# Action Falls Checklist

## Background

The Action Falls Checklist (formally GtACH) was devised by a group of falls experts from Nottinghamshire from a range of organisations including health, social care, the voluntary sector, university academics and patient groups. A systematic literature review was completed to ascertain risk factors for falls and actions that can reduce falls applicable to community dwelling older people. The Guide to Action Tool was published in 2010 (Robertson et al, 2010).

The Checklist was adapted for use in a Care Home environment through the Falls Research Project from 2008-2010 with care home staff helping to develop the wording and format. This was published in 2012 (Robertson et al, 2012). The research group undertook a clinical trial, the largest in the UK, and this trial found the Action Falls Programme, could reduce falls by 43%. This was published in the British Medical Journal (Logan, Horne, Robertson et al 2021).

## Purpose of the Action Falls Checklist

To act as a checklist to prompt a greater awareness of the many factors that can contribute to an older person falling. As recommended by the National Institute for Health and Care Excellence (NICE), the checklist identifies risk factors for the individual. This has been shown to be more effective than scoring a person's risk of falls.

To provide suggestions for action that can be taken to minimise or eliminate these risks factors for that individual person, including suggestions where a referral to other services could be made.

## What the Action Falls Checklist is not

✘ An Outcome Measure

✘ A standardised tool/assessment

# How to complete the Action Falls Checklist

The Checklist should be completed with the consent of the person it is about (or if they lack capacity, then consent from the person acting for them) and should be completed with them and their family members as far as is possible.

| Falls risk factors | √ | Suggested action | Action taken | Date action taken & by whom |
|---|---|---|---|---|

All information in the left hand column on the Checklist indicates a falls risk factor. Anything that is relevant to the person can be underlined or circled and the second column ticked to indicate risk factors identified

The third column suggests actions that could be taken to reduce or reverse the risk factor identified - this is not an exhaustive list and judgement should always be applied with regard to what is appropriate and acceptable for the individual resident

Actions to be taken should be recorded in the 4th column

Signed and dated in the 5th column

**A care plan should be put in place that reflects the actions to be taken to reduce a person's risk of falling**

# Case example with completed checklist

Betty is 85 and has lived at Sunnyview for about 5 months, moving here just after her husband died because she wasn't safe at home alone due to falls and confusion. Her and Jim had been married for 56 years and she often talks about him and how he will be missing her. Betty is very quiet, she likes to sit in her chair in the lounge, although she does ask to go to the toilet an awful lot. When she stands up she says she feels a bit strange, like the floor comes to meet her feet, and she seems very stiff in her joints a lot of the time – you often see her rubbing her arms or legs. She doesn't like cups of tea much, often leaving them and she hasn't got much appetite either. She struggles to get out of her chair and her walker has seen better days. She's got glasses but doesn't often wear them - she tends to bump into things too.

Betty had a fall the other night, which was a bit of a surprise as she hasn't fallen here before. She says when she fell at home, Jim used to get her up but we really struggled. It looks like she fell out of bed as she was on the floor in her room –she says she'd got up to go to the toilet. She has a skin tear on her arm and says her wrist hurts. She broke it a few years ago when she fell at home. Her current medications are: paracetamol, oxybutinin, atenolol, furosemide, donepezil, lorazepam at night, calcichew D3.

## Actions taken:

- GP asked to review medication - postural drop in blood pressure may be side effects of medications, has a urinary tract infection and appears to be in pain
- Walking frame needs replacing
- An alternative higher chair needs to be provided to aid sit to standing
- All staff to encourage Betty to move more during the day, provide supervision if she is anxious and encourage her to call for help
- Fluid chart started
- Staff to talk to Betty about what she would like to eat and drink
- Staff to document when Betty has near misses and bumps into things

# ACTION FALLS | Checklist: A Guide to Action for Care Homes

| Resident's Name | | D.O.B. | |
|---|---|---|---|

- Underline statements relevant to the person you are completing the tool with
- If section is not relevant, write this in action box
- Date and sign when actions taken

## Falls History (1 of 4 sections)

| Falls risk factors | √ | Suggested action | Action taken | Date action taken & by whom |
|---|---|---|---|---|
| **History of falls**<br>• History of falls prior to admission to care home<br>• Falls reason for admission to care home | ✓ | Review all incidents using Incident Analysis form, look for any patterns to falls e.g. time of day, activity at time of fall – fill in 'Fall Incident Analysis'<br>Inform GP of falls history and any recent falls<br>Postural blood pressure to be checked i.e. in lying, sitting and standing - alert GP if drop is greater than 20mmHg<br>Request medical review to identify any medical causes of falls e.g. infection, stroke, low blood pressure, heart problems<br>Identify any possible causes of falls and take steps to reduce those risks | Lying and standing blood pressure checked – 150/80sitting 125/75 standing.<br>GP informed - request to review blood pressure and medications that may cause postural drop in BP. | 2.4.18<br>TR |
| **History of falls**<br>• History of falls since admission | ✓ | | | |
| **Recent falls**<br>• 2 or more falls in past 6 months (A fall is defined as an unexpected event in which residents come to rest on the ground or floor) | | | | |
| **Fractures**<br>• Has broken bones as result of fall: Wrist, hip, arm, pelvis, spine, ribs, collar bone, shoulder, ankle<br>• Is at risk of fracture because takes steroids, has rheumatoid arthritis or drinks 3 or more units of alcohol a day | ✓ | At risk of Osteoporosis<br>Ask GP to review if person is falling and has previous fracture(s) | GP request to review. | 2.4.18<br>TR |
| **Hospital admission**<br>• Attended A&E due to fall<br>• Ambulance called - not taken to hospital,<br>• Admitted to hospital due to fall | | Review causes of fall<br>Initiate any treatment recommended<br>Inform GP | | |
| **Other injury due to fall**<br>• Head injury, cuts, bruises, grazes, skin tear | ✓ | | Ask DN to review skin tear. Check this daily for signs of infection and that wound is healing. Report to DN if any concerns. | 2.4.18<br>TR |
| **Coping strategies**<br>• Unable to get up from floor without help<br>• Unable to summon help | ✓ | Ensure call buzzer easily accessible and working,<br>Consider use of sensor equipment<br>Increase level of supervision and document | Does not like to use call bell. Agreed to use now if gets up at night to toilet. Discussed use of floor sensor mat but Betty declined. | 2.4.18<br>TR |
| **Fear of falling**<br>• Is anxious/worried about falling, lacks confidence<br>• Remains seated for much of the day due to fear of falling | ✓ | Consider reasons for fear of falling<br>Increase supervision<br>Ensure mobility maintained<br>Encourage and reassure | Says she's worried about falling. All staff to encourage her to move more with supervision. | 2.4.18<br>TR |

## **Medical History** (2 of 4 sections)

| Falls risk factors | √ | Suggested action | Action taken | Date action taken & by whom |
|---|---|---|---|---|
| **Medical history**<br>• Stroke, Parkinson's Disease, dementia, epilepsy, diabetes, heart disease, blackouts, arthritis, high/low blood pressure | ✓ | Check for signs of acute illness/ infection, consider medical review from GP if condition not been reviewed in last 6 months, if low blood pressure prompt to stand still on 1st standing up | See above, postural drop in BP, GP review requested. Staff to advise to get up slowly. | 2.4.18<br>TR |
| **Medication**<br>• On 4 or more prescribed medications, on sedatives, on antidepressants,<br>• On blood pressure medication | ✓ | Check medications against the medication and falls chart in the Action Falls Manual. Medication should be reviewed by GP every 6 months, consider side effects of medication i.e. dizziness, sedation, confusion and refer to GP if concerned | GP review requested Ask about any dizziness when getting out of bed or sitting for some time. Report any dizziness. | 2.4.18<br>TR |
| **Dizziness**<br>• Complains of dizziness,<br>• Dizzy on first standing | ✓ | Postural blood pressure to be checked i.e. in lying, sitting and standing - alert GP if drop is greater than 20mmHg, advise to move legs and feet before standing and to stand still and count to 10 on first standing up | Blood pressure checked – 142/87 sitting 130/65 standing<br>GP informed. | 2.4.18<br>TR |
| **Cognition**<br>• Does not recognise own limitations<br>• Poor understanding of space and distance<br>• Unaware of risks and hazards,<br>• Poor short term memory | ✓ | Refer to GP for review if not reviewed in last 6 months, use signage for toilet, bedroom, lounge<br>Use physical gestures and prompts<br>Repeat information when person unable to remember, increase supervision | Bumps into things – could be vision or spatial awareness. Observe, document and report occurrences. | 2.4.18<br>TR |
| **Behaviour**<br>• Agitated, unsettled, anxious<br>• Periods of aggression, risk to others | | Refer to GP if medical review required, Mental Health services, ensure no acute illness or infection, be aware of risk of introducing/increasing psychotropic medication | | |
| **Comprehension**<br>• Has difficulty understanding verbal instructions/questions | | Speak clearly, use simple instructions, give physical gestures as prompts<br>Consider hearing or eye test | | |
| **Mood**<br>• Low mood, depression, anxious, fearful | | Reassure, encourage socialisation<br>Be aware of risk of introducing/ increasing psychotropic medication | | |
| **Communication**<br>• Unable to express needs verbally<br>• Difficulty making self understood clearly | | Consider using pictures signs and images to support their communication<br>Observe behaviour and routines for insight into how the person is feeling | | |

## Movement and Environment (3 of 4 sections)

| Falls risk factors | √ | Suggested action | Action taken | Date action taken & by whom |
|---|---|---|---|---|
| **Transfers**<br>• Needs help on/off chair, bed, toilet<br>• Unsteady when transferring<br>• Tends to rush | ✓ | Consider use of alternative furniture, refer to OT if advice required, prompt to not rush | Provide alternative higher chair.<br>Observe pressure areas especially sacrum for any signs of redness and report. If concerned refer to DN. | 2.4.18<br>TR |
| **Balance**<br>• Holds furniture when moving, unsteady when walking<br>• Loses balance on turning<br>• Cannot walk unsupported due to unsteadiness | | Encourage to stand still on first standing, advise to keep head and feet in line when turning, increase supervision, consider referral to physiotherapist | | |
| **Stumbles and trips**<br>• Stumbles and trips even if no obstacle, near misses noted | ✓ | Document incidents, review incidents for time, location, activity at time. Review possible causes e.g. footwear, eyesight | Chart started to document near misses / bumping into things. | 2.4.18<br>TR |
| **Gait**<br>• Shuffles, leans to side, leans backwards, walks fast | | Advise to stand upright, supervise, consider referral to physiotherapist for advice | | |
| **Walking**<br>• Needs supervision when walking<br>• Needs assistance of 1 or 2 to walk | | Consider referral to physiotherapist for advice, assist to complete any exercise programme prescribed | | |
| **Walking aids**<br>• Uses incorrectly<br>• Refuses to use, forgets to use<br>• Poor condition | ✓ | Check correct height, check ferrules, prompt to use correctly | Needs replacing – request sent to physiotherapist. | 2.4.18<br>TR |
| **Heating / body temperature**<br>• Feels cold, sits for long periods<br>• Does not recognise when cold | | Ensure draught free environment, check not cold if sitting for long periods, mobilise regularly | | |
| **Alarm**<br>• Can't reach call alarm<br>• Does not remember how to use<br>• Does not call for assistance | ✓ | Ensure access to alarm, consider use of sensor equipment, increase supervision | Ensure call alarm is left within easy reach of resident when alone in bedroom. Encourage to use call buzzer. | 2.4.18<br>TR |
| **Flooring**<br>• Clutter, rugs and flexes<br>• Slippery floor coverings<br>• Spillages | | Ensure floors free of clutter, rugs and flexes, avoid patterned flooring, avoid raised thresholds between rooms, keep floor dry at all times | | |
| **Lighting**<br>• Poor lighting day and/or night<br>• Location of light switches inaccessible | | Ensure good lighting with no glare night and day, consider use of light in room at night, ensure switches accessible | | |

## **Personal** (4 of 4 sections)

| Falls risk factors | √ | Suggested action | Action taken | Date action taken & by whom |
|---|---|---|---|---|
| **Nutrition**<br>• Needs encouragement to eat<br>• Poor appetite, recent weight loss | ✓ | Encourage to eat small amounts regularly, ensure teeth well fitted, review reasons for poor appetite and weight loss - refer to GP, dietician | Look at smaller portions and snacks between meals. Monitor food intake on a food and fluid chart and weigh weekly. Report any further weight loss to GP. | 2.4.18<br>TR |
| **Fluid intake**<br>• Drinks less than 5 cups of fluid a day, needs encouragement to drink<br>• Often leaves drinks unfinished | ✓ | Encourage to drink 6-8 cups of fluid a day, stay with person whilst having a drink, document poor fluid intake if does not finish drinks, review reasons for poor fluid intake e.g. worried about getting to toilet | Start fluid chart, ask what drinks she prefers, encourage fluids, assist to toilet regularly to reduce anxiety. Encourage fluids during the day. If UTI confirmed by GP monitor to check infection has cleared. | 2.4.18<br>TR |
| **Continence**<br>• Incontinent of urine/faeces<br>• Catheter<br>• Difficulty accessing toilet, frequency, urgency, needs to get up to toilet at night<br>• Concerned re continence<br>• Difficulty managing clothes<br>• Constipation | ✓ | Ensure continence assessment completed, refer to community nurse/continence service, consider sending urine for testing, assess for constipation, consider signage to toilet, refer to OT if required, consider commode for night use, check regularly if requires toilet | If GP referral confirmed UTI, monitor to check infection has cleared. Monitor reports of dizziness on rising and report this. | 2.4.18<br>TR |
| **Sleep**<br>• Unsettled at night<br>• Sleeps a lot during day<br>• Complains of feeling tired | ✓ | Encourage activity during the day, consider time goes to bed, be aware of risk of medication to aid sleep increasing risk of falls, increase night supervision, consider use of sensor equipment | Encourage more activity in day, GP asked to review Lorazepam at night. | 2.4.18<br>TR |
| **Vision**<br>• Has diagnosed sight loss<br>• Wears varifocal or bifocal glasses<br>• Refuses to wear glasses | ✓ | Ensure access to regular sight checks (every 1-2 years), ensure adequate lighting day and night, advise against varifocal/bifocal glasses | Not had eyes tested for years. Arrange optician. Monitor re bumping into things. | 2.4.18<br>TR |
| **Footwear**<br>• Unsupportive footwear<br>• footwear too loose/tight<br>• Painful feet | | Advise on suitable footwear, check footcare - nails, corns, callouses, refer to podiatry | | |
| **Pain**<br>• Has specific pain/general pain<br>• Pain not helped by painkillers<br>• On medication for pain that causes side effects eg constipation, dizziness<br>• Unable to communicate is in pain | ✓ | Refer to GP if pain poorly controlled, review medication if side effects to prescribed tablets, observe behaviour and facial expression for signs of pain if unable to communicate | Appears to be in some pain. GP asked to review 27/11/2015.<br>Monitor pain and effects of any medications given for this. Report this to GP. | 2.4.18<br>TR |

| **Completed by** | Tracy Renalds | **Date** | 2.4.18 |
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