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Risk assessment audit on psychiatric out-patient case notes

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Introduction

Risk assessment is a process of gathering information for use in decision making and formulation of treatment related to various risk issues. It is important that the process is guided by the professional knowledge and available scientific evidence, and that the finding is properly documented in case notes for communication among health care professions. We identified a group of salient factors which are to be categorized into 3 columns, with reference to current scientifically established risk assessment tools. Documentation of each item is rated upon its presence, clarity and clinical appropriateness. The completion of checklist will inform the auditor the overall quality of risk assessment documentation.

Objectives

This study aimed at auditing the quality of risk assessment in case notes of a psychiatric out-patient clinic.

Methodology

A panel was formed by 3 associate consultants for the preparation of the audit and formation of the audit checklist. A pilot study was performed with 20 cases from 2 psychiatric out-patient clinics by 2 auditing doctors, with interrater correlation and calibration. 100 out-patient cases from both clinics, of adult age range (18-64) were obtained by a designated nurse using OPAS. The scope was case notes in recent 5 years (from 2009 onwards). The list was randomized and presented to the 2 auditors for evaluation.

Result

32 case notes from UCHPC and 65 case notes from YFSPC were obtained and

evaluated. 3 case notes were found to be duplicated and not analyzed. Suicidal attempts, mental state examination, suicidal idea / plan, and current support system were relatively well documented. However, previous offence records, personality disorders, non-compliance to treatment, child abuse, violent idea / plan, insight, supervision response, and arrangement of other psychosocial intervention all yielded less than 50% in documentation. A substantial portion of case notes had very brief first consultation notes. This was especially the case when the history was already well documented in the in-patient case notes or consultation liaison notes. This reflected the importance of cross reference with case notes other than out-patient notes in order to offer comprehensive management plan. There was also a discrepancy between documentation of suicidal risk and violent risk, with the former documented much more frequently than the latter. This may be due to the clinicians' focus on the patients' suicidal risk more than the violent risk to others, or the consultation process suggested that the violent risk was minimal. Tactful interview and focus on possible domestic violence or child abuse may offer better documentation in this aspect.