University Hospitals Plymouth NHS Trust

Surname:
First Name:
Hospital Number:
NHS Number:
DOB:
Affix patient label here

Falls Risk Assessment and Falls Prevention Care Plan

Falls risk assessment & care plan to be fully completed on all patients aged 65 years & over, or those patients whose clinical condition increases their risk of falling or any other patient considered at risk of a fall during this admission. The assessment of falls risks must be multi-factorial - to identify those factors which may increase a patient's risk of falling.

Falls Risk Assessment	Yes	No	Action
PART A (Increased risk of falls)			**If yes to any question ensure ESSENTIAL bundle of interventions implemented**
Is the patient aged 65 or over?			
Does the patient's clinical condition increase the risks of falling?			
Is the patient known to have a dementia?			
Has the patient developed delirium or become acutely confused?			
Does the patient have poor balance?			
Does the patient have an impaired gait?			
Does the patient usually use walking aids?			
Does the patient have good vision?			
Is the patient on any medications associated with an increased risk of falling? (Refer to falls resource folder for list of medications)			
PART B (serious harm from injury risk)			**If patient has risk factors from PART A and B then implement ESSENTIAL AND CONSIDER HIGH RISK bundle**
Is the patient on anti-coagulants or do they have a clotting impairment?			
Is the patient on treatment for osteoporosis or known to have a previous fragility fracture?			
PART C (History of falls)			**Implement ESSENTIAL AND CONSIDER HIGH RISK bundle**
Has the patient fallen in the past 12 months?			
Does the patient have a fear of falling?			

Risk Assessment Sign Off	
Signature of Registered Nurse	
Print name of Registered Nurse	
Date and time of assessment	

To record completed Interventions sign, date and time each intervention.

Essential Bundle of Interventions	Sign	Date	Time	Variances
Minimum of 2 hourly intentional care rounding				
Record lying and standing blood pressure using the lying and standing blood pressure chart.				
Assess for any continence issues especially urinary frequency.				
Ensure manual handling assessment and care plan are completed and accurate				
Ensure bedrail assessment completed				
Ensure any walking aids that the patient has been assessed to use are available and within reach				Document aids being used here
Ensure patient has appropriate footwear. If not available provide non slip socks.				Document footwear type here
Refer to physiotherapist for mobility and gait assessment				
Request a review of any medicines that are associated with an increased risk of falling or harm from falling. (Refer to falls resource folder for list of medications)				
Provide patient and/or carer with falls prevention in hospital advice leaflet.				
High Risk Bundle of interventions (assess if appropriate to use for the patient if not appropriate provide rationale in variances	Sign	Date	Time	Variances
Increase intentional care rounding to 1 hourly *Prescribe frequency as per trust policy*				
Nurse patient in observable bed space near to the nurses station				
Chair/bed sensor alarms in place *Check equipment in working order and correctly positioned*				
Low profile bed in place *Check in working order and that the bed is used in its lowest position*				
Continuous observation in place *(Refer to Enhanced Observation Policy for Guidance)*				

Record of Care Plan Review (Every 3 days or if patient falls or condition changes)					
Date/Time					
Is this a review post fall? (yes or no)					
RN Signature					
RN Print Name					