ASK

Many older people who have fallen don't talk about it.

1 Have you slipped, tripped or fallen in the last year?

2 Can you get out of a chair without using your hands?

3 Have you avoided some activities because you might lose your balance? Do you worry about falling?

Looking and listening as a skilled health professional... What do you see? What is not being said?

ASSESS

Check with the older person and their family/whānau about what they see as problems and risks.

Assess falls risk factors related to:

			Refer for specialist input as needed. Put interventions and supports in place to:
	Address identified risk factors with specific actions		
PHYSICAL ACTIVITY	Balance, strength and gait	▶	Enhance balance and strength
	Mobility	▶	Improve or assist mobility
	Muscle strength (especially lower limb)	▶	Prescribe vitamin D supplements if at risk of deficiency
	Feet and/or shoes	▶	Address foot problems and ensure safe footwear
UNDERLYING CONDITIONS	Medicines (especially psychotropics)	▶	Review and optimise medicine use
	Dizziness or postural hypotension	▶	Manage and monitor hypotension
	Cognition	▶	Put in place measures for orienting the person and reducing delirium risk
	Vision	▶	Optimise vision
	Continence problems	▶	Manage continence problems
	Any other health problems that may increase the risk of falling	▶	Address other health problems
	Home safety	▶	Optimise home safety

ACT

Talk with the older person and their family/whānau about what they think will be most helpful.

IN HOSPITAL:

- **Regard** all older patients as being at risk of falling, as well as any other patients where an underlying condition puts them at risk.
- For all patients at risk, **consider** systematic assessment of risk factors and individualised interventions.

IN THE COMMUNITY:

- **Ask** older people whether they have fallen in the past year – enquire about the frequency, context and characteristics of the fall/s.
- **Offer** systematic assessment of risk factors and individualised interventions for older people at risk.

RESOURCES

Ask, Asses, Act pocket cards and posters available from:
www.livestronger.org.nz/home/resources
Help sheet, patient letter and related online learning activities available from:
www.hqsc.govt.nz/our-programmes/reducing-harm-from-falls

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ASK

- Are there obvious or hidden **injuries**?
- Do any of these **factors** make this person more susceptible to injury?

A = **A**ge or frailty

B = **B**ones (fracture risk or history)

C = anti**C**oagulation (blood thinning medicines such as aspirin or warfarin)

- What **monitoring, investigation** or **clinical referral** is needed?
- Who should be **informed** of this fall (family/whānau, senior staff)?

ASSESS/REASSESS

- Falls **risk factors** in the light of this incident.

ACT

- Implement or modify **individualised interventions** for identified falls risk factors.
- **Involve** the older person and their family/whānau in the plan of care.

COMPLETE

- Case notes.
- Incident report (according to policy).
- ACC45 Injury Claim Form (even if no apparent injury – to cover delayed diagnosis and/or community support).

CARE AFTER A FALL

IS THE OLDER PERSON IN YOUR CARE AT RISK OF FALLING?

- Falls are the leading cause of injuries to older people.
- One out of three older people has a fall each year, and the likelihood of falling increases with advancing age.
- Underlying conditions or problems with balance, strength or mobility increase the risk of falling for older people.

By using **ASK, ASSESS, ACT** you can identify older people at risk of falling and help keep them safe.

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Fold 1 Fold 2 Fold 3

1 2 3 4 5