Version 4

Tenant Risk Assessment

Tenant information			
Name		Date of birth	

Sight	**Yes**	**No**
Tenant wears glasses		
Tenant wears contact lenses		
Tenant is registered blind		
Hearing	**Yes – state L/R or both**	**No**
Tenant wears hearing aids		

History of medical conditions and how this affects mobility, relevant information regarding history of falls and current CFS score
Bed Rails in place – See index section 1 (Authorisation sheet) for letter confirming details of restrictions in place.

Yes	**No**

Actions to be taken in the event of a fall ***Please ensure falls checklist is always completed***	In the event of no physical/or apparent injuries, if the tenant can stand with verbal guidance and encouragement only (no physical touch technique)	In the event the tenant is unable to stand independently, Emergency services are to be called.

Fit/Mild Frailty CFS 1 – 5	
Is this person over-exercising regularly and fittest in their age group?	CFS Score 1 – Very fit
Does this person have no active disease symptom and exercise only occasionally?	CFS Score 2 - Well
Does this person have medical problems that are well controlled but they are not regularly active beyond routine walking?	CFS Score 3 – Managing well
Whilst not dependent on others, does this person's symptoms limit their activities?	CFS Score 4 - Vulnerable
Does this person need help with instrumental activities of daily living e.g. finances, banking, transport, heavy housework, meal prep or medications?	CFS Score 5 – Mildly frail
Moderate Frailty CFS 6	
Does this person need help with all outside activities, keeping hour and/or bathing?	CFS Score 6 – Moderately frail
Severe Frailty CFS 7 - 9	
Is this person completely dependent for personal care?	CFS Score 7 – Severely frail
Is this person completely dependent and approaching the end of their life?	CFS Score 8 – Very severely frail
Is this person terminally ill with a life expectancy of <6 months?	CFS Score 9 – Terminally ill

5x5 Risk Matrix Example

Impact

How severe would the outcomes be if the risk occurred?

What is the probability the risk will happen?

Probability

	Insignificant 1	Minor 2	Significant 3	Major 4	Severe 5
5 Almost Certain	Medium 5	High 10	Very high 15	Extreme 20	Extreme 25
4 Likely	Medium 4	Medium 8	High 12	Very high 16	Extreme 20
3 Moderate	Low 3	Medium 6	Medium 9	High 12	Very high 15
2 Unlikely	Very low 2	Low 4	Medium 6	Medium 8	High 10
1 Rare	Very low 1	Very low 2	Low 3	Medium 4	Medium 5

When completing this risk assessment, please ensure you take into account any risks identified on original assessment, any control measures and how these link in with daily practice.

Remember to include if there is any assistive technology currently in place to help reduce the risk.

Behaviour	**Sleeping**	**Psychological and Emotional Needs**	**Communication**	**Allergies**	**Cognition**
Sense of danger Sense of time Sense of location Befriending Indirect triggers – Environment Noise Crowds Direct triggers– Individual interaction Activity Sensory – Smell Light Temperature	Sleep apnea Narcolepsy Restless leg syndrome Sleepwalking Difficulty falling or staying asleep Excessive daytime sleeping Insomnia Parasomnia	Depression/low mood General anxiety Short temper/ aggression Lack of interest Health anxiety Panic Phobias Obsessive compulsive disorder	Verbal Non-verbal Written Listening Visual	Tree/Grass/Weed pollen Mold spores Cats/Dogs Dust mites Food Gluten Insect stings	Forgetting things more often Missing appointments/events Loosing train of thought Trouble following a conversation Trouble finding the right word or language Struggle to make decisions, finish a task or follow instruction Trouble finding way around places they know

Nutrition – food and drink	**Continence**	**Breathing**	**Altered States of Consciousness**	**Hygiene (washing/grooming/ dressing)**	**Mobility**	
Variety of food eaten Amount of food eaten Frequency of food eaten Type of drink Amount of drink Frequency of drinking Weight Safe use and understanding of cooking appliances/ small kitchen electrical items	No needs Incontinence pads Commode Catheter Stoma bag Personal hygiene Other	Asthma COPD Lung Cancer Heart problems Airway infections Panic attack/ anxiety Allergic reactions Pulmonary embolism Anaemia Safe smoking practices	Confusion Disorientation Forgetfulness (amnesia) Hallucinations Delusions Incoherent or nonsensical speech Slow responses to questions or stimuli	Personal hygiene Wearing appropriate clean clothes Hair care Nails care Skin care Dental care	Health conditions Dietary/nutrition conditions Cultural/ religious considerations Standing Mobilising Walking Rising from a chair Sitting down in a chair Repositioning in chair Chair to chair Getting in/out of bed Bed to chair Turning in bed	Repositioning in bed Toileting Bathing Showering Stairs/steps Washing Dressing Undressing Oral care Use of kettle Use of microwave Use of cooker/ hob Use of plugs/ extension leads Moving with hot drinks/liquids

Hazard	Probability	Impact	Grade	Current control measures	Probability	Impact	Grade	Actions

Record of Moving and Handling Equipment			
Type of equipment	Date in place	Name of prescriber	Comments

Assessing officer	
Date	