Case Study 3

It is six months since Mr. Casey was admitted to your facility and three months since he fell going out to the garden.

Last night the night staff nurse found Mr. Casey on the bathroom floor. He had fallen and sustained a head injury and laceration. The Falls Algorithm was used and the guideline followed in relation to post-fall assessment and management. Following medical review he was transferred to the acute hospital for assessment and intervention. He received treatment for the laceration, all scans and x-rays were clear, he was treated for a UTI and is completing the course of antibiotics. In the transfer notes it is reported that he has developed daytime urinary frequency in addition to nighttime.

The Nursing Post-Fall Checklist was completed by staff on duty the night he fell.

He has now returned to the residential care facility and you are required to complete the MRFA to review risk factors and review the appropriate interventions in the care plan to address these risk factors.

You notice that he appears to have lost weight and is reluctant to engage with staff. He was observed to be distressed, confused and reluctant to mobilise when transferred by ambulance staff.

When invited to attend the dining room for supper, Mr Casey, who usually helps the staff to set out the place mats and cutlery, refused to stand and shouted at staff to be left alone.

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

MULTIFACTORIAL FALLS RISK ASSESSMENT

Attach patient label here

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	Withdrrawn and not engaging with staff
Family input	Yes / No	
Carer input/other	Yes / No	Staff input
History of falls		**COMMENTS**
Previous falls	Yes / No	2 falls
Cause of fall(s) *(slip, trip, fall, medical event e.g.blackout, dizziness)*	Missed step for 1st fall, Second fall unwitnessed in bathroom	
Injuries from previous fall(s)	Yes / No	1st fall –Laceration knee, 2nd head injury and laceration
Fear of falling: Does the patient worry about falling or losing their balance?	Yes / No	Reluctant to mobilise
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	Difficult to assess, used stick pre fall. Now needs assist of 2
Has the gait recently changed?	Yes / No	Reluctant to stand or walk since readmission, needs assist
Does the patient use mobility aids?	Yes / No	
What mobility aids does the patient use? *How long? Assistance required?*	Before recent fall used 1 stick	
Impaired Transfers/Impaired ADL's	Yes / No	Requires assistance for ADLs
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 review 8 months ago
Consider (Refer to workbook for further information): *Ophthalmology referral*		
Patient has hearing deficit	Yes / No	Assistance to put in hearing aids. Last reviewed 8 months
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

Cognition		COMMENTS
Patient has communication impairment?	Yes / No	Not engaging
Patient has confusion/disorientation or altered mental state?	Yes / No	Diagnosis of advanced mixed dementia
Patient has memory loss?	Yes / No	Forgets stick, hearing aids
Patient is agitated, impulsive, or unpredictable?	Yes / No	Appears agitated and confused since readmission
Patient overestimates/ forgets limitations?	Yes / No	Forgets stick
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	Now has daytime frequency in addition to nighttime
Patient has a UTI?	Yes / No	On antibiotics
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 and prompting
Has the patient experienced recent unexplained weight loss?	Yes / No	Observed weight loss, trousers loose since hospital admission
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	Resolving UTI, day x of antibiotics
Does the patient have any other risk factors?	Yes / No	? delirium associated with infection ad underlying dementia

Further comments and observations:
Need to weigh Mr. Casey to determine weight loss, he needs cues to eat so communicate this to all staff. New mobility status, reluctant to mobilize needs 2to help– refer to physio

Name of healthcare professional who completed this falls risk assessment:

Name	Signature	Date

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