

HCPA Multifactorial Risk Assessment



Guidance Notes for using the Multifactorial Risk Assessment (MFRA) for Falls Prevention

This information is taken from the NICE CG161 2013, the National Audit of Inpatient Falls (NAIF) and Public Health England Guidance - Falls: applying All Our Health (Updated 31 January 2020) and is intended to accompany the Falls Multifactorial Risk Assessment document.

What is a fall?

A fall is defined as an unintentional/unexpected loss of balance resulting in coming to rest on the floor, the ground, or an object below knee level.

Statistics

- Falls and fall-related injuries are a common and serious problem for older people. People aged 65 and older have the highest risk of falling, with 30% of people older than 65 and 50% of people older than 80 falling at least once a year.
- About 40–60% of falls result in major lacerations, traumatic brain injuries, or fractures.
- Other complications of falls include distress, pain, loss of self-confidence, reduced quality of life, loss of independence, and mortality.
- Falling also affects the family members and carers of people who fall. Falls are estimated to cost the NHS more than £2.3 billion per year (College of Optometrists/British Geriatrics Society, 2011). Therefore, falling has an impact on quality of life, health and healthcare costs.

Consequences of falls

Falls are not an inevitable result of ageing, but they do pose a serious concern to many older people and to the health system. Older people have a higher risk of accidental injury that results in hospitalisation or death than any other age group (Cryer 2001).

The Royal Society for the Prevention of Accidents (ROSPA) estimates that one in three people aged 65 years and over experience a fall at least once a year – rising to one in two among 80 year olds and older.

Although most falls result in no serious injury, approximately 5 per cent of older people in community-dwelling settings who fall in a given year experience a fracture or require hospitalisation (Rubenstein et al. 2001).

Incidence rates for falls in nursing homes and hospitals are two to three times greater than in the community and complication rates are also considerably higher. Ten to 25 per cent of institutional falls result in fracture, laceration or need for hospital care (Rubenstein 2001).

Other consequences for an individual of falling or of not being able to get up after a fall can include:

- psychological problems, for example, a fear of falling and loss of confidence in being able to move about safely
- loss of mobility, leading to social isolation and depression
- increase in dependency and disability
- hypothermia
- pressure-related injury
- infection

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Who should we assess?

- Older people in contact with healthcare professionals should be asked routinely whether they have fallen in the past year and asked about the frequency, context and characteristics of the fall/s.
- Older people who present for medical attention because of a fall, or report recurrent falls in the past year, or demonstrate abnormalities of gait and/or balance should be offered a multifactorial falls risk assessment. This assessment should be performed by a healthcare professional with appropriate skills and experience, normally in the setting of a specialist falls service. This assessment should be part of an individualised, multifactorial intervention (NICE CG161).
- Older people reporting a fall or considered at risk of falling should be observed for balance and gait deficits and considered for their ability to benefit from interventions to improve strength and balance. (Tests of balance and gait commonly used in the UK are detailed in section 3.3.) [2004]

NICE CG161 recommendations

- Do not use risk prediction tools especially those that assign a numerical score or hierarchy of risk.
- Do not offer “one size fits all” blanket interventions.
- Do use individual multifactorial assessment
- Do use multifactorial intervention plans
- Do provide relevant oral and written information about individual falls risk factors

Multifactorial falls risk assessment (NICE, 2017) is:

An assessment with multiple components that aims to identify a person's risk factors for falling. The more risk factors a person has, the higher their risk of falling.

This assessment should be performed by a healthcare professional with appropriate skills and experience. It should be part of an individualised, multifactorial intervention.

A multifactorial assessment may include the following:

- identification of falls history
- assessment of gait, balance and mobility, and muscle weakness
- assessment of osteoporosis risk
- assessment of the older person's perceived functional ability and fear relating to falling
- assessment of visual impairment
- assessment of cognitive impairment and neurological examination
- assessment of urinary incontinence
- assessment of home hazards
- cardiovascular examination and medication review

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What are the risk factors?

The risk of falling is multifactorial, and prevention is usually based on assessing multiple risk factors [[NICE, 2013a](#)].

- A history of falls is one of the strongest risk factors for a fall, and all older people in regular contact with healthcare professionals should be asked routinely whether they have fallen in the past year.
- Other risk factors for falls in older people include:
 - A history of falls — after a first fall, people have a 66% chance of having another fall within a year [[Vieira, 2016](#)].
 - Conditions that affect mobility or balance, such as arthritis, diabetes, incontinence, stroke, syncope, or Parkinson's disease.
 - Other conditions, including muscle weakness, poor balance, visual impairment, cognitive impairment, depression, and alcohol misuse.
 - Polypharmacy, or the use of psychoactive drugs (such as benzodiazepines) or drugs that can cause postural hypotension (such as anti-hypertensive drugs).
 - Environmental hazards, such as loose rugs or mats, poor lighting, uneven surfaces, wet surfaces (especially in the bathroom), loose fittings (such as handrails), and poor footwear.
- The more risk factors a person has, the greater their risk of falling.
 - Over 65% of people aged 65 years and over have two or more long-term conditions (multimorbidity) [[PHE, 2017](#)].
 - Falls can also be a sign of underlying health issues, such as frailty [[PHE, 2017](#)].

([Vieira, 2016](#); [PHE, 2017](#); [Haddad, 2018](#); [Hopewell, 2018](#); [PHE, 2018](#); [BMJ, 2019](#))

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Supporting information relating to the risk factors identified on the 'Falls Multifactorial Risk Assessment'

Intrinsic Factors

1. History of falls (number in 12 months)

Identify people aged 65 years and over who have had one or more falls in the last 12 months

- A history of falls is one of the strongest risk factors for a fall, and all older people in regular contact with healthcare professionals should be asked routinely whether they have fallen in the past year. After a first fall, people have a 66% chance of having another fall within a year
- Check history
- Check staff have attended HCPA's training courses for Falls Prevention and Intervention
- Provide relevant oral and written information about individual risk factors

1.1 Education and information giving

- All healthcare professionals dealing with patients known to be at risk of falling should develop and maintain basic professional competence in falls assessment and prevention
- Individuals at risk of falling should be offered relevant oral and written information and support information, about:
 - What measures they can take to prevent further falls
 - How to stay motivated if referred for falls prevention strategies that include exercise or strength and balancing components
 - The preventable nature of some falls
 - The physical and psychological benefits of modifying falls risk
 - Where they can seek further advice and assistance
 - How to cope if they have a fall, including how to summon help and how to avoid a long lie
 - providing up-to-date patient information on falls, such as [Get up and go - a guide to staying steady English version | The Chartered Society of Physiotherapy \(csp.org.uk\)](http://www.csp.org.uk)
- The individual's ability to understand and retain information should be considered, and information should also be given to relevant family members and carers if the patient agrees, (or if the individual lacks capacity, in their best interests). This should include:
 - Encouraging them to use the call bell when they need help
 - Informing family members and carers about when and how to raise and lower bed rails
 - Providing consistent messages about when a patient should ask for help before getting up or moving about
 - Helping the individual to engage in any multifactorial intervention aimed at addressing their individual risk factors

2. Recent history of falls (number in last month) plus causes and consequences

- Check falls diary/ incident reports
- Check care plan
- Causes and Patterns –
 - Ask about and document how often the person has fallen, the circumstances in which the fall(s) occurred, such as:
 - place

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- time of day
- whether medication has been changed
- activity being attempted/performed
- factors such as, needing the toilet, or being in pain, which may have led to an unsafe or rushed manoeuvre
- preceding symptoms, for example light headedness or loss of consciousness
- And the consequences of the fall(s) (such as injuries, fear of falling, difficulty performing daily activities, activity restriction, and/or pain). If possible, obtain an eye-witness account.
- This will help to distinguish a simple fall (caused by a chronic impairment of cognition, vision, mobility, or balance) from a collapse (caused by an acute medical problem, for example, arrhythmias, transient ischaemic attack, or vertigo).

3. Fear of falling

- It is widely documented that there is a deterioration in balance, dual task performance and quality of life, and a decrease in physical activity levels in elderly individuals with a fear of falling
- Assesses fear of falling in elderly with increased fall risk
- Use Falls Efficacy Scale (FES-I) assessment to establish fear of falling
- **The Falls Efficacy Scale International version (FES-I) - [Falls Efficacy Scale \(FES and FES-I\) Calculator \(mdapp.co\)](http://mdapp.co)**

4. Frailty

- Use PRISMA7, Gait Speed Test and Timed Up and Go test to assess for frailty
- Or refer to a clinician (GP or Physiotherapist) for a Clinical Frailty Scale (Rockwood) Assessment
- [NHS England » Identifying frailty](#)

5. Known cognitive impairment

- Individuals with a cognitive impairment may be at a higher risk of falls due factors such as: confusion, hallucinations, lack of awareness of their own ability, inability to understand/follow instructions, lack of safety awareness
- Use strategies known to help the individual understand instructions
- Check for signs of acute illness if there is increased confusion
- Ensure Deprivation of Liberty Safeguards (DOLS) are in place where necessary, to ensure any restraint used is the least restrictive option

6. New confusion/delirium e.g. due to dehydration or acute infection (UTI/Chest infection/wound infection)

- Use NEWS2 and RESTORE2 [RESTORE2™ official \(westhampshireccg.nhs.uk\)](http://westhampshireccg.nhs.uk) to establish acute illness and take appropriate action according to NEWS2 and HERTS escalation pathway
- Send urine for analysis
- Ensure plenty of fluids are taken
- Refer to SALT/999 if problems with fluid intake
- Referral to GP/Community Mental Health Team (CMHT) for diagnosis if new onset, but not acute illness

7. Continence problems

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- Rushing to the toilet or attempting to remove clothing before reaching the toilet may cause falls. Additionally, urinary accidents can cause slip hazards and anxiety, which can further increase falls
- Practice mobility often
- Ensure call bells are within reach
- Check that the individual has used the toilet if needed before mobility practice
- Ensure lighting is in place at night
- Ensure trip hazards are minimised where possible, especially at night

8. Health problems that affect falls risk (e.g. Parkinson's Disease, History of Stroke, Diabetes, Peripheral Vascular Disease (causing numbness in feet), COPD (Chronic Obstructive Pulmonary Disease), Inner ear problems (infections, Vertigo, Ménière's Disease) etc

- Refer to Physiotherapist for assessment and advice as appropriate
- Ensure staff are familiar with conditions and how individuals may present and are aware that there may be an added falls risk.
- Ensure vigilance and that good verbal cues are given E.g., for numbness in feet
- Parkinson's Disease [What is Parkinson's? | Parkinson's UK \(parkinsons.org.uk\)](http://parkinsons.org.uk)
- History of Stroke (which may affect strength, co-ordination, and balance) [Stroke Association | Home](#)
- Diabetes [Diabetes - NHS \(www.nhs.uk\)](http://www.nhs.uk) (which may cause a loss of consciousness)
- Osteoarthritis [Osteoarthritis - NHS \(www.nhs.uk\)](http://www.nhs.uk) or Rheumatoid Arthritis (which may cause pain, weakness, and unsteadiness) [Rheumatoid arthritis - NHS \(www.nhs.uk\)](http://www.nhs.uk)
- Peripheral arterial disease (which may cause numbness in the feet) [Peripheral arterial disease \(PAD\) - NHS \(www.nhs.uk\)](http://www.nhs.uk)
- Chronic Obstructive Pulmonary Disease (COPD) (which may cause shortness of breath and anxiety leading to rushing and therefore being at a higher risk of falling) [Chronic obstructive pulmonary disease \(COPD\) - NHS \(www.nhs.uk\)](http://www.nhs.uk)
- Inner ear problems such as infections, Vertigo, Ménière's Disease (which may cause balance disturbances) [Ménière's disease - NHS \(www.nhs.uk\)](http://www.nhs.uk)

Ménière's disease is a condition of the inner ear that causes sudden attacks of:

- feeling like the room is spinning around you ([vertigo](#))
- a ringing noise inside the ear ([tinnitus](#))
- pressure felt deep inside the ear
- hearing loss

Symptoms of Ménière's disease

During an attack of Ménière's disease, you may:

- feel dizziness with a spinning sensation (vertigo)
- feel unsteady on your feet
- feel sick (nausea) or be sick (vomit)
- hear ringing, roaring or buzzing inside your ear
- have a sudden drop in hearing

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9. Syncope syndrome (fainting, blackouts, postural (orthostatic) hypotension)

- Give time in standing, walk on spot before mobilising. Have 2-3 staff with wheelchair/to move chair behind in case service user moves forward from the chair
- Ensure the person is hydrated before standing up
- Take lying and standing BP
- Ensure staff are up to date with Moving and Handling training, which includes 'supporting a falling person to the floor' and 'assisting a person to get up from the floor'

Causes of Syncope - [Causes of Syncope - Syncope](#)

Transient loss of consciousness (TLoC, fainting, blackout, syncope) is caused by a temporary reduction in blood flow to the brain. Blood flow to the brain can be interrupted for a number of reasons. Different causes are listed below.

TRIGGERS THAT CAN CAUSE SYNCOPE

- Transient loss of consciousness is most commonly caused by a temporary glitch in the autonomic nervous system. This is sometimes known as autonomic (neurally) mediated syncope. The autonomic nervous system is made up of the brain, nerves and spinal cord. It regulates automatic bodily functions, such as heart rate and blood pressure.
- An external trigger can temporarily cause the autonomic nervous system to stop working properly, resulting in a fall in blood pressure and transient loss of consciousness. The trigger may cause your heartbeat to slow down or pause for a few seconds, resulting in a temporary interruption to the brain's blood supply. This is called benign vasovagal syncope, or fainting.
- The trigger can be anything from sudden severe pain, to fear, needles or sight of blood.
- LOW BLOOD PRESSURE WHEN YOU STAND UP
- Light-headedness, or fainting, can also be caused by a fall in blood pressure when you stand up. This is called postural, or orthostatic, hypotension, and tends to affect older people, particularly those aged over 65. It's a common cause of falls in older people.
- When you stand up after sitting or lying down, gravity pulls about 750ml of blood down into your legs, which reduces your blood pressure. The nervous system usually counteracts this by making your heart beat faster and narrowing your blood vessels. This stabilises your blood pressure.
- However, in cases of orthostatic hypotension this doesn't happen, leading to the brain's blood supply being interrupted and causing you to feel lightheaded, or even faint.

Possible triggers of orthostatic hypotension include:

- dehydration – if you're dehydrated, the amount of fluid in your blood will be reduced and your blood pressure will decrease. This makes it harder for your nervous system to stabilise your blood pressure and increases your risk of fainting
- medication – several medications including those for high blood pressure, heart disease, and Parkinson's disease can cause orthostatic hypotension
- neurological conditions – conditions that affect the nervous system, such as Parkinson's disease, can cause orthostatic hypotension
- diabetes – uncontrolled diabetes makes you urinate frequently, which can lead to dehydration. High blood sugar levels can also damage the nerves that

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help regulate blood pressure

HEART PROBLEMS

Heart problems can also interrupt the brain's blood supply and cause loss of consciousness. This type of fainting is called cardiac syncope. The risk of developing cardiac syncope increases with age. You're also at increased risk if you have:

- narrowed or blocked blood vessels to the heart (coronary heart disease)
- chest pain (angina)
- had a heart attack in the past
- weakened heart chambers (ventricular dysfunction – heart failure)
- structural problems with the muscles of the heart (cardiomyopathy)
- an abnormal electrocardiogram (ECG) – a test that checks for abnormal heart rhythms
- repeated loss of consciousness that come on suddenly without warning

10. Medication - Polypharmacy, or the use of psychoactive drugs (such as benzodiazepines) or drugs that can cause postural hypotension (such as anti-hypertensive drugs, Parkinson's medication etc)

- Check individual's medications against HCPA Medication resource for side effects. See HCPA's StopFalls brochure, page 11-12 [Resource Library \(hcpastopfalls.info\)](http://hcpastopfalls.info)
- Consider especially any new medications
- Refer for medication review with modification or withdrawal– GP, Community Mental Health Team (CMHT)

11. Mobility and/or balance problems or weakness

- Older people reporting a fall or considered at risk of falling should be observed for balance and gait deficits and considered for their ability to benefit from interventions to improve strength and balance
- Strength and balance training is recommended. Those most likely to benefit are older people living in the community with a history of recurrent falls and/or balance and gait deficit. A muscle strengthening and balance programme should be offered. This should be individually prescribed and monitored by an appropriately trained professional
- Use HCPA's 'Sit Less, Move More', 'StopFalls', and 'Enabling Care' brochures [Resource Library \(hcpastopfalls.info\)](http://hcpastopfalls.info) to encourage people at risk of falls to undertake the recommended levels of physical activity safely, to establish practical ways to include people in extended care settings in movement and exercise programmes
- For detailed guidance on the amount and type of physical activity people should be doing to improve their health from the Chief Medical Officer (2019), see [Physical activity guidelines: UK Chief Medical Officers' report - GOV.UK \(www.gov.uk\)](http://www.gov.uk)
- Check staff have attended HCPA's training courses for Enabling Care, Chair-Based Exercises and Postural Stability Instructor

12. Depression and/or anxiety

- Screen for depression using the PHQ-2 (Patient Health Questionnaire – Depression-2) with appropriate onward referral (see NHS E&N Herts Frailty Pathway)
- Screen for anxiety using GAD-2 (Generalised Anxiety Disorder Assessment-2) with appropriate onward referral (see NHS E&N Herts Frailty Pathway)

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- [Identification of Frailty V3.pdf \(enhertscg.nhs.uk\)](#)
- [Common mental health problems: identification and pathways to care | NICE](#)

13. Alcohol/recreational drugs misuse

- Is the individual free from the influence of alcohol/other recreational drugs that may put them at risk of falling?
- Consider Mental Capacity (MCA) and Liberty Protection Safeguards (LPS) (previously DoLS) if appropriate
- [Mental Capacity \(Amendment\) Act 2019: Liberty Protection Safeguards \(LPS\) - GOV.UK \(www.gov.uk\)](#)
- [Liberty Protection Safeguards \(LPS\) | SCIE](#)
- Helpful resources:
- [Alcohol-related brain damage legal issues - using the Mental Capacity Act | Alcohol Change UK](#)
- [Mental-Capacity-Report-July-2020-HWDOL.pdf \(mentalcapacitylawandpolicy.org.uk\)](#)
- [Alcohol and capacity \(localgovernmentlawyer.co.uk\)](#)
- [More awareness around alcohol and self-neglect needed, study argues \(communitycare.co.uk\)](#)

14. Visual impairment

- Check glasses correct, on, and clean
- Refer to optician for vision assessment
- There is no evidence that referral for correction of vision as a single intervention for older people living in the community is effective in reducing the number of people falling. However, vision assessment and referral has been a component of successful multifactorial falls prevention programmes

15. Hearing impairment

- Check hearing aid clean, in and working
- Demonstrate ahead of tasks and ensure understanding prior to undertaking tasks which may involve a risk of falling
- Check staff have attended a training course for people with a hearing impairment where needed

16. Osteoporosis (increases fracture risk)

Osteoporosis is a disease characterized by low bone mass and structural deterioration of bone tissue, with a consequent increase in bone fragility and susceptibility to fracture. Osteoporosis itself is asymptomatic and often remains undiagnosed until a fragility fracture occurs.

An osteoporotic fracture is a fragility fracture occurring as a consequence of osteoporosis. Characteristically, fractures occur in the wrist, spine, and hip, but they can also occur in the arm, pelvis, ribs, and other bones.

A fragility fracture is defined as a fracture following a fall from standing height or less, although vertebral fractures may occur spontaneously, or as a result of routine activities such as bending or lifting (2017a; NOGG, 2019; BMJ Best Practice, 2020).

- Check history
- Refer for bone density assessment (bone scan) if needed
- Consider exercise. The Royal Osteoporosis Society have guidance (and a flowchart) on the amount and type of exercise needed to promote bone strength, the importance of including exercise to reduce falls and resulting fractures [ros-strong-steady-straight-quick-guide-february-2019.pdf \(theros.org.uk\)](#):
 - a. Physical activity and exercise has an important role in the management of osteoporosis – promoting bone strength, reducing falls risk and managing symptoms:

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- b. People with osteoporosis should be encouraged to do more rather than less. Adopt a positive and encouraging approach – ‘how to’ rather than ‘don’t do’.
- c. Physical activity and exercise is not associated with significant harm including vertebral fracture – though some caution is advised, the benefits of physical activity and exercise outweigh the risks
- d. People with painful vertebral fractures need clear and prompt guidance on how to adapt movements involved in day-to-day living, and exercises for posture and pain.
- e. SAFETY – Adopt a positive encouraging approach – explain that fractures are rarely caused by exercise and the benefits outweigh the risks.
 - With osteoporosis:
 - Recommend correct techniques when using weights or resistance bands, gym equipment – get specialist advice if unsure.
 - Recommend modification of exercises that involve end range sustained repeated forward bending unless you are using the ‘hip hinge’/are very experienced/have very good muscle tone and control.
 - Always increase intensity gradually and tailor according to individual fitness and ability. With vertebral or multiple low trauma fractures
 - Recommend lower impact rather than moderate impact exercise (jogging, low level jumping) as a general rule. May be appropriate to increase after individualised discussion
 - With poor balance:
 - Recommend improving balance and muscle strength before increasing physical activity levels
- Use HCPA’s ‘Sit Less, Move More’, ‘StopFalls’, and ‘Enabling Care’ brochures [Resource Library \(hcpastopfalls.info\)](http://Resource Library (hcpastopfalls.info)) to encourage people at risk of falls to undertake the recommended levels of physical activity safely, to establish practical ways to include people in extended care settings in movement and exercise programmes
- **Ensure Calcium/Vitamin D is prescribed (awaiting CCG guidance)** Vitamin D. There is evidence that vitamin D deficiency and insufficiency are common among older people and that, when present, they impair muscle strength and possibly neuromuscular function, via CNS-mediated pathways. In addition, the use of combined calcium and vitamin D3 supplementation has been found to reduce fracture rates in older people in residential/nursing homes and sheltered accommodation. Although there is emerging evidence that correction of vitamin D deficiency or insufficiency may reduce the propensity for falling, there is uncertainty about the relative contribution to fracture reduction via this mechanism (as opposed to bone mass) and about the dose and route of administration required. No firm recommendation can therefore currently be made on its use for this indication. [NICE 2004, amended 2013]

17. Malnutrition

- Malnutrition impacts on every system of the body. It reduces the ability to fight infections, increasing the risk of pneumonia and septicaemia. Muscle density reduces, decreasing mobility and increasing the risk of falls.
- Screening for malnutrition and the risk of malnutrition both in hospital and the community forms part of NICE guideline [CG32] on nutrition support. The malnutrition universal screening tool MUST [Malnutrition Universal Screening Tool \(bapen.org.uk\)](http://Malnutrition Universal Screening Tool (bapen.org.uk)) is the most commonly used in UK and is referred to in the NICE guidance on nutrition support
- Check and update weight
- Assess for malnutrition using the MUST tool
- Refer to the Dietician/SALT/GP/Emergency services/Prevention of Admission services as appropriate

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- Additional resources:
- [Helping older people maintain a healthy diet: A review of what works - GOV.UK \(www.gov.uk\)](https://www.gov.uk/government/consultations/helping-older-people-maintain-a-healthy-diet-a-review-of-what-works)
- [Falls Fact Sheet Integrating nutrition into falls pathways A HEALTHCARE PROFESSIONAL FACT SHEET \(malnutritionpathway.co.uk\)](https://malnutritionpathway.co.uk/falls-fact-sheet)

18. Weakness – new onset or recent deterioration

- Seek advice from Physiotherapist or Occupational Therapist on strength testing in sitting if unable to straighten and bend lower limbs or unable to use hands to grip to use a rollator frame
- Refer to GP/Emergency services/Prevention of Admission services/Physiotherapist as appropriate especially if sudden onset

19. Pressure sores

Whilst it does not appear to be widely documented that pressure sores directly increase the risk of falling, factors such as pain, avoidance of weightbearing on a foot which has a pressure sore and fear of falling may be added risks for falling. Also, many of the risk factors for developing pressure sores are risk factors for falls. These are:

- being over 70 – older people are more likely to have mobility problems and skin that's more easily damaged through dehydration and other factors
- being confined to bed with illness or after surgery
- inability to move some or all of the body (paralysis)
- obesity
- urinary incontinence and bowel incontinence
- a poor diet
- medical conditions that affect blood supply, make skin more fragile or cause movement problems – such as diabetes, peripheral arterial disease, kidney failure, heart failure, multiple sclerosis (MS) and Parkinson's disease
- Carry out and document an assessment of pressure ulcer risk for individuals if they have a risk factor, for example:
 - significantly limited mobility (for example, people with a spinal cord injury)
 - significant loss of sensation
 - a previous or current pressure ulcer
 - nutritional deficiency
 - the inability to reposition themselves
 - significant cognitive impairment
- Use a validated scale to support clinical judgement (for example, the Braden scale [Home | Braden Scale](#), the Waterlow score [What is the Waterlow Score and how can it](#)

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[help assess risk of pressure injuries? - CareDocs](#) or the Norton risk-assessment scale [Norton Score For Pressure Ulcer Risk Calculator \(mdapp.co\)](#) when assessing pressure ulcer risk.

- Reassess pressure ulcer risk if there is a change in clinical status (for example, after surgery, on worsening of an underlying condition or with a change in mobility)
- Ensure the individual is checked for pressure areas that may cause unsteadiness in steadiness (e.g. on the feet) or pain, which may also increase risk of falling.
- Use RESTORE2 and NEWS2 [RESTORE2™ official \(westhampshireccg.nhs.uk\)](#) to assess for infection and refer to the GP/Tissue Viability Nurse (TVN)/Emergency services/Prevention of Admission services as appropriate
- Ensure bodymap and care plan is updated

For more information visit:

[Pressure ulcers \(pressure sores\) - Treatment - NHS \(www.nhs.uk\)](#)

Extrinsic Factors

20. Footwear that is unsuitable or missing

- Check shoes/slippers for safety and suitability
- Check who is responsible for purchasing new ones and ensure this is followed up immediately

21. Home hazards, such as loose rugs or mats, poor lighting, wet surfaces (especially in the bathroom), and loose fittings (such as handrails)

- Hazard assessment and intervention:
 - Check the area is free of obstacles/trip hazards, the floor is free of spillages and all fixtures are safe.
 - Ensure night lighting is adequate

22. Mobility aids

- Check mobility aid is safe and within reach
- Refer to Physiotherapy for mobility aid or if current one is broken, or appears unsuitable or unsafe
- In the rare case that a person who lacks capacity to make decisions, mobilises, but cannot do so without falling and potentially causing themselves significant harm, measures such as removing a person's frame, (or indeed *any* measure that may restrict a person's mobility), may be considered as a *Least Restrictive Option that is proportionate to the harm prevented*. Any such decision **MUST** be accompanied by a separate risk assessment and a DoLS (Deprivation of Liberty Safeguard) **MUST** be also applied for

23. Pendant alarm/call bell

- Check this is within reach and that the person can use it

24. Sensor mats

- Ensure these are in place if appropriate for the individual and that they are working, and effective
- Ensure sensor mat itself is not causing further risk by being a trip hazard or an obstacle

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25. Bedrails and bed height

- Ensure bedrails are only used in line with latest guidance and local policy
- Ensure bed height is in line with latest guidance and local policy and that low profiling beds are used wherever possible
- Ensure the correct measures are in place regarding Mental Capacity and Consent/Best Interests and Liberty Protection Safeguards

26. Positioning in chair

- Check there is a one-way glide sheet in place if needed to prevent slipping from the chair
- Check the individual's pelvis is positioned evenly and to the back of the chair
- Reposition and check for pressure areas regularly if the individual is unable to move themselves
- Use HCPA's 'Enabling Care' brochure [Resource Library \(hcpastopfalls.info\)](http://Resource Library (hcpastopfalls.info))
- Check staff have attended HCPA's training courses for Enabling Care, Chair-Based Exercises and Postural Stability Instructor

General Considerations

27. Is the person mobilising for the first time after an episode of acute illness, for example after being discharged from hospital?

- If the individual has not been weightbearing for 6 weeks or more, check with GP that it is safe for the person to attempt mobilising.
- If the person has not been weightbearing for 12 weeks, refer for assessment of bone density due to the increased risk of fractures.
- Think 'Safety': Minimise risk
- Practise Sit to Stand first, before mobilising.
- Ensure staff and equipment in correct position
- Ensure there is a wheelchair and walking aid plus
- 3 staff, 1 either side and 1 for wheelchair behind.
- Refer to Physiotherapy if needed

28. Is NOW the best time of day for the individual?

- If the individual's ability to mobilise fluctuates throughout the day, pick a time when they are likely to be at their best
- If there are times of the day where there are likely to be more distractions/obstacles, pick a time when these are minimised
- Ensure any patterns in the person's ability are documented and handed over to other staff

29. Sedentary behaviour

- Use the Bed Prevention tool to ensure every effort is made to reduce the risk of an individual being in bed
- Practice sit to stand regularly
- Encourage independence, mobility and exercise
- Seek advice from Physiotherapist or Occupational Therapist on strength testing in sitting if unable to straighten and bend lower limbs or unable to use hands to grip to use a rollator frame
- Use HCPA's 'Sit Less, Move More', 'StopFalls', and 'Enabling Care' brochures Resource Library (hcpastopfalls.info) to encourage people at risk of falls to undertake the recommended levels of physical activity safely, to establish practical ways to include people in extended care settings in movement and exercise programmes
- For detailed guidance on the amount and type of physical activity people should be doing to improve their health from the Chief Medical Officer (2019), see

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<p>Physical activity guidelines: UK Chief Medical Officers' report - GOV.UK (www.gov.uk)</p> <ul style="list-style-type: none"> • Check staff have attended HCPA's training courses for Enabling Care, Chair-Based Exercises and Postural Stability Instructor
<p>Specific Considerations for individuals on a NON-WEIGHTBEARING PATHWAY</p>
<p>30. Are there signs that the individual feels unwell?</p> <ul style="list-style-type: none"> • Check for infection – Use RESTORE2 and NEWS2 RESTORE2™ official (westhampshireccg.nhs.uk) and take appropriate action according to NEWS2 and HERTS escalation pathway
<p>31. Are there signs of local/systemic infection?</p> <ul style="list-style-type: none"> • Check wound for exudate, swelling, unpleasant odour • Check limb for discolouration • Check for infection – Use RESTORE2 and NEWS2 RESTORE2™ official (westhampshireccg.nhs.uk) and take appropriate action according to NEWS2 and HERTS escalation pathway • Refer back to the Intermediate Care Team or other referring team, or to the GP/Tissue Viability Nurse (TVN)/Emergency services/Prevention of Admission services as appropriate
<p>32. Is there bleeding from the wound?</p> <ul style="list-style-type: none"> • Refer back to the Intermediate Care Team or other referring team, or to the GP/Tissue Viability Nurse (TVN)/Emergency services/Prevention of Admission services as appropriate
<p>33. Are there signs that the individual is in pain?</p>
<p>34. Are there signs of a DVT/fat embolism?</p> <ul style="list-style-type: none"> • What is a fat embolism? • A fat embolism (FE) is a piece of intravascular fat that lodges within a blood vessel and causes a blockage of blood flow. Fat emboli commonly occur after fractures to the long bones of the lower body, particularly the femur (thighbone), tibia (shinbone), and pelvis. • While fat emboli are common and generally resolve on their own, they can lead to a serious condition called fat embolism syndrome (FES). FES can cause inflammation, multi-organ dysfunction, and neurological changes that can be deadly. • According to research, FES can be seen in 3 to 4 percent of those with one long-bone fracture and up to 15 percent of those with multiple long-bone traumas. • Symptoms of fat embolism syndrome • Signs of FES generally appear 12 to 72 hours Trusted Source after trauma. Symptoms tend to occur throughout the body and include: <ul style="list-style-type: none"> • rapid breathing • shortness of breath • mental confusion • lethargy • coma

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- pinpoint rash (called a petechial rash), often found on the chest, head, and neck area, which occurs due to bleeding under the skin
- fever
- anaemia

[Fat Embolism Syndrome: Symptoms, Causes, and Treatment \(healthline.com\)](https://www.healthline.com/health/fat-embolism-syndrome)

[Embolism NHS - NHS \(www.nhs.uk\)](https://www.nhs.uk/conditions/fat-embolism/)



Falls Severity Incident
Report form.docx

Following a fall happening, please refer to the Falls Severity Incident Report form and Hertfordshire Post Falls Pathway (update awaited) in line with your organisation's local policy

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