PATIENT ID LABEL

FALLS RISK ASSESSMENT

To Be Completed For All Patients Within 24 Hrs Of Admission And On Transfer To Another Ward

NHS Greater Glasgow and Clyde

GENERAL SAFETY PRECAUTIONS TO BE UNDERTAKEN FOR ALL PATIENTS

Action the following safety precautions on admission to your ward. Update weekly or on change of condition.

	Ward: Date: Time: -----:------	Ward: Date: Time: -----:------	Ward: Date: Time: -----:------	Ward: Date: Time: -----:------	Ward: Date: Time: -----:------
1. Document mobility status in clinical record and complete a moving and handling assessment (if appropriate).					
2. Check walking aid (if required) is in reach and in use.					
3. Check call bell is in reach and working. Provide and document alternative measures if patient is unable to use call bell.					
4. Check footwear is safe (refer to NHSGGC Footwear guidance).					
5. If glasses are worn, check they are available and in use.					
6. If hearing aid/s are worn, check they are working and in use.					

RISK ASSESSMENT

If Yes to any of the 5 questions below complete the falls checklist (overleaf). Whether Yes or No, update this assessment weekly in acute wards or, at the time of a fall or, upon a change in patient's clinical condition. **ALL patients in older people's wards must have a falls checklist in place (overleaf)**

Tick Yes or No	Yes	No	Yes	No	Yes	No	Yes	No	Yes	No
1. Has the patient fallen in the last 6 months – including during this admission?										
2. Does the patient have cognitive impairment or a possible delirium?										
3. Does the patient attempt to walk alone although unsteady or unsafe?										
4. Does the patient or their relative have a fear or anxiety of the patient falling?										
5. Based on **your** clinical judgement, is this patient at high risk of falling?										
Signature of nurse completing assessment / update										

Highlight risk of fall at the ward safety brief.

PATIENT ID LABEL

FALLS INTERVENTION CHECKLIST

EVIDENCE ALL INTERVENTIONS IN NURSING CARE PLAN

NHS Greater Glasgow and Clyde

Complete for all patients identified at risk of falling and all patients in older people's care wards	**Ward: Date: Time: -----:------**	**Ward: Date: Time: -----:------**	**Ward: Date: Time: -----:------**	**Ward: Date: Time: -----:------**	**Ward: Date: Time: -----:------**
BED AND SEATING					
Check the patient's bed and chair are at the right height for the patient. Consider referral to OT/ Physiotherapy for transfer, mobility or specialist seating advice. (Patient care plan 8)					
Assess if a low bed is required (Patient care plan 9)					
SAFETY					
Complete / update bedrails risk assessment if bedrail in use. (Patient Care plan 9)					
Review the frequency of care rounding prescribing in relation to the falls risk – consider the use of a patient monitoring chart. (**Patient** care plan 9)					
If the patient is cognitively impaired or has poor mobility and known not to ask for assistance, provide close observation whilst using commode, toilet, bath or shower.					
HEALTH					
Complete /Document 4AT – follow THINK DELIRIUM guidelines. (Patient care plan 4)					
Document continence problems and link to care rounding (Patient care plan 6)					
Record lying and standing blood pressure. If results show deficit, follow protocol for ongoing monitoring and inform medical staff of any concerns. (Patient care plan 1)					
If medication is suspected of contributing to the patient's falls risk – highlight to medical staff.					
COMMUNICATION					
Give the patient / relatives / carers an inpatient falls prevention leaflet. Discuss safety precautions with patient / carer / relative. (Patient care plan -negotiated care)					
Update the ward team of the patient's mobility status. (Patient care plan 8)					
Discuss the patient's fall risk at safety briefs and MDT meetings. (if appropriate)					
Consider a referral to the Hospital Falls Service for advice using trackcare. (if appropriate)					
Signature of nurse completing falls checklist / or update					

*****If a fall has occurred, refer to the Post Fall Poster and report in Datix. Share post fall lessons learned with the team*****