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PREPUBLICATION DRAFT

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'Managing risk in community practice: nursing, risk and decision-making', in: Paul Godin (ed.) *Risk and Nursing Practice*, Palgrave, London, pp. 24-41, 2006

The development of modern nursing practice was closely linked to the development of health care institutions such as hospitals and asylums in the 19th Century and its development outside such settings occurred more recently mainly in the second half of the 20th Century. Since these two settings differ both in the type of risk which nurses are likely to experience and in the ways in which nurses assess and manage risk, I will compare and contrast these two settings before considering in more detail risk in community nursing practice.

Risk in Institutional and Community Settings

Risk was central to the development of health care institutions and their internal structuring. A common theme in the history of institutions is the way in which they were established to manage dangers that threatened established order within society, whether such dangers came from infectious disease, crime, madness, vagrancy or degeneration of the population. Indeed, as Rothman noted in his study of the development of institutions in the United States of America, these threats were often seen as interlinked in the early 19th Century resulting in a common institutional response to a range of social issues (Rothman, 1971).

Since institutions were designed to deal with risks, albeit risks associated with different types of hazard, they shared common physical and social structures and managed risk in similar ways. Risk was constructed and managed through the structuring of activities and relationships in time, institutional routines, and space, batch management of inmates or patients (see Goffman, 1968 for a classic account of the 'total institution'). In acute hospitals, risks were primarily conceptualised in terms of biomedical threats, such as infection or contamination by pathogenic organism or germs and controlled through institutional hygienic routines, for example cleaning routines, asepsis and barrier nursing. This response is still evident in the ways in which hospitals and the government are responding to the 'superbug' MRSA. For example in England the Chief Nursing Officer at the Department of Health (DoH) launched a 'Think Clean Day' to raise the profile of good hygiene in hospitals to ensure safety (DoH, 2005).

While these routines are overtly oriented towards the management of biomedical threats, they also have the effect of structuring relationships between nurses and patients enabling nurses to manage and process individuals through the system. Ethnographic studies of hospitals in the 1950s and 1960s clearly identified the ways in which these hygienic practices were used to structure space and manage or control the patients' passage through defined spaces and across prescribed boundaries. For example Rosengren and DeVault (1963) analysed the ways in which the physical structure of delivery suites was used to manage pregnancies. All women in labour

passed through the same spaces and by implication stages of labour but at different speeds. Rapid deliveries were rushed through. Roth (1957) focussed on the rituals which accompanied the control of risks. During work hours staff who entered potentially infected spaces wore protective clothing such as masks, outside work hours they entered the same space without taking protective measures against infection.

The major threats in acute hospital are depersonalised and externalised as ‘germs’ or ‘superbugs’. However, in practice, individuals are a prime source of danger as carriers of and the source of infection. For example in the Netherlands, the response to MRSA has been to classify all patients and healthcare workers who enter a hospital into one of four risk groups, Class A - proven, Class B -high risk, Class C - increased risk Class D - no risk (Vos, 2005) and Class A and B patients are nursed in isolation until they are shown to be safe. In England some hospitals have created security boundaries, preadmission clinics to screen patients to ensure that they are safe to admit (French, 2005).

In psychiatric and learning disability institutions, there was no such externalisation, the hazard was located within and represented by each and every individual classified as mentally ill or leaning disabled. In this context institutions were designed to identify and manage such risks and the threat they posed to wider society. The internal structure of the institution was not only a mechanism of control but also a mechanism for organising and displaying different forms of illness and disability. It was a taxonomy and a source of knowledge about the nature of illness and disability, the threat it posed and how such threats could and should be managed. This taxonomy was centred on risk. For example Samuel Tuke, one of the founders in the early nineteenth century of Moral Treatment and institutional care for people with mental illness, stressed the importance of proper classification as the basis of effective treatments:

Those who are violent, require to be separated from the more tranquil... the patients are arranged into classes, as much as may be, according to the degree in which they approach rational or orderly conduct (Tuke, 1964: 141).

The knowledge encoded in the taxonomy and the physical structure of the institution formed the basis of the identification and management of the risks associated with illness and disability. Key professionals such as doctors developed this structure through their scientific research and publication and, as Foucault (1971: 270) noted, had the standing and moral authority to apply it to individual cases through their expertise in diagnosing and prescribing treatment. This power involved not only control of institutional ‘inmates’ but also of the other institutional staff who managed inmates and the risks they presented on a day-to-day basis. In the early stages of the development of institutions these other staff were unskilled workers, in asylums ‘attendants’, who were recruited and socialised into the institutional regime and its discourse.

With the development of professional education and training in the 20th century nursing, played a more prominent role in assisting doctors in diagnosis and treatment, and in managing the day-to-day routine of the institutions, such as supervising nursing assistants or auxiliaries and student nurses. Thus nurses occupied an

important position within the staff hierarchy and the system of surveillance through which institutions identified and managed risk. They had responsibility for surveillance in a defined space, a unit or ward, over a period of time, a shift. They were responsible for observing, recording and reporting actions and activities of both patients and staff within this space, especially those that disrupted the routine and caused harm or threatened safety. In turn their actions were subject to surveillance both from senior nurses who had overall responsibility for the institution and by doctors who were responsible for care of the patients on the wards. Nurses, therefore, played a key role in the total institution which, by structuring space and time, sought to exercise the total surveillance of a panopticon, a system designed to make inmates permanently visible and observable (Foucault, 1979, p. 201). This panopticon combined a physical structure with an asymmetrical relationship between observer and observed and permitted:

an internal, articulated and detailed control – to render visible those who were inside it...the hospital building was gradually organized as an instrument of medical action: it was to allow better observation of patients, and therefore a better calibration of their treatment; the form of the buildings, by careful separation of patients, was to prevent contagions (Foucault, 1979: 172).

In reality institutions could not achieve the ideals of the panopticon. Design defects, lack of imaging technology such as CCTV and management problems meant that there were always spaces outside central surveillance and control. Within these spaces alternative cultures could and did develop, for example unit or ward level staff developed their own informal beliefs and practices (Belknap, 1956) and inmates could exploit 'free places' outside the 'surveillance space' to sustain an underlife (Goffman, 1968: 187-266).

In the mid 20th century, there was a major shift in perceptions of risk and the associated responses to different forms of illness. Social and technological changes appeared to reduce the threat of illness while new treatment technologies, especially drug therapies seemed to offer mechanisms for managing illness which were previously difficult to treat. For example long term improvements in diet and health plus new drug therapy meant that infectious diseases such as TB were no longer major killers and such a threat to the health of the population (McKeown, 1979). In mental health and especially in learning disabilities, there was a shift in collective sensibility with a greater emphasis on the vulnerability of individuals rather than their dangerousness. New therapies such as psychoanalysis and drug therapies underpinned professional optimism that any elements of dangerousness could be effectively managed (Alaszewski, 1983, Alaszewski, 2003). These changes were linked to a major shift in the role of institutions within society. The role of institutions shifted from being the centre for managing all forms of risk to managing 'high' risk. Thus in acute hospitals, the emphasis in England was on district general hospitals to manage the acute high risk phases of illness requiring specialist expertise and technology. This meant that other hospitals such as local cottage hospitals, convalescence hospitals, longstay units for the chronically ill and specialist units for infectious disease such as TB sanatoria were surplus to requirements and low risk illness such as chronic illness could be managed in the community by GPs and community nurses. This shift was even more marked in the management of mental illness and learning disabilities. In mental illness it was accepted that there should be

a role for institutions in the acute phase of illness but as a break with past practices and cultures these in-patient units were to be located within district general hospital structure. In learning disability, initially there was no role for institutions and all care was to be provided within community settings. In England and Wales these major changes in the role of institutions and the patterns of treatment and risk management were formally accepted as government policy in two white papers issued in the early 1960s on hospitals (Ministry of Health (MoH), 1962, Allen, 1979) and community care (MoH, 1963).

The precise implications of these changes for the nature of risk construction and management are the subject to debate. It is possible to argue that the development of care in the community did not in reality make a major difference in the management of risk. For example Foucault argued that the development of psychoanalysis did not change the essential nature of power and control and the need to manage the risk present in the patient, it merely shifted it from the structure of the institution to the practice of the doctor: 'To the doctor, Freud transferred all the structures Pinel and Tuke had set up in confinement' (Foucault, 1971: 278). While the role of the institutions was considerably reduced, their influence over risk management in the community was maintained as they continued to manage the most dangerous patients and diseases. Heyman et al. have conceptualised the overall system of care and risk management as a risk escalator which has three main characteristics:

...differentiation of steps in treatment regime in terms of the degrees of risk severity they are designed to manage; attempted congruence between varying levels of safety/autonomy balance and assessed client riskiness; and the potential to move individuals up towards increased safety (for self and/or others) and down towards greater autonomy. (Heyman et al, 2004: 310).

As Heyman et al note, such a model can be identified in a wide range of health care systems, for example, the system of screening babies to reduce the risk of them being born with chromosomal abnormalities, and to mental health and learning disabilities services, in which independent living represents the bottom of the escalator and forensic units the top.

Even if the institutional influence remains pervasive, it is important to recognise that there are significant differences between institutional and community settings that will shape the ways in which risk is identified and managed. Partly this reflects the development of different groups of nurses working in the community, mental health and learning disability nursing went through a process of deinstitutionalisation with, in the case of learning disability nursing a very strong and ideologically-grounded rejection of institutional practice (Alaszewski and Ong 1990). In contrast district nursing developed within the context of primary care. It also reflects major changes in the location of work. The institutional structure of classification, surveillance and control is significantly changed in the community. Much of the activity takes place within spaces that are not designed or control by professionals, for example the service users own home. While imaging technology can be installed within such spaces to observe, in practice given limitation of resources, such technology is only installed in high risks environments, for example, in the homes of vulnerable individuals who are exposed to particular risks. In practice the activities of professionals within such spaces are virtually invisible to either their line managers or

other professionals. Thus nurses working in the community are effectively operating in 'free places' outside surveillance. Such places are often controlled and managed by clients, and when entering them community nurses do not have the protection of the institutional environment and are of necessity forced to recognise and acknowledge the interest and concerns of the clients and therefore the ways in which users define and manage risk. The practicalities of managing every-day interactions mean that community staff will develop their own routines of work. Lipsky (1980) argues that these routines make up a 'street-level bureaucracy' and one of their prime functions is to 'control clients and reduce the consequences of uncertainty' (1980: 86), in other words manage the risks of front-line work, and that such routines exist and function independently of agency policy which may or may not acknowledge and support them.

Nurses who work in the community are working on the frontline mostly outside the structure, protection and surveillance of the institution. There is pressure for them to effectively assess and manage risk, for example a series of high profile inquiries in mental health services have highlighted public concerns and the need to identify and manage dangerous individuals (Ritchie Inquiry, 1994). However this does not necessarily mean that all nurses working in the community have internalised dominant definitions of risk. In the next section I will consider the extent to which nurses working in the community use definitions that challenge the dominant paradigm.

2. Defining risk: Challenging dominant hazard-based definitions

As Eldridge and Hill (1999) has noted, an area of central importance in risk research is to explore which and whose definitions of risk are accepted in different contexts. While risk appears to have entered the English language during the 17th century its use and meaning have changed overtime. Initially risk was associated probability especially with gambling and games of chance whose study created a specialist branch of mathematics, statistics (Douglas, 1990). In modern society interest in risk has become more pervasive and linked to danger and the 'threat to desired outcomes' (Giddens 1991). However risk is not only a way of managing the future but also serves a forensic function, the retrospective allocation of responsibility and blame when this process fails and significant harm such as death occurs (Douglas 1986: 59).

Contemporary health and welfare agencies are concerned with both aspects of risk, they need to identify risk so that they can avoid investigation and blame. In the mid 1990s we undertook a study the risk policies of agencies and found that the operating definition of risk was risk as danger of hazard which had to be identified and managed to ensure the safety of users. Thus one learning disability agency used hazard and harm interchangeably in its policy statement on identifying risk:

The review should contain accurate information about the hazard, the risk including evidence of the harm that can/has been caused by a particular risk. There is a strong argument for recording all risks then eliminating certain risks which are considered to be trivial... immediate steps can be taken to eliminate a risks where costs may be low and action simple. Merely to have reviewed will have raised a heightened awareness of risk. Actions should be recorded and

taken. If some risk remains, the process will need to be continued (Alaszewski et al, 1998: 55).

A starting point for reviewing the ways in which community nurses identify and manage risk, is to consider the ways in which they define risk and especially the congruence between their definitions of risk and the prominent 'risk as hazard' discourse. With a number of colleagues, at the end of the 1990s I undertook a study of the ways in which community nurses supporting vulnerable adults (including older people, people with mental health needs and people with learning disabilities) in the community, assessed and managed risk (see Alaszewski et al, 2000). We started by examining the ways in which nurses conceptualised risk. While all the participants in our study, except for one group, accept that risk formed an important part of nursing practice and that risk tended to be an internalised taken-for-granted concept. When invited to define risk most nurses did not have an immediate response, they needed to pause to consider it and indeed some were initially reluctant to provide a definition. When they did articulate their reply, the majority (59, 82%) saw risk in terms of hazard and harm especially the negative consequences of decisions or actions. For example a community mental health nurse stated:

I see risk as a very negative thing because most of the risk that I'm dealing with is the risk of people self-harming or committing suicide...

While a mental health nurse lecturer commented:

Risk to me connotes something negative, danger, needs something doing about it, it's dangerous, it's negative and something awful is going to happen.

Nurses using this approach did not need to justify or particularly elaborate on it as it fitted the dominant organisational approach to risk as they grouped together a whole range of issues. For example one mental health nurse when asked whether he linked safety with risk emphasised his managerial responsibility for a range of hazards:

Yes, mainly around self-harm and harm to other people; but I think, again as a manager, being aware of legislation around health and safety at work, COSHH regulations, manual handling, those kinds of things and heightening staff awareness around those kinds of issues—infection control. We're having to get involved in both infection control and manual handling.

However we also found definitions of risk that challenged the dominant risk paradigm. Nurses who recognised the possibility of alternative definitions of risk noted that this was a contested area and that the ways in which one definition had become prominent was the result of social processes not just the reflection of an objective reality. For example a mental health nurse commented when invited to define risk:

That's the 50 million dollar question. What may be a risk for me may not be for another person—it very much depends on your point of view of what risk is. The definition causes me problems. The other thing I have a problem with is who has the right to define it because that will affect what you do about it.

Some nurses (22, 31%) argued for a more positive approach in which risk-taking was seen as a potentially liberating experience and an essential part of human growth and development. For example the learning disability nurses recognised that such an approach challenged the official or organisational definition to risk:

What I understand by risk and what the health authority understands is two different things. To me risk is a way of clients gaining knowledge, being able to develop, learn new things... often staff as well—the staff taking risks they actually learn things by that and learn what the clients can do from risks. The health authority thinks of risk as... protecting their backs.

While the risk as hazard approach can be seen as an internalisation of the dominant risk paradigm, discussions, which identified the positive aspects of risk, implied a degree of distrust of organisational motives, especially avoidance of bad publicity. Thus one mental health nurses described the impact of such publicity in the following way:

You only have to open the papers. I think this morning there was a sex offender escape from a medium secure unit...As soon as anything like that happens, it has a knock-on effect for client decisions...It depends politically what happens

As a result nurses tended to justify this approach not by reference to organisational or even professional standards but by reference to the ordinariness of risk-taking as part of every-day life. For example a learning disability student nurse described risk in the following way:

[It] depends on your point of view and style of life and philosophy. I might see going to the casino and gambling as a risk but someone else might not. [Risk can be defined as] a result of circumstances involving an activity. There is a risk in everything and it is what is 'acceptable'. Taking a gamble—the idea of being bad being more fun than being good. It's an aspect of life which most people enjoy—a bit of fear, getting the adrenaline going can be a good thing.

'Risk as a hazard to be identified and avoided' versus 'risk-taking as an opportunity for learning and development', represent two very different and apparently irreconcilable approaches. However there was an intermediate position in which nurses (38, 58%) recognised both dangers and opportunities and saw risk as a process of balancing the two. A nurse with a community nursing background commented:

[It's] part of allowing people to stay at home. If you've got older people living on their own it's that balance—it's the danger to themselves and the danger to the neighbour—it's when you start looking and say how far down the line can I go with these risks. But if someone is adamant, that they do not wish to move, in many ways it allows them to take that risk

In this approach risk involves a recognition of hazard and danger but it also involves factoring in other aspects so that risk management is not restricted to hazard identification and management or safety at all costs, but involves identifying and balancing outcomes, safety versus autonomy. Adopting such an approach involves an element of trust. Accidents happen and on occasion users and others may be harmed.

Nurses adopting this approach need to trust that the agency employing them will not hold them accountable and blame them if they can demonstrate that they acted reasonably.

Within all the areas of nursing within the community which we included in our study, the common sense approach of ‘risk as a hazard to be identified and avoided’ predominated. However there was a difference between different groups of nurses. Mental health nurses tended to place the greatest emphasis on this approach. Learning disability nurses appeared more ready to recognise the positive aspects of risk taking while nurses providing support for older people were the most willing to recognise the balancing approach.

Table 1 Definitions of risk (Note: in some interviews more than one definition was identified)			
	Hazard	Balance	Opportunity
Mental health n = 24	21 (87.5%)	15 (62.5%)	5 (21%)
Older people n = 24	20 (83%)	16 (67%)	7 (29%)
Learning Disability n = 24	18 (75%)	7 (29%)	10 (42%)
All nurses n = 72	59 (82%)	38 (53%)	22 (31%)

The mental health nurses in our study did acknowledge that their approach to risk emphasised the potential harmful consequences of the actions of acutely ill clients. They felt that this emphasis was a product of external pressure on nurses in this area of practice. In particular they were concerned about the potential consequences of high-profile incidents in which acutely ill individuals had harmed themselves, members of the public or individuals providing them with support. Such incidents had resulted in public inquiries which had attracted considerable media coverage and resulted in the allocation of blame. As Cambridge has noted such inquiries ‘seek to allocate some level of individual responsibility or blame’ (2004: 235). For example the committee of inquiry into the killing of Jonathan Zito by Christopher Clunis (Ritchie Inquiry 1994) highlighted the failure of individual practitioners to effectively assess the danger posed by Christopher Clunis. It recommended that in the case of patients who had been violent, aftercare plans should include ‘an assessment... as to whether the patient’s propensity for violence presents any risk to his own health or safety or to the protection of the public’ (Ritchie Inquiry, 1994, p. 111). Mental health nurses in our study saw a link between high profile media coverage and a narrow defensive approach to risk. One mental health nurse articulated this link in the following way:

Interviewer: ‘What’s happening that’s made people more aware [of risk]?’

Nurse A: ‘It’s probably because there’s less hospital beds and closing down of institutions.’

Nurse B: ‘High media profile’.

Nurse A: ‘And ever since Ben Sillcot... just jumped into the lion’s den it’s become a very hot topic... So a lot of it’s to do with media coverage... and that has made management more aware and that filters down to clinicians’ level...’

Mental health nurses in our study felt that there was pressure from Government ministers and the Department of Health to prevent such incidents and to ensure that professionals identified and managed hazards effectively.

3. Risk and decision-making

While definitions provide some indication of the ways in which nurses structure risk, they are an indirect measure of the actual risk management practices, there can be a significant gap between saying and doing. Examining the ways in which community nurses make decisions about users is one way of exploring actual practices. As Narayan and Corcoran-Perry have noted: 'Decision-making tasks of interest in professional domains are characterised by complexity, ambiguity, and uncertainty' (1997: 354).

We invited 20 community nurses to record their decision-making in a clinical log or diary. Through this process we identified 584 separate decisions. Most of these (464, 80%) involved client care. We also identified decisions that concerned the nurses' own situation, especially work load or safety issues. For example one experienced district nurse recorded her decision to question workloads and activities:

Meeting at 12 with our Team Manager. We are told that the over 75s service is to be within our remit. [I] advised the manager we have trouble getting reassessments done. Apparently she wasn't aware! It is clear that she doesn't fully understand our role as District Nurses and seems to relate to hospital nurses. [I] had to put forward what we see as our role as, and that we just do not go into homes and fill in forms without looking at the patient as a whole. This is taking our accountability to the full, rather than creating face to face contact [to fulfil the conditions of the] GP contract.

We explored and examined the decision making process, in particular identifying whether nurses used structured decision-making, negotiating methods or intuition. Structured decision-making can be linked to a hazard approach as it involves checklists to assess risk and guidelines for making decisions and leaves an audit trail that can be used to demonstrate that reasonable efforts were made to identify and account for risk. Negotiation can be linked to a definition of risk which recognises the existence of different and conflicting definitions of risk and therefore by implication the need, through negotiation, to create the best possible balance and, where possible, maximise support for a decision. Intuition can be linked to the risk-taking approach as it emphasise personal empathy and the use of every-day common-sense.

The differences between such approaches can be seen in the diary entries. In the following extract an experienced district nurse describes how she responded to a serious incident which could have had fatal consequences, a client burnt her legs on a gas fire without realising:

Outlined risk of gas fire [to client] + advised not to sit directly in front of fire + keep legs away from direct heat. Assessed other aspects of safety—seemed to be no other problems. Water low—low risk Lifting + handling—no risk. Social services involved = has home help. Visits organised for 3x weekly.

An experienced community psychiatric nurse (CPN) also recorded her use of structured approach to justify her decisions not to accept three referrals for further treatment:

am C.P.N Clinic three referrals—Reasons for referral two stress reaction and one grief reaction. Each referral received one hour assessment. Decision made not to offer further appointment, assessment also encompassed 'risk'. C.P.N. clinic used as a 'screening' to facilitate decision to accept client into Mental Health [services]. I believe my training is sufficient to formulate decision regarding option of accepting or declining referral. My decision is based upon Generic Psychiatric Assessment—Risk Assessment and Research based practice stating reactive mental health resolves its problem without Community Psychiatric Nurse involvement, affectionately known as the 'worried well'.

The nurse in this situation was able to use a structured approach to decision as the nature of the decision was relatively easy to define, i.e. whether or not to accept the patients into the service, she could identify specific methods of identifying information and she felt there was a structured evidence base that she could draw on to justify her decision. However in many situations the nature of the decision is complex, there are competing interests and no amount of additional evidence will assist in the process. In such contexts negotiation is often used. For example the following decisions involved an experienced district nurse who felt that she was under pressure to increase the dosage of a painkiller to dangerous levels and reached an agreement with the patient's GP to maintain the current dosage

31st March

Terminal lady on syringe driver [for pain relief]. One colleague, who worked over the weekend has suggested that the Diamorphine need[ed] to be increased. On visit this morning and pm I felt this was not justified. Family not in attendance and the manager of the home agree[d] with me in one way but also remark[ed] that the family had taken 3 days off work [in anticipation of patients death]!! I need to review this lady condition in the morning to feel that the increase is justified for the patient rather than the family/home. Being a patient advocate is not easy, or black and white when a situation like this occurs. I am aware what the increase will do but I also see that the patient is very comfortable and not in pain.

1st April

Early start with patients before meeting the GPs at 8.30am. Needed to discuss with GP re the syringe driver [who agrees to maintain dose]...

Reference the syringe driver. The family still seem unhappy, even with the GP decision, of maintain[ing] the Diamorphine dose. I feel this was the right decision I now have to discuss this with the family and advise referral to GP if they want to do so. Handling relatives with this issue cannot be given in training. Even with a broad amount of training in bereavement will not prepare how either you will react or the relatives in a given situation. Maybe scenarios or role play may help.

In the diaries we were also able to identify decisions based on intuition which were grounded in the personal knowledge and expertise that the nurse has developed over time, for example knowledge of specific clients. Nurses could use such knowledge to identify ‘warning signals’, i.e. attach specific meaning and significance to relatively minor comments or actions. For example in the following diary extract, an experienced CPN indicated how he used his personal knowledge of a client to identify warning signals and prioritise a particular case to prevent a potential suicide:

Message on answerphone from Client M. She wants to talk to me. When I phone back she says she doesn’t need me, she is going to [famous landmark on the English coast]. As she is not driving at the moment, I question this and she hangs up. M. was previously admitted to hospital before Easter when I prevented her from taking herself to the sea ‘to join her sister’ who had been dead for a number of years. My decision is to cancel my first client and go round to M. I find her staring through the window, refusing to let me in. Eventually I persuade her to open the door. She is monosyllabic, apparently attending to and responding to voices. She then indicated to me that she is going to drive off [famous landmark on the English coast] to join her sister. I arrange for the ward to take her... and she is admitted.

While there is clearly pressure for nurses to adopt a hazard-based approach to risk management and to use structured systems to assess and manage risk, nurses in our study felt able to resist such pressures when appropriate. Overall there was a relatively even division between the different approaches to decision-making and risk with a small preponderance of formal decision-making and less evidence of intuitive decision-making. However there were important differences between the different areas of nursing. Community nurses emphasised formal decision-making reflecting the development of risk assessment tools, such as those used to assess pressure sores, plus evidence based guidelines. However they were also willing and able to use intuition, indeed some nurses stressed the need for different forms of knowledge as in the following extract from the diary of an experienced district nurse:

Training gave me knowledge and awareness of risk and tools used not only became part of every day working with experience and practice in the community and drawing on past experience.

Learning disability nurses made the most use of intuition and also engaged in negotiation. Mental health nurses appeared to be less willing than other nurses to take the personal responsibility implicit in the use of intuition and keener to share responsibility or to ground their decisions in a formal structured approach.

	Formal	Negotiated	Intuition
Mental health nurses n = 160	31%	48%	21%
Community nurses n = 274	45%	22%	33%
Learning disability nurses n = 113	19%	39%	42%
All nurses n = 584	35%	33%	32%

4. Final comment

When professionals assess and treat individuals they utilise skills based on knowledge. Professionals can use different types of knowledge which they acquire from different sources. For example evidence-based practice is based on knowledge acquired from the systematic evaluation of practice. This type of knowledge can be referred to as encoded knowledge (Lam, 2000) as it is often collected and codified in documents such as clinical guidelines. In contrast reflective practice is based on knowledge acquired by an individual practitioner and based on reflection of individual cases (Schön, 1988, Benner, 1984). It can be classified as embodied knowledge as it is used intuitively by individual professionals to respond to the unique circumstances of a particular case. Lam (2000) identifies two other forms of knowledge, 'embrained' which is based on an individual's use of cognitive and conceptual skills to solve problems, and 'embedded' which is based on the development of shared routines that have been successful in the past. Current pressure in risk assessment and management involves an emphasis on encoded knowledge:

Medicine combines aspects of both 'embrained' and 'embodied' knowledge, and... current schemes of clinical governance represent a drive to transform medicine into 'encoded knowledge' (especially through the promulgation of Clinical Guidelines by NICE...)(Flynn, 2002: 168)

Such changes will reduce the individual scope of professional autonomy and judgement. However there is little evidence at present to indicate whether the changes will improve the quality of decision-making and the safety of users.

While Beck (1992) has characterised contemporary society as Risk Society increasing health and welfare agencies can be seen as Risk or Safety Agencies. As Kemshall has argued:

Risk, particularly an individualized and responsabilized risk, is replacing need as the core principle of social policy formation and welfare delivery (Kemshall, 2002: 1).

Kemshall analysed the ways in which the development of more responsive public services which are 'safety oriented' is reshaping public services. A more responsive public service is not only more exposed to risk as it is expected to reach higher standards often on lower resources, but is also subject to greater scrutiny through audit systems which are often linked to naming and shaming mechanisms. As Kemshall has noted the culture of safety as evidenced in various health and social care inquiries has been a major factor in this development:

Our era is dominated by a peculiarly defensive attitude to risk, which Frank Furedi... has labelled a 'culture of safety' in which risks are almost always framed by the precautionary principle of 'better safe than sorry' (Kemshall, 2002: 1).

Thus central to the current restructuring of public services is replacement of need as the key principle of welfare rationing and provision the observation with risk and vulnerability. In some services such as child protection, mental health and probation services, this process is quite advanced (Kelmshaw 1998 and 2002). An important issue is whether this change will bring benefits and if so for whom. This depends how risk is defined and used (Kelmshaw 2000). If risk is defined in a narrow hazard oriented way then risk management can be a mechanism of protecting the agency and its employees from blame and litigation at the cost of restricting users' choices and rights. If on the other hand it is defined in a broader more creative way, for example, as reasonable risk-taking, then it can be used as a way of empowering users. Given current pressures on agencies and the professionals they employ, from Inquiries, the Government and the media, it seems likely that there will be continued pressure for nurses working within the community to adopt a structured approach to decision-making which emphasises the importance of systematically identifying and counteracting hazards.

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