Case Study 2

Mr. Casey has been a resident in the HSE residential facility for 3 months and has had a fall. The fall occurred going out from the sun room to the garden. Mr. Casey was using his stick and walking with a HCA but missed the step and fell. He sustained a cut to his right knee. You completed post-fall assessment (using the Falls Algorithm as a guide) and Medical advice was sought as per the guideline. The Nursing Post Fall Checklist has been completed and now you are completing the MFRA to review risk factors and identify any change/new interventions required in the care plan to address the risk factors.

There are no new medical issues. There have not been any changes to medication. Mr. Casey is otherwise well and back to his normal engaging self with no new issues.

Complete the MRFA and using the Falls Reduction Workbook for Clinicians consider what to do next.

- Are any reviews required?
- Which ones?
- What must be considered as part of his care plan?

HSE MID WEST
COMMUNITY HEALTHCARE
Mental Health | Older Persons | Disabilities
Primary Care | Health & Wellbeing

Attach patient label here

MULTIFACTORIAL FALLS RISK ASSESSMENT

Complete for residents/patients aged 65 years+:	**Complete for residents/patients 50-64 years (under 50 years where appropriate) with one of the following:**
• Within 24 hours of admission to ward/unit • In the event of a fall. • At 4 monthly intervals if the resident is long stay • If there is a significant change in condition	• A fall in the last year or admitted with a fall • Difficulties with gait or balance • Fear of falling • Any clinical condition that increases the risk of falling

Item	**Circle**	**COMMENTS**
Resident/Patient input	**Yes** / No	
Family input	Yes / No	
Carer input/other	Yes / No	Staff input
History of falls		**COMMENTS**
Previous falls	Yes / No	
Cause of fall(s) *(slip, trip, fall, medical event e.g.blackout, dizziness)*	Missed the step to the garden	
Injuries from previous fall(s)	Yes / No	Laceration to right knee, dressing applied
Fear of falling: Does the patient worry about falling or losing their balance?	Yes / No	
Consider (Refer to workbook for further information): *Frequent falls can indicate health deterioration or Blackouts– consult GP/Medical Officer* *Occupational therapy referral, Physiotherapy referral*		
Mobility		**COMMENTS**
Unstable gait or looks unsafe walking	YES / No	If not using his stick, needs reminders to use it
Has the gait recently changed?	Yes / No	
Does the patient use mobility aids?	Yes / No	
What mobility aids does the patient use? *How long? Assistance required?*	stick	
Impaired Transfers/Impaired ADL's	Yes / No	
Inappropriate Footwear/Foot Disorder	Yes / No	
Consider (Refer to workbook for further information): *Occupational therapy referral, Physiotherapy referral, Podiatry referral,Medical review, Other*		
Vision, hearing, language		**COMMENTS**
Patient has visual deficit	Yes / No	
Patient wears glasses?	Yes / No	Reading glasses, last r/v 5 months ago
Consider (Refer to workbook for further information): *Ophthalmology referral*		
Patient has hearing deficit	Yes / No	Requires assistance to put them in
Hearing aids are functional	Yes / No	
Consider (Refer to workbook for further information): *Audiology referral*		
Patient speaks and understands English?	Yes / No	
Consider (Refer to workbook for further information): *Use of interpreter*		

Falls risk assessment

Adapted with permission from Health, Quality & Safety Commission, New Zealand https://www.hqsc.govt.nz/assets/Falls/PR/risk-assessment-tool-Oct-2014.pdf

Cognition		COMMENTS
Patient has communication impairment?	Yes / No	
Patient has confusion/disorientation or altered mental state?	Yes / No	Diagnosis of advanced mixed dementia, forgets stick
Patient has memory loss?	Yes / No	Needs prompts to use stick, hearing aids
Patient is agitated, impulsive, or unpredictable?	Yes / No	
Patient overestimates/ forgets limitations?	Yes / No	Forgets stick and can attempt to walk without it
Consider (Refer to workbook for further information): *Observe, Medical review, Written visual prompts, OT referral*		

Continence		COMMENTS
Patient has frequency, urgency or incontinence?	Yes / No	Urinary frequency at night, forgets to use call bell
Patient has a UTI?	Yes / No	
Consider (Refer to workbook for further information): *Catheter, Commode/urinal by bed, Assessing for appropriateness of incontinence aids, Complete continence assessment*		

Nutrition		COMMENTS
Does the patient have difficulties eating or drinking enough?	Yes / No	Requires cues to eat
Has the patient experienced recent unexplained weight loss?	Yes / No	
Consider (Refer to workbook for further information): *Referral to dietician, SLT or GP*		

Bone Health & Fracture Risk		COMMENTS
Does the person have contributing factors that place them at risk of bone fracture?	Yes / No	
Consider (Refer to workbook for further information): *Consult with GP/MO if Bone Health Review is needed, is the person on bone protection medication?*		

Medications		COMMENTS
Patient takes four or more drugs/day?	Yes / No	

High Falls Risk Medications *(Tick drug class below)*

❑ Anticholinergics	❑ Anti-Emitics	√Anti-Hypertensives	❑ Diuretics	❑ Drugs with sedative effect	❑ Hypnotics/ Anxiolytics	❑ Laxatives	❑ Opioid Analgesics

Consider (Refer to workbook for further information):
Pharmacy/Medication review, Monitoring lying and standing BP, Assistance with mobilisation

Environmental Hazards		COMMENTS
Are there environmental hazards (personal or structural)? **(Use Environment & Orientation Check)**	Yes / No	Step to garden
Consider: *Footwear & clothing, flooring, lighting & contrast,bed,bathroom, hallways, furniture & eating, walking aid & wheelchair* **(Refer to Environment & Orientation Check and workbook)**		

Other risks		COMMENTS
Other Health Conditions eg stroke, frailty, infection, delirium	Yes / No	
Does the patient have any other risk factors?	Yes / No	

Further comments and observations:

Continue cues and prompts for safety. Monitor ability on step to garden. Ensure someone is with him for this

Name of healthcare professional who completed this falls risk assessment:

Name	Signature	Date