Working with Risk ~ Detailed Review
(Steve Morgan – Practice Based Evidence)

NAME: **D.o.B.: / / ID No:**

ADDRESS:

POSTCODE:

DATE/PERIOD OF REVIEW: **NEXT REVIEW DATE: / /**

The following checklist provides a 'bridge' for detailed considerations when translating the brief 'Working with Risk ~ Current Situation' records into the more detailed review provided through processes of Person-Centred Planning and the Care Programme Approach (CPA).

NETWORK OF SUPPORT:

CONFIDENTIALITY OF INFORMATION:

SOURCES OF INFORMATION AVAILABLE:

SERVICE USER CURRENT ASSESSMENT OF RISKS (in their own words):

CARER(S) CURRENT ASSESSMENT OF RISKS (in their own words):

SUMMARY OF ASSESSMENT (since last review) (Including, for example: context, situations, positive resources, early warning signs, staff allocation, environmental factors, *intuitions* needing to be investigated further, etc.)

RISK MANAGEMENT PLAN (Including, for example: who, what, how, when, expected outcome, positive potentials, etc. Considering, for example, risk minimisation, early warning signs, crisis responses, long-term management, positive risk-taking [check Structured Checklist], levels of observation, etc.)

KNOWN CHRONOLOGY OF RISK INCIDENTS (To include, for example: specific dates, category/description of risk, detailed context/situation, service user's account, carer(s) account, corrections to previously inaccurate information)

STRENGTHS (i.e. abilities, capabilities, interests, personal qualities, protective factors, sources of support, etc.) specifically linked to *working with risk*

WORKING WITH RISK – DETAILED REVIEW 'GUIDELINES'

This is used to document more detailed risk assessments and risk management plans, as well as updating knowledge of the chronology of events and risk-related *strengths* as a part of a regular review process. **It remains strongly based in individual and collective *professional judgements***. The format focuses on a flexible narrative style of capturing the individuality of an assessment and management plan through a checklist acting as a prompt, which can be used as a standalone format or be integrated into other method of documentation (e.g. a Care Programme Approach care plan). Its freeform structure permits the potential to 'reference' or 'import' other detailed sources of the information instead of the administrative need to repeat it for the purpose of completing a form.

WHO IS IT FOR?

It is to be used for all people accepted into health and social care services who require more than a brief contact through A & E Liaison, or a short-term crisis response, or a brief admission. However, it is also to be used in these short-term service contacts where for reasons of complexity, history or high potential it is determined that a more thorough investigation of the risks is needed. Beyond this description it is *professional judgement* that determines the need and timing of this tool… if it is considered but clearly decided not to proceed, the reasons should be documented. The format is equally relevant for all services: adult and older people's mental health, community and in-patient, learning disability and for substance misuse services where a mental health diagnosis has been established, as well as a broader range of disability and impairment (where details may change but the process remains the same).

WHEN IS IT USED?

Its use commences as soon as a *professional judgement* about its need is made. It should dovetail with other more comprehensive needs assessments and care plans. It should be reviewed *no less than annually*. As a part of the flexibility of a *multi-level* system, and to minimise the focus on volume of paperwork, the 'Working with Risk' format may be used to document many of the changes to risk information which happen between major review dates; or for subsequent reviews where little has changed in the overall picture for an individual. This format may only need to be re-visited earlier than scheduled when a series of changes in risk status occurs that alters *significant* amounts of the information currently documented. Its review date is then a *professional judgement* of the whole team.

Use of this tool is a *professional* not an administrative decision!

'Working with Risk – Current Situation' may be used to record any significant changes that do not require a revision of the whole 'Working with Risk – Detailed Review' format. Psychiatric liaison services, psychiatric out-patient appointments and others offering brief therapy or treatment (e.g. frequently in primary care), are less likely to be completing this second format. But, they may frequently contribute information to its commencement before handing on to another part of the services.

'Working with Risk – Detailed Review' may offer significant indications of areas of unmet need, requiring organisational decisions on priorities and resources. They

may also lead to informing a healthier understanding of the *reasonable expectations* that can be placed on service providers working in challenging circumstances.

HOW IS IT USED?

As with the 'Working with Risk ~ Current Situation' it is not to be used as an interview format, as this format is more focused on collaborative discussion, reflection and review of teams, services and others involved in an individual's care and support. However, collaborative assessment and management of risk involving the service user, and relevant carers, should also be a primary aim. In this sense, it is a matter of individual/collective *professional judgement* as to whether and how the actual format is worked through with the service user. It should be the standardised method for documenting the reflections and multiple sources of risk information leading to the decisions made by individuals and teams across the whole service, and how these link with a wider care plan.

STRUCTURE OF FORMAT

- Network of support relates to the discussions and circulation of the risk information; it is not intended to be the attendance list for multidisciplinary review meetings
- Confidentiality of information will be detailed in other policy documents, but its connection to risk information requires a statement be made and reviewed in relation to individuals. Information is confidential, and only to be shared within boundaries which are strict, but also transparent for the service user (i.e. members of the relevant multidisciplinary team and network of care supporting the individual). The service user may have good reasons for requiring a tighter boundary on information sharing, which will usually be respected. Only in rare occasions will confidentiality be breached, where a serious and imminent risk of harm is identified
- Sources of information available enables you to communicate clearly what the decisions and actions were based on. It is often unreasonable to assume that all the relevant information was available, or even accurate at the time of assessment
- Service user, and carer, personal assessments of risk should be elicited and documented wherever possible; particularly where they conflict with the service view
- Summary of Assessment is the (usually collective, but occasionally individual) formulation of the complex risks and social circumstances experienced and/or posed by the individual at this time. It should capture the most significant factors for the individual circumstances, and add something of the ***context*** in which you assess the risks may take place. It should introduce new information, where relevant, about any environmental or organisational factors that may contribute to the risks (e.g. influence of service settings, impact of delayed service responses, early warning signs needing quick responses, *gut reactions* where you feel able to defend the feelings if challenged)
- Risk Management Plan should detail the specific actions (usually collectively agreed) being planned to meet the areas identified on the *Summary of Assessment*. Content within brackets offers indications of what may be considered in compiling a risk management plan. Carefully considered risk-taking, with identified positive outcomes, should be

documented, where relevant (see also Section 7 and Appendix 3 of this resource). The people individually responsible for carrying out the actions across the plan should also be clearly identified

- Known Chronology of Risk Incidents is a list that we should be developing and continually adding to as new information comes to light. It should be accurate in detail, but equally in the context of what happened at each incident. Furthermore, it should be able to accommodate the indication of inaccuracies when they come to light in order to minimise the stigma associated with inaccurate statements of risk tracking people for life
- The detail of a person's Strengths can act as the counter-balance to the negative information usually developed through risk assessment, as well as offering indications of available resources and the confidence to take risks constructively. This is not a comprehensive *strengths assessment*, but should highlight the positives that have some relevance to the considerations of risk in the individual situation.