Wakefield Multi-agency Adult Level Two Falls Risk Assessment Tool Resource Pack

This resource pack has been developed to support the effective use of the Multi-agency Adult Level Two Falls Risk Assessment Tool.

The tool and its guidance are intended for use by any health, social service or voluntary service individuals to assist in the identification of falls risk factors.

Work within your own knowledge and competency base.

Version:	Version 7
Date Approved:	November 2018
Author:	Wakefield Council Public Health
Date issued:	November 2018
Review date:	November 2018

This resource pack has been prepared so that it prints in Duplex i.e. both side of the page. However, if you have downloaded the document and printed single sided, you may notice what appear to be additional blank pages. This occurs when Page Section Breaks have been inserted to ensure that a new section begins on the right hand side when viewed in booklet form.

Produced in partnership with:

NHS Wakefield CCG
South West Yorkshire Partnership Foundation Trust
The Mid Yorkshire Hospitals NHS Trust
Wakefield Council

Version Control Sheet

Document Title: Wakefield Multi-agency Adult Level Two Falls Risk Assessment Tool Resource Pack

Version:

The table below logs the history of the steps in development of the document.

Version	Date	Author	Status	Comment
V7	2017	Wakefield Council	Working document	Annual review
V6	2016	Wakefield Council	Working document	Review
V5	2015	Wakefield Council	Working Document	Annual review
V4.2	2013	Wakefield Council	Working Document	Annual review
V4	2012	Wakefield District Falls & Bone Health Task Group	Working document	Annual review
V3	2011	Wakefield District Falls & Bone Health Task Group	Working document	Approved by: • WDCHS Quality Forum • WDPCT Clinical Policy Group March 2011
V2	2008	Wakefield District Falls & Bone Health Task Group	Working document	Approved as a working document
V1	2006	Jill Jackson Lynn Williamson Multi Agency focus group Wakefield District Falls & Bone Health Task Group	Working document	Approved as a working document by: • Wakefield District Older Peoples Partnership Board • WDPCT Clinical Records Management Group Won SHA Modernisation Award for best practice in the Assessment & Diagnosis Category
0.1	2003 - 2005	Jill Jackson Sue Potter Health Nurse Team for Older People Josie Payne & Church Street District Nursing Team	Draft	Multi-factorial Falls Risk Assessment Tool developed for multi-professionals to raise awareness of evidence based falls risk & to act as a prompt to instigate. Tool approved by Wakefield District NSF OP Standard 6 Falls Task Group

Contents

Appendices

Acknowledgements:

Sincere thanks go to all those who have been involved in the development of the Multi-Agency Adult Level One and Two Falls Risk Assessment Tool especially the Falls Prevention Group. A specific acknowledgement goes to the staff involved with the development of the original Wakefield Multi-agency Multi-factorial Falls Risk Assessment Guidance Resource Pack developed in 2003.

Introduction:

NICE recommends that older people reporting a fall or at risk of falling should be considered for risk assessment and risk reduction interventions. NICE CG 161 & QS86 (2017) states that older people at risk of falling are offered a multifactorial risk assessment, and older people assessed as being at increased risk of falling should have an individualised multifactorial intervention:

- Older People in contact with healthcare professionals should be routinely asked whether they have fallen in the past year and asked about the frequency, context and characteristics of the fall.
- Older people who present for medical attention because of a fall, or report recurrent falls in the past year, or demonstrate abnormalities of gait and/or balance should be offered a multifactorial falls risk assessment.
- Following treatment for an injurious fall, older people should be offered a multidisciplinary assessment to identify and address future risk, and individualised intervention aimed at promoting independence and improving physical and psychological function.
- Individuals at risk of falling and their carers, should be offered information verbally and in writing about what measures they can take to prevent further falls, how to cope if they have a fall, including how to summon help and how to avoid a long lie, advice as to the physical and psychological benefits of modifying falls risk, and where they can seek further advice and assistance.
- All healthcare professionals dealing with patients known to be at risk of falling should develop and maintain basic professional competence in falls assessment and prevention.

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Background:

Falls and fall-related injuries are a common and serious problem for older people. People aged 65 and older have the highest risk of falling, with 30% of people older than 65 and 50% of people older than 80 falling at least once a year.

The human cost of falling includes distress, pain, injury, loss of confidence, loss of independence and mortality. Falling also affects the family members and carers of people who fall. Falls are estimated to cost the NHS more than £2.3 billion per year. Therefore falling has an impact on quality of life, health and healthcare costs. (NICE 2017).

In 2004, NSF Standard 6 Falls Task Group produced the Wakefield *Guidelines for the Prevention and Management of Falls in the Elderly* and a Wakefield multi agency multi factorial falls risk assessment tool that was standardised and universally adopted was developed.

How to use the Falls Screening Tool:

Level One Screening Tool is designed to be used opportunistically to identify those that may require a more in-depth falls risk assessment at Level 2. This Multi-Agency Adult Level Two Falls Risk Assessment Tool Resource Pack is designed to be used either as a result of Level One screening, or following referral into a service following a fall to assist in identifying falls risk and working with the individual to manage the risks to reduce the frequency and impact of future falls.

The Level 2 falls screening tool and resource are intended for use by any health, social service or voluntary service individuals to assist in the identification of falls risk factors. Using the Tool will enable health and social care workers to carry out holistic falls risk assessments in a consistent manner, and will act as an effective means of referral onwards into appropriate specialist services.

Notes for Assessors:

For Health Care Professionals the Level 1 should be completed to identify anyone at risk of falling.

The Multi- Agency Adult Falls Risk Assessment Tool is designed to support professional practice rather than determine it.

Where referral of a client for further treatment is thought to be detrimental or not beneficial, identified problems should be referred to the client's GP for monitoring and referral where appropriate.

When deciding on actions to take, the assessor should also consider treatment that the client is already receiving or services that they are already accessing.

The assessment does not have to be completed in the order that it is listed but it does need to be a systematic assessment.

Clients should be given the opportunity to explain their concerns first before any direct questions are asked.

The areas covered in the assessment tool are not exhaustive. Clients may have additional needs that need to be explored.

Abbreviations:

SAP Single Assessment Process
NICE National Institute for Clinical Excellence
ACN Adult Community Nurse
SPOC Single Point of Contact
PN Practice Nurse
GP General Practitioner
MYHT Mid Yorkshire Health Trust
LTC Long Term Conditions
DH Department of Health
MUR Medicines Use Review

Multi-Agency Adult Level One Falls Risk Assessment Tool

Please tick ☐ to indicate consent has been received to complete the assessment and to share information.

Personal Details	
First Name:	Address:
Surname:	
D.O.B:	Postcode:
NHS number: ☐☐☐ ☐☐☐ ☐☐☐☐	Other unique identifier:
GP:	Surgery:

Adult Level One Falls Risk Assessment	
1. Have you had any falls in the last 12 months	***Yes** / No
2. Do you take 4 or more medications?	**Yes** / No
3. Do you have a diagnosis of Stroke and/or Parkinson's disease?	**Yes** / No
4. Do you have problems with balance, feel unsteady?	**Yes** / No
5. Are you unable to rise from a chair (of knee height) without using your arms? (assessed by asking the person to do this)	**Yes** / No
Score **"1"** for each indicator of falls risk **(in bold)**. **Score:**	

***If yes to question one:**

- How many falls in the last 12 months? _____
- Did you blackout? _____
- Did you suffer any bony injuries? _____

If an individual has **already fallen in the last 12 months** and/ or the **score is 3** or more then progress onto an Adult Level Two Falls Risk Assessment.

Actions Taken/ Referrals Made

Completed by:	Profession:	Signed:	Date:

Repeat faller dates: __/__/____ __/__/____ __/__/____ __/__/____ __/__/____

An adaptation from the FRAT tool cited in:
Nandy, S., Parsons, S., Cryer, C., Underwood, M., Rachbrook, E., Carter, Y., Eldridge, S., Close, J., Skelton, D., Taylor, S., Feder, G. and Fall Prevention Pilot Steering Group. Development and preliminary examination of the predictive validity of the Falls Risk Assessment Tool (FRAT) for use in primary care. *Journal of Public Health* 2004 vol 26 pt 2 pp 138-143.

Multi-Agency Adult Level Two Falls Risk Assessment Tool

Please tick ☐ to indicate consent has been received to complete the assessment, to share information with health and social professionals for client care, and to use the data obtained for monitoring and evaluation to help improve services.

Personal details	
First name:	Address:
Surname:	
D.O.B:	Postcode:
NHS No: ☐☐☐ ☐☐☐ ☐☐☐☐	Other unique identifier:
GP:	Surgery:

Please tick ☐ to indicate that the 'Staying Steady' leaflet has been received. *This leaflet provides advice and information on how to prevent slips, trips and falls.* ***Copies are available to download from (SKYLINE)***

Page		Suggested actions	Action taken/comments
17	**Health history** Recent or noticeable changes relevant to falls.	Referral to GP	
18	**History of falls** Number of falls in last year, frequency and causes.	Use falls diary. GP to refer to specialist clinic	
19	**Previous fracture** Osteoporosis diagnosis, compliant with medication.	Consider osteoporosis. Refer to GP	
20	**Medication** 4+ medications, recent changes, medication review.	Medication review. Refer to GP.	
21	**Dizziness** Unexplained falls, Difficulty remembering the fall itself.	Refer to GP	
22	**Postural hypotension** Dizziness on standing / sitting up.	Refer to GP for postural blood pressure check.	
23	**Nutrition/Hydration** Loss of weight.	Refer to Dietician via SPOC or GP	

Completed by:	Profession:	Signed:	Date:

Personal details		
First name:	Surname:	D.O.B:
NHS number: ☐☐☐ ☐☐☐ ☐☐☐☐	Other unique identifier:	

Page		Suggested action	Action taken/comments
24	**Alcohol** Alcohol consumption.	Alcohol screening tool. Brief intervention or referral.	
25	**Continence** Incontinence of urine/ faeces.	Refer to continence service.	
26	**Vision** Difficulty reading or recognising objects/people.	Recommend an eyesight test.	
27	**Hearing and balance** Difficulty hearing conversational speech.	Referral to GP, PN or ACN. Consider hearing test or possible infection.	
28	**Footwear / foot care** Difficulty with foot care or footwear affecting mobility.	Advise re correct fitting footwear Advise to see podiatrist	
29	**Balance/walking/transfers** Unsteady sitting-standing, unsteady walking, lack of control moving.	Refer to MY Therapy or consider walking aid	
30	**Environment/coping strategies** Check home environment. Can client get up?	Staying Steady home checklist & falls advice. Refer to Social Care Direct for Care Link.	
31	**Mood** Fear of falls, depressed, lacking motivation.	Refer to GP. Consider Integrated Networks	
32	**Memory**	Refer to GP for specialist services.	

On completion of tool, develop a action plan in your professional documentation to address any identified falls risk factors. The screening tool may then be used as part of a referral for a specialist assessment or inserted in the client's "Your Care File" (SAP folder)

Completed by:	Profession:	Signed:	Date:

A recommendation cited from: Feder G., Cryer C., Donovan S., Carter, Y. and Guidelines Development Group. Guidelines for the prevention of falls in people over 65. *British Medical Journal* 2000, vol 321 pp 1007- 1011.

Review of health history

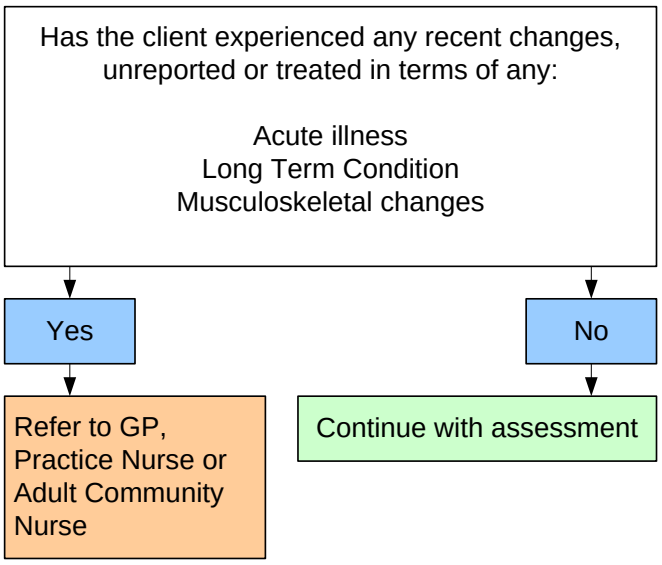
Introduction:

It is important to take a medical history when assessing a client for falls or further risk of falls to check if they have a condition that may affect mobility or balance, and to check if there are any recent changes.

Delirium

Delirium is a condition where people have increased confusion, changes in thinking and a reduced attention span. Symptoms can develop quickly and often fluctuate during the day.

Action:



Acute illness:

- Changes in condition
- Generally unwell
- Unexplained temperature
- Dizziness
- Colds or flu
- Attended GP or hospital recently
- New unreported problems – palpitations, pain
- Feeling of low mood
- Recent changes or new problems with vision and/or hearing

Long Term Condition (LTC):

- Diabetes
- Stroke
- Parkinsons disease
- Arthritis
- Osteoporosis
- Blood pressure concerns
- Cognitive disorders, dementia
- Neurological conditions

Musculoskeletal changes:

- Any changes in gait or balance
- Foot disorders e.g. bunions or callouses
- Musculoskeletal changes/disorders/muscle weaknesses

Single Question in Delirium = ‘Do you think the patient has been more confused lately?’ Ask a friend or family member.

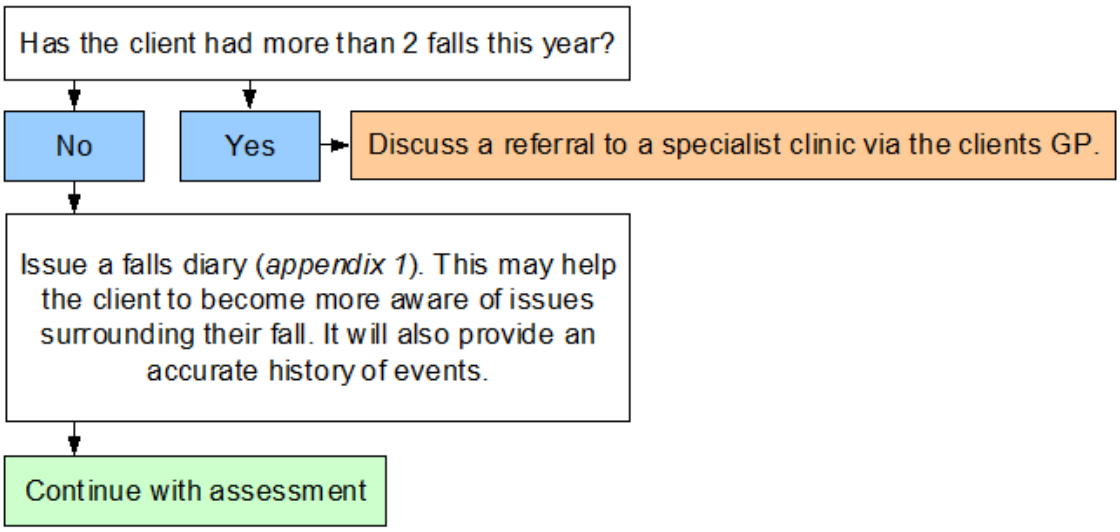
History of falls

Introduction:

Falls and fall-related injuries are a common and serious problem for older people. People aged 65 and older have the highest risk of falling, with 30% of people older than 65 and 50% of people older than 80 falling at least once a year (NICE 2013).

Evidence shows that once someone has fallen, they are more likely to fall again. One fracture makes a subsequent fracture 5 times as likely. Two fractures increase the rate of further fracture by up to 7 times (Ross et al 1993).

Action:

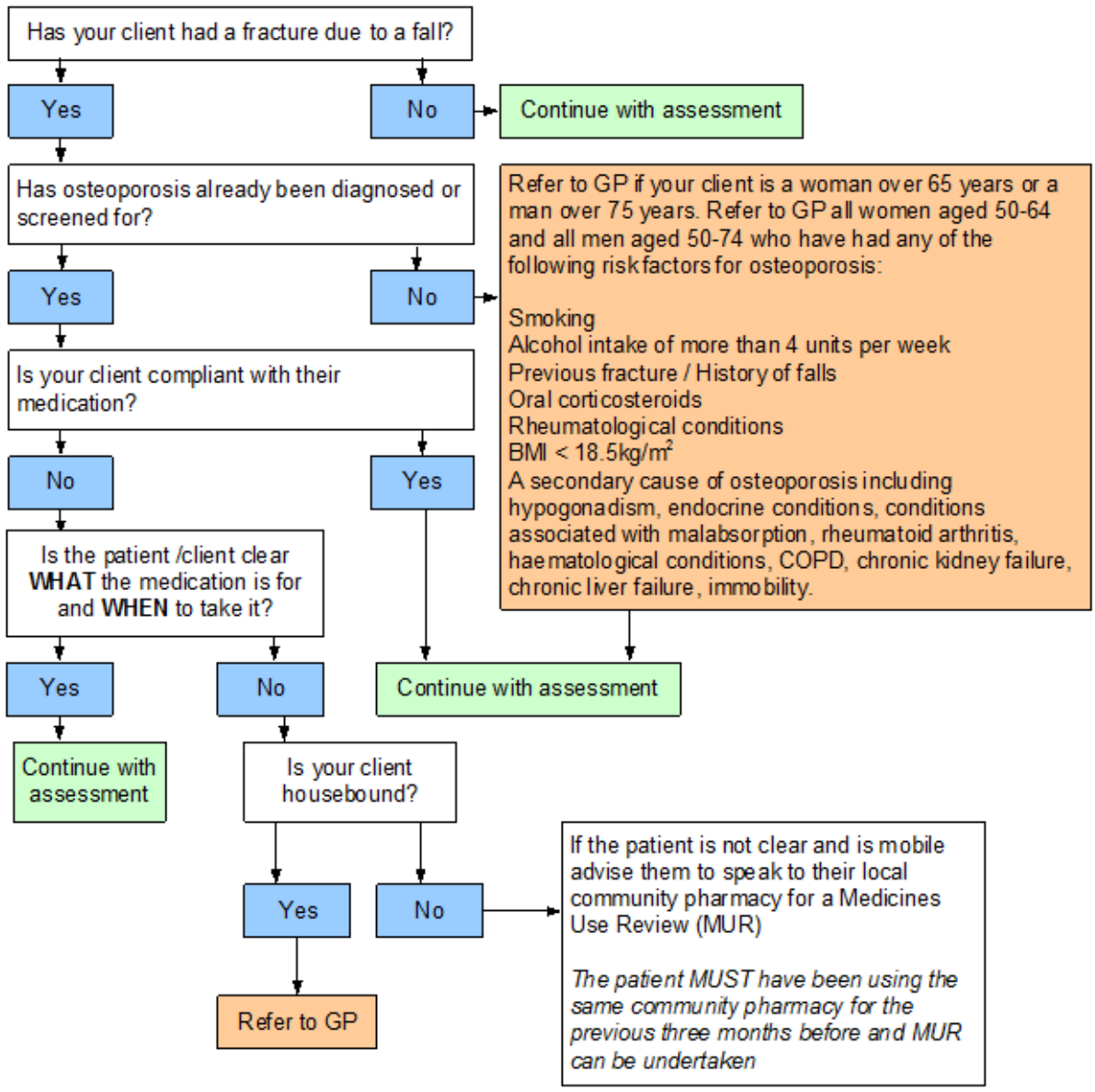


Previous fracture

Introduction:

Direct medical costs from fragility fractures to the UK healthcare economy were estimated at £1.8 billion in 2000, with the potential to increase to £2.2 billion by 2025, most of these relating to hip fracture care. Osteoporosis leads to nearly 9 million fractures annually worldwide, and over 300,000 patients present with fragility fractures to hospitals in the UK each year. Because of increased bone loss after the menopause in women, and age-related bone loss in both women and men, the prevalence of osteoporosis increases markedly with age, from 2% at 50 years to more than 25% at 80 years in women. (NICE 2016)

Action

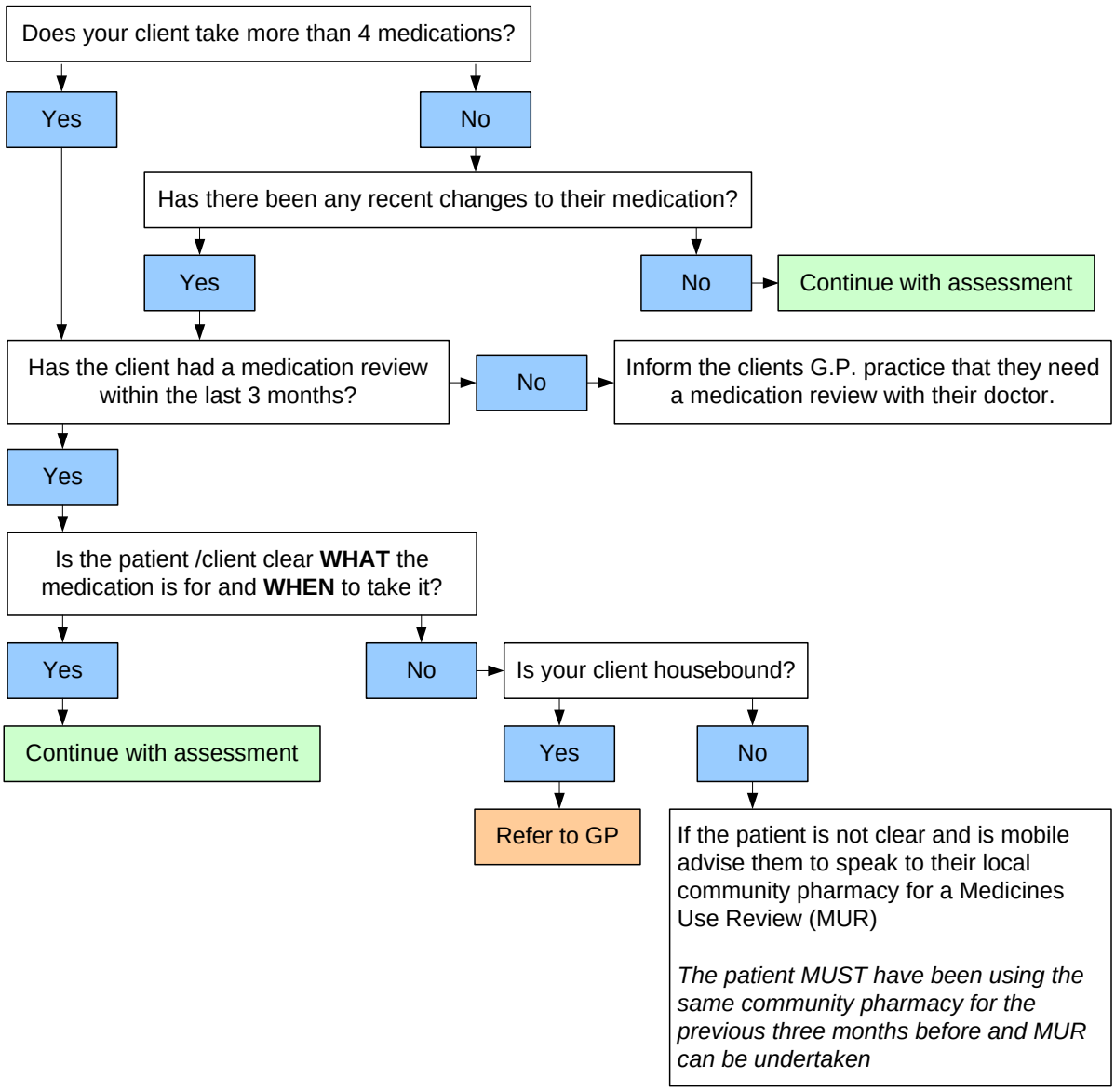


Medication

Introduction:

Patients on **four** or more medicines are at greater risk of having a fall. Taking four or more medications significantly increases the risk of falling because of the potential side effects and the intensity of such side effects. Anyone on more than **four** medicines, especially centrally sedating or blood pressure lowering medication, should have a regular review of their medication.

Action:



More information:

For more information and advice speak to the community pharmacist or if you are employed by:

- The Mid Yorkshire Hospitals NHS Trust contact 01924 [54]1394
- South West Yorkshire Partnership Foundation Trust contact 01924 327619
- NHS Wakefield CCG – Medicines Optimisation Team contact 01924 315744

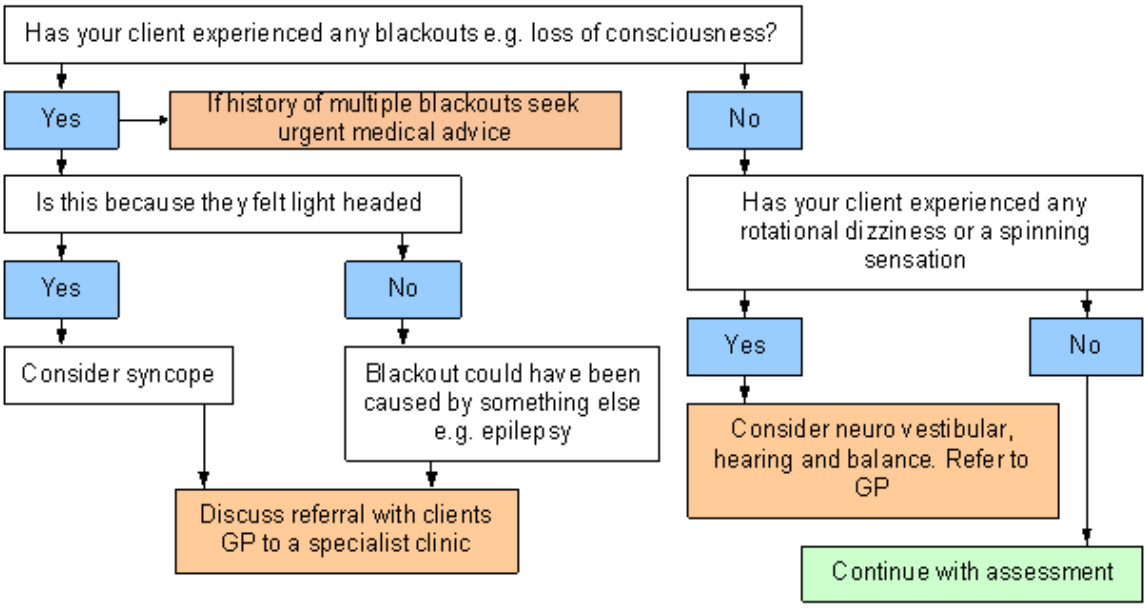
Dizziness

Introduction:

Falls history can play an important role in identifying transient loss of consciousness - syncope. Transient loss of consciousness (TLoC) is very common, it affects up to half of the population in the UK at some point in their lives. TLoC may be defined as spontaneous loss of consciousness with complete recovery. There are various causes of TLoC, including cardiovascular disorders (which are the most common), neurological conditions such as epilepsy, and psychogenic attacks (NICE 2014).

Syncope causes a significant number of falls in older adults, particularly where the falls are sudden and not obviously the result of a trip or slip. Many older adults will only recall a fall and will not realise they have blacked out. Greater awareness of syncope as a cause of falls is key to effective treatment and prevention of recurring falls.

Action:

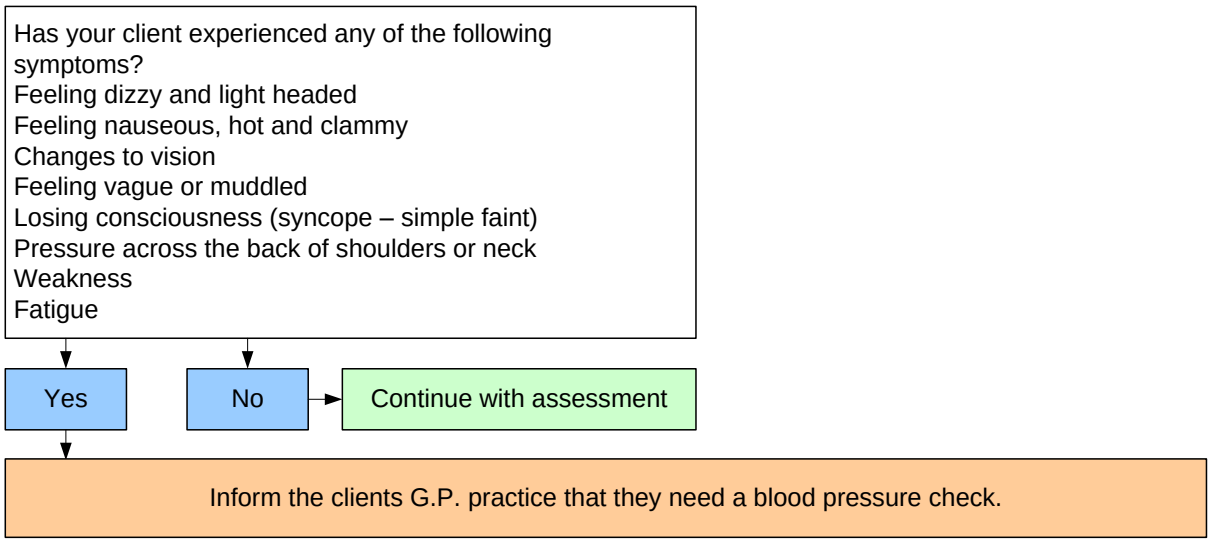


Postural Hypotension

Introduction:

Postural Hypotension is a fall in blood pressure which occurs when changing lying to sitting or sitting to standing. A fall in blood pressure leads to reduced blood supply to organs and can cause a variety of symptoms. This is likely to occur when there is an increased demand on blood e.g. standing/sitting suddenly, in the morning, after meals or alcohol, during exercise, straining on the toilet, illness, anxiety and panic. Certain medications may also worsen/cause Postural Hypotension.

Action:

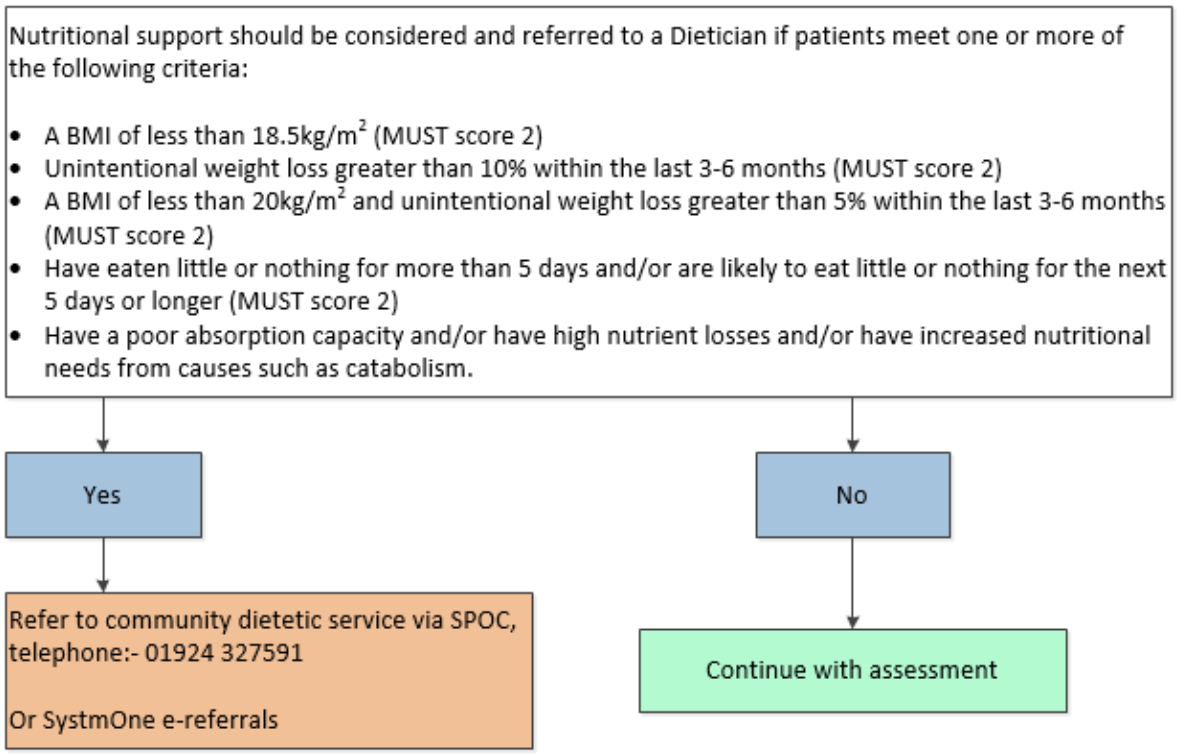


Nutrition and Hydration

Introduction:

Nutrition is an important factor in falls prevention, as frailty and weakness results in loss of muscle mass and strength, limited mobility and malnutrition. Nutrition is related to many risk factors for falls, and has been shown to be a determining factor in not only the severity of injuries from falls, but also recovery time after the injury. Good hydration can assist in preventing or treating dizziness and confusion.

Action:



It is advised that patients are screened using MUST, a validated malnutrition screening tool.

If you are not trained using this tool the following link provides guidance on how to support clients to self-screen.
http://www.malnutritionselfscreening.org/self-screening.html

Please note MY Therapy Dieticians will see patients over 18 requiring a home visit. For those patients able to attend a clinic, they should be referred to Pinderfields Acute Dietetic Service by their clinician on the following number – **01924 543580**

Useful Questions:

Are you drinking less than usual?

Do you need assistance to get a drink?

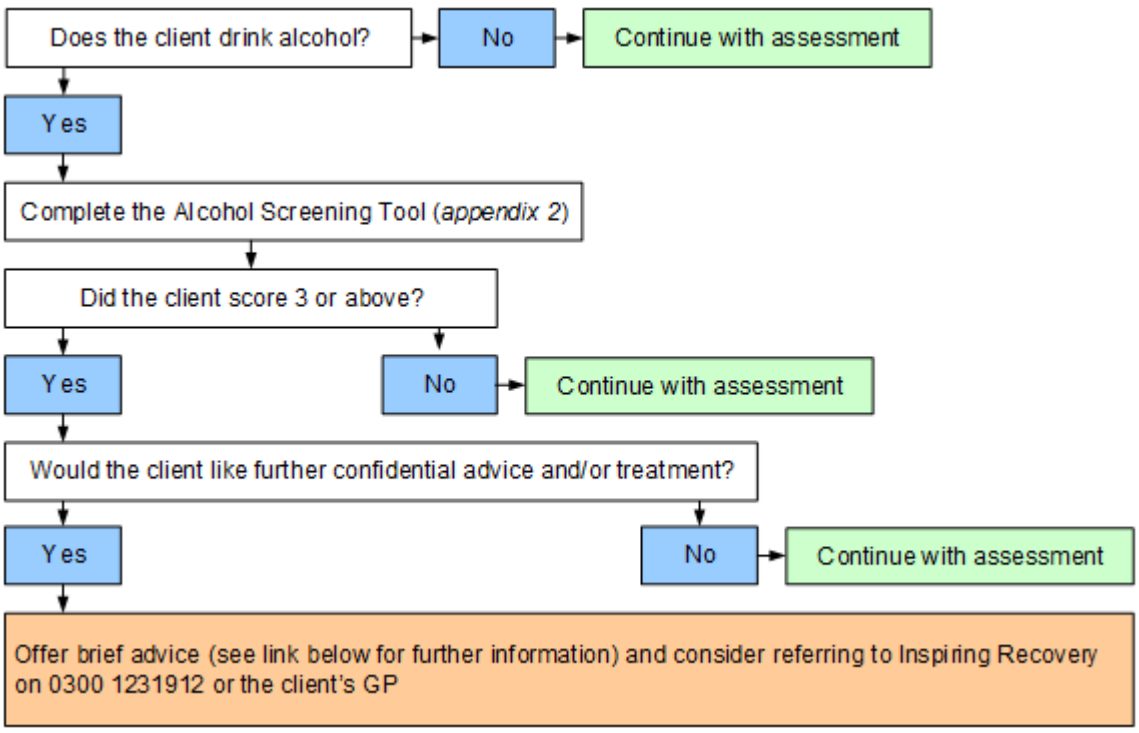
Think Delirium
Single Question in Delirium = 'Do you think the patient has been more confused lately?' Ask a friends or family member.

Alcohol

Introduction:

Wakefield has above average rates of alcohol related hospital admissions (PHE, 2015). Falls injury is one of the top ten diagnosis for alcohol related hospital admissions and accounted for ten percent of admissions attributable to alcohol in 2009/10 (Kanis et al. 2005). There is strong evidence to show that brief interventions are both an effective and cost effective method for reducing alcohol consumption with 1 in 8 people reducing their drinking to lower-risk levels following brief alcohol advice (NHS Y&H 2010). NICE guidance recommends professionals from a range of health and social care settings should screen people who may be at risk of harm from the amount of alcohol they drink (NICE 2010). Those identified as drinking at increasing or higher risk levels should be offered brief advice on alcohol or referred to specialist treatment

Action:



More information:

E learning is available to help professionals with identifying those individuals whose drinking might be impacting on their health and delivering simple, structured advice. Follow the link for more information:
www.alcohollearningcentre.org.uk/eLearning/IBA/platforms/

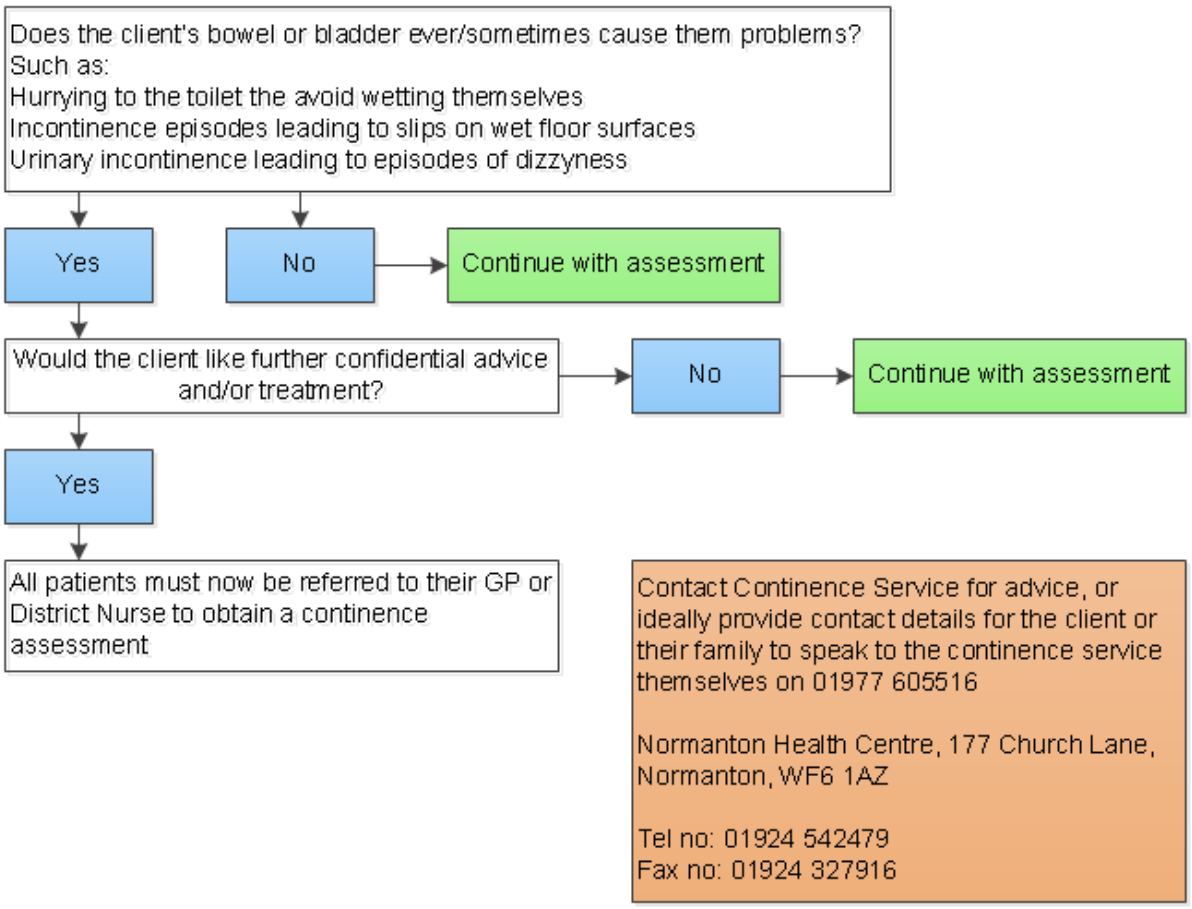
More information can be found at:
www.alcohollearningcentre.org.uk/Topics/Browse/BriefAdvice/
Or
www.nhs.uk/Change4Life/Pages/drink-less-alcohol.aspx

Continence

Introduction:

The wish to avoid being incontinent is such that people will make extraordinary efforts to achieve this, including placing themselves at risk of falling. Firstly, there is the incontinence episode and associated potential for a slip on the soiled or wet floor surface. Secondly, in the presence of urge incontinence, the risk of falling may increase when a person hurries to the toilet. Urinary tract infections can cause incontinence delirium, drowsiness and hypotension.

Action:



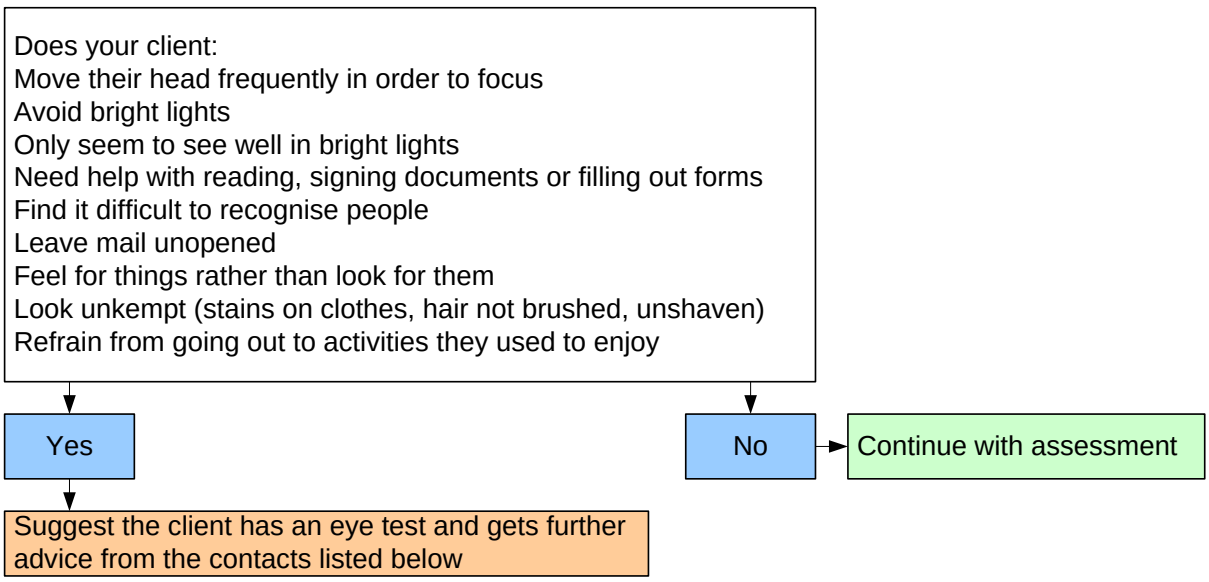
Please note the number for the Continence Service is not always manned and an answering machine may operate, remember to leave a name and contact number.

Vision

Introduction:

Poor vision can increase the risk of falling. An older person with impaired vision may not see hazards, particularly if peripheral vision is limited; may not see the poorly lit bottom step, particularly if depth perception is affected; and may not notice the change from carpet to slippery tiles, particularly if contrast sensitivity is impaired (Campbell 2010). Vision can also play an important role in balance.

Action:



More information:

- ECLO (Eye Clinic Liaison Officers)
    - Wakefield: 01924 541214
    - Pontefract: 07540677014
    - Dewsbury: 01924 512459
    - Ophthalmology Department – 0844 8118110

⇒ Free eye tests in your own home: www.outsideclinic.com tel: 0800 85 44 77

⇒ Royal National Institute for the Blind: www.rnib.org.uk or email helpline@rnib.org.uk 0303 123 9999

⇒ Social Care Direct: Tel: 0845 8 503 503 to make a referral to the Sensory Impairment Team. *The Sensory Impairment Team helps people who have a sight loss or a hearing loss or a combination of both, which affects their safety, independence and well-being.*

⇒ DIAL – Disability Information and Advice Line Tel 01977 723933/4

⇒ Wakefield District Sight Aid – Tel: 01924 215555

⇒ Other sources of help and advice:

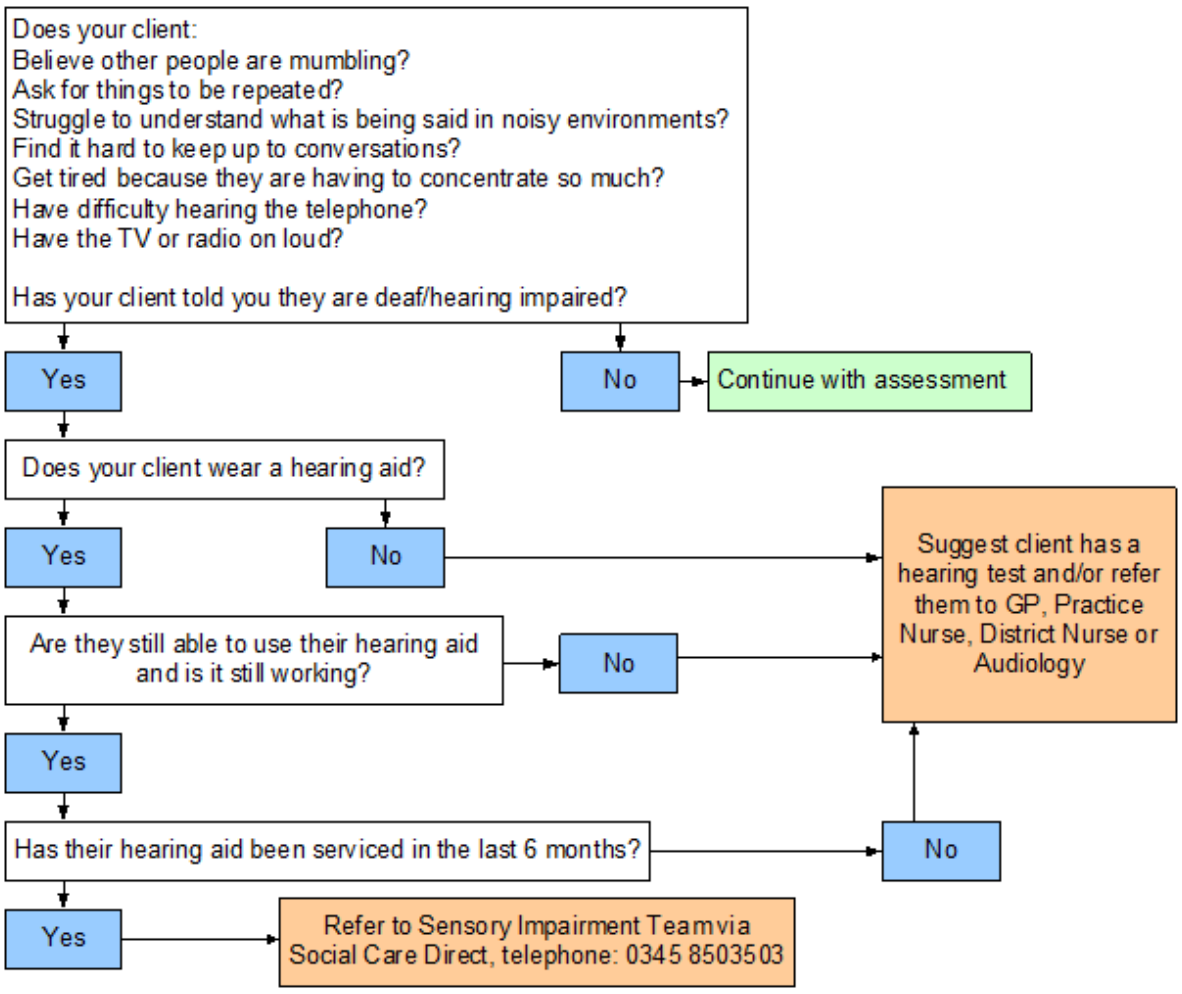
- Age UK Wakefield and District Tel: 01977 552114
- Carers Association Wakefield and District: Tel:01924 305544
- Citizens Advice Bureau Tel: 0844 499 4138
- Live Well Wakefield Tel: 01924 255363

Hearing and balance

Introduction:

A loss of hearing can cause dizziness and balance problems which increase the risk of falling. Hearing also provides sensory information about the environment, enabling us to notice and avoid hazards that may lead to a fall.

Action:



More information:

⇒ Action on Hearing Loss' Helpline: Freephone: 0808 808 0123 Textphone: 0808 808 9000 Visit website www.actionhearingloss.org.uk Or e-mail: information@hearingloss.org.uk

⇒ The Wakefield Deaf Society: Tel: 01924 375958

⇒ DIAL – Disability Information and Advice Line Tel 01977 723933/4

⇒ Telephone Hearing Check: Tel: 0844 800 3838

⇒ Other sources of help and advice

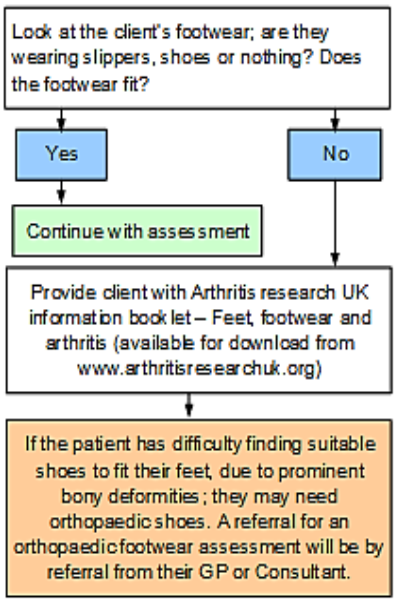
- Age UK Wakefield and District Tel: 01977 552114
- Carers Association Wakefield and District Tel: 01924 305544
- Citizens Advice Bureau: Tel: 0344 411 1444
- Live Well Wakefield Tel: 01924 255363

Footwear and foot care

Introduction:

It is important to always attend to foot problems quickly as this will save discomfort in the future and will reduce the risk of falling.

Action:



Slippers:

Look at the style and condition. Slippers sometimes contribute to falls in the elderly. Slippers need to fit properly and should not be too loose. Backless slippers and slippers with a high heel should be avoided. The features of the ideal slipper are generally the same as for the ideal shoe.

Shoes:

Comfort is the main consideration when choosing shoes. The ideal shoe:

Should be soft and flexible and ideally waterproof.
The toe box should be deep enough to allow wiggling of the toes and be a similar shape to the natural shape of the foot.
The sole should be strong and flexible for grip.
The heel needs to have a broad base for stability
The fastenings should provide a stable fit and allow some flexibility for feet with deformities or swelling.
Fastenings should be laces, buckles, Velcro or zips.

SLIP-ON SHOES ARE OFTEN TOO SMALL AND CAUSE CRAMPING OF THE TOES

Socks and Stockings:

Make sure they are not too tight. Advise to change them every day and keep the feet clean.

Referral Criteria for Podiatry Services

- Dermatological problems
- High risk patients – management and monitoring in Primary Care Clinics of patients presenting with long term complications of systematic conditions e.g. Rheumatoid Arthritis, Peripheral Vascular Disease, Diabetes Mellitus (Amber and Red Risk) etc
- Diabetic Foot Ulcerations (DFU) in accordance with the District Diabetes Foot Integrated Care Pathway
- Nail pathologies which include advice and management of pathological nails and nail surgery using local anaesthetics
- MSK podiatry which includes gait problems in the high risk foot, Podopaediatrics and musculo-skeletal sports injuries

The podiatry service does not provide:

- A social nail cutting service for patients. Nail care provision by a relative / carer should be encouraged in all patients who present with no nail pathology or medical complications to contraindicate this practice. For those patients who require social nail care, we can provide advice for self management on foot / nail care techniques for carers / relatives taking on this responsibility.
- Routine foot screening for patients with diabetes who fall into to the green clasifications (in accordance with the District Diabetes Foot Integrated Care Pathway)

More information:

Contact Podiatry Office: 01924 541447, 541448, 541449

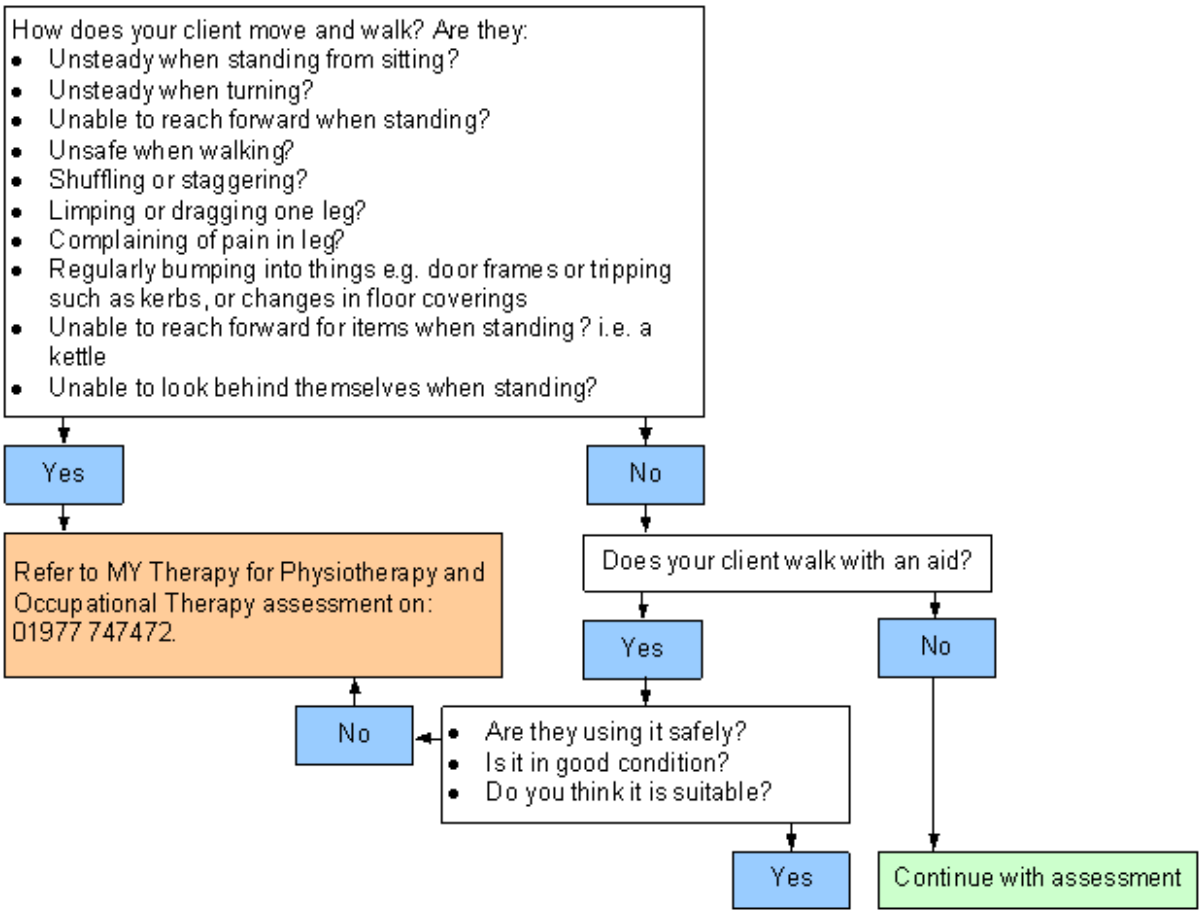
Balance and walking and transfers

Introduction:

Balance impairment and muscle weakness caused by ageing and lack of use are the most prevalent modifiable factors for falls. Evidence suggests that a previous fall and/or gait and balance disorders are the strongest risk factor for falls (NICE 2015).

It is important to assess the client's balance and walking and refer appropriately as this will reduce the risk of falling.

Action:



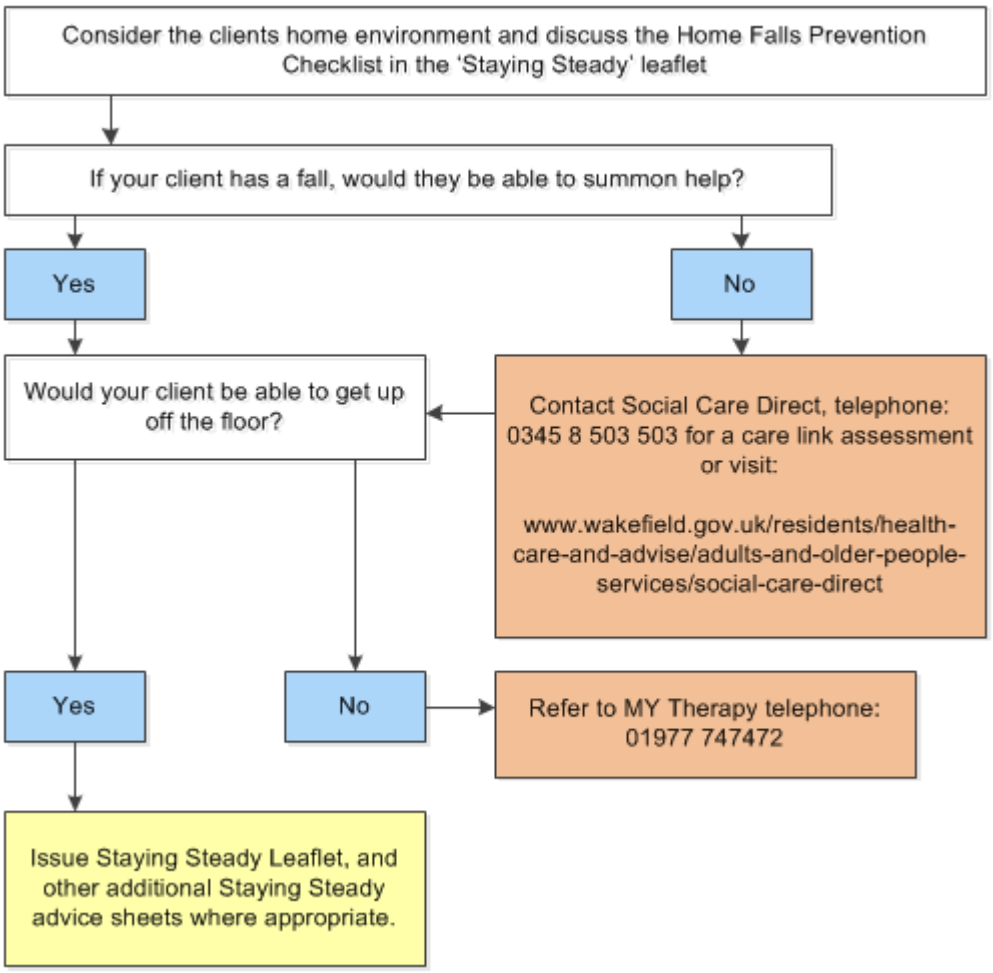
Environment and coping strategies

Introduction:

Falls, slips and trips are the most common type of accident in the home. By taking some sensible precautions most accidental falls can be prevented. Adapting or modifying the home environment is an effective way of reducing the risk of falls for older people living in the community (NICE 2015). A Cochrane Collaboration systematic review on interventions to prevent falls in community dwelling adults found that home hazard assessment and modification carried out by occupational therapists reduced the rate of falls by 19% and the risk of falling by 12%.

Fear of falling can have a negative impact on an individual's health and well-being. When the fear of falling is intense it can prompt the individual to limit or avoid certain activities. This restriction on activities can lead to premature physical and functional decline, and ultimately increase the risk of falls.

Action:



Age UK have a series of leaflets and resources, these are available from www.ageuk.org.uk

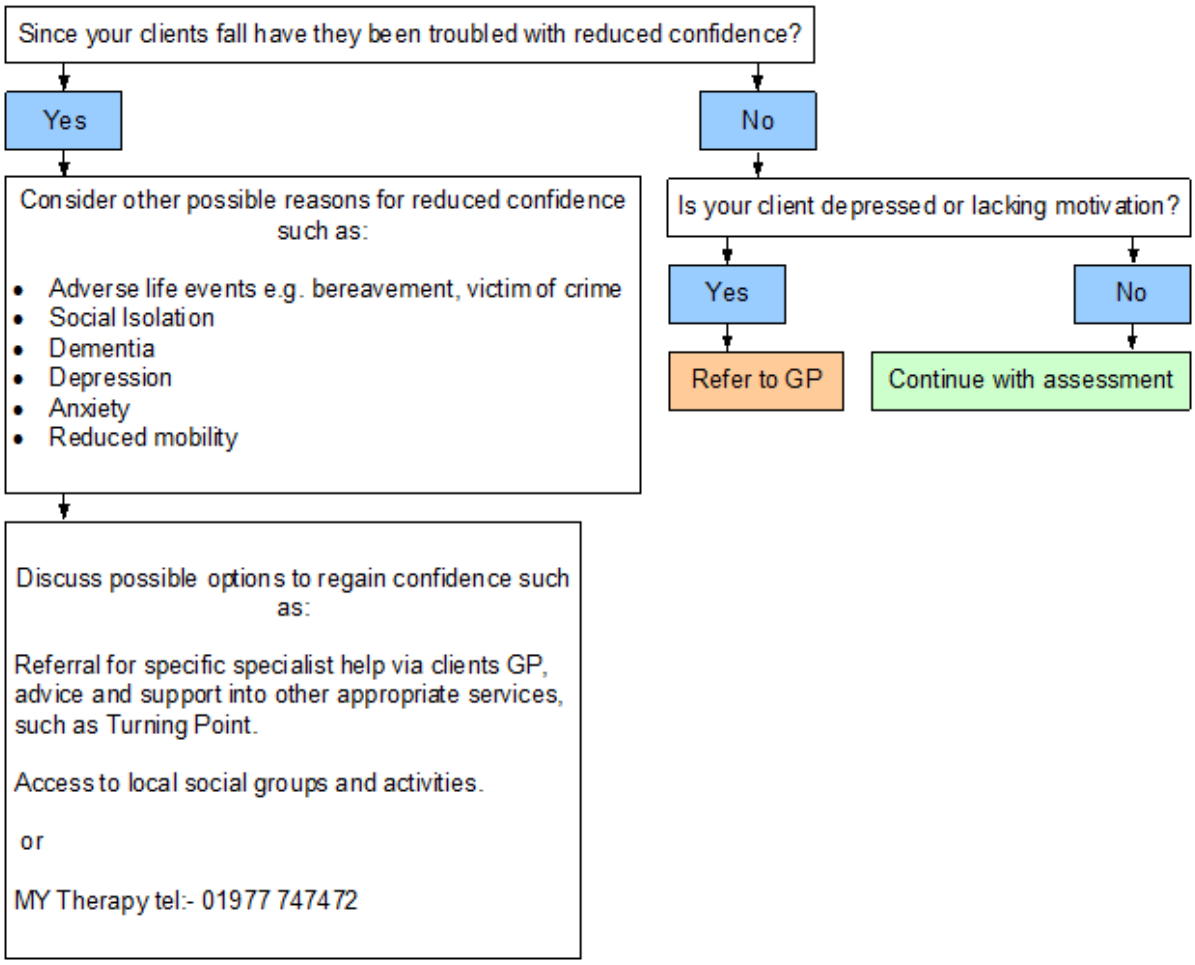
Live Well Wakefield
A service to support adults to improve their health and wellbeing.
Telephone 01924 255363

Mood

Introduction:

The human cost of falling includes distress, pain, injury, loss of confidence, loss of independence and mortality. Falling also affects the family members and carers of people who fall. Therefore falling has an impact on quality of life, health and healthcare costs (NICE 2015).

Action:



More information:

Age UK Wakefield District has an electronic directory of social activity groups and lunch clubs throughout the Wakefield district. Access the directory online on www.ageuk.org.uk or contact Age UK Wakefield District by phone on 01977 552114

Live Well Wakefield
A service to support adults to improve their health and wellbeing.
Telephone 01924 255363

Turning Point Talking Therapies
Turning Point provides free Talking Therapy services to people aged 18 years or older who are registered with a GP surgery in the Wakefield District.
Telephone 01924 234860

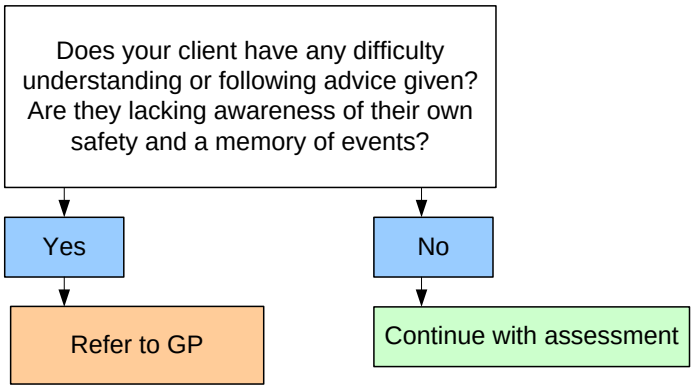
Memory

Introduction:

Problems with concentration and forgetfulness can create the potential for falls. There may be the need to encourage individuals to focus on one action at a time. Encourage those who are prone to forget things to get into a routine of putting them in the same place so that they do not have to rush to find them, or planning their day to reduce the risk of falls due to hurrying.

Single Question in Delirium = 'Do you think the patient has been more confused lately?' Ask a friend or family member.

Action:



More information:

SWYMHT have a home care treatment team. The Rapid Access Service is able to take on patients with mental health diagnoses, confusion, dementia etc. Referral to the service is via the GP, however the service is happy to provide advice or support to any health professional(s) who might need some help with the management of their patient(s) as long as they informed the patients G.P

Rapid Access Service Tel: 01924 327442. The service hours are 8am to 8 pm Mon to Fri, 12 – 8pm Sat/Sun and Bank holidays.

Appendix 1. Falls Diary

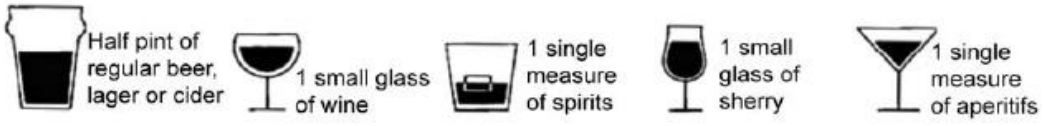
My Falls Diary

Name: ……. DOB:
NHS Number: …… Page No.

Date of fall	Time of day (am/pm night)	Did you hurt yourself, if so how?	Why do you think you fell?	What did you do/or have you done to prevent it happening again?	How do you feel about it?

Appendix 2. Alcohol Screening Tool

This is one unit of alcohol…



…and each of these is more than one unit

AUDIT – C

Questions	Scoring system					Your score
	0	1	2	3	4	
How often do you have a drink containing alcohol?	Never	Monthly or less	2 - 4 times per month	2 - 3 times per week	4+ times per week	
How many units of alcohol do you drink on a typical day when you are drinking?	1 -2	3 - 4	5 - 6	7 - 9	10+	
How often have you had 6 or more units if female, or 8 or more if male, on a single occasion in the last year?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily	

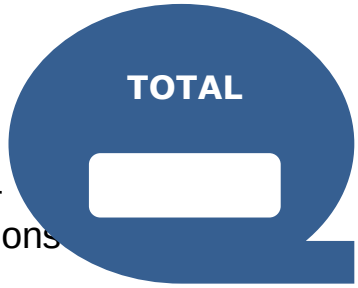
Scoring:
A total of 5+ indicates increasing or higher risk drinking.
An overall total score of 5 or above is AUDIT-C positive.

Score from AUDIT- C (other side)

Remaining AUDIT questions

Questions	Scoring system					Your score
	0	1	2	3	4	
How often during the last year have you found that you were not able to stop drinking once you had started?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily	
How often during the last year have you failed to do what was normally expected from you because of your drinking?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily	
How often during the last year have you needed an alcoholic drink in the morning to get yourself going after a heavy drinking session?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily	
How often during the last year have you had a feeling of guilt or remorse after drinking?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily	
How often during the last year have you been unable to remember what happened the night before because you had been drinking?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily	
Have you or somebody else been injured as a result of your drinking?	No		Yes, but not in the last year		Yes, during the last year	
Has a relative or friend, doctor or other health worker been concerned about your drinking or suggested that you cut down?	No		Yes, but not in the last year		Yes, during the last year	

Scoring: 0 – 7 Lower risk, 8 – 15 Increasing risk,
16 – 19 Higher risk, 20+ Possible dependence



TOTAL Score equals
AUDIT C Score (above) +
Score of remaining questions