**React to Falls Prevention Training Resource Evaluation**

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| 1. | **Which Staff Group best describes you?** | RN | HCSW/HCA | Carer | Other *(Please state)* |
| 2. | **Have you ever attended falls training in the past?** | Yes | No |  |  |
| 3. | **Prior to today’s training how would you rate your knowledge of falls prevention** | Excellent | Good | Average | Poor |
| 4. | **Following training how confident do you now feel about recognising falls risks in your residents?** | Very confident | Confident | Slightly confident | Not confident |
| 5. | **How confident do you now feel about where to seek further help/support/referral to other agencies?** | Very confident | Confident | Slightly confident | Not confident |
| 6. | **How would you rate this training?** | Excellent | Good | Average | Poor |

Care Home………………………………………………………….. Date……………………………

*Please respond to each question by circling the appropriate response.*

*Please circle the words that best represent your thoughts on today’s training.*

Valuable

Good

Not achievable

Adequate

Educational

Helpful

Unnecessary

Appropriate

Excellent

Boring

Clear

Waste of time

Useful

Important

Stimulating

Unclear

Basic

Interesting

Complicated

Informative

Difficult

Confusing

Empowering

Realistic

Please give any comments you may have on the structure, format and contents of this training.