

Falls Risk Assessment and Prevention

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

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Title	Falls Risk Assessment and Prevention
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Effective date	{{document.effective_date}}
Next review	{{document.review_date}} (12 months, or sooner after any incident or change)
Replaces	Replaces the earlier short form
Standards and criteria supported	Standard 1, criterion 1.4 (non-negotiable)
Evidence basis	E-008, 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. Assess every patient for falls risk on admission, using the falls risk assessment tool (PSF-FRM-002).
2. Identify the risk factors and set interventions for each one. Write them in the care plan.
3. Review the assessment daily, and after any change in condition, medicine or location.
4. After any fall, check the patient at once, inform the doctor, and record it on PSF-FRM-001.
5. Review the falls log every month and report trends.

Stop and get help straight away if: the patient has a fall with a head strike, new weakness, severe pain, or reduced consciousness. Call the doctor at once and follow the hospital head-injury procedure.

1. Purpose

To find patients at risk of falling, reduce the risk with interventions that fit the person, and learn from every fall [E-008]. Falls are a common cause of injury in hospital and can cause serious harm, loss of independence and longer stays.

2. Scope

Applies to	All nursing, medical, allied health and support staff who care for patients
Locations	All inpatient wards, day care and any area where patients stand, walk or transfer at {{facility.legal_name}}
When	On admission, daily, after any change, after any fall, and on transfer between areas
Does not apply to	Falls prevention for patients in community settings, covered by the home care standard

3. Definitions and abbreviations

Term	Meaning in this SOP
Fall	An unplanned event where the patient comes to rest on the ground, floor or another lower level, or is caught by someone or something

Term	Meaning in this SOP
Near fall	A loss of balance that was stopped before the patient reached the ground (recorded the same way as a fall)
Risk factor	A condition, medicine, or circumstance that increases the chance of a fall
Intervention	An action taken to reduce the risk for a specific patient
Falls risk score	The total from PSF-FRM-002, classed as low, moderate or high using the bands set by the clinical director (EC)

4. Background and rationale

Older people and patients with reduced mobility, confusion, or on certain medicines are at highest risk. WHO recognises falls as a major and preventable cause of injury, and recommends a multifactorial approach: assessment of individual risk, tailored interventions, medicine review, and an environment and staff practice that support safe movement [E-008].

This SOP is the method for criterion 1.4: falls are assessed, and falls and prevention are recorded. The falls log extract (last 6 months) is the audit evidence.

5. Responsibilities

Role	Duties in this SOP	Competence needed
Nurse in charge of the ward	Completes the initial assessment, sets interventions, reviews daily	Trained in the falls tool and interventions
Doctor	Reviews patients with high falls risk, reviews medicines that increase risk, assesses after a fall with injury	Competent in medicine review
Pharmacist	Reviews medicines for patients with high risk within 24 hours of request	Clinical pharmacy competence
Chief nurse	Owns the process, reviews the falls log monthly, reports trends to the quality committee	Quality and governance training
Allied health staff (physiotherapy, occupational therapy)	Assess mobility and advise on equipment and exercise where referred	Own professional competence

6. Equipment, materials and resources

Item	Specification or standard	Check before use
Falls risk assessment tool (PSF-FRM-002)	Current version approved by the clinical director	Version and date correct
Falls log (PSF-FRM-001)	Current version	Available on each ward
Equipment for the ward	Bed height adjustable; call bell within reach; non-slip footwear; walking aids; sensory aids where needed (glasses, hearing aids)	Working, clean and in place
Bed or chair alarms (where used)	Used only after individual assessment and recorded in the care plan (EC)	Tested at start of each shift

7. Safety and infection prevention

- Do not use restraint as a way of preventing falls. Restraint is covered by the restraint policy and needs its own assessment.
- Always help a patient who is falling to the floor to lower safely. Do not try to hold them up.
- Ensure the floor is dry, clean and free of clutter. Report spills and trip hazards at once.

8. Before you start

- Check the patient's medical record for previous falls, and the medicines on their chart.
- Check the patient's mobility aids, footwear and glasses or hearing aids are available and in use.

- Explain to the patient and family what the assessment is for and how they can help.

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	Complete the initial falls risk assessment within the first hours of admission.	• Use PSF-FRM-002. Ask the patient about previous falls, mobility, continence, vision and hearing, and dizziness. • Check the medicine chart for sedatives, antihypertensives, diuretics, opioids and any medicine that causes low blood pressure or drowsiness. • Assess cognition: is the patient confused, does the patient remember the call bell? • Score the tool and classify the risk using the bands.	Assess early. Most falls happen when the patient is new to the ward and unfamiliar with the environment (EC).
2	Set the interventions for each risk factor.	• For each positive item, write one intervention in the care plan (for example, bed in low position; call bell within reach; supervision when walking; toileting schedule; footwear checked). • If a medicine increases risk, ask the doctor to review it within 24 hours and record the request. • If a patient has a mobility problem, request physiotherapy or occupational therapy assessment for equipment and exercise.	Interventions must match the risk. Generic lists that are not checked for each patient do not prevent falls.
3	Communicate the risk to the team and the patient.	• Mark high-risk status on the ward board or the electronic record, as the hospital uses. • Tell the patient and family what to do and what to ask for (for example, call before getting up at night). • Record the handover at each shift for high-risk patients.	The whole team must know who is at risk, not only the person who did the assessment.
4	Review the assessment daily and after any change.	• Review every patient at least once each day. • Review again after: a fall or near fall, a new medicine that increases risk, a change in mobility or consciousness, a transfer to another area, or return from theatre. • Update the score and interventions. Record the date and initials.	Risk changes with illness, medicines and time in hospital. A single assessment is not enough.
5	Respond immediately to any fall.	• Do not move the patient unless they are in danger. Check breathing, consciousness, and injury. • Call for help and inform the nurse in charge and the doctor. • If there is a head strike, a patient on anticoagulants, new weakness, severe pain or reduced consciousness, call the doctor urgently and follow the head injury procedure. • Help the patient up only after the doctor has assessed them, unless it is safe and they are not injured.	The first check after a fall decides whether there is serious injury. Do not rush the patient up.
6	Record and review every fall.	• Complete PSF-FRM-001: date and time, location, cause (as far as known), injury, response, doctor informed, review date. • Repeat the falls risk assessment and update interventions the same day. • Report to the ward head. Complete an incident report (INC-POL-001) for every fall with harm, and for every fall of a high-risk patient. • Root-cause review within 72 hours for any fall with harm (EC).	Every fall is a learning opportunity. Records must be specific enough to change the next intervention.
7	Review the falls log monthly.	• The chief nurse reviews all falls each month, looks for patterns (time, location, medicine, equipment), and sets actions. • Report the number of falls and falls with harm to the quality committee.	Patterns show what the single assessment misses, such as a ward with poor lighting or a medicine given at night.

Decision points

- If the risk score is low, follow the standard care plan and review daily.
- If the risk score is moderate or high, set interventions for each risk factor and inform the team.
- If the patient has a fall with harm, follow step 6 and the head injury procedure where relevant.

10. Special situations

Situation	What to do
Patient with delirium or confusion	Increase supervision, review medicines, keep the environment familiar, and involve family. Do not use restraint to manage confusion (EC).
Patient in theatre, imaging or therapy	Hand over the falls risk before the patient leaves the ward and check again on return.
Day care patient	Give the patient the falls risk information on discharge and check on the day of the next visit (EC).
Patient using a bed or chair alarm	Test the alarm at the start of each shift. Alarms do not replace checking on the patient.

11. Problems and escalation

- If a fall causes injury, inform the doctor at once and record the time.
- If a medicine increases the risk and the doctor does not agree to review it, escalate to the clinical director.
- If the falls rate rises for a ward for two months in a row, the quality lead starts a review.

12. Monitoring and compliance

What is checked	Target	How often	Who	If the target is missed
High-risk patients with interventions documented in the care plan	100%	Monthly audit of 20 patient records	Chief nurse	Review of each missing case; ward-level coaching
Falls risk assessment completed within the first hours of admission	Target set by committee (EC)	Monthly audit	Quality lead	Ward-level review
Falls per 1,000 patient days	Set by committee; trend reported	Monthly	Chief nurse	Review by ward; action plan if trend rises for two months
Falls with harm reviewed within 72 hours	100%	Monthly	Quality lead	Escalation to clinical director

13. Records

Record	Where it is kept	Kept for
PSF-FRM-002 Falls Risk Assessment Tool	Medical record	{{facility.records_retention_years}} years
PSF-FRM-001 Falls Log	Ward file and quality file	{{facility.records_retention_years}} years
Incident report (INC-POL-001)	Incident log	{{facility.records_retention_years}} years

14. Training and competence

- All nursing and clinical staff complete falls training at induction, including the tool and interventions (EC).
- Refresher each year and after a significant falls event on the ward (EC).
- Staff are assessed by observation and case review before they lead the falls assessment alone (EC).

15. Related documents

ID	Title	Relationship
PSF-FRM-001	Falls Log	Used in step 6
PSF-FRM-002	Falls Risk Assessment Tool	Used in steps 1 and 4
PSF-GDL-001	Falls Prevention Guideline	Recommendations behind this SOP
INC-POL-001	Incident Reporting and Management	Falls with harm are incidents
Restraint policy (generic)	Restraint policy	Restraint is not a falls intervention

16. Evidence

ID	Source and status
E-008	World Health Organization. Global Report on Falls Prevention in Older Age (2007).
E-009	ASF Expert Committee consensus. Score bands, assessment time, falls review timing and alarm use are EC decisions.

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}}	Full procedure written; added tool use, decisions, interventions, after-fall response, and monthly review	Approved by the ASF Expert Committee