THE FOCUS CHART

F = Falls; **O** = Orientate; **C** = Continence; **U** = Understanding; **S** = Skin / Position

GUIDANCE

- The FOCUS tool is a prompt to help staff to focus on meeting the needs of patients in order to reduce potential harm.
- It is an intervention tool to be utilised on patients who are at risk of Falling, developing Pressure Damage (Braden <17) or with Dementia or Delirium.
- Braden Score should be calculated daily and Falls Risk documented daily.

The Newcastle upon Tyne Hospitals NHS
NHS Foundation Trust

Affix patient identification label in box below or complete details

Surname	Patient i.d.No.
Forename	D.O.B. DDMMYYYY
Address	NHS No.
	Sex. Male / Female
Postcode	

DATE		Minimum checks every 2 hours																			
		05.00	06.00	07.00	08.00	09.00	10.00	11.00	12.00	13.00	14.00	15.00	16.00	17.00	18.00	19.00	20.00	22.00	00.00	02.00	04.00
F	**Footwear** Ensure appropriate footwear is in situ when required including when sitting in a chair.																				
O	**Orientate** During usual conversation **inform** patient (don't ask them to tell you) of time, date, who they are, what is happening. Chat to them about what is going on.																				
C	**Constipation** Ask **once** a day: **'Have you moved your bowels today?'** Manage constipation if present																				
	Patient Needs **'Do you need to go the toilet?'** Assist patient to the toilet or provide commode / bedpan / urinal.																				
U	**Pain** **'How is you pain?'** Identify cause and provide suitable pain relief.																				
	Possessions **'Would you like a drink?'** Ensure water is available, make sure call bell, bedside table, walking aid (if applicable), are within easy reach. Ensure patient has correct and clean glasses on (if applicable). Ensure patient has a working and available hearing aid (if applicable). Switch on when interacting with patient.																				
S	**Skin / Position** **'Are you comfortable?'** Turn patient as per NUTH289. Stand hourly if seated in chair. Offer hourly positional changes to ensure comfort. Rearrange pillow and covers. If incontinent, change.																				
	Staff Member Initials																				

BRADEN	
Deliver care in line with **Pressure Ulcer Prevention and Treatment Plan of Care** (NUTH 289)	Level of care **B** **C** **D**
MATTRESS	
CUSHION PROVIDED	Yes / No
AT RISK OF FALLS	Yes / No

All	
✔	- done / checked
Blank	- not assessed
AS	- asleep
X	- declined / refused
Patient Needs	
T	- toilet / commode / urinal / bedpan
C	- catheter check
S	- stoma check
Pain	
C	- comfortable
A	- pain relief given
P	- pain nurse informed
Possessions	
D	- drink
N	- nil by mouth
M	- mouth care
Skin / Position	
L	- left
R	- right
B	- back
S	- stood
W	- walked
T	- turned
U	- assisted to sit in chair

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