Abstract

Objective: The purpose of this study was to audit the completion of risk assessment documentation by staff working within an acute adult mental health setting.

Method: Fifty risk assessment forms in a district health board's acute adult mental health service were audited for completion. Clinicians provided verbal feedback on the audit results.

Results: Risk assessment forms were completed in 58.3% of cases. A risk formulation statement was completed in 43.8% of cases. Rates of completion varied between senior medical officers, registrars and nurses.

Conclusion: Accurate risk formulation and safety planning are more important than ensuring all boxes are ticked on a form. Optimising the design of electronic forms may enhance access to information about historical risk.

INTRODUCTION

Risk formulation is considered an essential aspect of a psychiatric evaluation. Clinicians seek to analyse, understand and communicate key features of an individual's risk [1] in a systematic process of gathering and integrating relevant clinical information. [2] Understanding of a person's symptoms, personality and environment with a judgement about risk in an individual case [3] highlights priorities in negotiating a tailored plan for treatment. [4]

Risk assessment provides a foundation for safety. The range, extent and depth of risk assessment tools used to evaluate a patient's risk varies across mental health services.

Clinicians may employ structured clinical judgement to understand patterns of risk and make decisions on managing specific risks. An acturarial approach emphasises static, historical and dynamic risk factors, based on research conducted on high risk populations. A more informal approach is a clinician's unstructured clinical judgement, based on his or her evaluation and experience.

At the authors' district health board, risk assessment documentation was identified as a priority topic for a clinical audit. A review of serious incidents within mental health services raised concerns about missing information in electronic risk assessment forms (Figure 1). The risk assessment document was created in 2006 based on evidence based guidelines[14] and revised in 2015 by three district health boards in Auckland, New Zealand. The revision reflects decisions made a regional level to incorporate key elements of evaluating risk, although the form has not been evaluated in practice. The framework used to assess risk is incorporated in a comprehensive assessment form that is completed at the time of initial assessment or admission to an inpatient setting. Family violence screening questions are displayed for women aged 16 to 65 years. These screening questions for family violence were developed in accordance with guidelines provided by the New Zealand Ministry of Health. Clinicians are required to attend a one-day training workshop in risk assessment, documentation, communication and risk management that includes case scenarios. Updating risk assessment documentation is recommended at the time a case is reviewed, every three or six months.

Audit has been suggested as a means to evaluate risk formulation. [1] There is little guidance on evaluating risk formulation and what outcomes are important to

measure.[1] The authors' objective in conducting the audit was to ascertain the information contained within documents to inform the development of revised guidelines for completing a risk assessment.

METHOD

The audit team submitted a protocol that was approved by the district health board's clinical governance group. Data was collected from risk assessments (Figure 1) of a random sample of fifty adult clients assessed by an acute crisis mental health team over a 12-month period from July 2016 to June 2017.

The data was audited from electronic clinical assessment forms, de-identified and entered into an Excel spreadsheet. . The following areas were audited:

1) Patient age, gender and ethnicity;
2) Completion of the entire risk assessment form;
3) Search for risks that were not documented in the risk assessment form;
4) Specific risks such as harm to self, harm to others, environmental risks, situational risks, medical, and physical vulnerability, substance use relapse of mental illness, vulnerability to harm by others, legal risks, vulnerability to rights violations, cultural risks including racism and risks associated with treatment.
5) Completion of a risk formulation statement
6) Discussions about risk, for example, with family members and other agencies.

The audit was compared against the district health board's policy for risk assessment and management. This policy is based on the New Zealand guidelines for

documenting risk assessment[14] and contains information about definitions and formulation of risk. The five standards for the audit provide an information base to manage risk:

1) To identify risk and safety concerns for service users on entry to services;

2) To identify risks in a specific document in electronic notes;

3) Participation of service users and partners in care in risk assessment;

4) Consideration of mental state, medical, environment, historical risk and culture when assessing risk; and.

5) Completion of a risk formulation.

RESULTS

1) Study population

Two cases were excluded from the audit sample (n=48) as they were adolescents. The average age of patients was 33 years. Twenty-nine were females (60%) and nineteen were males (40%). The main diagnoses were psychotic spectrum disorders, mood and anxiety disorders and a combination of mental and personality disorder. There were seventeen Māori and Pacific Island service users within the audit sample.

2) Completion of risk assessment

Risk assessment forms were completed in 58.3 percent (95% confidence interval (CI): 44.4 - 72.2) of cases. Completion was defined as boxes that were ticked for specific risks and documentation of patterns of risk behaviour, internal state and situational factors. Forty two of 48 cases had partially completed risk assessments that required further searching in other documentation There were specific risks that had a low rate

of completion. For example, risks relating to the service user's culture was documented in just two cases.

[insert table 1]

3) Risk formulation

A risk formulation statement was completed in 43.8% of cases (95% CI: 29.7 -57.8). These documented substance use (50% of cases), family violence (14.6%), medical problems (14%) and cultural risk factors (14%). Involvement of partners in care was documented in 35.4 percent of cases (family members, friends and professionals such as general practitioners and counsellors).

[insert table 2]

4) Documenting risk assessment by role

Senior medical officers (consultants and medical officers) completed risk assessment documents in 82.4% of cases (95% CI: 64.2 - 100); nurses 61.5% (95% CI: 35.1 - 88) and registrars in 26.7% (95% CI: 4.3 - 49).

[insert table 3]

DISCUSSION

This article describes a clinical audit of risk assessment documentation. The purpose of clinical audit is to improve professional practice.[5, 6] This audit found that a risk formulation was completed in 48 percent of cases and provided an opportunity to reflect on improving the quality of documentation in conveying risk posed by and to service users.

When the audit results were presented to clinicians at a multidisciplinary educational meeting, they gave three main points of feedback:

1) A clinician's role is to accurately document salient risks. The design of the risk assessment form was considered overly comprehensive for the context of an acute assessment.

2) Electronic risk documentation is a double edged sword. Important risk information can be buried in electronic formats. Clinicians acknowledged the value in locating and taking time to read about historical risks before conducting an assessment.

3) Potential ways to improve completion of documentation included: i) electronic individual feedback on completion of risk assessment forms ii) orientating registrars on new rotations about the rationale for completing documentation iii) upskilling staff about risk formulation and iv) optimising information technology functions to auto-populate historical risk in subsequent documents.

The audit generated robust debate among clinicians about the value of completing documentation, which does not necessarily capture all that is discussed in an assessment. Risk assessment is not just a case of ticking boxes to identify specific risk factors. Risk formulation is anchored in the clinical context and captures the dynamic nature of risk.[8]

Staff need to be skilled in communicating essential elements of risk.[8] Information about the context of the assessment and relevant discussions with the service user and his or her family and carers about process[9] and treatment are also important.[10] This audit informs further discussion about the concept of risk assessment as a shared safety agenda between a service user, his or her family and mental health services.[16]

Risk formulation is viewed as part of an ongoing process of tailoring interventions to minimise harm, influenced by static and dynamic risk factors, with essential involvement of partners in care.

Cultural risks for this sample were not well documented, considering the high proportion of Māori, Pacific and ethnic minority service users. In the acute context, clinicians focus on acute and obvious risks relating to the service user in the initial assessment. The clinician's own culture and cultural experiences may influence the risk assessment of service users of various cultural and ethnic groups.[15]

Completing a risk assessment form does not mean harm or violence can be prevented. It is not possible to predict suicide and serious violence with a degree of accuracy that is clinically meaningful. [12] Categorising risk as high or low is not useful or correlated with severity of outcome. [7]There is no evidence base or agreement for evaluating a risk formulation. [11] Yet documentation does matter. Clinicians should strive to clearly, accurately and coherently document relevant risks that will increase the likelihood of collaborative action to manage those risks. [2]

Clinicians will judge for themselves what constitutes an adequate or quality risk assessment. The aim is to provide optimal care according to the treatment needs of each service user, regardless of the perceived risk of adverse events. [7]

CONCLUSION

Risk assessment documentation is completed variably by different disciplines. An

accurate risk formulation and safety plan are more important than ensuring all boxes are ticked on a form. Optimising the design of electronic forms may enable clinicians to readily access information about historical risk.

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