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|   | **Risk Assessment Management Plan – Falls Risk Assessment** |

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| **RISK ASSESSMENT** |
| **Name** |  | **Reference Number** |  |
| **Identified Risk** | Risks to health from Falls  |
| **Assessment Date** |  |
| **Risk Factors** | **Likelihood** | **Severity** |
| Rare | 1 | None / Trivial | 1 |
| Unlikely | 2 | Minor / No Injury | 2 |
| Likely | 3 | Moderate / First Aid | 3 |
| Very Likely | 4 | Severe / Medical assistance | 4 |
| Almost Certain | 5 | Extreme / Fatal | 5 |
| **Risk Matrix** | **=** | **Severity** |
| **Likelihood** | **1** | **2** | **3** | **4** | **5** |
| **1** | 1 | 2 | 3 | 4 | **5** |
| **2** | 2 | 4 | 6 | 8 | 10 |
| **3** | 3 | 6 | 9 | 12 | 15 |
| **4** | 4 | 8 | 12 | 16 | 20 |
| **5** | 5 | 10 | 15 | 20 | 25 |
| **Risk Level and Action** | **Level** | **Action** |
| 1 – 4 | NO CURRENT RISK | No further action, but ensure controls are maintained and monitored |
| 5 – 9 | LOW RISK | Develop management plan and review quarterly |
| 10 – 16 | MEDIUM RISK | Develop management plan and review monthly |
| 16+ | HIGH RISK | Develop management plan and review subject to each occurrence |
| **Assessment Summary** |  |
| **Author(/s)** | **Print Name** | **Position / Relation** | **Signature** |
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| **RISK MANAGEMENT PLAN** |
| **Purpose** | The purpose of this risk management plan is to identify the risks and measures to be taken to minimise risks associated with Falls |
| **Proactive Measures** | **The following risks need to be considered for people with a history of or who are considered to be at risk of falling.*** Conditions that affect mobility or balance.
* Prescribed medication.
* Environmental hazards.
* Previous history of falls.
* Consent for use of equipment.
* Consent to measures that may be deemed restrictive if applicable.

**Action to be taken to minimise the risk of falls:**Staff awareness of conditions known to affect mobility and or balance.Care plan to be created with staff guidance on what to do should a fall occur.Be aware of medication taken such as psychoactive drugs (such as benzodiazepines) or drugs that can cause postural hypotension (such as anti-hypertensive drugs).Staff awareness of visual / hearing impairment.Staff awareness of cognitive impairment.Consent to equipment used such as alarm mats, bed rails, lap straps.MCA / BI for those who may be deemed not to have capacity.Make sure the environment is safe, well-lit, and free of obstruction.Wet floor signs are in use.Cables and leads not to be left across the floorStaff awareness of trip and slip hazards.Well-fitting footwear.All falls to be documented and reported to other relevant authorities as applicable and families made aware.Actions noted if required and staff feedback.Amendment of care plan.Referral to other professionals. |
| **Individual Risk Measures and specific guidance**  | *You may want to include some of the following: (this list is not exhaustive)* *History of falls.**Previous injury caused by falls**Outside professional input and referrals.**Known conditions that may be a cause of falls**Name of medication taken that may affect mobility and balance.* *Who to notify in case of falls and injury.**Name of equipment used.**Location of consent / MCA paperwork.* |
| **Author(/s)** | **Print Name** | **Position / Relation** | **Signature** |
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| **Cosignatories** **(Staff Team)** | **Print Name** | **Position / Relation** | **Signature** |
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|  | **RISK ASSESSMENT REVIEW**  |  |
| **Date** | **Notes** | **Name & Signature** |
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