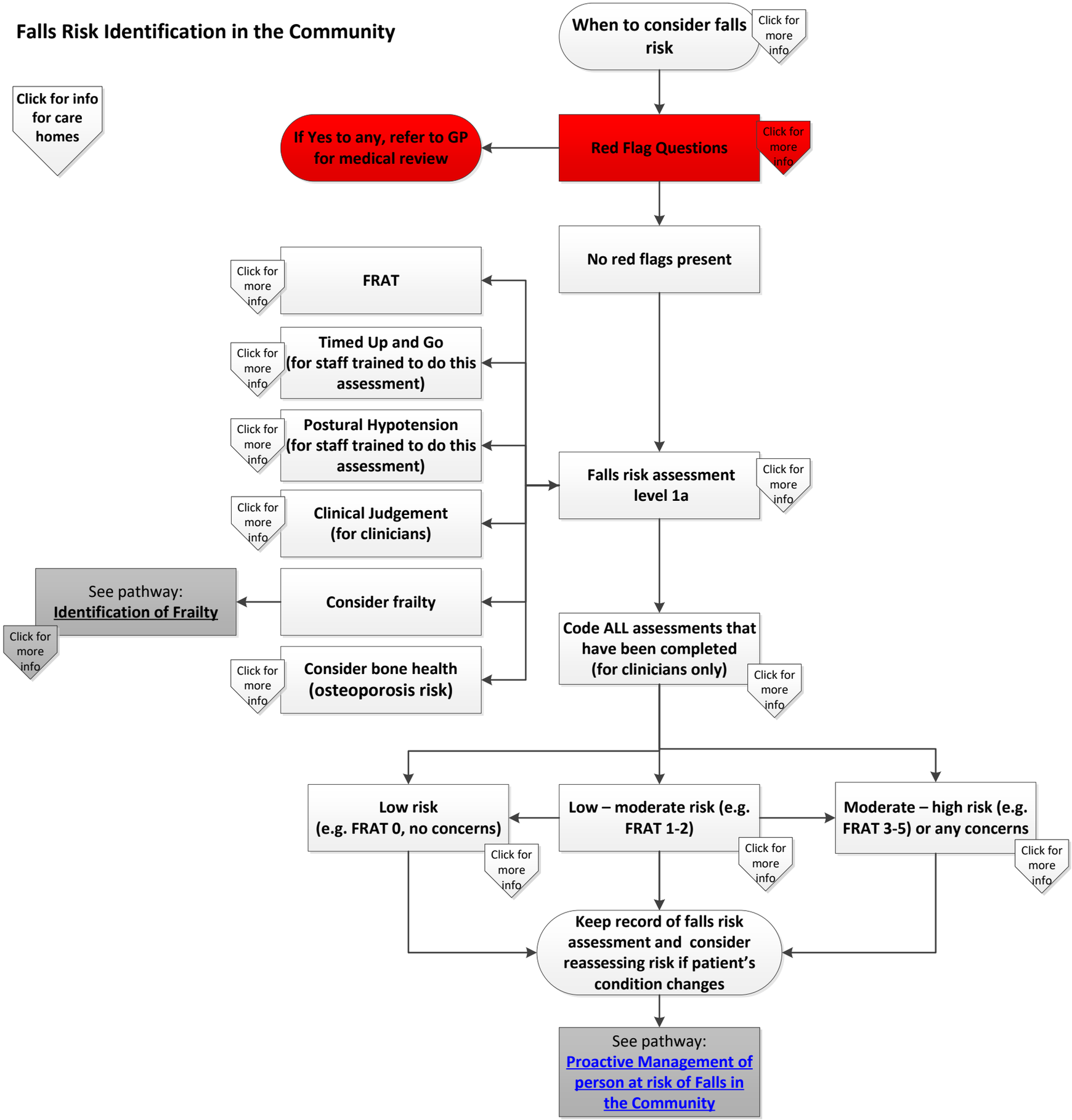
Falls Risk Identification in the Community



Back to pathway

When to consider falls risk

Falls risk could be considered by anyone, including clinicians and non-clinicians, professional and non professionals, both in and outside the health, social care & voluntary/third sector. This should also include individuals, carers and families.

Falls risk should be considered in:

- All individuals aged 65 and over (or younger with risk factors)
- History of falls or near misses
- Frailty (Rockwood score indicating frailty diagnosis)
- Unsteadiness on feet
- Balance problems
- Dizziness
- Visual or hearing impairment
- Fear of falling
- Fractures
- Osteoporosis
- Immobility (e.g. sudden change in mobility, 'gone off legs' 'stuck in toilet')
- Delirium (e.g. acute confusion, 'muddled', sudden worsening of confusion in someone with previous dementia or known memory loss)
- Dementia or mild cognitive impairment (MCI)
- Change in continence (new onset or worsening continence problems, including being unable to control opening of bowels or urination)
- Susceptibility to side effects of medication (e.g. confusion with codeine, hypotension with antidepressants, benzodiazepines, antipsychotics.) and/or withdrawal from medication
- Multiple medications (four or more regular medications)
- Underweight BMI <19
- Obesity (Older obese people have an increased risk of falls and obese fallers may have a higher prevalence of pain and inactivity than fallers of a healthy weight)
- Diabetes
- Alcohol Misuse
- Environmental hazards; e.g. loose rugs or mats, poor lighting, uneven surfaces, wet surfaces (especially in the bathroom), loose fittings (such as handrails) and poor footwear
- Hypotension

Gradual decline (Also consider frailty – see STP *Identification of Frailty* pathway)

- Deteriorating function
- Weakness
- Slow walking speed
- Significant weight loss
- Exhaustion
- Low physical activity
- Depression

For people who have additional needs (e.g. deafness, learning disability or dementia) or in whom English is not their first language, reasonable adjustments should be made to the delivery of the assessments. For example, this may include having an interpreter or carer present.

Presence of additional needs should not be a barrier to assessing a person for frailty or falls.

Back to pathway

Red Flag Questions

Consider the following three questions in all people.

If the answer is yes to ANY, refer the patient to their GP* for a medical review:

- Any history of any **unexplained** falls (No clear cause e.g. person blacked out, will need medical investigation)?
- Do they have any dizziness on standing (new or unknown cause, not previously investigated, affecting balance)? If able, assess for postural hypotension.
- Do they have new or worsening observed balance or gait problems not previously investigated or managed?

*If it is within your capability to investigate and manage the red flags you should do so. In this case, please inform the GP of the outcome.

In cases where patients are routinely under a specialist care team e.g. neurology, it may be appropriate for the patient to be referred there for investigation, as long as the patient can be seen in a timely manner.

Back to pathway

Falls risk assessment Level 1a

Has person been assessed for falls risk in previous 12 months?

- Yes and no new concerns – Continue current management. Discuss how patient is managing with any relevant interventions including any barriers or issues with compliance, and provide support as needed. This may include reinforcing health and wellbeing choices and benefits of strength and balance exercise, within your competence level.

If patient has a care plan, please review and document discussion.

- Consider assessing patient for frailty – see STP *Identification of Frailty* pathway.

- If the patient has not been assessed in the previous 12 months or there are new concerns, screen for patients falls risk.

Consent
Obtain consent to share findings of assessment with GP and care professionals as relevant before starting assessment. If the person does not consent to share information but is willing to be assessed, you can still carry out the assessment. If you feel they need to be referred, encourage self-referral and signpost to self-management.

Note: If you have concerns about the persons capacity or feel the patient is at a high risk of harm consider the local safeguarding policy and/or Mental Capacity Assessment (MC) .

Components of falls risk assessment level 1a:

Telephone contact
- Red flag questions
- FRAT questions
- Consider frailty (PRISMA 7 questions – see STP *Identification of Frailty* pathway)
- Consider Bone Health

Face- to-face contact
- Red flag questions
- FRAT questions
- Optional assessments (dependent on competence and ability to perform) Timed Up and Go, Postural Hypotension
- Consider Frailty (PRISMA 7 questions – see STP *Identification of Frailty* pathway)
- Consider bone health

Clinical staff should also use their clinical judgement alongside these screening tools.
Clinical decision tools are not advocated in isolation to determine falls risk.

If there are any concerns about the individual, negative screening should not be a barrier to onward referral.

Record all results of assessments completed in STP Care plan (if available)

Back to pathway

FRAT Questions

- Ask the following 5 questions.
- Each answer should be 'Yes' or 'No'
- Score 1 for every answer of 'Yes'

Falls Risk Assessment Tool (FRAT)

1. **Have you had a fall in the previous year?** Yes □ No □

2. **Are you taking four or more medications per day?** Yes □ No □

3. **Have you had a stroke? Have you been diagnosed with Parkinson's disease?** Yes □ No □

4. **Do you have any problems with your balance?** Yes □ No □

5. **Are you unable to stand up from a chair of knee height without using your arms?** Yes □ No □

TOTAL SCORE (Score 1 for each 'Yes') ……

How to interpret the FRAT score

Score 0 = You have a lower risk of falls. To help you maintain independence, stay steady and reduce your future risk of falls, we have simple self-help advice (See *Proactive management of falls risk in the community* pathway – low risk).

Score 1-2 = You have a Lower risk of falls but do have some risk factors. Use our Step-by-step guide to staying independent and preventing future falls, which will give you further advice about reducing your risk factors. We also have simple self-help advice to help you (See *Proactive management of falls risk in the community* pathway – low-moderate risk).

Score 3 – 5 = Higher risk of falls. You have risk factors which could increase your risk of falls, so you will benefit from an assessment by a healthcare team to look at these factors in more detail (a multi-factorial risk assessment).

Your health, social or voluntary/third sector worker who completed this FRAT score can refer you for this assessment (via GP or Community Trust, or falls and frailty hub is available).

If you completed this score yourself, please inform your GP practice.

Codes (clinicians only)

FRAT questions asked:

CTV3 (SystmOne)	XaZP6
V2 (EMIS)	38GK.
SNOMED Concept ID	839781000000108

Back to pathway

Timed Up and Go instructions

Ensure the environment is suitable and safe to perform this test in, in particular look for any trip hazards (e.g. rugs, obstacles and wearing inappropriate foot wear)

Instructions for the assessor:
Make sure that the person taking the test is wearing their regular footwear and if they normally use a walking aid (stick, Zimmer frame etc.) make sure that they use this during the test. You should not assist the person during the test. They may stop to rest but they may not sit down during it.

If the person is very unsteady and likely to fall do not perform this test.
If the person becomes unwell or very unsteady during the test, stop the test and assist the person.

Equipment requirements:
Stopwatch/phone with stopwatch function
Chair with armrests
Measured distance of 3m (10ft)

Instructions to explain to the person taking the test:

I will count to three and then say 'go'.
When I say go, I will start the stopwatch, I would like you to stand up from the chair. You may use the arms of the chair to help you stand up.

I would then like you walk until you pass this piece of tape (marked end of the course). You may take any route that you would like, I would like you to move as quickly as you feel comfortable and safe walking at.

Once you have reached the end of the course, I would like you to turn around and walk back to the chair and sit back down on it.

I will stop the timer when your back touched the back of the chair.

You will complete one practice run and then two runs that are counted.

Instructions for the assessor:
Start timing on the word 'go', stop timing when the person taking the test has sat back on the chair.

Results:
Practice Test
Test 1 =
Test 2 =
Average time (add test 1 and test 2 times, divide the result by 2) =

Understanding the results
<12 seconds = Lower risk of falls
> 12 seconds = Higher risk of falls.

Note: If >10 seconds, also consider frailty – please see STP *Identification of Frailty* pathway

Codes (clinicians only)

Timed Up and Go completed:

CTV3 (SystmOne)	XaluJ
V2 (EMIS)	3986.
SNOMED Concept ID	401196007

Back to pathway

Postural Hypotension instructions

Note: This assessment should only be performed by staff who have had appropriate approved training and with equipment which has been calibrated.

Instructions to the assessor:

- Do you sometimes or regularly feel unsteady, light-headed, dizzy or faint after getting up from lying or sitting?

Ideally, complete a full assessment including a LYING AND STANDING blood pressure as below:

- Identify if you are going to need assistance to stand the person and simultaneously record a BP.
- Explain procedure to the person

1st Measurement - After lying for **at least 5 minutes**

2nd Measurement - After standing, in the **first minute**

3rd Measurement - After standing for **3 minutes**

Further measurements - If blood pressure is still falling

If not possible to do lying and standing blood pressure, record a SITTING AND STANDING blood pressure as below (this test is less sensitive than the lying and standing test):

1st Measurement - After sitting for **at least 5 minutes**

2nd Measurement - After standing, in the **first minute**

3rd Measurement - After standing for **3 minutes**

Further measurements - If blood pressure is still falling

Further measurements - If blood pressure is still falling

- Symptoms of dizziness, light-headedness, vagueness, pallor, visual disturbance, feelings of weakness and palpitations should be documented.

A positive result is one or more of the following:

1. A drop in systolic BP of 20mmHg or more (with or without symptoms)
2. A drop to systolic BP below of 90mmHg on standing even if the drop is less than 20mmHg (with or without symptoms)
3. A drop in diastolic BP of 10mmHg with symptoms (although clinically much less significant than a drop in systolic BP)

- Advise person of results

If postural hypotension is present, risk of falls is increased.
Refer/advise person to have a clinical assessment (if non-clinical).

Codes (clinicians only)

Lying blood pressure reading

CTV3 (SystmOne)	246C.
V2 (EMIS)	246C.
SNOMED Concept ID	163033001

Standing blood pressure reading

CTV3 (SystmOne)	246D.
V2 (EMIS)	246D.
SNOMED Concept ID	163034007

Postural hypotension

CTV3 (SystmOne)	G971
V2 (EMIS)	G870.
SNOMED Concept ID	28651003

Back to pathway

Clinical Judgement (for clinicians)

Alongside the assessment tools, **clinical judgment** should be used to determine a patients falls risk.

The risk assessment tools (including FRAT and the Timed Up and Go) are to be used as guides in the decision making process. The results are not absolute, so if there are any concerns about an individual's risk of falls, you should provide ongoing assessment and support as appropriate, regardless of how a patient scores on the risk assessment tools.

Supplementary questions about falls risk should be asked as necessary to aid in decision making, e.g. does the patient have a fear of falling?

FRAT is a validated tool which could be used to assist in clinical decision making, alongside clinical judgement. NICE recommends Timed Up and Go as an adjunct to clinical judgment to assess gait and balance.

NICE reports that history of falls in the past year is the single most important risk factor and predictor of future falls. In terms of primary prevention, balance and unsteadiness is a key risk factor.

Consider an individual's home circumstances, including if they live alone and/or if they have support available.

Communication should be sensitive to the fact that individuals may feel reluctant to admit to falling. (NICE QS86)

Back to pathway

Consider bone health (osteoporosis risk)

If an individual is at risk of falls, it is also important to consider their bone health.
Falls resulting in fractures can be devastating – but positively there are lots of simple ways to improve bone health.

Who is at risk?

Risk factors for osteoporosis:

- Increasing age
- Genes
- White or Asian ethnicity
- Female
- Low body weight (BMI <19)
- Diet lacking in vitamin D and calcium
- Lack of exercise
- Smoking
- Alcohol
- Previous fractures
- Anorexia
- Steroids
- Diabetes
- Thyroid problems
- Lack of testosterone
- Premature menopause

Self-Management:
Encourage self-management in all patients to protect bones and prevent future fractures:

- Exercises (Strength/Balance/Flexibility/Sitting)
- Diet (Calcium/Vitamin D)

Further advice is available here:
https://www.nhs.uk/Livewell/healthy-bones/Pages/healthy-bones.aspx

If there are concerns about the risk of fractures, you should advise the person to speak to their GP about their risk.

For more information see local osteoporosis pathways and guidelines

Back to pathway

Code ALL assessments that have been completed (for clinicians only)

FRAT questions asked:

CTV3 (SystmOne)	XaZP6
V2 (EMIS)	38GK.
SNOMED Concept ID	839781000000108

Timed Up and Go completed:

CTV3 (SystmOne)	XaluJ
V2 (EMIS)	3986.
SNOMED Concept ID	401196007

Standing blood pressure reading

CTV3 (SystmOne)	246D.
V2 (EMIS)	246D.
SNOMED Concept ID	163034007

Postural hypotension

CTV3 (SystmOne)	G971
V2 (EMIS)	G870.
SNOMED Concept ID	28651003

Back to pathway

Low risk (e.g. FRAT 0, no concerns)

For example (all of the following dependant on how many assessments are carried out):

- Over the age of 65 - no history or immediate risk of falls identified. Not yet fallen
- Scores 0 on the Falls Risk Assessment Tool (FRAT)
- <12 seconds result on Timed up and Go (TUG)
- No indication of postural hypotension
- No concerns about person's falls risk
- No indication of frailty

If you have any concerns about the person, regardless of the outcome of the screening tool, negative screening is not a barrier to referral.

Back to pathway

Low – moderate risk

For example (all of the following dependant on how many assessments are carried out):

- Mild deficit in strength and balance
- No more than 1 fall in last 12 months - judged at low risk of recurrent falls
- Reduced confidence
- Score 1-2 on the Falls Risk Assessment Tool (FRAT)
- <12 seconds result on Timed up and Go (TUG)
- No indication of postural hypotension
- Mild concerns about person's falls risk
- No indication of frailty, or indication of mild frailty

If you have any concerns about the person, regardless of the outcome of the screening tool, negative screening is not a barrier to referral.

Back to pathway

Moderate – high risk

For example (one or more of the following dependant on how many assessments are carried out):

- Recurrent falls, recent injurious fall, fear of falling. Issues with strength, balance or gait contributing to risk
- Mild deficit in strength and balance plus cognitive/ motivational issue
- Score 3 or above on the Falls Risk Assessment Tool (FRAT)
- >12 seconds result on Timed up and Go (TUG)
- Indication of postural hypotension
- Concerns about person's falls risk
- Indication of mild, moderate or severe frailty

If you have any concerns about the person, regardless of the outcome of the screening tool, negative screening is not a barrier to referral.

Back to pathway

Information for care homes

- Individuals living in care homes and other residential settings, should have equal access and opportunity to all risk tools and assessments (as appropriate for them).
- For people who have additional needs (e.g. deafness, learning disability or dementia) or in whom English is not their first language, reasonable adjustments should be made to the delivery of the assessments. For example, this may include having an interpreter or carer present.
- Presence of additional needs should not be a barrier to assessing a person for frailty or falls.
- Contact local Care Providers association for details of local support and training packages available e.g. Hertfordshire Care Providers Association has launched the Stop Falls Campaign for Health and Social care staff across Hertfordshire, funded by Hertfordshire County Council. The campaign aims to increase knowledge on minimising risk and understanding how to asses clients at risk of falls in social care settings, by upskilling staff through education and our 'Top Tip' Resource packs. To view our materials visit www.hcpa.info/stopfall<http://www.hcpa.info/stopfall