**Pre-Falls Risk Assessment**

This falls risk assessment has been compiled by leaders, managers, and senior staff of care home providers during a series of countywide falls CPD workshops in May and July 2024 ran by the Provider Quality Team, Essex County Council.

Following completion of the risk assessment, this risk matrix can be used to determine the overall level of risk of falls for the person being assessed. This matrix has been adapted from the risk management strategy accessible at [www.beh-mht.nhs.uk](http://www.beh-mht.nhs.uk)

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| **Risk assessment details:** |
| Date of assessment: |  |
| Name of staff member completing assessment: |  |
| Signature of staff member completing assessment |  |
| Role of staff member completing assessment: |  |

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| **Person (Client/Resident) Details:** |
| Name |  |
| Room number/location: |  |
| Height: |  |
| Weight: |  |

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| **Likelihood/probability** |
| **Severity of harm** |  | Rare | Unlikely | Possible | Likely | Almost certain |
| Severe | Medium | High | High | Extreme | Extreme |
| Significant | Medium | Medium | High | High | Extreme |
| Moderate | Low | Medium | Medium | High | High |
| Minor | Low | Medium | Medium | Medium | High |
| Negligible | Low | Low | Low | Medium | Medium |

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| **Overall level of risk assessed as:** |
| **Extreme** [ ]  **High** [ ]  **Medium** [ ]  **Low** [ ]  |

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| **Questions about the person** | **If yes, risk of falls increases:** | **Comments:** |
| 1. Does the person have a medical condition or physical impairment that increases their risk of falls?
 | Yes [ ]  No [ ]  |  |
| 1. Does the person experience uncontrollable pain levels?
 | Yes [ ]  No [ ]  |  |
| 1. Does the person have increased frailty? (reduced muscle strength, increased fatigue levels and reduced resilience to physical and mental illness)
 | Yes [ ]  No [ ]  |  |
| 1. Does the person have a cognitive impairment? (such as dementia, Parkinson’s, or other neurological condition)
 | Yes [ ]  No [ ]  |  |
| 1. Does the person experience delirium? (a fast change in mental abilities – increased confusion, feeling disorientated to time and place, attention difficulties etc.)
 | Yes [ ]  No [ ]  |  |
| 1. Does the person lack capacity to understand risks associated with walking and transfers?
 | Yes [ ]  No [ ]  |  |
| 1. Is the person on high-risk medication (such as hypnotics, sedatives, hypertensives, antipsychotic) or polypharmacy (on 5 or more medications)?
 | Yes [ ]  No [ ]  |  |
| 1. Do they have postural drop? (Low blood pressure when standing from seating)
 | Yes [ ]  No [ ]  |  |
| 1. Does the person have a history of falls? (experiencing 2 or more in the last 12 months)
 | Yes [ ]  No [ ]  |  |
| 1. If the person has experienced falls before, are these during the day or night?
 | Yes [ ]  No [ ]  |  |
| 1. If the person has experienced falls before, do they have a fear of falling?
 | Yes [ ]  No [ ]  |  |
| 1. Does the person sit for long periods of time? Inactivity can lead to falls due to muscle wastage – move it or lose it!
 | Yes [ ]  No [ ]  |  |
| 1. Do they have mobility and/or balance problems? Are they unsteady on their feet?
 | Yes [ ]  No [ ]  |  |
| **Questions about the person** | **If yes, risk of falls increases:** | **Comments:** |
| 1. Does the person slip down in their chair and require regular repositioning? If yes, alternative furniture or equipment could be explored.
 | Yes [ ]  No [ ]  |  |
| 1. Do they have frequency and urgency to use the toilet?
 | Yes [ ]  No [ ]  |  |
| 1. Does the person have poor nutritional intake? Does the person lack variety in their choice of food?
 | Yes [ ]  No [ ]  |  |
| 1. Does the person need constant reminding to stay well hydrated?
 | Yes [ ]  No [ ]  |  |
| 1. Do they have more than recommended levels of caffeinated drinks during the day? (average recommendation is 4-5 cups per day. Caffeine is a known diuretic; it can cause frequency/urgency to toilet and interrupt sleep cycles)
 | Yes [ ]  No [ ]  |  |
| 1. Does the person have poor sleep patterns/ length of sleep?
 | Yes [ ]  No [ ]  |  |
| 1. Does the person need glasses or have poor vision?
 | Yes [ ]  No [ ]  |  |
| 1. Does the person need hearing aids? Does the person experience ear infections frequently?
 | Yes [ ]  No [ ]  |  |
| 1. Does the person have difficulty communicating?
 | Yes [ ]  No [ ]  |  |
| 1. Is the person prone to UTI’s or other infections which could impact on their confusion/physical ability?
 | Yes [ ]  No [ ]  |  |
| 1. Does the person have unpredictable behaviour?
 | Yes [ ]  No [ ]  |  |
| 1. Does the person frequently walk with purpose?
 | Yes [ ]  No [ ]  |  |
| 1. Does the person drink alcohol? How many units per week?
 | Yes [ ]  No [ ]  |  |
| **Questions about the environment & equipment:** | **If no, risk of falls increases** | **Comments:** |
| 1. Is the environment free from clutter? Including mats, wiring across floors, additional furniture
 | Yes [ ]  No [ ]  |  |
| 1. Is the lighting adequate to see clearly in all areas the person uses?
 | Yes [ ]  No [ ]  |  |
| 1. Does the person have well-fitting/suitable footwear? Is it the right size?
 | Yes [ ]  No [ ]  |  |
| 1. Does the persons clothing fit well, do they wear any loose-fitting clothing or long clothing which cause a trip hazard?
 | Yes [ ]  No [ ]  |  |
| 1. If the person has a mobility aid, are the ferrules still in good condition? Can you see the rings clearly – if worn they need changing
 | Yes [ ]  No [ ]  |  |
| 1. If the person has a walking aid, is it at the correct height for them? Handles should be level with wrist crease
 | Yes [ ]  No [ ]  |  |
| 1. Is there assistive technology in use – sensor mats, falls pendent? Is it working properly, is it plugged in?
 | Yes [ ]  No [ ]  |  |
| 1. Is the furniture at the right height for the person to transfer from/to? Optimum height for the person is the same as the measurement from just behind their knee, whilst seated, to the floor.
 | Yes [ ]  No [ ]  |  |
| 1. Does the person need help to transfer?
 | Yes [ ]  No [ ]  |  |
| 1. Does the person have bed rails or a floor bed in use?
 | Yes [ ]  No [ ]  |  |
| 1. Can the person manage to go up/downstairs safely?
 | Yes [ ]  No [ ]  |  |
| 1. If so, is there handrails on both sides of the stairs? Are the stairwells well lit?
 | Yes [ ]  No [ ]  |  |
| 1. Are they able to use the call bell? Can they reach their bell?
 | Yes [ ]  No [ ]  |  |
| 1. Is the person able to reach other items they require next to their bed? Such as clock, glasses, light-switch, TV remote.
 | Yes [ ]  No [ ]  |  |