OLDER ADULTS

Falls risk assessment in older patients in hospital

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Conflict of interest
None declared

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Aims and intended learning outcomes
This article aims to provide an overview of the risk assessment tools used to identify risk factors for falls in hospital inpatients aged 65 years and over. After reading this article and completing the time out activities you should be able to:
» Discuss the incidence of falls
associated with hospitalisation
among older inpatients.
» Describe the physical, psychological,
social and economic consequences of
falls for older inpatients.
» List the risk factors for falls for older
inpatients.
» Explain the aims and characteristics of
risk screening tools designed to identify
individuals who are at increased risk
of falls.
» Explain the aims and characteristics of
risk assessment tools designed to
identify individual risk factors for falls in
older inpatients.

» Identify the core components of a
multifactorial falls risk assessment tool
for older inpatients.

Abstract
Falls are the most frequent adverse event reported in hospitals, usually affecting older patients. All hospitals in NHS organisations develop risk prevention policies that include falls risk assessment. Falls risk assessment involves the use of risk screening tools, aimed at identifying patients at increased risk of falls, and risk assessment tools, which identify a patient’s risk factors for falls. Various risk screening tools have been used in clinical practice, but no single tool is able to identify all patients at risk of falls or to accurately exclude all those who are not at risk of falls. Guidelines recommend that patients aged 65 years and over who are admitted to hospital should be considered at high risk of falls and that a multifactorial falls risk assessment should be performed. Therefore, falls risk assessment tools should be used to identify the risk factors for each inpatient aged 65 years or over, in order to determine the most appropriate care plan for falls prevention and to maximise patient mobility and independence.

Keywords
falls, falls risk assessment, falls risk assessment tools, falls risk prevention, older people, patient safety, risk assessment, risk prevention

Introduction
Falls are the most frequent adverse events occurring in hospital. More than 200,000 falls in England and Wales were reported by acute hospitals to the National Reporting and Learning System in the 12 months to the end of September 2009 (National Patient Safety Agency (NPSA) 2010 (On June 1 2012, the key functions and expertise for patient safety developed by the National Patient Safety Agency (NPSA) transferred to the NHS Commissioning Board Special Health Authority (www.england.nhs.uk/patientsafety)). In a national audit of inpatient falls, the rate of falls among older inpatients ranged from 0.82 to 19.20 falls per 1,000 occupied bed days, with a mean rate of 6.63 falls per 1,000 occupied bed days (Royal College of
Physicians (RCP 2015). It should be noted that not all falls are reported, especially when there is no harm to the patient. Therefore, it is likely that falls rates are underestimated (Shorr et al 2008).

Falls can occur in patients of any age. However, older inpatients are increasingly vulnerable to falls because of their general frailty, which is associated with the effects of acute and chronic illnesses, treatments and the hospital environment. In reported hospital falls where age was provided, 82.2% of falls occurred in patients aged 65 years and over and 67.6% of falls occurred in patients aged over 75 years (NPSA 2010). Approximately 31% (64,747/208,338) of inpatient falls result in physical injury, for example contusion, laceration, fractures, brain injury and patient death (NPSA 2010). In a national audit of inpatient falls, the mean rate of falls resulting in moderate harm, severe harm and death was 0.19 per 1,000 occupied bed days, with a range of 0.01-2.00 (RCP 2015). A fall may have psychological, social, and economic effects, in addition to physical effects, such as fear of falling, anxiety, depression, loss of self-confidence, a prolonged stay in hospital and increased healthcare costs (Healey et al 2008, RCP 2015).

TIME OUT 1
What is the rate of falls occurring in patients aged over 65 years in your ward or hospital? If you work in the NHS, locate the data related to your organisation at: www.rcplondon.ac.uk/projects/outputs/naif-audit-report-2015 (RCP 2015). Compare the falls rate per 1000 occupied bed days and the falls rate resulting in moderate harm, severe harm and death per 1,000 occupied bed days for your organisation with the national data of a mean rate of 6.63 falls per 1,000 occupied bed days, and a mean rate of falls resulting in moderate harm, severe harm and death of 0.19 per 1,000 occupied bed days (RCP 2015). What are the possible reasons for differing falls rates in NHS organisations?

A fall can be defined as ‘an event that results in a person coming to rest inadvertently on the ground or floor or other lower level’ (World Health Organization 2012). There are various ways in which a fall may be classified. An intrinsic fall results from factors related to patient conditions, whereas an extrinsic fall results from factors external to the patient, for example environmental factors (Masud and Morris 2001). An explained fall is one in which it is possible to identify the cause or causes of the fall, for example a syncope, slip or trip, while an unexplained fall has no apparent cause. A fall may be single or recurrent, depending on the frequency of occurrence. An injurious fall is one that leads to physical harm, while a non-injurious fall does not (Masud and Morris 2001). The National Reporting and Learning System grade the degree of harm caused by a fall as follows (NPSA 2007):

- No harm – when no consequences occur.
- Low harm – when a fall leads to limited consequences and minor treatments are required.
- Moderate harm – when a treatment is requested but a full recovery is expected.
- Severe harm – when a fall causes a permanent disability or reduces patient independence.
- Death – when the patient’s death is directly related to a fall.

TIME OUT 2
Consider how the risk factors for falls might be classified. List the risk factors for falls in older inpatients that you think are most important.

Risk factors for falls in older inpatients
More than 400 risk factors are associated with falls, many of which are modifiable (Masud and Morris 2001). Risk factors for falls are often classified into two categories: intrinsic risk factors which are related to patient conditions, and extrinsic risk factors which are related to environmental or organisational factors (Masud and Morris 2001). It important to note that falls among older inpatients are often caused by a synergic combination of intrinsic and extrinsic risk factors.

Several intrinsic risk factors are relevant for older people. Many
age-related chronic conditions are associated with an increased risk of falls. For example, Parkinson’s disease causes musculature and joint rigidity, slowness in initiating movement and postural instability. Stroke, degenerative joint diseases and arthritis may also cause muscle weakness or impair balance or gait. Older patients with diabetes are at increased risk of falls compared to patients who do not have diabetes. Other conditions associated with an increased risk of falls include: altered mental status, confusion, delirium, cognitive impairment, urinary incontinence, depression and postural hypotension (Todd and Skelton 2004).

Visual impairment is an important falls risk factor; older patients with suboptimal vision as a result of cataract, glaucoma or macular degeneration are increasingly likely to fall and experience fractures as a result (Todd and Skelton 2004). Bifocal or multifocal lenses often contribute to the risk of falls because they alter perception of distances (Todd and Skelton 2004). Medication taken by patients is an important risk factor, especially psychotropic, antipsychotic and antidepressant, antidiabetic, antiarrhythmic, antihypertensive, diuretic and hypnotic medication. The risk of falls increases if the patient is taking more than four medications, irrespective of the types of medication (Todd and Skelton 2004).

Fear of falling has been shown to correlate with suboptimal postural performance, slower walking speed and muscle weakness (Todd and Skelton 2004). Foot problems, for example bunions, toe deformities, ulcers, deformed nails and pain when walking can compound difficulties in maintaining balance, thus increasing the risk of falls (Todd and Skelton 2004). Non-medical factors associated with healthcare may also increase the risk of falls, such as a prolonged hospital stay, a history of falls or care dependency (Zhao and Kim 2015). The environmental risk factors that frequently contribute to falls in older inpatients include: low or inadequate lighting, slippery floors, badly fitting footwear or clothing, bed rails and assistive devices, such as sticks, walking frames or wheelchairs. Characteristics of care staff and the care setting can also contribute to falls in older inpatients. Falls occur more frequently in older people’s units, internal medicine and neurological units, mostly during shift changes or during night and evening shifts (Zhao and Kim 2015). Certain patient activities are associated with an increased risk of falls, such as walking, transferring, for example from sitting to standing position, or attending to urinary or bowel elimination needs (Zhao and Kim 2015).

TIME OUT 3
Are you familiar with the policy for the prevention and management of falls in your practice setting? Consult the falls prevention policy document for your hospital or healthcare organisation and describe the falls risk assessment strategy.

Falls prevention programmes
Older people can be admitted to most hospital wards, including surgical wards and medical wards. Therefore, the issue of falls among older inpatients is relevant to all clinical staff, hospital administrators and managers. All hospitals in NHS trusts have falls prevention policies that are designed for all patients. However, particular attention is given to patients aged 65 years and over (RCP 2015). Local falls prevention policies often refer to national guidelines, such as those promulgated by the National Institute of Health and Care Excellence (NICE) (2013) or the NPSA (2010). However, local policies may differ in the interventions recommended, the resources involved and the level of integration with related hospital policies, for example delirium or dementia policies (RCP 2015).

Falls risk assessment strategies are the first stage in any falls prevention programme. Early identification of older inpatients who are at increased risk of falls on admission and during their hospital stay is essential in enabling...
healthcare staff to implement effective and timely preventive measures to reduce the incidence of falls and their consequences (American Geriatrics Society et al. 2001, Perell et al. 2001). Most falls prevention programmes require the use of specific tools to assess the risk of falls. Two types of tool are frequently used to assess the risk of falls in hospital: falls risk screening tools and falls risk assessment tools. The terms screening and assessment are often used interchangeably. However, the aims and characteristics of assessment and screening tools differ significantly (Haines et al. 2007, Oliver and Healey 2009, NICE 2013).

Falls risk screening or prediction tools, sometimes known as falls risk scores, aim to identify patients at high risk of falls among those admitted to a ward, so that preventive interventions targeted for their specific falls risk level can be implemented. Falls risk screening tools can also be used to identify patients for whom a comprehensive multifactorial falls risk assessment should be performed. The screening tools usually consist of a list of risk factors with a numerical value assigned to the presence or absence of each factor; the sum of all values provides the tool score. This indicates if a patient is at risk of falls, by either a ‘yes’ or ‘no’, or identifying their level of risk as high, medium or low (Haines et al. 2007, Oliver and Healey 2009).

Falls risk screening tools may consider risk factors that include: the patient’s physiological condition; sensory deficits; impaired mobility and/or elimination; mental health status, for example depression; the presence of acute or chronic illnesses; the types, number, and dosage of medications; and past history of falls. Falls risk screening tools may include a physical assessment of the patient’s health condition and mobility functions in addition to self-reported risk factors. For example, clinicians can put the patient through a ‘get-up and go’ test, in which a patient is observed rising from a chair, walking 10ft, then returning to the chair and sitting down. The patients are scored on their performance to assess their risk of falls (Mathias et al. 1986). Falls risk screening tools can be administered by nursing staff or other healthcare personnel at admission and should be updated regularly, or whenever there is a change in the patient’s condition (Oliver and Healey 2009).

Falls risk assessment tools aim to identify the risk factors present, and manage these to reduce the likelihood of falls for the patient. These tools usually include a list of falls risk factors that should be assessed, together with a care plan devised for each factor identified. The risk factors included may be intrinsic, for example clinical conditions, confusion or delirium, medications, postural hypotension, vision or hearing impairment, or extrinsic, for example footwear or walking aids (Haines et al. 2007, Oliver and Healey 2009). These tools are not intended to provide a measurement of falls risk. Therefore, a score is not calculable. Falls risk assessment tools should be used by nurses or other healthcare professionals with appropriate skills and experience at patient admission (NICE 2013).

**TIME OUT 4**

What falls risk screening tools and falls risk assessment tools are used in your practice setting? List the risk factors considered in these tools.

**Falls risk screening tools**

Various screening tools have been developed to identify patients at risk of falls in hospitals. The following falls risk screening tools are frequently used in NHS hospitals: the St Thomas risk assessment tool in falling elderly inpatients (STRATIFY) (Oliver et al. 1997); the Conley scale (Conley et al. 1999); the Morse Fall scale (Morse et al. 1989); the Falls Risk Assessment Tool (FRAT) (Nandy et al. 2004); and the NPSA scale (NPSA 2007) (Table 1). STRATIFY was developed to assess the risk of falls in the older population. It considers five risk factors: recent history of patient falls, patient agitation, visual...
impairment, frequency of toileting, and transfer and mobility abilities. Patients who score above 2 are identified as being at high risk of falls (Oliver et al 1997). The Conley scale comprises six risk factors: a history of falls, dizziness or vertigo, altered elimination, the use of walking aids, cognitive impairment and agitation. A score above 2 identifies patients at risk of falls (Conley et al 1999). The Morse Fall scale assesses six risk factors: a history of falls, the presence of a secondary diagnosis, the use of mobility aids, intravenous therapy, patient gait and mental status. A score above 45 identifies patients at risk of falls (Morse 2008). The FRAT assesses five risk factors: a history of falls, the number of patient medications (four or more), a history of Parkinson’s disease or stroke, problems with balance and problems rising from a chair. A score of 3 or more identifies patients at risk of falls (Nandy et al 2004). The NPSA scale evaluates four factors: a general history of falls, a fall that occurred during the current hospitalisation, unsteady or unsafe patient mobility with or without walking aids when the patient is trying to walk alone and fear of falling. A ‘yes’ to any of these factors identifies the patient as being at risk of falls (NPSA 2007).

Hospitals may use and develop other falls risk screening tools that are customised by the experience of local healthcare personnel and/or the type of patients admitted. Such screening tools may be integrated into electronic health records or be added as a supplementary document to the patient clinical record. Falls risk screening tools differ in the type and number of risk factors considered. The only risk factor common to the five most frequently used tools is the history of falls (Table 1). These screening tools give different value and weight to various risk factors, as described in the studies that developed them. Therefore, they screen the population in different ways.

The predictive capacity of a falls risk screening tool to identify patients at risk is a crucial aspect of any screening tool, since this determines its effectiveness and clinical use. Various studies in clinical practice have attempted to identify which screening tool identifies most accurately inpatients at risk of falls. An ideal falls risk screening tool would identify all patients at risk of falls (100% sensitivity), as well as identifying all those not at risk of falls (100% specificity). A sensitivity and specificity of 70% is indicated as the minimum accuracy value for a screening tool.

<table>
<thead>
<tr>
<th>TABLE 1. Risk factors included in falls risk screening tools</th>
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<tr>
<td>Risk factors</td>
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<tr>
<td>History of falls</td>
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<td>Patient agitation</td>
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<tr>
<td>Visual impairment</td>
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<tr>
<td>Frequency of toileting or altered elimination</td>
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<tr>
<td>Transfer and mobility abilities or gait</td>
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<tr>
<td>Dizziness or vertigo</td>
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<tr>
<td>Use of walking aids</td>
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<td>Cognitive impairment or mental status</td>
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<td>Disease or comorbidity</td>
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<tr>
<td>Therapeutic devices</td>
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<tr>
<td>Medication</td>
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<tr>
<td>Fear of falling</td>
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</table>

(STRATIFY: the St Thomas risk assessment tool in falling elderly inpatients (Oliver et al 1997); the Conley scale (Conley et al 1999); the Morse Fall scale (Morse et al 1989); FRAT: the Falls Risk Assessment Tool (Nandy et al 2004); NPSA: National Patient Safety Agency scale (NPSA 2007)).
tool. However, none of the screening tools described in Table 1 have 70% sensitivity or specificity (Perrel et al 2001, Oliver et al 2004, NICE 2013, Matarese et al 2015).

The accuracy of a falls risk screening tool can be affected by many factors, including: the characteristics and health conditions of older people admitted to the ward (patient case mix), the nursing and support staff employed, the nurse-patient ratio, the specific skills and training of healthcare personnel, the existence of falls prevention measures and the environmental characteristics of the ward (Matarese et al 2015).

Limitations
The NICE (2013) clinical guideline, Falls in Older People: Assessing Risk and Prevention recommends that falls risk screening tools should not be relied on to assess the falls risk for inpatients aged 65 years and over. It recommends that all older patients admitted to hospital be considered at risk of falls and that they should therefore undergo a multifactorial falls risk assessment (NICE 2013). Older people acquire falls risk factors when hospitalised, even if they were fit and capable before admission. Acute illness, delirium, cardiovascular disease, impaired mobility and new medication may combine with an unfamiliar hospital environment to increase the risk of falls (NICE 2013).

Falls risk assessment tools
A multifactorial falls risk assessment is typically performed using specific tools that cover a range of risk factors. There are no standardised multifactorial falls risk assessment tools. Therefore, healthcare organisations may develop their own tools based on research evidence and national guidelines (RCP 2015). The multifactorial falls risk assessment should be carried out as soon as possible after admission, or as soon as the patient’s condition permits. When a risk factor is confirmed, remedial actions are suggested or reference is made to a specific plan of care, for example a delirium or osteoporosis risk protocol. The NICE (2013) guideline recommends including the following factors in the hospital’s multifactorial falls risk assessment tool: cognitive and visual impairment, continence problems, a history of falls, mobility problems, medications, balance and postural problems, health problems, and syncope syndrome.

Cognitive impairment should be assessed using standardised tools, such as the Mini-Mental State Examination (MMSE) or the Abbreviated Mental Test (AMT) score to identify cognitive problems, which may be caused by dementia or delirium. A MMSE score under 10 indicates marked severe cognitive impairment, which is likely to require 24-hour supervision. An AMT score of under 4 indicates severe impairment. Delirium may also be assessed using the Confusion Assessment Method or other specific tools. Falls teams should consult with dementia and delirium teams, if available, to ensure optimum treatment of these high-risk patients.

The patient’s ability to read and recognise objects from the end of the bed or across the room can be used as a test of visual impairment. It is also necessary
to check if the patient uses spectacles or bifocals and if these cause any visual disturbance. If vision problems exist, the patient should be formally assessed by a specialist. Patients with urinary and/or faecal incontinence can be asked about frequency and urgency, nocturia, and whether supervision or help to reach the toilet is required. The cause of incontinence should be investigated, and a urinalysis should be performed if there are signs of urinary tract infection.

Previous falls are a significant predictor of future falls. For this reason, healthcare professionals should always ask whether the patient has fallen in the past, how frequently falls occur, the context and characteristics of any falls, whether any injuries resulted and if the patient has a fear of falling. A specific fear of falling tool may be used. If the patient is unable to provide such information, their family, friends or patients or carers should be interviewed.

Older patients may experience postural hypotension, as a result of physiological changes resulting from the ageing process, cardiovascular disease or the effects of medications. Postural or orthostatic hypotension is diagnosed when the systolic blood pressure drops by at least 20mmHg or the diastolic blood pressure drops by at least 10mmHg within 3 minutes of standing (Freeman et al 2011). The risks associated with balance and postural problems can be modified by reviewing medication, control of fluid intake and patient education on how to stand up slowly. The patient’s medications should be reviewed with particular attention given to medications that are likely to increase their falls risk, for example central nervous system medications such as antidepressants and hypnotics, and cardiovascular agents such as antihypertensives and diuretics. A pharmacist or doctor should be consulted to review any prescriptions.

Postural instability and problems with gait, balance and mobility can be assessed by observing the patient or through a performance test, such as a ‘get-up and go’ test or any other gait or balance test, appropriate to the health condition of the patient. Physiotherapy staff can provide a comprehensive assessment of the patient’s balance and mobility. Footwear should be checked for secure fit and non-slip soles, and to make sure there are no trailing shoelaces. The hospital should supply appropriate footwear to patients who are without relatives or friends to provide them. General foot care and nail condition should also be evaluated, and a podiatrist should be consulted if necessary.

Syncope syndrome or sudden loss of consciousness can be caused by decreased cerebral blood flow, metabolic factors or cardiovascular problems. Certain medications, such as diuretics, beta and alpha blockers, angiotensin-converting enzyme inhibitors or calcium-channel blockers, can also cause syncope (Mets 1995). The patient’s health should be evaluated to identify acute or chronic illnesses that may cause syncope, and all medications should be reviewed.

Risk assessment tools may also consider additional factors. For example, it is necessary to identify all patients who require walking aids and ensure they have access to appropriate aids on admission to the ward. Osteoporosis risk factors may also be assessed, for example using the FRAT, according to hospital policy. A multifactorial falls risk assessment should identify the patient’s personal risk factors for falls in hospital and these factors should be treated, improved or managed during the patient’s hospital stay (NICE 2013). As well as the patient’s intrinsic risk factors, the environment should also be assessed, including flooring, lighting, furniture and fittings such as hand rails. Some falls prevention policies include an assessment tool to evaluate the possible environmental hazards, for example the height of beds or chairs, levels in ward rooms, and accessibility to the call bell.

**TIME OUT 5**
Which risk factors recommended by the NICE (2013) clinical guideline are included in the multifactorial falls risk assessment in use in your workplace?

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**KEY POINT**
‘Previous falls are a significant predictor of future falls. For this reason, healthcare professionals should always ask whether the patient has fallen in the past, how frequently falls occur, the context and characteristics of any falls, whether any injuries resulted and if the patient has a fear of falling. A specific fear of falling tool may be used’
Conclusion
A risk assessment for older inpatients at risk of falls is an important aspect of hospital falls prevention policies. Assessment must occur promptly on patient admission and should be repeated at regular intervals during the patient’s stay in hospital, or when their health condition changes. Various falls risk screening tools are used in hospitals to classify older patients at risk of falls. However, research has shown that none of these tools are accurate enough to identify all older inpatients at high risk of falls. Therefore, the NICE (2013) and AHRQ (2013) guidelines recommend that all inpatients aged 65 years and over should be considered at high risk of falls and that a multifactorial falls risk assessment is carried out for all these patients. The multifactorial falls risk assessment may be performed using specific risk assessment tools, often created at the healthcare organisation level. NICE (2013) indicates that a multifactorial falls risk assessment tool should include the following risk factors: cognitive and visual impairment, impaired continence, history of falls, impaired mobility or balance, medications, health issues and syncope syndrome.

TIME OUT 6
Now that you have completed the article you might like to write a reflective account in preparation for revalidation.

References


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Falls risk assessment
TEST YOUR KNOWLEDGE BY COMPLETING SELF-ASSESSMENT QUESTIONNAIRE 854

1. A potential consequence for the patient of falls in hospital is:
   a) Physical harm  □
   b) Loss of self-confidence □
   c) A longer stay in hospital □
   d) All of the above □

2. National Institute for Health and Care Excellence (NICE) guidelines (2013) recommend that:
   a) All patients admitted to hospital should be considered at high risk of falling □
   b) All patients aged over 45 admitted to hospital should be considered at high risk of falling □
   c) All patients aged over 55 admitted to hospital should be considered at high risk of falling □
   d) All patients aged over 65 admitted to hospital should be considered at high risk of falling □

3. An extrinsic risk factor for falls is:
   a) Muscular and joint rigidity □
   b) Urinary incontinence □
   c) Low or inadequate lighting □
   d) Cognitive impairment □

4. Inpatient falls are less likely to occur:
   a) During shift changes □
   b) When patients are attending to urinary or bowel elimination needs □
   c) During day shifts □
   d) In neurological units □

5. Risk screening tools for falls:
   a) Identify the risk factors for falls in a patient □
   b) Identify patients at high risk of falling among those admitted to a ward □
   c) Include a list of risk factors for falls that should be assessed □
   d) Include a care plan for each factor identified □

6. Which risk factor is common to the main risk screening tools?
   a) A history of falls □
   b) Visual impairment □
   c) Transfer and mobility abilities and gait □
   d) Mediations □

7. Patients are at increased risk of falling if they are taking more than how many medications?
   a) One □
   b) Two □
   c) Three □
   d) Four □

8. A multifactorial risk assessment:
   a) Does not include a Mini Mental State Examination (MMSE) □
   b) Uses specific tools that contain a wide range of factors □
   c) Does not include visual assessment □
   d) Does not include an assessment of the patient’s mobility and gait □

9. Which statement is false?
   In a multifactorial risk assessment:
   a) Risk factors identified should be treated, improved or managed during a patient’s stay □
   b) The environment does not need to be assessed □
   c) Environmental hazards may also be assessed □
   d) It is necessary to ensure patients have access to appropriate walking aids □

10. The minimum accuracy value for a screening tool is:
    a) 40% sensitivity and specificity □
    b) 65% sensitivity and specificity □
    c) 70% sensitivity and specificity □
    d) 85% sensitivity and specificity □

How to complete this assessment
This self-assessment questionnaire will help you to test your knowledge. It comprises ten multiple choice questions that are broadly linked to the CPD article in this issue. There is one correct answer to each question.

- You can test your subject knowledge by attempting the questions before reading the article, and then go back over them to see if you would answer any differently.
- You might like to read the article before trying the questions. The correct answers will be published in Nursing Standard on 10 August.

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This self-assessment questionnaire was compiled by Beth Knight

The answers to this questionnaire will be published on 10 August

Answers to SAQ 852 on an overview of diabetes, which appeared in the 13 July issue, are: