Correspondence

Inconsistencies in risk assessment

Sir: We were pleased to read the audit on risk assessment by Harwood & Yeomans (*Psychiatric Bulletin*, July 1998, **22**, 446–449) as it seems to be the first published audit on the topic in the country. However, as no audit standards were set, it would be more accurate to describe the article as a preliminary research survey. We wish to report the findings of an audit we recently carried out on the same topic.

For the purposes of the study we agreed on the following standards: every in-patient must have a risk assessment (either formal or informal); the management plan must reflect this assessment; a date of review should be set; and communication with other professionals should be adequate. The case notes of 22 consecutive in-patients to Bromsgrove and Redditch, in February 1998, were examined. Twenty-one patients had risk assessments, of which four were formal. The management plan and communications were adequate but assessments were not easily identifiable in the notes, and dates for review were not set.

As a result of the audit it was suggested that at the end of the clerking a clear statement is made of the level of risk as well as date of review set (e.g. ward round). The Trust is having discussions to agree uniform standards across hospitals and the audit will be repeated once the standards are agreed. Arguably the most significant finding was the degree of anxiety the topic caused to fellow clinicians. This raises the question which we believe has so far not been addressed (and probably explains the sparseness of publications on the topic): risk to whom are we really assessing? Is it the patient, the public, the trust or the professionals? The way the above question is answered could profoundly affect the doctor–patient relationship.

SARA SMITH, *Registrar*, D. SCHULTEWOLTER, *Senior House Officer*, F. SOUZA FARIA, *Consultant Psychiatrist, Brook Haven, Princess of Wales Community Hospital, Stourbridge Road, Bromsgrove B61 0BB*

Sir: Having completed an audit of risk assessment recording in medical case notes, it was interesting to read the paper by Harwood & Yeomans (*Psychiatric Bulletin*, July 1998, **22**, 446–449).

It was of no surprise that recording was found to be unsystematic and often unstructured. Although the Royal College of Psychiatrists (1996) have published guidelines for risk assessment and recommend it be completed for every patient, no national standard exists and local standards are few and far between.

Notably, Harwood & Yeomans omitted to set an audit standard before proceeding with their work, to recommend standards after completion or to complete the audit cycle. The risk assessment tool was not standardised and had not been validated.

When designing our own audit, resistance from clinicians to formalising the risk assessment procedure was high. The implications, it was felt, of statements of risk was great, although accurate prediction is recognised as difficult (Ferris *et al*, 1997).

Assigning a level of risk, as Harwood & Yeomans did, although convenient, is often misleading and meaningless. Risk is related to many factors (e.g. substance use, personal history, past behaviour and gender). These factors are not conveyed by a level or number. Routine weekly assignment of similar levels of risk in a regional secure unit was unhelpful and abandoned. Use of standardised tools has its own risk – a false sense that assessment is complete.

Although the requirement for more formal, structured risk assessment is increasing, perhaps emphasis should be on accessibility of clear, relevant information which is well communicated to the multi-disciplinary team, allowing each member to draw their own conclusion.

FERRIS, L. E., SANDERCOCK, J., HOFFMAN, B., *et al* (1997) Risk assessments for acute violence to third parties: a review of the literature. *Canadian Journal of Psychiatry*, **42**, 1051–1060.

ROYAL COLLEGE OF PSYCHIATRISTS (1996) *Assessment and Clinical Management of Risk of Harm to Other People* (Council Report CR53). London: Royal College of Psychiatrists.

S. SMITH, *Senior House Officer in Learning Disabilities, Lea Castle Hospital, Lea Castle Drive, Wolverley, Near Kidderminster, West Midlands*

Maximum output of ECT machines

Sir: Dykes & Scott (*Psychiatric Bulletin*, May 1998, **22**, 298–299) in their examination of

https://doi.org/10.1192/pb.22.11.713 Published online by Cambridge University Press