

CONNECTICUT VALLEY HOSPITAL OPERATIONAL PROCEDURE MANUAL

SECTION II:	ORGANIZATION FOCUSED FUNCTIONS
CHAPTER 5:	Improving Organization Performance
PROCEDURE 5.6:	Risk Management
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PURPOSE: The purpose of the Hospital's Risk Management Procedure is to provide a structure that includes performance improvement processes to identify and reduce risk for patients served. In implementing the Risk Management Procedure, the hospital will provide patients with interventions and take corrective actions commensurate with the level of risk to maintain a safe and therapeutic environment. This procedure is supported and supplemented by the Incident Management Procedure.

POLICY:

The hospital will provide a safe therapeutic environment that utilizes a Risk Management process involving a continuous and direct approach to identifying and analyzing risks and implementing measures to protect patients, staff, and visitors by reducing or eliminating the risk of harm. Staff will ensure that standardized procedures are used when addressing identified behavioral, psychiatric and medical risk conditions, as well as other high-risk situations.

PROCEDURE:

- I. The Risk Management process will support timely identification of high-risk behaviors, conditions or situations of an immediate nature, as well as long-term systemic problems that need corrective actions to remedy risks, and timely interventions to prevent or minimize harm to patients, staff, and visitors.
 - A. The Risk Management process includes the following components:
 1. Data collection tools and a centralized-database to collect and provide information on various categories of high-risk incidents and behaviors.
 2. Identification of triggers and thresholds, that address various levels of risk involving patients and that require timely review by the Interdisciplinary Team.
 3. Formalized mechanisms for notification of Interdisciplinary Teams and disciplines to support timely corrections.
 4. Monitoring systems to support timely implementation of interventions.
 5. Identification and management of long-term trends and patterns.
 6. An oversight mechanism that ensures data are tracked, trended, and analyzed using a performance improvement methodology in an effort to provide ongoing oversight and monitoring of the effectiveness of the hospital's Risk Management process.

B. The Performance Improvement Department will maintain and utilize risk management data as follows:

1. Ensure that all risk management data (incident reports) are entered into a hospital-wide database,
2. Sort data by individual, unit, program, and division, as required,
3. Sort the data by incidents, triggers, and thresholds, as required,
4. Utilize the database to analyze risk management data; monitor triggers and thresholds, and identify potential patterns and trends.

The hospital will identify patients at risk for harm as a result of meeting Triggers and Thresholds or other behavioral, psychiatric and medical conditions.

The hospital's triggers and their thresholds are presented in Appendix A.

Sample high risk behavioral, psychiatric and medical conditions are presented in Appendix B.

For newly admitted patients, the Ambulatory Care Clinician identifies medical risks using information from the Admission History and Physical and the Attending Psychiatrist identifies behavioral and psychiatric risks using information from the Admission Psychiatric Evaluation to ensure risk conditions are reviewed and addressed in the initial treatment plan. Risks are identified throughout the course of hospitalization based on ongoing assessments.

II. The hospital will use an established hierarchy of reviews that correspond to the level of high-risk in order to address the risk and reduce the potential or actual harm to patients involved in any incident, who meet the threshold for a trigger behavior or meet the threshold for high-risk behavioral, psychiatric and medical conditions.

A. Each Interdisciplinary Treatment Team will perform the following routine functions:

1. Develop and maintain an updated risk profile for all patients in their care. The risk profile will be documented in the patients' Present Status section of the Case Formulation in the treatment plan;
2. Review all patients who (a) are involved in any incident (b) exhibit a trigger or threshold behavior or exhibit a new behavioral, psychiatric or medical high risk condition;
3. Identify predisposing factors for behaviors and/or conditions that may occur in the absence of preventative interventions for each high risk condition identified in the patient's risk profile, focusing on factors that impact the patient's health and wellness.
4. Identify precipitating factors for each high risk condition identified in the patient's risk profile, focusing on those factors that will precipitate adverse outcomes for the patient.
5. Identify perpetuating factors for each high risk condition identified in the patient's risk profile, those factors that are maintaining adverse conditions or outcomes for the patient.
6. Incorporate the analysis of the patient's predisposing, precipitating and perpetuating factors into specific goals, objectives and treatment interventions to eliminate or reduce the identified behavioral, psychiatric or medical risk condition.
7. Review all incidents, as well as trigger and threshold behaviors, that involve patients in their care to determine the nature and context of the incident or

behavior, contributing (predisposing, precipitating and perpetuating) factors and appropriate behavioral, psychiatric, or medical interventions;

8. Review the current treatment plan in terms of the effectiveness of specific goals, objectives and treatment interventions already in place in eliminating or reducing the risk associated with involvement in an incident, trigger or threshold behavior or high-risk behavioral, psychiatric and medical conditions;
9. Revise the current treatment plan as indicated or document the rationale for continuing with the current goals, objectives and treatment interventions that are relevant.
10. Continue to update and build upon the individual's treatment plan based on new assessments, consultations, other information and the patient's progress for the first 60 days of admission or the first 60 days from a newly exhibited risk behavior or condition.
11. Incorporate recommendations from the Division Review Committee and the Hospital Review Committee, as applicable, into the individual's treatment plan.

B. *First Level Review:* Division Review Committee (DRC)

1. Membership of the DRC will include the following individuals within the respective Patient Care Division:
 - a. Division Director;
 - b. Division Medical Director;
 - c. Service Medical Director(s);
 - d. Psychology Associate Discipline Chair;
 - e. Social Work Associate Discipline Chair;
 - f. Rehabilitation Therapy Associate Discipline Chair;
 - g. Chief of Patient Care Services; and
 - h. Performance Improvement Manager.

The Division Director will serve as the chair.

2. The DRC will hold regular weekly meetings.
3. The functions and responsibilities of the DRC include:
 - a. Afford the Interdisciplinary Treatment Team 60 days to assess and manage newly identified behavioral, psychiatric and medical risk conditions and newly exhibited trigger and threshold behaviors, while being available for consultation if requested.
 - b. Review treatment interventions as presented by the Interdisciplinary Treatment Teams, and provide clinical recommendations with rationale as warranted, for all patients in their division who (a) continue to exhibit trigger or threshold behavior(s) 60 days after admission, or 60 days after the initial trigger or threshold behavior is exhibited for patients with a length of stay greater than 60 days, (b) re-identified as high risk for behavioral, psychiatric or medical conditions for a second time in a six-month period or (c) remain at high-risk for the same behavioral, psychiatric or medical condition ~~list~~ more than six consecutive months;
 - c. Clinical recommendations are based on a review of the behaviors and treatment teams actions to manage the behaviors.
 - d. Monitor the Interdisciplinary Treatment Teams to ensure the implementation of Division Review Committee clinical recommendations and corrective

- actions;
- e. Refer cases to the Hospital Review Committee for consultation when clinical recommendations and corrective actions are implemented and fail to manage trigger or threshold behaviors or high risk behavioral, psychiatric or medical conditions and the DRC feels it has exhausted its resources; and
- f. Maintain meeting minutes and forward to the Hospital Review Committee immediately following each meeting.

C. Second Level Review: Hospital Review Committee (HRC)

1. Membership of the HRC will include the following individuals:

- a. Medical Director of Medical Staff Academic Affairs
- b. Chief of Professional Services;
- c. Nurse Executive;
- d. Director of Psychology;
- e. Director of Social Work;
- f. Director of Rehabilitation Therapy Services;
- g. Director of Ambulatory Care Services; and
- h. Director of Compliance & Performance Improvement

The Medical Director of Medical Staff Academic Affairs will serve as chair.

The following Division and/or Unit staff may be involved in the second level review as determined by the HRC:

- 1. Division Director;
 - 2. Division Medical Director;
 - 3. Program Manager;
 - 4. Chief of Patient Care Services;
 - 5. Psychology Associate Discipline Chair;
 - 6. Unit Director;
 - 7. Treatment Team Psychiatrist;
 - 8. Unit Head Nurse/Staff Nurse; and
 - 9. Treatment Team Psychologist
2. The HRC will hold regular monthly meetings.
3. The functions and responsibilities of the HRC include:
- g. Afford the Division Review Committees 60 days to review treatment interventions, provide clinical recommendations to the Interdisciplinary Treatment Teams and ensure recommendations are implemented for patients who (a) continue to exhibit trigger or threshold behaviors (b)re-identified as high risk for behavioral, psychiatric or medical conditions for a second time in a six-month period or (c) remain at high-risk for the same behavioral, psychiatric or medical condition more than six consecutive months, while being available for consultation if requested;
 - a. Review all patients who continue to exhibit threshold behaviors 60 days after the Division Review Committee has reviewed treatment interventions and provided clinical recommendations (threshold behaviors exhibited 120 days after admission or 120 days from when initial threshold behavior exhibited for patients with length of stay greater than 120 days) or are referred by the DRC for recurrent or prolonged high risk behavioral, psychiatric or medical

conditions. Ensure a thorough case review including, but not necessarily limited to, review of clinical background, ongoing assessments, consultations and outcomes, previous treatment interventions and response to treatment. This review is holistic as opposed to an assessment of the specific threshold behavior;

- b. Consider the need for additional psychology services including assessments and the development and implementation of specific behavioral, psychosocial and cognitive rehabilitation interventions;
- c. Ensure that all patients exhibiting threshold behaviors have been assessed for a Positive Behavioral Support Plan;
- d. Provide specific clinical recommendations, with rationale, to the Interdisciplinary Treatment Teams for further assessments and/or interventions;
- e. Monitor the Interdisciplinary Treatment Teams to ensure the implementation of Hospital Review Committee clinical recommendations and corrective actions;
- f. Consider external consultation on cases that continue to prove intractable to current treatments; and
- g. Maintain and forward meeting minutes, including conclusions and recommendations, to the Quality Risk and Safety Committee following each meeting.

D. Third Level Review: Quality, Risk and Safety (QRS) Committee

- 1. The Quality, Risk and Safety (QRS) Committee will provide oversight and monitor the hospital's incident and risk management processes to reduce or eliminate the risk of harm to patients, employees and visitors.
- 2. Membership of the QRS will include the following individuals:
 - a. Chief Executive Officer;
 - b. Chief of Professional Services;
 - c. Medical Director of Medical Staff Academic Affairs
 - d. Director of Psychology;
 - e. Nurse Executive;
 - f. Director of Compliance & Performance Improvement;
 - g. Division Directors;
 - h. Division Medical Directors;
 - i. Performance Improvement Managers;
 - j. Director of Facility Operations;
 - k. Director of Staff Development; and
 - l. Director of Ambulatory Care.

The Chief Executive Officer will serve as chair.

- 3. The QRS Committee will hold regular monthly meetings, and special meetings called by the chair, as necessary.
- 4. The functions and responsibilities of the QRS Committee include:
 - a. Oversee all risk management activities, including the status and effectiveness of reviews and corrective actions of the Division Review Committees and the

- Hospital Review Committee;
- b. Review and analyze aggregate hospital-wide risk management data and identify individual and systemic patterns and trends;
 - c. Develop and implement corrective actions, including:
 1. Investigation of identified patterns and trends;
 2. Referral to various committees, teams and staff for corrective actions;
 3. Implementation of systemic changes; and
 4. Future monitoring needs and other follow-up activities;
 - d. Ensure the implementation and effectiveness of remedial actions as demonstrated by outcome data;
 - e. Review and revise risk management policies, procedures, and practices as indicated by hospital data;
 - f. Assign performance improvement projects;
 - g. Maintain written minutes of each meeting; and
 - h. Prepare a quarterly report for the hospital's Governing Body.

APPENDIX A

Triggers, Thresholds and Measurement Definitions

ID	Sub-ID	Trigger Behavior	Measurement Definition
1		AGGRESSIVE ACT TO SELF <u>Source: RIMES</u>	Self inflicted injuries, including burns, head banging, ingestion of foreign bodies or potentially toxic substances, cutting. (Incident Code 100)
	1.1 Trigger	Individuals with one aggressive act to self, independent of severity of injury	Number of individuals in the reporting month with one aggressive act to self.
	1.2 Threshold	Individuals with 2 or more aggressive acts to self in 7 consecutive days, independent of severity of injury	Number of individuals in the reporting month who reached threshold one or more times. Acts occurred within a 7 day rolling period where the 2nd incident occurred during the reporting month.
	1.3 Threshold	Individuals with 4 or more aggressive acts to self in 30 consecutive days, independent of severity of injury	Number of individuals in the reporting month who reached threshold one or more times. Acts occurred within a 30 day rolling period where the 4th incident occurred during the reporting month.
2		AGGRESSIVE ACT TO OTHERS <u>Source: RIMES</u>	Hitting, pushing, kicking or similar acts directed against another person to cause potential or actual injury.
	2.1 Trigger	Individuals with one aggressive act against a peer, independent of severity of injury	Number of individuals in the reporting month with one aggressive act against a peer. (Incident Code 101-Peer)

	2.2 Trigger	Individuals with one aggressive act against a staff member, independent of severity of injury	Number of individuals in the reporting month with one aggressive act against a staff member. (Incident Code 101-Staff)
	2.3 Threshold	Individuals with 2 or more aggressive acts to peers and/or staff in 7 consecutive days, independent of severity of injury	Number of individuals in the reporting month who reached threshold one or more times. Acts occurred within a 7 day rolling period where the 2nd incident occurred during the reporting month. (Incident Code 101-Peer/Staff)
	2.4 Threshold	Individuals with 3 or more aggressive acts to peers and/or staff in 30 consecutive days, independent of severity of injury	Number of individuals per reporting month who reached threshold one or more times. Acts occurred within a 30 day rolling period where the 4th incident occurred during the reporting month. (Incident Code 101-Peer/Staff)

ID	Sub-ID	Trigger Behavior	Measurement Definition
3		ALLEGED ABUSE, NEGLECT or EXPLOITATION <u>Source:</u> RIMES	Abuse is the knowing infliction of injury, unreasonable confinement, intimidation, or punishment with resulting physical harm, pain or mental anguish. The abuse could be emotional/psychological, physical, verbal or sexual. Neglect is failure to provide goods or services necessary to avoid physical harm, mental anguish or mental illness, which results in injury or probable risk of harm. Exploitation is the deliberate misplacement, misappropriation or wrongful, temporary or permanent use of individual's belongings or money with or without consent. (Incident Codes 200-205)
	3.1 Trigger	Individuals with one alleged abuse, neglect or exploitation	Number of individuals in the reporting month with one allegation of abuse, neglect or exploitation.
	3.2 Threshold	Individuals with 2 or more alleged abuse, neglect or exploitation in 7 consecutive days	Number of individuals in the reporting month who reached threshold one or more times. Alleged abuse, neglect or exploitation within a 7 day rolling period where the 2nd incident occurred during the reporting month.

	3.3 Threshold	Individuals with 4 or more alleged abuse, neglect or exploitation in 30 consecutive days	Number of individuals in the reporting month who reached threshold one or more times. Alleged abuse, neglect or exploitation within a 30day rolling period where the 4th incident occurred during the reporting month.
4		CHOKING <u>Source:</u> RIMES	Any episode of airway obstruction by food or foreign object.
	4.1 Trigger	Individuals with an incidence of choking who were able to self-clear the airway	Number of individuals in the reporting month who reached trigger one or more times. (Incident Code 500)
	4.2 Threshold	Individuals with an incidence of choking, requiring intervention (e.g., Heimlich) to clear the airway	Number of individuals in the reporting month who reached threshold one or more times. (Incident Code 501)

ID	Sub-ID	Trigger Behavior	Measurement Definition
5		ELOPEMENT <u>Source:</u> RIMES	Attempts or successful elopements from hospital grounds.
	5.1 Trigger	Any elopement/attempt where patient remains on hospital campus	Number of incidents occurring during the reporting month. (Incident Codes 800-802)
	5.2 Threshold	Any elopement where patient leaves hospital campus	Number of incidents occurring during the reporting month. (Incident Codes 803-809)
6		FALLS <u>Source:</u> RIMES	An uncontrolled, unintentional, downward displacement of the body to the ground or other object, excluding falls resulting from violent blows, other purposeful actions, stroke, fainting or seizures. (Incident Code 400)
	6.1 Trigger	Any fall resulting in injury requiring medical intervention or hospitalization	Number of incidents in the reporting month.
	6.2 Threshold	Individuals with 3 or more falls in 30 consecutive days, independent of severity of injury	Number of Individuals in the reporting month, who reached threshold one or more times. Falls occurred within a 30 day rolling period where the 3 rd incident occurred during the reporting month.

7		MURDER <u>Source: RIMES</u>	Injury inflicted on an individual either having the potential to, or resulting in death.
	7.1 Threshold	Any murder attempt	Number of incidents in the reporting month determined by DMHAS Police to meet CT Penal Code Sections 53a-54a and 53a-49. (Incident Code 106)
	7.2 Threshold	Any murder	Number of incidents in the reporting month determined by DMHAS Police to meet CT Penal Code Section 53a-54a. (Incident Code 603)

ID	Sub-ID	Trigger Behavior	Measurement Definition
8		MORTALITY <u>Source: RIMES</u>	Death of an individual served.
	8.1 Threshold	Unexpected Death	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. <ul style="list-style-type: none"> • Suicides would be counted both in 8.1 AND 15.3. • Murders would be counted both in 8.1 AND 7.2 (Incident Codes 601, 602 and 603)
	8.2 Threshold	Expected Death	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. (Incident Code 600)
9		ONE-TO-ONE/ CONTINUOUS OBSERVATIONS <u>Source: Observation Database</u>	By physician order for enhanced observation due to behavioral or psychiatric reasons. Excludes observation of seclusion or restraint and medical observations/treatment.
	9.1 Threshold	Individuals on 1:1/continuous observation for psychiatric/behavioral 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/continuous observation within a 7 day rolling period where the 25th hour occurred during the reporting month.

	9.2 Threshold	Individuals on 2:1 for psychiatric/behavioral 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 7 day rolling period where the 25th hour occurred during the reporting month.
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ID	Sub-ID	Trigger Behavior	Measurement Definition
10		PNEUMONIA <u>Source</u> : AVATAR	Any diagnosis of pneumonia as confirmed by chest x-ray, or other diagnostic test (e.g., bronchoscopy, blood sample).
	10.1 Trigger	Individuals with a diagnosis of aspiration pneumonia.	Number of individuals in the reporting month.
	10.2 Trigger	Individuals who acquired pneumonia at the hospital, excluding aspiration pneumonia.	Number of individuals in the reporting month.
	10.3 Threshold	Individuals with recurrent pneumonia.	Number of individuals with recurrent (more than one) episodes of pneumonia during the reporting month (any type). Individuals with unresolved episodes of pneumonia <u>should not</u> be included in this category; there should be clear evidence of recurrence.
11		POLYPHARMACY <u>Source</u> : PYXIS	Multiples of inter and intra class psychotropic medications. Excludes PRN and STAT medications.
	11.1 Threshold	Individuals with 2 or more intra-class (same class) psychotropic medications for psychiatric reasons	Number of individuals in the reporting month who reached threshold one or more times. When ordered for psychiatric or behavioral reasons, medications for insomnia and EPS are included. Polypharmacy includes those cases that have an approved drug review or the medication is being tapered.
	11.2 Threshold	Individuals with 3 or more inter-class (different classes) psychotropic medications for psychiatric reasons	Number of individuals in the reporting month who reached threshold one or more times. When ordered for psychiatric or behavioral reasons, medications for insomnia and EPS are included. Polypharmacy includes those cases that have an approved drug review or the medication is being tapered.

ID	Sub-ID	Trigger Behavior	Measurement Definition
12		PRN MEDICATIONS <u>Source:</u> PYXIS	Administered with physician order for psychiatric/behavioral reasons. Exclude insomnia and EPS.
	12.1 Trigger	Individuals with 3 or more PRNs in 7 consecutive days	Number of individuals per reporting period who reached threshold one or more times. Administered within a rolling 7-day period where the 3rd administration occurred during the reporting month.
	12.2 Threshold	Individuals with 15 or more PRNs in 30 consecutive days	Number of individuals per reporting period who reached threshold one or more times. Administered within a rolling 30 day period where the 15th administration occurred during the reporting month.
13		RESTRAINT <u>Source:</u> RIMES	Any manual method, physical or mechanical device, material or equipment that immobilizes or reduces the ability of a patient to move his or her arms, legs, body or head freely.
	13.1 Threshold	Individuals restrained continuously for more than 4 hours	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 >4 hours.
	13.2 Threshold	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. Occurring within a 7 day rolling period where the 2nd episode occurred during the reporting month.
	13.3 Threshold	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. Occurring within a 30-day rolling period where the 4th episode occurred during the reporting month.

ID	Sub-ID	Trigger Behavior	Measurement Definition
14		SECLUSION <u>Source: RIMES</u>	The involuntary confinement of a patient in a room or an area, whether alone or with staff supervision, where he/she is prevented from leaving.
	14.1 Threshold	Individuals secluded continuously for more than 4 hours	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 >4 hours.
	14.2 Threshold	Individuals with 2 or more episodes of seclusion in 7 consecutive days	Number of individuals in the reporting month who reached threshold one or more times. Occurring within a 7 day rolling period where the 4th episode occurred during the reporting month.
	14.3 Threshold	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. Occurring within a 30 day rolling period where the 4th episode occurred during the reporting month.
15		SUICIDE <u>Source: RIMES</u>	Self inflicted injury either having the potential to, or resulting in death.
	15.1 Trigger	Any suicide threat	Number of reported incidents of any verbal indications that signal a client is going to make a suicide attempt that occurred during the reporting month. (Incident Code 911)
	15.2 Threshold	Any suicide attempts	Number of occurrences that occurred during the reporting month. (Incident Code 910)
	15.3 Threshold	Any suicide	Number of suicides that occurred during the reporting month. (Incident Code 602)

APPENDIX B
Sample Behavioral, Psychiatric and Medical Risk Categories

<u>Risk Category</u>	<u>Criteria for Consideration</u>
Bowel Dysmotility	<ol style="list-style-type: none"> 1. Previous diagnosis of bowel adhesions 2. History of bowel obstruction 3. Prescribed Clozapine 4. Diagnosis of constipation not relieved by routine prevention
Choking/Aspiration	<ol style="list-style-type: none"> 1. Diagnosis of Dysphagia 2. Choking Episode in Past Year 3. Overloads Mouth 4. Eats Too Quickly 5. Steals Food 6. Talks or Vocalizes With Food in Mouth 7. Edentulous On A Regular Diet 8. Does Not Chew Food Before Swallowing 9. Hyperextension of Head/Neck During Swallow 10. Episode/history of recurrent aspiration pneumonia within past year 11. Esophageal Dysphagia/ Dysmotility 12. Tracheotomy 13. Altered consciousness or significant lethargy associated with medication or physical status 14. GERD without symptoms 15. Tardive Dyskinesia /EPS/Tardive Akathesia 16. Dependent in Receiving Nutrition 17. Unresolved Cough/Gagging 18. Frequent Emesis/ Regurgitation 19. Fatigue associated with Meal/Medications

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 impairment 5. Dementia 6. Renal impairment
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<u>Risk Category</u>	<u>Criteria for Consideration</u>
Diabetes - Risk for complications including Hypoglycemia and Hyperglycemia	<ol style="list-style-type: none"> 1. Diagnosed with Diabetes 2. Currently receiving insulin therapy 3. Non-compliance with ADA diet 4. Rigorous exercise 5. Blood sugar readings in excess of 250 mg/dl twice in a two week period 6. Blood sugar of less than 60 mg/d twice in a two week period 7. Infection or other physiologic stress; refusing insulin; taking new generation antipsychotic 8. Certain surgeries that affect food absorption (e.g. gastric bypass)
Falls	Risk assessment indicates high risk for falls
Fractures	<ol style="list-style-type: none"> 1. Low bone mineral density 2. Prior fragility (low trauma) fracture 3. Long-term (more than 3 months continuously) use of Glucocorticoid Therapy such as Prednisone 4. Individuals with 3 or more falls in 30 days

<u>Risk Category</u>	<u>Criteria for Consideration</u>
Hospitalization	<ol style="list-style-type: none"> 1. Refusal of medical care for unstable medical conditions or diagnosis 2. Individual with two or more hospitalizations in the last 6 months, with or without the same diagnosis 3. Individual admitted to the hospital within 7 days of an ER visit
Multidrug Resistant Organisms	<ol style="list-style-type: none"> 1. History of MRSA, C. Diff, Legionella, etc. 2. Open wound with Signs/Symptoms (S/S) of infection within the last 3 months 3. Any decubitis 4. Any individual who refuses treatment to a non-healing wound

<u>Risk Category</u>	<u>Criteria for Consideration</u>
Metabolic Syndrome	<ol style="list-style-type: none"> 1. Diagnosis of Dyslipidemia 2. Elevated BMI >30 3. Diagnosis of Hypertension 4. Waist circumference over 35 for females and 40 for males 5. Diagnosis of Diabetes
Osteoporosis	<ol style="list-style-type: none"> 1. Age > 65 2. Family history of osteoporotic fracture or individual history of low trauma fracture after age 40 3. Osteopenia on x-ray 4. Medical conditions that inhibit nutrient absorption e.g., Crohn's disease, Celiac disease 5. Hormonal imbalances such as Hyperparathyroidism, Hypogonadism, Menopause before age 45 6. Long term (more than three months continuously) use of Glucocorticoid Therapy such as Prednisone

<u>Risk Category</u>	<u>Criteria for Consideration</u>
Seizure Disorder/Seizures	<ol style="list-style-type: none"> 1. Severe Metabolic abnormalities such as Hypo- or Hypernatremia, Acute Metabolic Acidosis or Alkalosis, Acute Uremia, etc. 2. Acute direct cortical insult such as newly found tumor, depressed skull fracture, or stroke 3. Sudden withdrawal of Benzodiazepines or anti-epileptic drugs used for non-epileptic conditions 4. CNS infection (abscess, meningitis, encephalitis). 5. Noncompliance with anti-epileptic drugs (AEDs) in an individual with a Seizure Disorder 6. Sub-therapeutic levels of AEDs in an individual with a Seizure Disorder 7. Withdrawal from AED in individual with Seizure Disorder 8. Changing from one AED to another in an individual with a Seizure Disorder 9. Addition of seizure threshold lowering medications (especially Clozapine, Bupropion, Diphenhydramine 50mg or greater, or Chlorpromazine) in individual with Seizure Disorder

<u>Risk Category</u>	<u>Criteria for Consideration</u>
Psychogenic Polydipsia	<ol style="list-style-type: none"> 1. Polydipsia 2. Weight gain of 10 lbs in 30 days without identified cause 3. Sodium or potassium levels in blood work in the critical values 4. Multiple physical signs with unknown etiology: edema of extremities, abdominal distention, periorbital puffiness, nausea or vomiting
Impaired Skin Integrity	<ol style="list-style-type: none"> 1. Impaired/decreased mobility, decreased functional ability or cognitive decline 2. Co-morbid conditions, such as end stage renal disease, thyroid disease, diabetes mellitus, terminal cancer, liver and/or heart disease

	<p>3. The individual receives two or more of the following treatments: Steroid therapy, Radiation therapy, Chemotherapy, Renal dialysis</p> <p>4. Head of bed elevated the majority of the day due to a medical condition</p> <p>5. Impaired diffuse or localized blood flow, for example, generalized atherosclerosis or severe peripheral vascular disease</p> <p>6. Incontinence</p> <p>7. Under nutrition, malnutrition, hydration deficits and presence of edema</p> <p>8. An ulcer in the past six months</p>
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<u>Risk Category</u>	<u>Criteria for Consideration</u>
Aggression	<p>1. High risk for aggression at admission per the violence risk assessment</p> <p>2. Physical aggression resulting in injury requiring first aid or higher level of treatment within the last 3 months</p> <p>3. Credible threat, including homicidal ideation and threat of bodily harm within the past 30 days</p> <p>4. Any confirmed sexual assault, within the past year</p>

<u>Risk Category</u>	<u>Criteria for Consideration</u>
Aggressive Act to Self (self injury)	<p>1. Physical aggression to self resulting in injury requiring first aid or higher level of treatment within the last 3 months</p> <p>2. Episode of PICA or foreign body ingestion within the last 3 months</p>
Elopement	<p>1. Elopement where patient remains on grounds or leaves hospital campus within the last year</p>
Illicit Substance Use	<p>1. Substance Abuse diagnosis</p>

	<p>2. Non-adherence to random drug screens within the last 3 months</p> <p>3. Non-adherence to any substance abuse treatment within the last 3 months</p> <p>4. New Diagnosis of Depression</p> <p>5. Any incidents of prescribed benzodiazepine to an individual with a substance abuse history, with the exception of that prescribed for drug or alcohol detoxification within the last month</p>
Property Destruction	<ul style="list-style-type: none"> • Destruction or defacement of property that does not belong to the individual served within the last 3 months

Risk Category	Criteria for Consideration
Refusal of Psychotropic Medications	<ul style="list-style-type: none"> • Refusal of psychiatric care or treatment that exacerbates a medical condition within the last 3 months. <i>Example: delusions that the food provided is poisoned</i>
Suicide	<ul style="list-style-type: none"> • Suicide risk assessment indicates a high risk for suicide within the last 6 months
Victimization	<ul style="list-style-type: none"> • Repeat victim of any physical or sexual aggression or exploitation