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WELCOME

Learning to Improve: Clinical Risk Assessment

Dr Michael Smith, Lead Associate Medical Director, NHS Greater Glasgow & Clyde

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Session Overview

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- **Learning from practice**
  Dr Nagore Penades, Consultant Psychiatrist
- **Why bother with risk assessment?**
  Dr Brian Gillatt, Consultant Forensic Psychiatrist
- **Implementation in practice**
  Sharon Pettigrew, Professional Nurse Advisor
- **Question and Answer Session (Panel)**
  Katrina Phillips, Head of Adult Services,
  Lynnette Cameron, Clinical Risk Manager,
  Dr Ruth Ward, Consultant Psychiatrist,
  Sharon Pettigrew, Professional Nurse Advisor

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Learning from Practice

Lynnette Cameron, Clinical Risk Manager
Nagore Penades, Consultant Psychiatrist

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Learning from Practice

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- Lessons from Significant Clinical Incidents (SCIs) in Mental Health Services (MHS) NHS Greater Glasgow & Clyde (GG&C)
- Inpatient suicides in NHS GG&C
- The National Confidential Inquiry into Suicide and Safety in Mental Health (NCISH) – key findings and recommendations

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Lessons from Significant Clinical Incidents (SCIs)

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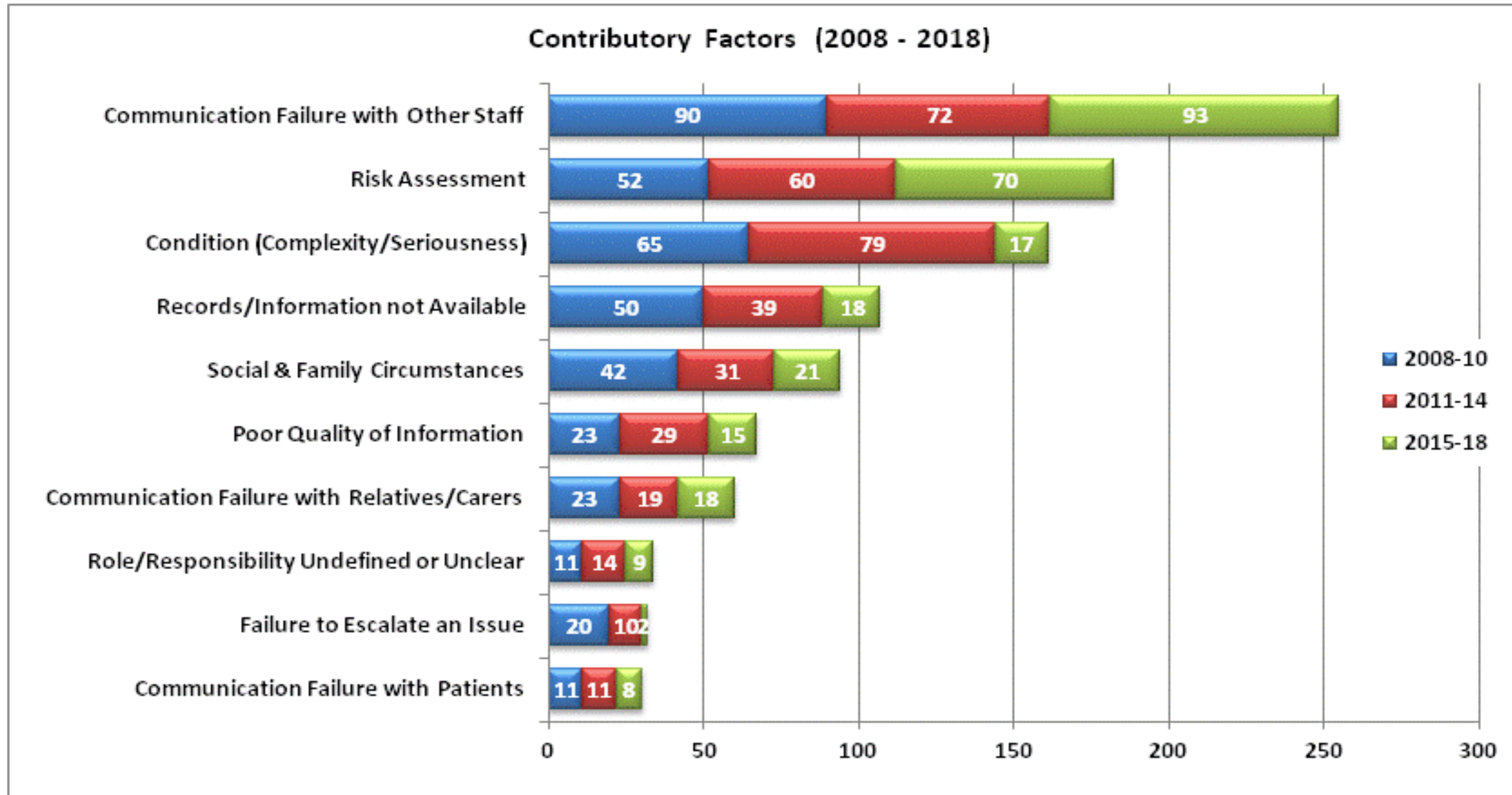
Contributory Factors



Lessons from SCIs

Thematic Learning

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- **Communication / Information sharing / Documentation**

  By far the most common issues overall
- **Risk assessment** and management
- **Family** involvement
- Joint working

  - Team **interface and Transitions** of care (Community Mental Health Team/Addictions, Crisis, GP)

  - **Difficulties** in **accessing records** leading to poor documentation and communication.

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Lessons from SCIs

Thematic Learning

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Datix and MH specific Section 17

- Developed in 2016 and implemented in January 2017
- Main aim is to helps us better learn from SCIs
- MH specific Datix section looking at :
  - Diagnosis
  - Contributory factors
  - Stages of care
  - Thematic learning
  - ....

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Lessons from SCIs

Datix Section 17

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Diagnosis

Primary Diagnosis	Number
F10	4
F11	2
F13	2
F20	2
F31	1
F32	**8**
F33	**6**
F40	1
F43	3
F45	2
F60	4
F84	1
X01	1
X02	1

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Lessons from SCIs

Datix Section 17

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Contributory Factors

Option	Number
Bereavement	5
Employment	9
Features of BPD (self harm)	4
Financial	5
None	1
Physical Health	**16**
Relationships	15
Social Isolation	9
Other*	6
Total	**70**

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Lessons from IP Suicides

Inpatient Suicides in NHS GGC (2010 – 2018)

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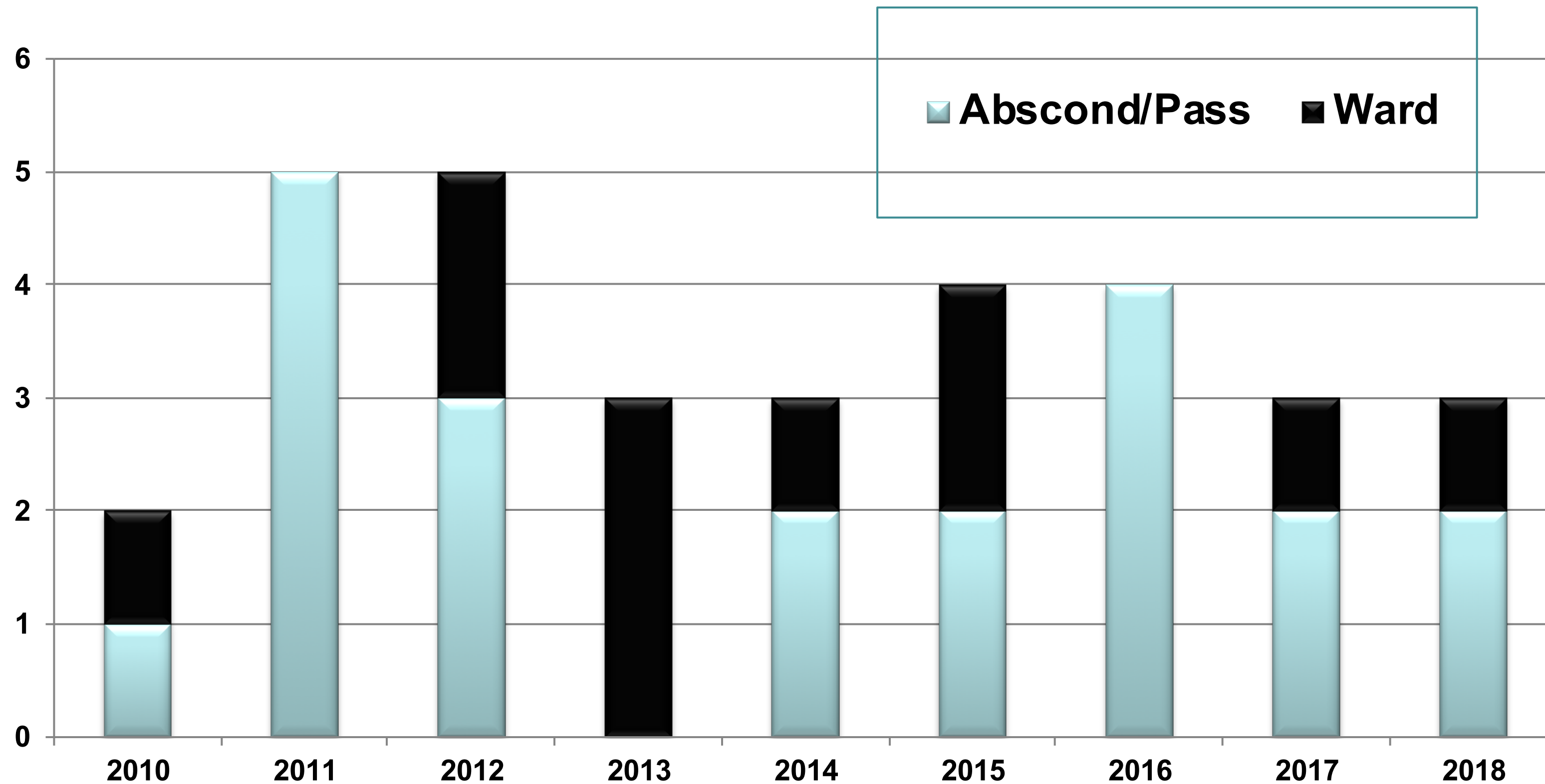

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Lessons from IP Suicides

Inpatient Suicides in NHS GGC (2014 – 2017)

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Finding and Recommendations

Total of 14 IP suicides in NHSGGC

In vast majority of cases **Risk Assessment** and **Communication** were highlighted as contributory factors.

Care Planning and **MDT working** were other common contributory factors.

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Learning from NCISH

Population data

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- **Learning from NCISH**
  Population data

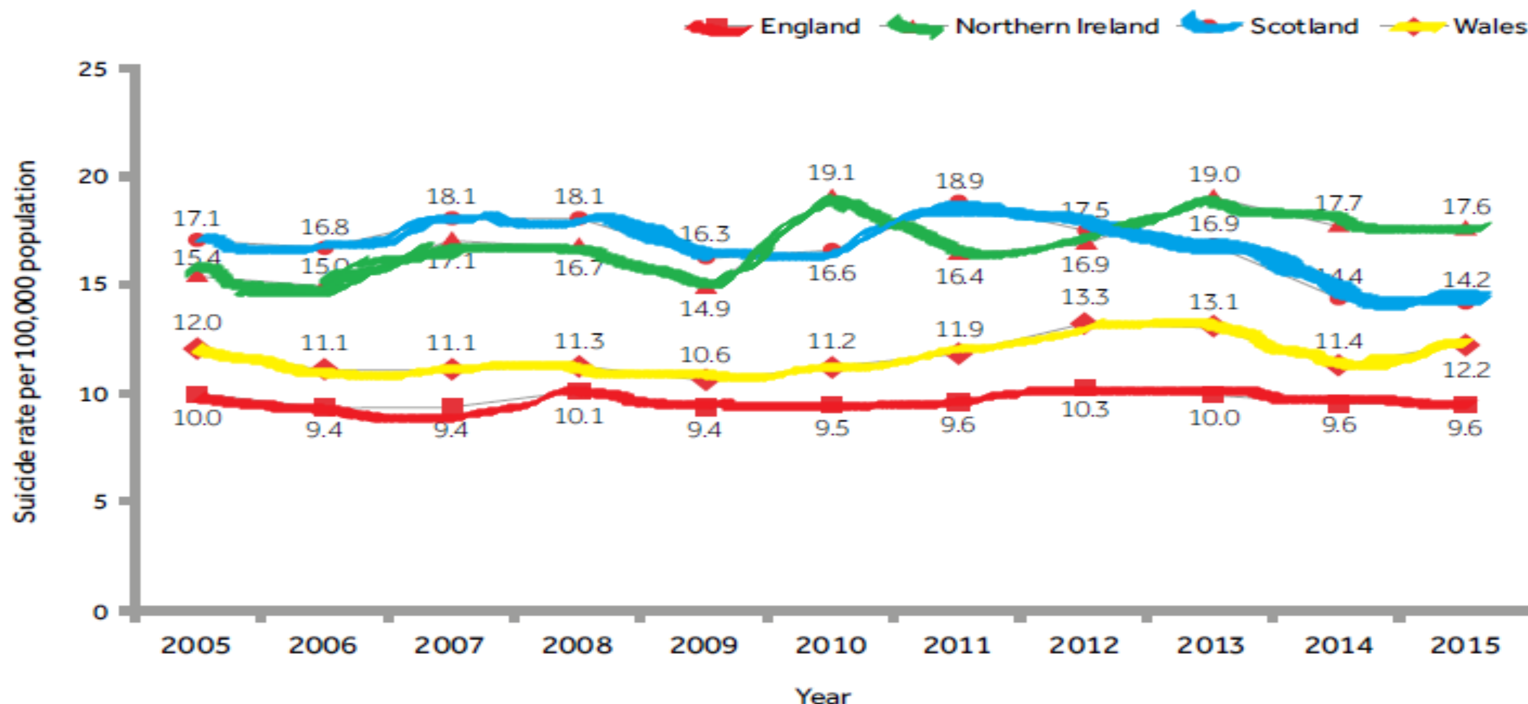

Figure 89: Suicide rates in the general population, by UK country

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Population data

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- Suicide rates in general population higher in Scotland than UK
- Suicide rates have fallen in Scotland over last decade
- Methods:
  - In the 1970s poisoning 50%, drowning 20% of total suicides
  - In 2017 hanging/strangulation/suffocation 53% and poisoning 25% of total suicides.
  - Opiates now most common drug in fatal OD
- UK rise in male suicide, particularly 45-54 age group
- Suicides amongst student population are increasing

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Learning from NCISH

Inpatient Suicides

What the evidence shows:

- 25 – 33% suicides occur on the ward
- 37-58% occur on agreed leave or absconsion from the ward
- >95% on general or intermittent observation
- Incidents involving patients on observations are more likely associated with less experienced staff or those less likely to know the patient

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Risk factors for inpatient suicides

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- Affective disorders
- Short duration of illness < 1 year
- Recent life events/family relationship issues (incorporate into initial risk assessment)
- Previous history of self harm
  - in particular self harm in week prior to admission (x5 risk)
- Early in the admission (25-34% first week)
- Reduced staff availability – nights/changeovers
- Isolated unsupervised ward areas – bed and bathrooms

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Inpatient Suicides

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What it highlights:

- Importance of staff vigilance and awareness in prevention of suicide
- Importance of improving *'relational security'* - through engagement and maintaining continuity of staffing
- The need for transition to general observations to be planned and involve Multidisciplinary team
- Environmental safety – sight lines, ligature points

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Clinical Messages

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- Work with **families**: consult in 1st contact and involve at all stages of care.
- Address identified **high risk factors**: alcohol misuse, isolation, economic issues....
- **Physical Health** needs:
  - Good physical care can reduce suicide risk
  - Care plans should reflect physical health needs
  - Assess physical health asap after admission
- Be aware of medication availability/means
- High risk stages/situations:
  - Point of discharge/out of hours admissions
  - Crisis Teams
- Assertive follow up and treatment

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Why bother with risk assessment?

Dr Brian Gillatt

Consultant Forensic Psychiatrist

NHS Greater Glasgow & Clyde

Why risk assess?

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- Completed suicide claims one life every 40 seconds[1]
- For every death from suicide, 30 people make an attempt[2]
- Suicide second leading cause of death in 15-29 year olds worldwide[1]
- 804,000 suicides worldwide in 2012[1]
- In NHS England between 2013-14 - 68,683 assaults on staff, 69% in Mental Health[3]
- May 2013 – World Health Organisaton adopted first Mental Health Action Plan, committed to reducing suicide rates globally by 10% by 2020
- Mental Health action plan – 'Health care services need to incorporate suicide prevention as a core component'[1]

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Situation in Glasgow

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- Jan 2017 – Dec 2018 – 119 Significant Clinical Incident reviews were 'closed' by Mental health services
- 40 made recommendations around risk assessment, listing either non compliance with policy, risk assessments were completed poorly or not completed at all
- Frequent recommendations included – 'remind staff to complete', 'training on risk assessment', 'need to update regularly'

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Staff Survey 2014

- 55% felt that risk assessment is for prediction
- 79% believed that consultant psychiatrists are expected to predict risk
- 77% strongly believed that it is an essential part of clinical practice
- 82% completed it because is Policy
- Clinical Risk Screening and management tool (CRSMT): *“far from ideal"," dilemma about how to make it available and highlight risks to colleagues and other professionals”*

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Risk assessment staff survey 2017

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- 453 (21%) of NHS GG&C mental health clinical staff responded to survey on current risk tool
- Split of staff reflected numbers in the various professional groups
- 25.6% medics completed a risk tool on patients under their care vs 88% nursing staff
- 84% of nurses felt the tool aids decision making vs 22% of medics
- 35% of staff reported being trained in the tool (no training is available)

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Risk Assessment Survey 2017

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- 2.4% medics, 18% of nurses review risk tool at every patient contact
- 47% of all staff seldom or never consult the patient when completing the tool
- 76% of staff seldom or never consult family members or carers
- Thematic analysis of free text comments – 'defensive medicine' 'keep managers happy', 'tick box exercise',

  'Latest BJPsych June 2017 confirming the mounting evidence supporting the avoidance of risk scales in clinical practice'
- So GG&C has some problems…

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Should we use standard risk assessment scales?

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- NICE guidelines suggest risk assessment tools and scales should not be used to predict future suicide or repetition of self-harm
- Most literature looks at Positive Predictive Value (PPV) of risk tools (proportion of those who are predicted to complete suicide, go on to complete suicide)
- Carter et al[5] meta-analysis in 2017 reviewed 70 studies looking at biological and psychological risk tools found a range of PPV from 4-21% for suicide
- They suggested this is far too low and state 'no tool is sufficiently accurate as a basis to determine allocation to intervention'
- BUT – in clinical practice main aim of risk assessment is to **manage** risk, not predict, so patients being identified at risk of suicide will have interventions, meaning PPV is potentially a flawed value to use.

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So what might be useful?

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It's not clear

Reviews suggest comprehensive clinical assessment may be helpful[5]

NICE[6] would like a 'needs based approach', which could include –

- skills, strengths and assets
- coping strategies
- mental health problems or disorders
- physical health problems or disorders
- social circumstances and problems
- psychosocial and occupational functioning, and vulnerabilities
- recent and current life difficulties, including personal and financial problems
- the need for psychological intervention, social care and support, occupational rehabilitation, and also drug treatment for any associated conditions
- the needs of any dependent children

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What else?

Risk assessment that includes (for management of self harm) –

- methods and frequency of current and past self-harm
- current and past suicidal intent
- depressive symptoms and their relationship to self-harm
- any psychiatric illness and its relationship to self-harm
- the personal and social context and any other specific factors preceding self-harm, such as specific unpleasant affective states or emotions and changes in relationships
- specific risk factors and protective factors (social, psychological, pharmacological and motivational) that may increase or decrease the risks associated with self-harm
- coping strategies that the person has used to either successfully limit or avert self-harm or to contain the impact of personal, social or other factors preceding episodes of self-harm
- significant relationships that may either be supportive or represent a threat (such as abuse or neglect) and may lead to changes in the level of risk
- immediate and longer-term risks.

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Can uptake and use of the tool be improved?

No literature on this available

The Challenge for Glasgow

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- Develop a tool that isn't a tick box exercise
- That doesn't divide patients into risk categories that are used to allocate care
- Does cover risk of suicide and risk of violence
- That addresses repeated concerns raised in SCIs and elsewhere that risk management is a major issue
- That involves patients, carers and families
- That prompts staff to risk *manage* rather than only assess
- Is short and understandable so it might actually be completed by staff
- Can be used by staff on day one of the job just as effectively as those on day 2001
- That staff may even find helpful
- That can be audited easily, across a large health board with lots of staff
- That works with our electronic case notes

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What is Risk assessment?

- Risk assessment is not about making 100% accurate predictions
- Risk assessment cannot be about avoidance of all risk
- Risk assessment is about making defensible decisions (defensible clinically, logically and medico-legally)[4]
- The emphasis should be on risk management which is relevant to the current situation

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Aims of the Clinical Risk Assessment Framework in Teams (CRAFT)

- As part of assessment tries to encourage the user to think about current, relevant risk factors, both risk enhancing and risk protective
- Encourages engagement with service users and their families to consider risk management, including development of a safety plan (crisis contacts, enviromental risks etc) until *next review*
- Prompts user to develop a longer term risk management plan including range of interventions and timescales for delivery
- Overall aim is to shift the emphasis to risk modification, rather than assessment

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Rollout and Audit

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Will be introduced June 2019 as part of the electronic case record (EMIS)

Form will be able to auto populate with historical data

Audit will initially be electronic, gathering data on -

- Whether the CRAFT is completed at initial assessment, at Transitions of care, after significant incident
- If nothing else happen then at least once per year (EMIS will prompt the user to update the form at this point)
- Also to complete the CRAFT within 2 hours of admission
- Finally within 7 days of discharge

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Other evaluations of the tool

- No ability to assess quality of risk assessment or things like whether the risk assessment has been discussed with the family, this will require local audit
- Wider project (IRAMP) – looking at risk assessment throughout the board, to include staff surveys, staff and patient focus groups, direct observation of team discussions around risk and hand review of CRAFT assessments

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References

1. WHO – Preventing Suicide, a Global Imperative, 2014
2. Crosby et al Suicidal Thoughts and Behaviours amongst Adults – MMWR Surveillance Summary 2011 63: 1-22
3. Violence and aggression: short-term management in mental health, health and community settings, NICE guideline 2015
4. Vinestock - Risk Assessment, A Word to the Wise, Advances in Psychiatric Treatment, 1996 vol 2 pp3-10
5. Carter et al - Predicting suicidal behaviours using clinical instruments: systematic review and meta-analysis of positive predictive values for risk scales BJPsych June 2017 210 387—395
6. NICE guideline CG 133 Self harm in over 8s, long term management

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Implementation in practice

Sharon Pettigrew

Professional Nurse Advisor

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What did we learn?

- Experience of the Patient Safety Programme
- Policies are important but not enough (some were updated)
- Training is important, as is motivation to ask is as important as information

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Policy

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- Suicide Prevention Guidance
- Suicide Risk, Environment & Design Standards Meeting
- Guidance on Ligatures & the Use of the Big Fish Safety Knife Cutters
- Environment of Care (EoC) is a consideration in care planning (which required a new EoC audit and work on design)

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Suicide Prevention Guidance

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Background

- From November 2014 – February 2015 there were 3 completed suicides within Adult inpatient areas where the door to the bedroom or the en suite had been used as a point of ligature
- The Adult Mental Health planning group reviewed these and commissioned a short life working group
- Remit of the group was to review current environmental risk assessment processes, clinical risk screening to reduce known risk on individuals and relevant policies
- Scope of the review was to consider designs and alarm options for door frames that may reduce the risks of doors being used as a ligature point in the future

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Outcome of the review

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- Data review of records (260425) for use of doors as points of ligature records suggested no significant frequencies of these types of incidences and that these are uncommon but the outcome remains of high concern
- Consideration of information on the design of doors from inpatient mental health areas across Scotland predominantly with en suite bathroom areas or toilet cubicles and not as main bedroom doors
- Following the review of available information, prevalence of incidents relating to doors as points of ligatures and lack of evidential data to determine the impact of electronic solutions consideration was given to the development of a GGC Suicide Prevention Policy/Guidance

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Benefits of the guidance

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- Supports the existing clinical risk policy
- Supports the safe and supportive observation policy
- Supports the missing person policy
- Supports the absconding policy
- Potential to have a greater impact on the ability to reduce the risk of doors being used as point of ligature

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Challenges that remain

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- En suite bathrooms and the level of privacy they offer provides a place where the likelihood of being able to self harm is increased due to the reduced ability to observe easily
- Risks of self harm and suicidal behaviours within mental health environment can only be reduced and not eliminated
- Robust clinical risk assessment and management that identify control measures such as enhanced observations and therapeutic engagement are key to reducing the risk of significant clinical incidents within the inpatient setting

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Suicide Risk, Environment and Design Standards group development

In 2017, following the development of the Suicide Prevention Guidance, members from this group suggested a short life working group was pulled together to discuss the issues of suicide risk, environment and design. Agreed actions from this were

- Review existing In-Patient Guidance, veteran's administration environmental checklist, ligature cutter guidance to develop a local environmental audit and associated guidance for staff undertaking such audit activity to assess risk in existing units
- Develop a medium – long term workplan to address identified risks
- Review all relevant existing building guidance to begin the work to develop core guidance for new builds and refurbishments across the mental health system
- Ensure consolidation of environmental and clinical aspects into the Suicide Prevention Policy
- Once core guidance agreed, share with national agencies such as the Mental Welfare Commission, Healthcare Improvement Scotland (HIS) and the Health and Safety Executive

Membership

- Heads of Service
- Clinical representation (Medical, Nursing, Infection Control)
- Clinical Risk Department
- Estates
- Health and Safety Service Manager, Property, Procurement and Facilities Management

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Outputs from this group include

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- Implementation of the Self Harm Control checklist (Environmental) – designed to assist local managers and staff in Mental Health Inpatient Facilities to identify and assess environmental features of wards and departments. It is a live document and reviewed as necessary, minimum annually or particularly when a room lay out is altered
- Ongoing review of doors as point of ligature and includes demonstrations, visits to areas outwith GGC
- Review of relevant risk assessments most recent clinical wash hand basins
- The short life working group has now extended to regular ongoing meetings

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Development of Guidance on Ligatures & the Use of the Big Fish Safety Cutters

Background

- Developed as a direct result of data from the thematic learning of lessons from inpatient suicides in GGC
- Review of Datix recording of completed suicide and attempted suicide by hanging in Mental Health Inpatient areas predominately but not exclusive too
- Was written with the aim of supporting staff to provide best practice when dealing with people who are found using a ligature.
- To ensure a consistent approach when dealing with patients

Scope

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- Applies to all Mental Health and Associated Services including Day facilities
- Applies to all GGC Emergency Departments
- Applies to all GGC Acute Receiving units
- Applies to main building (all wards) Queen Elizabeth University Hospital
- Is used in tandem with the Self Harm Control Checklist (Environmental)

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Benefits

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- Clear step by step instruction on what to do if you find someone using a ligature
- Clear identification of the Big Fish Safety Knife
- Clear instruction on what to do when on the rare occasion the Big Fish is unable to cut through the material and the recommendation that alternatives such as touch cutters should be used
- Clear pecos ordering instructions
- Clear guidance on where to safely store for easy access

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Implementation and Training

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Following the launch of the guidance (2017)

- Immediate support was provided from the Partnership Resuscitation Offers and Resuscitation Trainers across GGC to provide initial awareness sessions across all inpatient areas and representation from Community areas to attend was taken up fully
- A check of each inpatient area by the Resuscitation Officer after this was completed was carried out to ensure wards had everything in place or needed any additional support to implement fully in areas

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Currently

- Safe and Effective use of the Big Fish Safety knife to cut ligatures is incorporated in to the training for all clinical inpatient staff through the yearly update Medical Emergency Training
- Specialist support and advice continues from our Inpatient Resuscitation Officer
- Basic Life Support training within community areas has built in a session for the demonstration of the use of the Big Fish Safety knife and can tailor the training to individual areas on request eg prison services

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Future

- Like everyone else we do not stand still long
- National guidance from HIS recently launched “From observation to intervention: Responding proactively to the needs of deteriorating or acutely unwell people in mental health” means revisiting our safe and secure observation policy
- GGC has 2 demonstrator wards participating in this work and this has highlighted things mentioned in previous slides here– communication, MDT working and good leadership at Senior Charge Nurse level being key to improvements
- We need to ensure our clinicians continue to be fully involved in the development of our new policy

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Thank you for your time