CARE 24/7
HEALTHCARE

Care 24/7 Healthcare Limited
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Risk Assessment - Service User - Falls & Mobility

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 - IDENTIFICATION OF RISK FACTORS			
Tick box if applicable			
Visual / sight problems	☐	History of fits / seizures	☐
Hearing problems	☐	Confusion / disorientation	☐
Speech impediment	☐	Arthritis of knees / hip	☐
Cognitive impediment	☐	Cardiac disease	☐
Limited / impaired mobility	☐	Arterial disease	☐
History of falls	☐	Parkinson's Disease	☐
Fear of falls	☐	Postural hypotension	☐
Urinary incontinence	☐	Use of antidepressants	☐
Faecal incontinence	☐	Use of sedatives	☐
History of smoking	☐	Peripheral neuropathy	☐
History of alcohol abuse	☐	Controlled drugs being prescribed	☐

C: FALLS - CONTRIBUTORY FACTORS	
Criteria	**Considerations**
Previous history of falls	
Inability or unwillingness to call for assistance	
Limited mobility or movement, or unsteady gait	
Confusion, disorientation, effects of medication or other type of altered mental state	
Impaired vision / hearing / other sensory defect	
Frequency of micturition or defecation and / or incontinence	
Recent cardiovascular accident or neurological impairment	

D: EASE OF MOBILITY / MOVEMENT			
Activity	**Normal Capabilities**	**Abnormal Capabilities**	**Aids Used**
Rising from chair			
Stand for approx. 30 seconds after rising			
Stand with eyes closed for 15 seconds			
Walking - distance of 15 feet and back			
Walking - distance of 5 feet and turn around			
Sitting down in a chair			
Negotiating stairs / steps			
Going to bed			
Rising from bed			
In bed - need for bed rails			
Toileting			
Washing			
Showering / bathing			
Feeding			

E: GENERAL SAFETY AWARENESS		
Smoking	Smokes in own home	
	Discarding cigarette butts / use of ashtrays	
Going Out	Sense of danger	
	Sense of time	
	Sense of location	
	Sense of direction	
Electricity	Can reach power points easily	
	Can reach & manipulate light / lamp switches easily	
	Can reach telephone easily	
	Sense of danger (overloading power points etc)	

F: AIDS TO DAILY LIVING

Tick box if applicable			
False teeth	☐	Walking stick	☐
Spectacles	☐	Zimmer frame	☐
Contact lenses	☐	Wheelchair	☐
Hearing aid	☐	Bed rails	☐

G: COMMENTS, OBSERVATIONS & RECOMMENDATIONS

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