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| **Patient specific risk assessment form for challenging behaviour[[1]](#footnote-1)** |  |

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| **Name of Patient:**  |  |
| **Department:** |  |
| **Present Behaviour \*** |  | **Diagnosis \*\*** |  |
| Subject of Assessment: E.g.: hazard, task, equipment, location, people |
| Verbal or physical aggression by patients with identified challenging behaviour which could result in physical or psychological injury to staff or other patients or visitors within ward environment |
| Hazards (Describe the harmful agent(s) and the adverse consequences they could cause)**Tick all that are relevant and add if other hazards not listed.** |
| Lack of or reduced level of understanding by patient due clinical condition. | **[ ]**  |
| Acute psychotic episodes – patient disorientated, confused, afraid as a result of hallucinations (auditory and visual). | **[ ]**  |
| Sense of perception severely altered due to medication, sedation or sleep deprivation resulting in absence of insight. | **[ ]**  |
| Ataxia – standing/walking balance impaired resulting in an increased likelihood of falls. | **[ ]**  |
| Fixtures in room – possible weapons e.g. drip stands. | **[ ]**  |
| Permanent fixtures – possible weapon/self harm e.g. windows, sink, towel/glove dispensers. | **[ ]**  |
| Triggers - ↑ noise, ↑ ward activity, over stimulation / reduced stimulation. | **[ ]**  |
| Free movement being prevented, being physically helped/held at times when pt. is in immediate danger of falling or during nursing interventions. | **[ ]**  |
| Other……………………………………………………………………………………………………. | **[ ]**  |

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| Description of RiskDescribe the work that causes exposure to the hazard, and the relevant circumstances. Who is at risk? Highlight significant factors: what makes the risk more or less serious – e.g.: the time taken, how often the work is done, who does it, the work environment, anything else relevant. |
| Nursing interventions, personal hygiene of patient, etc. requires hands on contact between nurse and patient, which due to patient’s medical/clinical status this may introduce a level of misunderstanding of caring situation or activity.Patient’s clinical condition increases risk of confusion, higher level of agitation, unpredictability.Clinical activity may introduce or be perceived to introduce level of pain or discomfort to patient.Preventing patient leaving ward / invading other patients’ space may increase agitation of patient. |

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| **Existing Precautions** & **Potential controls In place (add others not listed).****Tick an answer for all potential controls listed. Action plan should pick up all those not currently implemented but planned. Update risk assessment when actions have been implemented.** | **Describe if these controls are in place or planned at time of assessment.**  |
| **In place** | **Planned** | **Not planned** |
| All staff have attended violence and aggression training and are taught de-escalation techniques and physical intervention skills. | **[ ]**  | **[ ]**  | **[ ]**  |
| Advice and support from Psychiatric Services has been given. | **[ ]**  | **[ ]**  | **[ ]**  |
| Advice and support from Brain injury specialists has been given. | **[ ]**  | **[ ]**  | **[ ]**  |
| Advice and support from Addictions specialists has been given. | **[ ]**  | **[ ]**  | **[ ]**  |
| Advice and support from Learning Disabilities specialists has been given. | **[ ]**  | **[ ]**  | **[ ]**  |
| Advice and support from ……………………… specialists has been given. | **[ ]**  | **[ ]**  | **[ ]**  |
| Assessment of any interventions, that may be antecedents to aggression in this individual patient e.g. assisting to mobilise, feeding, dressing and bathing, toileting or any therapeutic treatment that may result in discomfort or pain has been done and communicated to all staff. | **[ ]**  | **[ ]**  | **[ ]**  |
| All staff have been made aware to observe for early physical signs of aggression, which may include:* Increased motor agitation
* Verbal content such as aggressive language.
* Change in voice tone or volume
* Posture and body language, such as fist clenching and thigh tapping
* Sudden cessation of activity
 | **[ ]**  | **[ ]**  | **[ ]**  |
| An assessment has been made as to the ratio of staff to patient required for activities/interventions e.g. staff should work in two’s or three’s (where required. See Guidelines for the Observation of patients with Acute Behavioural Disturbance in Acute Division Wards | **[ ]**  | **[ ]**  | **[ ]**  |
| All staff are compliant with the uniform policy.  | **[ ]**  | **[ ]**  | **[ ]**  |
| All staff have been reminded to remove all pens, badges and other items before entering a potentially violent situation. | **[ ]**  | **[ ]**  | **[ ]**  |
| All staff have been reminded of local emergency procedure to call for assistance in a violent situation e.g. shouting or using any alarm system.  | **[ ]**  | **[ ]**  | **[ ]**  |
| A behaviour monitoring or Antecedent/Behaviour/Consequences (ABC) chart has been commenced.  | **[ ]**  | **[ ]**  | **[ ]**  |
| Patient in single room to reduce sensory load. | **[ ]**  | **[ ]**  | **[ ]**  |
| Patient close to nurses station to provide closer observation. | **[ ]**  | **[ ]**  | **[ ]**  |
| Unnecessary furniture removed from immediate vicinity. | **[ ]**  | **[ ]**  | **[ ]**  |
| A clinical review has been performed to eliminate possible exacerbating factors e.g. by doing an infection screen E.g. MSSU. If patient has delirium follow guidelines. Review environment to ensure patient is in most appropriate ward. | **[ ]**  | **[ ]**  | **[ ]**  |
| Family kept informed of patient careplan and asked to sit with patient where appropriate | **[ ]**  | **[ ]**  | **[ ]**  |
| Relatives or carers have asked to be involved by identifying known triggers and calming/diversionary strategies. Completing ‘Getting to Know Me’ document. | **[ ]**  | **[ ]**  | **[ ]**  |
| Consider use of Standards of Behaviour Protocol | **[ ]**  | **[ ]**  | **[ ]**  |
| Other……………………………………………………………………………………… | **[ ]**  | **[ ]**  | **[ ]**  |

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| **Report all incidents or near miss situations on Datix.****Ensure senior management are aware if violence is increasing or felt to be unmanageable.**See ‘Escalation Process for Acute Inpatients Exhibiting Challenging Behaviour’ |

**Level of Risk -** Is the control of this risk adequate?

Give more than one risk level if the assessment covers a range of circumstances. You can use the ‘matrix’ to show how ‘likelihood’ and ‘consequences’ combine to give a conclusion. Also, be critical of existing measures: if you can think how they might fail, or how they could be improved, these are indications of a red or orange risk.

**Risk Matrix**

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| --- | --- | --- | --- |
| Likelihood |  | Impact/Consequences |  |
|  | Negligible | Minor | **Moderate** | **Major** | **Extreme** |
| **Almost Certain** | **Medium** | **High** | **High** | **V High** | **V High** |
| **Likely** | **Medium** | **Medium** | **High** | **High** | **V High** |
| **Possible** | **Low** | **Medium** | **Medium** | **High** | **High** |
| **Unlikely** | **Low** | **Medium** | **Medium** | **Medium** | **High** |
| **Rare** | **Low** | **Low** | **Low** | **Medium** | **Medium** |

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|  | **Very High** |  |  | **High** |  |  | **Medium** |  |  | **Low** |

**Current risk level**

Given the current precautions, and how effective and reliable they are, what is the current level of risk? **Green** is the target – you have thought it through critically and you have no serious worries. Devise ways of making the risk green wherever you can. **Yellow** is acceptable but with some reservations. You can achieve these levels by reducing the inherent risk and or by effective and reliable precautions.

**High (Orange) or Very High (Red) risks are unacceptable and must be acted on: use the Action Plan section to summarise and communicate the problems and actions required.**

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| **Assessment of risk is Likelihood**  |  | **X Severity**  |  | **= Level** |  |

**Action Plan** (if risk level is **High (Orange) or Very High (Red)**

Use this part of the form for risks that require action. Use it to communicate, with your Line Manager or H&S / Risk Coordinator or others if required. If using a copy of this form to notify others, they should reply on the form and return to you. Check that you do receive replies.

Describe the measures required to make the work safe. Review the controls list above for any that have still to be implemented. Include hardware – engineering controls, and procedures. Say what you intend to change. If proposed actions are out with your remit, identify them on the plan below but do not say who or by when; leave this to the manager with the authority to decide this and allocate the resources required.

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| **Proposed actions to control the problem**List the actions required. If action by others is required, you must send them a copy | **By Whom** | **Start date** | **Action due date** |
|  |  |  |  |

**All staff who may come in contact with this patient should be aware and have access to this risk assessment to ensure they are familiar with the controls that should be in place.**

**The risk assessment must be updated on a regular basis to ensure any changes in actions completed or changing patient behaviour is taken into consideration.**

# Consider if you need to inform or require action / support by others e.g. H&S, V&A Coord, Line manager, specialist clinician, Addictions.

# Please enter below who you have contacted and their response.

|  |  |  |  |
| --- | --- | --- | --- |
| **Date contacted** | **Name** | **Position** | **Response** |
|  |  |  |  |

##### Reply

##### If you receive this form as a manager from someone in your department, you must decide how the risk is to be managed.

**If you receive this as an adviser or other specialist, reply to the sender and investigate further as required.**

##### Please add in the section below any further action taken from those who have received this form.

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| --- | --- | --- |
| Action | Taken by | Date |
|  |  |  |

Ensure the action plan is updated and reply with a copy to others who need to know. If appropriate, you should escalate to senior management in the Sector /Directorate. See Escalation process for Acute Inpatients Exhibiting Challenging Behaviour in place

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| **Assessment completed by:** |  |
| **Date of assessment:** |  |
| **Review date:** |  |

**Calming strategies & de-escalation checklist**

**Please ensure this list is shared with all staff who will be working with the patient as a reminder of how to behave to reduce the chance of conflict and to minimize it if it occurs.**

* Make other staff aware of a potentially violent situation and that they should not enter it unobserved.
* Staff should if possible ask other patients to leave the area.
* Staff must not encroach upon the patient’s personal space. Keep at arms length.
* Staff to ensure that there is a clear exit from the situation and avoid cornering the patient. Do NOT block exit path for patient.
* All staff should observe the area around the patient for potential weapons, e.g. vase, cup, jug, bottles etc.
* Staff must try to appear confident, calm and relaxed. Do not fold arms, maintain an open posture.
* Move slowly, showing that you have nothing in your hands.
* Staff should talk quietly and clearly to the patient. Staff must not argue or become defensive.
* Staff should ask open questions and try to work at problem solving to reduce the patient’s frustration and carry out the actions decided upon with the patient.
* Staff should be aware of emergency protocol for their area (e.g. Use alarm system, call security and/or Police etc).
* Encourage patient to move to a quieter area of the ward, away from any source of irritation.
* Engage in distracting activities or conversation.
* Encourage patient to talk, listen to what is said and reassure patient.
* Continually assess patient’s body language, speech, level of distress or agitation.
* Do not restrict patient’s mobility unless a risk to self or others.
1. **\*** Trying to leave ward / Verbal aggression / Physical aggression / Self harm / Other –specify

\*\* Alcohol withdrawal related issue /Drug intoxication **/** Dementia **/** Delirium **/** Head Injury **/** Pre existing Mental Illness **/** Other - specify [↑](#footnote-ref-1)