**Falls Action Plan**

**Resident’s Name:**

**Date of Plan: Date of next review:**

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| **Falls Risk Area** | **YES/NO** | **Action taken/date referred to another service** |
| 1. Are they unsteady on their feet and in fear of further falls? |  | *(E.g. Referred to Physiotherapy and date, referred to Telecare Service and date, sensor mats trialled in chair/bed)* |
| 2. Have they any problems with their feet and/or their footwear? |  | *(E.g. New shoes sourced, referred to podiatry, arranged Chiropody visit once a month)* |
| 3. Do they get dizzy or light-headed when standing up from a sitting or lying position? |  | *(E.g. Contacted GP/District Nurse for lying/standing blood pressure reading, date of last medication review by GP)* |
| 4. Do they have problems with their eyesight or glasses? |  | *(E.g. Optician appointment arranged, ensure correct prescription glasses are worn at appropriate time and these are cleaned regularly and fit well)* |
| 5. Do they take more than 4 medications without having had a recent medication review? |  | *(E.g. Date of most recent medication review, ensuring residents on more than 4 medications are reviewed by GP every 6 months)* |
| 6. Are they unwell, eg. Chest infection, Urine infection? |  | *(E.g. Date of most recent urine dip, if recurrent UTI’s encourage fluid intake, monitor for symptoms and contact GP accordingly)* |
| 7. Do they have any difficulty with toileting? |  | *(Look into reasons around difficulty, can they find the toilet, do they require assistance, refer as appropriate. E.g. referral to continence team, telecare or GP)* |
| 8. Could the fall be caused by the surrounding environment? |  | *(Carry out environmental audit, eliminate trip hazards, ensure adequate lighting, do they require assistance to navigate due to poor vision? Is there adequate lighting at night if they get up to use the bathroom? Is their walking aid within their field of vision and easy to reach?)* |
| 9. Could long clothing contribute to the fall? |  | *(E.g. Ensure clothing fits well or belt worn)* |
| 10. Do they eat regular healthy meals and drink enough fluids? |  | *(E.g. If weight loss evident carry out 3 day food and fluid chart, if eating well and weight loss continues contact GP, if poor intake of food/fluid consider referral to dietician or Speech and Language Therapist)* |
| 11. Could the fall be linked to alcohol? |  | *(Be aware of reactions with medication)* |
| 12. Are they able to call for assistance?  |  | *(Consider Telecare referral, more frequent checks and offering assistance)* |

If you have any queries or require assistance when completing this form, please contact:

Care Home Support Team on 0300 421 8293