Tool 4a
Multifactorial Falls Risk Screen (MFRS) and falls care plan (includes an osteoporosis risk screen)

Name of resident:

DOB: **Room no.:**

Name of assessor:

Date of assessment:

Record all falls risks and actions in the resident's falls care plan and in the general care plan.

Risk factor (Tick if applicable, then link with recommended actions)	**Recommended actions** (Select appropriate interventions and record in care plan)	**Date and sign**
1. History of falling: ☐ Has the resident had one or more falls in the past 12 months?	a. Obtain details about past falls, including how many in the past week, month and six months, causes, activity at time of fall, injuries, symptoms such as dizziness, and previous treatment received. Determine any patterns and consider throughout assessment. Ask about/ observe for fear of falling. b. Discuss falls risk with resident, family and others as appropriate. c. Note in falls care plan, general care plan and at handover if resident is at an increased risk of falls. **Consider:** d. Contacting GP or falls prevention services to review resident's falls risks if there have been unexplained falls **or** several falls in a short period of time. Give details of specific concerns. e. If recent falls, and the resident has a temperature (fever), consider checking for infection (with urine, sputum and stool samples). f. Assess for postural/orthostatic hypotension (a drop in blood pressure when standing up). Record in resident's progress notes and inform GP if hypotension found. g. Consider how the resident can be observed/supervised more easily.	

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2. Balance and mobility: ☐ Is the resident unsteady/unsafe walking? ☐ Does the resident have difficulty with transfers (getting on and off the toilet/bed/chair)? ☐ Have there been recent changes to the residents walking, balance and/or mobility.	a. Ensure mobility aid and rails are used correctly and consistently. Prompt, place within reach, and use visual cues if appropriate. (Seek advice if unsure of correct use of mobility aids). b. Provide supervision when walking or transferring if required. Record what assistance is required. c. Record recommendations from physiotherapist regarding mobility and transfer status (for example, if supervision is needed) and handover information to other staff. d. Review bathroom grab rails. Are they appropriate and in good condition? Refer to maintenance if necessary. e. Ensure brakes are on bed at all times. Ensure correct height of bed and chairs. f. Ensure that frequently used items are within easy reach for example, glasses, drinks, walking aid. g. Ensure call bell is within easy reach and the resident is able to use it. h. 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). i. Increase opportunity for appropriate physical activity and exercise through Activities of Daily Living (ADL) and an activities programme. **Consider:** j. If required, discuss concerns with the GP or physiotherapist to identify need for assessment of balance, walking and transfers, assessment for/review of mobility aid particularly if there are recent changes in mobility. Record concerns in the resident's notes. k. Hip protectors - discuss suitability and funding with residents, the resident's care manager, family and others as appropriate.	
3. Osteoporosis: ☐ Does the resident have osteoporosis (check transfer notes or ask GP)? 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?	a. If osteoporosis is diagnosed check the resident is taking medication for osteoporosis as prescribed and speak to the GP if there is a problem complying to medication. b. If at high risk speak to GP about osteoporosis risk and further investigation and/or treatment.	–

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4. Medication: ☐ Is the resident taking 4 or more medications? ☐ Is the resident taking any of the following? – Sedatives – Anti-depressants – Anti-Parkinsonian medication – Diuretics (water tablets) – Anti-histamines – Opoid analgesics – Anti-hypertensives – drugs for psychosis and agitation ☐ Has there been a recent change in medication that may effect falls risk (for example, changes involving any of the above?) ☐ Has the resident got possible side effects – changes in mood – unsteadiness – dizziness – walking/transferring – drowsiness.	a. Check medications have been reviewed with respect to falls risk (within the last 12 months is good practice). b. Read patient information leaflet which comes with the medication or speak to local pharmacist for information on medication side effects and interactions. c. Anticipate side-effects and take appropriate measures: – 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. d. Report side-effects/symptoms of medication to GP. e. Assess for postural/orthostatic hypotension before and one hour after morning medications, for three days. f. Write all issues in progress notes and alert staff at handover.	–

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5. Dizziness and fainting: ☐ Does the resident experience: – dizziness on standing – a sensation of the room spinning when moving their head or body – blackouts – heart palpitations?	a. Carry out a lying standing BP reading to check for postural/orthostatic hypotension if staff trained to do so. b. Refer the resident to the GP for review of dizziness/ blackouts/heart palpitations or postural drop for lying/standing BP. c. 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 the resident lost weight unintentionally or do they have little appetite? ☐ Does the resident spend little time outside in daylight? ☐ Does the resident take enough fluids?	a. Refer to GP or dietician. b. In consultation with GP or dietician: – commence food record chart. – consider food supplements. c. Refer to GP for assessment of vitamin D levels. d. Encourage resident to take enough fluid to stay well hydrated (recommended 1500ml daily).	
7. Mild Cognitive impairment and dementia: ☐ 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?	a. If there is a new change in cognitive status monitor for pain, signs of infection or constipation. b. Monitor behavioural issues including fluctuations and patterns, discuss with the resident's GP the need for review. c. Include behavioural issues in care plan and follow with regard to falls prevention. d. Consider the need for falls prevention equipment in keeping with local policies and in discussion and agreement with resident, family and others as appropriate. e. Do not leave the resident unattended on commodes, in toilets, baths or showers. f. Optimise environmental safety- remove clutter and hazards. g. Use visual cues (for example, signs and symbols) as reminders or to aid orientation. h. Use routine practices when instructing/supporting the resident. i. Record useful practices in care plan. j. Investigate the resident's previous patterns and incorporate into care plan (for example, usual time of showering or preferred side of bed). k. Ask family/relatives to visit at particular times of day to assist with management and care if appropriate. l. Consider the need for falls prevention equipment in keeping with local policies and in discussion and agreement with family and principal carer.	

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8. Delirium: ☐ Is the resident in an 'acute confusional state'? – altered level of alertness – behavioural changes – mood/sleep disturbance – hallucinations/ delusions.	a. If there is a sudden, new change in cognitive status investigate any possible causes such as the effects of medication or infection. b. Complete the 4AT assessment. c. Inform GP. d. Use comfort and reassurance when providing care and reinstate daily routines as far as possible. e. Consider the need for additional falls prevention strategies during delirium and discuss with resident, family and others as appropriate.	
9. Continence: ☐ Do continence issues contribute to the resident's falls risk?	a. If no toileting routine is in place, carry-out a continence assessment and/or review of continence chart. b. Agree a toileting regime and use of continence products as appropriate. c. Optimise environmental safety - remove clutter and hazards, consider night lighting, monitor floors for wet areas - clean or report as soon as possible. d. Ensure adequate hydration during the day, not excessive in late afternoon. e. Provide with commode chair or urinal as appropriate. **Consider:** f. If required, referral to district nurse or the continence service.	

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10. Sensory impairment: ☐ Does the resident have poor vision? (Remember: following a stroke someone may have restricted vision on one side, some people with dementia experience visual problems) ☐ Does the resident have poor hearing?	a. If vision has not been tested in past 12 months, refer to optometrist. b. Ensure room is free of clutter and obstacles. c. Ensure bedroom lighting is adequate, consider need for night lights. d. Ensure glasses are in good condition, clean (each morning), worn consistently (prompting, note in care plan), kept within reach when not worn, and appropriate (for example, reading vs. distance) e. If hearing has not been assessed in last 12 months, discuss options, including referral to audiologist with GP. f. Ensure hearing aid is clean, batteries are working and it is worn. g. Use common gestures/cues/instructions. h. Minimise excess noise.	
11. Night patterns: *to be completed by night staff ☐ Does the resident often get out of bed overnight? If yes: ☐ Is the resident able to get in and out of bed safely on their own?	a. Provide night lighting appropriate to vision. b. Optimise environmental safety – remove clutter and hazards. c. Check bed height is suitable for the resident. d. Ensure spectacles and call bell are within easy reach. e. Discuss with family if nightwear is not appropriate – consider especially slippers (should be good fit, with back and heel support) and length of nightgowns. **Consider:** f. Treaded bed socks. g. Alert pad if resident is likely to fall while moving around the room. h. Hi-low bed. Keep in a position to suit the resident's needs overnight. i. Provide with commode or urine bottle for night toileting. j. If agitated at night: – Ensure calm environment and follow advice in the behavioural plan for settling the resident. – Observe every 15 to 30 minutes overnight. – Engage in regular activity during the day to aid sleep at night and/or reduce agitation during the day. k. Refer to GP for review of evening or night medication.	

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12. Feet and footwear: ☐ Does the resident have corns, ingrown toe nails, bunions, fungal infections, pain or loss of the sensation in their feet or painful callouses? ☐ Does the resident wear ill-fitting shoes, high-heel shoes, or shoes without grip?	a. Refer to podiatrist (or GP if fungal infections). b. Start a good foot care regime. c. Liaise with family or others to provide shoes with flexible nonslip sole, low/enclosed heel, fastening mechanism. d. Do not walk with socks only. If shoes are too tight or loose fitting, walk with bare feet. e. Consider rubber tread socks if shoes are often removed.	
13. New or respite resident: ☐ Is the resident oriented to their new environment? ☐ Does the resident have suitable clothing and footwear?	a. Orientation to facility/unit including their room, the bathroom, communal areas and outdoor areas. b. Optimise environmental safety - remove clutter and hazards. c. Inform and discuss with family/visitors as appropriate. d. Refer to pre admission information to identify specific issues. (pre-admission falls questionnaire, tool 3 in pack). e. Liaise with family and principal carer to provide suitable clothing and footwear. f. Refer to information gathering from carer or other with regard to safety and falls risks.	
Other: Are there other factors that you consider relevant in considering this resident's falls risk, eg alcohol intake, pain, low mood/ depression?	• Identify suitable action/s.	

Consider the relevance of the following risk factors:

Perceptual/Cognitive	Physical	Environment	Activities
Insight/ judgement	Balance	Footwear	Mobility
Cognitive status	Strength	Aids	Transfers
Memory	Vision	Equipment	ADL
Orientation	Hearing	Clothing	Opportunity for exercise
Psychiatric condition	Continence	Lighting	High risk activity
Anxiety	Nutritional status	Floor surface	Inactivity
Depression	Time spent outside	Location of bedroom	Fitness
Motivation	Medical condition	Seating	
Medication effects	Medication effects	Bedroom furniture	
Communication	Sensation	Signage	
Nocturnal patterns	Range of movement	Contrasting colours	
	Foot health		
	Constipation		
	Dizziness		

Falls action plan:

Risk factors identified	Recommended actions

NB: the falls action plan above should be documented in the general care plan.

Date: **Signature:**

Review date:

Adapted from a tool developed by Westerlands Care Home, Stirling