CARE HOME STAGE 2 - MULTIFACTORIAL FALLS RISK ASSESSMENT AND MANAGEMENT PLAN

FIRST NAME: LAST NAME:	DATE OF BIRTH:	NHS NO:	CARE HOME:	ROOM NO:

Assessment to be completed on all residents aged 65 or older and any younger resident who is judged by staff to be at higher risk of falling because of an underlying condition

Note: All sections below to be completed within 24 hours of admission and thereafter reviewed at monthly intervals and / or following a fall / change in resident's condition / transfer from another care setting. Review dates should be recorded on communication sheets and care plans updated as necessary.

Risk Factor	Recommended actions	Action/s taken	Initials of assessor
Tick Box if answer YES to question	Consider recommended actions below. Select appropriate intervention and document in Action/s taken column	Document relevant actions taken in this section. Refer to Care Plans initiated.	
1. History of falling			
Has the resident had one or more falls in the past twelve months? ☐	a) Obtain details about past falls, including how many, causes, activity at time of fall, injuries, symptoms such as dizziness, and previous treatment received. Determine any patterns andconsider throughout assessment. Ask about / observe for fear of falling. b) Discuss falls risk with family. Consider: c) Contacting GP to review resident's falls risks if at high risk or there have been unexplained falls or several falls in a short period of time. Give details of specific concerns.		

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	d) If recent falls, and the resident has a temperature (fever), consider checking for infection. e) Assess for postural or orthostatic hypotension (a drop in BP when standing up) if trained to do so. Record in resident's progress notes and inform GP if hypotension found and any associated symptoms. f) Consider how the resident can be observed / supervised more easily.		
2. Balance and mobility			
Is the resident unsteady / unsafe walking? ☐ Does the resident have difficulty with transfers (getting on and off the toilet / bed / chair)? ☐	a) Ensure mobility aid and rails are used correctly and consistently. Prompt, place within reach, and use visual cues if appropriate. (Seek advice if unsure of correct use). b) Provide supervision when walking or transferring if required. Record what assistance is required. c) Record and hand-over recommendations from physiotherapist regarding mobility and transfer status (e.g. if supervision is needed) d) Review bathroom grab rails. Are they appropriate and in good condition? Refer to maintenance if necessary. e) Ensure brakes are on bed at all times. Ensure correct height of bed and chairs. f) Ensure that frequently used items are within easy reach i.e. glasses, drinks, walking aid. g) Ensure call bell / alternative is within easy reach and the resident is able to use it. h) Ensure residents with poor mobility, who are known not to ask for assistance, are not left unattended on commodes, toilets, baths and showers (consider/ discuss		

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Does the resident spend long periods of time being sedentary (sitting or lying down?) ☐	the balance between safety and dignity). i) Increase opportunity to move more often , be physically active every day, take part in appropriate exercise through Activities of Daily Living (ADL) and the activities programme. Consider: j) If required, discuss concerns with the GP or physiotherapist to identify need for assessment of balance, walking and transfers, assessment for/ review of mobility aid. Record concerns in the resident's notes. k) Hip protectors - discuss suitability and funding with resident's care manager and family.		
3. Osteoporosis			
Does the resident have osteoporosis (check transfer notes or ask GP) ☐ If not: Is there a risk of osteoporosis? Ask the following: • Has he/she had fracture after a minor bump or fall, over the age of 50? ☐ • Is there a family history of osteoporosis or hip fracture? ☐	a) If osteoporosis is diagnosed check the resident is taking medication for osteoporosis as prescribed. b) If at high risk speak to GP about osteoporosis risk and further investigation and/or treatment.		

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• Has he/she been on steroids for 3 months or more? ☐ • Is there loss of height and an outward curve of the spine? ☐			
4. Medication			
Is the resident taking 4 or more medications? ☐ Is the resident taking any of the following? (circle) • Sedatives • Anti-depressants • Anti-Parkinson's • Diuretics (water • tablets) • Anti-psychotics • Anti-hypertensives	Check medications have been reviewed with respect to falls risk (within the last 12 months is good practice). a) Report side-effects / symptoms of medication to GP. b) Read patient information leaflet which comes with the medication or speak to practice based pharmacist for information on medication side effects and interactions. c) Anticipate side-effects and take appropriate measures: ・ Sedatives: toilet and prepare for bed before giving night sedation. Monitor at all times, but especially overnight and supervise in the morning. ・ Anti-psychotics: can cause sedation, postural hypotension and impaired balance. Anticipate and compensate and report to GP. ・ Inform GP if the resident is excessively drowsy or mobility has deteriorated. ・ Diuretics: anticipate immediate and subsequent toileting. Ensure easy access to toilet and assist if required. d) Write in progress notes and alert staff at handover. e) Report changes in alertness or mobility.		

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Has there been a recent change in medication that may affect falls risk (e.g. changes involving any of the above)? ☐	f) Check Blood Pressure before and one hour after morning medications, for 3 days if any symptoms of postural hypotension. *Refer to SCHT Postural Hypotension leaflet. · Anticipate side-effects and take appropriate measures.		
5. Dizziness and fainting			
Does the resident experience: (circle) • dizziness on standing? • a sensation of the room spinning when moving their head or body? • fainting attacks? • palpitations?	a) Carry out a lying / standing blood pressure reading to check for postural or orthostatic hypotension if staff trained to do so. b) Refer the resident to the GP for review of dizziness/fainting/blackouts/palpitations. c) If postural/orthostatic hypotension prompt resident to move ankles up and down before rising, then rise slowly and with care from lying to sitting, and sitting to standing *.		
6. Nutrition and Hydration			
Has the resident lost weight unintentionally or do they have little appetite? ☐ Does the resident spend little time outside in daylight? ☐ Does the resident drink less than recommended daily fluid intake? ☐	a) Complete MUST Tool. b) Refer to GP or dietician if concerned. · commence food record chart. · consider food supplements. c) Discuss with GP / Practice based Pharmacist regarding any Vitamin D supplements required. d) Encourage good fluid intake. . commence fluid record chart if concerned.		

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7. Cognitive impairment			
Is the resident confused, disorientated, restless or highly irritable or agitated? ☐ Does the resident have reduced insight and/or judgement and/or are they uncooperative with staff? ☐	a) If there is a new change in cognitive status monitor for pain, signs of infection or constipation. b) Monitor behavioural issues and discuss chart with GP. c) Include behavioural issues in care plan and follow with regard to falls prevention. d) Ensure the resident's GP has reviewed this condition. Report fluctuations and patterns to treating GP. e) Do not leave the resident unattended on commodes, in toilets, baths or showers. f) Optimise environmental safety- remove clutter and hazards. g) Use visual cues (e.g. signs and symbols) as reminders or to aid orientation. h) Use routine practices when instructing/assisting the resident. i) Record useful practices in care plan. j) Investigate the resident's previous patterns and incorporate into care plan (e. g usual time of showering or preferred side of bed). k) Ask family/relatives to visit at particular times of day to assist with management and care when able. l) Consider the need for falls prevention equipment in keeping with local policies and in discussion and agreement with family and principal carer.		

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8. Continence			
Do continence issues contribute to the resident's falls risk? ☐	a) If no toileting routine is in place, carry-out a continence assessment and/or review of continence chart. b) Agree a toileting regime and use of continence products as appropriate. c) Optimise environment safety - remove clutter and hazards, consider night lighting, monitor floors for wet areas - clean or report as soon as possible. d) Ensure adequate hydration during the day, not excessive in late afternoon. e) Provide with commode chair or urinal as appropriate. Consider: f) If required, referral to district nurse or the continence service.		
9. Sensory impairment			
Does the resident have poor vision? ☐ (Remember following a stroke the person may have restricted vision on one side, some people with dementia experience visual problems) Does the resident have poor hearing? ☐	a) If vision has not been tested in past 12 months, refer to optometrist if appropriate. b) Ensure room is free of clutter and obstacles. c) Ensure bedroom lighting is adequate, consider need for night lights. d) Ensure glasses are in good condition, clean (each morning), worn consistently (prompting, note in care plan), kept within reach when not worn, and appropriate (e.g. reading vs. distance) e) If hearing has not been assessed in last 12 months, discuss options, including referral to audiologist with GP.		

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	f) Ensure hearing aid is worn, clean and batteries are working. g) Use common gestures/cues/instructions. Minimise excess noise.		
10. Night patterns - to be completed by night staff			
Does the resident often get out of bed overnight? ☐ If yes: Is the resident able to get in and out of bed safely on their own? ☐	a) Provide night lighting appropriate to vision. b) Optimise environmental safety – remove clutter and hazards. c) Check bed height is suitable for the resident. d) Ensure spectacles and call bell/alternative in easy reach. e) Discuss with family if nightwear is not appropriate – consider especially slippers (should be good fit, with back and heel support) and length of nightgowns. Consider: f) All round tread socks if resident forgets to put slippers on. g) Alert pad if resident is likely to fall while moving around the room. Discuss with resident / family. h) Hi-low bed. Keep in a position to suit the resident's needs overnight. i) Provide with commode or urine bottle for night toileting. j) If agitated at night: • Ensure calm environment and follow advice in the behavioural plan for settling the resident. • Observe every 15 to 30 minutes overnight. • Engage in regular activity during the day to aid sleep at night and/or reduce agitation during the day.		

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	·If not improving refer to GP for review of evening or night medication.		
11. Feet and footwear			
Does the resident have corns, ingrown toe nails, bunions, fungal infections, pain or loss of the sensation in their feet? ☐ Does the resident wear ill-fitting shoes, high- heel shoes, or shoes without grip? ☐	a) Refer to podiatrist. Start foot care regime. b) Liaise with family to provide shoes with thin hard sole, enclosed heel, fastening mechanism. c) Do not walk with socks only but consider all round tread socks if shoes are often removed. d) If shoes are too tight or loose fitting, discuss risks with resident / family and advise them on obtaining more appropriate footwear.		
12. New or respite resident			
Is the resident oriented to their new environment? ☐ Does the resident have suitable clothing and footwear? ☐	a) Complete environmental risk assessment. b) Orientation to facility/unit including their room, the bathroom, communal areas and outdoor areas. c) Optimise environmental safety - remove clutter and hazards. d) Inform and discuss with family/visitors as appropriate. e) Refer to pre admission information to identify specific issues. f) Liaise with family and principal carer to provide suitable clothing and footwear. Refer to information sent in from carer with regard to safety and falls risks.		

Other Risk Factors (Please circle below)			
Perceptual/Cognitive	**Physical**	**Environment**	**Activities**
Insight / judgement Cognitive status Memory Orientation Psychiatric condition Anxiety Depression/ low mood Motivation Medication effects Communication Nocturnal patterns Alcohol intake	Balance Strength Vision Hearing Continence Nutritional status Time spent outside Medical condition Medication effects Sensation Range of movement Foot health Constipation Pain	Footwear Aids Equipment Clothing Lighting Floor surface Location of bedroom Seating Bedroom furniture Signage Contrasting colours	Mobility Transfers ADL Opportunity for Exercise High risk activity Inactivity Fitness

Other Risk Factors identified as relevant when considering this resident's falls risk	**Action taken and referrals**
Details of person completing form	**Care Home:**
Name (Print):	**Date:**
Signature: **Initials:**	**Time:**