Plymouth Hospitals NHS
NHS Trust

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

Falls Risk Assessment & Care Plan

Falls risk assessment & care plan to be **fully completed on all patients aged 65years & over, or** those patients aged 50-64 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. **Record Yes/No**

Falls Risk factors	Initial Assessment	Review	Review	Review	Review	Review
History of Falls						
Has the patient fallen in the past 12 months?						
Has the patient fallen during this admission?						
Does the patient have a fear of falling?						
History of confusion						
Is the patient known to have a dementia?						
Has the patient developed delirium or become acutely confused?						
Mobility						
Does the patient have poor balance?						
Does the patient have an impaired gait?						
Does the patient usually use walking aids?						
Clinical Risk Factors						
Does the patient's clinical condition increase the risks of falling?						
Is the patient on any medications which increase the risks of falling?						
Risk Assessment sign off						
Date of risk assessment						
Signature of Registered nurse						

Review every 3 days or before if patient falls or condition changes.

Falls Care Plan to be completed on all patients as above

Aspect of care	**Action**
Infection Consider infection as a contributory cause of acute confusion or delirium. See guidance on delirium Falls Reduction Resource Folder	Refer patient for medical review for delirium and infection screening Take & record urinalysis Date completed _____/or not applicable* *delete as appropriate
Medications Check for medications associated with falls e.g antidepressants, night sedation, anti hypertensives strong analgesics. See list in Falls Reduction Resource Folder	Refer for medical review of medications Date completed _____/or not applicable* *delete as appropriate
Lying & standing BP Complete on • All patients who have fallen • Any patient with symptoms such as lightheadness / dizziness See guidance in Falls Reduction Resource Folder	Follow standard procedure Record on observation chart Report any orthostatic hypotension to medical team and ensure medication review has been undertaken

To be filed on the Second Spine (Second Clip) - Nursing Notes Section

Aspect of care	Action
Intentional Care Rounding addresses many factors associated with an increased risk of falls **Ward location and patient supervision** Patients may be safer nursed where they can more readily be observed. Consider whether a patient's family/carer may be able to assist or 1:1 supervision is required.	Intentional Care to be undertaken 1 hourly / 2hourly / 3hourly / 4hourly (circle) Nurse patient in most suitable area of ward (circle) : Cohort bay/ quiet area/ close to lavatory/ Close to nurses' station/ 1:1 supervision /Not Applicable Relatives/carer assistance
MDT - involvement & communication Involvement of the whole MDT is important for falls prevention Physio & occupational therapists have a key role in assessing a patient's gait and balance, ensuring correct walking aid and footwear is used and providing on going help with mobilisation Inform other members of the team if patient is considered to be at increased risk of falls and/or has fallen this admission. Involve patient & family, wherever possible, in measures which may reduce the risk of falls.	Refer patient to Physiotherapist: Yes date:_____/not applicable Occupational therapist: Yes date:_____/not applicable Patient safety briefing: Yes /not applicable Handover sheet: Yes/not applicable Information leaflet provided: Yes/not applicable *Avoiding falls whilst in hospital*
Sensory impairment (vision /hearing) Sensory impairment is a contributory factor in many falls. Consider whether a patient's visual impairment means they need assistance to mobilise. Check that glasses and hearing aids are available and in good working order.	Can the patient identify a pen from a bed length away (wearing usual glasses)? Yes/No If No does the patient require medical staff to formally assess their vision. Yes/No
Equipment It is important to check patient has suitable footwear. For advice see Falls Reduction Resource Folder Consider whether specialist equipment may reduce this patient's risk of a fall. If bed rails are used complete risk assessment	Footwear: patient's own suitable Yes/No Hospital provided Yes/No Low profile bed Yes/No Sensor alarm Yes/No Bed rails Yes/No

Record of Care Plan review (Review every 3 days or before if patient' falls or condition changes and record any progress or variance in care plan in main care plan evaluation record)

Date					
Name/ Signature of RN					