

Use addressograph (otherwise write in capitals)

Surname: _____

First name(s): _____

Address: _____

H&C number: _____ DOB: _____

Falls Prevention Pathway

(to be used alongside the HSC Person-centred Nursing Assessment)

If a patient is identified as being at risk of falling or has fallen in the last 12 months, the following pathway must be completed on admission.

This pathway has a range of interventions to be considered to prevent falls, whilst maintaining dignity and independence.

Please sign, date and time each intervention when implemented. If an intervention is not appropriate for the patient, provide rationale in variances.

Remember to re-evaluate the patients risk status and review interventions in the following instances:

- A- After a fall, a suspected fall or a near fall**
- B- If the patient demonstrates high risk behaviour**
- C- At least once weekly in a hospital setting**
- D- If concerns regarding falls are raised by the patient, their family or a member of staff**

Record of Intervention Review				
Reason for review				
Record any change to intervention				
Date/Time				
RN Signature				
RN Print name				

Essential Interventions for Patients at Risk	Signature	Date	Time	Variances
Minimum of 2 hourly intentional care rounding				
Record lying and standing blood pressure				
Perform urinalysis and assess for any continence issues				
Manual handling assessment completed and accurate				
Bedrail assessment completed				
Cognitive assessment completed				
Call bell and personal items in reach				
Any walking aids required are available and within reach				
Ensure appropriate footwear worn If not available, provide non-slip socks until appropriate footwear is available				
Ensure glasses and/or hearing aids are worn if required				
Communicate risk to all staff Use falling star at the bedside, add falls risk icon to flow board and include in Patient Safety Briefs				
Refer to physiotherapist for mobility and gait assessment				
Request a review of any medications that are associated with an increased risk of falling				
Provide patient and/or carer with falls prevention in hospital advice leaflet				

If the patient has had an inpatient fall or is at increased risk of falling, consider the following interventions.

Interventions for Patients at High Risk	Signature	Date	Time	Variances
Increase intentional care rounding to 1 hourly				
Nurse patient in observable bed space				
Chair/bed sensor alarms in place Refer to regional guidelines				
Low profile bed in place and at lowest height				
Promote meaningful engagement Use RITA if available				

If the patient is still felt to be at risk of falling consider continuous enhanced observation.

Continuous Enhanced Observation	Signature	Date	Time	Variances
1:1 observation in place				
Continue to promote meaningful engagement Use RITA if available				
Discuss with patient/carers to gain consent and consider Deprivation of Liberty				