FALLS RISK SCREEN

SECTION A – Falls Risk Screen (FROP-Com screen, 2009)

1. FALLS HISTORY
   - Number of falls in the past 12 months: 
     - [ ] No falls [ ] One fall [ ] Two falls
     - [ ] Three or more falls

2. FUNCTION IN INSTRUMENTAL ACTIVITIES OF DAILY LIVING (IADL)
   - Prior to today, how much assistance was the individual requiring for IADL?
     - [ ] Completely independent [ ] Supervision needed
     - [ ] Some assistance required [ ] Completely dependent

3. BALANCE
   - When walking or turning, does the person appear unsteady or at risk of losing their balance?
     - [ ] No unsteadiness observed [ ] Minimally unsteady
     - [ ] Moderately unsteady [ ] Consistently and severely unsteady [ ] Unable to observe walking

TOTAL RISK SCORE

Tick Risk Level
- [ ] Low = 0-1
- [ ] High = 4-9
- [ ] Low = 1-3

If the score is zero, no further action required.

SECTION B – IMMEDIATE FALLS PREVENTION PLAN

Permitted to do ADL / Mobility / Toileting [ ] Yes [ ] No, Rest in bed
- Supervision required [ ] Yes [ ] No
- Hands on assistance required [ ] Yes [ ] No
- Equipment / aids to be used [ ] Yes [ ] No
   - Mobility aid: [ ] Yes
   - Glasses: [ ] Yes
   - Footwear: [ ] Yes
   - Other: [ ] Yes

Call bell, personal items left within reach [ ] No [ ] Yes

Falls risk care plan discussed with patient / carer? [ ] Yes [ ] No, why not?
- [ ] Yes, specify

Other

SECTION C – ACTIONS COMPLETED PRIOR TO DISCHARGE / TRANSFER

Transfer [ ] Patient being transferred to ward or another health service
[ ] Falls risk included in handover
- Low risk (Score 1-3) [ ] GP notified if presented following fall [ ] GP notified
- High risk (Score 4-9) [ ] GP notified and assessment requested [ ] GP notified and assessment requested
- Referral to community falls prevention service [ ] Recommend physiotherapist assessment
- Referral to hospital avoidance program
- Patient / carer given written information about falls prevention, and available services
- Other

Discharge [ ] Patient being discharged home
[ ] Patient discharged to residential aged care
- Low risk (Score 1-3) [ ] GP notified if presented following fall [ ] GP notified
- High risk (Score 4-9) [ ] GP notified and assessment requested [ ] GP notified and assessment requested
- Referral to community falls prevention service [ ] Recommend physiotherapist assessment
- Referral to hospital avoidance program
- Patient / carer given written information about falls prevention, and available services
- Other

Please use black or blue ballpoint pen when completing this form

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Guidelines for use of the MR58B Falls Risk Screen

This form can be used in emergency, short stay, outpatient and day patient areas.

When to use the MR58B Falls risk screen
Use this form within 2 hours of presentation in emergency, to screen:
- all patients aged ≥65 years.
- Aboriginal or Torres Strait Islander patients ≥50 years.
- younger people with a history of falls or a condition that is associated with increased risk such as osteoporosis, neurological conditions or disability affecting mobility.

How to use the MR58B Falls risk screen
- Use Section A to screen for risk level, and commencement of care planning (see overleaf Guide for scoring).
- Use Section B to document safety strategies to be used during care in current location. Sign, date and notify team.
- Use Section C (overleaf) to record discharge plans and actions as discussed with patient / carer and depending on risk level. Sign and date.

Possible NOTE: If the person presented after a fall involving a head clamp but are on anticoagulant therapy, additional observation may be required in case of intracranial bleeding (see post fall protocol).

Guide for scoring the Falls Risk Screen (FROP-Com Screen)

Question 1. Number of falls in the past 12 months?
Explain what is meant by a fall. “Any time you have slipped, tripped, fallen or stumbled and ended up on the floor, ground or other lower surface.” Family or carers may be able to assist with recall.

Question 2. Prior to the fall, how much assistance was the individual requiring for IADL?
Instrumental activities of daily living (IADL) includes activities performed during a normal day, such as shopping, housekeeping, laundry and preparing meals. Excludes personal care.

Score 0 completely independent with IADL.
Score 1 requires another to be present but no requiring physical assistance e.g. accompanied shopping.
Score 2 requires assistance on most occasions with one or more of the above tasks e.g. carrying shopping bags, assistance with the heavier housework.
Score 3 requires assistance to perform all of the above tasks including smaller chores e.g. dishes.

Question 3. When walking and turning, does the person appear unsteady or at risk of losing their balance?
Do not base on self-report. Score as 3 if the person is unable to attempt walking due to injury / illness or it is unsafe or contraindicated to attempt.
If you assess it is safe to do so, ask the person to stand, walk a few metres, turn and sit, using their usual walking aid(s). Observe the performance of this activity and provide close supervision if the person is at all unsteady.
If level fluctuates, tick the most unsteady rating.
Score 0 if no unsteadiness observed.
Score 1 if the person appears unsteady at any time, or is modifying the activity to appear steady (e.g. increased level of effort; or is consistently touching the walls or furniture).
Score 2 if the person appears moderately unsteady and / or you provide supervision or prompting.
Score 3 if the person is consistently or severely unsteady on walking or turning and hands-on assistance is required.
Score 3 if the person is unable to attempt walking.

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Score 3 if the person is unable to attempt walking.


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