DBHDS, Division of Developmental Services

Annual Risk Awareness Tool (RAT)

Individual's Name: **ISP Dates**: to

Last Annual Risk Awareness Tool (RAT) Completed:

Last SIS Completed: **SIS Level**: **Tier**:

This form is intended to develop awareness of potential triggers to adverse events and fatal outcomes. This form is designed to be a worksheet completed during the annual ISP process to identify potential areas of risk leading a review by a Qualified Healthcare Professional or Therapeutic Consultation.

SECTION A - Pressure Injury

	Pressure Injury (decubitus ulcer) *describes injuries to skin and underlying tissue resulting from prolonged pressure on the skin.*		
		YES	**NO**
Step 1:	The person was diagnosed by a medical professional with a **pressure injury** (decubitus ulcer) in this past plan year.		

If YES is checked in Step 1 (above), the new diagnosis must be addressed in the ISP. Skip Steps 2-3 and proceed to Section B. If NO is checked in Step 1 (above), complete Steps 2-3 below before proceeding to Section B.

Step 2: If the person does not meet the criteria in Step 1 (above), consider if these common indicators for **pressure injury** occurred in the past plan year. (Check all that apply)

- ☐ Regularly spends a majority of each day in a bed, chair or wheelchair
- ☐ Has experienced sensitive or fragile skin prone to injury or skin breakdown
- ☐ Has experienced an unexplained weight loss
- ☐ Has been unable to change body position independently
- ☐ Has experienced any incontinence (bowel or bladder)
- ☐ Has diagnosis of diabetes
- ☐ Has the presence of any wound or skin breakdown
- ☐ Has presence of swelling of ankles or feet

Step 3: If one or more of the common indicators above were selected, a referral to a qualified Healthcare Professional is recommended to evaluate and help develop a plan to reduce the risk of **pressure injury (decubitus ulcer)**.
If no risk indicators were selected, proceed to Section B.

Individual declined referral to Qualified Healthcare Professional (please select one of the options below)

☐ Currently have a Support Plan/Protocol ☐ Other:________________________________

Qualified Healthcare Professional will be contacted by: **Target Date:**

SECTION B - Aspiration Pneumonia

	Aspiration Pneumonia *is inflammation of the lungs and airways to the lungs (bronchial tubes) from breathing in foreign material. Aspiration pneumonia occurs when foreign materials (usually food, liquids, vomit or fluids from the mouth) are breathed into the lungs or airways leading to the lungs.*		
		YES	**NO**
Step 1:	The person has been diagnosed by a medical professional with **aspiration pneumonia** in the past plan year.		

If YES is checked in Step 1 (above), the new diagnosis must be addressed in the ISP. Skip Steps 2-3 and proceed to Section C.
If NO is checked in Step 1 (above), complete Steps 2-3 below before proceeding to Section C.

Step 2: If the person does not meet the criteria in Step 1 (above), consider if these common indicators for **aspiration pneumonia** occurred in the past plan year. (Check all that apply.):

- ☐ Has a diagnosis of dysphagia
- ☐ Has a diagnosis of GERD
- ☐ Has a diagnosis of Hiatal Hernia, Gastroparesis, Peptic Ulcer, Crohns Disease, Irritate Bowel Syndrome, Irregular Cleft Palate
- ☐ Has required assistance to be fed (food or liquid)
- ☐ Has experienced a choking episode
- ☐ Regularly coughs while eating
- ☐ Has a feeding tube (G Tube, J Tube, NG Tube)
- ☐ Is missing the majority or all of their teeth
- ☐ Is often lethargic or falls asleep in the daytime
- ☐ Has eating habits that could lead to choking (e.g. stuffing mouth, eating too quickly, jumping in seat)
- ☐ Has an altered textured diet or drink modifications (e.g. bite size, pureed, thickened liquids)
- ☐ Has a diagnosis of any neurologic disorder (e.g. Cerebral Palsy, Stroke, Dementia , Alzheimer's Disease)

Step 3: Based on the above selected risk indicators, a referral to a qualified Healthcare Professional is needed to evaluate and help develop a plan to reduce the risk of **aspiration pneumonia**.
If no risk indicators were selected, proceed to Section C.

Individual declined referral to Qualified Healthcare Professional (please select one of the options below)
☐ Currently have a Support Plan/Protocol ☐ Other: ______________________________

Qualified Healthcare Professional will be contacted by: **Target Date:**

SECTION C - Fall with Injury

*A **Fall with Injury** is an event which results in a person coming to rest inadvertently on the ground or floor or other lower level that results in an injury.*

		YES	NO
Step 1:	The person has been diagnosed by a medical professional with an **injury from a fall** in this past plan year.		

If YES is checked in Step 1 (above), the new diagnosis must be addressed in the ISP. Skip Steps 2-3 and proceed to Section D.
If NO is checked in Step 1 (above), complete Steps 2-3 below before proceeding to Section D.

Step 2: If the person does not meet the criteria in Step 1 (above), consider if these common indicators for **fall with injury** occurred in the past plan year. (Check all that apply)

- ☐ Has been diagnosed with a seizure disorder indicating the risk of a fall with injury
- ☐ Has a diagnosis of arthritis
- ☐ Takes more than 4 medications (daily or PRN/prescription or OTC)
- ☐ Utilizes walking aids and/or other Durable Medical Equipment
- ☐ Has difficulty lifting/carrying more than 10 lbs.
- ☐ Is diagnosed with a heart condition
- ☐ Experiences back pain
- ☐ Experiences any incontinence (bowel or bladder)
- ☐ Experiences unexpected weakness or fatigue when walking

Step 3:	Based on the above selected risk indicators, a referral to a qualified Healthcare Professional is needed to evaluate and help develop a plan to reduce the risk of a **fall with injury**. **If no risk indicators were selected, proceed to Section D.** **Individual declined referral to Qualified Healthcare Professional** (please select one of the options below) ☐ Currently have a Support Plan/Protocol ☐ Other: ___________________________ **Qualified Healthcare Professional will be contacted by:** **Target Date:**		
SECTION D - Dehydration			
	Dehydration *is an abnormal loss of water from the body, especially from illness or physical exertion.*		
		YES	**NO**
Step 1:	The person has been diagnosed by a medical professional with **dehydration** in this past plan year.		
If YES is checked in Step 1 (above), the diagnosis must be addressed in the ISP. Skip Steps 2-3 and proceed to Section E. **If NO is checked in Step 1 (above), complete Steps 2-3 below before proceeding to Section E.**			
Step 2:	If the person does not meet criteria in Step 1 (above), consider if these common indicators for **dehydration** occurred in the past plan year. (Check all that apply) ☐ Refuses to drink water ☐ Requires assistance to be fed (food or liquid) ☐ Has experienced diarrhea ☐ Has experienced unexplained weight loss ☐ Has experienced dry mouth ☐ Has experienced strong smelling or darkened urine ☐ Is prescribed laxatives or enemas (daily or PRN / prescription or OTC) ☐ Has experienced vomiting ☐ Is prescribed routine diuretic medication		
Step 3:	Based on the above risk indicators, a referral to a qualified Healthcare Professional is needed to evaluate and help develop a plan to reduce the **risk of dehydration.** **If no risk indicators were selected, proceed to Section E.** **Individual declined referral to Qualified Healthcare Professional** (please select one of the options below) ☐ Currently have a Support Plan/Protocol ☐ Other ___________________________________ **Qualified Healthcare Professional will be contacted by:** **Target Date:**		
SECTION E - Bowel Obstruction			
	Bowel Obstruction *is a partial or complete blockage of the bowel so that the contents of the intestine cannot pass through it.*		
		YES	**NO**
Step 1:	The person has been diagnosed by a medical professional with a ***bowel obstruction*** in this past plan year. If yes, the plan for support and/or prevention must be included in the ISP.		
If YES is checked in Step 1 (above), the diagnosis must be addressed in the ISP. Skip Steps 2-3 and proceed to Section F. **If NO is checked in Step 1 (above), complete Steps 2-3 below before proceeding to Section F.**			

Step 2: If the person does not meet the criteria in Step 1 (above), consider if these common indicators for **bowel obstruction** occurred in the past plan year. (Check all that apply)

- ☐ Has been diagnosed with constipation
- ☐ Is prescribed laxatives or enemas (routine or PRN)
- ☐ Refuses to drink water
- ☐ Requires assistance to be fed (food or liquid)
- ☐ Is prescribed psychiatric and / or narcotic medications (routine or PRN)
- ☐ Has limited mobility
- ☐ Has diagnosis of neuromuscular disorder (Cerebral Palsy, Spina Bifida, Muscular Dystrophy)
- ☐ Has diagnosis of pica

Step 3: Based on the above risk indicators, a referral to a qualified Healthcare Professional is needed to evaluate and help develop a plan to reduce the **risk of bowel obstruction.**

If no risk indicators were selected, proceed to Section F.

Individual declined referral to Qualified Healthcare Professional (please select one of the options below)
☐ Currently have a Support Plan/Protocol ☐ Other ________________________________

Qualified Healthcare Professional will be contacted by: **Target Date:**

SECTION F - Sepsis

Sepsis *is the body's overwhelming and life-threatening response to an infection which can lead to tissue damage, organ failure, and death.*

		YES	NO
Step 1:	The person has been diagnosed by a medical professional with **sepsis** in this past plan year.		

If YES is checked in Step 1 (above), the diagnosis must be addressed in the ISP. Skip Steps 2-3 and proceed to Section G.
If NO is checked in Step 1 (above), complete Steps 2-3 below before proceeding to Section G.

Step 2: If the person does not meet the criteria in Step 1 (above), consider if these common indicators for **Sepsis** occurred in the past plan year. (Check all that apply)

- ☐ Has been diagnosed with one or more of these illnesses: Diabetes, Chronic Obstructive Pulmonary Disease (COPD), Cirrhosis, Chronic kidney disease, Congestive Heart Failure (CHF) and Cancer.
- ☐ Has had more than one infection treated with antibiotics
- ☐ Has had hospitalization that lasted greater than 48 hours
- ☐ Has had any open wound or diagnosis of cellulitis
- ☐ Has been diagnosed with a urinary tract infection (UTI)
- ☐ Has experienced any pressure injury (decubitus ulcer)

Step 3: Based on the above risk indicators, a referral to a qualified Healthcare Professional is needed to evaluate and help develop a plan to reduce the **sepsis.**
If no risk indicators were selected, proceed to Section G.

Individual declined referral to Qualified Healthcare Professional (please select one of the options below)
☐ Currently have a Support Plan/Protocol ☐ Other ________________________________

Qualified Healthcare Professional will be contacted by: **Target Date:**

SECTION G - Seizure

Seizures *(Epilepsy) a neurological brain disorder where the nerve cells in the brain are overactive and abnormal. These are caused by a sudden overload of electrical activity in the brain.*

		YES	NO
Step 1:	The person has been diagnosed by a medical professional with a ***seizure disorder*** in this past plan year.		
If YES is checked in Step 1 (above), the diagnosis must be addressed in the ISP. Skip Steps 2-3 and proceed to Section H. If NO is checked in Step 1 (above), complete Steps 2-3 below before proceeding to Section H.			
Step 2:	If the criteria in Step 1 (above) are not met, consider if these common indicators for **seizures** occurred in the past plan year. (Check all that apply) ☐ Has been diagnosed with seizure indicating the risk of a seizure disorder ☐ Has experienced a change in routine anti-epileptic medications (AEM) ☐ Has missed or refused routine anti-epileptic medications (AEM) ☐ Has been diagnosed with dehydration ☐ Has been diagnosed with one or more of the following: Autism Spectrum Disorder, Cerebral Palsy, Dementia, Alzheimer's, Muscular Dystrophy, Obstructive Sleep Apnea, and Traumatic Brain Injury. ☐ Has been diagnosed with Obstructive Sleep Apnea		
Step 3:	Based on the above risk indicators, a referral to a qualified Healthcare Professional is needed to evaluate and help develop a plan to reduce the **seizure.** **If no risk indicators were selected, proceed to Section H.** **Individual declined referral to Qualified Healthcare Professional** (please select one of the options below) ☐ Currently have a Support Plan/Protocol ☐ Other ________________________________ **Qualified Healthcare Professional will be contacted by: Target Date:**		
Section H - Community Safety Risks		**YES**	**NO**
Step 1:	***Law Enforcement Involvement:*** *Has the person engaged in or attempted to assault and/or injure others; property destruction due to fire setting and/or arson; and/or sexual aggression and has been* ***CONVICTED,*** *through the criminal justice system, of a crime related to these risks?*		
Step 2:	***Non-Law Enforcement Involvement:*** *Has the person engaged in or attempted to assault and/or injure others; property destruction due to fire setting and/or arson; and/or sexual aggression and has* ***NOT BEEN CONVICTED*** *of a crime related to these risks, but displays the same community safety risk as a person found guilty through the criminal justice system?*		
If YES is checked in Step 1 *or* 2 (above), proceed to Steps 3-4 below. If NO is checked in Step 1 *and* 2 (above), skip to Section I - Self-Harm.			
		YES	**NO**
Step 3:	Does the person have a behavior support plan or behavioral guidelines in place, related to these risks?		
Step 4:	If answered "**NO**" to Step 3 above, has the person been referred to therapeutic consultation for assessment and treatment recommendations? **Individual declined referral to Therapeutic Consultation Professional** (please select one of the options below) ☐ Currently have a Support Plan/Protocol ☐ Other ________________________________ **Therapeutic Consultation Professional will be contacted by: Target Date:**		
Section I - Self-Harm		**YES**	**NO**
Step 1:	***Self-Harm:*** *Does the person displays self-injury; pica; physical self-harm and/or suicide attempts which seriously threaten their own health and/or safety?*		
If YES is checked in Step 1 (above), proceed to Steps 2-3 below. If NO is checked in Step 1 (above), skip to Section J.			

Step 2:	Does the person have a behavior support plan or behavioral guidelines, in place, related to the risks secondary to self-harm?		
Step 3:	If answered "No" to #2 above, has the person been referred to therapeutic consultation for assessment and treatment recommendations? **Individual declined referral to Therapeutic Consultation Professional** (please select one of the options below) ☐ Currently have a Support Plan/Protocol ☐ Other ________________ **Therapeutic Consultation Professional will be contacted by: Target Date:**		
Section J - Elopement		**YES**	**NO**
Step 1:	***Elopement:*** *Does the person leave supervised areas without permission; fail to return from visits or outings; if lives unsupervised, goes missing for extended periods; or ignores community property boundaries that may threaten their safety and/or risk confrontation with local law enforcement?*		
If YES is checked in Step 1 (above), proceed to Steps 2-3 below. **If NO is checked in Step 1 (above), skip to Section K.**			
Step 2:	Does the person have a behavior support plan or behavioral guidelines in place addressing their elopement behavior?		
Step 3:	If answered "No" to Step 2 above has the person been referred to therapeutic consultation for assessment and treatment recommendations? **Individual declined referral to Therapeutic Consultation Professional** (please select one of the options below) ☐ Currently have a Support Plan/Protocol ☐ Other ________________ **Therapeutic Consultation Professional will be contacted by: Target Date:**		
Section K - Lack of Safety Awareness		**YES**	**NO**
Step 1:	***Lack of Safety Awareness:*** *Does the person display a pervasive lack of safety awareness throughout their daily living due to communication deficits combined with cognitive deficits and/or brain injury that leaves them open to victimization (financial, daily living, socio-sexual)?*		
If YES is checked in Step 1 (above), proceed to Steps 2-3 below. **If NO is checked in Step 1 (above), proceed to Summary Page.**			
Step 2:	Does the person have steps addressing the lack of safety awareness in their ISP?		
	Does the person have a behavior support plan or behavioral guidelines in place addressing their challenging behavior that results due to a lack of safety awareness?		
Step 3:	If answered "No" to Step 2 above, has the person been referred to therapeutic consultation for assessment and treatment recommendations? **Individual declined referral to Therapeutic Consultation Professional** (please select one of the options below) ☐ Currently have a Support Plan/Protocol ☐ Other ________________ **Therapeutic Consultation Professional will be contacted by: Target Date:**		

DBHDS, Division of Developmental Services

Annual Risk Awareness (RAT) Tool

Individual's Name: **ISP Dates**: to

Last SIS Completed: **SIS Level**: **Tier**:

The purpose of the Summary Section of the RAT is a worksheet designed to serve as a "To Do List" as well as to highlight data elements that will be utilized for systems education and improvements. These data elements include 1. SIS levels, 2. New Diagnoses or concerns and 3. potential areas of risk.

Fill out the Summary below utilizing the worksheet above. For each Section, identify whether or not the individual received a New Diagnosis/Concern and/or has a Potential Risk Identified. If the individual has neither a New Diagnosis/Concern nor an identified risk for a section, please leave that section blank and proceed to the next section. In addition, please mark whether or not an individual was referred to a QHP or TC Professional. For examples, see below.

Summary of Risk Awareness					
Sec. A	Identified Area			**Referred to QHP**	
	Pressure Injury	☐ New Diagnosis	☐ Potential Risk Identified	☐ YES	☐ NO
Sec. B	Identified Area			**Referred to QHP**	
	Aspiration Pneumonia	☐ New Diagnosis	☐ Potential Risk Identified	☐ YES	☐ NO
Sec. C	Identified Area			**Referred to QHP**	
	Fall with Injury	☐ New Diagnosis	☐ Potential Risk Identified	☐ YES	☐ NO
Sec. D	Identified Area			**Referred to QHP**	
	Dehydration	☐ New Diagnosis	☐ Potential Risk Identified	☐ YES	☐ NO
Sec. E	Identified Area			**Referred to QHP**	
	Bowel Obstruction	☐ New Diagnosis	☐ Potential Risk Identified	☐ YES	☐ NO
Sec. F	Identified Area			**Referred to QHP**	
	Sepsis	☐ New Diagnosis	☐ Potential Risk Identified	☐ YES	☐ NO
Sec. G	Identified Area			**Referred to QHP**	
	Seizure	☐ New Diagnosis	☐ Potential Risk Identified	☐ YES	☐ NO
Sec. H	Identified Area			**Referred to TC**	
	Community Risks	☐ New Concern	☐ Potential Risk Identified	☐ YES	☐ NO
Sec. I	Identified Area			**Referred to TC**	
	Self-Harm	☐ New Concern	☐ Potential Risk Identified	☐ YES	☐ NO
Sec. J	Identified Area			**Referred to TC**	
	Elopement	☐ New Concern	☐ Potential Risk Identified	☐ YES	☐ NO
Sec. K	Identified Area			**Referred to TC**	
	Lack of Safety Awareness	☐ New Concern	☐ Potential Risk Identified	☐ YES	☐ NO
Signature					
Support Coordinator Signature:				**Date:**	

Example: In "Section A - Pressure Injury" of the worksheet, you indicated in "Step 1" that an individual did receive a diagnosis in this past plan year as well as met one or more of the common indicators in "Step 2." On the Summary Form in "Sec. A" above, you would check both "New Diagnosis" as well as "Potential Risk Identified." If you selected "NO" in "Step 1" of the worksheet but did the individual did meet one or more common indicators in "Step 2", you would leave "New Diagnosis" blank and select "Potential Risk Identified" in "Sec. A" on the Summary Form. In addition, if the individual was referred to a Qualified Health Professional in "Step 3," you would select "YES" in "Sec. A" under "Referred to QHP." If you selected "NO" in Step 1 under "Section A" of the worksheet and the individual did not meet any common indicators in "Step 2," you would leave "Sec. A" of the Summary Sheet blank and proceed to "Sec. B."

Upload this page to WAMS as a component of the annual ISP when the ISP is entered.