Mid West Community Healthcare Area Level 1 Falls Conversation and Multi-Factorial Screening

Client's Name: _____	**GP's Name:** _____
Client's Address: _____	GP's Address: _____
D.O.B: _ _ /_ _ /_ _ _ _	Carer/Relative Name: _____
Phone Number: _____	Carer/Relative Number: _____

Consent to sharing of information, onward referral where appropriate and audit: YES ☐ NO ☐

LEVEL 1 FALLS CONVERSATION

NB: Ask **ALL** five questions below:

1- Have you had more than one fall in the past year?	Yes ☐	No ☐
2- Have you had an unexplained fall or fall as a result of losing consciousness/dizziness? (refer to GP urgently)	Yes ☐	No ☐
3- Do you or your relative/carer worry you might have a fall?	Yes ☐	No ☐
4- Do you feel unsteady or have difficulties with walking or balance?	Yes ☐	No ☐
5- If you have had a fall are you less able to do the things you used to be able to do before the fall?	Yes ☐	No ☐

If YES is indicated in any of above 5 questions, proceed with the Multi-Factorial Falls Screening below:

MULTI-FACTORIAL FALLS SCREENING (MFS)

RISK FACTOR	SCREENING QUESTIONS	YES or NO *Please Tick*		POSSIBLE INTERVENTIONS	Refer To: *Please Tick*
1- Falls history	How many falls have you had in past: Week: _____ Month: _____ Year: _____			Frequent falls can indicate health deterioration, if a problem seems urgent consult **GP**	**GP** ☐
	Were you able to get up?	Yes ☐	No ☐	Provide Information regarding ''rest and wait'' or ''getting up'' plan **(OT/PT)**	**OT** ☐ **PT** ☐
	Were you able to summon help?	Yes ☐	No ☐	Demonstrate how to get from the floor, if appropriate **(OT/PT)**	**OT** ☐ **PT** ☐
	Do you have a plan if you fall again?	Yes ☐	No ☐	Discuss use of pendant alarms	**Alarm contact** ☐
	Did you get a blackout/loss of consciousness or did you find yourself on the floor and were unable to recall how you fell	Yes ☐	No ☐	Person requires urgent medical assessment. Advise person to consult with **GP**	**GP** ☐
	Did you feel dizzy before you fell?	Yes ☐	No ☐	Postural Hypotension-Advise person to consult with **GP**	**GP** ☐
Tell the person addressing their risk factors will help reduce their anxiety about falls					
2- Muscle Weakness / poor balance	Do you have problems with your balance or walking?	Yes ☐	No ☐	Consider **Physiotherapy** for assessment of balance and walking	**PT** ☐
3-Transfers and daily activities	Do you have any difficulties dressing/washing/bathing/meal preparation and/or getting on or off the bed/chair or toilet	Yes ☐	No ☐	Consider **OT** and **Home Support**	**OT** ☐ **Home Support** ☐
	Do you feel dizzy when you get up after sitting or lying?	Yes ☐	No ☐	Provide advice & arrange for postural hypotension check with **GP**	**GP** ☐
4-Nutrition	Do you have difficulties eating or drinking enough?	Yes ☐	No ☐	Consider referral to **Dietician**	**Dietician** ☐
	Have you experienced recent unexplained weight loss?	Yes ☐	No ☐	Consider referral to **SALT/GP**	**SALT** ☐ **GP** ☐

For further information refer to: **Community Multifactorial Falls Risk Screening** Version 2
Source: http://www.nhshighland.scot.nhs.uk/YourHealth/Falls/Documents/Revised%20Community%20Multifactorial%20Falls%20screening.pdf

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RISK FACTOR	SCREENING QUESTIONS	YES or NO *Please Tick*		POSSIBLE INTERVENTIONS	Refer To: *Please Tick*
5- Osteoporosis	Have you been prescribed bisphosphonate medication for osteoporosis?	Yes ☐	No ☐	Advise person to consult with **GP** if indicated.	**GP** ☐
	Are you taking it?	Yes ☐	No ☐	Advise on correct method of medication administration	
	Are you taking it correctly	Yes ☐	No ☐		
	If not on osteoporosis medication, ***Ask person*** do you smoke or drink excessively? Have you a previous fracture? Do you have rheumatoid arthritis and/or long term steroid use? Are you underweight?	Yes ☐	No ☐	Advise person to consult **GP** regarding risk of osteoporosis	**GP** ☐
6- Medication	Are you taking more than **6** medications?	Yes ☐	No ☐	Advise person to consult **GP** or local **Pharmacist**	**GP** ☐
	Are you experiencing: dizziness/double or blurred vision/drowsiness/light headedness/weakness/disturbed balance/confusion (Tick if **Yes** to any symptoms?)	Yes ☐	No ☐	Advise person to consult **GP** or local **Pharmacist** In addition, ***Tell the person*** some medications can increase the risk of falls	**GP** ☐
7- Alcohol	Has alcohol contributed to a fall/loss of balance?	Yes ☐	No ☐	Consider brief alcohol intervention or **GP** consult	**GP** ☐
8- Eyesight	Have you had your eyes tested in the last 2 years? (last year if over 75yrs)	Yes ☐	No ☐	Recommend the person contacts their **Optician**. Give details.	
	Do you wear bifocals/varifocals	Yes ☐	No ☐	Suggest person discusses this with the **Optician** as can increase risk of falls.	
9- Foot problems / footwear	Do you have pain in your feet?	Yes ☐	No ☐	Consider referral to **Podiatry/PT**	**Podiatry** ☐ **PT** ☐
	Do you have appropriate footwear?	Yes ☐	No ☐	Advise on good fitting footwear	
10-Cognition / Mood	Do you or a relative/carer worry that you have become more forgetful / confused/anxious/low for a while?	Yes ☐	No ☐	Advise consult with **GP**	**GP** ☐
11- Continence	Do you have problems getting to the toilet in time?	Yes ☐	No ☐	Consider **PHN** or Women's Health **Physiotherapy**	**PHN** ☐ **WHPT** ☐
12- Environment	Consider the following outdoors & indoors. Circle/insert as appropriate	Yes ☐	No ☐	Problems identified. Consider referral to **OT**	**OT** ☐

Outdoors: Gates, paths, steps, stairway, door opening, threshold, night lighting

Indoors: Floor coverings, floor mats, light/power switches, brightness, clutter, hazards, space, telephone location, tidiness/cleanliness, pets, stairs. ***Comments:*** _____

_____

13- Additional Information: **Stay Strong Stay Steady Booklet given** ☐

14- Refer to Primary care Clinical Team Meeting		Yes ☐	No ☐
Screened by:	_____	Discipline:	_____
Name:	_____	Phone number:	_____
Health Centre:	_____	Date:	_ _ / _ _ / _ _ _ _

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Source: http://www.nhshighland.scot.nhs.uk/YourHealth/Falls/Documents/Revised%20Community%20Multifactorial%20Falls%20screening.pdf