Falls, pressure injury and nutrition risk screening

Standard operating procedure (SOP) | LTC-SOP-001

Document type	Standard operating procedure (SOP)
Title	Falls, pressure injury and nutrition risk screening
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Prepared by	{{roles.quality_lead.name}}, Quality lead
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Approver and signature	{{roles.clinical_director.name}}, Clinical director Signature: _____ Date: _____
Effective date	{{document.effective_date}}
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Replaces	None (new document)
Standards and criteria supported	System S4 (Long-term care), criterion S4.1
Evidence basis	E-006, E-009
Status of this document	Recommended best-practice model. A hospital may adopt, adapt or replace it with an equivalent that meets the same criteria.

At a glance: what to do

1. Screen every resident on admission for falls, pressure injury and nutrition risk.
2. Repeat the screen on the schedule set for each risk level and after any fall, skin change or weight loss.
3. Put a written measure in place for every resident at risk.
4. Review the measures at each screen.

Stop and get help straight away if: a resident at risk has no screen on record, or no measure in place for a known risk.

1. Purpose

To find residents at risk of falls, pressure injury and malnutrition early, and to act before harm happens (S4.1).

2. Scope

Applies to	Clinical and support staff in the hospital
Locations	All wards, clinics and departments of {{facility.legal_name}}
When	Whenever the activity described is carried out
Does not apply to	Activities covered by another document listed in section 15

3. Definitions and abbreviations

Term	Meaning in this SOP
Clinical lead	The doctor or nurse in charge of the area at the time

4. Background and rationale

Older people and people with limited mobility can fall, develop pressure injuries, or lose weight quickly, often without anyone noticing until harm is done. A risk check on arrival and on a schedule, with measures put in place, prevents most of these.

5. Responsibilities

Role	Duties in this SOP	Competence needed
Care home nurse in charge	Completes the screen and sets the measures	Registered nurse
Care staff	Watch for change and report it the same shift	Trained in the screen

6. Equipment, materials and resources

Item	Specification or standard	Check before use
Records and forms named in this document	Current version	Checked before use

7. Safety and infection prevention

- Stop and call for help if a patient is at immediate risk. Do not delay urgent care to complete paperwork.

8. Before you start

- Confirm the forms and equipment named in this document are available and current.

9. Procedure

Follow the steps in order. Where a step says "If", take the action for the case that applies. Do not skip a step. If a step cannot be done, use section 11 and section 12.

Step	Action	How to do it	Key point
1	Screen on admission.	• Complete the falls, pressure injury and nutrition screen within 24 hours of arrival. • Record the result on LTC-FRM-001.	Admission is the first and most important screen.
2	Set measures.	• For each resident at risk, write the measure: mobility aids, pressure relieving equipment, or food and fluid plan. • Tell the care team where it is recorded.	A risk with no measure is not managed.
3	Repeat and react.	• Repeat the screen on the schedule for the risk level. • After any fall, new skin change or weight loss, screen again the same day.	Change is the trigger.
4	Record in the register.	• Enter each at-risk resident on LTC-REG-001 with the date of the next screen.	The register shows who is due.

Decision points

- No decision points in this procedure.

10. Special situations

Situation	What to do
Out of hours	Follow the same steps. Use the on-call contact on the wall of the area.

11. Problems and escalation

- Any serious problem goes to the duty clinical lead at once and to the clinical director the same day.

12. Monitoring and compliance

What is checked	Target	How often	Who	If the target is missed
Residents screened on admission within 24 hours	100%	Monthly	Nurse in charge	Escalate to clinical lead
At-risk residents with a measure in place	100%	Monthly	Nurse in charge	Escalate to clinical lead
Screens repeated on schedule	At least 70%	Quarterly	Clinical lead	Escalate to clinical lead

13. Records

Record	Where it is kept	Kept for
Record named in this document	Patient record or the area file	{{facility.records_retention_years}} years

14. Training and competence

- Staff are trained in this document at induction and refreshed each year, with a recorded competency check.

15. Related documents

ID	Title	Relationship
LTC-FRM-001	Risk screen and measures record	Screen form
LTC-REG-001	Falls, pressure injury and weight register	Register

16. Evidence

ID	Source and status
E-009	ASF Expert Committee consensus. Scale choice to follow the national care home guidance.
E-006	ASF Policy Framework v1.2. Adapted.
E-009	ASF Expert Committee consensus.

EC = ASF Expert Committee consensus. Items marked EC are reviewed by the Committee each year.

17. Change history

Version	Date	What changed	Approver and signature
1.0	{{document.effective_date}}	First version	Pending Expert Committee approval