

TOOL 1

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



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 Falls Guidelines (2025) for Australian Hospitals, Residential Aged Care and Community Care Services. Use of these tools ensures that the requirements of the National Safety and Quality Health Service Standards (NSQHSS) are met. Falls risk screening may be included in a risk screening tool that includes other elements from NSQHS Comprehensive Care Standard.

The Falls Prevention eLearning course is available to all SA Health employees via iLearn. It assists 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 in a hospital ward setting. 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**. The equivalent of this form is available in Sunrise EMR.
- **Fall and fall injury risk review** is designed to record the frequent review of the care plan and actions taken for a consumer in a hospital ward setting, 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**. The equivalent of this form is available in Sunrise EMR.
- **Falls Risk for Older People - Community (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 Sunrise EMR this tool is available in the Emergency Department (ED) section. The medical records form that includes this tool is numbered **MR58b**. 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 transfer or discharge planning.
- **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.
- **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.

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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
<p>Is the consumer:</p> <ul style="list-style-type: none"> aged >65 years Aboriginal or Torres Strait Islander and aged >50 years younger, and <ul style="list-style-type: none"> – 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? <p>If yes to any, this consumer requires fall and fall injury risk assessment.</p>	<p>Complete within 8 hours of admission, for all those who meet screening requirements.</p> <p>Use MR58, or Sunrise EMR fall risk assessment or equivalent.</p> <p>Additionally – any consumer who falls or becomes unsteady during an admission requires assessment</p>	<p>Development</p> <p>Consumer, carer and relevant members of the multidisciplinary care team should be involved in care planning.</p> <p>Document care plan within 24 hours (using MR58 or MR58a, or Sunrise EMR or equivalent).</p> <p>Review</p> <p>Any consumer with changeable fall risk factors, eg delirium should have care plan reviewed each shift using MR58a.</p>	<p>Re-assess using MR58 or equivalent if:</p> <ul style="list-style-type: none"> there is a fall or near miss this shift, or a significant change in the patient’s <ul style="list-style-type: none"> – physical health status and/or mobility – behaviour, cognition or mental status – medication (multiple changes, sedation or general anaesthetic) – environment. 	<p>Include falls risk information in all occasions of handover.</p> <p>Re-assess using MR58 or equivalent if discharge is planned within the next 24 hours.</p> <p>This enables effective handover, and referral to services for further falls risk reduction.</p> <p>Arrange devices, equipment and modifications to home with allied health assistance.</p>

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
<p>Not required for consumer who is unconscious, or unable to move independently in bed or barouche.</p> <p>Is the consumer:</p> <ul style="list-style-type: none"> aged >65 years Aboriginal or Torres Strait Islander and >50 years younger, and <ul style="list-style-type: none"> admitted as the result of a fall, or has a condition or disability that is associated with increased risk of falls/fall injury? <p>If yes to any, within 2/24 of admission complete the 3 question FROP-Com screen (in MR58b or equivalent).</p>	<p>Risk assessment only recommended if consumer stays >12 hours in ED/ short stay area.</p> <p>Use MR58, or Sunrise EMR or equivalent.</p> <p>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?”</p>	<p>Develop and document care plan within 2/24. Plan to maintain safety/ reduce risk during stay.</p> <p>Review care plan if:</p> <ul style="list-style-type: none"> there is a fall or near miss, or a significant change in the patient’s <ul style="list-style-type: none"> physical health status and/or mobility behaviour, cognition or mental status medication (multiple changes, sedation). 	<p>Only if risk assessment was completed using MR58 or equivalent.</p>	<p>Depending on next location:</p> <ul style="list-style-type: none"> Handover falls risk to ward. Handover falls risk to residential aged care staff and General Practitioner (GP). Discharge planning and referral for those at risk who are going home. Advise GP if high falls risk. <p>Community or aged care liaison officers, and/or allied health can be involved.</p>

Day patients, day surgery, pre-admission clinics

Falls risk screening	Falls and injury risk assessment	Development and review of care plan for those at risk	Reassessment	Preparation for transfer or discharge
<p>Use 3 question FROP-Com screen (in MR58b or equivalent).</p> <p>Complete at preadmission or within 2/24 of admission for consumers who are:</p> <ul style="list-style-type: none"> aged >65 years, or Aboriginal or Torres Strait Islander >50 years, or younger, and have a condition or disability associated with increased risk of falls/fall injury. 	<p>If consumer is at high risk, ask consumer or carer: “What assistance do we need to give you today when you are moving around?”</p>	<p>After screening, plan care with consumer to provide necessary assistance to maintain safety during stay.</p> <p>Review care plan if:</p> <ul style="list-style-type: none"> there is a fall or near miss, or a significant change in the patient’s <ul style="list-style-type: none"> physical health status and/or mobility behaviour, cognition or mental status medication (multiple changes, sedation). 	<p>Re-assess mobility after procedure, or if the consumer falls, using question 3 of the FROP-Com screen (in MR58b or equivalent).</p>	<p>Depending on rate of recovery, and mobility, there may be a need to arrange:</p> <ul style="list-style-type: none"> follow-up care until recovery complete risk assessment via GP. referral to community-based falls prevention services <p>Community or aged care liaison officers, and/or allied health can be involved.</p>

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
<p>All patients</p> <p>Is this consumer able to independently move within bed?</p> <p>If yes, fall risk assessment required.</p>	<p>Fall risk assessment using MR58 or equivalent is required if/as soon as the consumer is starting to move independently in bed.</p>	<p>Develop care plan Within 8 hours of assessment.</p> <p>Review care plan Any consumer with changeable fall risk factors, eg delirium should have care plan reviewed each shift using MR58a.</p>	<p>Re-assess using MR58 or equivalent if there is:</p> <ul style="list-style-type: none"> • a fall or near miss this shift, or • a significant change in the patient's <ul style="list-style-type: none"> – physical health status and/or mobility – behaviour, cognition or mental status – medication (multiple changes, sedation or general anaesthetic) – environment. 	<p>Handover and transfer includes:</p> <ul style="list-style-type: none"> • current falls and fall injury risk • current interventions in place • precautions that receiving ward team needs to be aware of.

Dialysis units (<i>caring for a high risk group, over long term</i>)				
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	<p>All patients.</p> <p>MR58 or equivalent, within 2 weeks of admission.</p>	<p>Develop care plan Within 1 week of assessment.</p> <p>Plan care to provide assistance to maintain safety:</p> <ul style="list-style-type: none"> • during and after treatment • at home • consider referral to community-based falls prevention services, including allied health home safety assessment. <p>Community or aged care liaison, and allied health can be involved</p> <p>Provide advice and/or written materials to consumer and carer eg Falls Prevention Fact Sheets.</p>	<p>Re-assess using MR58 or equivalent if there is:</p> <ul style="list-style-type: none"> • a fall or near miss, or • a significant change in the patient's <ul style="list-style-type: none"> – physical health status and/or mobility – behaviour, cognition or mental status – medication (multiple changes) – environment. <p>Otherwise, routine review 4 monthly.</p>	<p>Handover and transfer includes:</p> <ul style="list-style-type: none"> • current falls and fall injury risk • current interventions in place.

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
<p>Ask the following consumers if they have had more than 1 fall in the past 6 months:</p> <ul style="list-style-type: none"> • 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. <p>OR Self-screen questionnaire with follow-up discussion of results with clinician.</p>	<p>If yes to screening questions, ask consumer or carer:</p> <p>“What assistance do we need to give you while you are here, when you are moving around?”</p>	<p>Document actions required to provide assistance to maintain safety during visit.</p>	N/A	<p>Include level of falls risk in communication to GP.</p> <ul style="list-style-type: none"> • consider referral to community-based falls prevention services. <p>Community or aged care liaison officers, and/or allied health can be involved.</p> <p>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.</p>

Residential aged 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	<p>All residents (permanent and respite).</p> <p>MR58 or equivalent within 24 hours of admission.</p> <p>Review any handover information eg from hospital.</p>	<p>Develop care plan Within 1 week.</p> <p>Review care plan Routine re-assessment monthly.</p>	<p>Re-assess using MR58 or equivalent if there is:</p> <ul style="list-style-type: none"> • a fall or near miss or • a significant change in the resident’s <ul style="list-style-type: none"> – physical health status and/or mobility – behaviour, cognition or mental status – medication (multiple changes, sedation) – environment. 	<p>Handover to acute services includes:</p> <ul style="list-style-type: none"> • current 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
<p>All patients who are:</p> <ul style="list-style-type: none"> attended as a result of a fall >65 years (>50 years for ATSI) but not if unconscious, or unable to move independently. <p>If treat not transport:</p> <ul style="list-style-type: none"> use 3 question FROP-Com screen (MR58b) assess ability to walk safely (if previously ambulant). 	<p>If transported:</p> <ul style="list-style-type: none"> assess ability to transfer safely onto barouche, as per procedure. 	<p>If transported:</p> <ul style="list-style-type: none"> document any actions or precautions to reduce fall risk. 	N/A	<p>If transported:</p> <ul style="list-style-type: none"> handover mobility status and precautions to ED staff. <p>If treat not transport: For those at high risk:</p> <ul style="list-style-type: none"> 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
<ul style="list-style-type: none"> Self-screen questionnaire 3 question FROP-Com screen (MR58b or equivalent). <p>Note that these may be used separately or combined – refer to local procedures.</p>	<p>For those at high risk on screening:</p> <p>Use FROP-Com assessment tool or equivalent.</p> <p>Conduct or arrange home safety assessment where indicated by Occupational Therapist and/or Physiotherapist where practicable.</p>	<p>Develop care plan Within 1-2 weeks of assessment (depending on frequency of appointments)</p> <p>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.</p>	<p>Re-assess using FROP-Com assessment tool or equivalent if:</p> <ul style="list-style-type: none"> there has been a fall or near miss, or a significant change in the patient's <ul style="list-style-type: none"> physical health status and/or mobility behaviour, cognition or mental status medication (multiple changes) environment. <p>Routine re-screening six monthly.</p>	<p>Handover to acute services includes:</p> <ul style="list-style-type: none"> current 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
<ul style="list-style-type: none"> 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? <p>If yes to either of the above, fall and fall injury risk assessment is required</p> <p>For community mental health services, add the following italicised words to the second question <i>'Prior to today, how much assistance was the individual requiring for Instrumental Activities of Daily Living (IADL)? because of physical limitations.</i></p>	<p>Use FROP-Com assessment tool or equivalent.</p> <p>In addition, conduct, refer for or arrange home safety assessment by Occupational Therapist and/or Physiotherapist where practicable.</p>	<p>Develop care plan Within 1-2 weeks of assessment (depending on frequency of appointments)</p> <p>Review care plan This will depend on the nature of the interventions, including referral.</p> <p>Routine re-screening six monthly.</p>	<p>Re-assess using FROP-Com assessment tool or equivalent if:</p> <ul style="list-style-type: none"> there has been a fall or near miss, or a significant change in the patient's <ul style="list-style-type: none"> physical health status and/or mobility behaviour, cognition or mental status medication (multiple changes) environment. 	<p>Handover to acute services includes:</p> <ul style="list-style-type: none"> current falls and fall injury risk current interventions in place precautions that future care providers need to be aware of. <p>Consider referral to the LHN falls prevention service (use directories). Community allied health can be involved.</p>

Adult mental health and hospital inpatients (older person's 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
N/A	Complete MR58 within 8 hours of admission, for all patients.	<p>Develop Consumer, carer and relevant members of the multidisciplinary care team should be involved in care planning. Document care plan within 24 hours (using MR58 or 58a).</p> <p>Monitor Any consumer with the following should have their care plan reviewed each shift using MR58a until stable:</p> <ul style="list-style-type: none"> • post ECT • increases in psychotropic medications • changeable fall risk factors, eg delirium. 	<p>Re-assess using MR58:</p> <ul style="list-style-type: none"> • if there is a fall or near miss • following ECT • if psychotropic medications have been increased or commenced • if there is a significant change in the patient's physical health status and/or mobility • if behaviour, cognition or mental status changes • if there is a change of environment or room. 	<p>Include falls risk information in all occasions of handover.</p> <p>Re-assess using MR58 or equivalent if discharge is planned within the next 24 hours.</p> <p>This enables effective handover, and referral to services for further falls risk reduction.</p> <p>Arrange devices, equipment and modifications to home with allied health assistance.</p>

Discharge planning

Ensure discharge summaries include information about current risk level, precautions taken and recent falls or near misses.

Refer to relevant Local Health Network (LHN) Falls Prevention Service – see [local falls prevention services](#) on the [SA Health fall prevention and management webpage](#).

Use [My Aged Care](#) web portal to find community-based services. Phone: 1800 200 422.

For more information

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