RISK SCREENING PROCEDURE – GUIDE FOR CASE MANAGERS

Risk is the **likelihood** of an incident set against the **severity** of the consequence if it did happen.

The 'Risk Screening Procedure' can be used to identify applicable risk factors for the client. These areas are not exhaustive but merely act as a prompt to ensure that more detailed risk assessments are carried out by the clinical service providers involved with the client.

Consider the areas on the list. Decide on a risk rating for each area.

1 - Immediate, current concern
2 - Significant history or current concern
3 - Some history, not current concern.

A risk rating of **'1'** or **'2'** needs detailed risk assessment, and action plan. Concrete hazards applicable to the client need to be identified at the end of each section.

The following matrix is a useful frame of reference for prioritising areas of risk to be dealt with.

Severity

Likelihood		Minor	Moderate	Major
	Low	3	3	2
	Medium	3	2	1
	High	2	1	1

RISK SCREENING PROCEDURE

Risk rating:

1 - Immediate, current concern
2 - Significant history or current concern
3 - Some history, not current concern.

RISK OF EXPLOITATION OR ABUSE:- FINANCIAL	**1**	**2**	**3**
High income			
Claim for damages settled/pending			
Medical affirmation of Incapacity			
Does not have official Administrator/Receiver			
Directly employed carers/direct financially dependent carers			
Has financially dependent family members			
Does not have independent advocate/adviser			
Previous indication of predation/exploitation.			
Is socially disinhibited			
Is impulsive			
Has poor judgement			
Hazards identified / comments:			

RISK OF EXPLOITATION OR ABUSE:- SEXUAL / PHYSICAL / EMOTIONAL	**1**	**2**	**3**
Past history/indication			
Communication problems			
Has multiple carers			

Social disinhibition noted			
Sexual disinhibition noted Poor judgement			
Depends on others to carry out intimate care tasks			
Does not have independent advocate			
Does not have care regime monitored by independent body/organisation			
Does not have care recruited by independent/reputable organisation			
Does not have contact with anyone other than care providers			
Hazards identified / comments:			

RISK OF HARM TO SELF	1	2	3
Past history/indication			
Suicide Attempts/Overdoses/deliberate self harm			
Expressing suicidal ideas – Considered/planned intent			
Expressing high levels of distress			
Family history of suicide			
Relatives'/carers' concerns			
Diagnosis of mood disorder/depression			
Low mood			
Social Isolation			
Financial Stress			
GP contact re low mood/depression (? Anti – depressant medication)			
Problems with Prescribed Medication (non-compliance, misuse, infrequent medical review)			
OTC medication misuse – (eg analgesia, laxatives)			
Illegal Drug use/dependence			
Alcohol misuse/dependence Recent life events (eg divorce, job loss, home/placement breakdown, loss of significant other)			
Eating disorder			
Hazards identified / comments:			

RISK OF NEGLECT / HEALTH AND SAFETY ISSUES	1	2	3
Previous history of neglect			
Failing to eat or drink properly			
Immobility – (carry out pressure area assessment)			
Falls			
Poor self - care			
Communication difficulties			
Lack of insight			
Care provision by others breaking down / unsatisfactory			
Refusing to accept care			
Living in inadequate accommodation / environment			
Social Isolation			
Significant Physical Illness/medical condition (specify)			
Diabetes			
Epilepsy			
Risk of choking			
Serious Allergy			
Hazards identified / comments:			

RISK TO OTHERS	**1**	**2**	**3**
Previous incidents of aggression/violence			
Admissions to secure environment			
Misuse of drugs/alcohol			
Expression of intent to harm others			
Previous dangerous impulsive acts			
Indicated psychiatric diagnosis (paranoid delusions, violent command hallucinations)			
Sexually inappropriate behaviour			
Socially inappropriate behaviour			
Abuse/exploitation/harassment of others			
Risks to child(ren)			
Damage to property			
Hazards identified / comments:			