Perth & Kinross Falls Service
Care Home Multifactorial Falls Risk Assessment and Management Tool
(Including Osteoporosis Risk Screen)

Residents Name	……
DOB	……
Room Number	……
Name of Assessor:	……
Date of Assessment	……

Falls Risk and Possible Intervention (the below is not exhaustive)	**Specific Action/Care Plan for Resident** (Write out specific care plan/action for resident below and review/update regularly)	**Date & Sign**
1. History of falling: ☐ • How many falls in 12 months • Activity at time of fall – where? when? why? time, frequency • Any injuries sustained • Symptoms e.g. dizziness, blackouts, • Any fear of falling • Any changes made to reduce falls risk **Consider:** • Discuss falls risk with resident/family. • Alert in care plan and at handover if resident is high falls risk. • Contact GP to review falls risks if high risk **or** unexplained falls • If recent falls, and resident has a temperature (fever), consider checking for infection (with urine, sputum and stool samples). • Assess for postural or orthostatic hypotension. Record in progress notes and inform GP if hypotension found. • Consider how resident can be observed/ supervised more closely.		
2. Balance and mobility: Is the resident unsteady/ unsafe when walking? ☐ Does the resident have difficulty with getting on and off the toilet/bed/chair? ☐ **Consider** • Ensure mobility aid and rails are used correctly and consistently. • Provide supervision when walking or transferring if required. • Ensure brakes are on bed at all times. • Ensure correct height of bed/chairs. • Consider one-way glide sheet for chair • Ensure frequently used items are within reach i.e. glasses, drinks, walking aid. • Ensure buzzer is within easy reach and resident is able to use it. • 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 the balance between safety and dignity) • Increase opportunity for appropriate exercise through Activities of Daily Living (ADL) and activities programme • If required, discuss concerns with the GP or physiotherapist for mobility/walking aid/transfer/balance assessment • If appropriate consider hip protectors		
3. Osteoporosis: Does the resident have osteoporosis (check transfer notes or ask GP) ☐ If osteoporosis is diagnosed check the resident is taking medication for osteoporosis as prescribed. If not: Is the resident at 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? • Has he/she been on steroids for 3 months or more? • Is there loss of height and an outward curve of the spine? If at high risk speak to GP about osteoporosis risk and further investigation and/or treatment. ☐		
4. Medication: Is the resident taking 4 or more medications? ☐ Is the resident taking any of the following? – Anti-depressants ☐ – Anti-Parkinson's – Diuretics (water tablets) – Anti-psychotics – Anti-coagulants – Anti-hypertensives **Consider** • Check medications have been reviewed with respect to falls risk • Report side-effects/symptoms to GP. • 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. • Write in progress notes and alert staff at handover • Report changes in alertness or mobility. • Assess for postural hypotension before		

and one hour after morning medications, for 3 days.		
5. Dizziness and fainting: Does the resident experience: • dizziness on standing • a sensation of the room spinning when moving their head or body ☐ • fainting attacks • palpitations? **Consider** Carry out lying standing BP to check for postural or orthostatic hypotension. Refer to GP for review of dizziness/ fainting/ blackouts/ palpitations. 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 Has resident lost weight unintentionally or do they have little appetite? ☐ **Consider** • Complete MUST tool • Refer to GP or dietician. • In consultation with GP or dietician: - Commence food record chart - Consider food supplements Does the resident spend little time outside in daylight? ☐ Refer to GP for assessment of vitamin D levels. Is resident taking a balanced nutritional diet? Are there any issues with under nourishment which may affect balance/ dizziness? Is there good fluid intake? **Consider** • Any changes in appetite and reasons for this • Check oral hygiene and dentures • At all times encourage fluid		
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? ☐ **Consider** • If there is a new change in cognitive status monitor for pain, signs of infection or constipation. • Monitor behavioural issues and discuss chart with GP. • Include behavioural issues in care plan and follow with regard to falls prevention. • Ensure GP has reviewed condition. Report fluctuations and patterns to GP. • Do not leave unattended on commodes, in toilets, baths or showers.		

• Optimise environmental safety – remove clutter and hazards. • Use visual cues (e.g. signs and symbols) as reminders or to aid orientation. • Use routine practices when instructing/ assisting the resident. • Ask family/relatives to visit at particular times of day to assist with management and care when able.		
8. Continence: Do continence issues contribute to the resident's falls risk? ☐ **Consider** • If no toileting routine is in place, carry-out a continence assessment and/or review of continence chart. • Agree a toileting regime and use of continence products as appropriate. • Optimise environment safety – remove clutter and hazards, consider night lighting, monitor floors for wet areas – clean or report as soon as possible. • Ensure adequate hydration during the day, not excessive in late afternoon. • Provide with commode chair or urinal as appropriate. • Test urine and arrange treatment if UTI • Consider referral to community nurse or the continence service		
9. Sensory impairment: Does the resident have poor vision? ☐ Does the resident have poor hearing? ☐ **Consider** • If vision has not been tested in past 12 months, refer to optometrist. • Ensure room clutter and obstacle free. • Ensure bedroom lighting is adequate, consider need for night lights. • 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) • If hearing has not been assessed in last 12 months, discuss options, including referral to audiologist with GP. • Ensure hearing aid is worn, clean and batteries are working. • 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 are they able to get in and out of bed safely on their own? ☐ **Consider** • Provide night lighting appropriate to vision e.g. bedside light, night light • Optimise environmental safety – remove		

clutter and hazards. • Suitable bed height • Ensure spectacles and buzzer are within easy reach. • Ensure nightwear is appropriate and slippers fit well with back/heel support • Bed exit monitor. • Hi-low bed. Keep in position to suit the resident's needs overnight. • Commode/urine bottle for night toileting. • Refer to GP for review of evening or night medication. • Assess need for bed rails and complete risk assessment and consent forms. • Consider use of a crash mat (this may create a falls hazard though)		
11. Feet and footwear: Does the resident have corns, ingrown toe nails, bunions, fungal infections, pain or loss of sensation in their feet? ☐ Does the resident wear ill-fitting shoes, high heel shoes or shoes without grip? ☐ **Consider** • Refer to podiatrist (or GP if fungal infections). Start foot care regime • Slippers should NOT be worn during day • Liaise with family for shoes with thin flat sole, enclosed heel and a fastening. • Do not walk with socks only. If shoes are too tight or loose fitting, bare feet is safer • Consider rubber tread socks if shoes are often removed.		

Risk Factors Identified	**Intervention strategies and referrals**
Signature	Date