

## HCPA COMPREHENSIVE MULTIFACTORIAL FALLS RISK ASSESSMENT (May 2025)

NAME:

DOB:

RISK	Tick	Suggested Risk Reduction Strategies (Please note, the Screening Tools and Outcome Measures suggested here are just suggestions, that may be useful when a person has a specific risk factor, which requires more in-depth assessment or intervention to reduce the risk. It is not expected, or necessary, that you use all of the Screening Tools and Outcome Measures for everyone)	Risk Reduction Strategies implemented and added to care plan (Include advice given by GP, Physiotherapist/OT or other specialist)	When and by whom?
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<b>Intrinsic Factors</b>						
<p>1. History of falls (How many in the last 12 months?)</p> <p><i>New NICE (2025) recommendations for people who are:</i></p> <ul style="list-style-type: none"> <li>• aged 65 or over</li> <li>• aged 50 to 64 with 1 or more factors that could increase their risk of falls.</li> </ul> <p><i>Offer a comprehensive falls assessment and comprehensive falls management plan to people who have fallen in the last year and meet any of the following criteria:</i></p> <ul style="list-style-type: none"> <li>• Are living with frailty</li> <li>• Were injured in a fall and needed medical (including surgical) treatment</li> <li>• Have experienced a loss of consciousness related to a fall</li> <li>• Have been unable to get up independently after a fall</li> <li>• Have had 2 or more falls in the last year</li> </ul>	Yes		<p>Check history.</p> <p>Check staff have attended HCPA's training courses for Falls Prevention and Intervention.</p> <p>Provide the person and their caregiver relevant oral and written information about individual risk factors for falls.</p>		Date	
	No				Signed	
	N/A					
<p>2. Recent history of falls (in last month) plus causes and consequences, night patterns etc</p>	Yes		<p>Check falls diary/ incident reports.</p> <p>Check care plan.</p>		Date	
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			Establish possible causes, patterns (including night pattern), and trends.		
3. Fear of falling	Yes		<p>Use Falls Efficacy Scale (FES-I), or the Short FES-1, to assessment to establish fear of falling and use strategies to reduce/minimise fear as appropriate (e.g. reassurance, informing the person on the benefits of staying mobile, Back on Feet Risk Assessment)</p> <p>If indicated, screen for anxiety using GAD-2 (Generalised Anxiety Disorder Assessment-2) with appropriate onward referral (<i>see NHS E&amp;N Herts Frailty Pathway</i>).</p> <p>Consider referral to specialist.</p> <p>Remember to practise mobility, and to build the person's confidence. Using SMART goal setting can help with this.</p>		Date
	No				Signed
	N/A				
4. Frailty	Yes		<p>Use Edmonton Frail Scale, or Timed Up and Go (TUG) Test to assess for frailty.</p> <p>Or refer to a clinician (GP or Physiotherapist) for a Clinical Frailty Scale (CFS/Rockwood) Assessment.</p>		Date
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			Remember to consider general health and lifestyle, including diet and exercise, as well as the need for mental health support where appropriate.		
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<b>COGNITIVE FUNCTION and MENTAL HEALTH</b>					
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5. Cognitive impairment	Yes		Screen for cognitive disorders including executive functioning for example by using the clock drawing test or Montreal Cognitive Assessment (MoCA), or Trail Making Test Part B (TMT-B). If indicated, refer to Neuropsychology for further assessment and additional testing. Use strategies known to help the individual understand instructions. If possible, include both the older adult's, and the caregiver's perspectives, when creating the individual falls prevention care plans for adults with cognitive impairment, since this strategy has shown better adherence to interventions and outcomes. Use strategies known to help the individual understand instructions. For people with known cognitive impairment, ensure there is appropriate engagement and mental stimulation strategies are in place, especially around sundowning.		Date
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			Check for signs of acute illness   there is increased confusion. Ensure Deprivation of Liberty Safeguards (DOLS) are in place where necessary, to ensure any restraint used is the least restrictive option.		
6. New confusion/delirium/or signs of acute unwellness (e.g. due to dehydration or acute infection (UTI/Chest infection/wound infection))	Yes		Use NEWS2 and RESTORE2 to establish acute illness and take appropriate action according to NEWS2 and HERTS escalation pathway. Send urine sample for analysis. Ensure plenty of fluids are taken. Refer to SALT/999 if problems with fluid intake. Assess presence of delirium, preferably structured by, e.g., 4AT Delirium Assessment Tool (4AT), Delirium Observation Screening Scale (DOS) or Confusion assessment method (CAM), with clinical judgement. Refer to GP/Community Mental Health Services (HPFT) for diagnosis if new onset, but not acute illness. Ensure all appropriate infection control measures are adhered to.		Date
	No				Signed
	N/A				
7. Depression and/or anxiety	Yes		Screen for depression using the PHQ-2 (Patient Health Questionnaire – Depression-2) with appropriate onward referral (see NHS E&N Herts Frailty Pathway).		Date
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			Screen for anxiety using GAD-2 (Generalised Anxiety Disorder Assessment-2) with appropriate onward referral (see NHS E&N Herts Frailty Pathway).		
8. Behaviour	Yes		Assess behaviour, preferably structured.		
	No		Ensure Positive Behaviour Support plans are in place.		
	N/A		Ensure that staff have had training in Positive Behaviour Support.		

### DISEASE HISTORY

9. Health problems that affect falls risk (e.g. Parkinson's Disease, History of Stroke, Diabetes, Osteoarthritis or Rheumatoid Arthritis, Peripheral Arterial Disease, COPD (Chronic Obstructive Pulmonary Disease))	Yes		Refer to Physiotherapist for assessment and advice as appropriate. Ensure staff are familiar with conditions and how individuals may present and are aware that there may be an added falls risk. Ensure vigilance and that good verbal cues are given when mobilising or transferring e.g., for numbness in feet.		Date	
	No				Signed	
	N/A					
10. Dizziness/vestibular signs (e.g., Inner ear problems - infections, Vertigo, Ménière's Disease)	Yes		Ensure staff are familiar with conditions and how individuals may present and are aware that there may be an added falls risk. Ensure vigilance. Give time in standing, walk on spot before mobilising.			
	No					
	N/A					

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			<p>Have 2-3 staff with wheelchair/to move chair behind in case service user moves forward from the chair.</p> <p>Ensure the person is hydrated before standing up.</p> <p>Take lying and standing BP (blood pressure)</p> <p>Consider referral to ENT specialist.</p>		
11. Syncope syndrome (e.g., Fainting, blackouts, Postural (Orthostatic) Hypotension)	Yes		<p>Give time in standing, walk on spot before mobilising.</p> <p>Have 2-3 staff with wheelchair/to move chair behind in case service user moves forward from the chair.</p> <p>Ensure the person is hydrated before standing up.</p> <p>Take lying and standing BP (blood pressure).</p> <p>Ensure staff are up to date with Moving and Assisting/Handling training, which includes 'supporting a falling person to the floor' and 'assisting a person to get up from the floor'.</p> <p>Consider referral to specialist where needed.</p>	Date	
	No			Signed	
	N/A				
12. Continence problems	Yes		<p>Practice mobility often.</p> <p>Ensure call bells are within reach and that they work.</p> <p>Check that the individual has used the toilet if needed before mobility practice.</p> <p>Ensure lighting is in place at night.</p>	Date	
	No			Signed	
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			Ensure trip hazards are minimised where possible, especially at night. Refer to a continence specialist as appropriate.		
13. Osteoporosis (increases fracture risk)	Yes		Check history.		Date
	No		Refer for bone density assessment (bone scan) if needed.		Signed
	N/A		Ensure Calcium/Vitamin D is prescribed. Consider exercise. The Royal Osteoporosis Society have guidance (and a flowchart) on the amount and type of exercise needed to promote bone strength, the importance of including exercise to reduce falls and resulting fractures – see MFRA Guidance notes.		
14. Pressure sores	Yes		Carry out and document an assessment of pressure ulcer risk for individuals if they have a risk factor, using validated scale to support clinical judgement (for example, the Braden scale, the Waterlow score, or the Norton risk-assessment scale. Reassess pressure ulcer risk if there is a change in clinical status (for example, after surgery, on worsening of an underlying condition or with a change in mobility). Ensure body map and care plan is updated		Date
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			Ensure the individual is checked for pressure areas that may cause unsteadiness in steadiness (e.g., on the feet) or pain, which may also increase risk of falling. Use RESTORE2 and NEWS2 to assess for infection, and refer to the GP/Tissue Viability Nurse (TVN)/Emergency services/Prevention of Admission services as appropriate.		
15. Medication - Polypharmacy, or the use of psychoactive drugs (such as benzodiazepines) or drugs that can cause postural hypotension (such as anti-hypertensive drugs, Parkinson's medication etc)	Yes		Check individual's medications against HCPA Medication resource for side effects. Consider especially any <i>new</i> medications. Refer for medication review with modification or withdrawal– GP, Community Mental Health Team (CMHT).	Date	
	No			Signed	
	N/A				

**MOBILITY AND FUNCTION**

16. Balance problems	Yes		Check mobility aid is safe and within reach. Refer to Physiotherapy for mobility aid, or if current one appears unsuitable (see also Risk Number 30 - Mobility aids). Screen for balance disorders for example by One Leg Stand test. Use the BERG Balance Scale, if appropriate, to assess balance.	Date	
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			Refer to Physiotherapy/Community Falls team for assessment as appropriate.. Practise 1:1 strength and balance exercises – with appropriate risk assessment in place – refer to HCPA resources: StopFalls app, ‘Sit Less-Move More’ – for 1:1 strength and balance exercises. Check staff have attended HCPA’s training courses for Enabling Care (including Enabling and Mobility Champion), Chair-Based Exercise Instructor and Strength and Balance in Care Instructor Training. If indicated, consider referral to Physiotherapist.		
17. Gait	Yes		Screen for mobility problems using a structured approach for example by Short Physical Performance Battery (SPPB) or the Timed Up and Go (TUG) Test. If indicated, consider referral to Physiotherapist.		Date
	No				Signed
	N/A				
18. Muscle strength	Yes		Seek advice from Physiotherapist or Occupational Therapist on strength testing in sitting if person is unable to straighten and bend lower limbs, or unable to use hands to grip to use a rollator frame.		Date
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			Refer to HCPA resources: StopFalls app, 'Sit Less-Move More' for 1:1 strength and balance exercises. Check staff have attended HCPA's training courses for Enabling Care (including Enabling and Mobility Champion), Chair-Based Exercise Instructor and Strength and Balance in Care Instructor Training.		
19. Foot Problems - pain (e.g., from bunions, ingrowing toenails), deformity, stiffness, loss of sensation in one or both feet, foot/lower limb oedema)	Yes		Refer to Podiatrist. Check footwear is comfortable and appropriate. Refer to GP for pain relief/assessment if new onset. Ensure vigilance and that good verbal cues are given e.g., for numbness in feet. Refer to specialist if new onset.		Date
	No				Signed
	N/A				
20. ADLs/Functional ability	Yes		Assess Activities of Daily Living (ADLs) using the Barthel Index (also suitable for care home residents), and Instrumental Activities of Daily Living (IADLs) in a structured manner, preferably by using modified Katz (community dwellers) or NEADL.		
	No				
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21. Weakness - new onset or recent deterioration	Yes	Seek advice from Physiotherapist or Occupational Therapist on strength testing in sitting if unable to straighten and bend lower limbs or unable to use hands to grip to use a rollator frame.  Refer to GP/Emergency services/Prevention of Admission services as appropriate, especially if sudden onset.		Date	
	No			Signed	
	N/A				
22. Fatigue – new onset or recent deterioration		Check whether the person is sleeping well. Check any new medications for side effects. Check for acute illness. Check for anxiety and depression. Refer to GP if indicated.		Date	
				Signed	
	N/A				

<b>SENSORY FUNCTION</b>					
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23. Visual impairment	Yes	Ask the person/family/friend about their vision if any problems are noticed. Check glasses are correct, on, and clean. Refer to optician for vision assessment as indicated.		Date	
	No			Signed	
	N/A				
24. Hearing impairment	Yes	Ask the person/family/friend about their hearing if any problems are noticed. Check hearing aid in and working. Demonstrate and ensure understanding prior to undertaking tasks which may involve a risk of falling.		Date	
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			Check staff have attended a training course for people with a hearing impairment where needed.		
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<b>OTHER HEALTH RISK FACTORS</b>					
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25. Nutrition and Hydration	Yes		<p>Check and update weight.</p> <p>Assess for malnutrition using the MUST tool.</p> <p>Check that there is nutritional optimisation for bone health, including food rich in calcium and proteins, as well as vitamin D supplementation, as part of a multidomain intervention for falls prevention in care home residents.</p> <p>Check and monitor fluid intake, and check that the person is taking adequate fluids.</p> <p>Also check they are managing to swallow - remember repeated chest infections may indicate the person is aspirating when they swallow.</p> <p>Refer to the Dietician/SALT/GP/Emergency services/Prevention of Admission services as appropriate.</p>		Date	
	No				Signed	
	N/A					

26. Alcohol/recreational drugs misuse	Yes		Is the individual free from the influence of alcohol/other recreational drugs that may put them at risk of falling?		Date	
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			Consider Mental Capacity (MCA) and Deprivation of Liberty Safeguards (DoLS) if appropriate.		
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<b>Extrinsic Factors</b>					
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27. Footwear that is unsuitable or missing	Yes		<p>Check shoes/slippers for safety and suitability.</p> <p><b>Worn-out slippers</b> with holes, frayed uppers or broken-down backs need to be changed.</p> <p><b>Loose fitting shoes</b> can slip off and won't support the ankle and heel properly.</p> <p><b>Tight shoes</b> can cause blisters, inflammation, and circulation problems.</p> <p>Recommend that slippers should have good grip, must fasten properly, and stay on.</p> <p>Heels should be low and broad.</p> <p>Look out for a 'slipper swap' event at a local library.</p> <p>Check grip/wear of the sole.</p> <p>Round or square-toed shoes for more toe space.</p> <p>Recommend styles with fastenings (laces/straps) to give extra support.</p> <p>Speak to GP if the person has painful, swollen or 'tingly' feet.</p>		Date	
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			Check who is responsible for purchasing new footwear and ensure this is followed up immediately.		
28. Home hazards - such as loose rugs or mats, uneven flooring, pets, furniture, obstacles, litter and other trip hazards, steps/stairs, poor lighting, wet surfaces (especially in the bathroom), poor heating, and loose fittings (such as handrails), or a lack of other appropriate adaptations	Yes		Hazard assessment and intervention: Check the area is free of <b>obstacles/trip hazards</b> . Check the floor is free of <b>spillages</b> . Check all <b>fixtures</b> are safe. Ensure all <b>rugs</b> have non-slip underlay and replace frayed <b>carpets</b> . Ensure <b>handrails</b> are easily accessible and easily located. Ensure <b>stairs and steps</b> have appropriate handrails. <b>Nonslip mats</b> in bathroom and shower. <b>Two-way switches</b> (maybe glow-in-the-dark) in the bedroom and hallways so residents do not walk in the dark. Ensure <b>night lighting</b> is adequate (consider glow-in-the-dark footsteps, night lights). Check <b>heating</b> is working properly and rectify as able. Refer to Social Worker, for Care at Home clients, if there are any concerns.		Date
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			Request a <b>Home Hazard Assessment</b> (local OT service, local council or fire and rescue can help).		
29. Outdoor hazards - such as icy walkways, above average heat, curbs, uneven pavements	Yes		Complete a full risk assessment, document ALL risks, and ensure risks are minimised wherever possible.  If, as a last resort, measures such as removing a frame from a person who lacks capacity for this decision, (or indeed <i>any</i> measure that may restrict a person's mobility), are considered, this <b>MUST</b> be the LEAST RESTRICTIVE OPTION, and must be accompanied by a separate risk assessment and a DoLS (Deprivation of Liberty Safeguard) <b>MUST</b> be applied for.		Date
	No				Signed
	N/A				
30. Mobility aids	Yes		Check mobility aid is safe and within reach. Refer to Physiotherapy for mobility aid or if current one is broken or appears unsuitable or unsafe.  If, as a last resort, measures such as removing a frame from a person who lacks capacity for this decision, (or indeed <i>any</i> measure that may restrict a person's mobility), are considered, this <b>MUST</b> be the LEAST RESTRICTIVE OPTION, and must be accompanied by a separate risk assessment and a DoLS (Deprivation of Liberty Safeguard) <b>MUST</b> be applied for.		Date
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31. Clothing	Yes	<p>Check that clothes are not too loose, long or trailing on the floor.</p> <p>Belts and cords may need to be tightened to avoid tripping.</p> <p>If the individual has lost weight, this can be evident in their clothes, and this should also trigger a frailty assessment (PRISMA7).</p> <p>Also screen for malnutrition.</p>			
	No				
	N/A				
32. Pendant alarm/call bell	Yes	<p>Check this is within reach and that the person has the physical and cognitive ability to use it effectively.</p>			Date
	No				Signed
	N/A				
33. Sensor mats	Yes	<p>Ensure these are in place if appropriate for the individual and that they are working, and effective.</p> <p>Ensure sensor mat itself is not causing further risk by being a trip hazard or an obstacle.</p> <p>Consider the potential roles for e-health including wearables, virtual reality applications and other environmental monitoring devices.</p>			Date
	No				Signed
	N/A				
34. Bedrails and bed height	Yes	<p>Ensure bedrails are <u>only</u> used in line with latest guidance and local policy.</p> <p>Ensure bed height is in line with latest guidance and local policy and that low profiling beds are used wherever possible.</p>			Date
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			Ensure the correct measures are in place regarding Mental Capacity and Consent/Best Interests and Deprivation of Liberty Safeguards.		
35. Positioning in chair – is the chair the correct height, or are they too low, or too high for e.g., for optimal sit to stand?	Yes		<p>Check there is a one-way glide sheet in place if needed to prevent slipping from the chair.</p> <p>Check the chair height is correct for the person so that they can sit at '90',90',90' (hips, knees and ankles).</p> <p>Check the individual's pelvis is positioned evenly and to the back of the chair.</p> <p>Reposition and check for pressure areas regularly if the individual is unable to move themselves.</p> <p>Refer to HCPA's "Bums on Seats" webinar.</p> <p>Check staff have attended HCPA's training courses for Enabling Care and Mobility Champion, Chair-Based Exercise Instructor and Strength and Balance in Care Instructor training, and the 'Bums on Seats' (chair height) webinar.</p>		Date
	No				Signed
	N/A				

<b>General Considerations</b>					
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36. Is the person mobilising for the first time after an episode of acute illness, for	Yes		If the individual has not been weightbearing for 6 weeks or more, check with GP that it is safe for the person to attempt mobilising. If the person has not been weightbearing for 12		Date
	No				Signed
	N/A				

## HCPA COMPREHENSIVE MULTIFACTORIAL FALLS RISK ASSESSMENT (May 2025)

NAME:

DOB:

RISK	Tick	Suggested Risk Reduction Strategies (Please note, the Screening Tools and Outcome Measures suggested here are just suggestions, that may be useful when a person has a specific risk factor, which requires more in-depth assessment or intervention to reduce the risk. It is not expected, or necessary, that you use all of the Screening Tools and Outcome Measures for everyone)	Risk Reduction Strategies implemented and added to care plan (Include advice given by GP, Physiotherapist/OT or other specialist)	When and by whom?
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example after being discharged from hospital?	N/A		<p>weeks, refer for assessment of bone density due to the increased risk of fractures. Think 'Safety': Minimise risk. Practise Sit to Stand first, before mobilising.</p> <ul style="list-style-type: none"> <li>• <b>Use HCPA's 'Back on Feet Risk Assessment to ensure you do this safely</b> (Ensure staff and equipment in correct position, ensure there is a wheelchair and walking aid plus 3 staff, 1 either side and 1 for wheelchair behind). See HCPA's 'Back on Feet Risk Assessment. for guidance. Refer to Physiotherapy if needed.</li> </ul>		
37. Is NOW the best time of day for the individual?	Yes		<p>If the individual's ability to mobilise fluctuates throughout the day, pick a time when they are likely to be at their best. If there are times of the day where there are likely to be more distractions/obstacles, pick a time when these are minimised. Ensure any patterns in the person's ability are documented and handed over to other staff.</p>		Date
	No				Signed
	N/A				
38. Sedentary behaviour, or a recent decrease in mobility or general activity	Yes		<p>Use the Bed Prevention tool to ensure every effort is made to reduce the risk of an individual being in bed. Practise sit to stand regularly.</p>		Date
	No				Signed
	N/A				

**HCPA COMPREHENSIVE MULTIFACTORIAL FALLS RISK ASSESSMENT (May 2025)**

NAME:

DOB:

RISK	Tick	Suggested Risk Reduction Strategies (Please note, the Screening Tools and Outcome Measures suggested here are just suggestions, that may be useful when a person has a specific risk factor, which requires more in-depth assessment or intervention to reduce the risk. It is not expected, or necessary, that you use all of the Screening Tools and Outcome Measures for everyone)	Risk Reduction Strategies implemented and added to care plan (Include advice given by GP, Physiotherapist/OT or other specialist)	When and by whom?
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		<p>Encourage independence, mobility and exercise, as well as involvement in everyday ADLs and IADLs – see Risk number 20.</p> <p>Seek advice from Physiotherapist or Occupational Therapist if person is unable to straighten and bend lower limbs, or is unable to use hands to grip to use a rollator frame.</p> <p>Practise 1:1 strength and balance exercises – with appropriate risk assessment in place – refer to HCPA resources: StopFalls app, ‘Sit Less-Move More’ – for 1:1 strength and balance exercises.</p> <p>Refer to Physiotherapy/Community Falls team for assessment if needed.</p> <p>Check staff have attended HCPA’s training courses for Enabling Care and Mobility Champion, Chair-Based Exercise Instructor, and Strength and Balance in Care Instructor training</p>			
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**Specific Considerations for individuals on e.g. a NON-WEIGHTBEARING PATHWAY**

39. Are there signs that the individual feels unwell?	Yes	Check for infection – Use RESTORE2 and NEWS2 and take appropriate action according to NEWS2 and HERTS escalation pathway.		Date	
	No			Signed	
	N/A				

**HCPA COMPREHENSIVE MULTIFACTORIAL FALLS RISK ASSESSMENT (May 2025)**

NAME:

DOB:

RISK	Tick	Suggested Risk Reduction Strategies (Please note, the Screening Tools and Outcome Measures suggested here are just suggestions, that may be useful when a person has a specific risk factor, which requires more in-depth assessment or intervention to reduce the risk. It is not expected, or necessary, that you use all of the Screening Tools and Outcome Measures for everyone)	Risk Reduction Strategies implemented and added to care plan (Include advice given by GP, Physiotherapist/OT or other specialist)	When and by whom?
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40. Are there signs of local/systemic infection?	Yes	<p>Check wound for exudate, swelling, unpleasant odour.</p> <p>Check limb for discolouration.</p> <p>Check for infection – Use RESTORE2 and NEWS2 and take appropriate action according to NEWS2 and HERTS escalation pathway.</p> <p>Refer back to the Intermediate Care Team or other referring team, or to the GP/Tissue Viability Nurse (TVN)/Emergency services/Prevention of Admission services as appropriate.</p>		Date	
	No			Signed	
	N/A				
41. Is there bleeding?	Yes	<p>Follow your local First Aid guidelines and refer to Emergency services/Prevention of Admission services as appropriate.</p>		Date	
	No			Signed	
	N/A				
42. Are there signs that the individual is in pain?	Yes	<p>Refer back to the Intermediate Care Team or other referring team, or to the GP for pain relief if necessary.</p>		Date	
	No			Signed	
	N/A				
43. Are there signs of a DVT/fat embolism?	Yes	<p>Use RESTORE2 and NEWS2 and take appropriate action according to NEWS2 and HERTS escalation pathway.</p>		Date	
	No			Signed	
	N/A				