Risk assessment and record keeping

Guidelines from the Department of Health and Social Care (DHSC) on Best practice in managing risk define risk in mental health as relating to a negative event, such as violence, self-harm/suicide or self-neglect. Assessing and managing risk provides an opportunity to engage with patients, and their carers and families, in order to promote the patients' safety, recovery and wellbeing. It is integral to providing safe and effective care and making decisions on transition between services.

Risk assessments should take into account information about the patient's history, including any incidents of violence, or self-harm or self-neglect, and should assess how the person using services is feeling, thinking and perceiving others – not just how they are behaving.

As part of our review of VC's care and treatment, and the 10 cases we reviewed for benchmarking purposes, we looked at the risk assessments carried out by Nottinghamshire Healthcare NHS Foundation Trust (NHFT) for each patient, as well as any information relating to risk.

NHFT records risk assessments on its electronic patient records system. This has an in-built tool that prompts for specific information which it then uses to provide an assessment of risk to inform treatment plans.

VC's records showed that 8 risk assessments were completed between May 2020 and February 2022. These appear to have been completed for each of his admissions to hospital, as well as being updated at other times during his care and treatment in the community.

While some key risks were identified, we found that risk assessments minimised or omitted key details including:

- refusing medicine
- ongoing and persistent symptoms of psychosis
- levels of violence against others when his psychosis was not managed well
- escalation of violence towards others in the later stages of his care under NHFT.

Risks assessments did not provide a suitable analysis of the risks or identify the factors that may reduce his risk of violence and how this would be managed. They also did not outline the seriousness and the immediate threat of the risks and the known issues that would increase his risks, or provide a written outline of the scenarios where the risk of violence would escalate and who may be put at risk. As a result, the extent of the risk did not fully inform his care and treatment planning.

Our review of VC's care also found concerns around his capacity to consent to treatment and whether these were considered in his risk assessments. The Mental Health Act Code of Practice is clear that "a person is 'unable to make a decision' for themselves if they are unable to do any one of the following:

- understand information which is relevant to the decision to be made
- retain that information in their mind
- use or weigh that information as part of the decision-making process, or
- communicate their decision (whether by talking, sign language or any other means)."

As described in the background to this report, throughout the period he was under the care of NHFT, as part of the symptoms of his psychosis VC showed little understanding or acceptance of his condition. This is likely to have significantly impaired his ability to weigh up the information regarding the need for antipsychotic treatment and the risks of discontinuing it. On that basis, VC should have had assessments of his capacity to consent to treatment in the community. However, opportunities to assess his capacity to consent to treatment in the community were not taken. (See also section on Medicines management.)

There does not appear to have been an updated risk summary or review of the level of risk before he was discharged from the early intervention in psychosis (EIP) team to the GP in September 2022. This was a missed opportunity in highlighting to the GP the risk of him not taking his medicine, and the possibility of him having a psychotic relapse as a result.

In the cases we reviewed as part of our benchmarking, we also found inconsistency in the risk assessment records. In most cases, we found that the EIP team assertively managed patients' psychosis, with risk assessments reviewed frequently and updated in response to changes in a patient's risk profile. However, there were examples where the 'Risk and Summary Assessment' could have contained more detail and been reviewed more regularly.

For example, in one patient record the reviews of risk were very limited in detail and there was no evidence that the care co-ordinator had reviewed the patient's risks. The only relevant entry across the 9 risk assessments for this patient did not identify any related actions or activity that were associated with the risks identified. There was also uncertainty about the patient's documented diagnosis and whether it was first episode psychosis or drug-induced psychosis.

Findings from our review of VC's case and the benchmarking cases highlight many of the same concerns that we raised in our wider review of NHFT around inconsistent approaches to risk assessment. In our first report, we flagged concerns that there was variation in how well staff assessed and managed risk. Although the trust told us some teams held daily risk assessment meetings (RAM) to 'RAG' rate people in their care according to their level of risk and the severity of their needs, not all teams were using this. We also found that teams did not keep clinical records of RAM meetings to allow audit and learning. Together, these increased the risk of people coming to harm.

Our findings reflect feedback we received from people using services during the first part of our review, which highlighted significant shortcomings in managing risk. For example, people told us about repeated instances of risk to individuals' physical and mental health that were not adequately addressed. This included failing to manage interpersonal conflicts that escalated into violence, improper handling of medicine, and neglecting the mental health needs of individuals in distress.