Working with Risk ~ Current Situation
(Steve Morgan – Practice Based Evidence)

NAME: …………………………………….. **D.o.B.:** / / **I.D. No:**……………………….
ADDRESS:…………………………………………………………………………………………
…………………………………………………………… **POSTCODE:**………………………

RISK FROM OTHERS **YES/NO/UNKNOWN**
(eg. abuse, exploitation, threats, violence, contacts with services)
Details of identified risk:

RISK TO SELF **YES/NO/UNKNOWN**
(eg. suicide, self-harm, reckless behaviours, substance misuse)
Details of identified risk:

RISK TO OTHERS **YES/NO/UNKNOWN**
(eg. aggression, violence, impulsive behaviours)
Details of identified risk:

RISK OF NEGLECT **YES/NO/UNKNOWN**
(eg. health, personal, inadequate living skills)
Details of identified risk:

RISK TO CHILDREN **YES/NO/UNKNOWN**
(eg. neglect, physical/emotional abuse)
Details of identified risk:

RISK FROM PHYSICAL CONDITIONS **YES/NO/UNKNOWN**
(eg. medical, sensory, physical disability, end-of-life care)
Details of identified risk:

RISK OF WANDERING and/or FALLS **YES/NO/UNKNOWN**
(e.g. disorientation, physical environment, use of aids/adaptations)
Details of identified risk:

MEMORY & COGNITIVE IMPAIRMENT **YES/NO/UNKNOWN**
(eg. forgetfulness, medical condition)
Details of identified risk:

CHALLENGES TO SERVICES **YES/NO/UNKNOWN**
(eg. inappropriate demands, poor service responses, issuing threats)
Details of identified risk:

PROTECTIVE FACTORS **YES/NO/UNKNOWN**
(for reducing or mitigating risks eg. personal resources, agreed plans, engaged with services)
Brief details:

SIGNIFICANT KNOWN HISTORY [linked to current risks] (including: known chronology of events, complex conditions, previous responses to risks):

INITIAL ASSESSMENT OF RISK (including: context, situations in which risks may occur, impressions/feelings, potential for *positive risk-taking*):

INITIAL RISK MANAGEMENT PLAN (including: who is to do what, further areas of information needed, identifying initial risk decisions):

INFORMATION SOURCES AVAILABLE AT THIS ASSESSMENT:

HOW WAS THIS ASSESSMENT MADE? (e.g. interview with service user &/or carer, observations, service notes/discussion, multiple sources)

INVOLVEMENT and/or AGREEMENT OF PERSON and/or CARER IN PROCESS: Comments:

Service user signature (optional) **Carer signature** (optional)

Completed by: **Date: / / Time:**

Discussed with: **Next intended update: / /**

WORKING WITH RISK ~ CURRENT SITUATION 'GUIDELINES'

This is a *flexible tool* primarily designed to give a quick overview of the broad areas of *potential* clinical and social risk presented in the *here and now*. It prompts practitioners to investigate the *broad categories* of risk commonly encountered across all sectors of the service, and to *specify* your understanding of the risks initially identified. Where more detail is required, the statements on the reverse side ('Initial Assessment of Risk' and 'Initial Management Plan') can be used to develop the information.

This is a *risk screening tool* not an in-depth assessment of large volumes of information. Where such a need exists this format should provide a brief reasoning and direction to the location of the appropriate details (e.g. letters, reports, discharge summaries, social and tribunal reports, CPA reviews, specialist risk assessments). This format is designed to reduce the potential volumes of paperwork necessary for large numbers of people seen by practitioners, particularly those who do not need to have a more detailed risk assessment and management plan.

The assessment and planning process offers further flexibility by potentially frequent and/or rapid up-dating of information through completion of several copies. For example:

- Fluctuating risk status during the first week of an in-patient admission may be reflected in the completion of multiple *timed* and *dated* copies of this tool
- Significant change in the risk status brought about through accessing a new and vital source of information in a community team may result in an updated version
- The point of any transition between teams/parts of the service should trigger a review of the current risks.

The timing and frequency of re-using the format will be a matter of *professional judgement*. The emphasis should be on quick completion but providing useful information. It provides a *structured approach* to identifying and recording a *dynamic* process.

WHO IS IT FOR?

All people who are referred into any part of the health and social care services, however long or short the duration of contact. This would include people who are only seen very briefly by one member of staff, and who have no previous history of contact with services; through to those with long histories of contact and/or multiple admissions to in-patient/residential units. **Not all eventualities can be covered in these guidelines**, but the brief nature of documenting your *professional judgements* means there should be no exclusions from using this tool.

In circumstances where you feel exposed by a lack of resources to fulfil unmet needs, or where a person has acted in a risky manner beyond your control, it is better to *record* your concerns and attempts to communicate them with others.

WHEN IS IT USED?

It should be considered from the initial point of referral into the service. This will usually include the first point of direct (face-to-face) contact, but may occasionally be completed on the information only available from referral, past notes, other sources of information (e.g. other people).

For in-patient or residential units, where 24 hour staffing is available, it is expected that this level of assessment and management plan could be completed within the first 24 hours of acceptance. It will be a significant part of your thinking and discussion, so it should be something that can be quickly recorded. Even where the need for more detail is indicated, subsequent updates of the form may be completed as frequently as needed where risks are rapidly changing (e.g. daily completion for short periods of time may be applicable for a minority of people seen). Where these expectations cannot be met, it is important to clearly *document the reasons* (e.g. staff shortages at a time of multiple risks on a unit).

For *one-off* and *brief periods of contact*, it is expected that this format will be completed immediately or soon after the point of contact. It should be completed quickly, not adding an unnecessary burden of paperwork, yet documenting the fact that a contact took place and the circumstances in which the assessment happened. In many cases it will be supplementary to the main purpose of the contact.

For most areas of community services, an *initial* assessment should be completed within 24 working hours of the first planned contact with the service user (successful or not). This may have to rely only on information from referral and past notes, or it may rely on a very brief face-to-face contact. Subsequent *timed* and *dated* copies can be quickly compiled as new information becomes available. In this way, the recording of risk information can reflect the *dynamic* nature of risk as closely as possible, not become just an administrative requirement to meet audit purposes.

HOW IS IT USED?

It is not an interview format. The structure provides a *prompt* to the broad areas of risk that may be considered within the individual circumstances and context of the person being assessed. It acts as a format for documenting broad assessments of risk information derived from your *professional judgements* and views expressed by others, verbally or in writing.

The most important aspect of a *risk screening* assessment is that it forms an integral part of your formalised/informal manner of initially engaging the service user. This will not always be helped by having pieces of paper between yourself and the service user, though occasionally you may decide that this can be useful (this is a *professional judgement* in its own right). More usually, the assessment of the 'current situation' and thinking about an 'initial management plan' will be quickly documented on this format after the contact (e.g. in an office setting).

The 'Initial assessment of risk' and 'Initial risk management plan' are areas where you may choose to record links to other/specialist risk assessment sources (e.g. manual handling, falls, HCR-20, detailed assessment reports).

STRUCTURE OF FORMAT

Not all permutations for interpreting and using this format can be covered in brief and practical guidelines, so this section will remain as an overview (if you have specific queries about its structure and use you are encouraged to discuss them with a colleague, supervisor, manager, or in a team meeting).

- Most of the broad categories on the first page could apply in circumstances encountered by any sector across the services (e.g. ‘wandering and falls’ could apply to any age group)
- The examples in brackets after most broad categories of risk are indicators of what may be interpreted in each category. They are not exhaustive or prescriptive lists. Use your discretion in where you record information, and briefly explain your use of the relevant categories, if needed
- Where you determine ***no risk*** to be present, on the information you have available, circle *‘No’*. You are not accountable for the information you did not have, and you are making a brief assessment of the *here and now*. Indicate on the second page the sources of information available to you, at this time. But, you must up-date the assessment immediately when new information becomes available to indicate a ‘No’ could be a ‘Yes’ or ‘Unknown (uncertain)’. You should be continually inquisitive, searching for new information
- **Unknown** is not an easy option of circling as the completed task. This prompt relates to those *intuitive* feelings you should be urgently reflecting on and checking out. Circling ‘unknown’ requires that you state briefly what your concern is, but also in the ‘Initial risk management plan’ what you intend to do about it
- **Challenges to services** can be interpreted as behaviours that are inappropriate (e.g. demanding hospital admission or medications with threats); behaviours associated with personality disorders (e.g. impulsive actions causing risks); behaviours associated with wishes not being met (e.g. disengagement or non-compliance). It may also cover a host of examples where service providers do not agree on the assessment or course of action, provide inappropriate services to needs, or have to accept the difficulties associated with unmet needs. [N.B. There may be many other interpretations of what could be included in this area of the form, which should be discussed with colleagues as they arise]
- **Protective Factors** is a recognition that our assessment needs to consider the counter-balance to the *prevailing negativity* of risk assessment. People have personal resources and external supports, they have tolerances and thresholds of experience, and they have their own individualised ways of coping with very difficult situations. These all amount to indications about how risk can be managed and minimised, and how people may be able to take personal risks without succumbing to negative consequences
- **Significant known history** should only include a brief statement of what is currently known (i.e. it cannot require a detailed search of complete clinical and social risk histories of everyone seen by services). Where a major and significant *risk history* is indicated, there will be an expectation that a clear link will be offered as to where this information is recorded or

stored (e.g. in the Appendix 2 of the Working with Risk tools, or in another specialist assessment format)

- **Initial assessment of risk** should be a succinct formulation of the information you have gathered – what may happen in what circumstances, based on your *professional judgement* and *discussions* with others (including 'uncertainties' needing further investigation), where possible. This section prompts thinking about the potential for '*positive risk-taking'*, in a proactive or reactive way
- **Initial risk management plan** may be as simple as an urgent need to gather specific information (e.g. follow-up to 'unknown' assessments), an urgent need for a detailed review (e.g. Appendix 4 of the Working with Risk tools), referral on to a specific service, purchasing a specific resource through care management/personalisation, notifying other relevant services of the outcome of assessment (e.g. the referrer), expressing major concerns about a person who has absconded, taking the assessment to a Senior Manager for supportive discussion
- **Sources of information available** – your assessment and plan are only as good as the quality of information you had available to you. Document the sources available, and possibly the further information needed (which should be indicated in your *initial risk management plan*)
- **In what way has this assessment taken place** is the space for clearly stating where, and in what circumstances the assessment was made (e.g. engaged and full discussion; tense and short meeting before person demanded to leave/absconded)
- It is important to have a brief statement of how involved and/or in agreement the service user and any relevant carers were in the process of this assessment and management plan (use the 'Comments' box to describe the quality of involvement/agreement)
- The **next intended update** is a *professional judgement* at your discretion (in consultation with others). It could be a matter of hours, days, or at the point of the next formal review of care (e.g. next community-based appointment, or CPA review).

This tool forms the *first level* of ***risk screening*** assessment and management for all people seen in the services. Links to other assessments may be made in clearly written ways on this form. It is *professional* judgement and discretion as to where you capture the links to other sources, for example:

- Short-stay services requiring to complete a further more detailed 'falls' or 'manual handling' assessment as part of their specialised needs, may indicate this on the 'Wandering/falls' section of page 1, or in the 'Initial management plan' on page 2
- Forensic services required to perform a detailed assessment of the risk of violence and aggression may indicate this is to be found in HRC-20 on the 'Risk to others' section of page 1, or the 'Initial management plan' on page 2.

There is not only one correct way of using this format… it is about clearly indicating *how you are using it* to document important information. The primary test: Is it an accurate reflection of what you have identified and what you assess could happen, and can this be easily understood by anyone else needing to access and use this information?