

Level 1

'Screen' for Falls or Risk of Falling for clients over 65 yrs.

Client Name: _____

Address: _____

Telephone Number: _____

Consent Obtained: Yes ☐ No ☐

Question 1

Ask: Client ☐ and / or Carer ☐

"In the past year have you had any fall, including a slip or trip, in which you lost your balance and landed on the floor or ground or lower level?"

☐ No → Proceed to Question 2

☐ Yes → (A) How many times did you fall in the past year? _____

(B) How did you fall? Please describe:

Activity:

Place:

Time:

☐ Single Fall → Gait & Balance Test*(see below) - ☐ Pass → Proceed to Question 2 & 3

or

- ☐ Fail → Multi-factorial Assessment.

☐ Recurrent Falls (two or more falls in the previous year) → Multi-factorial Assessment

Question 2

Ask Client: "Are you afraid of falling?"

☐ No (If no, proceed to question 3)

☐ Yes → Multi-factorial Assessment if considered clinically significant (Level 2)

(Significant = interfering with activities of daily living)

Question 3

Ask Client: "Have you any difficulty with your walking or balance?"

☐ No → No further Intervention

☐ Yes → Gait and Balance and, if fail, then Multi-factorial Assessment (Level 2)

*Gait and Balance Test (Please refer to Appendix 6 for rationale and references for Get Up and Go protocol)

The client is asked to do the following (normal mobility aid can be used):

- Client is asked to sit in a standard height arm chair (approx seat height of 46cm), arms resting on the arms of the chair
- Then he/she is asked to stand up, walk a distance of approximately 3 metres at normal pace
- Turn,
- Walk back and sit down again
- The subject wears their regular footwear and uses their customary walking aid (none, cane, or walker). No physical assistance is given.
- The observed performance is scored as steady or unsteady.

Individuals fail the test if they are unable to perform/complete the test, or have difficulty or demonstrate unsteadiness performing any component of the test

Assessor: _____

Profession: _____

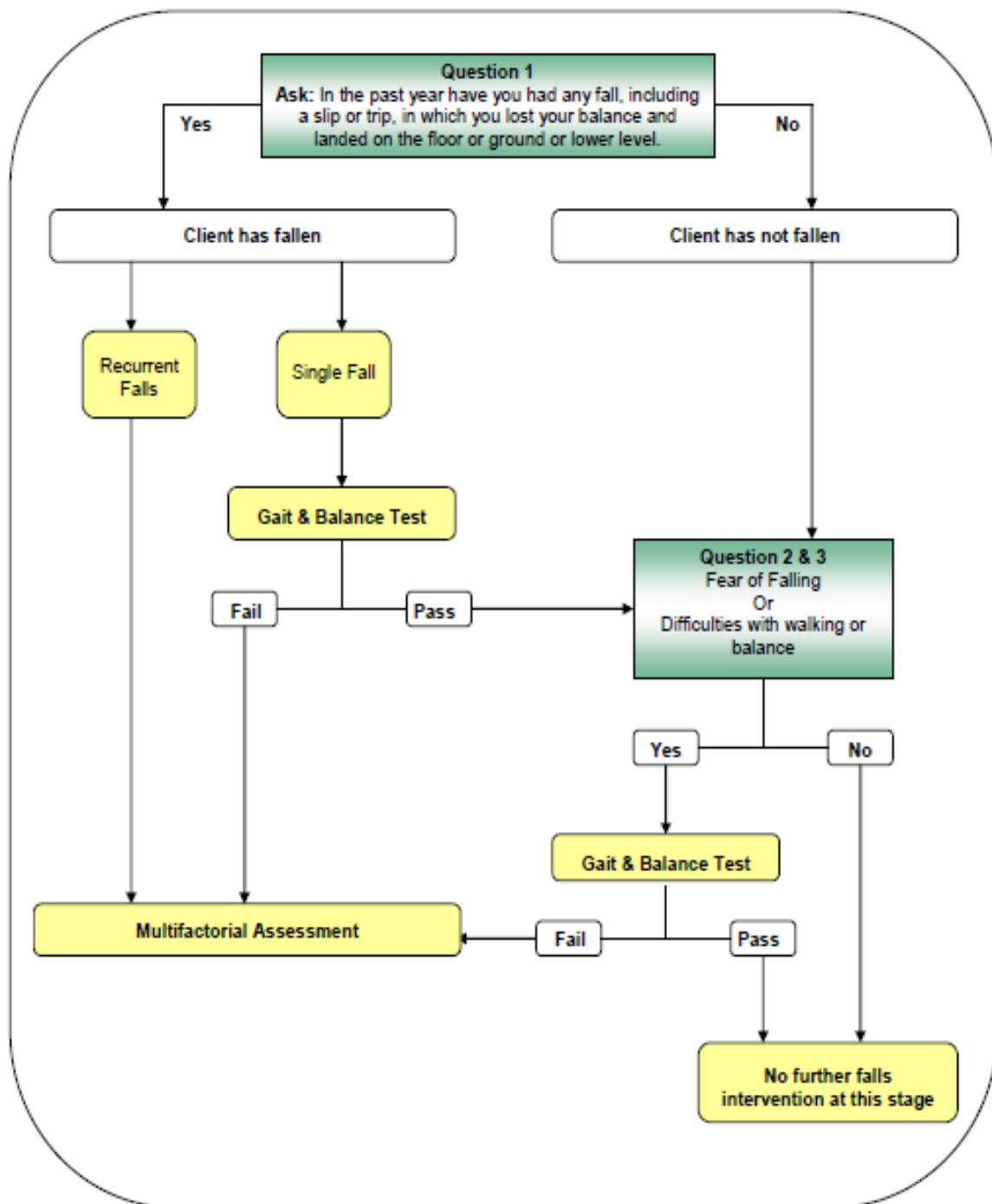
Date: _____

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REFERENCE: HSE, Dept. of Health and Children (2008) 'Strategy to Prevent Falls and Fractures in Ireland's Ageing Population'. National Council on Aging and Older People, Report of the National Steering Group on the Prevention of Falls in Older People and the Prevention and Management of Osteoporosis throughout life. Available from www.hse.ie.

Falls Algorithm



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Level 2: Multi-factorial Falls Risk Assessment

The form is intended to be completed by any healthcare professional on a primary care team. As local arrangements may vary the assessor/health care professional should complete the form in so far as their scope of practice allows and refer to their colleagues as required for full completion of the appropriate parts. The Clinician who initiates the process should maintain the record of the assessment and a register should be maintained by the Primary Care Team or Administration Support. This register would allow clients to be called back for follow up as required.

Assessor: _____		Date: _____	
Information obtained from: <input type="checkbox"/> Client <input type="checkbox"/> Carer <input type="checkbox"/> Other (Specify _____)			
Demographic details			
Name: _____ Address: _____ Telephone number: _____ Date of Birth: _____ GMS/LTI Card No: _____	Next of kin: _____ Relationship: _____ Tel. No: _____ GP: _____ Address: _____ Tel. No: _____		
Past Medical History			
Social History			
Living Alone <input type="checkbox"/> Yes <input type="checkbox"/> No		Carer <input type="checkbox"/> Yes <input type="checkbox"/> No	
1. Falls History			
History of Falls: <input type="checkbox"/> Yes <input type="checkbox"/> No			
Number of falls in last 12 months? : _____			
Location of fall(s): Indoors <input type="checkbox"/> _____ Outdoors <input type="checkbox"/> _____			
Time of the day falls occurred? _____			
How did the fall occur/what was the activity at the time? _____			

What (in the person's opinion) was the cause of the fall(s)? _____			

Has the person changed their routine or environment since the fall?		<input type="checkbox"/> Yes <input type="checkbox"/> No	
Did the person receive any injuries as a result of the fall?		<input type="checkbox"/> Yes <input type="checkbox"/> No	
Episodes of dizziness associated with falling?		<input type="checkbox"/> Yes <input type="checkbox"/> No	
Episode of blackout		<input type="checkbox"/> Yes <input type="checkbox"/> No	
Was the person able to get up from the floor?		<input type="checkbox"/> Yes <input type="checkbox"/> No	
Was the person able to summon help following the fall?		<input type="checkbox"/> Yes <input type="checkbox"/> No	
Does the person have a pendant alarm?		<input type="checkbox"/> Yes <input type="checkbox"/> No	
(If yes, was the person wearing pendant alarm at time of fall?)		<input type="checkbox"/> Yes <input type="checkbox"/> No	

Client:		DOB:	
2. Gait and Balance			
Gait analysis (unsteady on feet/shuffles/uneven stride length etc):			
Poor balance:	<input type="checkbox"/> Yes	<input type="checkbox"/> No	
Reported difficulty climbing stairs/steps to house:	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> N/A
Walking aid:	<input type="checkbox"/> Yes (please specify): _____		<input type="checkbox"/> No
3. Functional Ability			
Activities of Daily Living: Ask the client are they: Independent (I), requires Assistance (A), or Dependent (D) with each of the following tasks?			
Personal Activities of Daily Living (Dressing, Bathing, Toileting)	<input type="checkbox"/> I	<input type="checkbox"/> A	<input type="checkbox"/> D
Transfers (Toilet, Bed, Chair)	<input type="checkbox"/> I	<input type="checkbox"/> A	<input type="checkbox"/> D
Domestic Activities of Daily Living (Housework, Meal Preparation, Shopping)	<input type="checkbox"/> I	<input type="checkbox"/> A	<input type="checkbox"/> D
4. Fear of Falling			
Fear of falling or restricting any activity they appear capable of doing			<input type="checkbox"/> Yes <input type="checkbox"/> No
If yes, details: _____			
5. Home Safety			
Does the client have:			
Steps / Stairs in the home either inside or outside unprotected by a rail?	<input type="checkbox"/> Yes <input type="checkbox"/> No		
A shower with step or a bath without grab rails?	<input type="checkbox"/> Yes <input type="checkbox"/> No		
Indoor hazards present (cluttered rooms, rugs, cords)	<input type="checkbox"/> Yes <input type="checkbox"/> No		
6. Perceived Functional Ability			
Demonstrates decreased awareness in reporting falls, risks and consequences of falls			<input type="checkbox"/> Yes <input type="checkbox"/> No
7. Cognitive Function			
Complete The Abbreviated Mental Test Score – Appendix 7			
8. Urinary Incontinence			
Urinary Incontinence <input type="checkbox"/> Yes <input type="checkbox"/> Urgency <input type="checkbox"/> Nocturia <input type="checkbox"/> Other (_____)			
<input type="checkbox"/> No			
9. Foot Problems and Footwear			
Foot problems i.e. corns, bunions, swelling, overgrown toenails			<input type="checkbox"/> Yes <input type="checkbox"/> No
Inappropriate, poorly fitting or worn footwear			<input type="checkbox"/> Yes <input type="checkbox"/> No
10. Assessment of Mood			
During the last month have you been bothered by feeling sad, depressed or hopeless?			<input type="checkbox"/> Yes <input type="checkbox"/> No
During the last month have you often had little interest or pleasure in doing things?			<input type="checkbox"/> Yes <input type="checkbox"/> No
11. Nutrition			
11(i)			
Weight loss (within previous 12 months)			<input type="checkbox"/> Yes <input type="checkbox"/> No
Loss of appetite			<input type="checkbox"/> Yes <input type="checkbox"/> No
Are there issues impacting on dietary intake			<input type="checkbox"/> Yes <input type="checkbox"/> No
(If client answers "yes" carry out 11(ii) as appropriate ('MUST' screening - refer to MUST tool in Appendix 4)			
11(ii) 'MUST' screening:			
Height :	Weight (kg):	BMI (kg/m ²):	'MUST' Score: _____ 0 – Low risk: Monitor. 1 – Med risk: Implement 'First Line Dietary' advice (Appendix 4). ≥ 2 – High risk: Implement 'First Line Dietary' advice (Appendix 4) & refer to dietitian.

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Client:	DOB:
12. Bone health	
Previous low trauma fracture	<input type="checkbox"/> Yes <input type="checkbox"/> No
Xray evidence of osteopenia	<input type="checkbox"/> Yes <input type="checkbox"/> No
Corticosteroid Use (i.e. prednisolone for ≥3months)	<input type="checkbox"/> Yes <input type="checkbox"/> No
Family history of osteoporosis (especially maternal hip fracture)	<input type="checkbox"/> Yes <input type="checkbox"/> No
Other clinical risk factors: height loss, kyphosis, low Body Mass Index (<19kg/m ²)	<input type="checkbox"/> Yes <input type="checkbox"/> No
Possible secondary osteoporosis (primary hyperparathyroidism, poorly controlled thyrotoxicosis, malabsorption, rheumatoid arthritis, liver disease, alcoholism, primary hypogonadism)	<input type="checkbox"/> Yes <input type="checkbox"/> No
Untreated oestrogen deficiency (history of surgical or natural menopause <45 years, secondary amenorrhoea > 6 months not due to pregnancy or primary hypogonadism)	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> N/A
13. Drug History	
Medications: Is the client on 4 or more medications? <input type="checkbox"/> Yes <input type="checkbox"/> No Is the client on psychotropic medication, e.g. night sedation, anti depressants, anxiety meds? <input type="checkbox"/> Yes <input type="checkbox"/> No List all medications (including dosage): Document below or attach print out 	
Alcohol: Does the client have alcohol dependency issues? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, alcohol units per week: _____	
14. Vision	
15(i) Does person report any vision related problems e.g. poor eyesight, cataracts etc.? <input type="checkbox"/> Yes <input type="checkbox"/> No <i>(If client answers "yes" complete part (ii) below or complete onward referral for completion)</i> Under 70: Has the client had an eye test in last 2 years? <input type="checkbox"/> Yes <input type="checkbox"/> No 70 or over: Has the client had an eye test in last year? <input type="checkbox"/> Yes <input type="checkbox"/> No Does the client wear bifocals? <input type="checkbox"/> Yes <input type="checkbox"/> No	
15(ii) Visual acuity test: R = L = Are visual fields normal? <input type="checkbox"/> Yes <input type="checkbox"/> No	
15. Clinical observations	
Record BP and HR after 2 minutes lying: BP: ____/____ HR: ____ Record BP and HR after 1 minute standing: BP: ____/____ HR: ____ (Postural hypotension: fall of 20mmHg systolic or 10mmHg diastolic with dizziness)	
Assessor:	Date:



Féilthmeannacht na Seirbhíse Sláinte
Health Service Executive

XXX Primary Care Team

Date: _____

Dear _____,

I have conducted the Multi-factorial Falls Risk Assessment on

Client Name: _____

Client Address: _____

Client Date of Birth: _____

I would be grateful if you would complete the following sections of the Multi-factorial Falls Risk assessment:

Please return your completed sections me at the address below and please contact me with any further enquiries regarding this matter.

Thank you

Signature: _____

Name: _____

Profession: _____

Address: _____

Contact Phone No.: _____

Please attach a copy of the Multifactorial Falls Risk Assessment with this letter.

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Falls risk factor present	Suggested referral options and interventions
History of Falls (Review incident(s), identifying precipitating factors)	<ul style="list-style-type: none"> • Refer to GP, nurse, physiotherapist, occupational therapist as appropriate. • Refer for personal alarm and/or hip protectors. • Consider referral to a specialist falls assessment service where there is a complex interaction of risk factors, or unexplained, multiple falls or falls continuing despite local actions
Dizziness Blackout Postural Hypotension	<ul style="list-style-type: none"> • GP review with onward referral where indicated • Onward referral by the GP for investigations to out-rule cardiovascular disorders should be considered in older persons who present with transient loss of consciousness with amnesia or transient hypotensive episodes or where heart rate or rhythm abnormalities are detected on clinical examination.
Gait / Balance/Strength Impairment	<ul style="list-style-type: none"> • Refer to physiotherapist for gait, balance and strength rehabilitation • Exercise may be performed in groups or as individual (home) exercises, as both are effective in preventing falls. • Exercise programmes should take into account the physical capabilities and health profile of the older person, (i.e. be tailored) and be prescribed by qualified health professionals or fitness instructors. • The exercise programme should include regular review, progression and adjustment of the exercise prescription as appropriate. • Initiating exercise programmes with patients who have limited mobility and are not used to exercising should be done with caution as some studies have shown that exercise may increase the rate of falls in this population.
Difficulty with activities of daily living (A.D.L.s)	<ul style="list-style-type: none"> • Refer to occupational therapist (OT) for review of A.D.L.s / prescription of assistive equipment as appropriate • Refer to physiotherapist for walking aid assessment where indicated • Ensure assistive devices are in good working condition and provide education on correct use of assistive devices (if indicated).
Fear of Falling	<ul style="list-style-type: none"> • Discuss fear of falling & realistic preventative measures • Refer to PT/OT where appropriate • Refer to psychologist where appropriate
Home Safety Concerns	<ul style="list-style-type: none"> • Refer to occupational therapist (OT) for review of A.D.L.s , prescription of assistive equipment or home modifications as appropriate • Intervention should include mitigation of identified hazards in the home, and evaluation and interventions to promote the safe performance of daily activities.
Cognitive Function	Refer to GP +/- OT for detailed cognitive assessment with onward referral to specialist where indicated
Urinary Incontinence	Refer to GP, nursing, physiotherapist or occupational therapist as appropriate. Management of urinary incontinence as appropriate
Foot Problems and Footwear	<ul style="list-style-type: none"> • Refer to chiropodist/ podiatrist / physiotherapist as appropriate • Treatment of foot problems • Footwear Advice - Older people should be advised that walking with shoes with low heel height and high surface contact area may reduce the risk of falls

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Falls risk factor present	Suggested referral options and interventions	
Mood	Refer to GP or Psychologist as appropriate	
Nutrition	<ul style="list-style-type: none"> • GP review • Refer to dietician 	
Bone Health	Refer to GP, physiotherapist or dietician as appropriate. Refer for bone mineral density testing Management of osteopenia /osteoporosis as appropriate	
Neurological Disorders	Physiotherapy Assessment and treatment as appropriate GP review with referral to neurologist where indicated	
Drug History	On 4 or more medication	Consider referral to GP/Pharmacist for review of all medications & dosage - consider withdrawal or minimisation (Appendix 8)
	On psycho-active medications or other culprit medications	Refer to GP for review of psychoactive medications or other culprit medication (e.g. class 1a antiarrhythmic medications, digoxin, diuretics) - consider withdrawal or minimisation with appropriate tapering if indicated (Appendix 8)
	Determine if the client is able to manage their medications safely.	
Visual Related Problems	<ul style="list-style-type: none"> • GP review • Refer to optician • Refer to occupational therapist for home safety assessment • Treatment of remediable abnormalities, particularly cataracts. • An older person should be advised not to wear multifocal lenses while walking, particularly on stairs. 	