

Falls risk assessment and guidelines



Working together to prevent falls

Risk assessment tool developed by: National Ageing Research Institute, Cyril Jewell House & Boyne Russell House

This falls risk assessment tool and guidelines were developed by the National Ageing Research Institute, in conjunction with two residential aged care services at Melbourne Health, Cyril Jewell House and Boyne Russell House. The tool was developed through a consultation process with nursing staff from the residential aged care facilities, a physiotherapist and the project officers.

It is a comprehensive risk assessment tool that has accompanying strategies and guidelines for completion. It should be completed for all residents on admission, after 2 weeks, after a fall or acute episode, and reviewed in accordance with your organisation's policy. For each risk factor rated as **yes** refer to the suggested strategies.

(Downloadable)

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In 2005 the Department of Human Services funded the National Ageing Research Institute to review and recommend a set of falls prevention resources for general use. The materials used as the basis for this generic resource were developed by the National Ageing Research Institute, Cyril Jewell House and Boyne Russell House under a Service Agreement with the Department of Human Services. This and other falls prevention resources are available from the department's Aged Care website at: <http://www.health.vic.gov.au/agedcare>.

Working together to prevent falls

Falls risk assessment

Place UR sticker here

Facility: _____

- To be completed on all residents on admission, after 2 weeks of admission, after an acute episode or fall and in conjunction with the care plan review.
- For each risk factor rated "yes" refer to management options sheet and document actions overleaf.

Assessed by:	Date of assessment: / /
General issues (do not use in final score): <ul style="list-style-type: none"> • <u>New resident</u>: has the resident been oriented to the facility and routines, and a resident information brochure/booklet provided? (Supervision or observation may be required or information regularly reinforced in the first few weeks of admission.) • <u>Communication</u>: is there a problem with communication (eg. Language or Dysphasia)? • <u>Environment</u>: has the resident's environment been assessed and is it safe? (Is the seating/bed the correct type and height, is the call bell within reach, is the room free of clutter, is assistive equipment required, eg. monkey bar, bedstick?) 	(do not use in final score): <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> No
RISK FACTOR	YES or NO
History of falling <ul style="list-style-type: none"> • Has the resident had more than 2 falls in the last six months? 	<input type="checkbox"/> <input type="checkbox"/>
Medications <ul style="list-style-type: none"> • Is the resident taking 4 or more medications? • Does the resident take any of the following types of medication? <div style="display: flex; justify-content: space-between; font-size: small;"> <input type="checkbox"/> vasodilator/cardiac <input type="checkbox"/> analgesic <input type="checkbox"/> psychotropic <input type="checkbox"/> antihypertensive <input type="checkbox"/> anticonvulsants </div> <div style="display: flex; justify-content: space-between; font-size: small;"> <input type="checkbox"/> antiparkinsonian <input type="checkbox"/> diuretics <input type="checkbox"/> sedative <input type="checkbox"/> vestibular suppressant <input type="checkbox"/> antidepressants </div>	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
Transfers and gait <ul style="list-style-type: none"> • Does the resident have difficulty getting on and off the toilet/bed/chair and/or tend to make use of towel rails/bedside tables or other furniture or fixtures to assist them transferring or for additional support while ambulating? (<input type="checkbox"/> Immobile = No) 	<input type="checkbox"/> <input type="checkbox"/>
Balance <ul style="list-style-type: none"> • Is the resident unsafe/unsteady when asked to stand from a chair, walk 3 metres, turn and return to the chair independently (using a walking aid if the resident normally walks with an aid)? (<input type="checkbox"/> Immobile = No) 	<input type="checkbox"/> <input type="checkbox"/>
Sensory loss <ul style="list-style-type: none"> • Does the resident have an uncorrected sensory deficit/s that limits their functional ability? <ul style="list-style-type: none"> ➤ Vision <input type="checkbox"/> <input type="checkbox"/> ➤ Hearing <input type="checkbox"/> <input type="checkbox"/> ➤ Somato Sensory (touch) <input type="checkbox"/> <input type="checkbox"/> 	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
Feet and footwear <ul style="list-style-type: none"> • Does the resident have corns, ingrown toenails, bunions, etc.? • Does the resident wear ill-fitting shoes/slippers, high heels and/or shoes with poor grip? (<input type="checkbox"/> Immobile = No) 	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
Continance and bowel problems <ul style="list-style-type: none"> • Is the resident incontinent, do they require frequent toileting or prompting to toilet, or do they require nocturnal toileting? 	<input type="checkbox"/> <input type="checkbox"/>
Mental state <ul style="list-style-type: none"> • Is the resident experiencing: <div style="display: flex; justify-content: space-between; font-size: small;"> <input type="checkbox"/> Anxiety <input type="checkbox"/> Depression </div> <div style="display: flex; justify-content: space-between; font-size: small;"> <input type="checkbox"/> Decreased co-operation, insight or judgement especially regarding mobility </div> <div style="display: flex; justify-content: space-between; font-size: small;"> <input type="checkbox"/> Confusion <input type="checkbox"/> Disorientation <input type="checkbox"/> Wandering </div>	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
Nutrition <ul style="list-style-type: none"> • Has the resident's food intake declined in the past 3 months due to a loss of appetite, digestive problems, chewing or swallowing difficulties? • Has the resident lost or gained weight in the last 3-12 months? 	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
Acute illness <ul style="list-style-type: none"> • Does the resident have any sign of acute illness, eg. altered behaviour, confusion, pain, malaise, fever, cough, urinary symptoms? 	<input type="checkbox"/> <input type="checkbox"/>
Chronic medical condition <ul style="list-style-type: none"> • Does the resident have any of the following medical condition/s that affect their balance and mobility? <div style="display: flex; justify-content: space-between; font-size: small;"> <input type="checkbox"/> Arthritis <input type="checkbox"/> Respiratory condition <input type="checkbox"/> Parkinson's Disease <input type="checkbox"/> Lower Limb Amputation </div> <div style="display: flex; justify-content: space-between; font-size: small;"> <input type="checkbox"/> Diabetes <input type="checkbox"/> Peripheral neuropathy <input type="checkbox"/> Cardiac condition <input type="checkbox"/> Stroke/TIA </div> <div style="display: flex; justify-content: space-between; font-size: small;"> <input type="checkbox"/> Dementia <input type="checkbox"/> Vestibular Disorder (eg. dizziness, postural dizziness, Meniere's Disease) </div> <div style="display: flex; justify-content: space-between; font-size: small;"> <input type="checkbox"/> Other neurological conditions </div>	<input type="checkbox"/> <input type="checkbox"/>
Functional behaviour <ul style="list-style-type: none"> • Do observed behaviours in Activities of Daily Living and Mobility indicate that the resident under-estimates their abilities/is inappropriately fearful of activity or over-estimates their abilities resulting in frequent risk-taking behaviour? 	<input type="checkbox"/> <input type="checkbox"/>
Total risk factors identified	

- **11 or more risk factors identified indicate resident at high risk of falling.**
- All risk factors should be addressed individually (see list of strategies overleaf). Those identified as high risk may require some additional interventions.

Strategies for residents at risk of falling:**General issues:**

- Optimise environmental safety: bed/chair at correct height and brakes on (regularly check), mattress on floor if required; bedside table in reach and items frequently used in reach and safely accessed; furniture which might be used for balance is stabilised; ensure call bell working and within reach; proper lighting, reduce sun glare and minimise noise; night lights at bedside; remove clutter; clean and dry floor surfaces; walkways clear and handrails accessible; secure loose carpets, mats or tubing from items such as Oxygen supply.
- Place at risk residents closer to nurses' station.
- Assess for fear, or decreased confidence related to previous falls.
- Provide falls prevention education.
- Extra supervision.
- Provide regular activities during the day to aid sleep at night or reduce agitation during the day.
- Reorient to facility regularly.
- All staff to use uniform methods when instructing/assisting resident in all transfers/mobility/ADL's; including verbal prompts, physical techniques.
- Regular equipment and aids maintenance (such as glasses, hearing aids, walking aids, chairs, wheelchairs).

History of falling:

- Obtain details of previous falls to determine any pattern – time of day, after medication, activity at the time, environmental impacts - refer to incident register.
- Document in nurse care plan. Place "Falls Alert" identifier in front of summary or working care plan.

Medications:

- Place "Falls Alert" identifier on medications chart.
- Medication review – Has the resident's medication been reviewed by the doctor/pharmacist in the last month?

Transfers and mobility:

- A full physiotherapy assessment of all residents is performed within 7 days of admission.
- Assess for appropriate chair type and height. Assess for use of aids, eg. bed sticks, rails, gait aids.
- Ensure all wheelchairs are safe and in full working order. Refer to mobility and dexterity group.
- Refer to physiotherapist for appropriate assessment and intervention as required.
- Lock both brakes on wheelchairs/shower chairs when stationary.

Balance:

- A full physiotherapy assessment of all residents is performed within 14 days of admission.
- Refer to physiotherapist for appropriate assessment and intervention as required. Consider hip protectors.
- Ensure appropriate gait aid is supplied. Refer to mobility and dexterity group.

Sensory loss:

- If resident's vision/hearing has not been tested within the last year organise a referral.
- Ensure resident wears appropriate glasses/hearing aids and that they are clean and in good working order.
- Refer to optometrist/opthamologist/audiologist for glasses/hearing aid.
- Communication – common gestures/cues, liaise with family members; referral to Speech Pathology; use of interpreters, signs in Languages Other Than English.

Feet and footwear:

- Refer to podiatrist. Provide education on correct footwear (brochure on good footwear).
- Liaise with family/carer to replace/find alternative footwear.

Continance and bowel problems:

- Instigate or re-evaluate an appropriate continence management plan. Refer to continence group or continence clinic.

Cognition:

- Bed/chair monitor. Medical review if change in cognition noted.
- Consider removal of gait aid from vision if resident consistently uses aid in an unsafe manner (only if safe to do so and if retraining is not achievable).
- Consider engagement in physical activities / other activities.

Nutrition:

- Dietitian referral/assessment. Supplements (requires dietitian referral/assessment).

Medical conditions:

- Refer the resident to doctor for a review of management of medical condition(s) and medications.

Psychological and functional behaviour:

- Address resident anxieties/reassure resident – evaluate causes of anxiety and agitated behaviour.
- Greater (strict) supervision required (lack insight)? Attention seeking behaviour – ongoing assessment of underlying issues.
- Depression/Withdrawn? Appropriate referrals to GP and/or psychologist/neuropsychologist.

Referral options and equipment requirements:

Referral to:	Purpose for referral (please specify)
<input type="checkbox"/> General practitioner	
<input type="checkbox"/> Physiotherapist	
<input type="checkbox"/> Occupational therapist	
<input type="checkbox"/> Podiatrist	
<input type="checkbox"/> Dietitian	
<input type="checkbox"/> Other (eg. continence group, mobility and dexterity group, etc) Please specify:	

Equipment required:

- hip protectors high-low bed walking aid bed alarm chair alarm Other (please specify)

Strategies noted in care plan:

Signed: _____

Date: / /

Falls risk assessment guidelines

General instructions:

This form is to be used in conjunction with the "Falls Risk Assessment Form". It provides a range of definitions and explanatory notes in relation to each risk factor and the risk assessment process.

Where risk factors have been identified please refer to the "*Strategies for Residents at Risk of Falling*", located at the back of the falls risk assessment form, for a range of management strategies aimed at reducing resident falls and injuries. Strategy options are provided for each risk factor. This is not an exhaustive list and there may be alternative or additional strategies indicated for individual residents.

The information required to complete the risk assessment form may be in resident histories or care plans, allied health notes, and/or obtained by asking residents/next of kin.

Definition of a fall: Any event which results in a person coming to rest inadvertently on a lower level, other than as a consequence of a violent blow, loss of consciousness, sudden onset of paralysis such as a stroke, or an epileptic fit (Kellogg International Working Group on Prevention of Falls by the Elderly, 1987).

When to use the risk assessment form:

This form is to be completed by nursing staff on admission, 2 weeks after admission, after an acute episode or fall, and in conjunction with the care plan review.

Falls risk assessment form - components

GENERAL ISSUES:

The three areas covered under general issues (new residents, communication, environment) are **not** to be used in the final risk score. They are prompts to nursing staff to ensure these important issues are addressed, not only as a falls prevention activity, but routine care.

ASSESSABLE FALLS RISK FACTORS:

History of falling:

This information can be obtained from the incident reports, resident's history or care plan.

Medications:

Number of medications - this refers to any medications taken, prescription and non prescription, irrespective of its medication category (specific medication categories are covered in the question related to 'type of medication' taken - see below).

Type of medication - these medication categories have been associated with an increased risk for falls.

- In terms of categorising medications you may need to seek further advice from a Division 1 nurse or refer to the MIMS.
- Please ensure that you tick the particular medication category boxes as well as the **Yes/No** box.

Transfers and gait:

If the resident is immobile or bed bound and not likely to improve this question is not applicable and you should tick both the immobile box and the **No** box. Otherwise, record transfer and mobility status using the listed options.

Balance:

If the resident is immobile or bed bound and not likely to improve this question is not applicable and you should tick both the immobile box and the **No** box. Otherwise, record balance status using the listed options.

Sensory loss:

Refers to an uncorrected sensory deficit that limits the resident's functional abilities.

- Vision or hearing is not impaired if it is corrected by glasses/hearing aid (and they are worn).
- Somatosensory deficit mainly refers to the lack of sensation, generally in the foot. This can be ascertained using the touch sensation test (using cotton wool).

Feet and footwear:

Feet - it is important to assess for foot problems (tick **Yes** if present) and treat them regardless of whether the resident is immobile or bed bound and not likely to improve.

Footwear - if the resident is immobile or bed bound and not likely to improve the question regarding footwear is not applicable and you should tick both the immobile box and the **No** box. Otherwise, record footwear suitability using the listed options.

Continence and bowel problems:

Tick **Yes** if incontinent of urine or bowel.

If this information is not available in the resident's history/care plan/continence chart, or by asking the resident/family/other staff, observation of continence patterns over a short period may be required.

Mental state:

Please ensure that you tick the particular mental state category boxes, as well as the **Yes/No** box. Management strategies may vary depending on the specific problem identified.

Nutrition:

Significant weight loss has been shown to be a risk factor for falls. Although not supported by literature as a risk factor for falls, substantial weight gain that places undue stress on a resident's lower limbs should also be noted, monitored and addressed.

Acute illness:

An acute illness, such as urinary tract infection or chest infection, can increase a resident's risk of falling by increasing confusion and affecting balance. If the resident is suffering from an acute illness it is important that they are reassessed after an acute illness to see if their risk level has changed.

Chronic medical condition:

To be answered regardless of whether the resident is immobile or bed bound and not likely to improve.

Please ensure that you tick the particular medical condition category boxes as well as the **Yes/No** box.

Functional behaviour:

Fearful of activity - anxiety and/or depression may result in reduced ability to recall staff instructions and follow directions (eg. regarding supervision), rigidity of posture impeding movement, over-reaching to 'furniture walk', attempts to sit again prior to completion of transfer, reluctance to stand straight and poor foot lift during mobility etc, even with staff present.

Over estimates abilities - poor awareness of current capacity, frequent risk-taking behaviour due to, for example over confidence, poor insight, determination for immediate independence, poor short term memory, agitation, disorientation, impulsive/poor self monitoring etc.

Strategies:

It is important to address each risk factor individually (see recommended list of strategies) irrespective of the overall falls risk. Those identified as high risk may require some additional interventions. **High risk** is indicated by a **total score of 11 or more**.

For residents identified at 'high risk of falling':

- Place 'Falls Alert' identifier in front of summary or working care plan.
- Please place a completed copy of their falls risk assessment form in the GP communication book.

Please date and sign both the assessment form and the management strategies.

In 2005 the Department of Human Services funded the National Ageing Research Institute to review and recommend a set of falls prevention resources for general use. The materials used as the basis for this generic resource were developed by the National Ageing Research Institute, Cyril Jewell House and Boyne Russell House under a Service Agreement with the Department of Human Services. This and other falls prevention resources are available from the department's Aged Care website at: <http://www.health.vic.gov.au/agedcare>.