Risk Screening in Developmental Disabilities

Health and Safety Screening Checklist

Name: **Date:**
Identifier: **Case Manager/Service Coordinator:**

Name of Individuals Helping to Complete the Health and Safety Screening:

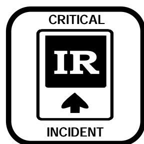
This checklist may be used when there is no established form or protocol for screening risk that is required by the service/support organization or public regulatory agency. If there is a required form it should be used. If not, this checklist can help identify important risk areas. It should be reviewed prior to the development of a support plan, *e.g.,* annually or more often if major changes take place for an individual. Any issue or concern that poses an immediate risk should be addressed without delay.

If any major risks are identified through the screening process it is recommended that the support plan include methods to minimize the risk, consistent with the individual's lifestyle goals and preferences – see **My Health and Safety** checklist for reviewing associated lifestyle preferences. Methods for measuring risks and corresponding incidents and for evaluating the effectiveness of the planned supports in achieving goals should be incorporated into the plan where feasible and as required by policy/guideline.

CRITICAL/SERIOUS INCIDENTS

Have there been any of the following incidents recorded or reported in the past 12 months?

Please check all that apply:



☐ Severe Injury needing medical attention	☐ Police Arrest
☐ Vehicle Accident with severe injury	☐ Abuse or Neglect Report within past year
☐ Missing Person incident needing to be reported	☐ Emergency Medical Treatment in a Hospital
☐ Fire requiring emergency response and/or involving severe injury	☐ Victim of Larceny or Theft
☐ Victim of Assault or Aggression	☐ Incident of Choking or Aspiration that required medical attention
☐ Victim of Rape or Other form of Sexual Assault	☐ Other (list):

Has an assessment or review been done to evaluate area(s) identified as presenting special risk?

☐ **Yes.** Specify assessment(s) or review(s) done:

☐ **No.** If no, will an assessment or review be done to evaluate this risk area? What type of assessment or review is needed and who will conduct it or make needed referrals?

Comments:

SERIOUS/CHRONIC/OTHER MEDICAL CONDITIONS

Are there any new or existing and chronic medical conditions that require careful monitoring and/or adaptations or home-based care activities - that if not properly implemented could result in significant harm or a medical emergency?

Please check all that apply:

Neurological	**Gastrointestinal/Kidney/Liver**
☐ CVA or TIA (Stroke)	☐ GERD
☐ Neurological Disorder-Movement (e.g., Parkinson's, Muscular Dystrophy, Myasthenia Gravis, Multiple Sclerosis, Cerebral Palsy, Guillian Barre)	☐ Ulcers
☐ Neurological Disorder- Sensation (e.g., Peripheral Neuropathies, Multiple Sclerosis)	☐ Crohn's, Irritable Bowel Syndrome (IBS), Celiac
☐ Dementia (Alzheimer's Disease, Organic Brain Syndrome)	☐ Pancreatitis
☐ Seizure Disorder (new onset or one or more seizures in past 3 months)	☐ Kidney Disease (requiring dialysis)
☐ Problems Swallowing or Choking (Dysphagia)	☐ Chronic Constipation
☐ Paraplegia/Quadriplegia	☐ Liver Failure
☐ Other Neurological:	☐ Other GI/Renal/Hepatic:
Respiratory	**Skin/Bone/Joint**
☐ Asthma	☐ Arthritis
☐ Chronic Obstructive Pulmonary Disease (COPD)	☐ Osteoporosis
☐ Emphysema/Chronic Bronchitis	☐ Active Pressure Ulcers
☐ Pulmonary Hypertension	☐ Risk of Skin Impairment (e.g., picking, cracked skin, sunburn, use of prosthesis)
☐ Sleep Apnea	☐ Other Skin/Bone/Joint:
☐ Other Respiratory:	**Cardiovascular**
Endocrine/Cancer/Blood Disorder	☐ History of Myocardial Infarction (MI) or Heart Attack
☐ Cancer - specify type and stage:	☐ Hypertension
☐ Hypothyroidism	☐ CHF (Congestive Heart Failure)
☐ Diabetes Mellitus or Glucose Intolerance	☐ Peripheral Vascular Disease or Venus Insufficiency
☐ Other Endocrine:	☐ CAD (Coronary Arterial Disease, Angina
Other Special Medical Concern	☐ Other Cardiovascular:
☐ Dehydration Risk	**Health Maintenance**
☐ Infectious Disease	☐ Problems with medical appointments (e.g., getting to office)
☐ Autoimmune Disorder (Lupus)	☐ Difficulties with routine health care (e.g., physical exams)
☐ Eating Disorder	☐ Specialized Post-hospitalization Plan
☐ Significant Obesity	☐ Specialized medical care needs (specify:)
☐ Significant Dental Need	☐ Other Health Maintenance:
☐ Other (list):	

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Comments:

MEDICATIONS

Does the individual use a medication that requires careful monitoring for side effects or has a high potential for addiction? Have there been frequent changes in medications?

Please check all that apply:

☐ Long-term use of Psychotropic Drug (e.g. Haldol, Thorazine, Ambien, Ativan, Klonopin, Valium, Lithium)	
☐ Heart Medications or Blood Thinners (e.g. Lasix, Digoxin, Coumadin)	
☐ Addictive Medication (e.g. Codeine, Percocet, Vicodin, Chloral Hydrate)	
☐ Multiple Anti Seizure Medication (e.g. Depokate, Dilantin, Phenobarbital, Valproic Acid)	
☐ Complex or Variable medication administration schedules	☐ Using multiple over the counter (OTC) drugs
☐ Frequent Changes in Medication	☐ Medication allergy (specify:)
☐ Injection Medications (e.g., insulin, lovenox)	☐ Latex Allergy (Note: frequent in Spina Bifida)
☐ Other Medication Risk:	☐ Other Medication Risk:

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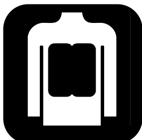
Comments:

SPECIAL MEDICAL DEVICES

Are there any implanted or other special medical devices that may require care or attention?

Please check all that apply:



☐ Feeding tube (J or G tube)	☐ Seizure management device
☐ Pacemaker	☐ Ostomy pouch (illeostomy, colostomy)
☐ Insulin pump	☐ Prostesis (artificial limb)/
☐ assistive device (orthotic shoes, knee brace, back brace)	☐ PICC line (Peripherally Inserted Central Catheter)
☐ Other (list):	☐ Other (list):

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Comments:

MOBILITY/TRANSFER

Is there a significant impairment in mobility that requires supervision, equipment and/or interaction that if not present places the person at high risk of injury or harm?

Please check all that apply:

☐ Falls down - *see special risk screening for Falls*	☐ Special Transfer Procedure
☐ Use of Bedrails	☐ Other (list):
☐ Special Bathing Procedure Used	☐ Other (list):
☐ Special Positioning Procedure	☐ Other (list):

Has an assessment(s) or review(s) been done to evaluate area(s) identified as presenting special risk? For more detail regarding risk of falling, see **Falls Risk Checklist** included in the toolkit.

☐ **Yes.** Specify assessment(s) or review(s) done:

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Comments:

SENSORY DISABILITIES/DISORDERS

Are there any significant sensory impairments that require supervision, adaptation and/or interaction that if not present may create a high risk of injury or harm?

Please check all that apply:

☐ Visual	☐ Tactual/Kinesthetic
☐ Auditory	☐ Other:

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Comments:

SPECIAL DIETARY REQUIREMENTS

Is there a required diet or eating procedures that if not properly utilized poses a significant risk of injury or harm?

Please check all that apply:

☐ Special Diet or Food Allergy	☐ Special Eating Program/Procedure
☐ Special Food Consistency	☐ Other:

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Comments:

FUNCTIONAL & ADL

Is there a serious risk to safety for the person that is due to severe limitations or special needs in functional life skills, particularly if the individual is living alone or with only periodic support?

Please check all that apply:

☐ Bathing	☐ Hygiene and Personal Care
☐ Cooking	☐ Dressing Properly for Weather
☐ Recognizing Signs/Symptoms of Illness	☐ First Aid for Minor Injuries
☐ Other:	☐ Other:

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Comments:

RISK TO SELF

Has the individual engaged in behaviors that pose a significant risk of injury to self and that require supervision or treatment interventions?

Please check all that apply:

☐ Elopement/Running Away	☐ Alcohol or Substance Abuse
☐ Compulsive Eating	☐ Severe Depression or Suicidal Gestures
☐ Impulsive Food Ingestion	☐ Impulsive or Uninhibited Sexual Activity
☐ Pica	☐ Other:
☐ Self Injury	☐ Other:

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Comments:

RISK TO OTHERS

Does the individual engage in behaviors that pose a significant risk of injury or harm to other people and that require close supervision or treatment interventions?

Please check all that apply:

☐ Physical Assault of others	☐ Inappropriate sexual behavior *(e.g., stalking, inappropriate touching, voyeurism, exhibitionism)*
☐ Sexual Assault	☐ History of Arrest or Misdemeanors
☐ Fire Setting - arson	☐ Is on Parole or Probation
☐ Vehicle Theft	☐ Other:

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Comments:

PHYSICAL CONTROL RISKS

Does the person have a history of emergency physical or mechanical restraints, any injuries that occurred during restraint, or is there a current behavioral treatment/support plan that utilizes an aversive procedure or prone restraint procedure?

Please check all that apply:

☐ Emergency Restraint	☐ Prior Injury during restraint
☐ Prone Restraint	☐ Other (list):
☐ Aversive Procedure (Current)	☐ Other (list):

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Comments:

PERSONAL SAFETY

Does the individual require specialized support or supervision to stay safe at home or when traveling in the community?

Please check all that apply:

☐ Needs Assistance for Fire Evacuation	☐ Public Transportation Concerns
☐ Unsafe Neighborhood	☐ Street Safety and Travel Concerns
☐ Vehicle Safety and Private Transportation Concerns	☐ Water Temperature and Control Concerns (risk of scalding)
☐ Water Safety Concerns (e.g., swimming, fishing, boating, skating)	☐ Risk of Eviction (resulting in homelessness)
☐ Risk of Financial Exploitation	☐ Other (list):

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Comments:

EMERGENCY PREPAREDNESS

Has there been formal emergency preparedness review and planning to reduce safety risks in case of natural or man-made disasters?

Please check all that apply:

☐ No Emergency Preparedness Plan developed	☐ No Communication protocol (support persons, telephone numbers, other contact information)
☐ No Emergency Supply Kit available	☐ No Evacuation Plan
☐ No Identification of special needs to local Emergency Response entity	☐ Other (list):

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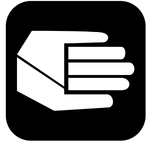
Comments:

CAREGIVER AND STAFF CONCERNS

Is the individual living in a situation where their primary caregiver or support staff may not be able to provide the appropriate level or type of supervision or support that is needed?

Please check all that apply:



☐ History of Being Left Alone for Extended Periods of Time	☐ History of Neglect or Abuse by Caregiver
☐ History of Financial Exploitation	☐ History of Sexual Abuse or Exploitation
☐ Incapacitated Caregiver	☐ New or Untrained Staff or other Support Professionals
☐ Refusal of Critical Services or Noncompliance by Caregiver	☐ Inconsistent Availability of Personal Support Professionals
☐ Social Isolation by Caregiver	☐ Criminal Activity by Caregiver
☐ Other:	☐ Other:

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Comments:

HOME SAFETY (For People Living Independently or at Home with Family)

Are there any serious safety concerns associated with where the person lives?

Please check all that apply:

☐ Unsanitary living condition	☐ Basic first aid supplies not available
☐ Access to phone in emergencies is limited	☐ Home not accessible to meet the individual's needs
☐ Smoke detectors not available or not working	☐ Bathing facilities are not adequate to special needs
☐ Improper storage of poisons other unsafe material	☐ Obstructions limit access and/or easy escape
☐ Exterior doors require key or tool to open from inside	☐ Other:
☐ Other:	☐ Other:

Has an assessment(s) or review(s) been done to evaluate area(s) identified?

☐ Yes. Specify assessment(s) or review(s) done:

☐ No. If no, an assessment(s) or review(s) must be done to evaluate this area and referenced in the Individual Plan/Action Plan. Specify assessment(s) or review(s) needed:

Comments:

OTHER

List and describe any additional concerns or issues that pose special risks and adversely affect personal safety or well-being that should be carefully reviewed when developing a personal support plan: