RESIDENT'S NAME	DOB

Falls risk factors	√	Suggested action	Action taken	Date action taken & by whom
FALLS HISTORY				
History of falls History of falls prior to admission to care home Falls reason for admission to care home		Review all incidents using Incident Analysis form, look for any patterns to falls e.g. time of day, activity at time of fall – fill in 'Fall Incident Analysis' Inform GP of falls history and any recent falls Postural blood pressure to be checked i.e. in lying, sitting and standing - alert GP if drop is greater than 20mmHg, Request medical review to identify any medical causes of falls e.g. infection, stroke, low blood pressure, heart problems Identify any possible causes of falls and take steps to reduce those risks		
History of falls History of falls since admission				
Recent falls 2 or more falls in past 6 months (A fall is defined as an unexpected event in which residents come to rest on the ground or floor)				
Fractures Has broken bones as result of fall: Wrist, hip, arm, pelvis, spine, ribs, collar bone, shoulder, ankle		At risk of Osteoporosis Ask GP to review if person is falling and has previous fracture(s)		
Hospital admission Attended A&E due to fall, Ambulance called - not taken to hospital, Admitted to hospital due to fall		Review causes of fall, initiate any treatment recommended, inform GP		
Other injury due to fall Head injury, cuts, bruises, grazes, skin tear				
Coping strategies Unable to get up from floor without help, Unable to summon help		Ensure call buzzer easily accessible and working, Consider use of sensor equipment Increase level of supervision and document		
Fear of falling Is anxious / worried about falling, lacks confidence, remains seated for much of the day due to fear of falling		Consider reasons for fear of falling, increase supervision, ensure mobility maintained, encourage and reassure		
MEDICAL HISTORY				
Medical History Stroke, Parkinson's Disease, dementia, epilepsy, diabetes, heart disease, blackouts, arthritis, high / low blood pressure		Check for signs of acute illness / infection, consider medical review from GP if condition not been reviewed in last 6 months, if low blood pressure prompt to stand still on 1st standing up		

Medication **On 4 or more prescribed medications, on sedatives, on antidepressants, on diuretics**		**Medication should be reviewed by GP every 6 months, consider side effects of medication i.e. dizziness, sedation, confusion and refer to GP if concerned**		
Dizziness **Complains of dizziness,** **dizzy on first standing**		**Postural blood pressure to be checked i.e. in lying, sitting and standing - alert GP if drop is greater than 20mmHg, advise to move legs and feet before standing and to stand still and count to 10 on first standing up**		
Cognition **Does not recognise own limitations, poor understanding of space and distance,** **unaware of risks and hazards, Poor short term memory**		**Refer to GP for review if not reviewed in last 6 months, use signage for toilet, bedroom, lounge** **Use physical gestures and prompts** **Repeat information when person unable to remember, increase supervision**		
Behaviour **Agitated, unsettled, anxious,** **periods of aggression, risk to others**		**Refer to GP if medical review required, Mental Health services, ensure no acute illness or infection, be aware of risk of introducing/increasing psychotropic medication**		
Comprehension **Has difficulty understanding verbal instructions / questions**		**Speak clearly in short sentences, use simple instructions, use physical gestures as prompts**		
Mood **Low mood, depression, anxious, fearful**		**Reassure, encourage socialisation,** **be aware of risk of introducing/increasing psychotropic medication**		
Communication **Unable to express needs verbally, difficulty making self understood clearly**		**Consider alternative communication methods e.g. pictures, signs, observe behaviour and routines for insight into how the person is feeling**		
Falls risk factors	√	**Suggested action**	**Action taken**	**Date action taken & by whom**
MOVEMENT AND ENVIRONMENT				
Transfers **Needs help on/off chair, bed, toilet** **Unsteady when transferring,** **tends to rush**		**Consider use of alternative furniture, refer to OT if advice required, prompt to not rush**		
Balance **Holds furniture when moving, unsteady when walking,** **loses balance on turning,** **cannot walk unsupported due to unsteadiness**		**Encourage to stand still on first standing, advise to keep head and feet in line when turning, increase supervision, consider referral to physiotherapist**		
Stumbles and Trips **Noticed to stumble and trip even if no obstacle, near misses noted**		**Document incidents, review incidents for time, location, activity at time. Review possible causes e.g. footwear, eyesight**		

Gait **Shuffles, leans to side,** **leans backwards, walks fast**		**Advise to stand upright, supervise, consider referral to physiotherapist for advice**		
Walking **Needs supervision when walking, needs assistance of 1 or 2 to walk**		**Consider referral to physiotherapist for advice, assist to complete any exercise programme prescribed**		
Walking aids **Uses incorrectly, refuses to use, forgets to use, poor condition**		**Check correct height, check ferrules, prompt to use correctly**		
Heating / body temperature **Feels cold, sits for long periods,** **does not recognise when cold**		**Ensure draught free environment, check not cold if sitting for long periods, mobilise regularly**		
Alarm **Unable to reach call alarm,** **does not remember how to use,** **does not call for assistance**		**Ensure access to alarm, consider use of sensor equipment, increase supervision**		
Flooring **Clutter, rugs and flexes,** **slippery floor coverings, spillages**		**Ensure floors free of clutter, rugs and flexes, avoid patterned flooring, avoid raised thresholds between rooms, keep floor dry at all times**		
Lighting **Poor lighting day and/or night, location of light switches inaccessible**		**Ensure good lighting with no glare night and day, consider use of light in room at night, ensure switches accessible**		
PERSONAL				
Nutrition **Needs encouragement to eat,** **poor appetite, recent weight loss**		**Encourage to eat small amounts regularly, ensure teeth well fitted, review reasons for poor appetite and weight loss - refer to GP, dietician**		
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, stay with person whilst having a drink, document poor fluid intake if does not finish drinks, review reasons for poor fluid intake e.g. worried about getting to toilet**		
Continence **Incontinent of urine / faeces, catheter, difficulty accessing toilet, frequency, urgency, needs to get up to toilet at night, concerned re continence, difficulty managing clothes, constipation**		**Ensure continence assessment completed, refer to community nurse / continence service, test urine, assess for constipation, consider signage to toilet, refer to OT if required, consider commode for night use, check regularly if requires toilet**		
Sleep **Unsettled at night,** **sleeps a lot during day,** **complains of feeling tired**		**Encourage activity during the day, consider time goes to bed, be aware of risk of medication to aid sleep increasing risk of falls, increase night supervision, consider use of sensor equipment**		

Vision **Has diagnosed sight loss,** **wears varifocal, bifocal glasses, refuses to wear glasses**		**Ensure access to regular sight checks (every 1-2 years), ensure adequate lighting day and night, advise against varifocal/bifocal glasses**		
Footwear **Unsupportive footwear,** **footwear too loose / tight, painful feet**		**Advise on suitable footwear, check footcare - nails, corns, callouses, refer to podiatry**		
Pain **Has specific pain / general pain,** **pain not helped by painkillers, on medication for pain that causes side effects eg constipation, dizziness, unable to communicate is in pain**		**Refer to GP if pain poorly controlled, review medication if side effects to prescribed tablets, observe behaviour and facial expression for signs of pain if unable to communicate**		