that?

Depending on the nature of the risks, practitioners may want to explore:

- Equipment / Assistive technology
- Connection to a community group/ volunteering/ education
- Employment preparation / Training/ enablement
- Befriending/ buddy service/ informal network support
- Home safety intervention
- Specialist assessment (OT/ neurological/ sensory)
- Package of care / short breaks/ change of accommodation
- Can I evidence I have supported the person to think through the pros and cons of the different choices available?

Appendix 4. Risk assessment: Step 4

Support the person to develop an action plan that manages the identified risks

- Be clear about intended outcomes
- What needs to and can change?
- What may be the pitfalls?
- Who is going to do what and when? How will the coordinator know that's it's been done?
- What mitigation actions can be put in place? (to reduce or eliminate long-term risk)
- Is there a need for a short-term / medium-term and /or long- term management plan? If so, are we clear about goals to be reached for each plan?
- How could the plan be sabotaged? What contingency/ communication plan can we put in place to prevent this happening?
- Who agrees or disagrees with the proposed plan?

A good decision should include the following narrative elements:

- **A statement of the decision**
- **The reasons for the decision**
- **A description of the main alternatives**
- **Reasons why the alternative is not the best option**

Appendix 5. Risk assessment: Step 5

Management of the risk(s) and reviews

Monitoring:

- How will this first plan be monitored and by whom?
- What mechanisms have we put in place to help the person to self-monitor and report to the lead supporter?
- Have we implemented a way of working which helps to act on immediate changes to be made in response to changing levels of risk?
- Have we established the named person who can approve immediate decisions?
- How will the small changes made in response to monitoring be communicated by the lead person to all interested parties?

Reviews:

- What has worked well and why? Identify specific actions / behaviours which proved helpful, so we may continue doing them
- What did not work well and why? Identify specific actions / behaviours which proved unhelpful
- What is still getting in the way of the risk being managed to an acceptable level to all?
- What creative options can we keep on exploring?
- What needs to happen now and who is the lead person to make it happen?
- How are we going to celebrate the person's achievements? (however small these appear to be)
- Have we updated or rewritten the risk management plan?
- How will the new plan be monitored and by whom?
- How often do we need to review this new plan? (this will depend on the severity of the risk)
- Have we reviewed the frequency levels for reviewing?
- Is there a review date in place? If not, why not?

Appendix 6- A Supported Decision Tool (page 1/3)

This tool is designed to guide and record the discussion when a person's choices involve an element of risk. It will be particularly helpful to a person with complex needs or if someone wants to undertake activities that appear particularly risky.

It can be amended to suit different service user groups.

It can be completed by the practitioner with the person or by the person themselves with any necessary support, (including the use of communication aids/ pictures where necessary). It is important that, in discussing any risk issues, the person has as much information as possible (in an appropriate form), fully appreciates, and genuinely understands any consequences, to enable them to make their best decisions.

Using the tool – Practitioners need to:

- Ensure that the person has the right support to express their wishes and aspirations
- Assume capacity unless otherwise proven
- Consider the physical and mental health of the person and any specialist services they need or are already receiving

Issues for the practitioner to consider

When using the tool with the individual, consider carefully the following aspects of the person's life and wishes:

- dignity
- diversity, race and culture, gender, sexual orientation, age
- religious and spiritual needs
- personal strengths
- ability/willingness to be supported to self-care
- opportunities to learn new skills
- support networks
- environment - can it be improved by means of specialist equipment or assistive technology?
- information needs /communication needs- tool can be adjusted (braille, photo's, simplified language)
- ability to identify own risks /ability to find solutions/ least restrictive options
- social isolation, inclusion, exclusion
- quality of life outcomes and the risk to independence of 'not doing'.

Appendix 6 - Supported decision tool (page2/3)

1. What is important to you in your life?	
2. What is working well?	
3. What isn't working so well?	
4. What could make it better?	
5. What things are difficult for you?	
6. Describe how they affect you living your life	
7. What would make things better for you?	
8. What is stopping you from doing what you want to do?	
9. Do you think there are any risks?	
10. Could things be done in a different way, which might reduce the risks?	
11. Would you do things differently?	
12.Is the risk present wherever you live?	
13 What do you need to do?	

14. What do staff / organisation need to change?	
15. What could family/carers do?	
16. Who is important to you?	
17. What do people important to you think?	
18. Are there any differences of opinion between you and the people you said are important to you?	
19. What would help to resolve this?	
20. Who might be able to help?	
21. What could we do (practitioner) to support you?	
Agreed next steps-who will do what	
Record of any disagreements between people involved	
Date agreed to review how you are managing	
Service user's signature	
Practitioner's signature	

Appendix 7. Checklist for use by LD service provision staff.

If you have followed every step in the checklist below and can evidence you have done so, you will be supported by the organisation should something happen despite all your best efforts to minimize the risk:

Step 1	Read the policy and work to the principles of the policy
Step 2	Work with the person and their support network to identify the activity the person wants to do Focus on what is important to the person and identify the strengths they bring in relation to the proposed activity
Step 3	Do a risk assessment (using the forms for your service) involving the person and their support network (this helps the family members/ support network to feel confident that the activity being proposed is properly thought through to minimize risks to their loved one) Share the risk assessment with the person's care manager
Step 4	Raise any serious risk issue(s) with your line manager and record what actions you will take following the discussion Share those actions with the person and whoever needs to know (such as support network, care manager, support staff etc)
Step 5	Have an agreed plan of action (signed by everyone involved in the plan) to support the person undertake the activity – this will involve writing precisely: • Who will do what and when to make the activity happen? • Who will do what as part of the contingency plan?
Step 6	Review the risk plan after the activity and amend if needed Celebrate achievements

Appendix 8. Another tool you may choose to use when working on a multi-agency basis:

Solution-focused meeting template

Over the past three decades or so, a new approach to helping people has been steadily emerging within education, social work, health and other organisations. This approach is known as *solution oriented approaches* has its origins in therapeutic approaches known as Solution Focused Brief therapy and Solution Oriented Brief Therapy.

Recommended strategies to Solution Focussed Meetings:

a. **Start with the solution**: The first step in the solution-focused process is to start by defining the solution, or range of solutions which need to be considered. In essence, this is the goal which should encompass how to create the change or improvement that matters.

b. **Create steps that move you towards the solution**: Once the solution is identified the next stage is to identify interim objectives which move towards the solution. These become the markers in knowing you are moving towards the solution.

c. **Build upon existing strengths of the client and what is working in current practice**: no matter how small or insignificant these strengths may be, the cumulative effect and learning can help us consider what approaches will work best.

Preparing for your meeting:

Share 2 documents with attendees prior the meeting:

1. Aims of the meeting

AIMS OF THE MEETING:

- This meeting is being structured as a solution focussed meeting which will draw on collaborative solution-building.
- We will spend approximately 80% of the time on discussing strengths, goals and solution-building and 20% on problem discussion.
- The outcome of this meeting should provide a consideration of all the options of support to (the person) and ensure consistency and support across different agencies.
- The meeting will focus on what works, with an emphasis on strengths, resources, successes and what people **can** do – not what they can't.
- Participants will be asked to think of solutions from inside and outside of their own organisation.
- We will retain a perspective that 'The problem is the problem, not the person'.
- We will develop a clear set of Actions / Outcomes.

2. Format of the meeting:

Solution-Focussed Risk Meeting

The 6 steps of this meeting are:

1. **Current situation**: where are we now?
2. **Start with the solution**: what do we want to achieve?
3. **Problem identification**: what needs to change to achieve step 2?
4. **Problem prioritisation**: agree what needs to be worked on first
5. **Create steps for change**: how will we do this? What is working at the moment? Identify the person's strengths and existing support
6. **Action planning:** agree who will do what and when; identify core team to ensure effective communication and review

Meeting agenda with timings:

Step 1. <u>Where are we now?</u> (10 minutes)

1. **Details of adult at risk:**
   Select 1 person to provide a summary based on a Multi-Agency Client Chronology.

2. **Views of the person:**
   Try to facilitate person concerned to attend the meeting, what support would be required? If the individual is not attending, ensure that their views are sought prior to the meeting.

3. **Confirmation of mental capacity to make a decision regarding the risk issue :**
   Example 1: P has fluctuating capacity to make decisions about …...
   Example 2: Professionals have been unable to make sufficient contact with P in order for a Mental Capacity Assessment to be undertaken.

Step 2. <u>Start with the solution</u> (10 minutes)

Ideally, what does P want to achieve and what do we think needs to be achieved?
List all answers on whiteboard/ flipchart

Step3. <u>Problem identification</u> (10 minutes)

What needs to change to achieve step 2?
Example: “What are the issues / concerns which we need to work on to support P”?
i.e. accommodation/ mental health/ emotional wellbeing/ personal care etc…

Step 4. Problem Prioritisation (10 minutes)

Agree what needs to be worked on first:

- Which of the above issues will be of the most benefit to focus on first?
- Whose benefits will they serve?

Step 5. Create steps for change (20 minutes)

How will we do this?

- I how many ways might we work together on providing support? what is already working? Can we do more of this?

- Examples: support and advice; provision of domiciliary support; P is engaging with...; P is accepting support for...; support for each other across organisations…

Step 6. <u>Action planning</u>

List on Whiteboard/flipchart

Agree who will do what and when. Identify core team to ensure effective communication and review

- *"*We have agreed to *provide the following support* in order to *work collaboratively to support P…* We can complete our Action Plan now.

What Action:	*complete*
Who	*complete*
How	*complete*
By when	*complete*

What Action:	*complete*
Who	*complete*
How	*complete*
By when	*complete*

- **Date of next meeting to check progress?**
- **Who needs to attend?**
- **How will we keep in contact?**
- **Who should be the core contact team?**

Thank you all for attending and participating today.

Appendix 9. References

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Appendix 10. ASCH Positive Risk Management Risk Rating Form

Likelihood	Very likely		5 Low	10 Medium	15 Medium	20 High	25 High
	Likely		4 Low	8 Medium	12 Medium	16 High	20 High
	Possible		3 Low	6 Low	9 Medium	12 Medium	15 Medium
	Unlikely		2 Low	4 Low	6 Low	8 Medium	10 Medium
	Very Unlikely		1 Low	2 Low	3 Low	4 Low	5 Low
RISK RATING MATRIX			Minor	Moderate	Significant	Serious	Major
Impact							

Use risk assessment key to determine the possible impact (level of harm) that might result and the likelihood (chance of the event occurring) from each risk.

Risk Rating

LOW	MEDIUM	HIGH
1 - 6	8 – 15	16 - 25

Risk Level	Action and Timescale
Low	No additional measures are required; however you must monitor to ensure that the risk(s) remain acceptably low.
Medium	Take prompt action to address the risk(s). Timescales must be consistent with the complexity of the issues and the likely impact on service users and others if action was delayed.
High	Take immediate steps to address the risk(s).

This risk rating form must be used with the risk evaluation form (see reverse) to calculate the overall risk score and risk level. Where there are multiple risks the overall risk level will be determined by the highest risk score.
This form must be used to develop the detailed action plan and be placed in the service user's case file.

POSITIVE RISK MANAGEMENT RISK EVALUATION FORM

Service User name:……. Service User ref:…… Risk Score:…… Overall Risk Level…….

Assessor's name (print):…….. Assessor's signature…… Date of Assessment……...

Define risk (Describe it)	Evaluate risk	Risk Score	Actions to address risk	Resulting score	Monitor and review
give a brief description	Weigh up the strengths, opportunities and protective factors with the impact and likelihood of the activity/inactivity	20	List actions	8	Describe how you will monitor and how frequent (in proportion to risk)