Mental Health : Risk Assessment

Key Points

1. Risk assessment is required in patients who are identified or suspected to be at risk of self-harm or violence.

2. A risk assessment tool is presented and classifies patients into four levels.
   - Level 1: High risk of injury to other persons (including staff)
   - Level 2: High risk for self-harm
   - Level 3: Moderate risk for self-harm
   - Level 4: Low risk for self-harm

3. Risk assessment is commenced during triage and regularly reviewed.

4. Risk Level may be used to determine the nursing or security requirements for patient.

One of the immediate priorities in a patient who presents with suicidal or homicidal ideation, altered behaviour or disturbed thought process is to establish their level of risk of self-harm or violence. The purpose of the risk assessment is to determine the level of risk of the patient harming other persons (including patients, relative and staff) and/or of harming themselves.

Where the patient is at high risk of harm (toward others or themselves) immediate measures will be required to prevent self-harm or violence. In the patient at high risk this may include patient restraint such as the presence of security staff, use of a seclusion room and in severe instances the application of shackles.

Most “at risk” patients will not require restraint and the decision to restrain a patient needs to be carefully considered and regularly reviewed. Where restraint is required careful documentation of the reasons for restraint must be made in the case notes and the use of restraint must follow established protocols.

Risk Assessment Procedure

A risk assessment should be routinely performed on all patients who are identified or suspected to be at risk of self-harm or violence.

The risk assessment can be used to determine the requirement for frequent or continued patient observation, presence of security staff and patient restraint.

Structured Assessment of Risk

There are a variety of risk tools used for structured risk assessment. Many are too complex or detailed for routine use in an emergency department or by staff unfamiliar with risk assessment.

The ED Risk Tool, a tool developed for use in the emergency department, is described on the following pages. The ED Risk Tool has been shown to be easily learnt and applied to clinical care by all levels of medical and nursing staff in the emergency department and in addition has the benefit of providing a common language with which to describe patient risk.

The tool is described in detail because it provides a useful way to think about how to classify risk and how to decide on the appropriate level of care that is likely to required to manage the patient.
**ED Risk Assessment Tool**

The Risk Tool categorises patients into one of the four levels of risk:

- **Level 1**: High risk of injury to other persons (including staff)
- **Level 2**: High risk for self harm
- **Level 3**: Moderate risk for self-harm
- **Level 4**: Low risk for self-harm

The risk level may be used to standardise patient care: eg Level One patients receive a security guard, Level two patients require a nurse special.

The ED Risk Tool is summarised in the table below and discussed on the following pages.

<table>
<thead>
<tr>
<th>Level 1: High risk of injury to others (including staff)</th>
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<tbody>
<tr>
<td>- Verbal Threats of violence toward another person/s</td>
</tr>
<tr>
<td>- Heated verbal encounters with staff</td>
</tr>
<tr>
<td>- Attempts to inflict injury on another person/s</td>
</tr>
<tr>
<td>- Past history of physical assault / violence toward staff</td>
</tr>
<tr>
<td>- Case note “Alert” for acts or threats of physical violence to staff</td>
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</tbody>
</table>

<table>
<thead>
<tr>
<th>Level 2: High risk for self harm</th>
</tr>
</thead>
<tbody>
<tr>
<td>- High lethality / intention suicide attempt (eg hanging, CO poisoning)</td>
</tr>
<tr>
<td>- Severe depressive illness + well planned suicidal intent</td>
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<tr>
<td>- Altered cognitive state with repeated suicidal ideation</td>
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<tr>
<td>- Well formed and highly lethal plan and capacity to enact the plan</td>
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<tr>
<td>- Very psychotic disorganised person with at risk behaviour</td>
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<table>
<thead>
<tr>
<th>Level 3: Moderate risk for self harm</th>
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<tbody>
<tr>
<td>- Suicide attempt with moderate suicidal intent (eg overdose)</td>
</tr>
<tr>
<td>- Symptoms of a severe depressive illness without suicidal ideation</td>
</tr>
<tr>
<td>- Repeated suicidal ideation without severe depression or psychosis</td>
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<tr>
<td>- Poor social support</td>
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</tbody>
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<table>
<thead>
<tr>
<th>Level 4: Low risk for self harm</th>
</tr>
</thead>
<tbody>
<tr>
<td>- No symptoms of a severe depressive illness or psychosis</td>
</tr>
<tr>
<td>- Denies suicidal ideation or plan for suicide</td>
</tr>
<tr>
<td>- No suicide attempt</td>
</tr>
</tbody>
</table>
ED Risk Tool

Assessment of the level of risk must take into account the presentation, previous behaviour of the patient, environment (eg availability of security staff) and level of experience of the clinician. The clinical indicators for the four levels should be treated as guidelines to determining risk level.

Risk assessment is commenced when the patient first presents (eg at the triage desk in an emergency department). It should be reviewed during medical assessment and then regularly as part of the routine patient observation. The results of the risk assessment should be discussed with staff involved in the immediate care of the patient (eg nursing staff, other medical staff, mental health clinicians) and a joint management plan determined with respect to the use / non-use of restraint.

One of the major secondary benefits of using structured risk assessment procedure is that it provides a useful way to standardise patient care in relation to the resources allocated to managing patients at risk.

Level 1 : High risk of injury to other persons (including staff)

A high risk of injury to other persons is indicated by any of the following

- Verbal Threats of violence toward another person/s (including staff)
- Heated verbal encounters with staff
- Attempts to inflict physical injury on another person/s (including staff)
- Past history of physical assault / violence toward staff
- Alert in the notes related to acts or threats of physical violence to ward staff

Management : Risk Level 1

Measures to ensure staff / other patient’s safety will be required. This will generally involve the use of a security guard. It is critical that the patient’s condition and risk assessment is regularly reviewed to assess whether a continued security presence is required.

The administration of sedation will generally be required to reduce patient agitation and reduce the risk for violence. The use of shackles is reserved to patients unable to be managed with lesser degrees of restraint and should be used for as brief a period as possible.

Level 2 : High risk for self harm

One or more of the following indicates a high risk for self-harm

- High lethality / high intention suicide attempt (eg hanging, carbon monoxide poisoning)
- Symptoms of a severe depressive illness and well planned suicidal intent
- Altered cognitive state with repeated suicidal ideation
- Well formed and highly lethal plan and capacity to enact the plan (eg access to a shot gun)
- Very psychotic disorganised person whose behaviour places themselves or others at risk

Management : Risk Level 2

Measures to ensure patient safety will be required. This will generally involve the use of a nurse special. Regular medical review of the patient’s condition and risk assessment must be undertaken.

In the absence of an overdose with sedative agents the administration of sedatives should be considered to reduce agitation. A violence response call will be required if the patient attempts to leave.
Level 3: Moderate risk for self harm

One or more of the following indicates a moderate risk for self-harm

- Presents as a result of a suicide attempt with moderate suicidal intent (e.g., overdose)
- Symptoms of a severe depressive illness without a plan or repeated suicidal ideation
- Repeated suicidal ideation without clinical features of severe depression or psychosis
- Poor social support

Management: Risk Level 3

Measures to ensure patient safety will be required. This will generally involve placing the patient in an area adjacent to the nursing station where they can be clearly observed. More frequent nursing review will be required. If the patient is detained and absconds from hospital the Police should be notified.

Level 4: Low risk for self harm

The presence of the following indicates a low risk for self-harm

- No suicide attempt,
- Denies suicidal ideation or plan for suicide
- No symptoms of a severe depressive illness

Management: Risk Level 4

Measures to ensure patient safety will be required. This will generally involve placing the patient in an area adjacent to the nursing/medical areas where they can be clearly observed. Routine nursing review will be undertaken.