ALL WALES FALLS & BONE RISK ASSESSMENT

GIG CYMRU NHS WALES

NHS Wales v1.2 (16/01/2025)

ADDRESSOGRAPH

Assess to be completed within 6 hours of admission/transfer

Guidelines for completion

- Following a fall, following any change in patient's clinical condition; a deterioration or improvement, or every week as a minimum
- Involve patient and family in assessment and action planning, taking into account a patient's ability to understand/retain information
- All 'YES' answers must be actioned, but the examples given should be considered as prompts and are not an exhaustive list
- Multifactorial Actions and Interventions MUST be reviewed with each reassessment

Mandatory actions for all adult patients

Standard Guidance:

- Lying and Standing BP and HR must be taken prior to completion of this form
- Call bell working and in reach (where applicable)
- Advise on safe transfer/mobility and promote consistent messages
- Advise on safe footwear
- Note warfarin/anticoagulants and identify at safety briefing/handover

Environment and/or Equipment:

- Orientate patient to ward
- Advise on risks from drips/tubing/aids
- Mitigate any slip or trip hazards

Post anaesthetic/procedure

- Advise about transfer/mobilising following anaesthetic/ procedure

Hospital					
Ward					
Date					
Time					

1. Falls

Number of falls in the last 12 months (insert number)						
Has the patient had an inpatient fall since the last assessment?	**Y**es/**N**o					
Does the patient have a fear of falling or anxiety?	**Y**es/**N**o					

Remember: Complete bedrail assessment for each patient

All 'YES' answers must complete Actions and Intervention section on page 3

2. Medication

- Patients prescribed anticoagulants/ Warfarin are at increased risk of injury following a fall
- Patients prescribed sedatives, hypnotics, antipsychotics or diuretics are at an increased risk of falls
- Medications that lower BP or cause dizziness increase falls risks

Is the patient on medication that could increase the risk of injury and falls?	**Y**es/**N**o					

All 'YES' answers must complete Actions and Intervention section on page 3

3. Risks

Is the patient medically unwell? (e.g. scoring on NEWS)	**Y**es/**N**o					
Is the patient at risk of seizures?	**Y**es/**N**o					

Blood pressure measurements

After lying for 5 mins (**U** if unable to perform)	Heart rate					
	Blood pressure	/	/	/	/	/
After standing for 1 min (**U** if unable to perform)	Heart rate					
	Blood pressure	/	/	/	/	/
After standing for 3 mins (**U** if unable to perform)	Heart rate					
	Blood pressure	/	/	/	/	/
Is there evidence of postural drop in BP? If no measurement available use professional judgement	**Y**es/**N**o					

All 'YES' answers must complete Actions and Intervention section on page 3

4. Cognitive/ Mental State

- Being agitated, restless, impulsive, disoriented, confused or similar increases the risk of falls
- THINK DELIRIUM and its causes

Does the patient have any issues with cognitive/mental state?	**Y**es/**N**o					

All 'YES' answers must complete Actions and Intervention section on page 3

5. Mobility

Patients are at an increased risk of falls if:

- They need help to stand, transfer and or walk
- Try to walk unaided but are unsafe
- They use a walking aid
- They have gait or balance problems
- They have issues with seating, e.g. slipping out of the chair

Does the patient have any risk associated with mobility that could increase the risks of falls?	**Y**es/**N**o					

All 'YES' answers must complete Actions and Intervention section on page 3

6. Foot Health • Wearing inappropriate footwear increases the patient's risk of falls • Foot pain or foot health issues for example, overgrown toenails, dressings, pressure damage, oedema increases the patient's risk of falls						
Does the patient have appropriate footwear?	Yes/No					
Does the patient have any issues with foot health or pain that could increase the risk of falls?	Yes/No					
All 'YES' answers must complete Actions and Intervention section on page 3						

7. Sensory Deficits						
Does the patient have vision or hearing impairment?	Yes/No					
Does the patient have numbness, weakness or spatial perception problems??	Yes/No					
All 'YES' answers must complete Actions and Intervention section on page 3						

8. Additional risks • Factors such as equipment, nutrition and hydration, continence bundle, dementia, pain assessment, substance misuse, sleep deprivation and rest can increase the risk of falls						
Does the patient have any additional risks that could increase the risk of falls?	Yes/No					
All 'YES' answers must complete Actions and Intervention section on page 3						

9. Patient/Family Views • The patient and/or family may identify factors that can increase the risk of falls						
Does the patient/family identify any factors that could increase the risk of falls?	Yes/No					
All 'YES' answers must complete Actions and Intervention section on page 3						

10. Fractures & Osteoporosis • History of fractures and osteoporosis increases the risk of falls						
Does the patient have a history of fractures/Osteoporosis?	Yes/No					
All 'YES' answers must complete Actions and Intervention section on page 3						

11. Environmental Issues • The bedside/ward environment, single room and home environment may increase the risk of falls						
Does the patient have any environmental issues that could increase the risk of falls?	Yes/No					
All 'YES' answers must complete Actions and Intervention section on page 3						

Based on this assessment are there any targeted interventions required?	Yes/No					
After reviewing this risk assessment is the patient at risk of falls?	Yes/No					
If the patient is at risk of falls, have you provided a patient information leaflet in relation to falls prevention?	Yes/No					
All 'YES' answers must complete Actions and Intervention section on page 3						

Completed by	Name					
	Signature					
	Designation					

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- Document actions and interventions for ALL ‘YES’ responses below.
- Multifactorial Actions and Interventions MUST be reviewed with each reassessment. Document review and changes below.

Interventions & Actions

- **In addition to patient centred interventions, targeted interventions may reduce the risk of falls for patients**

Date	Time	Section number	Interventions & Actions (See Falls & Bone Guidance to support correct documentation)	Name, Signature, Designation

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Guidance to support completion of the All Wales Falls & Bone Risk Assessment

Please consider the following in relation to actions and interventions:

Falls
- See Targeted Interventions below
- Re-assess if fallen (give date fall)
- Provide reassurance and consider assisting / accompanying
- Remember: Complete Bedrail Assessment and safe handling plan for all patients

Medication
- Patient prescribed anticoagulants/ Warfarin are at increased risk of injury following a fall
- Medication review by doctor or pharmacist
- Patient prescribed sedatives, hypnotics, antipsychotics or diuretics are at an increased risk of falls
- Medication that lower BP or cause dizziness increase falls risk

Risks
- Consider medical review
- Inform doctor if systolic blood pressure drops by 20 mmHg and / or Diastolic drops by 10 mmHg from baseline, particularly if patient is symptomatic
- Advise caution when changing posture, e.g. lying or sitting to standing

Cognitive/Mental State
- Delirium screen
- Cognitive Screening Tool
- 24 hour behaviour chart
- Utilise life-story tool e.g. 'This is me'

Mobility
- Refer to physiotherapy
- Record/and use individual plan for safe transfer/mobilising/toileting
- Place aids within reach
- Consider one way glide sheet

Foot Health
- Assess problems that would impede safe mobilisation e.g. overgrown toenails that require social nail cutting, dressings, pressure damage, oedema etc.
- Consider referral to podiatry for other foot health or pain issues
- Consider other core assessments including the use of body map

Sensory Deficits
- If glasses or hearing aid unavailable request relatives bring in glasses / obtain a hearing aid battery / refer appropriately
- Numbness, weakness or spatial perception problems: Undertake actions for individual care needs

Additional Risks
- Consider how these contribute to falls risk e.g. continence urgency, dehydration etc
- Refer to national and local pathways and other core risk assessments

Patient/Family Views
- With patient consent involve family in care planning

Fractures/ Osteoporosis
- Liaise with doctor re anti osteoporotic medications/screening

Environmental Issues
- Bed side/ Ward environment: If confused or short term memory deficit - Consider actions e.g. increased care/ intentional rounding and/ or other actions needed?
- Single room - consider visibility, location and level of care of patient on ward. How will they alert help? If confused or short-term memory deficit - consider actions e.g. sensor mat, increased care/ intentional rounding and/ or other actions needed?
- Home environment - do they have any risk factors which may impact upon falls risks & safe mobility and ADL's at home? Have they/ family any concerns regarding risks in home environment? Consider referral to Occupational Therapy, Care & Repair etc as appropriate.
- All three - Environment to be kept clutter free, Remove hazard if inpatient setting, location of items, visible and in reach, Night-time arrangements-lighting, toileting etc

Targeted interventions

Describe measures in use e.g.
- Low bed
- Safety mat
- Close observation
- Intentional rounding
- Sensors etc
- Bed in observable position