MOONSTONE CARE UK
Domiciliary care

SERVICE USER ASSESSMENT INCLUDING RISK ASSESSMENT

Date Assessment Performed: Assessed by:

Service User Name:		
Preferred Form of Address:		
Address: Post Code:		
Telephone Number:		Community Alarm: Yes or No
Date of Birth:		Gender: Male / Female
Other Household Members:		
Pets:		
Ethnicity:		
Language:		
Religion:		
Preferred Communication:		
GP Name:		
GP Address:		
GP Telephone Number:		
GP Emergency Number:		
District Nurse Contact No:		
Chiropodist Contact No:		
Optician Contact No:		
Other Health Contacts:		
Next of Kin Name:		
Next of Kin Address:		
Next of Kin Telephone No:		Key Holder: Yes or No
Next of Kin Name:		
Next of Kin Address:		
Next of Kin Telephone No:		Key Holder: Yes or No
Local Key Holder Name:		
Address:		
Telephone Number:		
Access Details:	Able to open door / Key Safe / Speak Lock / Intercom / Other: Key Code:	

Type of Accommodation:	House / Flat / Warden Controlled / Shared Accommodation / Other:

1 = Independent, 2 = Minor Assistance, 3 = Major Assistance, 4 = Totally Dependent on others

General Health	**Ability 1**	**2**	**3**	**4**	**Complete comments box where 2, 3 or 4 are scored for any category**
Nutrition					
Faecal Continence					
Urinary Continence					
Hearing					
Speech					
Sight					
Communication					
Breathlessness					
Pain					
Seizures					
Infectious Diseases					
Diabetes					
Medication					List current medication below.
Other					

Person responsible for placing medication in property or collection instructions:	Contact Number
Medication Location:	
Service user illness, if any:	

Comments: The likelihood of the risk occurring and action required to eliminate, reduce or manage the risk.	**Date actioned / referred on**

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Mobility	**Ability**				
	1	**2**	**3**	**4**	
Able to Weight Bear					
Able to transfer to chair					
Walk					
Get up					
Go to Bed					
Move in Bed					
Able to go Outside the House					
Use of House Steps					
Use of Stairs					

Do the operations to assist this service user involve a significant risk of injury **If 'yes' complete a full manual handling risk assessment** **If 'no' sign declaration below :**	**YES / NO**

The service user needs no assistance with mobility

Signed:…………………………………… Date:…………………………………..

1 = Independent, 2 = Minor Assistance, 3 = Major Assistance, 4 = Totally Dependent on others					
Personal Care Ability	**Ability 1**	**2**	**3**	**4**	**Comments: Ensure all details are complete**
Wash Themselves					(note any hazards arising from hot water or bath water)
Bath					
Shower					
Wash Hair					
Dress					(note whether shoes can be put on/off unaided)
Undress					
Oral Hygiene					
Change Incontinence Pad					
Brush Hair					
Shave					

Prepare Breakfast					
Prepare Light Meal					
Prepare Hot / Cold Drink					
Prepare Flask					
Feed Themselves					
Empty Commode					
Catheter Care					
Stoma Care					
Go to the Toilet					
Go to bed at night					

Comments: The likelihood of the risk occurring and action required to eliminate, reduce or manage the risk.	**Date actioned / referred on**
note any hazards from eating raw or non-food items or food that is off and note any hazard from sharp objects, knives or glasses) **Also, note any specific dietary needs.**	

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Domestic Activity	**Ability** 1	2	3	4	**Comments**
General Housework					
Laundry					
Cooking					
Shopping					
Pension Collection					
Change Bed / Make Bed					

Ironing					
Management of Bills					(Note whether there is any risk of financial exploitation)
Looking after Pets					

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Tick box & comment

Mental Health / Dependency issues

	No risk		**Low risk**		**High risk**	
Behaviour known to be aggressive						
Behaviour known to be violent						
Known to have physically harmed others						
Destructive to immediate environment						

Uses objects or weapons to harm self								
Uses objects or weapons to harm others								
Lacks understanding of injurious actions								
Sexually inappropriate behaviour (including removing clothing in public)								
Fears or phobias, please state								
History of Mental Illness								
History of paranoid delusions								
History of psychiatric admissions								
Attempts or thoughts of suicide								
Uses recreational drugs to excess								
Uses alcohol to excess								
Smokes								
Coherent	Always		Usually		Occasionally		Never	
Orientation	Full		Not Always		Disorientated		Other	
Sleep Pattern	Good		Fair		Sleeps Little		Other	
Wanders	Never		Sometimes		Often		Always	

Comments: (Action required to eliminate, reduce or manage the risk)	**Date actioned /referred on**

Personal Safety		**Please Identify by Ticking Statement, & Comment Below**					
Outdoors (note if at risk from traffic)	Independent		Minor Help		Major Help		Unable	
Indoors (note if may climb out of windows)	Independent		Minor Help		Major Help		Unable	
Falls	Never		Occasionally		Often		Other e.g.out of	

							bed	
Can be left alone	Always		Long Period		Short Period		Not At All	
Lives with	Partner		Family		Carer		Alone	
Family Contact	Frequent		Occasionally		None		Other	
Friends Contact	Frequent		Occasionally		None		Other	
Carer	Frequent		Occasionally		None		Other	
Sleep Upstairs	Always		Occasionally		Often		Never	
Sleep Downstairs	Always		Occasionally		Often		Never	

Comments: The likelihood of the risk occurring and action required to eliminate, reduce or manage the risk.	**Date actioned / referred on**

Mobility Equipment N/A	Please complete all details – If **not** applicable please circle N/A or comment below

Zimmer Frame	**Confident**		Minor Help		Unsteady		Risk	
Walking Stick	**Confident**		Minor Help		Unsteady		Risk	

Stair Lift N/A	**Confident**		**Nervous**		**Not Required**	
Responsible for Maintenance			Contact Tel No:			
Electric Hoist N/A	**Confident**		**Nervous**		**Not Required**	
Responsible for Maintenance			Contact Tel No:			
Manual Hoist N/A	**Confident**		**Nervous**		**Not Required**	
Responsible for Maintenance			Contact Tel No:			
Hospital Bed N/A	**Confident**		**Nervous**		**Not Required**	
Responsible for Maintenance			Contact Tel No:			
Bed Rails N/A	**Confident**		**Nervous**		**Not Required**	
Responsible for Maintenance			Contact Tel No:			
Bath Aids N/A	**Confident**		**Nervous**		**Not Required**	
Responsible for Maintenance			Contact Tel No:			
Wheelchair N/A	**Confident**		**Nervous**		**Not Required**	
Responsible for Maintenance			Contact Tel No:			
Other	**Confident**		**Nervous**		**Not Required**	
Responsible for Maintenance			Contact Tel No:			

Comments: The likelihood of the risk occurring and action required to eliminate, reduce or manage the risk.	**Completed: Date / Signed**

External Features	No risk	Low risk	High risk
Pathways			
Entrance Steps			
Hand Rails			
Lighting			
Access			
Hazard from ponds, rivers, the sea			

Comments: The likelihood of the risk occurring and action required to eliminate, reduce or manage the risk.	**Date Actioned or referred on**

Internal Features	Excellent	Good	Poor	Dangerous
Working Space				
Furniture				
Bed				
Carpets / Mats				
Floor Covering				
Hand Rails				
Step Ladders				
Fires / Heaters (note if inadequate, or if means of lighting poses a risk e.g. matches/lighters)				
Cleaning Equipment / Materials				

Comments: The likelihood of the risk occurring and action required to eliminate, reduce or manage the risk.	**Completed: Date / Signed**

Condition of Electrical Equipment		Excellent	Good	Poor	Dangerous
Kettle					
Toaster					
Cooker					
Fridge					
Iron					
Vacuum Cleaner					
Washing Machine					
Tumble Dryer					
Plug Sockets					
Electric Blankets					
Any other Appliances					
Are smoke detectors in place and working?	**YES / NO**	**If ‘no’, comment below**			

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Note down all substances which may be hazardous to health

	Lounge	**Bedroom**	**Kitchen**	**Toilet/Bathroom**	**Hall**	**Stairs**	**Other**
Cleaning Fluids							
Bleach							
Toilet Cleaners							
Oven Cleaners							
Fly Sprays							
Washing Powders							
Surface Cleaners							
Metal Cleaners							
Other							
Medicines							
Waste Disposal Bags							
Body Fluids							
Other							

Are all items satisfactorily secured? If not give details

Are labelling and directions clear and understandable? If not give details

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Total Hours per day to be supplied	1 or 2 Carers	Before 8am	Am	Midday	Pm	Evening before 8pm	Evening after 8pm	Total Hours
Monday								
Tuesday								
Wednesday								
Thursday								
Friday								
Saturday								
Sunday								

	Duties to be performed to meet outcomes desired	Hours
Service supplied AM		
Service supplied Midday		
Service supplied Early Evening		
Service supplied Evening		

Summary: Steps that should be taken to meet the identified risks to:	Date by which action should be taken
General Health:	
Mobility:	
Personal Care:	
Domestic Activity:	
Mental Health Dependency:	
Personal Safety:	
Mobility/ Equipment:	
Property, External and Internal:	
Electrical Equipment:	
Chemical Hazards C.O.S.H.H:	
Moving and Handling:	

General information to assist the care workers e.g. previous work or social interests, hobbies, leisure pursuits, family background, cultural /religious beliefs (note if the service user requires any help to practise their religion).

	Print Name	Signature
Service user : I have read, understood and agree to this care plan.		
Next of kin : I have read, understood and agree to this care plan.		
Risk Assessor		
Care Manager		
Review Date		