



Recurrent Falls Assessment

Inclusion criteria:

3 or more falls in the last 3 months. This form is designed to guide clinical assessment.

Exclusion criteria:

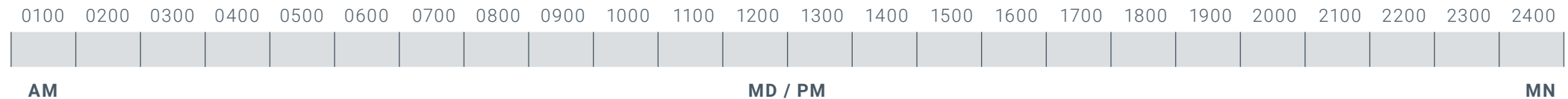
Previous assessment within the last 3 months.

PATIENT DETAILS / STICKER

Nursing assessment (pages 1-2 to be completed by nursing staff at the facility and returned to RCL)

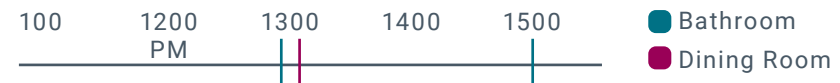
Record falls for the last 3 months. Mark the time on the "timeline" below as per the example using a different colour for each location.

TIMELINE



Timeline date range: ____ / ____ / ____ to ____ / ____ / ____

Example



ED admissions within the last 3 months:

Date/time	Any injury sustained	Outcome

Sleep assessment 7 days completed: Yes / No (Attach assessment)

Pain assessment 3 days completed: Yes / No (Attach assessment)

Fluid intake chart 3 days completed: Yes / No (Attach chart)

Bowel charts 7 days completed: Yes / No (Attach charts)

Cognition / behavioural issues: _____

Environment check: _____

Recurrent Falls Assessment (Continued)



Residential Care Line



Observations	Date:	Date:	Date:
Lying BP***			
Standing BP***			
Heart rate			
Rhythm (regular, irregular)			
Temperature			
Oximetry (SpO2)			

Blood glucose level		
Date	Fasting/random	Level
PVBS		
Date		

*** Lying and standing BP to be done within 1 minute of each other ***

Has there been a **significant weight change** recently (3-6 months)? **Yes / No** Comment: _____

Has an **oral assessment** been conducted? **Yes / No** Comment: _____

Are there any **nutritional concerns**? **Yes / No** Comment: _____

Rockwood Frailty Score _____ **ACP in place? Yes/ No** Comment: _____

Current falls reduction strategies and nursing comments

Comments:

Podiatry review

Comments:		
Podiatrist's name:	Signed:	Date of last review:

Physiotherapy / occupational therapy review

Comments:		
Clinician's name:	Signed:	Date of last review:

RCL assessment checklist



Residential Care Line



- ☐ Past medical history _____
- ☐ Medication chart attached:
- ☐ Recent medication changes (previous month) _____
- ☐ Anticoagulants and antiplatelet agents review:
 - ☐ Yes, list details: _____
 - ☐ Indications for the anticoagulant / antiplatelet, is it still required?: _____

Medication review, identify falls risk increasing drugs (FRID'S):

- | | | |
|---------------------|-------------------|-------------------|
| • Antihypertensives | • Antidepressants | • NSAIDs |
| • Antihistamines | • Nitrates | • Benzodiazepines |
| | • Opioids | • Antipsychotics |

- ☐ Vision assessment: Acceptable vision / impaired vision. Comments: _____
- ☐ Neurological causes (e.g. dementia, Parkinson's disease, other movement disorders): _____
- ☐ Delirium or intercurrent illness: _____
- ☐ Balance (e.g. BPPV, labyrinthitis): _____
- ☐ Gait and foot examination: _____
- ☐ Hydration status: _____
- ☐ Alcohol: _____
- ☐ Fracture risk assessment
 - Osteoporosis screen and treatment optimised?
 - Vitamin D supplementation

RCL assessment checklist (Continued)



Pathology

If not recently done consider: FBC, UEC, LFT, Fe studies, B12, Folate, Ca, Mg, Vitamin D, Fasting BSL, HbA1C, TFT, MSU

Brain imaging:

Previous imaging in the last 12 months **Yes / No**

Date/result:

RCL assessment findings – GP to please consider:

Clinician's name:

Signed:

Date:

Discussed with GP? **Yes / No**

Comments: