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| **Cornwall Partnership FT col ACommunity Multifactorial** **Falls Risk Assessment Tool** | | | | | |
| **Client Name: NHS number: Date of Birth:** | | | | | |
| **Falls History** | | | | | |
| Recent fall: What was the activity at time? When? Where?  Injuries sustained: Why do they think they fell?  Previous falls: How many in the last 12 months? How many of these were in the last 3 months? Is there a clear pattern? | | | | | |
| **Physical Health: Guided conversation** | | | **Other medical factors** | | |
| Any signs of infection? | | Y / N | **Take temperature:**  **Take blood pressure and radial pulse**  Lie patient flat for 15 mins and record BP and pulse  Repeat after 1 & 3 mins standing  **Pulse .......**beats per minute regular / irregular  **Lying Down BP** =  **Standing BP** 1 min =  3 min =  Feels light headedness on standing? Y / N  Appears unsteady? Y / N  **Postural Hypotension**  Drop of 20mm Hg or more in systolic reading **and/or**  Drop of 10mm Hg or more in diastolic reading Y / N | | |
| Any black outs or loss of consciousness? | | Y / N |
| Is there postural hypotension causing falls? | | Y / N |
| **Any dizziness?** (clarify below)  🞎Lightheaded – as if going to faint  🞎 Unsteady – as if drunk  🞎 Vertigo – sensation of motion  🞎 Other (describe)  **Duration of symptoms:**  🞎seconds/🞎minutes 🞎hours 🞎days  **Triggers for symptoms:**  🞎 head movements 🞎 change of position  🞎Lying down 🞎turning over in bed | | Y / N |
| **Past / Current Medical History** | | | **Action** | | |
| Any medical conditions that potentially contribute to falls risks? (List) | | Y / N | * Discuss appropriate support available * Consider GP or specialist service referral | |  |
| **Medications** consider non-prescribed over counter meds recreational / herbal as well as prescribed meds | | | | | |
| Polypharmacy - more than 4 medications  Any problems with taking medication?  Recent change or review?  Taking any hypnotics, antidepressants, sedatives, antipsychotics or hypertensives?  Self-management concerns? | | Y / N | **If yes** consider options  **For taking medication**,**consider:**   * Dosette / Blister pack – refer to Pharmacy * Automatic pill dispenser – refer to Telecare * Carer or other support – refer to appropriate service | |  |
| **Comments / Actions taken / Services already involved:** | | | | | |
| **Bone Health / Osteoporosis** | | | **Action** | |  |
| Known diagnosis?  If no known diagnosis, screen for risk factors below.  Is bone protection medication being taken correctly?  Are they getting exposure to sunshine or already on calcium and vitamin D supplements?  **Risk Factors:** | | Y / N  Y / N  Y / N | **If No**, refer for medical review with appropriate professional  **If Yes**, offer information leaflet from National Osteoporosis Society, for example:  Introduction to Osteoporosis / Osteoporosis and Men / Scans and Tests for Osteoporosis / Exercise and Osteoporosis (others available) | |  |
| * Low trauma fractures / previous vertebral fractures * High dose steroids (more than 7.5mg prednisolone daily or equivalent for 3 months or more) * High alcohol intake (4 units daily or more) * Current or previous secondary causes of osteoporosis (eg or Malabsorption or endocrine disorders, inflammatory bowel disease, liver disease, anorexia, prolonged immobility, BMI of 21 or less) | | Y / N  Y / N  Y / N  Y / N | **Yes to 2 or more risk factors**  **Further assessment** **required**   * Refer to GP to consider DEXA scan and /or bone protection medication (refer to NICE Guidance CG146) | |  |
| **Strategies following a Fall** | | | **Action** | |  |
| Are they able to get up following a fall?  Do they have an alarm system that they will use?  Do they have other means of summoning help?  Are they aware of strategies to keep warm / relieve pressure whilst on the floor? | | Y / N | **If no** Consider options   * Teach backward chaining method * Provide information on lifeline systems * Provide information on strategies following a fall/keeping warm/pressure relief | |  |
| **Fear of Falling:** | | | **Action** | |  |
| Client fearful of falling, stopped usual activities or has poor confidence with mobility.  Unable to move about & get up from floor independently?  Complete assessment: Falls Efficacy Scale-International shortened version (FES-I) (Higher score = greater fear) | | Y / N  /28 | **If yes or high FES-I score**   * Consider options for rehabilitation and ways to increase confidence - Voluntary / primary / adult social care / specialist team | |  |
| **Cognitive Impairment / Mental Health:** | |  | **Action** | |  |
| Is there existing cognitive impairment or confirmed dementia diagnosis?  Any difficulty with orientating themselves to negotiate their home environment safely?  Is the person unable to ask for help if it is needed?  Any untreated anxiety or depression?  Is there any acute confusional state and/or delirium? | | Y / N | **If yes** Consider options   * Further cognitive or mental health assessment with appropriate clinician * Set up strategies to support person at home or referral to appropriate service * Alert others already involved in the person’s care and agree intervention strategies. | |  |
| **Daily Living and Home Hazards** | |  | **Action** | |  |
| Is there any problem with personal care, toileting or getting meals and drinks?  Is there any problem with cleaning, laundry, shopping?  Are there concerns about home environment safety, eg. Stairs / lighting / smoke and CO2 alarms / heating / ventilation / clutter / loose mats. | | Y / N | **If yes** Consider options   * Further assessment using Assessment tool: HomeFAST to guide intervention. * Referral to Occupational Therapist * Referral for rehabilitation and/or urgent strategies to support person at home | |  |
| **Gait and Balance** | |  | **Action** | |  |
| Can the person get up from a chair without using arms?  Can they stand and balance unsupported for 30seconds?  Do they have adequate muscle strength/joint range?  Is their gait normal?  Is mobility aid appropriate and used safely?  Is mobility aid in good condition?  Is the person motivated to exercise? | | Y / N | **If no** consider options   * Arrange replacement walking aid * Advise on home exercise programme for Strength and Balance * Referral for Physiotherapy * Referral for rehabilitation and/or urgent strategies to support person at home | |  |
| **Feet and Footwear** | |  | **Action** | |  |
| Difficulty maintaining foot care?  Foot problem inhibiting gait/balance?  Unstable, loose or poorly fitting shoes/slippers worn?  Numbness or sensation changes? | | Y / N | **If yes** consider options   * Provide advice about suitable footwear * Advise on nail cutting services * If untreated problems, refer to Podiatry | |  |
| **Continence, Nutrition and Hydration** | |  | **Action** | |  |
| Has overwhelming urgency to pass urine?  Gets wet before reaching the toilet?  Needs to go frequently by day?  Is woken up from sleep with desire to pass urine?  Does this bother them? Would they like some help?  Is there a history of recurrent urine infections?  Constipation or other bowel problems?  Any signs of dehydration or inadequate daily fluid intake? Reduced appetite / nutrition intake or difficulty eating? | | Y / N | **If yes** consider options  Recommend 6-8 glasses (250mls) of fluid per day (unless contra-indicated eg. renal failure)  Arrange for urine tests and urinalysis  Complete bladder diary and use to guide intervention or onward referral  If not passing urine refer to urgent care  If infection suspected refer to appropriate clinician | |  |
| **Vision/Hearing:** | |  | **Action** | |  |
| Registered blind/partially sighted?  Wears glasses? Are they varifocals or bifocals?  Any recent change in vision/hearing?  Wears hearing aid /s? Last hearing review?  Last eye test was more than one year ago? | | Y / N | **If yes** consider options  Explain bifocal/varifocal risk of misjudging depth perception, make sure glasses are clean, and advise to book yearly eye test  If untreated double or blurred vision refer to GP | |  |
| There are likely to be several contributory factors to falls risks and intervention needs may cross over different services. | | | **You now need to complete a care plan with all the actions identified** | | |
| **MFRAT AND CARE PLAN COMPLETED BY:** | **Name** | **Signature** | | **Designation** | |
| **Date:** | **Contact details** | |
| A named key worker needs to co-ordinate the actions identified, and ensure that outcomes are reviewed and updated. | | | | | |
| **KEYWORKER** | **Name:** | **Date for review** | |  | |
| * Unexplained, unresolved falls or multifactorial reasons for falls – refer to Specialist Falls Service * Medical investigation required or medical review – refer to GP/Falls Consultant * If falls caused by blackout, collapse, loss of consciousness – refer to Eldercare Consultant or discuss with GP | | | | | |

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