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

	Circle	COMMENTS
Resident/Patient input	Yes / No	
Family input	Yes / No	
Carer/staff/other input	Yes / No	
History of falls		**COMMENTS**
Previous falls	Yes / No	*Frequency of falls?*
Cause of fall(s) *(slip, trip, fall, medical event e.g.blackout, dizziness)*		
Injuries from previous fall(s)	Yes / No	
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	
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?*		
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	
Consider (Refer to workbook for further information): *Ophthalmology referral*		
Patient has hearing deficit	Yes / No	
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	
Patient has memory loss?	Yes / No	
Patient is agitated, impulsive, or unpredictable?	Yes / No	
Patient overestimates/ forgets limitations?	Yes / No	
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	
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	
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	
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:

Name of healthcare professional who completed this falls risk assessment:

Name	Signature	Date