Name of Trainer	
Signature of Trainer	
Date:	

Name of Trainee:	
Signature of Trainee:	
Date:	

NOTES:

Contact details:

The Quality Nursing Team

Hnyicb-voy.yorkplacequalitynursingteam@nhs.net

http://www.reactto.co.uk

Care Homes and Domiciliary Care

NHS Humber and North Yorkshire Integrated Care Board (ICB)

REACT TO FALLS PREVENTION

Falls Prevention Self -Assessment Skills Booklet-Care Workers

A fall is when a person unintentionally comes to rest on the ground or on a lower level

Quality & Nursing Team NHS Vale of York CCG

	Confident?	
Review medical history and physical health	**YES**	**NO**
Can identify falls history, frequency and patterns in last 12 months.		
Able to identify any relevant medical and physical history that may increase falls risk including any fractures,		
Demonstrates an awareness of medication risks.		
Is able to recognise signs of illness/disease/pain/ distress.		
Can recognise signs of malnutrition and dehydration.		
Knows who to report concerns to and where to seek help.		
Environment and Equipment		
Demonstrates awareness of personal and environmental hazards and aware of who/where to report any issues to.		
Shows awareness of the importance of call bells/sensor mats and appropriate use of equipment and aids; and who/where to report any faults.		
Activity		
Can demonstrate an awareness of the need for residents to remain active.		
Can identify any changes in a residents ability or those that may become dizzy on standing and know who to refer to.		
Understands the importance of using appropriate mobilisation aids/support/supervision.		

	Confident?	
Communication and understanding	**YES**	**NO**
Can identify if a resident has difficulties with communication or understanding.		
Can identify if a resident is more confused or disorien-tated than normal.		
Demonstrates an awareness of how to support residents with communication difficulties.		
Shows understanding of how difficulties with vision and hearing can impacts on falls risks.		
Knows who to refer to for help.		
Toilet		
Understands the need for continence assessments.		
Can recognise if a residents toileting needs or continence has changed.		
Understands the need for regular toileting and aware of measures to assist residents with toileting.		
Aware of who to refer to for further support.		

Many falls are preventable and by recognising individual risk factors and reacting to them, you can reduce your resident's risk of falling.

You know your residents well and will notice changes. For example, if a resident becomes dizzy on standing when you are helping them, REACT and report it!

Identifying and assessing risks should be done regularly so you can recognise any changes and REACT.

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