

PATIENT'S NAME: Adams, Olaf

☐ Completed on: \_\_\_\_\_

**RISK ASSESSMENT AND MANAGEMENT PLAN**

Risk Assessment	Level of Risk
<input checked="" type="checkbox"/> <b>Risk to Self</b> (suicidal ideation / plan / means / etc.) <input checked="" type="checkbox"/> <b>Risks to Others</b> (aggression / threats / intent / means /drug-alcohol / etc.) <input type="checkbox"/> <b>Risk Assoc with Clinical Sx</b> (command hulluc / delusions / agitation / confusion) <input type="checkbox"/> <b>Risk Assoc with Behavior</b> (impulsiveness / agitation / threats / elopement) <input type="checkbox"/> <b>Vulnerability</b> (isolation / Exploitation / Self-Care deficits / Special Needs / Physical Problems)	<input type="checkbox"/> <b>Level 1 (Per remote history, upon admission)</b> <input type="checkbox"/> <b>Level 2 (Per recent history, less than 1 year or current mild risk)</b> <input checked="" type="checkbox"/> <b>Level 3 (Current indicators suggests moderate risk)</b> <input type="checkbox"/> <b>Level 4 (Current indicators suggest serious risk)</b> <input checked="" type="checkbox"/> <b>Other:</b> _____
<u>Description of Risk</u>	<u>Risk Management Plan</u>
	1. to search the bags of consumers known to have alcoholic hx when coming in rom pass 2. random check in the rooms of suspect for any alcoholic beverages 3. do alcoholic testing for any suspected s/sx 4. enrolment in substance abuse program and counseling with CM 3X/wee 5. offenders - regular intake of antabuse meds 6. refusal to take antabuse - involuntary discharge from the facility
<b>Mention any known triggers / stressors</b> Olaf A - consumer is depressed for not having a job	
<u>Level of Observations required</u>	
<input type="checkbox"/> <b>Level 1 (No Special observation required)</b> <input checked="" type="checkbox"/> <b>Level 2 (Every 30 minute checks)</b> <input type="checkbox"/> <b>Level 3 (Every 15 minutes)</b> <input type="checkbox"/> <b>Level 4 (Must be able to see the person at all times)</b> <input type="checkbox"/> <b>Level 5 (Must be with the person - within arms length)</b> <input type="checkbox"/> <b>Other:</b> _____	<b>STAFF or DEPARTMENT ASSIGNED:</b> <u>social service</u> _____

Signature of person completing form: \_\_\_\_\_ Date/Time 02/23/18  
 Nursing Log Support

Risk Assessment recommended review date: 3/2/18