FALLS RISK SCREEN

MR58B

Hospital: .....

Affix patient identification label in this box

UR Number: .....

Surname: .....

Given name: .....

Second given name: .....

D.O.B: __ __ / __ __ / __ __ __ __ Sex: .....

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

1. FALLS HISTORY		Score
Number of falls in the past 12 months?	[0] No falls [1] One fall [2] Two falls [3] 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?	[0] Completely independent [1] Supervision needed [2] Some assistance required [3] Completely dependent	
3. BALANCE		
When walking or turning, does the person appear unsteady or at risk of losing their balance?	[0] No unsteadiness observed [1] Minimally unsteady [2] Moderately unsteady [3] Consistently and severely unsteady [3] Unable to observe walking	
TOTAL RISK SCORE	**Tick Risk Level** ☐ **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 ☐ No ☐ Yes *specify*

– Hands on assistance required ☐ No ☐ Yes *specify*

– Equipment / aids to be used ☐ No ☐ Yes *specify*

Mobility aid ☐ No ☐ Yes *specify* Footwear ☐ No ☐ Yes *specify*

Glasses ☐ No ☐ Yes *specify* Other ☐ No ☐ Yes *specify*

Call bell, personal items left within reach ☐ No ☐ Yes

Falls risk care plan discussed with patient / carer?

☐ Yes *specify* ☐ No, why not?

Other

SECTION C – ACTIONS COMPLETED PRIOR TO DISCHARGE / TRANSFER

Transfer	☐ **Patient being transferred to ward or another health service** ☐ Falls risk included in handover	
Discharge	☐ **Patient being discharged home**	☐ **Patient discharged to residential aged care**
Low risk *(Score 1-3)*	☐ GP notified if presented following fall	☐ GP notified ☐ Recommend physiotherapist assessment
High risk *(Score 4-9)*	☐ GP notified and assessment requested ☐ Referral to community falls prevention service specify .... ☐ Referral to hospital avoidance program ☐ Patient / carer given written information about falls prevention, and available services ☐ Other	☐ Verbal or written recommendation that comprehensive assessment of fall and injury risk be arranged

Full Name *(Please Print)*	Designation *(Please Print)*	
Signature	Date __ __ / __ __ /20 __ __	Time __ __ : __ __

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 commence 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.

PLEASE NOTE: If the person presented after a fall involving head or brain trauma from direct or indirect forces/impact, and they 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 not 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.

Acknowledgement: *This screen is based on the FROP-Com screen (Russell M, Hill K, Day L, Blackberry, Gurrin L and Dharmage S (2009) Development of the Falls Risk for Older People in the Community (FROP-Com) Screening Tool. Age and Aging 38(1): 40-46)*