University Hospitals Plymouth NHS Trust

Surname:
First Name:
Hospital Number/Trial Number:
NHS Number:
DOB:
Affix patient label here

Risk Assessment Booklet

Guidance for Completing Risk Assessments

- Risk Assessments must be completed within 24 hours of admission, apart from the Moving and Handling Risk Assessment which must be completed within 6 hours of admission.
- Alcohol & Smoking Screening Tool is a **mandatory** assessment and **must** be completed for all adult patients within 24 - 36 hours of being admitted to hospital.
- Document all actions needed and taken in the patient's progress record in their Care Plan.
- Any risk assessment completed by a non-registered or non-regulated worker must be countersigned by a Registered Nurse.
- Sign the record of multidisciplinary staff signatures.
- **This booklet must stay at the patient's bedside and travel with the patient to other wards and departments.**

PLY0049 - Risk Assessment Booklet - HRDM No. 0724/3

This booklet contains the following Risk Assessments

1. **Alcohol & Smoking Screening Tool - Page 3**
   - *This is a mandatory assessment to be completed for all adult patients within 24 –36 hours of being admitted to hospital.*
2. **Malnutrition Universal Screening Tool - Page 5**
   - *To be calculated on admission then weekly thereafter.*
   - *To be completed for **all** patients.*
3. **Pressure Ulcer Risk Assessment and Skin Bundle Care - Page 7**
   - *Complete on admission, then daily. Care plan must be updated as the patient's needs change.*
   - *To be completed for **all** patients.*
4. **Patient Moving and Handling Risk Assessment and Care Plan - Page 9**
   - *Must be completed on admission for **all** patients and then every time there is a change in the patient's condition.*
   - *The form must be updated following any untoward incident involving the movement/ handling of any patient to which the form relates.*
   - *If there is no change in the patient's condition, then assess every 3 days.*
5. **Falls Risk Assessment - Page 13**
   - *Must be completed on admission for any patient aged 65 years or over, or those patients aged 50-64 whose clinical condition increases their risk of falling or any other patient considered at risk of a fall during this admission.*
   - *The form must be updated following any untoward incident involving the movement/ handling of the patient to which the form relates.*
   - *If there is no change in the patient's condition, then assess every 3 days.*
6. **Bed Rails Risk Assessment - Page 15**
   - *All patients at medium and high risk of falls to be assessed on admission and within 24 hours of transfer to the ward.*
7. **Enhanced Observation Risk Assessment - Page 16**
   - *Must be completed on all patients who require increased levels of observation.*
   - *Must be updated if the patient's condition changes.*
8. **Record of Mental Capacity and Best Interest - *Page 18***
   - *Only required to be completed in the event there is reasonable belief to suspect that the person may not have capacity in relation to the decision that needs to be made.*
9. **Reasonable Adjustments - Page 20**
   - *Reasonable Adjustments sticker to be inserted by the relevant specialist teams.*
10. **Restraining Therapy Risk Assessment - Page 21**
    - *Ensure this risk assessment is completed when considering the use of any restraint interventions including 1:1 care or Deprivation of Liberty safeguards.*
11. **Daily Foot Assessment - Page 24**
    - *This assessment should be undertaken in patients when diabetes is diagnosed and at least annually thereafter if any foot problems arise or on any admission to hospital and if there is any change in the patient's status while they are in hospital.*

Multidisciplinary Team Accountability

Before using this Risk Assessment document please complete the following information below

Name - print	Role	Signature	Initials

Alcohol Screening Tool

1 unit is typically:

UNIT GUIDE

Half-pint of regular beer, lager or cider; 1 small glass of low ABV wine (9%); 1 single measure of spirits (25ml)

The following drinks have more than one unit:

A pint of regular beer, lager or cider, a pint of strong /premium beer, lager or cider, 440ml regular can cider/lager, 440ml "super" lager, 175ml glass of wine (12%)

	Scoring system					Your Score
Questions	**0**	**1**	**2**	**3**	**4**	
How often do you have a drink containing alcohol?	Never	Monthly or less	2 - 4 times per month	2 - 3 times per week	4+ times per week	
How many units of alcohol do you drink on a typical day when you are drinking?	1 - 2	3 - 4	5 - 6	7 - 9	10+	
How often have you had 6 or more units on a single occasion in the last year?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily	
					Total score	

A total score of 5 or above is AUDIT-C positive – Staff to provide Brief Advice to patient

If total score is more than 8 or above patient requires a referral to Alcohol Liaison Nurse (ALN) via SALUS or tel 33963 / 33175. Please ensure the section below is completed prior to referral for clarification of criteria.

Name..... Date.....

To be completed by ward staff when Audit C score is above 8		
Was the patient given brief advice? (note: applicable to patients who drink above low risk levels, but not those who are potentially alcohol dependent)	Yes	No
Was the patient offered a referral to specialist services? (note: only applicable to patients who are identified as potentially alcohol dependent)	Yes	No
Did the patient accept the offer and was the referral made? (note: only applicable to patients who are identified as potentially alcohol dependent)	Yes	No

Name..... Date.....

Smoking Screening Tool

What is the patients smoking status	Never smoked ☐	Ex-smoker (quit >28 days ago) ☐	Current smoker or smoked within last 28 days ☐	
If a current smoker or smoked within last 28 days, please answer the following questions				
Has the patient been given very brief advice on the best way to quit smoking?			Yes	No
Has the patient been offered stop smoking medication?			Yes	No
Has the patient been offered a referral to a stop smoking service			Yes	No
If referral offered, please complete outcome			Referral Date..... By Whom..... Referral Declined ☐	

Smoking Referrals

Plymouth patients - referrals can be phoned to 01752 437177 or emailed to oneyou.plymouth@nhs.net. NOTE - Emailed referrals will need to include patient name, NHS Number, date of birth, address, contact number, consent given for contact, number of cigarettes smoked and any other information.

Cornwall patients - refer to the Cornwall Stop Smoking Service number on 01209 215666. They will take telephone referrals and need to know the patient name, address, date of birth, contact number, NHS number. They will also need to know the patient has given consent to be contacted by phone/text/email/leave a phone message. Alternatively there is a referral form that can be used at https://www.healthycornwall.org.uk/professionals/professional-referral-form/ (select stop smoking from the list of services on offer).

Devon patients who live outside the Plymouth or Torbay catchment area - For adults with a long term health condition, please send individual's name, contact number, email address to onesmallstep2.quit@nhs.net . For all other adults in this catchment who smoke (or have stopped in the past 2 weeks), advise them they can make a self-referral to their local stop smoking service, contact the Devon stop smoking service on 01392 908139, or visit www.onesmallstep.org.uk.

Name..... Date.....

MUST

Malnutrition Universal Screening Tool

PLEASE COMPLETE WITHIN 24 HOURS OF ADMISSION AND WEEKLY THEREAFTER

<table>
<tr><th colspan="2">STEP 1
BMI score

Height:……..</th><th colspan="2">STEP 2
Weight Loss Score

Usual/previous Weight:……...
Date:…….</th><th>STEP 3
Acute Disease Effect Score</th></tr>
<tr><td>BMI kg/m^2

> 20 (>30 = obese)
18.5 -20.0
<18.5</td><td>Score

0
1
2</td><td colspan="2">% Unplanned weight loss in past 3-6 months

% Weight Loss
< 5%
5-10%
> 10%

Score
0
1
2</td><td>Is the patient very ill? Have they had or likely to have limited oral intake for > 5 days?

If yes, Score 2
Otherwise Score 0</td></tr>
</table>

If unable to obtain height use ulna length & convert using tables. If unable to obtain weight, measure mid-upper arm circumference (MUAC), write in weight column and use tables to score BMI (If MUAC <23cm = score 1+)

STEP 4
Add scores together to calculate overall risk of malnutrition

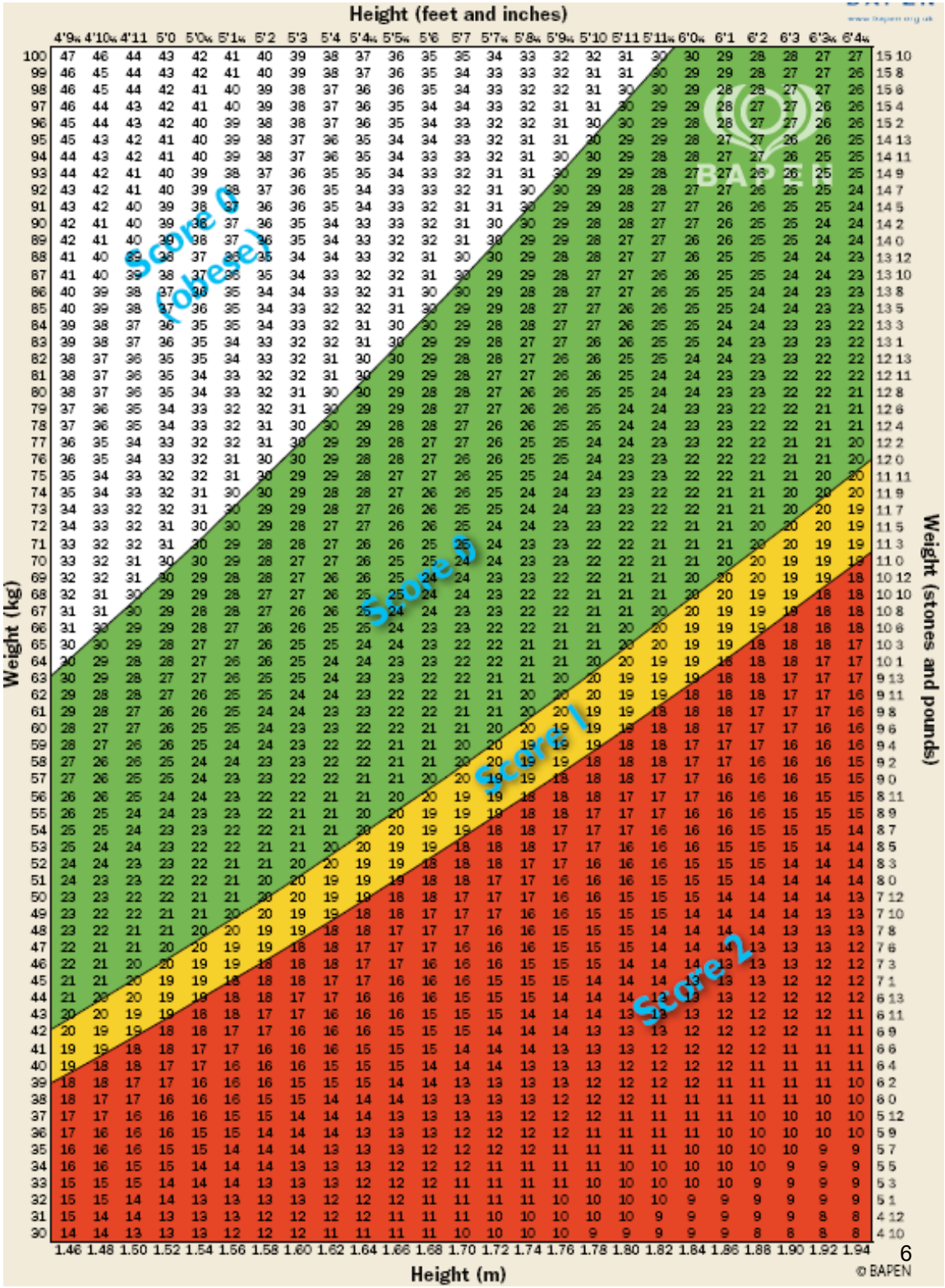
0 LOW RISK	1 MEDIUM RISK - Monitor	≥ 2 HIGH RISK - Treat
ROUTINE CLINICAL CARE • Offer help with eating and drinking if required. • Order special diet if required.	**3 DAY FOOD CHART** **NUTRITIONAL SUPPLEMENTS** • Offer Fresubin Energy/ supplement powder BD (i.e. Meritene) – please ask doctor to prescribe **for 3 days & discontinue supplements when intake improves.** • Offer energy dense choices on menu. • Encourage use of full cream/fat products (i.e. milk/yoghurts). • Offer nourishing drinks throughout the day e.g. milky drinks, fruit juice. • Order snack box/lite bite meal for any missed meals. • Request red tray/ update diet grid as appropriate. • Provide patient handout 'Eating & drinking well in hospital'. **If no improvement after 3 days:** recalculate MUST score and refer to Dietitian with reason for referral via Salus.	**FOOD CHART** **NUTRITIONAL SUPPLEMENTS** **Follow medium risk guidelines** And **REFER TO DIETITIAN** with MUST score and reason for referral via Salus

Method of weighing: Standing ☐ Seated ☐ Hoist ☐ Wheelchair ☐ Bed ☐
Document: Recalled (R) ☐ Estimated (E) ☐ Actual (Act) ☐

	Date	Weight	BMI	Step 1	Step 2	Step 3	MUST score	Actions Taken	Sign & Print name
Admission Assessment (<24hrs)									
Review 1									
Review 2									
Review 3									
Review 4									

Refer immediately to the Department of Nutrition and Dietetics if patient:

- Has dysphagia, an oesophageal stent, head and neck cancer, wired jaws, newly diagnosed diabetes, new dialysis or transplant, a condition requiring complex dietary modification, a known/suspected eating disorder (i.e anorexia nervosa), an inability to eat/drink.
- Is being considered for enteral feeding i.e. NG. **If patient requires parental nutrition (PN) refer immediately to the Nutrition Support Team (via Salus).**



BAPEN
bapen.org.uk

Current weight

kg	Score 0 Wt loss < 5%	Score 1 Wt loss 5 - 10%	Score 2 Wt loss > 10%	kg	Score 0 Wt loss < 5%	Score 1 Wt loss 5 - 10%	Score 2 Wt loss > 10%	kg	Score 0 Wt loss < 5%	Score 1 Wt loss 5 - 10%	Score 2 Wt loss > 10%	kg	Score 0 Wt loss < 5%	Score 1 Wt loss 5 - 10%	Score 2 Wt loss > 10%
	Weight loss in last 3 to 6 months				Weight loss in last 3 to 6 months				Weight loss in last 3 to 6 months				Weight loss in last 3 to 6 months		
	Less than (kg)	Between (kg)	More than (kg)		Less than (kg)	Between (kg)	More than (kg)		Less than (kg)	Between (kg)	More than (kg)		Less than (kg)	Between (kg)	More than (kg)
30	1.6	1.6 - 3.3	3.3	65	3.4	3.4 - 7.2	7.2	100	5.3	5.3 - 11.1	11.1	135	7.1	7.1 - 15.0	15.0
31	1.6	1.6 - 3.4	3.4	66	3.5	3.5 - 7.3	7.3	101	5.3	5.3 - 11.2	11.2	136	7.2	7.2 - 15.1	15.1
32	1.7	1.7 - 3.6	3.6	67	3.5	3.5 - 7.4	7.4	102	5.4	5.4 - 11.3	11.3	137	7.2	7.2 - 15.2	15.2
33	1.7	1.7 - 3.7	3.7	68	3.6	3.6 - 7.7	7.6	103	5.4	5.4 - 11.4	11.4	138	7.3	7.3 - 15.3	15.3
34	1.8	1.8 - 3.8	3.8	69	3.6	3.6 - 7.7	7.7	104	5.5	5.5 - 11.6	11.6	139	7.3	7.3 - 15.4	15.4
35	1.8	1.8 - 3.9	3.9	70	3.7	3.7 - 7.8	7.8	105	5.5	5.5 - 11.7	11.7	140	7.4	7.4 - 15.6	15.6
36	1.9	1.9 - 4.0	4.0	71	3.7	3.7 - 7.9	7.9	106	5.6	5.6 - 11.8	11.8	141	7.4	7.4 - 15.7	15.7
37	1.9	1.9 - 4.1	4.1	72	3.8	3.8 - 8.0	8.0	107	5.6	5.6 - 11.9	11.9	142	7.5	7.5 - 15.8	15.8
38	2.0	2.0 - 4.2	4.2	73	3.8	3.8 - 8.1	8.1	108	5.7	5.7 - 12.0	12.0	143	7.5	7.5 - 15.9	15.9
39	2.1	2.1 - 4.3	4.3	74	3.9	3.9 - 8.2	8.2	109	5.7	5.7 - 12.1	12.1	144	7.6	7.6 - 16.0	16.0
40	2.1	2.1 - 4.4	4.4	75	3.9	3.9 - 8.3	8.3	110	5.8	5.8 - 12.2	12.2	145	7.6	7.6 - 16.1	16.1
41	2.2	2.2 - 4.6	4.6	76	4.0	4.0 - 8.4	8.4	111	5.8	5.8 - 12.3	12.3	146	7.7	7.7 - 16.2	16.2
42	2.2	2.2 - 4.7	4.7	77	4.1	4.1 - 8.6	8.6	112	5.9	5.9 - 12.4	12.4	147	7.7	7.7 - 16.3	16.3
43	2.3	2.3 - 4.8	4.8	78	4.1	4.1 - 8.6	8.7	113	5.9	5.9 - 12.6	12.6	148	7.8	7.8 - 16.4	16.4
44	2.3	2.3 - 4.9	4.9	79	4.2	4.2 - 8.7	8.8	114	6.0	6.0 - 12.7	12.7	149	7.8	7.8 - 16.6	16.6
45	2.4	2.4 - 5.0	5.0	80	4.2	4.2 - 8.9	8.9	115	6.1	6.1 - 12.8	12.8	150	7.9	7.9 - 16.7	16.7
46	2.4	2.4 - 5.1	5.1	81	4.3	4.3 - 9.0	9.0	116	6.1	6.1 - 12.9	12.9	151	7.9	7.9 - 16.8	16.8
47	2.5	2.5 - 5.2	5.2	82	4.3	4.3 - 9.1	9.1	117	6.2	6.2 - 13.0	13.0	152	8.0	8.0 - 16.9	16.9
48	2.5	2.5 - 5.3	5.3	83	4.4	4.4 - 9.2	9.2	118	6.2	6.2 - 13.1	13.1	153	8.1	8.1 - 17.0	17.0
49	2.6	2.6 - 5.4	5.4	84	4.4	4.4 - 9.3	9.3	119	6.3	6.3 - 13.2	13.2	154	8.1	8.1 - 17.1	17.1
50	2.6	2.6 - 5.6	5.6	85	4.5	4.5 - 9.4	9.4	120	6.3	6.3 - 13.3	13.3	155	8.2	8.2 - 17.2	17.2
51	2.7	2.7 - 5.5	5.7	86	4.5	4.5 - 9.6	9.6	121	6.4	6.4 - 13.4	13.4	156	8.2	8.2 - 17.3	17.3
52	2.7	2.7 - 5.8	5.8	87	4.6	4.6 - 9.7	9.7	122	6.4	6.4 - 13.6	13.6	157	8.3	8.3 - 17.6	17.4
53	2.8	2.8 - 5.9	5.9	88	4.6	4.6 - 9.8	9.8	123	6.5	6.5 - 13.7	13.7	158	8.3	8.3 - 17.6	17.6
54	2.8	2.8 - 6.9	6.0	89	4.7	4.7 - 9.9	9.9	124	6.5	6.5 - 13.8	13.8	159	8.4	8.4 - 17.7	17.7
55	2.9	2.9 - 6.1	6.1	90	4.7	4.7 - 10.0	10.0	125	6.6	6.6 - 13.9	13.9	160	8.4	8.4 - 17.8	17.8
56	2.9	2.9 - 6.2	6.2	91	4.8	4.8 - 10.1	10.1	126	6.6	6.6 - 14.0	14.0	161	8.5	8.5 - 17.9	17.9
57	3.0	3.0 - 6.3	6.3	92	4.8	4.8 - 10.2	10.2	127	6.7	6.7 - 14.1	14.1	162	8.5	8.5 - 18.0	18.0
58	3.1	3.1 - 6.4	6.4	93	4.9	4.9 - 10.3	10.3	128	6.7	6.7 - 14.2	14.2	163	8.6	8.6 - 18.1	18.1
59	3.1	3.1 - 6.6	6.6	94	4.9	4.9 - 10.4	10.4	129	6.8	6.8 - 14.3	14.3	164	8.6	8.6 - 18.2	18.2
60	3.2	3.2 - 6.7	6.7	95	5.0	5.0 - 10.6	10.6	130	6.8	6.8 - 14.4	14.4	165	8.7	8.7 - 18.3	18.3
61	3.2	3.2 - 6.8	6.8	96	5.1	5.1 - 10.7	10.7	131	6.9	6.9 - 14.6	14.6	166	8.7	8.7 - 18.4	18.4
62	3.3	3.3 - 6.9	6.9	97	5.1	5.1 - 10.8	10.8	132	6.9	6.9 - 14.7	14.7	167	8.8	8.8 - 18.6	18.6
63	3.3	3.3 - 7.0	7.0	98	5.2	5.2 - 10.9	10.9	133	7.0	7.0 - 14.8	14.8	168	8.8	8.8 - 18.7	18.7
64	3.4	3.4 - 7.1	7.1	99	5.2	5.2 - 11.0	11.0	134	7.1	7.1 - 14.9	14.9	169	8.9	8.9 - 18.8	18.8

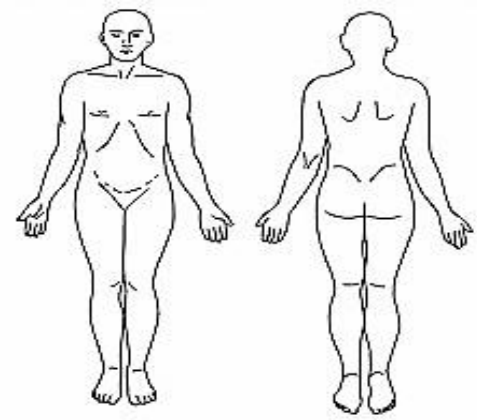
Pressure Ulcer Risk Assessment And Skin Bundle Care

WATERLOW RISK ASSESSMENT							
ıild/weight for height		**Sex**		**Age**		**Neurological deficit**	
Average (BMI 20 – 24.9)	0	Male	1	14 – 49	1	Diabetes, MS, CVA	4 - 6
Above average (BMI 25 – 29)	1	Female	2	50 – 64	2	Motor/Sensory	4 – 6
Obese (BMI >30)	2			65 – 74	3	Paraplegia	4 - 6
Below average (BMI< 20)	3			75 – 80	4	Dementia	4 - 6
				81+	5		

Malnutrition screening tool (Recent weight loss)		**Tissue Malnutrition**		**Medication**	
Patient has lost 0.5 - 5kg	1	Terminal cachexia (emaciation)	8	Cytotoxics	
Patient has lost 5 - 10kg	2	Multiple organ failure	8	Long term/high dose steroids	
Patient has lost 10 - 15kg	3	Single Organ failure (Resp, renal, cardiac)	5	Anti-inflammatory	
Patient has lost >15kg	4	Peripheral vascular disease	5	Max of 4	
Unsure if patient has lost weight	2	Anaemia (Hb<8)	2	**Major trauma**	
Pt eating poorly /lack of appetite	1	Smoking	1	Orthopaedics/spinal	5
Continence		**Skin Type visual risk areas**		**Mobility**	
Complete/catheterised	0	Healthy	0	Fully	0
Urine incontinence	1	Tissue paper	1	Restless/fidgety	1
Faecal incontinence	2	Dry	1	Apathetic	2
Urinary + faecal incontinence	3	Oedematous, clammy, pyrexia	1	Restricted	3
Major Surgery		EPUAP category 1	2	Bedbound e.g. traction	4
On table >2hrs#	5	EPUAP category 2 - 4	3	Chairbound e.g. wheelchair	5
On table >6hrs#	8				

#Scores can be discounted after 48hrs provided the patient is recovering normally
Waterlow Card is printed with the permission of Judy Waterlow MBE SRN RCNT www.judy-waterlow.co.uk

Waterlow Score - record daily							
Date							
Time							
Score Part A							
Score Part B							
Score Part C							
TOTAL							
Daily Skin Assessment (EPUAP score 0,1,2,3,4, DTI or US)							
Left Heel							
Right Heel							
Left Hip							
Right Hip							
Sacrum							
Left Elbow							
Right Elbow							
Other (state)							
Initials							



All pressure ulcers category 1-4, DTI and unstageable should be reported via Datix

Goal: Patient's skin remains intact, as evidenced by the absence of redness over bony prominences and capillary refill less than 6 seconds over areas of redness.			
		Planned care/actions	Signature/ Date
Risk assessment	Assess patient's individual risk factors for developing a pressure ulcer on admission and thereafter daily. The incidence and onset of skin breakdown is directly related to the number of risk factors present.		
Skin inspection	Assessment of the patient's skin on admission and thereafter daily gives a baseline for possible interventions. Check on bony prominences for areas of skin ischaemia and document the EPUAP score daily.		
Support surface	Patients who spend the majority of time on one surface require a pressure reduction or pressure relief device to distribute pressure more evenly and reduce the risk for breakdown.		
Keep your patient moving	Ambulation reduces pressure on the skin from immobility thus lessening the factors that may result in impaired skin integrity. Repositioning and offloading will be key to preventing skin breakdown in patients restricted to bed.		
Incontinence and moisture	Stool may contain enzymes that cause skin breakdown. The urea in urine turns into ammonia within minutes and is caustic to the skin. Use of incontinence pads hastens skin breakdown. Excess moisture may contribute to skin maceration.		
Nutrition and hydration	Sufficient hydration and nutrition help maintain skin turgor, moisture, and suppleness, which provide resilience to damage caused by pressure.		
give information and share learning	Educating patients and caregivers with methods to maintain skin integrity enhances their sense of self-efficacy and prevents skin breakdown.		

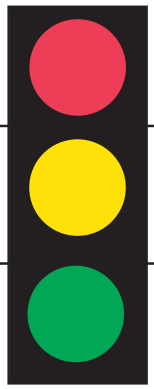
Patient Moving and Handling Risk Assessment

Location on Admission..... Date of Admission.....

Please assess risk on admission, following any change in condition and **every three days**. **Refer to 'Guidance for Completion' in Manual Handling Resource Folder.**

Date								
Patient has had a fall within the last 12/12 or AGE 65 and above?Yes/No - If yes, please complete a falls assessment								
Patient requires assistance to move	yes/no							
Mobility Able to weight bear and balance with 1 person ± equipment Able to weight bear and balance with 2 people ± equipment Unable to weight bear	1 3 7							
Mobility in bed Unable to use right arm Unable to use left arm Unable to use right leg Unable to use left leg	3 3 3 3							
Mental State Anxious Confused / disorientated Post-op. Drowsy/semi-conscious Unconscious Unco-operative	1 2 3 4 5							
Skin Condition: Bruising/discolouration Oedematous Dry/cracked/very thin Sores/wounds on or near lifting points	1 2 2 5							
Pain General mild discomfort Mild pain on movement Severe pain on movement Severe general pain Requires analgesia before moving	1 1 2 3 3							
Continence Incontinent of urine Incontinent of faeces Incontinent of body fluids	1 1 1							

*Score as multiples where neces-								
Height Below 5'4'' (1.62m) >5'4" to 5'8" (1.62 - 1.74m) >5'8" to 6' (1.74 - 1.84m) over 6' (1.84m)	 1 2 3 4							
Weight Under 55 kg 56 to 70 kg 71 to 90 kg 91 kg plus	 1 2 3 4							
Special Risks/Altered centre of gravity Giddiness or falls within 12/12 Plaster cast / bracing / traction* Spinal injury Altered tone	 1 2 3 5							
Monitoring / Invasive Equipment Score 1 for each item e.g. IVI, wound drain, urinary catheter								
Environment								
Working Enviroment Good Cluttered - able to clear Restricted - unable to clear	 1 2 3							
Bed / Trolley Bed rail in place, Date..... *- risk assessment documented* Fixed height Difficult to operate Requires maintenance / faulty, Date..... *- remove from use*	 2 2 2							
Total Score								
*Score as multiples where necessary								
High Risk (Score 20+) Hoist, Standaid, Pat, Sliding sheets, Transfer board, Hover matt.								
Moderate Risk (11-19) Transfer boards, Sliding sheets, Mobilising with 1 or 2 people.								
Low Risk (1-10) Minimal assistance or supervision/verbal prompt.								
Bariatric attribute completed on SALUS	yes/no							
Patient Handling Plan completed / updated where necessary?	yes/no							
Print Name								



Record any changes / fluctuating mobility over a 24hr period and indicate specific action

Patient Moving and Handling Plan

(To be completed by a registered health care professional)

* Trust Policy and Legislation require you to record a plan of care for each activity undertaken
* Refer to Manual Handling Folder for guidance on completion, diagrams of best practice & Trust guidelines for patient handling.
- Document the following - Handling method, equipment and number of staff required for safest practice.
- Ensure each review is dated and signed by appropriate person..
- Always consider patient's current physical state eg. level of fatigue.

N.B. These are guidelines to handling, a personal risk assessment must be conducted before each move

Handling Activity	**Method** Independent / assisted / supervision / mechanical aid	**Equipment** None / sling hoist / gantry hoist / handling belt / sliding sheets / boards / walking frame... etc	**Size*** S/M/L	**Number of staff** 0.1.2.3...etc	Date, Time, Signature and designation **for every assessment**
Turn over in bed					
Sit up from bed					
Move back up bed					
Sit up on side of bed					
Transfer bed / chair / commode / toilet					

Handling Activity	**Method** Independent / assisted / supervision / mechanical aid	**Equipment** None / sling hoist / gantry hoist / handling belt / sliding sheets / boards / walking frame... etc	**Size*** S/M/L	**Number of staff** 0.1.2.3...etc	Date, Time, Signature and designation **for every assessment**
Sit to stand from chair					
Walking					
Trolly to bed / trolly					
In / out of bath					
Other (name activity here)					

Specific Bariatric Equipment - *please print name and date in appropriate box*								
	Ultra Double Gantry	Freespan single Gantry	Riser Recliner	Static Chair	Commode	Wheelchair	Bariatric Re-Turn	Other
Trust owned								
Hired								

Review / evaluate each manoeuvre, assess and record changes as necessary

Futher advice required? Yes ☐ No ☐ Referred for advice to..... Date.....

Patient Consent - complete one of the following:
The patient handling plan has been explained to me and I agree with the measures proposed. I understand that the plan will be reviewed regularly and amended according to my changing clinical needs. Signature of patient ……Date…….
The patient is unable to sign the form but verbal consent for this handling plan has been obtained Signature of registered practitioner …… Print name……..... Date.....
The patient does not have the mental capacity to give consent to this handling plan; patient handling is therefore undertaken in the patient's best interests. The patient handling plan has been discussed with the patient's relative or advocate - Date of discussion with relative…….. Signature of registered practitioner …….. Print name…….....

Falls Risk Assessment and Falls Prevention Care Plan

Falls risk assessment & care plan to be fully completed on all patients aged 65 years & over, or those patients whose clinical condition increases their risk of falling or any other patient considered at risk of a fall during this admission. The assessment of falls risks must be multi-factorial - to identify those factors which may increase a patient's risk of falling.

Falls Risk Assessment	Yes	No	Action
PART A (Increased risk of falls)			**If yes to any question ensure ESSENTIAL bundle of interventions implemented**
Is the patient aged 65 or over?			
Does the patient's clinical condition increase the risks of falling?			
Is the patient known to have a dementia?			
Has the patient developed delirium or become acutely confused?			
Does the patient have poor balance?			
Does the patient have an impaired gait?			
Does the patient usually use walking aids?			
Does the patient have a visual impairment?			
Is the patient on any medications associated with an increased risk of falling? (Refer to falls resource folder for list of medications)			
PART B (serious harm from injury risk)			**If patient has risk factors from PART A and B then implement ESSENTIAL AND CONSIDER HIGH RISK bundle**
Is the patient on anti-coagulants or do they have a clotting impairment?			
Is the patient on treatment for osteoporosis or known to have a previous fragility fracture?			
PART C (History of falls)			**Implement ESSENTIAL AND CONSIDER HIGH RISK bundle**
Has the patient fallen in the past 12 months?			
Does the patient have a fear of falling?			

Risk Assessment Sign Off	
Signature of Registered Nurse	
Print name of Registered Nurse	
Date and time of assessment	

To record completed Interventions sign, date and time each intervention.

Essential Bundle of Interventions	Sign	Date	Time	Variances
Minimum of 2 hourly intentional care rounding				
Record lying and standing blood pressure using the lying and standing blood pressure chart.				
Assess for any continence issues especially urinary frequency.				
Ensure manual handling assessment and care plan are completed and accurate				
Ensure bedrail assessment completed				
Ensure any walking aids that the patient has been assessed to use are available and within reach				Document aids being used here
Ensure patient has appropriate footwear. If not available provide non slip socks.				Document footwear type here
Refer to physiotherapist for mobility and gait assessment				
Request a review of any medicines that are associated with an increased risk of falling or harm from falling. (Refer to falls resource folder for list of medications)				
Provide patient and/or carer with falls prevention in hospital advice leaflet.				
High Risk Bundle of interventions (assess if appropriate to use for the patient if not appropriate provide rationale in variances	Sign	Date	Time	Variances
Increase intentional care rounding to 1 hourly *Prescribe frequency as per trust policy*				
Nurse patient in observable bed space near to the nurses station				
Chair/bed sensor alarms in place *Check equipment in working order and correctly positioned*				
Low profile bed in place *Check in working order and that the bed is used in its lowest position*				
Continuous observation in place *(Refer to Enhanced Observation Policy for Guidance)*				

Record of Care Plan Review (Every 3 days or if patient falls or condition changes)					
Date/Time					
Is this a review post fall? (yes or no)					
RN Signature					
RN Print Name					

Bed Rail Assessment

All patients at medium or high risk of falls to be assessed on admission and within 24hrs of transfer to ward
After initial assessment and decision, document ONLY when decision changes (✓ all that apply)

		Initial	Review	Review	Review
BED RAILS NOT RECOMMENDED - If either of the following apply	Date				
	Time				
Patient is independent. Bed rails can be a barrier to independence for patients who otherwise could leave their bed safely without help					
Risk of entrapment of head, limbs, lines or drainage tubes Bariatric bed used instead D Low profile bed used instead D If it is safer to use bed rails even though there is a risk of entrapment, ALWAYS use bumpers					
BED RAILS RECOMMENDED - if any of the following apply					
History of falls. Patient has fallen out of bed or at high risk of falls					
Fluctuating conscious levels. Patient semi-conscious, sedated, drowsy or recovering from an anesthetic					
Sensory loss or confusion. Patient has a visual impairment, delirious or confused					
Patient lack awareness of own limitations					
Physical limitations. E.g. Patient has a partial paralysis, poor sitting balance etc...					
Seizures or Spasms					
Patient/carer request. Patient fears falling out of bed, uses bed rails at home					
Bed is covered with an overlay mattress for tissue viability. Transfer to an Airwave mattress to allow use of bed rails if required					
USE PROFESSIONAL JUDGEMENT - to decide if it is in the patient's best interest to use bed rails					
Patient is active or disorientated and likely to climb over the rail Not using bed rails? - Low profile bed used instead D Using bed rails? - Intentional Care frequency increased D					
Considering all of the above, document whether bedrails are to be used					
One bed rail to be used - write L or R (patients left or right)					
Both bed rails to be used? (✓)					
Are bumpers necessary? Yes / No					

Patient Consent - complete one of the following:

The bed rail assessment has been explained to me and I agree with the measures proposed. I understand that the assessment will be reviewed regularly and amended according to my changing clinical needs.

Signature of patient …….....Date…….....

The patient is unable to sign the form but verbal consent for this bed rail assessment has been obtained

Signature of registered practitioner…….....Print name.....Date…….....

The patient does not have the mental capacity to give consent to this bed rail assessment; a decision has therefore been taken in the patient's best interests. The bed rail assessment has been discussed with the patient's relative or advocate. Date of discussion with relative…….....

Signature of registered practitioner…….....Print name.....

Enhanced Observation of Care Risk Assessment

Patient requires enhanced level of observation to maintain safety in hospital - YES / NO (*please cricle)*			
Date..... Time..... Registered Nurse..... Signed.....			
Immediate Actions	**YES**	**NO**	**Subsequent Actions**
Recent medical/medication review			If NO - request review within 6 hours
Relevant History obtained - carers or NOK/ Passport/ Getting to Know You			If NO - provide "Getting to know you" document and involve patient/family/carers in completion/if not applicable = NA
Referral to the MDT? Clear MDT management plan including risk assessment?			If NO - make referrals and use the behaviour chart &/or night time functional chart to develop plan
Is there a current alcohol misuse problem?			If YES - refer to Alcohol Liaison Practitioner via SALUS or bleep 89174 - Complete CIWA pathway
Have environmental concerns been considered?			If NO - reduce environmental stimuli - noise etc... move to more observable position
Has the falls trigger assessment been completed?			If NO - complete and consider referral to falls team, ultralow bed/sensor alarm, completed falls assessment and refer to falls team
Is a Mental Health assessment pending or is the patient detained under the Mental Health Act?			If YES - refer to Psychiatric Liaison Nurse (PLNs) or Psychiatric SHO or On Call Manager to determine when MHA assessment is planned to take place. Ensure assessment time is documented
Does the patient have mental capacity?			If NO - complete capacity assessment
Has Mental Capacity been clearly documented - consider using Record of Capacity and Best Interest (MCA 2005)document			If Yes - ensure the restraining therapies is in place. Continue to review care plan regularly: review level of restraint and intensity and consider Deprivation of Liberty Safeguards (DoLS) application - refer to DoLS pathway. Consider daily; mental capacity, restraint and need for DoLS application. Safeguarding Adults team can advise.
Has intentional rounding been commenced?			If NO - complete and prescribe an individual plan for intentional rounding
Can the patient's care be safely maintained within the usual staffing levels?			If NO - proceed to section B and follow algorithm and clinical judgment to inform your request for a special

Section B Risk reason and Specialling recommendation algorithm			
No.	Risk/Reason	Tick	Recommended level of Specialling: professional/clinical judgement must be used
	ALL PATIENTS		
1 Low Risk	Can slip/fall from bed		**Manage with current ward establishment** • Consider Memory box/twiddle muff • Consider 1 hourly intentional rounding • Ensure patient has had relevant nursing risk assessments • Use strategies to minimise risk • Use of sensor alarms • Cohort patients where possible/safe • Consider family support when appropriate • Continue to risk assess - consider restraints therapy care plan and need for DoLS
	Reduced mobility or bedbound and attempting to mobilise		
	Calling out & disturbing other patients		
	Risk of pulling out any indwelling devices		

2 Med Risk	Confused and wandering		**Manage with current ward establishment may need additional support** • Consider family support where appropriate • Ensure patient has had relevant nursing risk assessments falls, cot sides assessment and care plan in line with the restraining therapy policy • Use strategies to minimise risk (bay nursing, reduced noise and light) • Continue to risk assess - consider restraints therapy care plan and need for DoLS • Consider booking Registered Mental Health Nurse (RN03) or Care Support Worker (CSW03) with mental health experience
	Risk of pulling out any indwelling devices with mitts		
	Agitation/Anxiety Impaired cognition/reduced insight Newly detained under the Mental Health Act or already detained and behaviour causing concern		
3 High Risk	Confused & wandering presenting risks to self and others (patients/staff)		**Consider family support** 1:1 HCA
	Violent behaviour & aggression to others and self. Immediate risk to self/harm to others. Substantial & immediate risk of absconding		**1:1 Bed watch or if not available security.** Follow Restraining Therapies Policy: if level of restraint is intensified over a prolonged period during the 72 hours period or restraint is still required after 72 hours and patient is not likely to regain capacity consider a Deprivation of Liberty safeguards application - follow the DoLS pathway. Security to be informed of stepped change. If risk of absconding security will special but only where a valid lawful authority exists (i.e. MHA, DoLS, Court of Protection)
	Expressing intent or recently attempted to self-harm/ suicidal ideation		**1:1 HCA or family support**
	Detained under Mental Health Act, expressing deliberate self-harm intent		**1:1 Mental Health HCA or RMN** dependant on patient need. Contact Duty Senior Nurse on 0355 to book if current RN not available. Consider use of Bed watch worker if patient violent or aggressive.

Ward Nurse to review individual patient needs		Circle		Sign/Date
	After completing the risk assessment do you feel in your professional judgement enhanced observation is still required?	Yes	No	
	Are other patients within the clinical area receiving enhanced observation? If YES - consider cohorting patients to enable closer supervision\and interaction. Patients under bed watch must remain on 1:1	Yes	No	

Shift	Can the patient's care be safely maintained within the usual staffing levels *(circle)*	If no indicate risk reason (1-3)	Sign + Print Name
Day	Yes / No		
Night	Yes / No		

Matron or CSM to authorise the booking of a special	
Identify what risk reason (1-3)	
If risk level 1-2 in your clinical judgement is an additional special require. Please state reason why you are authorising	
Recommendation (use Algorithm as stated on the form)	
Authorised by: Print..... Sign..... Date & Time.....	

RE-ASSESSMENT of RISK (each shift handover or if patients condition changes) Ward Manager to document they have reassessed every 48hrs				
Date	Time	Can the patient's care now be safely maintained within the usual staffing level?	If No indicate Risk Reason 1-3	Sign

Record of Mental Capacity and Best Interest (MCA 2005)

Name Of Decision Making Officer: Designation: Signed:	
Date process started:	
Ward:	
Who is Representing Patient (NOK, Friend, IMCA)	Include L**evel of Authority: (i.e. Power of Attorney for Health and welfare)**

Please give the name and status of anyone who assisted with making this best interest decision:

Name	Status	Contact Details

Details of the decision to be made on behalf of person who lacks capacity: e.g. medical intervention / DoLS

PART 1 DETERMINING LACK OF CAPACITY

	Response		Comments
	Yes	***No***	
1. Is there an impairment of, or disturbance in the functioning of the Patient mind or brain?			
2. Do you consider the Patient **able** to understand the information?			
3. Do you consider the Patient **able** to retain the information**?**			
4. Do you consider the Patient **able** to use or weigh that information?			
5. Do you consider the Patient **able** to communicate their decision?			
6. Has the Service User been determined as lacking capacity to make this particular decision at this moment in time?			

If you have answered **NO** to Q1 that there is no such impairment or disturbance of the mind/brain, then unless there are other behavioural reasons to assess capacity at the outset there is no need to continue any further as this must be present for the assessment to continue to the next steps and thus **THE PATIENT HAS CAPACITY** within the meaning of the Mental Capacity Act 2005. Sign/date this form above, record the outcome within the patient's records. **Do not proceed any further.**

If you have answered **Yes** to Q1 and **No** to any of Q2 to Q5, the Patient is considered on the balance of probability, **NOT to have the capacity to make this particular decision at this time**. Please complete **Part 2** with a least one other individual who knows the person/circumstances best (this may not necessarily be NOK).

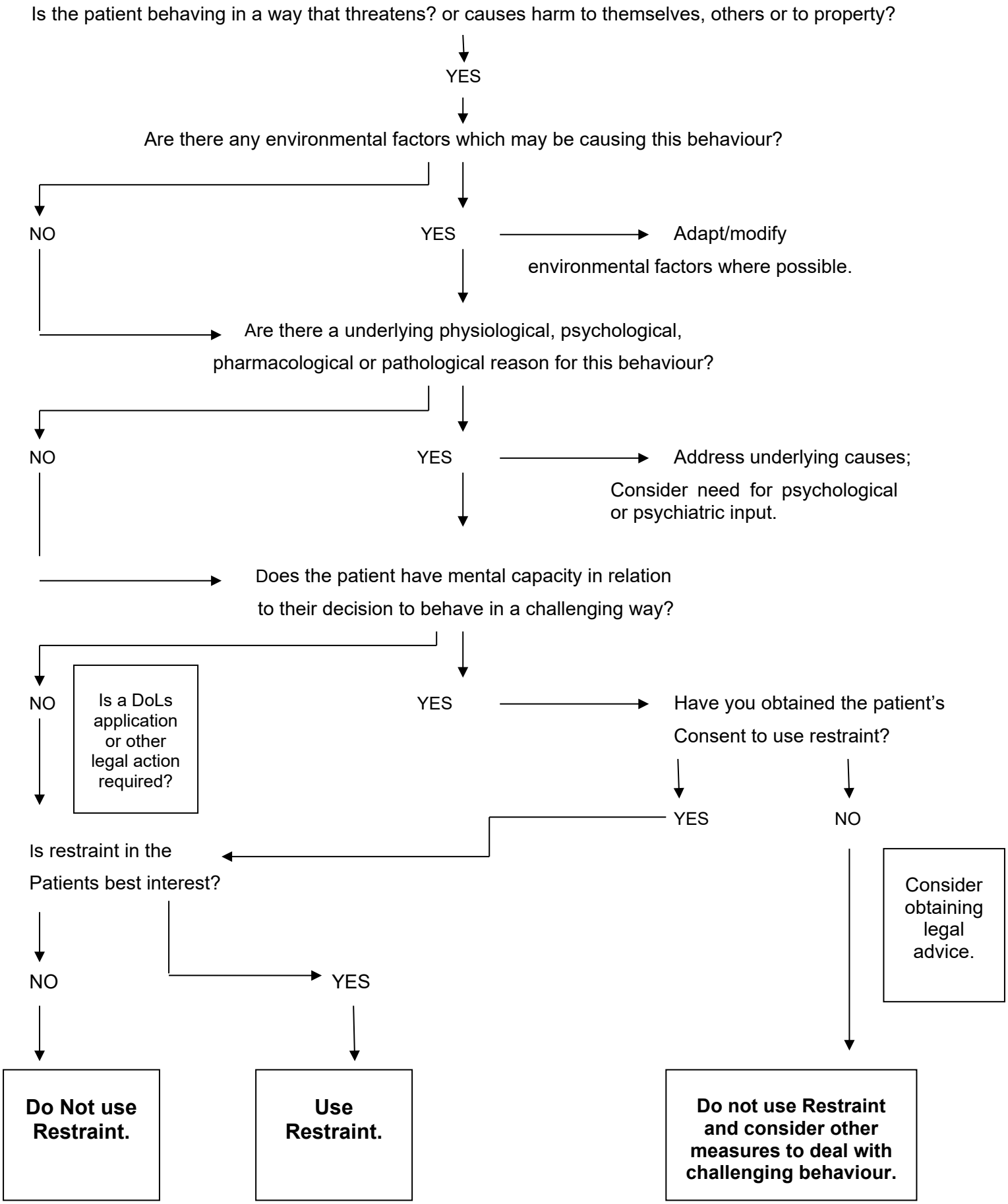
The MCA (2005) applies to those 16 years and over - you must consider the need for an advocate to be present for all young people aged 16 and 17 years and particularly where children are known to have a neurodevelopmental or mental health disorder. Remember **the safety of the child is paramount** and irrespective of whether the young person does or does not have mental capacity appropriate measures should be taken to ensure the young person's safety.

PART 2 – DETERMINING BEST INTERESTS **All steps and decisions taken for someone who lacks capacity must be taken in their best interests.**			
	Response		**Details of Actions**
	Yes	**No**	
Q1. **Avoid Discrimination – Guidance** Have you avoided making assumptions merely on the basis of the Patient's age, appearance, condition or behaviour?			
Q2. **Relevant Circumstances** – **Guidance:** Have you identified all the things the Patient would have taken into account when making the decision for themselves?			
Q3. **Regaining Capacity – Guidance:** Have you considered if the Patient is likely to have capacity at some date in the future and if the decision can be delayed until that time?			
Q4. **Encourage Participation** – **Guidance:** Have you done whatever is possible to permit and encourage the Patient to take part in making the decision?			
Q5. **Special Considerations** – **Guidance:** Where the decision relates to life sustaining treatment, have you ensured that the decision has not been motivated in any way, by a desire to bring about their death?			
Q6. **The Persons Wishes** – **Guidance:** Has consideration been given to the Patient past and present wishes and feelings, beliefs and values that would be likely to influence this decision including written statements?			
Q7. **Consult Others** – **Guidance:** Have you where practicable consulted and taken into account the views of others including those engaged in knowing or caring for the Patient, Attorney under a Lasting or Enduring Power of Attorney or Deputy of the Court of Protection? In cases of serious medical treatment including **DNR** decisions or changes to accommodation and there is no one identified here you must consider instructing an Independent Mental Capacity Advocate.			
Q8. **Avoid Restricting Rights – Guidance:** Has consideration been given to the least restrictive option for the Patient?			
Q9. **Other Considerations** – **Guidance:** have you considered factors such as emotional ties, family obligations that the Patient would be likely to consider if they were making the decision?			
Q10. Having considered all the relevant circumstances, what decision/action do you intend to take whilst acting in the Best Interests of the Patient?			
Signature:		**Date:**	

Reasonable Adjustments

Keep clear for Reasonable Adjustments sticker.

Clinical Decision Making Tool for Challenging Behaviours when considering the use of Restraint Intervention



Risk Assessment Record when Considering the use of Restraint Intervention.

This record must be used in the assessment, monitoring and evaluation of any patient who may require physical or chemical restraint intervention in order to maintain the patient's own safety and to prevent harm. Restraint intervention must be applied in the event of an emergency in the first instance and always in proportion to the risk and in the best interest of the patient.

Does the patient's behaviour have potential to endanger (tick those that apply)?		
Self	Staff	Others

No → **Do Not use Restraint.**

Yes ↓

Describe this behaviour:(this may be a combination of factors)	Yes	No
Wandering and may abscond the ward and is not free to leave?		
Identified high falls risk?		
Confused? Agitated? Aggressive? Combative?		
Attempting to remove medical devices?		
Other? Please describe:		

Repetitive removal of non-life threatening medical devices? (tick all that apply)			
IVI Peripheral		Dressings (VAC)	
NGT / PEG / PEJ		O_2 Mask	
Catheter		Epidural	
Drains		CVC	

Potential removal of any one of these life sustaining devices/treatments? (tick all that apply)			
CPAP/NIPPV		Chest Drain	
Inotropes		Art Line	
CVP		ICP Monitoring	
EVD /Lumbar drain		Tracheostomy	

Identify any impairment of brain function.	**Yes**	**No**
Acute confusion? Delirium? Pyrexia? Hypoxia?		
Withdrawal? (nicotine? drugs? alcohol ? [CIWA score]? Give detail:		
Bowel (Constipation)? Bladder (acute retention/UTI)? Give detail:		
Pain? Fear? Anxiety? Communication needs? Give detail:		
Long term cognitive impairment? Give detail:		

Initial interventions (Emergencies):	**Yes**	**No**
Remove harmful objects; Utilise verbal de-escalation techniques.		
Diffuse situation / use minimum of staff/ use trust approved proportionate restraint.		
Drug therapy/Chemical restraint eg. Sedation/ rapid tranquilisation?		
Call Security **3333** to ensure safety to self and others?		
Involve family or significant other?		
Provide orientation stimuli (clock, newspaper, radio)? Divisional activities (music, TV). Optimise environment.		
Utilise direct observation (1:1 HCA, Enhanced Care and Observation Team?		
Other. Give detail:		

Is the assessing nurse able to maintain patient safety through the above strategies?

NO

YES

Patient settled and outcome successful? Document strategies used/ inform MDT.

Inform medical team of potential need for on-going restraint intervention and document.

Has an assessment been documented of patients Mental Capacity and Best Interest decision been documented by a Registered Practioner?	**Date**	**Time**

In view of above decisions and current management plan,
Is Restraint Intervention Appropriate?

Yes

Decision making by clinical staff involved in the care of the patient of **safest, least restrictive option** regarding type of restraint intervention to be selected in accordance to individual patient's condition and situation specific.

Identify the least restrictive restraint intervention to be used for those requiring on-going restraint intervention. (tick all that apply)	
One to one supervision?	
Appropriate use of Bed Rails?	
Appropriate use of Seat Belt/ Sensor alarm?	
Appropriate use of Locked Doors?	
Appropriate use of Posey Control Mitts?	
Appropriate use of Pharmacological restraint?	
Appropriate use of Physical Interventions (Restraint)?	

ORAL or IM lorazepam 500 μg to 1mg STAT dose. Repeat after 30 minutes if necessary. Max 3mg in 24 hours:
Sedation in 30-45 minutes, peak effect in 1-3 hours.
Lorazepam is to be used with CAUTION in patients with or at risk of respiratory depression (or if appropriate follow alcohol withdrawal protocol)
NB. Local procedures may apply for specific patient groups (e.g. Neurosurgery/ICU/ED)
(Please also see Appendix F)

Patient's must be observed throughout – remember
CLINICAL OBSERVATIONS
Monitor RR, HR, BP, SATS every 15 minutes for 1st hour, if agitated continue every 15 minutes. Once settled and when consider medically stable then every 4 hours

	Print Name	**Date**	**Time**
Has a Relative/Carer/IMCA been informed regarding use of identified restraining therapy and provided with Patient Information Leaflet?			
Has consideration for a referral to Safeguarding Team been made?			
Has consideration for an Urgent DoLS Application been made?			
Signature of risk assessor.			
Signature of senior nurse in charge in clinical area.			

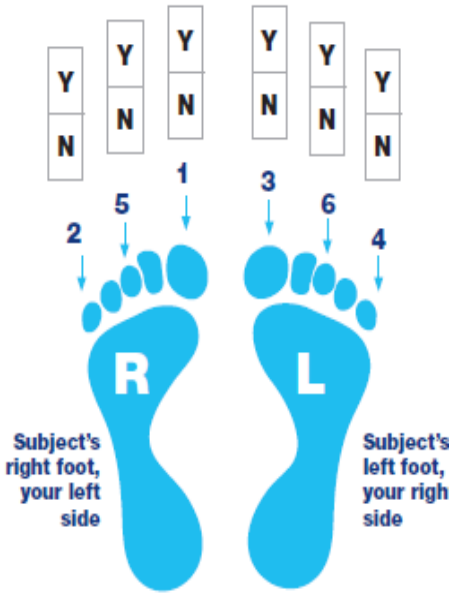
Repeat and review risk assessment every 8 hours to ensure that restraining measures remain the most appropriate least restrictive option

INPATIENT FOOT ULCERATION RISK ASSESSMENT FOR PATIENTS WITH DIABETES

ON ADMISSION – RN TO PERFORM IPSWICH TOUCH TEST *WITHIN 24 HOURS*

TO CHECK FOR LOSS OF SENSATION – 2 OR MORE NEGATIVES = HIGH RISK

The Ipswich Touch Test should only completed once for each admission unless there is a change in the patient's circumstances (NICE NG19, 2015) eg, new pressure ulceration



IPSWICH TOUCH TEST NOT APPLICABLE IF:

- Cognitive dysfunction
- Impaired consciousness
- Patient refusal

UNABLE TO PERFORM TEST DUE TO:

(Reason)

IPSWICH TOUCH TEST

- Ask patient to close their eyes
- Confirm right & left sides with patient
- Inform patient that you will touch their toes and they should say 'left' or 'right' when they feel the touch
- VERY LIGHTLY touch tips of toes for 1-2 seconds, as illustrated in the sequence shown
- Toe sequence = 1.right big, 2.right little, 3.left big, 4.left little, 5.right middle, 6. Left middle
- Record the results by circling **Y** if touch was felt and **N** if not

Two or more negatives = abnormal sensation
= HIGH RISK

DATE TEST COMPLETED:……. TIME:……. SIGNATURE:…….

The foot is at HIGH RISK OF FOOT ULCERATION if any of the following apply: (Circle)

- **Previous ulcer or amputation**
- **Active ulceration**
- **Deformity such as Charcot**
- **Known or suspected peripheral arterial disease (non-palpable pulses)**
- **Cognitive impairment**
- **Impaired consciousness**
- **Stroke**
- **Renal failure/Dialysis**
- **Visual impairment**
- **Known or suspected neuropathy**

INPATIENT FOOT RISK STATUS: HIGH RISK/LOW RISK (Circle) DATE……..

The Acute Diabetic foot should be referred IMMEDIATELY to the Diabetes Foot Team. See below for criteria.

DIABETIC FOOT INPATIENT DAILY FOOT ASSESSMENT

INSPECT FEET DAILY – UPDATE STATUS BELOW

Whole of foot inspection – unhealthy = discoloration, red/mottled skin, black or cracked skin, wounds. If unhealthy contact Podiatry using Salus referral.

WHOLE FOOT STATUS – can be completed by nurse or HCA

Circle below to show whether feet are healthy or unhealthy and then initial. If unhealthy, contact Podiatry via Salus

DATE:																					
Healthy	R	L		R	L		R	L		R	L		R	L		R	L		R	L	
Unhealthy	R	L		R	L		R	L		R	L		R	L		R	L		R	L	
DATE:																					
Healthy	R	L		R	L		R	L		R	L		R	L		R	L		R	L	
Unhealthy	R	L		R	L		R	L		R	L		R	L		R	L		R	L	
DATE:																					
Healthy	R	L		R	L		R	L		R	L		R	L		R	L		R	L	
Unhealthy	R	L		R	L		R	L		R	L		R	L		R	L		R	L	
DATE:																					
Healthy	R	L		R	L		R	L		R	L		R	L		R	L		R	L	
Unhealthy	R	L		R	L		R	L		R	L		R	L		R	L		R	L	
DATE:																					
Healthy	R	L		R	L		R	L		R	L		R	L		R	L		R	L	
Unhealthy	R	L		R	L		R	L		R	L		R	L		R	L		R	L	
DATE:																					
Healthy	R	L		R	L		R	L		R	L		R	L		R	L		R	L	
Unhealthy	R	L		R	L		R	L		R	L		R	L		R	L		R	L	
DATE:																					
Healthy	R	L		R	L		R	L		R	L		R	L		R	L		R	L	
Unhealthy	R	L		R	L		R	L		R	L		R	L		R	L		R	L	
DATE:																					
Healthy	R	L		R	L		R	L		R	L		R	L		R	L		R	L	
Unhealthy	R	L		R	L		R	L		R	L		R	L		R	L		R	L	
DATE:																					
Healthy	R	L		R	L		R	L		R	L		R	L		R	L		R	L	
Unhealthy	R	L		R	L		R	L		R	L		R	L		R	L		R	L	

Contact details for referral:
The Diabetes Foot Team consists of the following:
Diabetes On-Call Consultant – bleep 85694
Consultant Vascular Surgeon On-Call – contact via Switchboard
Inpatient Podiatrist – via Salus referral
Diabetes Specialist Nurse – bleep 0989, phone 52963

Date and Time of referral:

Referred to: (circle)

Vascular **Diabetes**

Podiatry

INPATIENT DIABETIC FOOT CARE PLAN & REFERRAL CRITERIA

CARE PLAN

1. Nurse on Airwave if required
2. Reduce pressure of feet resting on floor, stool or end of bed.
3. Daily foot inspection including checking between the toes and soles of the feet.
4. Use heel protectors, BUT if any pressure damage to heels, offload using Repose boots or pillows.
5. Update whole foot status on check box – DO THIS DAILY plus Waterlow.
6. Emollient – twice daily use of urea-based heel balm to prevent drying and cracking of feet – AVOIDING area between toes (Balneum etc – ensure ward stock).
7. Deterioration – consider if this is an ACUTE Diabetic foot problem and refer if necessary

ACUTE DIABETIC FOOT

If an ACUTE foot problem is suspected, please refer immediately:

- Any foot wound or gangrene at admission
- Any newly acquired foot wound or gangrene
- Suspected acute Charcot Arthropathy (i.e. heat, erythema, swelling)
- Any unexplained erythema, heat, discoloration or swelling in a foot or part of a foot
- Suspected foot infection
- Any unexplained foot pain in the foot of a patient with neuropathy
- Any patient at VERY high risk of developing a foot wound whilst an inpatient due to SEVERE Podiatric need, i.e. Infected in-growing toenail
- A cold, pale foot