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**Risk management in Adult Social Care**

**Introduction**

The provision of care is often complex and involves supporting individuals who present risk. This may be associated with physical, or mental health difficulties or other challenges that create risk for the service user or other members of the community.

Managing risk is therefore a fundamental part of professional practice within social care and it is important that individual staff are supported to hold that risk and that escalation and organisational awareness is promoted and maintained.

Risk will be seen in the context of individual cases whereby the risk that an individual poses to themselves, to others or to the authority needs to be considered and appropriately, managed, communicated and where necessary escalated.

As such, this document seeks to set out the processes by which risk will be assessed and communicated throughout Adult Social Care.

All contacts will be triaged against the Priority Tool, outlined in this Policy, to identify risk and to appropriately manage those contacts based on an appreciation of risk as we know it. We are not looking to remove all risk as we understand that positive risk taking must be incorporated in to daily practice.

[What Is Positive Risk Taking In Health And Social Care - BikeHike](https://bikehike.org/what-is-positive-risk-taking-in-health-and-social-care/)

[Working with risk (skillsforcare.org.uk)](https://www.skillsforcare.org.uk/Effective-deployment/Working-with-risk.aspx)

[Risk Assessment - Strengthening your Risk Assessments checklist (skillsforcare.org.uk)](https://www.skillsforcare.org.uk/resources/documents/Support-for-leaders-and-managers/Support-for-Registered-managers/Webinars/Leading-your-service/Strengthening-your-Risk-Assessments-checklist.pdf)

Social care operates in a person centred approach as this ensures Making Safeguarding Personal is a fundamental part of social work practice.

**2. Context**

The Care Act 2014 reminds us that the core purpose of adult care and support is to

help people to achieve the outcomes that matter to them in their life. In order to do

so, we have a duty to assess needs and meet those eligible needs where appropriate. While the Care Act is clear that needs can and should be met through a variety of creative ways and not depend on whether funded services are available, we know that for a large section of the population who need our assistance, that support is needed by carers going into people’s homes on a regular basis to meet care needs.

Currently, due to national and local market pressures as well as the continuing

social, commercial and workforce impacts of the coronavirus pandemic, there are

significant shortages in in the provision and availability of social care resource, both with inside and outside and without the local authority. Within Adult Social Care, this has resulted in major difficulties for Operational teams in conducting timely assessments and reviews. Any delay in assessment could result in a delay of identification and provision of support to meet eligible needs.

**3. Priority Rating**

Teams need to be able to apply the Priority Rating in a consistent way in order that those in most need are prioritised. When completing the priority rating assessment practitioners need to be mindful of the following:

* Wellbeing domains are not hierarchical – Practitioners must be aware that

the judgement being made is prioritising those who experience the most

significant impact to their wellbeing rather than one wellbeing domain being

more important than another.

**4. Human Rights Act 1998 (HRA)**

As a public authority we are bound by the HRA not only to uphold the rights of

those we support but also to promote them. The Local Authority (LA) may be at

risk of infringing a person’s human rights if it fails to provide care and support that

it has a legal duty to provide or it fails to take reasonable action to prevent harm

and distress to someone who has care and support needs. Further reading

regarding HRA considerations in adult social care can be found on RIP: [1-setting-the-context-introducing-legal-literacy\_proofed\_final.pdf (researchinpractice.org.uk)](https://www.researchinpractice.org.uk/media/4795/1-setting-the-context-introducing-legal-literacy_proofed_final.pdf)

When completing the rag rating practitioners need to explicitly consider the

following articles 2, 3, 4, 5, 8 (add hyperlink):

**5. Priority Rating Indicators**

**Immediate action, requiring same day response, will include:**

* There is an immediate risk to the person’s life/survival (Human Rights

article 2) these would need to be redirected to appropriate emergency service provision.

* Serious abuse to self or others has occurred, or is suspected to the extent

that protection measures are required

* There are extensive and constant care and support needs on an ongoing

or time limited basis that, if not met, present an immediate risk to the

person or others.

* The carer relationship(s) has collapsed and there is a need for immediate

care and support or there is no existing carer relationship.

* P’s basic needs (personal care/ nutrition/ hydration/ skin care/ medication

if ancillary to social care needs) must be met by agency as completely

isolated: no support network

* Very high dependency: P unable to do most things for themselves
* Immediate risk to the informal carer (s)
* Carers/support network has broken down
* Significant Safeguarding issue has been raised
* P’s Mental Health (MH) is declining as a consequence of not receiving

social care leading to high risk of harm occurring (suicide ideation)

**Priority 1: Significant risk where harm may occur within the following 14 calendar days, these may include;**

* Abuse to self or others has occurred or is at risk of occurring
* There are extensive care and support needs on an ongoing or time limited

basis.

* Absence or inadequacy of care and support is causing the person significant

distress and their health to deteriorate

* The carer relationship(s) is at risk of collapse and the person needs care and

support or there is no existing carer relationship

* P’s mental health is declining, and they are becoming withdrawn and less

willing to engage, with significant consequence.

* The existing care arrangements are not sustainable, risk of removal of commissioned service.
* P has noted significant increase in behaviours of concern
* P is experiencing significant “de-conditioning” due to placement in a short-term bed and needs to regain independence at home
* Moving & Handling; unmanaged risk to carer/client.

**Priority 2: risk where harm may occur within the following 28 calendar days, these may include;**

* Abuse to self or others has occurred or is at risk of occurring
* There are extensive care and support needs on an ongoing or time limited
* basis.
* Absence or inadequacy of care and support is causing the person distress and their health to deteriorate
* The carer relationship(s) is at risk of collapse and the person needs care and

support or there is no existing carer relationship

* P’s mental health is declining, and they are becoming withdrawn and less

willing to engage, with impactful consequence.

* The existing care arrangements are not sustainable, risk of removal of commissioned service.
* P has noted increase in behaviours of concern
* P is experiencing significant “de-conditioning” due to placement in a short-term bed and needs to regain independence at home
* Deteriorating conditions i.e MND, Huntingtons, Cancer, Progressive MS.
* Moving and Handling; potential risk identified i.e increasing difficulty with transfers.
* Postural seating.
* Palliative (not EOL).
* Package of care reduction- Optimal Handed Care.
* Unable to get in/out of property safely i.e Fire Risk.
* Unable to get up stairs safely and no provision for toileting downstairs/downstairs living.

**Priority 3: Moderate risk where harm may occur if action is not taken in the**

**longer term, these may include;**

* There are some signs of deterioration in mental and physical health that are of

concern but they’re being managed for now.

* There are some care and/or support needs that will, if not met, impair the

persons longer term capacity to regain, maintain or sustain their

independence or living arrangements

* The carer relationship (s) is under strain and unlikely to be sustainable in the

longer term.

* Person at risk of losing recently acquired skills if not supported to use them
* Person remains safe, but placement requires review, or capital drop requires assessment.
* Seating- functional transfers.
* Banding.
* Access, general OT/DFG .
* Re locating equipment/ out of county moves.

**6. Considering how risks can be reduced.**

All mitigations should be proportionate to the risk posed.

**Immediate Action Priorities**

Immediate same day assessment required, should not be placed on any allocation or waiting list.

It’s important that staff feel supported when holding risk and that senior managers are involved to provide support. This does not remove the need to actively support positive risk taking, but is in place to ensure that risk is shared appropriately and that staff feel and are supported with decision making. The level of escalation is not a decision making responsibility, it is a level of appropriate engagement and awareness to ensure that we engage in defensible decision making.

**Priority 1:**

This will need to be identified and the risk appreciated through triage, a Duty visit, or other virtual action may be required. This may also require consultation with or management by the Safeguarding Team to ensure that immediate risks are managed and the person remains safe.

Level of escalation, Strategic Managers.

**Priority 2:**

Assessment may be required, including by virtual means. Regular information gathering will be required to ensure that ongoing support and identification of risk is undertaken. Advice and guidance should be considered alongside referral to partner agencies.

Level of Escalation, Service Managers.

**Priority 3 :**

Advice and guidance should be considered alongside referral to partner agencies. This will enable People to help them identify solutions within their own support network.

Level of Escalation , Advanced Practitioners.

**7. Identifying Risk Associated with Individuals and Organisational Communication.**

It is important that individual professionals with teams communicate the risk that exists and that they are supported in decision making processes. It is equally important that risk is escalated as appropriate throughout the organisation to ensure that staff are supported and that any actions that are necessary to be taken at higher levels within the system are initiated.

As such, discussion of risk should be a fundamental part of each team meeting and individual supervision. The risk management spreadsheet at **Appendix A** should be maintained by each individual professional and shared at neighbourhood/team meetings and utilised to inform and lead professional supervision.

Business support will hold a team version of the spreadsheet and update it at each team meeting. This will ensure all members of the team understand and appreciate the levels of risk held by the team. Only those cases where risk exists commensurate with Priority 1 and 2 should be captured in this way.

It necessarily follows that Advanced Practitioners will utilise the team spreadsheet within their own professional supervision sessions with the relevant Service Manager to ensure that risk is discussed and appropriately escalated. It should be remembered that where at Business meetings individual risk management strategies may mean that as the spreadsheet is developed upwards cases may be removed. By this individuals risk documents may contain a number of cases, the team risk document will not necessarily be a combination of all risks, but be a reduced list of those cases not mitigated at that level.

Service Managers will discuss their risk documents with their Strategic Managers and as such risk will be discussed and objective considerations and mitigations considered at all levels within the organisation.

It is important to note that risk will continue to exist, upward communication will not by of itself reduce or control risk, but it will ensure that staff and managers are supported in holding and managing that risk and it will also ensure that organisational awareness and therefore that the safety of service users is communicated and remains of paramount importance.

**8. Decision Matrix – Managing the Risks Associated with Delay**

The following headings should form part of the information that practitioners will need to regularly update within case notes on Eclipse:

* What is the nature of presenting need and risk?
* Frequency, how often is it occurring?
* Intensity, what is the impact and how problematic is it?
* Predictability, is it predictable and can measures be put in place to anticipate and mitigate against it?
* Severity of consequence, what is the worst possible outcome, who is likely to experience harm and how likely is this?
* Intervention required, if so why now?

This information will help provide the evidence needed that we, in ASC, are doing

everything we can to mitigate risks in exceptional circumstances. Professionals must ensure that individuals or their representatives are clearly advised of the available mitigations and their own individual escalation processes, so they understand when and how to make contact should individual circumstances change .

Within the Neighbourhood Teams, on receipt of a request for assessment the triage function will appropriately determine whether there is sufficient grounds for allocation and will complete the Allocation Request form shown at **Appendix B**, this form will then enable the allocated worker and the Advanced Practitioner, responsible for allocating work, to assess the risk based on the questions above and rate the relevant Priority status.

Where there is insufficient resource to enable allocation, the case will be placed on the Allocation waiting list, and the relevant Priority Status clearly identified. Allocation list will then be reviewed (Priority 1’s weekly, Priority 2’s bi-weekly , Priority 3’s Monthly) to ensure that the appropriate contacts where necessary, are made to determine whether any deterioration has occurred and whether the level of need has changed.

**10. Case Load Risk**

Risk does not disappear once cases have been allocated to a worker. It is vital therefore that the evaluation of risk remains dynamic and also that the conversation around risk is prioritised through Neighbourhood/team meetings and individual professional Supervision. Case load risk management. Need to cover Supervision and discussions around risk management.

Staff hold significant risk, that is the nature of working within health and social care. We have also touched on the need to promote positive risk taking in order to achieve the right outcomes for people. What we then need to do, is ensure open transparent communication and shared risk management so that we develop and maintain a learning and supportive culture.

It is also vital to ensure that risk is appropriately documented and that the Eclipse Risk Assessment is completed as appropriate.

Risk and its management should be a fundamental part of Professional Supervision and due consideration should be given to understand the nature and scale of the risk. This will include, but not be exclusive to understanding:

* Whether there are no current risks involved or where the risk assessment is known and understood by all parties. With consequent decisions and actions, including contingency plans that have been negotiated and accepted by all involved parties.
* Whether the risk assessment is in the process of being undertaken, with options for action and decisions ready to be put into place.
* Whether the current risk has not been assessed or is highly changeable and/or unpredictable. Where there is a change in circumstances requiring new assessment.
* Whether there are forensic or additional health risks

**11. Action Card**

1. Applying the principles contained within this Policy, will help allocated workers and managers to provide a rating of priority 1, 2 or 3

Immediate Action Priorities: Critical risk where serious harm or loss of life may occur, same day action is required.

Priority 1 : Significant risk where harm may occur within the following 14 days, review weekly.

Priority 2 : Risk where harm may occur within the following 28 calendar days, review bi-weekly.

Priority 3: Moderate risk where harm may occur if action is not taken in the longer term, review monthly.

1. In the case notes, practitioners need to consider the following as a guide to what they need in order to be able to evidence their analysis and decision-making processes:

* What is the nature of presenting need and risk?
* Frequency, how often is it occurring?
* Intensity, what is the impact and how problematic is it?
* Predictability, is it predictable and can measures be put in place to anticipate and mitigate against it?
* Severity of consequence, what is the worst possible outcome, who is likely to experience harm and how likely is this?
* Intervention required, if so why now?

1. Using the agreed processes, the Risk Priority Ratings will be used to communicate risk and mechanisms by which it is to be mitigated.

Appendix A (Sharepoint Link)

|  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- |
| **Name** | **Per No.** | **Risk Priority** | **General Need** | **Care Act Eligible Needs** | **Allocated Social Worker** | **Current Update** | **Current level of Escalation** |
| Joe Bloggs | 12345 | 1 | Diagnosis of mental health disorder, currently homeless with multiple failed housing options. | Require support to maintain tenancy, not meeting current nutritional need. | John Smith | Supported by Homeless Nursing team | Strategic Manager aware and working within Creative Solutions Board. |
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Appendix B (Sharepoint Link)

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| --- | --- |
| **Per Number** |  |
| **Client Name** |  |
| **Priority Risk Rating** | (Priority 1, 2 or 3) |
| **Reason for allocation:**    **Example: Referral to lifeline, fire service, IRT, Rapid Response, Community Agent, Short term care, Respite, GP involvement, DNs, persons own support network.** | * What is the nature of presenting need and risk? * Frequency, how often is it occurring? * Intensity, what is the impact and how problematic is it? * Predictability, is it predictable and can measures be put in place to anticipate and mitigate against it? * Severity of consequence, what is the worst possible outcome, who is likely to experience harm and how likely is this? * Intervention required, if so why now?   What has been done to minimise risk: |
| **SW/ASCP/Sensory Loss** |  |
| **Is there current provision** |  |
| **Location e.g. Home, Placement, DoLS** |  |
| **Area e.g. Shepton, Wells, Street, Frome** |  |
| **Date of Referral** |  |
| **Best Person to contact** |  |
| **Lead Authorisation for allocation** |  |