GUIDE TO ACTION FOR FALLS PREVENTION TOOL IN-PATIENTS

<table>
<thead>
<tr>
<th>NAME:</th>
<th>DOB:</th>
<th>AGE:</th>
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<tbody>
<tr>
<td>NHS No:</td>
<td>WARD:</td>
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FALLS ASSESSMENT COMPLETED BY:

<table>
<thead>
<tr>
<th>Name (print)</th>
<th>Signature</th>
<th>Designation</th>
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DATE COMPLETED: | TIME:

ALL ADULTS OVER THE AGE OF 65 (AND THOSE OVER 50 AT RISK OF FALLS) ADMITTED TO HOSPITAL UNDER THE CARE OF THE TRUST SHOULD HAVE THEIR RISK OF FALLS ASSESSED AND ACTIONS TAKEN TO REDUCE THAT RISK. NB: THIS FORM IS A FALLS RISK ASSESSMENT AND CARE PLAN.

Completion Guidance:

To be completed within 24 hours of admission:
- Underline the statements in the left hand column and tick the Yes/No sections that are relevant for each patient.
- Carry out the actions required for the individual patient and tick the box applicable to the actions taken, state all care interventions and this is the falls prevention care plan.
- Date and sign each section.

Following a fall in hospital complete Datix and within 6 hours reassess falls risk and ensure all actions to reduce risk have been completed.

Rationale:

To assess falls risk on admission
To identify falls risk factors for each patient
To reduce that risk by taking targeted individualised actions for each patient.

To identify factors that contributed or caused that particular fall.
To amend the care plan to reduce the chance of a further fall. To ensure actions to reduce falls have been completed.

Have you offered falls advice and information e.g. information sheets, leaflets? YES / NO / DECLINED

<table>
<thead>
<tr>
<th>Falls risk factors</th>
<th>Yes / No</th>
<th>Suggested Actions</th>
<th>Individualised Care interventions</th>
<th>Date &amp; Sign</th>
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<tbody>
<tr>
<td>History of falls</td>
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<tr>
<td>History of falls <em>prior to or causing admission</em></td>
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<tr>
<td>History of falls <em>since admission</em></td>
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<tr>
<td>Injuries due to falls</td>
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<tr>
<td>Head injury, cuts, tears, bruises, grazes</td>
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<tr>
<td>Frailty Fractures: Wrist, hip, pelvis, spine, ribs, collar bone, shoulder, ankle</td>
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<td>Coping strategies: Unable to get up from floor without help, Unable to summon help</td>
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<td>Fear of falling: Is anxious / worried about falling, lacks confidence, remains seated for much of the day due to fear of falling</td>
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<td>Medical History: Stroke, Parkinson's Disease, dementia, epilepsy, diabetes, heart disease, blackout, arrhythmia, high blood pressure, low blood pressure</td>
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<td>Medication: On or more prescribed medications, on sedatives, antidepressants, diuretics, cardio-active drugs</td>
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<tr>
<td>Medication: Currently taking: hypnotics, antipsychotics and anxiolytics</td>
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If yes, to one of the types of medication above, please provide rationale for keeping them on the medication.

Interventions

- Lying BP
- Standing BP
- Risk of Osteoporosis assessed
- Baseline observations completed on admission
- Assessed for acute infection e.g. UTI
- Medication review completed
- Rationale provided if needed

Please provide rationale below.
### Dizziness
Complains of dizziness, dizzy on first standing

- Postural BP checked. Check for ear problems
- Advise to move legs and feet before standing and to stand still and count to 10 on first standing up

- Postural BP checked

### History of feeling lightheaded/fainting
Patient has postural hypotension if there is a 20mmHg systolic drop with or without symptoms or a systolic drop below 90mmHg or 10mmHg diastolic drop with symptoms/refer to doctor

- Take 3 readings:
  - >1st after 5 minutes of lying
  - >2nd on immediate stand(0-1 min)
  - >3rd after 3 minutes standing

### Cognition
Does not recognise own limitations, poor understanding of space and distance, unaware of risks and hazards, poor short term memory

- Use signage for toilet, bedroom, lounge
- Use physical gestures and prompt. Repeat information. Discuss with MDT/GP via GP/medical team if change from usual presentation. Medical review

- Referral for further assessment to: please state below

### Mental Health
Paranoia, hallucinations

- Discuss with MDT / Medical review via medical team

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### Falls risk factors
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| **Behaviour**
  - Agitated, unsettled, anxious, periods of aggression, risk to others, unpredictable
  - Medical review/discuss with MDT to ensure no acute illness or infection. Observations recorded and reported BEWATS tool. Metotropic drugs increase falls risk
| **Comprehension & Communication**
  - Difficulty understanding verbal communication.
  - Ask carers. Use photos / symbols simple statements. Check hearing
| **Mood**
  - Low mood, depression, anxious, fearful
  - Reassure, encourage socialisation
  - Discuss with CT
| **Transfers**
  - Needs help to transfer, unsteady, tends to rush
  - Balance
  - Holds furniture when moving, unsteady when walking, loses balance on turning, cannot walk unsupported due to unsteadiness
  - Stumbles and Trips
  - Noticed to stumble and trip even if no obstacle, near misses noted
  - Gait
  - Shuffles, leans to side, leans backwards, walks fast
  - Dual Tasking
  - Stops walking when talking
  - Review the height of bed, chairs etc. Promptly, encourage slow safe movements
  - Encourage to stand still on first standing, advise to keep head and feet in line when turning.
  - Incase supervision with reference to the Trust Observation Policy where appropriate
  - Encourage the use of walking aids as prescribed
  - Physiotherapy staff
  - Document incidents, review incidents for time, location, activity at time. Review possible causes e.g. footwear, eyesight
  - Advise to stand upright, supervise.
  - Referral to Physiotherapists
  - Do not overload with instructions or expect to multi-task
| **Walking (indoors and outdoor)**
  - Needs supervision when walking, needs assistance 1:1 or 2 to walk
  - Walking aids
  - Uses incorrectly, forgets to use, poor condition
  - Ask for any mobility aid to be brought from home, check condition of mobility aids
  - Assist to complete any exercise programme. Check correct height, prompt to use mobility aid correctly
  - Refer to Physiotherapists
| **Assessment completed by Physiotherapist**
| Date |
| **Assessment completed by OT**
| Date |
| **Basic Mobility Assessment completed**
| Date |
| **Patient requires walking aid**
| **Patient has been supplied with required walking aid**
| **Patient requires further assessment from a physiotherapist**
| (once assessment has occurred please fill in the date for the Physiotherapist section above)
<table>
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<tr>
<th>Category</th>
<th>Details</th>
<th>Actions/Notes</th>
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| Alarm                  | Unable to reach call alarm, cannot remember how to use, does not call for assistance when needed | Consider bedroom position  
Consider use of pressure sensors /alarms  
Increase supervision with reference to the Trust Observation Policy where appropriate |
| Flooring               | Clutter, clothing, client property, flexes                               | Bedroom and communal areas clear of trip hazards. Keep floors dry. Avoid clutter |
| Nutrition              | Needs encouragement to eat, poor appetite, recent weight loss             | Monitor weight. Dietician referral if appropriate  
Food chart. Check mouth health, teeth and dentures.  
**Referred to dietician due to nutrition concerns** |
| Fluid intake           | Drinks less than 5 cups of fluid a day, needs encouragement to drink, often leaves drinks unfinished | Encourage to drink 6-8 cups of fluid a day, review reasons for poor fluid intake e.g. worried about getting to toilet  
Monitor using Fluid Input Chart |
| Continence             | Incontinent of urine / faeces, difficulty accessing toilet, frequency, urgency, needs to get up to toilet at night, concerned re continence, difficulty managing clothes, catheter, constipation | Ensure continence assessment completed,  
Refer to continence service if required. Test urine to exclude UTI, assess for constipation, consider signage to toilet, check regularly, consider commode for night use, Consult medical team if needed |
| Sleep                  | Unsettled at night, sleeps a lot during day, complains of feeling tired   | Encourage activity during the day, consider time goes to bed, review re use of low bed / rails, be aware of risk of medication to aid, assess increasing risk of falls, Increase light supervision with reference to the Trust Observation Policy where appropriate, consider use of sensor equipment  
**Safe use of low bed assessment done**  
**Safe use of bed rails assessment done** |
| Vision / Hearing       | Has diagnosed sight / hearing loss, wears varifocal, bifocal glasses, refuses to wear glasses / hearing aid | Check date of last eye / hearing test. Encourage glasses / hearing aid being worn if required, ensure adequate lighting day and night, advise against varifocal / bifocal glasses. Offer assistance to navigate the ward area, Do no approach from behind |
| Footwear / Footcare    | Unsupportive footwear, footwear too loose / tight, painful feet          | Advice on suitable footwear, check footcare - nails, corns, callouses. Refer to podiatry/medical opinion if required |
| Pain                   | Has specific pain / general pain, pain not helped by painkillers, Unable to communicate is in pain | Referral to clinical team if pain poorly controlled,  
Observe behaviour and facial expression for signs of pain if unable to communicate |

**Patient/carer relative comments:**

**Date:**

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<tr>
<th>Question</th>
<th>Yes</th>
<th>No</th>
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<tr>
<td>Has a copy been offered to the patient/carer/relative?</td>
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<tr>
<td>Has this care plan been written with the patient's involvement? (If no, please explain Why).</td>
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<tr>
<td>Unable to sign due to cognition</td>
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<tr>
<td>This care plan has been agreed by:</td>
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