TOOL 2
When and how to do fall risk screening, assessment, care planning and discharge planning

Government of South Australia
SA Health

Purpose

This tool provides recommendations for when and how to do screening and/or assessment of a consumer's risk of falls or harm from falls in a variety of settings across SA Health.

It also includes recommendations about the process of planning care to reduce risk, including consumer and carer input.

Events and changes that trigger a review of the care plan and reassessment of the consumer are listed.

In order to be able to plan discharge, and provide current information to future care providers, there are recommendations for reassessment and additional actions.

SA Health screening and assessment tools

Recommendations for screening and assessment align with the national guidelines Best Practice for Preventing Falls and Harm from Falls in Australian Hospitals, Residential Care and Community Care services; and the Australian Commission on National Safety and Quality Health Service Standards (ACSQHC).

The online, interactive eLearning course – Falls Prevention includes videos and other resources to assist staff to become familiar with screening, assessment, planning for care and discharge in SA Health services.

Screening and assessment tools in use in SA Health services for falls prevention include the following.

- **Fall and fall injury risk assessment** is designed to identify falls history, risk factors for falling and for injury. The form assists with development and documentation of a falls prevention care plan, and recording of consumer engagement, referrals, reassessments and discharge planning. The medical records form is numbered **MR58** (except for Royal Adelaide Hospital (RAH) where it is numbered 24.0). The equivalent of this form is available in Enterprise Patient Administration System (EPAS).
- **Fall and fall injury risk review** is designed to record the frequent review of the care plan and actions taken for a consumer who has risk factors that can be rapidly changing, such as delirium. It is recommended that this review occur each shift where practicable. The medical records form is numbered **MR58a** (except for RAH where it is numbered 24.1). The equivalent of this form is available in EPAS.
- **FROP-Com Fall risk assessment** is a longer assessment tool, covering a range of risk factors designed for use in community settings. The i-HOM-FRA is an equivalent assessment.
- **FROP-Com screen** is a 3 item screening tool developed by National Ageing Research Institute that is designed to identify who is at a level of risk where a full assessment is warranted. In EPAS this tool is available in the Emergency Department (ED) section. The medical records form that includes this tool is numbered **MR58b** (except at RAH where it is numbered MR24.2). The paper form allows for documentation of the actions proposed (ie the care plan), engagement with consumer and carers and documentation of referrals and other actions as part of discharge planning.
- **Self-screen questionnaire** is a checklist designed for consumers to complete themselves, then discuss with a health professional. It is for awareness-raising and does not indicate level of risk.
- **Home safety assessment** is an assessment of the safety of the home and environs for the consumer, including their daily functional activities.

Contents

Acute and post-acute inpatient settings

Falls risk screening	Falls and injury risk assessment	Development and review of care plan for those at risk	Reassessment	Preparation for transfer or discharge
Is the consumer: • aged >65 years • Aboriginal or Torres Strait Islander and aged >50 years • younger, and - admitted as the result of a fall, or - unsteady, or - has a recent history of falls (2 or more falls in the previous 6 months), or - has a condition or disability that is associated with increased risk of falls or injury from falls? If yes to any, this consumer requires fall and fall injury risk assessment.	Complete within 8 hours of admission, for all those who meet screening requirements. Use MR58, or EPAS fall risk assessment or equivalent. Additionally - any consumer who falls or becomes unsteady during an admission requires assessment	**Development** Consumer, carer and relevant members of the multidisciplinary care team should be involved in care planning. Document care plan within 24 hours (using MR 58 or 58a, or EPAS or equivalent). **Review** Any consumer with changeable fall risk factors, eg delirium should have care plan reviewed each shift using MR58a.	Re-assess using MR58 or equivalent if: • there is a fall or near miss this shift, or • a significant change in the patient's - physical health status and/or mobility - behaviour, cognition or mental status - medication (multiple changes, sedation or general anaesthetic) - environment.	Include falls risk information in all occasions of handover. Re-assess using MR58 or equivalent if discharge is planned within the next 24 hours. This enables effective handover, and referral to services for further falls risk reduction. Arrange devices, equipment and modifications to home with allied health assistance.

Emergency Department (ED)

Falls risk screening	Falls and injury risk assessment	Development and review of care plan for those at risk	Reassessment	Preparation for transfer or discharge
Not required for consumer who is unconscious, or unable to move independently in bed or barouche. Is the consumer: • aged >65 years • Aboriginal or Torres Strait Islander and >50 years • younger, and - admitted as the result of a fall, or - has a condition or disability that is associated with increased risk of falls/fall injury? If yes to any, within 2/24 of admission complete the 3 question FROP-Com screen (in MR58b or equivalent).	Risk assessment only recommended if consumer stays >12 hours in ED/short stay area. Use MR58b, or EPAS or equivalent.	If consumer is at high risk (on screen), ask consumer or carer "What assistance do we need to give you while you are here, when you are moving around?" Develop and document care plan within 2/24. Plan to maintain safety/ reduce risk during stay. **Review care plan** if: • there is a fall or near miss, or • a significant change in the patient's - physical health status and/or mobility - behaviour, cognition or mental status - medication (multiple changes, sedation).	Only if risk assessment was completed using MR58 or equivalent.	Depending on next location: • Handover falls risk to ward. • Handover falls risk to residential care staff and General Practitioner (GP). • Discharge planning and referral for those at risk who are going home. Advise GP if high falls risk. Community or aged care liaison, and/or allied health can be involved.

Day patients, Day surgery

Falls risk screening	Falls and injury risk assessment	Development and review of care plan for those at risk	Reassessment	Preparation for transfer or discharge
Use 3 question FROP-Com screen (in MR58b or equivalent). Complete at pre-admission or within 2/24 of admission for consumers who are: • aged >65 years, or • Aboriginal or Torres Strait Islander and >50 years, or • younger, and have a condition or disability associated with increased risk of falls/fall injury.	N/A	If consumer is at high risk, ask consumer or carer: "What assistance do we need to give you today when you are moving around?" Develop care plan After screening, plan care with consumer to provide necessary assistance to maintain safety during stay. **Review care plan** if: • there is a fall or near miss, or • a significant change in the patient's - physical health status and/or mobility - behaviour, cognition or mental status - medication (multiple changes, sedation).	Re-assess mobility after procedure, or if the consumer falls, using question 3 of the FROP-Com screen (in MR58b or equivalent).	Depending on recovery, and mobility, there may be a need to arrange: • follow-up care until recovery complete • risk assessment via GP.

Intensive care and high dependency units				
Falls risk screening	**Falls and injury risk assessment**	**Development and review of care plan for those at risk**	**Reassessment**	**Preparation for transfer or discharge**
All patients Is this consumer able to independently move within bed? If yes, fall risk assessment required.	Fall risk assessment using MR58 or equivalent is required if/as soon as the consumer is starting to move independently in bed.	**Develop care plan** Within 8 hours of assessment. **Review care plan** Any consumer with changeable fall risk factors, eg delirium should have care plan reviewed each shift using MR58a.	Re-assess using MR58 or equivalent if there is: • a fall or near miss this shift, or • a significant change in the patient's - physical health status and/or mobility - behaviour, cognition or mental status - medication (multiple changes, sedation or general anaesthetic) - environment.	Handover and transfer includes: • assessment of falls and fall injury risk • current interventions in place • precautions that receiving ward team needs to be aware of.

Dialysis units *(Caring for a high risk group, over long term)*				
Falls risk screening	**Falls and injury risk assessment**	**Development and review of care plan for those at risk**	**Reassessment**	**Preparation for transfer or discharge**
All patients.	MR58 or equivalent, within 2 weeks of admission.	**Develop care plan** Within 1 week of assessment. Plan care to provide assistance to maintain safety: • during and after treatment • at home. Consider referral for allied health home safety assessment (*). Provide advice and/or written materials to consumer and carer eg Falls Prevention Fact Sheets.	Re-assess using MR58 or equivalent if there is: • a fall or near miss, or • a significant change in the patient's - physical health status and/or mobility - behaviour, cognition or mental status - medication (multiple changes) - environment. Otherwise, routine review 4 monthly.	Handover and transfer includes: • assessment of falls and fall injury risk • current interventions in place • precautions that receiving ward team needs to be aware of.

Outpatient clinics – *caring for high risk groups. This includes but is not limited to clinics such as endocrine, fracture, neurological, geriatric, and also some diagnostic services for example Dual energy x-ray absorptiometry (DEXA) scanning.*				
Falls risk screening	**Falls and injury risk assessment**	**Development and review of care plan for those at risk**	**Reassessment**	**Preparation for transfer or discharge**
• Ask the following consumers if they have had more than 1 fall in the past 6 months:all consumers aged >65 years • Aboriginal or Torres Strait Islander people >50 years • younger people, if they have a condition or disability that is associated with increased risk of falls or injury from falls. OR Self-screen questionnaire with follow-up discussion of results with clinician.	If yes to screening questions, ask consumer or carer: "What assistance do we need to give you while you are here, when you are moving around?".	Document actions required to provide assistance to maintain safety during visit.	N/A	Include level of falls risk in communication to GP. Consider referral via My Aged Care portal (*) or Falls Prevention services, or Falls Prevention Clinic, via Geriatric and Community Services, as per local procedures. Provide advice and/or written materials to consumer and carer about falls risk and local available services eg Falls Prevention Fact Sheets and directory of falls prevention services.

Residential Care Facilities (SA Health)				
Falls risk screening	**Falls and injury risk assessment**	**Development and review of care plan for those at risk**	**Reassessment**	**Preparation for transfer or discharge**
N/A	All residents (permanent and respite). MR58 or equivalent within 24 hours of admission. Review any handover information eg from hospital.	**Develop care plan** Within 1 week.	Re-assess using MR58 or equivalent if there is: • a fall or near miss or • a significant change in the resident's - physical health status and/or mobility - behaviour, cognition or mental status - medication (multiple changes, sedation) - environment. Routine re-assessment monthly.	Handover to acute services includes: • assessment of falls and fall injury risk • current interventions in place • precautions that future care providers need to be aware of.

SA Ambulance Service (SAAS)

Falls risk screening	Falls and injury risk assessment	Development and review of care plan for those at risk	Reassessment	Preparation for transfer or discharge
All patients who are: • attended as a result of a fall • >65 years (or <50 years for ATSI) but not if unconscious, or unable to move independently. **If treat not transport:** • use 3 question FROP-Com screen (MR58b) • assess ability to walk safely (if previously ambulant).	**If transported:** • assess ability to transfer safely onto barouche, as per procedure.	**If transported:** • document any actions precautions to reduce fall risk.	N/A	**If transported:** • handover mobility status and precautions to ED staff. **If treat not transport:** For those at high risk: • Ensure consumer can mobilise, and can get help if required. • Notify GP, and refer those at high risk, as per procedure to community-based services (*).

Care in the community

Falls risk screening	Falls and injury risk assessment	Development and review of care plan for those at risk	Reassessment	Preparation for transfer or discharge
• Self-screen questionnaire • 3 question FROP-Com screen (MR58b or equivalent). Note that these may be used separately or combined – refer to local procedures. For community mental health services, add the following italicised words to the second question 'Prior to today, how much assistance was the individual requiring for Instrumental Activities of Daily Living (IADL)?' *because of physical limitations*	For those at high risk on screening: Use FROP-Com assessment tool or equivalent. Conduct or arrange home safety assessment where indicated by Occupational Therapist and/or Physiotherapist where practicable.	**Develop care plan** Within 1-2 weeks of assessment (depending on frequency of appointments) **Review care plan** This will depend on the nature of the interventions, for example, an exercise program is reviewed frequently. Review implementation of all elements, including referral.	Re-assess using FROP-Com assessment tool or equivalent if: • there has been a fall or near miss, or • a significant change in the patient's - physical health status and/or mobility - behaviour, cognition or mental status - medication (multiple changes) - environment. Routine re-screening six monthly.	Handover to acute services includes: • assessment of falls and fall injury risk • current interventions in place • precautions that future care providers need to be aware of.

Care in the community (Mental Health services)				
Falls risk screening	**Falls and injury risk assessment**	**Development and review of care plan for those at risk**	**Reassessment**	**Preparation for transfer or discharge for those with falls care plan**
• Does the person have a recent history of falls (2 or more falls in the previous 6 months), or • When walking or turning, does the person appear unsteady or at risk of losing their balance? If Yes to any, fall and fall injury risk assessment is required	Use FROP-Com assessment tool or equivalent. In addition, conduct , refer for or arrange home safety assessment by Occupational Therapist and/or Physiotherapist where practicable.	**Develop care plan** Within 1-2 weeks of assessment (depending on frequency of appointments) **Review care plan** This will depend on the nature of the interventions, for example, an exercise program is reviewed frequently. Review implementation of all elements, including referral.	Re-assess using FROP-Com assessment tool or equivalent if: • there has been a fall or near miss, or • a significant change in the patient's - physical health status and/or mobility - behaviour, cognition or mental status - medication (multiple changes) - environment. Routine re-screening six monthly.	Handover to acute services includes: • current assessment of falls and fall injury risk • current interventions in place • precautions that future care providers need to be aware of. * Use LHN Falls prevention service directories

* Accessing community services

Please contact your local health service for information about services close to you.

Use My Aged Care web portal to find community-based services. Phone: 1800 200 422.

For more information

SA Health
Safety and Quality
Telephone: (08) 8226 2567
sahealth.sa.gov.au/falls

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