CARE 24/7
HEALTHCARE

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High Risk of Falls - Service User - Care Plan Guidance Checklist

A: DETAILS		
Surname:	First Name(s):	Title:
Age last birthday:	Date of Birth:	Place of Birth:
HEIGHT:	WEIGHT:	HISTORY OF FALLS ☐ YES / NO ☐

B: FALLS SCREENING CHECKLIST	
If the answer to any of the questions B.1 to B.4 below is YES, proceed to Part C of this Form: Care Plan Guidance Checklist	
B.1 Has the service user had a fall within the past 6 months?	☐ YES / NO ☐
B.2 Does the service user try to walk alone, but appears to be unsteady or unsafe?	☐ YES / NO ☐
B.3 Does the service user use walking aids?	☐ YES / NO ☐
B.4 Is the service user or relative anxious about falls?	☐ YES / NO ☐

C: CARE PLAN GUIDANCE CHECKLIST			
Is the service user having problems with, or at risk of:	Yes	No	If "YES", follow the interventions applicable to this service user and record details. The Care Plan should reflect and address identified issues.
Gait, balance, mobility and /or muscle weakness?	☐	☐	Refer to physiotherapist for treatment regime. Refer to GP for assessment.
Perceived functional ability, and / or fears relating to falling?	☐	☐	Refer to Occupational Therapist for treatment regime. Support service user when walking.
Visual impairment?	☐	☐	Refer to optician / ophthalmologist for treatment regime.
Cognitive impairment and / or neurological impairment?	☐	☐	Ensure Care Plan promotes mental well-being. Support with daily living activities (orientation etc).
Urinary incontinence?	☐	☐	Ensure continence Care Plan in place. Review medication regime.
Nutritional fluid intake?	☐	☐	Monitor dietary and fluid intake. Provide support with eating and drinking.
Environmental hazards; e.g. poorly-fitting footwear, inappropriate use of walking aids, home hazards?	☐	☐	Advice from physiotherapist on correct use of walking aids. Refer to Occupational Therapist for full home assessment.
Medication likely to cause risk of falls?	☐	☐	Review medication regime with community pharmacist. Review medication regime with specialist medical team.

D: COMMENTS, OBSERVATIONS & RECOMMENDATIONS

E: SIGNATORIES

INDIVIDUAL	SIGNATURE	DATE
Staff member undertaking Assessment:		
Service User (or advocate):		
Relative / Family Member (as appropriate):		
GP / Registered Nurse (as appropriate):		
OTHER (specify):		