



Chapter: Hospital Operations
Subject: RISK MANAGEMENT

Applicability: State Hospitals

Attachments:

- A - Triggers, Thresholds, and Measurement Definitions
B - Behavioral, Psychiatric, and Medical Risk Categories
C - Recovery Planning Team (RPT) or Interdisciplinary Team (IDT) Role and Responsibilities in the Risk Management Process
D - Hospital Review Committee (HRC) Roles and Responsibilities in the Risk Management Process
E - Quality Council (QC) Roles and Responsibilities in the Risk Management Process
F - Clinical High Risk Profile
F-1 - Instructions to Clinical High Risk Profile

Creation Date: January 12, 2010
Last Revision Date: December 1, 2011
Next Review Date: December 1, 2013
Full Implementation Date: March 1, 2012
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POLICY

DBHDD Hospitals utilize a Risk Management process that involves a continuous analysis and identification of risks followed by the implementation of interventions that are designed to protect the individual, staff, and visitors from any identified risk of harm in order to provide a safe environment.

PROCESS

The Risk Management process is directed at minimizing the risk of illness or injury to all of the individuals served by the DBHDD hospitals. The process begins with a review of each individual served, identifying the factors that place that individual at high risk of illness or injury and/or the factors that place those in the environment of that individual at high risk of injury. These risk factors are recorded on the Clinical High Risk Profile (Attachment F) and are addressed in the Individualized Recovery Plan or Individualized Service Plan for that individual.

The Risk Management process also uses a hierarchy for review of individuals who are involved in incidents, who meet thresholds for a trigger behavior (as presented in Attachment A - Triggers, Thresholds and Measurement Definitions) and/or who meet the criteria for a high-risk behavioral, psychiatric, or medical condition (as presented in Attachment B - Behavioral, Psychiatric and Medical Risk Categories). These reviews start with the Recovery Planning Team (RPT) or Interdisciplinary Team (IDT) and move forward to the Hospital Review Committee (HRC) and the Quality Council (QC). See Attachments C, D and E - Role and Responsibilities of the RPT/IDT, HRC, and QC, respectively.

The Risk Management process at each DBHDD Hospital includes the following components:

- 1. Data collection tools and a centralized database to capture and provide information on incidents, thresholds triggered, and high risk behavioral, psychiatric, and medical conditions.

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2. A process to ensure that all risk management data (e.g., incidents, triggers, high-risk conditions) are entered into hospital-wide and departmental databases with accuracy and completeness.
3. Identification of triggers, thresholds, and high-risk conditions that require timely review and intervention by the RPT or IDT.
4. Formalized mechanisms for notification of incidents to RPTs/IDTs and clinical disciplines to enable timely interventions.
5. Systems to monitor the timely implementation of interventions and the outcome of those interventions.
6. The monitoring of triggers, thresholds, high-risk conditions and individuals on high-risk lists for trends and patterns.

The Performance Improvement (PI) process at each State Hospital includes the following components:

1. A process that aggregates the “High Risk” factors identified by the initial Clinical High Risk Profile for each individual, as well as any subsequent changes to that Profile. This list is then reviewed by the Hospital Review Committee and the Quality Council in order to ensure that each individual on the list is reviewed as indicated by the Risk Management policy, and in order to determine the “health” of each hospital.
2. Identification of long-term trends and patterns leading to the implementation of system and process changes to improve performance.
3. The ability to sort and abstract multiple data fields in the data base including, but not limited to: individual, unit, program, incidents, triggers, and high-risk conditions.
4. The ability to generate routine and ad hoc reports for any clinical or administrative needs.
5. The monitoring and notification of the RPT’s/IDT’s and others of categorical data that indicate the need for and support timely interventions.
6. An oversight mechanism that ensures data are tracked, trended, and analyzed using a performance improvement methodology to determine the effectiveness of each hospital’s Risk Management process.

REFERENCES:

42 CFR § 482.21
 State of Georgia Regulations §§ 290-9-7-.11(b) and -.13
 OCGA §§ 37-1-2(a)(7); 37-1-21; 37-3-162(a); 37-4-122(a).

DBHDD Risk Management Policy
ATTACHMENT A: Triggers, Thresholds, and Measurement Definitions

ID	Sub-ID	Trigger* **	Measurement Definition
1		Aggressive act to self (IM – A2)	Self inflicted acts that cause injuries and that did not have suicidal intent. Examples include burns, head banging, ingestion of foreign bodies or potentially toxic substances.
	1.1	Individuals with one aggressive act to self	Number of individuals in the reporting month with one aggressive act to self.
	1.2	Individuals with 2 or more aggressive acts to self in 7 consecutive days	Number of individuals in the reporting month who reached threshold one or more times. Aggressive acts within a rolling 7-day period where the 2nd incident occurred during the reporting month.
	1.3	Individuals with 4 or more aggressive acts to self in 30 consecutive days	Number of individuals in the reporting month who reached threshold one or more times. Aggressive acts within a rolling 30-day period where the 4th incident occurred during the reporting month.
2		Aggressive act to others	<u>Aggressive Act – Physical:</u> Hitting, pushing, kicking or similar acts directed against another person that could cause potential or actual injury. <u>Sexual Assault:</u> Sexual contact by an individual involving using force or violence, or the threat of force or violence. <u>Sexual Contact:</u> Unwanted sexual contact against another individual which does not involve force or violence.
	2.1	Individuals with one physical aggressive act against a peer (IM – A3)	Number of individuals in the reporting month with one physical aggressive act against a peer.
	2.2	Individuals with one physical aggressive act against a staff member (IM – A4)	Number of individuals in the reporting month with one physical aggressive act, including sexual contact, against a staff.
	2.3	Individuals with 2 or more physical aggressive acts to peers and/or staff in 7 consecutive days (IM – A3, A4)	Number of individuals in the reporting month who reached threshold one or more times. Physical aggressive acts within a rolling 7-day period where the 2nd incident occurred during the reporting month.
	2.4	Individuals with 4 or more physical aggressive acts to peers and/or staff in 30 consecutive days (IM – A3, A4)	Number of individuals in the reporting month who reached threshold one or more times. Physical aggressive acts within a rolling 30-day period where the 4th incident occurred during the reporting month.
	2.5	Individuals with any episode of Sexual Assault against anyone (IM – A32)	Number of individuals in the reporting month with one or more acts of sexual assault against other individuals or staff.
	2.6	Individuals with any episode of Sexual Contact against another individual (IM – A33)	Number of individuals in the reporting month with one or more acts of sexual contact against another individual.
3		Alleged Abuse/Neglect/ Exploitation (IM – A8, A9, A10, A11, A12, A21, A22)	<u>Alleged Individual Abuse - Physical:</u> Any interaction or physical contact, motion, or action that is directed toward an individual by someone other than another individual (peer), which may cause harm or pain. Examples include shoving, hitting, slapping, pinching, shaking, kicking, punching, misuse of seclusion or restraint, unreasonable confinement, misuse of medication or excessive force during the provision of care. <u>Alleged Individual Abuse - Psychological:</u> Any act by someone other than another individual (peer) that causes or could reasonably be expected to cause emotional distress to an individual. Examples include but are not limited to use of intimidation to achieve compliance, retaliation, purposely not intervening in a behavior that is demeaning to the

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			<p>individual, deliberately inflicting mental pain, anxiety, confusion, humiliation, harassment, or coercion.</p> <p>Alleged Individual Abuse - Verbal: Any language by someone other than another individual (peer) that may be threatening, demeaning, discriminatory, pejorative, derogatory, or aggressive.</p> <p>Alleged Neglect: Failure by an employee to provide care or service, for example personal hygiene, food, shelter or clothing, medical care for physical or mental health needs, protection from health and safety hazards, or prevention of malnutrition or dehydration.</p> <p>Alleged Sexual Abuse: An employee engages in sexual contact with an individual. An employee encourages or allows sexual contact between individuals, one of whom is not consenting.</p> <p>Exploitation Individual/Individual: Selfish or unethical advantage or gain of an individual by another individual (peer) to gain money, property, or services. Examples include strong-arming or sexual activity for money.</p> <p>Exploitation Staff/Individual: Selfish or unethical advantage or gain of an individual by staff.</p>
	3.1	Individuals with 2 or more alleged A/N/E in 7 consecutive days	Number of individuals in the reporting month who reached threshold one or more times. Alleged A/N/E within a rolling 7-day period where the 2nd incident occurred during the reporting month.
	3.2	Individuals with 4 or more alleged A/N/E in 30 consecutive days	Number of individuals in the reporting month who reached threshold one or more times. Alleged A/N/E within a rolling 30-day period where the 4th incident occurred during the reporting month.
4		Choking	Any episode of airway obstruction by food or foreign object as evidenced by one or more of the following: a) inability to speak when asked if choking (if individual is verbal); b) inability to breathe or difficulty taking in adequate breaths; c) movements indicating distress such as grasping for neck or throat; or d) turning blue.
	4.1	Individuals who had a choking episode that required intervention (e.g., Heimlich) to clear the airway (IM – A40)	Number of individuals in the reporting month who reached threshold one or more times
	4.2	Individuals who had a choking episode that did <u>not</u> require intervention (i.e., they were able to self-clear the airway) (IM – A41)	Number of individuals in the reporting month who reached threshold one or more times
5		Elopement	<p>Elopement: Individual is not accounted for and is off the hospital grounds.</p> <p>Elopement Attempt: Individual is absent from a location defined by the individual’s level or legal status, but remains on hospital grounds</p>
	5.1	Any elopement attempt (IM – A38)	Number of incidents occurring during the reporting month.
	5.2	Any elopement (IM – A37)	Number of incidents occurring during the reporting month.
6		Falls (IM – A25)	An uncontrolled, unintentional, downward displacement of the body to the ground or other object, excluding falls resulting from violent blows, other purposeful actions,

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			stroke, fainting or seizures
	6.1	Any fall resulting in treatment beyond first aid	Number of incidents in the reporting month.
	6.2	Individuals with 3 or more falls in 30 consecutive days	Number of individuals in the reporting month, who reached threshold one or more times. Falls occurring within a rolling 30-day period where the 3rd episode occurred during the reporting month.
7		Homicide (IM – A27)	Injury inflicted on an individual either having potential to, or resulting in death
	7.1	Any homicide	Number of incidents that meet Georgia Penal Code.
	7.2	Any homicide attempt	Number of incidents that meet Georgia Penal Code.
8		Mortality	Death of an individual (includes the death of an individual on the census of the state hospital or within 2 weeks of being discharged or placed on conditional release).
	8.1	Unexpected Death (IM – A17)	Number of deaths in the reporting month for which the cause of death is not attributed to a terminal diagnosis or diagnosed disease process where the reasonable expectation of outcome is death. Although homicides and suicides are considered unexpected deaths, they are counted <u>only</u> in 7.1 and 14.1, respectively, and not in 8.1.
	8.2	Expected Death (IM – A16)	Number of deaths in the reporting month for which the cause of death is attributed to a terminal diagnosis or diagnosed disease process where the reasonable expectation of outcome is death.
9		Observations	By physician/psychologist order for enhanced observation due to behavioral or psychiatric reasons, but excludes observation of seclusion or restraint or medical treatment or hospitalization.
	9.1	Individuals on 1:1 for behavioral or psychiatric reasons over 24 hours in 7 consecutive days	Number of individuals in the reporting month who reached threshold one or more times. Individual accumulated more than 24 hours of 1:1 observation within a rolling 7-day period where the 25th hour occurred during the reporting month.
	9.2	Individuals on 2:1 for behavioral or psychiatric reasons over 24 hours in 7 consecutive days	Number of individuals in the reporting month who reached threshold one or more times. Individual accumulated more than 24 hours of 2:1 observation within a rolling 7-day period where the 25th hour occurred during the reporting month.
10		Pneumonia	Any diagnosis of pneumonia as confirmed by chest x-ray, or other diagnostic test (e.g., bronchoscopy, blood sample)
	10.1	Individuals who acquired non-aspiration pneumonia at the hospital	Number of individuals in the reporting month who reached threshold one or more times
	10.2	Individuals who acquired non-aspiration pneumonia off-hospital site (community hospital, family home)	Number of individuals in the reporting month who reached threshold one or more times
	10.3	Individuals with a diagnosis of aspiration pneumonia as determined or confirmed by the state hospital.	Number of individuals in the reporting month who reached threshold one or more times
	10.4	Individuals with recurrent aspiration or non-aspiration pneumonia	Number of individuals with recurrent (more than one) episodes of pneumonia during the reporting period (any type). Individuals with unresolved episodes of pneumonia should not

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			be included in this category; there should be clear evidence of recurrence.
11		Polypharmacy	Multiples of intra- and inter-class psychotropic medications, including standing PRN medications and STAT medications that are given on the day for which the report is generated.
	11.1	Individuals with 2 or more intra-class psychotropic medications for psychiatric reasons	Number of individuals in the reporting month who reached threshold one or more times. Polypharmacy includes those cases that have an approved drug review or the medication is being tapered.
	11.2	Individuals with 3 or more inter-class psychotropic medications for psychiatric reasons	Number of individuals in the reporting month who reached threshold one or more times. Polypharmacy includes those cases that have an approved drug review or the medication is being tapered.
12		Restraints	The use of any physical device, material, or equipment that immobilizes or reduces the ability of an individual to move his or her arms, legs, body or head freely, or restricts normal access to his or her body. Any restraint must be done with devices approved by the hospital that are manufactured and nationally recognized for the purpose of mechanical restraint. These devices are used in accordance with the manufacturer's directions. Such a device may be designed to restrain the individual's arms only (2-point), arms and legs (4-point), or arms, legs and torso (5-point). The use of any other item (for example, sheets, handcuffs, clothing items, etc.) to restrain an individual is prohibited unless approved in advance by the hospital's Clinical Director or designee.
	12.1	Individuals continuously restrained for more than 2 hour.	Number of individuals in the reporting month who reached threshold one or more times. Count of individuals restrained one or more times for a period of >2 hour.
	12.2	Individuals with 2 or more episodes of restraints in 7 consecutive days	Number of individuals in the reporting month who reached threshold one or more times. Restraints within a rolling 7-day period where the 2 nd episode occurred during the reporting month.
	12.3	Individuals with 4 or more episodes of restraint in 30 consecutive days	Number of individuals in the reporting month who reached threshold one or more times. Restraints within a rolling 30-day period where the 4th episode occurred during the reporting month.
13		Seclusion	The involuntary confinement of an individual alone in a room or in any part of a room and where the person is prevented from leaving, regardless of the purpose of this confinement. The practice of "restrictive time-out" (RTO) is included in this definition of seclusion. "Prevented from leaving" includes not only the use of a closed or locked door, but also includes the use of physical or verbal control to prevent the individual from leaving. The word "alone" refers to being separated and apart from all other individuals and staff.
	13.1	Individuals secluded for more than 2 hour.	Number of individuals in the reporting month who reached threshold one or more times. Count of individuals secluded one or more times for a period of >2 hour.
	13.2	Individuals with 2 or more episodes of	Number of individuals in the reporting month who reached threshold one or more times.

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		seclusion in 7 consecutive days	Seclusion within a rolling 7-day period where the 2 nd episode occurred during the reporting month.
	13.3	Individuals with 4 or more episodes of seclusion in 30 consecutive days	Number of individuals in the reporting month who reached threshold one or more times. Seclusion within a rolling 30-day period where the 4th episode occurred during the reporting month.
14		Suicide, Suicide Attempts, Suicide Threats	<u>Suicide:</u> The self-inflicted death of an individual on the census of the state hospital, or within 2 weeks of being discharged or placed on conditional release. <u>Suicide Attempt:</u> Deliberate act that may or may not result in injury with the potential to result in death made by an individual with suicidal intent. This includes but is not limited to ingestion of foreign bodies or potentially toxic substances. <u>Suicide Threat:</u> Any verbal indications that includes means, intent and/or plan signaling an individual at the hospital is going to make a suicide attempt.
	14.1	Any suicide (<i>IM – A34</i>)	Number of suicides that occurred during the reporting month.
	14.2	Any suicide attempts (<i>IM – A35</i>)	Number of suicide attempts that occurred in the reporting month.
	14.3	Any suicide threats (<i>IM – A36</i>)	Number of suicide threats that occurred in the reporting month.

* In any category, an individual is counted just once, at the highest level triggered by the individual during the reporting month.

** References in the Trigger column are referring to DBHDD Policy 03-515: Incident Management

BEHAVIORAL, PSYCHIATRIC, AND MEDICAL RISK CATEGORIES

See RM Policy – Attachment A for Detailed Definitions of Some Categories

CATEGORY	CRITERIA	IDENTIFICATION OF HIGH RISK	CRITERIA FOR REMOVAL FROM THE HIGH-RISK LIST
Choking and Aspiration	<ol style="list-style-type: none"> 1) Choking and Aspiration Risk Evaluation indicates high risk for choking and aspiration 	Criterion #1	No aspiration pneumonia for 6 months, AND No choking incidents for 6 months, AND Determined to be <u>not</u> at high risk as indicated by the Choking and Aspiration Risk Evaluation AND/OR subsequent evaluations (e.g., Swallowing and Mealtime evaluation, MBS)
Bowel Obstruction	<ol style="list-style-type: none"> 1) Previous diagnosis of bowel adhesions 2) History of bowel obstruction 3) Diagnosis of constipation not relieved by routine prevention 4) Prescribed clozapine 5) Prescribed opioid analgesics 6) Prescribed other medications that slow GI motility (risperidone, 1st generation antipsychotics, anticholinergics, tricyclic antidepressants) 7) 	Criterion #1 OR #2 AND Criterion #3 OR Criterion #4, #5, OR #6 AND Criterion #1, #2, OR #3	No bowel obstruction for 6 months AND Not prescribed clozapine or opioid analgesics
Cognitive impairment associated with Anticholinergic and Benzodiazepine medications	<ol style="list-style-type: none"> 1) Mental Retardation 2) Age > 60 3) History of delirium 4) Liver dysfunction as evidenced by elevated liver enzymes 5) Dementia 6) Renal impairment 	Any one criterion AND Prescribed an Anticholinergic or Benzodiazepine medication	No longer prescribed an Anticholinergic and Benzodiazepine medication.
Type II Diabetes Mellitus	<ol style="list-style-type: none"> 1) NOT currently diagnosed with Type II Diabetes 2) Prescribed New Generation Antipsychotic (e.g., olanzapine) 3) Family history of Type II diabetes 4) BMI greater than 30 5) Physical inactivity 6) Ethnicity (Hispanic-American, Asian-American, American Indian, Pacific Islander, Alaska Native, or African American) 7) History of gestational diabetes or having a baby weighing 9 pounds or more at birth 	Criterion #1 AND Criterion #2 AND Any one other criterion	Has not developed Type II Diabetes for 6 months, OR No longer prescribed New Generation Antipsychotic. <i>If the individual develops or is diagnosed with Type II Diabetes Mellitus while on the high risk list for Type II Diabetes Mellitus, remove the individual from the high risk list for Type II Diabetes Mellitus.</i>

BEHAVIORAL, PSYCHIATRIC, AND MEDICAL RISK CATEGORIES

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CATEGORY	CRITERIA	IDENTIFICATION OF HIGH RISK	CRITERIA FOR REMOVAL FROM THE HIGH-RISK LIST
Complications of Diabetes, including hypoglycemia and hyperglycemia	<ol style="list-style-type: none"> 1) Diagnosed with Diabetes 2) Change in insulin dose within the past 2 weeks 3) Change in the dose of oral diabetes medications within the past 2 weeks 4) Non-adherence to insulin or oral diabetes medications 5) Non-adherence to prescribed diet 6) A1c ≥ 7 7) Rigorous exercise 8) Blood sugar readings in excess of 250 mg/dl twice in a two week period 9) Blood sugar of less than 60 mg/dl twice in a two week period 10) Infection or other physiologic stress 11) Certain surgeries that effect food absorption (e.g., gastric bypass, duodenal switch, bowel resection) 	<p>Criterion #1 AND One or more of criteria #2 - #11</p> <p>OR</p> <p>Criterion # 6</p>	<p>No change in dose of insulin or oral diabetes medications (if applicable) within the past 2 weeks, adherent with prescribed diet and diabetes medications, not participating in sporadic rigorous exercise, and blood sugar levels stable in the desired range for 3 months, with no current infections or other physiologic stress and no additional GI surgeries that effect food absorption. AND A1c < 7</p>
Falls (Ref. RM Policy, Attachment A, #6 for definition.)	<ol style="list-style-type: none"> 1) Fall Risk Assessment indicates high risk for falls 	<p>Criterion #1</p>	<p>Fall free for 6 months AND Determined to be not at high risk on the Fall Risk Assessment.</p>
Fractures	<ol style="list-style-type: none"> 1) Osteopenia or osteoporosis by bone mineral density or DEXA scan 2) Prior "low trauma" fracture at any time 3) Long-term (more than 3 months continuously) use of glucocorticoid therapy such as prednisone in the last year 4) 3 or more falls in the past 30 days 	<p>Any two criteria</p>	<p>Normal bone density. AND Free of falls for 6 months. AND No glucocorticoid therapy for at least 6 months</p>
Hospitalization	<ol style="list-style-type: none"> 1) Currently has an unstable medical condition and is consistently refusing care. 2) Two or more unplanned hospitalizations in the last 6 months, with or without the same diagnosis. 3) Admitted to the hospital within 7 days of an ER visit, within the last 6 months 	<p>Any one criterion</p>	<p>Adherence to medical care for 6 months. AND No unplanned hospitalizations in the last 6 months</p>
TB - Active (continued on next page)	<ol style="list-style-type: none"> 1) History of TB – not currently active or on treatment 2) Any individual with a positive TST (PPD) <u>and</u> confirmation by chest x-ray or refusal of chest x-ray, within the past 6 months. 	<p>Any one criterion</p>	<p>Has not developed active TB in a 6 month period.</p>

BEHAVIORAL, PSYCHIATRIC, AND MEDICAL RISK CATEGORIES

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CATEGORY	CRITERIA	IDENTIFICATION OF HIGH RISK	CRITERIA FOR REMOVAL FROM THE HIGH-RISK LIST
	3) Immune system compromised by a permanent congenital or acquired deficiency (HIV) or by a transient situation (chemotherapy, radiation therapy, dialysis) that has been present within the past 6 months 4) Any individual with an exposure to active TB within the past 6 months		
MRSA	1) History of MRSA with persistent carrier status. 2) Any break in skin integrity within the last 3 months, regardless of cause. 3) Currently has a pressure ulcer (decubitus). 4) Currently refusing treatment of a non-healing wound.	Any one criterion	Resolution of all open wounds and no diagnosis of MRSA. If the qualifying criterion was #1, there must be a negative nasal swab culture to mitigate high risk.
Blood or Body Fluid Diseases	1) Incident of unprotected sex within the last 6 months 2) Incident of illicit IV drug use within the last 6 months 3) Incident of true exposure (contact of blood or body fluids from another person with non-intact skin or mucous membranes of the individual) within the last 6 months.	Any one criterion	No diagnosis of blood or body fluid disease within 6 months following the incident.
Metabolic Syndrome	1. NOT already diagnosed with metabolic syndrome. 2. Waist circumference 35 inches or more for females or 40 inches or more for males 3. Triglycerides 150 mg/dl or higher 4. HDL cholesterol less than 40 mg/dl for males or 50 mg/dl for females 5. Systolic blood pressure 130 mm Hg or higher, diastolic blood pressure 85 mm Hg or higher 6. Fasting glucose 100 mg/dl or higher	#1 AND any two other criteria (Any 3 of criteria #2 - #6 make the diagnosis of metabolic syndrome)	Less than two of criteria #2 - #6. If the individual develops or is diagnosed with metabolic syndrome while on the high risk list for metabolic syndrome, remove the individual from the high risk list for metabolic syndrome.
Osteoporosis <i>(continued on next page)</i>	1) NOT currently diagnosed with osteoporosis. 2) Age > 65 3) Family history of a fracture associated with osteoporosis or individual history of low trauma fracture after age 40 4) Osteopenia on current x-ray or bone density study and not on treatment for at least 6 months (Calcium+Vitamin D, Bisphosphonates, Calcitonin, etc.) 5) Malabsorption of nutrients – Crohn’s disease, celiac	#1 AND any two other criteria	#1 AND no more than one of criteria #2 - #9. OR Diagnosis and treatment/management of Osteopenia for at least 6 months AND No more than one other criterion. If the individual develops or is diagnosed with

BEHAVIORAL, PSYCHIATRIC, AND MEDICAL RISK CATEGORIES

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CATEGORY	CRITERIA	IDENTIFICATION OF HIGH RISK	CRITERIA FOR REMOVAL FROM THE HIGH-RISK LIST
	disease, bowel resection, gastric bypass, etc. 6) Current hormonal imbalance such as hyperparathyroidism, hypogonadism, menopause before age 45 7) Long term (more than three months continuously) use of glucocorticoid therapy such as prednisone 8) Low body weight 9) Sedentary, wheel-chair bound, or bed-ridden		osteoporosis while on the high risk list for osteoporosis, remove the individual from the high risk list for osteoporosis.
Seizures	1) Current severe metabolic abnormalities such as hypo- or hypernatremia, Acute Metabolic Acidosis or Alkalosis, Acute Uremia/renal failure, etc. 2) Current acute behavior, such as polydipsia, that could lead to these severe metabolic abnormalities 3) Acute direct cortical insult such as newly found tumor, depressed skull fracture, blood clot, or stroke. 4) Non-adherence to antiepileptic drugs (miss 3 doses in a row or any doses of a medication with a narrow therapeutic window or with a low therapeutic serum level the last time it was measured). 5) Sudden withdrawal of Benzodiazepines or antiepileptic drugs that were used for non-epileptic conditions. 6) CNS infection (abscess, meningitis, encephalitis).	Any one criterion	Correction of the metabolic abnormality. AND/OR No longer displaying the acute behavior for at least one month. AND/OR 3 months with no seizure following direct cortical insult. AND/OR Adherent to antiepileptic medications for at least one month. AND/OR No seizure for 10 days following withdrawal from benzodiazepines or antiepileptic medications used for non-epileptic conditions. AND/OR Resolution of infection with no seizure for 30 days following resolution.
Refractory Seizures	1) Has a diagnosis of Epilepsy or Seizure Disorder – active. 2) Chronic non-adherence to antiepileptic medication regimen (misses at least 4 doses per month over more than 1 month) 3) Un-planned sub-therapeutic levels of antiepileptic medications. 4) Addition of seizure threshold lowering medications (especially clozapine, bupropion, diphenhydramine 50mg or greater, or chlorpromazine).	#1 AND Any one other criterion	Adherence to antiepileptic medication regimen. AND Therapeutic (or desired) level of antiepileptic medications. AND/OR No seizures on a stable dose of seizure threshold lowering medication for at least 2 weeks.
Status Epilepticus <i>(continued on next page)</i>	1) Has a diagnosis of Epilepsy or Seizure Disorder – active. 2) Currently undergoing withdrawal from antiepileptic drugs.	#1 AND Any one other criterion	30 days with no seizure after antiepileptic drug withdrawal. OR 30 days with no seizure after antiepileptic

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CATEGORY	CRITERIA	IDENTIFICATION OF HIGH RISK	CRITERIA FOR REMOVAL FROM THE HIGH-RISK LIST
	3) Currently undergoing a change from one antiepileptic drug to another.		medication switch.
Electrolyte Imbalance	<ol style="list-style-type: none"> 1) Polydipsia 2) Greatly reduced fluid intake 3) Sudden appearance of or increase in peripheral edema, abdominal distention, or periorbital edema 4) No or little urine output over a 24 hour period 5) Dry mucous membranes and poor skin turgor, different from baseline 6) Protracted vomiting 7) Started on Lasix therapy within the past 2 weeks. 	Any one criterion	No evidence of electrolyte imbalance as measured by Sodium and Potassium blood levels for 3 months.
Impaired Skin Integrity	<ol style="list-style-type: none"> 1) Medical conditions that can make skin more fragile, such as end stage renal disease, thyroid disease, diabetes mellitus, terminal cancer, liver disease, malnutrition, and/or heart disease 2) On two or more of the following: Steroid therapy, Radiation therapy, Chemotherapy, Dialysis 3) Impaired blood flow - diffuse or local – such as atherosclerosis or peripheral vascular disease, or a history of ischemic digits 4) Current Decubitus (Pressure Ulcer) Risk Assessment indicates high risk for decubitus (pressure) ulcer 5) Development of a wound associated with fragile skin or pressure (decubitus) ulcer in the past 6 months 	Any one criterion	<p>Six months without development of a wound associated with fragile skin or pressure ulcer (decubitus)</p> <p>AND</p> <p>Determined to be not at high risk on the Decubitus (Pressure Ulcer) Risk Assessment.</p>
Aggression <i>(continued on next page)</i>	<ol style="list-style-type: none"> 1) High risk for aggression at admission per the violence risk assessment section of the Suicide, Violence, Victimization Risk Assessment (DBHDD Policy 03-504). 2) Physical aggression resulting in first aid or higher within the last 3 months 3) Credible threat, including homicidal ideation and threat of bodily harm, within the past 30 days 4) Any confirmed sexual assault, within the past year 5) Any new diagnosis of or admitted with a diagnosis of Intermittent Explosive Disorder, Antisocial 	<p>One of criterion #1 - #4</p> <p><i>The presence of criterion #5 may place someone "at risk" (see Attachment F) for aggression.</i></p>	<ol style="list-style-type: none"> 1) Absence of all criteria #1 - #4 for 3 months after admission. <p>AND/OR</p> <ol style="list-style-type: none"> 2) No incident of physical aggression resulting in first aid or higher within the past 6 months. <p>AND/OR</p> <ol style="list-style-type: none"> 3) No incident of reported credible threat, including homicidal ideation and threat of bodily harm, within the past 3 months. <p>AND/OR</p> <ol style="list-style-type: none"> 4) Absence of any confirmed sexual assault,

BEHAVIORAL, PSYCHIATRIC, AND MEDICAL RISK CATEGORIES

See RM Policy – Attachment A for Detailed Definitions of Some Categories

CATEGORY	CRITERIA	IDENTIFICATION OF HIGH RISK	CRITERIA FOR REMOVAL FROM THE HIGH-RISK LIST
	Personality Disorder, Dementia, or Bipolar of any type		sexual contact involving individuals using force or violence, or the threat of force or violence, including touching, rape or sodomy. Also, includes sexual contact, including consensual, between a person 18 or older and a person under age 15 or sexual contact between a person 21 or older and a person under age 17, during the past year. AND/OR 5) Absence of criteria #2 and #3 within the past 3 months for those with a new diagnosis or admitted with a diagnosis of Intermittent Explosive Disorder, Antisocial Personality Disorder, Dementia, or Bipolar of any type.
Aggressive Act to Self (Self-Injury)	<ol style="list-style-type: none"> 1) Physical aggression to self resulting in first aid or higher within the last 6 months. 2) Episode of pica (<i>ingestion of non-nutritive items/substances</i>) within the last 12 months 3) Any new diagnosis of or admitted with a Diagnosis of Borderline Personality Disorder 	<p>Criterion #1 AND/OR #2</p> <p><i>The presence of criterion #3 may place someone "at risk" (see Attachment F) for aggressive acts to self.</i></p>	<ol style="list-style-type: none"> 1) No incident of physical aggression to self within past 6 months. <p>AND/OR</p> <ol style="list-style-type: none"> 2) No incident of pica within past 12 months. <p>AND/OR</p> <ol style="list-style-type: none"> 3) Absence of criteria #1 and #2 within the past 6 months for those with a new diagnosis or admitted with a diagnosis of Borderline Personality Disorder.
Elopement	<ol style="list-style-type: none"> 1) Any elopement, or attempt, from any hospital within the last 6 months. 	Criterion #1	No elopement attempts for 6 months.
Illicit Substance Use	<ol style="list-style-type: none"> 1) Substance Abuse diagnosis 2) Non-adherence to random drug screens 3) Non-adherence to any substance abuse treatment 4) New Diagnosis of Depression 5) Diagnosis of Antisocial Personality Disorder 6) Prescribed a benzodiazepine, narcotic, or stimulant medication 	<p>Criterion #1</p> <p>AND</p> <p>Any one other criterion</p>	<p>No positive drug screens for 6 months</p> <p>AND</p> <p>Adherent to random drug screens</p> <p>AND</p> <p>Adherent to substance abuse treatment</p> <p>AND</p> <p>Discontinuation of benzodiazepine, narcotic, or stimulant medication</p>
Property Destruction	<ol style="list-style-type: none"> 1) Destruction or defacement of property, that does not belong to the individual, within the past 3 months 	Criterion #1	No destruction or defacement of property that does not belong to the individual, within the past 3 months.

BEHAVIORAL, PSYCHIATRIC, AND MEDICAL RISK CATEGORIES

See RM Policy – Attachment A for Detailed Definitions of Some Categories

CATEGORY	CRITERIA	IDENTIFICATION OF HIGH RISK	CRITERIA FOR REMOVAL FROM THE HIGH-RISK LIST
Refusal of Psychotropic Medications	1) Refusal of care or treatment that exacerbates a medical condition, in the last 30 days. Example: delusions that care providers are giving poison, and therefore does not take medication for a medical condition	Criterion #1	Accepting care or treatment for the medical condition.
Suicide	1) High Risk for suicide per the suicide risk assessment section of the Suicide, Violence, Victimization Risk Assessment (DBHDD Policy 03-504). 2) Current suicidal ideation or intent.	Criterion #1 AND/OR Criterion #2	Assessment by the Medical Practitioner indicates that the risk of suicide is none to low.
Victimization	1) High risk of physical, sexual, or emotional victimization per the victimization section of the Suicide, Violence, Victimization Risk Assessment (DBHDD Policy 03-504). 2) Repeat (2 or more times in the last 6 months) victim of any physical, sexual, or emotional abuse or of exploitation.	Criterion #1 AND/OR Criterion #2	No incident of victimization (i.e., physical, sexual, or emotional abuse or exploitation) within the last 6 months.

Instructions:

- If the individual is already diagnosed with the medical condition (e.g., diabetes, metabolic syndrome, osteoporosis), then the individual is not at risk for developing that condition.
- If a criterion for removal from the high risk list clearly applies to only one of the criterion for placement on the list, then that removal criterion does not need to be met if the person did not meet the corresponding criterion for placement on the list.

DBHDD Risk Management Policy
ATTACHMENT C:
RECOVERY PLANNING TEAM (RPT) OR INTERDISCIPLINARY TEAM (IDT)
ROLE AND RESPONSIBILITIES IN THE RISK MANAGEMENT PROCESS

Each **RPT/IDT** is responsible for the following tasks:

1. Development and maintenance of an updated clinical risk profile for each of the individuals in their care (as described in Attachment F).
2. Review, no later than the next working day, of all individuals who:
 - a) are involved in any incident,
 - b) are placed on the high-risk list for any single or multiple identified high risk factors for the first time in a six-month period (*i.e. previously none identified, then develops or team identifies a high risk behavioral, psychiatric, or medical condition*).
3. Review, at least weekly, of all individuals who meet thresholds for a trigger behavior.
4. Determination of the nature and context of each incident, the predisposing, precipitating, and perpetuating factors (3 P's), and the appropriate behavioral, psychiatric, or medical interventions. This information is documented in the progress notes of the medical record.
5. Development and implementation of appropriate interventions for individuals who meet the threshold for a trigger behavior. These interventions are directed at reducing the frequency of the trigger behavior by appropriately addressing the 3 P's and thereby addressing the function of the behavior. This information is documented in the progress notes of the medical record.
6. Determination of the 3 P's for each identified high-risk condition and development and implementation of interventions directed at the reduction of the risk status of individuals on the High-Risk List for behavioral, psychiatric, and medical conditions. This information is documented in the progress notes of the medical record.
7. Revision of the Individualized Recovery Plan (IRP) or Individualized Support Plan (ISP), and/or development or revision of the Behavior Support Plan (BSP), and/or Positive Behavior Support Plan (PBSP), to include the appropriate interventions designed by the above process and based on the analysis of the incident, trigger threshold met, and/or identified high risk factor.
8. Monitoring for the effectiveness of these interventions, with reassessment and revision if indicated.
9. Consultation request with (referral to) the Hospital Review Committee (HRC) when an individual:
 - a) Continues to meet threshold for triggers 60 days after the RPT/IDT has implemented interventions to address those factors (60 days from admission or 60 days from the emergence of a new trigger behavior),
 - b) Is placed on the High-Risk List for a **second** time in a six-month period (*currently has one or more high risk behavioral, psychiatric, or medical conditions and then another high risk factor is identified within 6 months of the identification of the previous high risk factors*),
 - c) Remains on the high-risk list for any single high risk factor for more than six consecutive months; or
 - d) At any time that the RPT/IDT needs assistance with an individual.
10. Review and incorporation of the recommendations from the HRC into the individual's IRP/ISP/BSP/PBSP.
11. Weekly provision to the HRC of a list of all individuals who meet criteria for HRC review.

DBHDD Risk Management Policy
ATTACHMENT D:
HOSPITAL REVIEW COMMITTEE (HRC)
ROLE AND RESPONSIBILITIES IN THE RISK MANAGEMENT PROCESS

1. Membership is comprised of:

- a) The Hospital Clinical Director, Chair;
- b) The Hospital Program Director;
- c) The Hospital (Clinical) Risk Manager;
- d) The Service/Program Medical Director(s), as applicable;
- e) The Service/Program Director(s) (administrative), as applicable;
- f) At least one highly experienced and knowledgeable clinician in the following areas:
 - Primary Care Medicine
 - Psychiatry
 - Psychology
 - Social Work
 - Rehabilitation Therapies, and
 - Nursing; and
- g) Others as designated by the Hospital Clinical Director.

2. Meetings are held weekly.

3. Function

- a) Monitor the activities of the RPTs/IDTs with relation to the Risk Management function.
- b) When requested, provide consultation with the RPT/IDT during the first 60 days of admission and/or identification of newly identified behavioral, psychiatric, and medical risk conditions and newly exhibited trigger behaviors.
- c) Perform a comprehensive and holistic review of all individuals who are referred by the RPT/IDT's. These include, but are not limited to, individuals who:
 - Continue to meet threshold for triggers more than 60 days after the RPT/IDT has implemented interventions to address those factors;
 - Are placed on the High-Risk List for a **second** time in a six-month period (*currently has one or more high risk behavioral, psychiatric, or medical conditions and then another high risk factor is identified within 6 months of the identification of the previous high risk factors*); or
 - Remains on the High-Risk List for any single high risk factor for more than six consecutive months.

This holistic review consists of a thorough review of the individual's medical records, including but not limited to clinical background, ongoing assessments, consultations and outcomes, and previous treatment outcomes. This review may also include direct observation of and/or interview with the individual in order to develop recommendations.

- d) Based on this review, provide recommendations, with rationale, to the RPTs/IDTs.
- e) Provide recommendations, with rationale, for specific internal and/or external consultation for individuals who are not adequately responsive to recommended interventions.
- f) Maintain and forward meeting minutes to the Quality Council following each meeting.

DBHDD Risk Management Policy
ATTACHMENT E:
QUALITY COUNCIL (QC)
ROLE AND RESPONSIBILITIES IN THE RISK MANAGEMENT PROCESS

1. **Membership** is comprised of:
 - a) The Regional Hospital Administrator, Chair;
 - b) The Hospital Clinical Director;
 - c) The Service/Program Medical Director(s), as applicable;
 - d) The Service/Program Director(s) (administrative), as applicable;
 - e) The Clinical Discipline Chiefs;
 - f) All Monitors/Mentors;
 - g) The Hospital (Clinical) Risk Manager;
 - h) The Hospital Quality Manager;
 - i) The Hospital Performance Improvement Director/Coordinator; and
 - j) Others as designated by the RHA or Hospital Clinical Director;

2. **Meetings** are held monthly.

3. **Function**
 - a) Monitor the activities of the HRC.
 - b) Review and analyze hospital-wide risk management data, sorted by individual, events, and thresholds, and aggregated.
 - c) Identify trends and patterns by individual and hospital-wide.
 - d) Based on the trends and patterns that are identified, develop and implement interventions which may include:
 - Investigation of identified trends and patterns,
 - Referral to various committees, teams, and staff for corrective action plans, and
 - Implementation of systemic changes;
 - e) Ensure the implementation and effectiveness of the interventions taken, as indicated by outcome data.
 - f) Review and revise Hospital policies, procedures, and practices as indicated by analyses of hospital data and current evidence-based practice.
 - g) Maintain and forward meeting minutes to DBHDD following each meeting.

Clinical High Risk Profile

Name: _____ Avatar #: _____ Living Unit: _____ Admit Date: _____ Date Risk Profile Initiated: _____

Date Risk Identified	Risk (e.g., Choking, Fall)	High Risk	At Risk	As Evidenced by	Initials	Date Removed from High Risk or At Risk	Rationale for Removal	Initials
		<input type="checkbox"/>	<input type="checkbox"/>					
		<input type="checkbox"/>	<input type="checkbox"/>					
		<input type="checkbox"/>	<input type="checkbox"/>					
		<input type="checkbox"/>	<input type="checkbox"/>					
		<input type="checkbox"/>	<input type="checkbox"/>					
		<input type="checkbox"/>	<input type="checkbox"/>					
		<input type="checkbox"/>	<input type="checkbox"/>					

No high risk/at risk factors identified for this individual. Date: _____ Initials: _____

Continued on back

MEDICAL ALERTS

- TST (PPD) positive – Date: _____ Allergies – List: _____
- Infection Control Issues – List: _____
- Other – Specify: _____

Initials	Signature	Initials	Signature

IDENTIFICATION

Date Risk Identified	Risk (e.g., Choking, Fall)	High Risk	At Risk	As Evidenced by	Initials	Date Removed from High Risk or At Risk	Rationale for Removal	Initials
		<input type="checkbox"/>	<input type="checkbox"/>					
		<input type="checkbox"/>	<input type="checkbox"/>					
		<input type="checkbox"/>	<input type="checkbox"/>					
		<input type="checkbox"/>	<input type="checkbox"/>					
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		<input type="checkbox"/>	<input type="checkbox"/>					
		<input type="checkbox"/>	<input type="checkbox"/>					
		<input type="checkbox"/>	<input type="checkbox"/>					
		<input type="checkbox"/>	<input type="checkbox"/>					

Initials	Signature	Initials	Signature	Initials	Signature

INSTRUCTIONS FOR COMPLETING THE CLINICAL HIGH RISK PROFILE

GENERAL

1. The Clinical High Risk Profile provides a list of all of the “High Risk” and “At Risk” factors for each individual. This is a fluid document that is reviewed and updated at any time.
2. The High Risk Behavioral, Psychiatric, and Medical Risk factors that are identified for each individual are addressed in the Individualized Recovery Plan (IRP) or Individualized Service Plan (ISP) for that individual (refer to the IRP Manual for details).
3. The Profile for each individual is started by the psychiatrist at the time of the Psychiatric Evaluation, or by the attending physician at the time of initial evaluation (ICF/MR or Adult Special Care).
4. Anyone on the Recovery Planning Team (RPT) or Interdisciplinary Team (IDT) can update the Profile, but the primary responsibility for maintaining an updated profile lies with the RPT Facilitator or IDT Team Leader and with the Attending Physician.
5. Once all of the risk factors listed in Attachment B of the Risk Management Policy 03-601 have been reviewed, the Clinical High Risk Profile is updated as appropriate and signed by the designated RPT member or by the RPT member making the updates.
6. In the event that an individual is already diagnosed with the medical high risk condition for which the individual is being assessed, the person is **no longer** at risk of developing that condition, and the condition must appear on the diagnosis list and NOT on the Clinical High Risk Profile. For example, if an individual already has Type II Diabetes Mellitus, then the individual is no longer at risk of developing Type II Diabetes Mellitus.

FREQUENCY OF REVIEWS/UPDATES OF CLINICAL HIGH RISK PROFILE

1. The Profile is updated by the RPT or IDT as new information becomes available during the assessment process.
2. The Clinical High Risk Profile form must be updated when any single risk factor changes.
3. At a **minimum**, the risk factors for an individual must be reviewed/updated by the RPT/IDT in the following circumstances:
 - a. An individual returns from acute care hospitalization;
 - b. Any major neurologic event or change in neurologic status of an individual;
 - c. Any time an individual meets threshold for any of the trigger behaviors (reference Attachment A of the Risk Management Policy 03-601);
 - d. Any major change in the status of the medical conditions with which an individual is already diagnosed;
 - e. Any newly diagnosed medical condition in an individual;
 - f. Any time new clinically significant information regarding an individual becomes available;
 - g. At or immediately before every Recovery or Treatment planning meeting, in order to ensure that all “High Risks” are addressed in the IRP/ISP;
 - h. Upon transfer between units (by the receiving unit); and
 - i. Prior to discharge, in order to provide updated information to the new caregivers.
4. Once all of the risk factors listed in Attachment B of the Risk Management Policy 03-601 have been reviewed, the Clinical High Risk Profile is updated as appropriate and signed by the designated RPT member or by the RPT member making the updates.

INSTRUCTIONS FOR COMPLETING THE CLINICAL HIGH RISK PROFILE

1. At the top of the form, enter:
 - a. Individual’s Name
 - b. Avatar #
 - c. Living Unit
 - d. Admit date
 - e. Date Clinical High Risk Profile Initiated
2. Use the criteria in Attachment B of RM Policy 03-601 to determine if the individual is at “High Risk” for any of the 26 categories listed in Attachment B.
3. If the criteria for “High Risk” are met for any of the Behavioral, Psychiatric, and Medical Risk factors, record the following on the Clinical High Risk Profile, for **each** high risk identified:

Column 1- ‘Date Risk Identified’	Record the date that the High Risk status was identified by the RPT/IDT.
Column 2 – ‘Risk’	Record the risk category (e.g. Choking and Aspiration, Falls).
Column 3 – ‘High Risk’	Check ‘High Risk’.
Column 5 – ‘As Evidenced By’	Briefly describe the reason the individual has been identified to be at High Risk using the criteria defined in Attachment B of the Risk Management Policy. DO NOT just list the numbers; enter words that indicate which criterion was met.
Column 6 – ‘Initials’	The staff member completing the columns 1 – 5 initials the entry. In addition, the first time that

	the staff member enters information onto the form, he or she must sign and initial in the signature box at the bottom of the form – once. Once any staff member has signed and initialed in this box, he or she need not repeat that on the same form.
Column 7 – ‘Date Removed from High Risk’	Record the date that the individual met criteria for removal of that particular high risk factor according to the criteria for removal defined in Attachment B of the Risk Management Policy.
Column 8 – ‘Rationale for Removal’	Briefly describe the reason that the particular high risk factor has been removed from the Clinical High Risk Profile for this individual, using the criteria for removal defined in Attachment B of the Risk Management Policy. For example, enter “diagnosed with Type 2 DM” as the reason for removing the high risk of developing Type 2 DM from that individual’s profile.
Column 9 – “Initials”	The staff member completing the columns 7 and 8 initials the entry. In addition, the first time that the staff member enters information onto the form, he or she must sign and initial in the signature box at the bottom of the form – once. Once any staff member has signed and initialed in this box, he or she need not repeat that on the same form.

AT RISK

If an individual **does not** meet high risk criteria for a particular risk factor but the RPT/IDT thinks that clinically significant risk still exists, the ‘At Risk’ designation can be used. Use clinical judgment, the individual’s history, etc., to determine any “at risk” status. For example, the person met one or more of the criteria for “High Risk”, but not the criteria needed to be considered “High Risk”. This would indicate that the RPT/IDT needs to pay attention to this risk factor in order to help the individual avoid progressing to the “High Risk” level of concern. “At Risk” can also include clinically significant issues that are not found in Attachment B of the RM policy. If ‘At Risk’ is met complete the following:

Column 1- ‘Date Risk Identified’	Record the date that the “At Risk” status was identified by the RPT/IDT.
Column 2 – ‘Risk’	Record the risk category (e.g. Choking and Aspiration, Falls)
Column 4 – ‘At Risk’	Check ‘At Risk’
Column 5 – ‘As Evidenced By’	For “At Risk”, enter into the “As Evidenced By” column a brief description of the reason that the individual has been determined to be “At Risk”, addressing the criteria defined in Attachment B of the Risk Management Policy at a minimum, then addressing history, etc. If based on historical information, enter “by history”.
Column 6 – “Initials”	The staff member completing the columns 1 – 5 initials the entry. In addition, the first time that the staff member enters information onto the form, he or she must sign and initial in the signature box at the bottom of the form – once. Once any staff member has signed and initialed in this box, he or she need not repeat that on the same form.
Column 7 – ‘Date Removed from At Risk’	Record date the RPT/IDT determined that the individual was no longer ‘At Risk’
Column 8 – ‘Rationale for Removal’	Briefly describe the reason the individual has been removed from ‘At Risk’, using the criteria from Attachment B at a minimum, then addressing the other factors.
Column 9 – “Initials”	The staff member completing the columns 7 and 8 initials the entry. In addition, the first time that the staff member enters information onto the form, he or she must sign and initial in the signature box at the bottom of the form – once. Once any staff member has signed and initialed in this box, he or she need not repeat that on the same form.

NO HIGH RISK/AT RISK FACTORS IDENTIFIED

If no “High Risk” or “At Risk” factors are identified for the individual, check the box, located at the bottom of the table, indicating that no high risk/at risk factors were identified for the individual and date and initial this entry. Again, if this is the first time that the staff member enters information onto the form, he or she must sign and initial in the signature box at the bottom of the form – once. Once any staff member has signed and initialed in this box, he or she need not repeat that on the same form.

CONTINUED ON BACK

If the front of the form is full, check the “continued on back” box and document on the back of the form in the same manner that the front was completed following the instructions above.

MEDICAL ALERTS

Check off or fill in as appropriate, listing allergies and delineating any “other” medical alerts that any staff person providing care to the individual needs to know. Do not repeat items that are included in the list of “High Risk” and “At Risk” items.