Northumberland, Tyne and Wear NHS Foundation Trust

FACE–Frequently Asked Questions March 2019

Authors: Paul Veitch, Nurse Consultant and Associate Director Safer Care
Emma Bailey, Community Modern Matron
February 2019

Caring | Discovering | Growing | **Together**

BACKGROUND

FACE (functional Analysis of Care environments) is the risk assessment tool which is utilised by Northumberland Tyne and Wear NHS Foundation Trust (NTW). FACE has now been used a number of years by all clinical services and teams (currently excluding from Psychiatric Liaison services). However, it is apparent that services, localities, teams and individual practitioners have used the tool differently over a number of years, minus any conclusive guidance available to answer queries and concerns.

The training guidance (2005) does not consider the use of electronic versions of the FACE tool, therefore queries around editing and deleting information are not answered within the document. Also, it is apparent that Clinicians have been trained differently across the organisation. This has particularly been noticeable when things have gone wrong and scrutiny has been applied to the documentation and risk assessment, however in these instances this was an incidental finding, rather than contributory to any incident.

The FACE provides a framework to record a risk assessment, formulation and risk management plan. The tool provides a risk profile which scores 0-4 for identified risks, including Suicide, self-harm, violence etc. The tool will not “Calculate” a patients risky behaviour and is completely reliant upon a clinicians ability to undertake an assessment of mental health needs, formulate the apparent risk and collaboratively draw up a management plan with the individual and their carers/ family to manage the risks identified.

PURPOSE

The purpose of this practice Guidance is to support the consistent use of FACE across the organisation. This document answers the most frequently asked Questions (FAQ’s) and provides guidance for all clinicians in the completion of FACE. A workshop was held in January 2019 inclusive of over 30 Multi-disciplinary clinicians in order to agree a consensus to the FAQ’s. A range of clinicians,

teams and services were represented. Clinical staff, NTW academy as well as senior managers supported the completion of this guidance.

OUTCOMES

Those in attendance agreed upon the guidance that should be provided to clinicians. The biggest risk to safety was that clinicians are recording information differently and the lack of consistency across NTW therefore it was imperative that we all work to the same standards and guidance.

FAQ's

When do we edit current or create new?

- **Always Create NEW**
- The purpose of edit is to go back to an incomplete document if you've been called away/ had to leave it incomplete
- Also, if using digital dictation the admin would create new and the clinician would edit current in order to save and validate
- FACE should be validated as per Trust record keeping standards and within the necessary timeframes outlined by policy. This would usually occur within the Care Programme Approach (CPA) or lead professional review.
- Contributors should be identified and one person complete on behalf of the MDT

Can we delete information?

- If it found to be incorrect- YES delete the information and provide the supporting narrative in a progress note
- After the completion of the first Risk assessment, when we create new, we will need to **extract pertinent information, summarise and update**. Attempt to keep the document as concise as possible with relevant information.
- Cutting and pasting from progress notes is not to occur

Do we score mitigated risk?

- Score **the identified risk**
- Any mitigation should be identified in the narrative.

Should the document contain dates or use phrases such as current/ historical?

- FACE should **not contain** a list of dates and events, as without context and interpretation they do not tell us what the risk concerns are.
- Clinicians should use Historical and Current
- If making reference to a significant event then provide a date.

Can people score lower than a two if they have historical risk?

- If there is a historical risk the scoring will usually not go below One, however clinical judgement with clear rational may indicate a score of Zero given some clinical situations. If in doubt the higher score should be used.

What is current and what is historical?

- Current refers to the last 4 weeks
- Historical refers to everything else- with clinical judgement

How often should we update the Risk Assessment?

- We assess risk all of the time and this is evidenced within the Progress notes (i.e. when a patient goes on leave, home visit etc.)
- The progress note should reference any apparent risks and provide assurance that clinician is aware of the FACE risk assessment and risk management plan.
- The FACE should be updated as follows;

    - Significant junctures in Care- (changes in care and treatment)

- When there is information which identifies that there is change in risk
- Minimum of 6 months as per Trust standard usually within a CPA or lead professional review.

Which risk assessment? And how do we communicate this?

- Best Practice would indicate that we have one risk assessment.
- We currently have 10 service specific FACE risk assessments available for staff to use. This has used some confusion.
- However, if you need to create a service specific risk assessment, the clinician needs to consider if this is necessary or could the current risk assessment be reviewed and amended to reduce repetition and improve communication. The clinician is to enter an alert identifying that there is more than one risk assessment and where to find these, the content should be reviewed by all clinicians. Any differences of opinion in relation to risk should be discussed with the other clinicians.