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Bury Care Organisation
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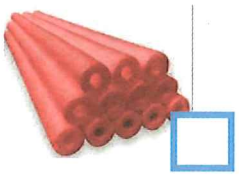
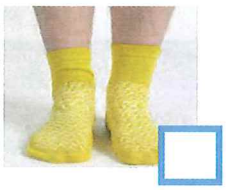
Patient Name: Hospital Number: DOB:

Falls Bundle / Moving and Handling Assessments

Does The Patient Have Any Falls Risk Factors			
A Assessment	Vision	Hearing	Continence
B Balance/Mobility	Balance	Remember To Use These Falls Risk Identifiers:   	
C Cognition			

Moving and Handling/Frailty Risk Assessment

Independent ☐ Walking Stick ☐ With Patient ☐ Provided by ED ☐
Frame ☐ Wheelchair ☐ Chair/Bedbound ☐

Falls Risk	Yes	No	Comment
Is a Lying/Standing BP indicated? (If unable state why, ie-Pt Unwell/ Pressures / Support Required)			
Has the patient fallen prior to or since admission?			
Does the patient have a cognitive impairment? (new or old)			
Does the patient have any mobility issues?			
Does the patient have any visual/hearing problems?			
Does the patient lack the mental capacity to understand instructions?			
Is the patient on any high-risk medication? (see guidance sheet)			
Does the patient have any condition/incontinence which increases the risk of falling?			

If YES complete the ED short form below if No Sign/Date/Time

Action Plan	Yes	No	Comments
Move to observable cubicle?			
Ensure trolley sides up			
Ensure call bell to hand			
Sitting in chair if appropriate			
Consider enhanced observation			
Wearing appropriate footwear			
Environment is clutter free			

Date	Time	Name Sign:	Print/stamp:

IF YOUR PATIENT FALLS WHILST IN THE DEPARTMENT . PLEASE FOLLOW THE TRUST FALLS BUNDLE. REMEMBER TO USE THE FALLS LEAF SYMBOL, YELLOW TOGGLE OR YELLOW SOCKS SO ALL STAFF ARE AWARE THE PATIENT IS A FALLS RISK. INFORM NIC IF PATIENT REQUIRES 1:1 OR BAY TAG

Remember to review the patient if any changes occur (e.g. if plaster of paris is applied, any new high risk medications administered etc.)

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Pressure Ulcer Risk Assessment – PURPOSE T (V2)

Patient name	DOB	Hospital / NHS number	Ward

Step 1 – screening

Mobility status – *tick all applicable*

- Needs the help of another person to walk ☐
- Spends all or the majority of time in bed or chair ☐
- Remains in the same position for long periods ☐
- Walks independently with or without walking aids ☐

If **ONLY** blue box is ticked

Skin status – *tick all applicable*

- Current PU category/stage 1 or above? ☐
- Reported history of previous PU? ☐
- Vulnerable skin ☐
- Medical device causing pressure/shear at skin site e.g. O_2 mask, NG tube ☐
- Normal skin ☐

If **ONLY** blue box is ticked

Clinical Judgment – *tick as applicable*

- Conditions/treatments which significantly impact the patient's PU risk e.g. poor perfusion, epidurals, oedema, steroids ☐
- No problem ☐

If **ONLY** blue box is ticked

No pressure ulcer not currently at risk

Tick if applicable ☐

Not currently at risk pathway

If **ANY** yellow boxes are ticked, **go to Step 2**

If **ANY** yellow or pink boxes are ticked, **go to Step 2**

If **ANY** yellow boxes are ticked, **go to Step 2**

Step 2 – full assessment

Complete ALL sections

Analysis of independent movement

Tick the applicable box (where frequency and extent categories meet)

Frequency of position changes	Extent of all independent movement / Relief of all pressure areas: Doesn't move	Slight position changes	Major position changes
Doesn't move	☐	N/A	N/A
Moves occasionally	N/A	☐	☐
Moves frequently	N/A	☐	☐

Sensory perception and response – *tick as applicable*

- No problem ☐
- Patient is unable to feel and/or respond appropriately to discomfort from pressure e.g. CVA, neuropathy, epidural ☐

Moisture due to perspiration, urine, faeces or exudate – *tick as applicable*

- No problem / Occasional ☐
- Frequent (2–4 times a day) ☐
- Constant ☐

Diabetes – *tick as applicable*

- Not diabetic ☐
- Diabetic ☐

Perfusion – *tick all applicable*

- No problem ☐
- Conditions affecting central circulation e.g. shock, heart failure, hypotension ☐
- Conditions affecting peripheral circulation e.g. peripheral vascular / arterial disease ☐

Nutrition – *tick all applicable*

- No problem ☐
- Unplanned weight loss ☐
- Poor nutritional intake ☐
- Low BMI (less than 18.5) ☐
- High BMI (30 or more) ☐

Medical device – *tick as applicable*

- No problem ☐
- Medical device causing pressure/shear at skin site e.g. O_2 mask, NG tube ☐

Vulnerable skin (precursor to PU) e.g. blanchable redness that persists, dryness, paper thin, moist.
NPUAP / EPUAP Pressure Ulcer Classification System (2009)
Cat / stage 1 Non-blanchable redness of intact skin
Cat / Stage 2 Partial thickness skin loss or clear blister
Cat / Stage 3 Full thickness skin loss (fat visible/ slough present)
Cat / Stage 4 Full thickness tissue loss (muscle/bone visible)
Cat / Stage U (Unstageable/Unclassified): full thickness skin or tissue loss - depth unknown
Cat / Stage SDTI (Suspected Deep Tissue Injury): Purple/maroon area discoloured intact skin or blood-filled blister - depth unknown)

Current Detailed Skin Assessment – *tick if pain, soreness or discomfort present at any skin site as applicable.*

For each skin site tick applicable column – either vulnerable skin, normal skin or record PU category/stage

Skin site	Pain	Vulnerable skin	PU category/ stage	Normal skin
Sacrum	☐	☐		☐
L Buttock	☐	☐		☐
R Buttock	☐	☐		☐
L Ischial	☐	☐		☐
R Ischial	☐	☐		☐
L Hip	☐	☐		☐

Skin site	Pain	Vulnerable skin	PU category/ stage	Normal skin
R Hip	☐	☐		☐
L Heel	☐	☐		☐
R Heel	☐	☐		☐
L Ankle	☐	☐		☐
R Ankle	☐	☐		☐
L Elbow	☐	☐		☐

Skin site	Pain	Vulnerable skin	PU category/ stage	Normal skin
R Elbow	☐	☐		☐
Other as applicable *(may be medical device site)*				
	☐	☐		☐
	☐	☐		☐
	☐	☐		☐
	☐	☐		☐

Previous PU history – *tick as applicable*

- No known PU history ☐
- PU history – *complete below* ☐
- Number of previous pressure ulcer(s)

Detail of previous PU (if more than 1 previous PU give detail of the PU that left a scar or worst category/stage).

Approx date	Site	PU cat	Scar	No scar
			☐	☐

Other relevant information (if required):

Step 3 – assessment decision

If **ANY pink boxes** are ticked / completed, the patient has an existing pressure ulcer or scarring from previous pressure ulcer.

PU Category/stage 1 or above or scarring from previous pressure ulcers

Tick if applicable ☐

If **ANY orange boxes** are ticked (but no pink boxes), the patient is at risk.

No pressure ulcer but at risk

Tick if applicable ☐

If **only yellow and blue boxes** are ticked, the nurse must consider the risk profile (risk factors present) to decide whether the patient is at risk or not currently at risk.

No pressure ulcer not currently at risk

Tick if applicable ☐

Nurse printed name	Nurse signature	Date	Time