Falls Risk Assessment

(Acute and Sub-Acute)

To be completed:

- Within 24 Hours of patient admission **and**
- After an acute episode which alters patient's functional state.

Information must be based on the last 24 hours of patient's status

PATIENT IDENTIFICATION LABEL

To complete: 1. Tick appropriate box/write score in shaded area
2. Add scores to give a total score

RISK FACTOR Strategies documented on care plan should be based on risk factors identified			DATE	DATE	DATE	DATE	DATE
Has the patient's environment been assessed as safe? Seating type and height, bed height, assistive devices			☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
Has the patient been oriented to the ward and routines?			☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
Has the patient had a fall in the last 12 months? Can tick more than 1 box	If more than 1 apply, Max score = **5**						
• Nil **(score 0)**			☐	☐	☐	☐	☐
• Prior to hospital admission, 1 fall **(score 1)**			☐	☐	☐	☐	☐
• Prior to hospital admission, 2 or more falls **(score 5)**			☐	☐	☐	☐	☐
• During current admission to hospital 1 or more falls **(score 5)**			☐	☐	☐	☐	☐
Does the patient have an altered cognitive state? Tick 1 box only	Max score = **3**						
• NO – intact or AMTS 9-10, MMSE 23-30 **(score 0)**			☐	☐	☐	☐	☐
• YES – minimally impaired or AMTS 7-8, MMSE 18-22 **(score 1)**			☐	☐	☐	☐	☐
• YES – moderately impaired or AMTS 5-6, MMSE 11-17 **(score 2)**			☐	☐	☐	☐	☐
• YES – severely impaired or AMTS 4 or less, MMSE 0-10 **(score 3)**			☐	☐	☐	☐	☐
		AMTS / MMSE Date					
If YES, is it Acute, Fluctuating or Chronic? Can tick more than 1 box	No score	Acute	☐	☐	☐	☐	☐
		Fluctuating	☐	☐	☐	☐	☐
		Chronic	☐	☐	☐	☐	☐
Is the patient affected by any of the following? Can tick more than 1 box	If more than 3 apply, Max score = **3**						
• No continence problems **(score 0)**			☐	☐	☐	☐	☐
• IDC in situ **(score 0)**			☐	☐	☐	☐	☐
• Incontinence of urine and/or faeces **(score 1)**			☐	☐	☐	☐	☐
• Frequency (empties bladder > 6 times daily) **(score 1)**			☐	☐	☐	☐	☐
• Urgency **(score 1)**			☐	☐	☐	☐	☐
• Needing nocturnal toileting, bladder and/or bowel **(score 1)**			☐	☐	☐	☐	☐
Is the patient aware of their own limitations when completing functional tasks? Tick 1 box only	Max score = **3**						
• YES – consistently aware, requests appropriate assistance **(score 0)**			☐	☐	☐	☐	☐
• AT TIMES – occasional risk taking behaviours **(score 1)**			☐	☐	☐	☐	☐
• NO – under estimates abilities/inappropriate fear or activities **(score 2)**			☐	☐	☐	☐	☐
• NO – over estimates abilities/frequent risk taking behaviours **(score 3)**			☐	☐	☐	☐	☐
Does the patient, upon observation, appear unsteady or at risk of losing their balance? Tick 1 box only. If functional level fluctuates, tick most unsteady rating	Max score = **5**						
• No unsteadiness exhibited **(score 0)**			☐	☐	☐	☐	☐
• On bed rest **(score 0)**			☐	☐	☐	☐	☐
• YES – minimally unsteady, (needs supervision) **(score 1)**			☐	☐	☐	☐	☐
• YES – moderately unsteady, (needs hands on assist at times) **(score 4)**			☐	☐	☐	☐	☐
• YES – severely unsteady, (needs constant hands on assist) **(score 5)**			☐	☐	☐	☐	☐
If YES, is it when standing, transferring or walking? Can tick more than 1 box	No score	Standing	☐	☐	☐	☐	☐
		Transferring	☐	☐	☐	☐	☐
		Walking	☐	☐	☐	☐	☐
If total is 10 or above:		**TOTAL**					
COMPLETE: 2nd page of WHeFRA & document strategies on falls prevention management plan		**Name**					
PLACE: Falls Risk Stickers in medical record and nursing care plan		**Designation**					
If score ≥ 10, patient is at potential risk for falls		**Signature**					

Tool developed based on the FROHP – National Ageing Research Institute

RISK FACTOR No scoring required on this page	DATE	DATE	DATE	DATE	DATE
Is the patient affected acutely, or chronically, by any of the following medical conditions which impact on their function?	Can tick more than 1 box				
• Arthritis	☐	☐	☐	☐	☐
• Osteoporosis	☐	☐	☐	☐	☐
• Primary cancer diagnosis	☐	☐	☐	☐	☐
• Depression	☐	☐	☐	☐	☐
• Dementia	☐	☐	☐	☐	☐
• Stroke	☐	☐	☐	☐	☐
• Parkinson's disease	☐	☐	☐	☐	☐
• Vestibular disorder (dizziness, Meniere's disease)	☐	☐	☐	☐	☐
• Other neurological conditions	☐	☐	☐	☐	☐
• Respiratory condition	☐	☐	☐	☐	☐
• Cardiac condition	☐	☐	☐	☐	☐
• Postural hypotension	☐	☐	☐	☐	☐
• Diabetes	☐	☐	☐	☐	☐
• Lower limb amputation	☐	☐	☐	☐	☐
• Other e.g. peripheral neuropathy Specify.....	☐	☐	☐	☐	☐
Does the patient have impaired vision, which limits their functional ability?	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
Does the patient have impaired hearing, which limits their functional ability?	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
Does the patient have problems with the sensation in their feet?	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
Does the patient have foot problems? e.g. corns, bunions, ulcers	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
Does the patient have communication difficulties? e.g. NESB or dysphasia	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
Does the patient have intravenous therapy/IDC/drains/NGT in situ?	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
Is the patient within 24 hours post surgery / anaesthetic?	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
How many medications does the patient have prescribed? Include all listed on drug chart, PRN Meds = 1 medication for that drug type eg: panadol, panadeine and panadeine forte prescribed as PRN = 1 medication.	Tick 1 box only				
• Less than 4 medications	☐	☐	☐	☐	☐
• 4 or more medications	☐	☐	☐	☐	☐
Does the patient take any of the following type of medications?	Can tick more than 1 box				
• Sedative	☐	☐	☐	☐	☐
• Psychotropic	☐	☐	☐	☐	☐
• Antidepressant	☐	☐	☐	☐	☐
• Analgesic	☐	☐	☐	☐	☐
• Antiparkinsonian	☐	☐	☐	☐	☐
• Anticonvulsant	☐	☐	☐	☐	☐
• Vestibular Suppressant (eg. antiemetics, antinauseants)	☐	☐	☐	☐	☐
• Antihypertensive	☐	☐	☐	☐	☐
• Vasodilator	☐	☐	☐	☐	☐
• Diuretic	☐	☐	☐	☐	☐
Does the patient wear appropriate, accurate fitting shoes with fastening mechanism and good sole grip?	If NO, tick A, B, C, D, E and / or F Can tick more than 1 box				
• YES	☐	☐	☐	☐	☐
• NO - **A** = bare feet or **B** = slippers, good fit with supportive back / heel	☐A ☐B	☐A ☐B	☐A ☐B	☐A ☐B	☐A ☐B
• NO - **C** = slippers, loose fitting or **D** = slippers, no back/heel support	☐C ☐D	☐C ☐D	☐C ☐D	☐C ☐D	☐C ☐D
• NO - **E** = TEDS in situ or **F** = tubigrip in situ	☐E ☐F	☐E ☐F	☐E ☐F	☐E ☐F	☐E ☐F
Is the patient's clothing too long or loose fitting?	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
Has the patient had a weight loss or decline in food intake in the last 12 months?	Tick 1 box only				
• Nil	☐	☐	☐	☐	☐
• Minimal or < 1kg weight loss, or intake minimally reduced	☐	☐	☐	☐	☐
• Moderate or 1-3kg weight loss, or mod loss of appetite	☐	☐	☐	☐	☐
• Severe or > 3kg weight loss or severe loss of appetite	☐	☐	☐	☐	☐
Name **Designation** **Signature**					

Potential Strategies for Patients at Risk of Falling (Acute & Sub-Acute)

There may be alternative/additional strategies indicated apart from those listed – document strategies on falls care plan

RISK FACTOR	STRATEGIES
History Of Falls	• Obtain details about previous falls from patient, medical record or family/carers to determine any pattern – time of day, after medication, activity at the time, environmental impact. Based on findings take appropriate actions. Assess for fear, decreased confidence related to previous falls • Document in nursing and falls care plan and in medical record
Altered Cognitive State	• If requires supervision or assistance with transfers or walking, remind patients to ask for assistance • Reorients to ward, especially to room/toilet .....hourly / every shift / each encounter as appropriate • Ensure bed rails are used appropriately, leave down if there is a risk that patient will climb over them • Discuss falls risk, preferred routines with family, encourage them to sit with patient • Investigate possible cause of confusion e.g. medications, sepsis • Position close to nurses station to enable close observation • Provide regular activity during the day to aid sleep at night and / or reduce agitation during the day • Use uniform methods when instructing/assisting patient • Integrate if possible into care plan, patient's previous / preferred ADL routines (e.g. evening shower) • Do not leave patient alone in shower or toilet
Continence Problems	• Provide toileting regime (e.g.2-4 hourly / after meals / before settling at night) and ensure adhered to (document in nursing care plan) • Place patients with urgency near toilets, consider use of commode if appropriate • Regular checks following laxatives or diuretics and at night if required • Monitor floor for wet areas and clean ASAP • Use night lights to ensure good visibility, supervise if needed • Continence assessment & / or review of continence chart, continence aids • Adequate hydration during day, not excess late pm
Impaired Judgement	• Address patient's anxieties / reassure patient, re-orientate patient to surroundings at each encounter, use uniform methods when instructing / assisting patient • Bed in lowest position when patient is resting, change to hi-lo bed, move bed against wall, consider concave mattress • Provide regular toileting • Place patient closer to nurses station if risk taking behaviours evident to ensure increased observation, visualise frequently, especially during the night • Provide supervision with ADLs, do not leave alone in toilet or shower, consider if patient's PADL's should be attended to before others • Medical assessment for depression / behaviour if appropriate
Unsteady Transfers/ Ambulation	• Ensure patient's feet are on the ground before standing up from chair/bed • Provide level of assistance indicated, assist / supervise ambulation and transfers - ask for demonstration by physiotherapist if unsure • Refer to physiotherapy if altered from previous functional level • Ensure call bell & other items within reach and gait aid within reach if appropriate • Consider hip protectors
Medical Conditions	• Liaise with medical staff for review of medical condition e.g. stability of condition, pain, medication • Consider Allied Health referral e.g. stroke, Parkinson's disease, respiratory conditions
Impaired Vision	• Provide optimal lighting e.g. night lights, reduce glare • Ensure glasses are clean, within reach & worn appropriately e.g. reading vs distance
Impaired Hearing	• Use common gestures / cues and minimise excess / extraneous noise • Remove wax and ensure hearing aid is worn, turned on and working
Sensation Loss in Feet	• Educate patient to monitor skin integrity daily, encourage regular community podiatry
Foot Problems	• If ulcers or foot condition impeding mobility, refer to podiatry
Communication Difficulties	• Use interpreters / family members and provide common cues / instructions • Refer to speech pathology if altered from previous level
IV Therapy In Situ	• Secure drip lines and provide assistance / instruction for ambulation
24 Hours Post Surgery	• Provide supervision with ADLs and ambulation (caution 1st time up)
Polypharmacy (≥4)	• Medication review by doctor: highlighting fall risk, total number of medications prescribed
Types of Medications	• Liaise with medical staff about timing of administration of medications and limit combinations • Educate patient– slow rising from sitting/lying position, sit on bed or stand for few minutes before moving off, esp if taking meds which may cause postural hypotension • Anticipate possible side effects & take appropriate measures, report if they occur • Sedatives – toilet & prepare for bed prior to giving night sedation, monitor overnight & supervise in morning • Psychotropics- causes sedation, postural hypotension & impairs balance • Diuretics – anticipate immediate and subsequent toileting
Footwear	• Liaise with family to provide appropriate shoes. If shoes too tight or loose fitting, ambulate bare feet. If using slippers, must be good fit with back of heel support • Do not ambulate with only socks on
Clothing	• Liaise with family to provide good fitting clothes – not too long or loose
Nutrition	• Encourage oral & fluid intake • Dietician referral

FALLS RISK STICKER

FALLS PREVENTION MANAGEMENT PLAN

UR 112233
Grigg
Georgie
F
05/05/1941
English
22 Nice St
Nicetown 8909
Phone: 92999167
DVA:
M/C:
today:

Document strategies after completing the WHeFRA within 24 hours of admission (refer to inside assessment page)
Re- Assessment with WHeFRA and review of strategies is required if a fall occurs or after an acute episode which alters their functional state

WHeFRA Assessment Date	/ /	/ /	/ /	/ /	/ /
WHeFRA Score					

FALLS PREVENTION STRATEGIES (Complete WHeFRA assessment first to identify patient specific risk factors) (Refer to back page for suggested strategies)	Start Date & Sign	Finish Date & Sign
Bed and Bathroom area to be clear and minimise clutter		
Bed to be adjusted to lowest level or at appropriate height and brakes on at all times, convey to orderly		
Chair to be adjusted to appropriate height e.g. patients hips and knees at 90°, feet flat on floor. Brakes on at all times, if applicable		
Items for the patient to be within easy reach at all times i.e. glasses, call bell, drinks, walking aid if appropriate		

If patient has fallen during admission, please document (in conjunction with adverse event form):

Date of fall	Time of fall	Location	Circumstance of fall e.g toileting	Adv event form completed	Sign

FALLS RISK