SESLHD GUIDELINE
COVER SHEET

NAME OF DOCUMENT	Falls prevention and management for non-admitted patients
TYPE OF DOCUMENT	Guideline
DOCUMENT NUMBER	SESLHDGL/044
DATE OF PUBLICATION	October 2023
RISK RATING	Medium
LEVEL OF EVIDENCE	National Safety and Quality Health Service Standards: Standard 5 - Comprehensive Care
REVIEW DATE	October 2026
FORMER REFERENCE(S)	N/A
EXECUTIVE SPONSOR	Director of Nursing and Midwifery, SESLHD
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FUNCTIONAL GROUP(S)	Falls Prevention
KEY TERMS	Falls, prevention, risk screening, assessment, management plan, post fall management, community, outpatient, ambulatory care, emergency department
SUMMARY	The purpose of this document is to outline best practice recommendations for the prevention and management of falls. The guideline is for people over the age of 65, Aboriginal and Torres Strait Islander people over the age of 45 and people with chronic health conditions who are non-admitted clients of South-eastern Sydney Local Health District (SESLHD). It details guidelines for Ambulatory Care, Infusion/Haematology/ Oncology Day Centres, Renal Dialysis units, Perioperative and Day Surgery Units, Emergency Departments and Community Health services. It outlines recommended strategies to identify and manage people at risk of a fall and/or fall-related injury. It **does not** pertain to people admitted to acute or sub-acute care (see SESLHDPR/380).

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Falls prevention and management for non-admitted patients

Acknowledgement of Country

South Eastern Sydney Local Health District respectfully acknowledges Aboriginal and Torres Strait Islander people as the Traditional Custodians on whose land we stand. We also acknowledge Elders past, present and future, and their continuing connection to country.

Section 1 - Background

One in three people over the age of 65 fall each year, increasing to one in two people over the age of 80. Falls can have serious consequences for older people, their families and carers. They can lead to reduced quality of life, injury and disability, reduced physical activity, social isolation, functional decline, need for residential care and even death.

In NSW, falls are a major cause of harm to older people, and fall-related injuries impose a substantial burden on the health care and aged care systems[1]. No other single cause of injury, including road trauma, costs the health system more than falls.

There are many risk factors for falling. Medical conditions that increase risk include dementia/cognitive impairment, stroke, incontinence, Parkinson's disease, diabetes and acute illness/delirium. Psychosocial and demographic risk factors include advanced age, living alone, female gender, physical inactivity, limitations with activities of daily living and a history of falls. Sensory and neuromuscular factors also contribute to risk. These include muscle weakness, poor balance, reduced peripheral sensation, poor reaction time and impaired vision. Other factors such as polypharmacy, use of centrally acting medications, substance induced intoxication (especially from excessive alcohol or benzodiazepine use), inappropriate footwear and glasses, poor lighting and home hazards are also risk factors for falls.

Yet falls and falls injuries can be prevented. There is good evidence for both the effectiveness and cost-effectiveness of a range of strategies across community settings[2].

SESLHD is committed to reducing the risk of falls and fall injury in clients who use our services. This guideline describes falls prevention screening and management for non-admitted patients in line with:

- National Safety and Quality Health Service (NSQHS) Standard 5 - Comprehensive Care
- Preventing Falls and Harm from Falls in Older People - Best Practice Guidelines for Australian Community Care 2009
- World guidelines for falls prevention and management for older adults: a global initative
- SESLHDGL/099 - Falls prevention and management: A best practice guide for Allied Health Professionals
- SESLHDGL/088 - Standard 5 Comprehensive Care - Guideline

Section 2 - Principles

This guideline outlines recommended strategies to identify and manage people at risk of a fall and/or fall-related injury in the following settings:

- Outpatient services, specifically Ambulatory care, Infusion Centres, Haematology/Oncology Day Centres and Renal Dialysis services (Refer to Section 5)
- Perioperative and day surgery units (Refer to Section 6)
- Emergency departments (Refer to Section 7)
- Community health services, including Mental health, Drug and Alcohol and Population health services (Refer to Section 8)

The target population is:

- People over the age of 65 years
- Aboriginal and Torres Strait Islander people over the age of 45 years
- People with chronic health conditions (see Definitions, Page 6). Please refer to the relevant section for a more detailed description of who should be screened for fall risk in specific clinical areas.

As in any clinical situation, there will be factors which cannot be addressed by a single set of guidelines. This document does not replace the need to use clinical judgement with regard to individual patients and situations.

It is recognised that SESLHD services for non-admitted patients are extremely diverse. For many services, such as specialist outpatient clinics and group programs, routine falls risk screening will not be feasible or appropriate. When considering which, if any, aspects of the guideline are most relevant for implementation, services should consider their client population, the purpose of the service, the setting in which care is provided, access to resources including multidisciplinary team members, opportunities to build falls screening and management into care provision and transfer of care, including communication with primary care practitioners.

EXCLUSIONS

This guideline **does not** pertain to falls prevention and management for acute and sub-acute care. Please refer to SESLHDPR/380 - Falls prevention and management for people admitted to acute and sub-acute care for the procedure in these clinical areas

Section 3 - Definitions

Chronic health conditions:

Chronic health conditions are illnesses or diseases of long duration and generally slow progression. The four main types are cardiovascular diseases (like heart attacks and stroke), cancers, chronic respiratory diseases (such as chronic obstructed pulmonary disease and asthma) and diabetes.

Other chronic conditions that are relevant to this guideline include human immunodeficiency virus (HIV), chronic kidney disease, progressive neurological diseases, dementia, mental health conditions, conditions associated with substance use.

Client:

A person who is not admitted as an inpatient under acute or sub-acute care but is receiving health care provided by a SESLHD service.

Fall:

For the purposes of this Guideline, a fall is defined as "an event which results in a person coming to rest inadvertently on the ground or floor or other lower level"[3].

Fall risk screening:

Refers to a relatively simple process (e.g. set of questions) that helps determine who is likely to fall and the level of risk[2].

Fall risk assessment:

A detailed and systematic process used to identify a person's risk factors for falling. It is used to help identify which interventions to implement[2].

Interventions:

An *intervention* is a therapeutic procedure or treatment strategy designed to cure, alleviate or improve a certain condition. In falls prevention, interventions can be:

- Targeted at a single risk factor *(single interventions)*
- Targeted at more than one risk factor:
  - *multiple component interventions:* where everyone receives the same, fixed combination of interventions
  - *multifactorial interventions*: where people receive multiple interventions, but the combination of these interventions is tailored to the person, based on an individual assessment[2].

Section 4 - Responsibilities

Service / Unit managers:

- Support the implementation of this best practice guideline for clients of your service within the target population
- Ensure that all relevant team members (e.g. nursing and allied health staff) are trained in the use of the recommended falls risk screen
- Where relevant, ensure all nursing and allied health staff are trained in implementing individual client falls risk assessment and implementation of management strategies
- For services providing hospital or centre-based care, conduct regular environmental audits and develop management plans to minimise environmental risk factors that might contribute to client falls
- Identify and facilitate access to the equipment and devices required for the patient population being served
- Investigate all client falls (within an occasion of service or patient found on floor on arrival) in accordance with NSW Ministry of Health Policy - PD2020_047 - Incident Management
- Follow Clinical Excellence Commission (CEC) post fall review procedure in community setting or inpatient setting and consider a post fall huddle.

Multidisciplinary team members:

- Routinely ask clients over the age of 65 years, Aboriginal and Torres Strait Islander people over the age of 45 and people with chronic health conditions about any falls in the last 12 months
- Where appropriate, complete the relevant falls risk screen or refer to another health care professional for falls risk screening and assessment
- Conduct discipline-specific assessments and interventions within the scope of their role in the service
- Communicate falls risk and the risk management plan as a routine part of clinical handover
- Document the outcome of falls risk screening, management strategies and referrals made in the client's health care record
- Discuss falls risk and develop any interventions in partnership with clients, families and carers. Use interpreters (face to face or telephone) if necessary for people who do not speak English as a first language

- Provide resource material to patients and their carers on preventing falls and harm from falls. People who do not speak English as a first language should be provided with translated resources, where available, in their preferred language
- Record any fall incidents (related to an occasion of service) in the incident management system. Community health workers should complete an incident report if the incident occurs during an occasion of service or if person is on the floor on arrival to a visit. Incidents between occasions of service do not need to be inputted into the incident reporting system unless the incident related to the care provided
- Complete post fall observations and interventions as per the relevant section of this Guideline (in-hospital or community care setting)
- Repeat the falls risk screen and complete/review management plan post fall incident or when clinically indicated e.g. change in condition
- Report any identified hazards or equipment needs to the Service/Unit manager
- Contribute to the review of fall incidents at service meetings
- Complete mandatory and other relevant training in falls risk screening, assessment and management.

Clinical Practice Improvement Units:

- Work collaboratively with clinicians and managers to improve both the quality and outcomes of clinical care through improvements in clinical and support systems at individual SESLHD sites
- Support relevant audits and improvement initiatives.

Falls Prevention Program Coordinator:

- Monitor the use of guidelines for preventing falls and harm from falls
- Support evaluation processes for falls prevention and management guidelines across SESLHD
- Support the implementation of this Guideline, working with individual services across SESLHD where appropriate
- Undertake periodic review of the Guideline to ensure it reflects best practice recommendations.

Section 5 - Ambulatory Care, Infusion Centres, Haematology/ Oncology Day Centre, Renal Dialysis

5.1 Who should be screened for falls risk?

Clients over the age of 65, Aboriginal and Torres Strait Islander people over the age of 45 and people with chronic health conditions, should be asked on their initial encounter about any falls in the last 12 months.

For example:

> *In the past year, have you had any falls including a slip or a trip in which you lost your balance and landed on the floor, ground or other lower level?*

People who report one fall in the past year should be further screened for falls risk. A history of two or more falls in the previous year negates the need for further screening and should trigger a detailed falls risk assessment or a recommendation for further assessment and potential tailored intervention, if not already undertaken.

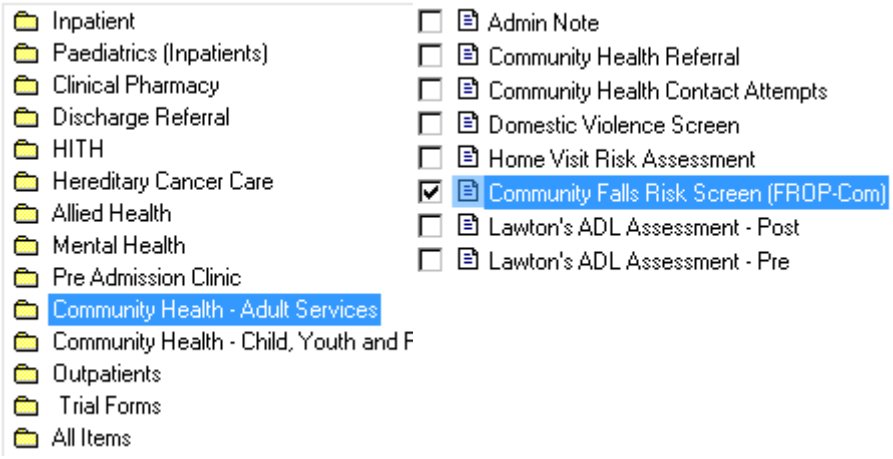
Some services may choose to screen all clients in the target group, rather than ask a pre-screening question.

5.2 Use of a best practice screening tool

The FROP-Com Community Falls Risk Screen[4] (FROP-Com Screen) is the recommended falls risk screening tool for non-admitted patients and accompanying CEC FROP-COM Falls Risk Screen Flow Chart.

This is available as an ad hoc form:

- In the Community Health and Outpatient Care (CHOC) electronic medical record (eMR).
- As an ad hoc form in PowerChart



- In ARIA and MOSAIQ for use where appropriate in Cancer care day services

Please note: The falls risk screen is a guide for staff and does not replace clinical judgement. If staff judge a client to be clinically at risk of a fall due to risk factors that are not considered within the screening tool, this always overrides an individual risk score. Further assessment and management should be recommended in these cases. If any risk factor is identified in the screen an associated mitigation strategy should be considered and documented in progress notes.

5.3 Identifying high risk clients

High risk status should be determined on the basis of:

- A score between four and nine (4-9) on the FROP-Com Screen **or**
- The judgement of the clinician or clinicians involved in the care of the client. Clinical judgement overrides an individual risk screen score.

The following group of patients should be automatically classified as high risk: previous fall in the last 12 months; or have a cognitive impairment, dementia, head injury, epilepsy, syncope, visual impairment, or are aged > 80.

High risk status should be documented in the clinical record as part of the care plan and communicated to relevant members of the multidisciplinary team. Where applicable, this should be as a routine part of clinical handover.

5.4 Frequency of falls risk screening

Falls risk screening should be repeated:

- If the client's condition changes e.g. fall, post hospital admission, deterioration in physical or mental condition
- Periodically, as determined appropriate by the specific service e.g. every three months.

5.5 Standard care actions for all clients

Falls prevention should be part of routine care for all clients who attend SESLHD facilities for treatment, regardless of risk status. Standard care actions should include:

- Orientate client to bed/treatment area, toilet and unit
- Establish the level of assistance that is required for mobility and personal care
- Instruct client on the use of the call bell, ensure it is within reach and advise to call for assistance if required
- Ensure frequently used items (including mobility aids) are within easy reach and are adjusted for the client
- Ensure bed and/or chair are at the appropriate height for the patient/client – instruct client on use if remote control operated position changes are possible
- Ensure bed and chair brakes are on at all times

- Position over-bed table on the non-exit side of the bed
- Place IV pole and all other devices/attachments on the exit side of the bed
- Ensure attachments (such as catheters, IVs) are secured
- Remove clutter and obstacles from treatment area and bathrooms
- Ensure client is using appropriate personal aids such as clean glasses and/or working hearing aids
- Ensure client wears appropriate footwear when ambulating
- Educate client and carer or family about the risk of falling and safety issues
- Where possible, place high risk clients in an area that is visible from the nurses station so the client can be more easily observed
- Encourage a carer or family member to stay with high-risk clients if possible / appropriate.

5.6 Information for high-risk patients

Clients and carers should be alerted to the client's high falls risk status and involved in discussions about falls risk management. The advice from clients and carers should be used to develop, where relevant, the client's management plan. Use Health Care Interpreters (face to face or telephone) to involve patients/carers who do not speak English as a first language.

Information should be provided to clients and carers. The most relevant resources for patients, carers and family will depend on the clinical setting but recommended resources available CEC website which includes Staying Active and on Your Feet Booklet to order Or download PDF and any culturally adapted resources.

Brochures (English only): stay safe at home, Dizziness, Eyesight, Postural Hypotension, Urge Incontinence, Discharge after Hospital.

Falls Prevention for Maternity Services, Moving around safety in hospital, Strength and balance exercise, Falls in public places, Information following a fall at home, Home Safety.

Brochures (**selection languages)**: Foot care and safe footwear, How to get up if you have a fall, Information for those at risk of a fall, Medication, Falls Prevention in Hospital, Patients who are confused could fall when in hospital, Home exercises, How to fall-proof yourself.

5.7 Referral options for further assessment

Clients who are deemed at high risk of falling after completion of a falls risk screening tool should undergo a more detailed assessment to identify contributory risk factors and enable targeted intervention[2].

For many services, it will not be feasible to conduct a more detailed falls assessment if screening indicates that a client is at high risk of falls. In these cases, it is recommended that the client's General Practitioner (GP) is alerted as to the client's high-risk status. A copy of the

falls risk screen, which outlines the domains contributing to the high-risk status, should be provided to the GP. Consider Falls Prevention Programs listed on the SESLHD District Falls prevention Program intranet page.

Other referrals that may be appropriate include:

- Specialist medical practitioners such as a Geriatrician or Ophthalmologist
- Specialist clinics e.g. falls clinic, osteoporosis clinic or aged care clinics
- Home medicines review
- Community health services
- Allied health and other health professionals e.g. physiotherapists, occupational therapists, dietitians, podiatrists, continence advisors
- Evidence-based multifactorial falls prevention such as Stepping On
- Evidence-based exercise such as Tai Chi.
- Aboriginal/Torres Strait island specific services (e.g. Aboriginal Medical Centre)

The CEC has produced a flowchart including suggested referral options based on the FROP-Com fall risk screen results. The flowchart may be used to guide actions after completion of the risk screen. Refer here for copy.

5.8 Clinical handover

Information that must be included as part of clinical handover varies depending on the point of handover but includes:

- High falls risk status
- Falls prevention strategies in place
- Fall incident details and post fall management if a fall occurs during an occasion of service.

Points of clinical handover may include:

- When transferring temporarily to other departments (e.g. for diagnostic procedures and operating theatres) to ensure appropriate supervision is provided. This includes instructing porters/technical aids of the level of assistance required during transit
- At shift handover so that commencing staff are aware of the patient's falls risk status and staff can be allocated accordingly
- Multidisciplinary team meetings such as case conferences.

Section 6 - Perioperative / Day Surgery Units

6.1 Who should be screened for falls risk?

People over the age of 65, Aboriginal and Torres Strait Islander people over the age of 45 and people with chronic health conditions should be screened for risk of falls pre-operatively. This includes **both admitted and non-admitted patients** who present to the perioperative unit to undergo a procedure.

It may also include patients who present to other departments for a day procedure and sedation is required e.g. interventional radiology.

If the person has been screened for falls risk in the pre-admission clinic, completion of the screening tool should be repeated on the day of the procedure.

6.2 Use of a best practice screening tool

The Ontario Modified Stratify (Sydney Scoring) falls risk screen is the recommended screening tool for perioperative and day surgery units.

The screening tool is available as part of the electronic medical record. Please see the CEC Falls Prevention page for a copy of the screening tool.

Please note: The falls risk screen is a guide for staff and does not replace clinical judgement. If staff judge an inpatient to be clinically at risk of a fall, this always overrides an individual risk score.

6.3 Identifying high risk clients

High risk status must be documented in the medical record and communicated to relevant clinical staff as a routine part of clinical handover.

An orange fall risk sticker (Stream Solutions stock code number NH600955) should be placed on the Pre and Post Procedure handover at a minimum.

Falls risk alerts will be automatically generated on eMR for patients who score greater than or equal to nine (9) on the OMS. High falls risk should also be included as part of clinical handover.

The following group of patients should be automatically classified as high risk: previous fall in the last 12 months; or have a cognitive impairment, dementia, head injury, epilepsy, syncope, visual impairment, or are aged > 80.

Information on identified falls risk and prevention strategies should be provided to patients and their carers in a format that is understood and meaningful. Use Health Care Interpreters (face

to face or telephone) and translated resources, if available, to provide information to high risk patients (and carers/families) who do not speak English as a first language.

Patients over the age of 65 who have had an anaesthetic should be considered at high risk of falls after surgery. In cases where re-screening is not feasible post-anaesthetic, staff should consider both the pre-anaesthetic falls risk status and previous function to guide the care of individual patients on the unit.

6.4 Standard care actions for all patients

Falls prevention should be part of routine care for all patients who attend SESLHD day surgery units for treatment, regardless of risk status.

Standard care actions should include:

- Orientate client to bed/treatment area, toilet and unit
- Instruct client on the use of the call bell, ensure it is within reach and advise to call for assistance if required
- Ensure frequently used items (including mobility aids) are within easy reach and are adjusted for the client
- The bed should be kept at the lowest height with bed brakes on and returned to appropriate height for nursing or medical procedures as required
- Position over-bed table on the non-exit side of the bed
- Place IV pole and all other devices/attachments on the exit side of the bed
- Ensure attachments (such as catheters, IVs) are secured
- Remove clutter and obstacles from the treatment area and bathrooms
- Ensure client is using appropriate personal aids such as clean glasses and/or working hearing aids
- Encourage the patient to wear appropriate footwear when mobilising and discourage mobilising in bare feet, socks, surgical stockings or slippers without adequate grip
- Establish client's level of personal care need
- Consider the use of bed rails on an individual basis and in discussion with the patient. It is recommended that the bed rails are up if the person is under the effects of anaesthesia
- Instruct the patient to move slowly when changing position e.g. from lying to sitting or sitting to standing and to alert staff if feeling dizzy or unwell
- Provide instruction on how to obtain assistance when getting in/out of bed, transferring to chairs and mobilising to the toilet post-procedure
- Assist or supervise the patient when they first mobilise post-procedure. Assess the need for ongoing assistance

- Educate client and carer or family about the risk of falling and safety issues.

6.5 Information for high risk clients

Clients and carers should be alerted to the client's high falls risk status and involved in discussions about falls risk management. The advice from clients and carers should be used to develop, where relevant, the falls prevention strategies. Use Health Care Interpreters (face to face or telephone) to involve patients/carers who do not speak English as a first language and any culturally adapted resources.

Information should be provided to clients and carers about falls risk and management. The CEC has produced a range of one page information flyers available here or by order through Stream Solutions (see page 11 for topics and order details). Some of these flyers, including 'Falls prevention in hospital', are available in languages other than English.

6.6 Referral options for further assessment

The patient and/or their carer and general practitioner should be informed that the patient was identified as having a high falls risk during their hospitalisation.

Communicate in-hospital fall incidents to the patient's GP and residential aged care facility (if applicable) for further assessment / follow up.

6.7 Clinical handover

Accurate information during clinical handover is key to patient safety.

Information that must be included as part of clinical handover varies depending on the point of handover but includes:

- High falls risk status
- Falls prevention strategies in place
- Fall incident details and post fall management if a fall occurs during admission to the unit.

Points of clinical handover may include:

- Before transfer between units to assist in appropriate bed and staffing allocation
- When transferring temporarily to other departments (e.g. for diagnostic procedures and operating theatres) to ensure appropriate supervision is provided. This includes instructing porters/technical aids of the level of assistance required during transit
- At shift handover so that commencing staff are aware of the patient's falls risk status and staff can be allocated accordingly.

Section 7 – Emergency Departments

7.1 Who should be screened for falls risk?

The Emergency department (ED) presents some unique challenges and opportunities for falls prevention and management. Teams working within Emergency departments care for both admitted and non-admitted patients as well as a diverse and high risk patient demographic including but not limited to, older adults, people with chronic health conditions, people presenting with mental health and/or drug and alcohol related concerns, and in some cases, children.

All people who present to the Emergency Department and are **admitted to** hospital must be screened for risk of falls within eight (8) hours of admission. Please refer to SESLHDPR/380 - Falls prevention and management for people admitted to acute and sub-acute care for the procedure for hospital inpatients.

If an admitted person is identified to be at high risk of falls in the Emergency Department, this should be communicated to the ward in **advance of the transfer.**

All people over the age of 65 or Aborignal and Torres Strait Island people over the age of 45 with chronic health conditions who are assessed by the specialist aged care services, such as Aged Care Service in Emergency Team (ASET) In the Emergency Department or any other service in the ED department should be asked about any falls in the last 12 months.

For example:

> *In the past year, have you had any falls including a slip or a trip in which you lost your balance and landed on the floor, ground or other lower level?*

People who report one fall in the past year should be further screened for falls risk. As part of screening, it is important for staff to speak with family/carers for collateral falls history especially with patients who have cognitive impairment or dementia.

People who report one fall in the past year should be further screened for falls risk. A history of two or more falls in the previous year negates the need for further screening and should trigger an assessment or a recommendation for referral for further assessment and potential tailored intervention, if not already undertaken.

7.2 Use of a best practice screening tool

The emergency department provides an opportunity to screen older people for their risk of falling and refer for further assessment.

The Ontario Modified Stratify (Sydney Scoring) falls risk screen is available in FirstNet for identifying people at high risk of falls. This tool has been validated for use in inpatients. However, given the need to identify people at high risk and implement falls prevention strategies for people whilst they are in the ED, this is currently the only available tool via eMR.

The following group of patients should be automatically classified as high risk and need a falls plan: previous fall in the last 12 months; or have a cognitive impairment, dementia, head injury, epilepsy, syncope, visual impairment, or are aged > 80.

Please note: The falls risk screen is a guide for staff and does not replace clinical judgement. If staff judge a patient to be clinically at risk of a fall, this always overrides an individual risk score.

7.3 Standard care actions for all patients

Falls prevention should be part of routine care for all patients who attend SESLHD Emergency Department, regardless of risk status.

Standard care actions should include:

- Orientate client to bed/treatment area, toilet and unit
- Instruct client on the use of the call bell, ensure it is within reach and advise to call for assistance if required
- Ensure frequently used items (including mobility aids) are within easy reach and are adjusted for the patients
- The bed should be kept at the lowest height with bed brakes on and returned to appropriate height for nursing or medical procedures as required
- Position over-bed table on the non-exit side of the bed
- Place IV pole and all other devices/attachments on the exit side of the bed
- Ensure attachments (such as catheters, IVs) are secured
- Remove clutter and obstacles from the treatment area and bathrooms
- Encourage the patient to wear appropriate footwear when mobilising and discourage mobilising in bare feet, socks, surgical stockings or slippers without adequate grip
- Consider the use of bed rails on an individual basis and in discussion with the patient.
- Instruct the patient to move slowly when changing position e.g. from lying to sitting or sitting to standing and to alert staff if feeling dizzy or unwell
- Provide instruction on how to obtain assistance when getting in/out of bed, transferring to chairs and mobilising to the toilet.
- **Assist or supervise the patient** when they **first mobilise** and provide **supervision** if the **bathroom for high risk** patients
- Assess the need for ongoing assistance.
- Educate client and carer or family about the risk of falling and safety issues.

7.4 Information for high risk patients

Information on falls and prevention strategies should be provided to clients and carers. The most relevant resources will depend on individual patient factors and should consider factors

such as cognition, preferred language and ability to read written information. Available resources include: CEC patients, carers and family falls prevention and management brochures and Staying Active and on your feet booklet.

7.5 Referral options for further assessment

The patient and/or their carer and general practitioner should be informed that the patient was identified as being at increased risk of falls and any referrals and/or recommendations should be detailed in the patient's discharge letter.

Communicate in-hospital fall incidents to the patient's GP and residential aged care facility (if applicable) for further assessment / follow up.

Consider Falls Prevention Programs listed on the SESLHD Falls prevention Program intranet page.

Discharge referrals that may be appropriate for people at high risk of falls include:

- Specialist medical practitioners such as a Geriatrician or Ophthalmologist
- Specialist clinics e.g. falls clinic, osteoporosis clinic or aged care clinic
- Home medicines review
- Community health services
- Allied health and other health professionals e.g. physiotherapists, occupational therapists, dietitians, podiatrists, continence advisors
- Evidence-based multifactorial falls prevention such as Stepping On
- Evidence-based exercise such as Tai Chi
- Aboriginal/Torres Strait Islander specific services (e.g. Aboriginal Medical Centre).

Section 8 – Community Health Services

8.1 Falls Risk Screening

8.1.1 Who should be screened for falls risk?

Clients over the age of 65, Aboriginal and Torres Strait Islander people over the age of 45 and people with chronic health conditions should be routinely asked about any falls in the last 12 months. For example:

> *In the past year, have you had any falls including a slip or a trip in which you lost your balance and landed on the floor, ground or other lower level?*

People who report one or more falls in the past year should be screened for falls risk or, where this is not feasible, be referred back to their General Practitioner for follow up. Some services may choose to screen all clients in the target group, rather than ask a pre-screening question.

8.1.2 Use of a best practice screening tool

The FROP-Com Community Falls Risk Screen[4] (FROP-Com Screen) is the recommended falls risk screening tool for community health clients.

This is available as an ad hoc form in the Community Health and Outpatient Care (CHOC) electronic medical record (eMR). Please refer to the CEC Falls Prevention page for a copy of the tool.

Please note: The falls risk screen is a guide for staff and does not replace clinical judgement. If staff judge a client to be clinically at risk of a fall due to risk factors not considered within the screening tool, this always overrides an individual risk score. Further assessment and management should be recommended in these cases.

The *Falls Risk Assessment Tool (FRAT) for use in primary care* is also a validated screening tool. This is available as an approved SESLHD form (SES060177) and may be scanned into the electronic medical record as per local procedure. Please refer to Appendix A for a copy of the FRAT screening tool.

8.1.3 Frequency of falls risk screening

Falls risk screening should be repeated:

- If the client's condition changes e.g. fall, post hospital admission, deterioration in physical or mental condition, functional improvement
- Periodically, as determined appropriate by the specific service e.g. every twelve months if there is no change in condition

8.1.4 Identifying high risk clients

High risk status should be determined on the basis of:

- A score between four and nine (4-9) on the FROP-Com Screen **or**

- Yes to Question one (1) or a score of three (3) or more on the FRAT **or**
- The judgement of the clinician or clinicians involved in the care of the client. Clinical judgement overrides an individual risk screen score.

High risk status should be documented in the clinical record as part of the care plan and communicated to relevant members of the multidisciplinary team. Where applicable, this should be as a routine part of clinical handover.

8.1.5 Standard care actions for all clients

Falls prevention should be part of routine care for all clients with identified fall risk factors. Standard care actions should include assessment and recommendations around the following:

- Client safety transferring from bed, chairs, toilet and bathroom (shower/bath)
- Bed/chair are appropriate height for client and client has been offered appropriate equipment e.g. over toilet aid, shower chair, reviewing use of bed rails/sticks if cognitive impairment present
- Safe mobility throughout home using appropriate walking aid. Remove clutter where possible for safe egress
- Client safety managing stairs if applicable
- Safe environment, that is free from hazards e.g. mats, slippery tiles
- Safe use of walking aids e.g. brakes on walking frame
- Discuss what client should do if they fall at home, provide written information and develop a falls plan
- Advise clients who are on anti-thrombotic agents (anti-coagulant and anti-platelet agents) of the increased risk of bleeding, including intracranial bleeding, after a fall event and advise to seek medical advice
- Provide information on ‘Personal Alarms’ where appropriate. If the client has a personal alarm, ensure it is working and the client understands how to use it
- Safe footwear
- Personal aids such as glasses and/or working hearing aids
- Educate client and carer or family about the risks of falls and safety issues and ensure they have input into the fall prevention plan
- Information on identified falls risk and prevention strategies must be provided to patients and their carers in a format that is understood and meaningful. Use Health Care Interpreters (face to face or telephone) and translated resources, if available, to provide information to high-risk patients (and carers/families) who do not speak English as a first language.
- See 8.2: Information for high-risk clients for a list of available resources.

8.2 Information for high-risk clients

Information on falls and prevention strategies should be provided to clients and carers. The most relevant resources will depend on the clinical setting, but recommended information includes:

CEC one-page flyers are available in *languages other than English*	http://www.cec.health.nsw.gov.au/keep-patients-safe/Falls-prevention/for-patients-carers-and-families
CEC Community Care resources	http://www.cec.health.nsw.gov.au/keep-patients-safe/Falls-prevention/Community-Care
	Staying Active and on Your Feet booklet ordered here, or Download PDF
Health pathways	This Primary Health website can also assist to find local exercise programs and other referral pathways for those at risk of falls. Visit https://www.cesphn.org.au/general-practice/healthpathways

8.3 Referral options for further assessment

Clients who are deemed at high risk of falling after completion of a falls risk screening tool should undergo a more detailed assessment to identify contributory risk factors[6].

For many services, it will not be feasible to conduct a more detailed falls assessment if screening indicates that a client is at high risk of falls. In these cases, it is recommended that the client's General Practitioner (GP) is alerted as to the client's high-risk status. A copy of the falls risk screen, which outlines the domains contributing to the high-risk status, should be provided to the GP where possible.

Consider Falls Prevention Programs listed on the SESLHD Falls prevention Program internet page.

Other referrals that may be appropriate include:

- Specialist medical practitioners such as a Geriatrician or Ophthalmologist
- Specialist clinics e.g. falls clinic, frailty clinic, Osteoporosis Refracture Prevention Service or aged care clinics
- General Practitioner who can refer for a Home Medicines Review

- Community health services
- Allied health and other health professionals e.g. physiotherapists, occupational therapists, community health liaison pharmacists, dietitians, podiatrists, continence advisors. Refer via My Aged Care for home therapy or for assessment for services at home e.g. Commonwealth Home Support Package, Home Care package
- Evidence-based multifactorial falls prevention such as Stepping On
- Evidence-based exercise such as Tai Chi
- Aboriginal/Torres Strait Islander specific services (e.g. Aboriginal Medical Centre).

The CEC has produced a flowchart including suggested referral options based on the FROP-Com fall risk screen results. The flowchart may be used to guide actions after completion of the risk screen. Refer to the CEC Falls Prevention page for a copy of the flowchart.

8.4 Multifactorial falls risk assessment

Service providers that have the capacity and skill-mix to provide a detailed falls risk assessment for clients identified at risk of falls on screening can consider use of the following validated falls risk assessment tools, or refer to Section 8.5:

- Falls Risk for Older People – Community setting (FROP-Com) Assessment Tool7
  - Consists of 28 domains that are rated, most on a 0-3 scale, and suggests management options for the risk factors identified.
  - Please click here for a copy of the tool
- QuickScreen©
  - Based on the sensorimotor functional model for falls prediction
  - Assesses multiple domains linked to falls risk and provides an opportunity to link with evidence-based, tailored interventions.
  - Details on QuickScreen can be found here

8.5 Common falls risk factors and management strategies

Multifactorial falls risk assessment and management should include assessment of common risk factors. A summary of common falls risk factors and management strategies is included below.

The information is from the Australian Commission on Safety and Quality in Health Care Best Practice Guidelines for Australian Community Care 2009[2]. It has been published here with permission of the ACSQHC. Please refer to the full guidelines for more detailed assessment and management options when required.

8.5.1 Balance and mobility limitations

Assessment

- Use assessment tools to:

- quantify the extent of balance and mobility limitations and muscle weakness
- guide exercise prescription
- measure improvements in balance, mobility and strength
- assess whether the older person has a high risk of falling

Intervention

- Refer client for physiotherapy assessment and intervention, where available
- Offer balance and strength exercise programs to at-risk people who live in the community (e.g. Stepping On, group exercise classes, strength and balance training at home, tai chi classes). http://www.activeandhealthy.nsw.gov.au/ to find a local exercise program.
- All older people should undertake exercises to prevent falls.
- Improve the effectiveness of current exercise programs for preventing falls by including challenging balance training and frequent exercise.
- Encourage frequent and ongoing exercise 2-3 hours per week and increased physical activity in all people in the community, not only those who have an increased risk of falls.

8.5.2 Cognitive impairment

Assessment

- People with cognitive impairment have an increased risk of falls
- People presenting with an acute change in cognitive function should be assessed for delirium and the underlying cause of this change
- People with gradual onset, progressive cognitive impairment should undergo detailed assessment to determine diagnosis, and where possible, reversible causes of the cognitive decline. Reversible causes of acute or progressive cognitive decline should be addressed and treated
- Consider referral to a Geriatrician, neuropsychologist or specialist clinic for assessment
- If a person with cognitive impairment does fall, reassess their cognitive status, including presence of delirium (e.g. using the Confusion Assessment Method or 4AT tool).

Intervention

- Interventions shown to work in cognitively intact populations should be offered to cognitively impaired populations; however, may need to be modified and supervised, as appropriate.

  The Clinical practice guidelines and principles of care for people with dementia[9] clearly state that people with dementia should not be excluded from any health care services because of their diagnosis, whatever their age.

8.5.3 Continence

Assessment

- Older people should be offered a continence assessment to check for problems that can be modified or prevented. Consider common causes of urinary and bowel dysfunction including urinary tract infection, nocturia, urinary frequency and urgency, constipation (causing overflow diarrhea).

Intervention

- Manage problems associated with urinary tract function as part of a multifactorial approach to care
- Consider referral to a Continence nurse or clinic, where available.

8.5.4 Dizziness and vertigo

Assessment

- Vestibular disorders as a cause of dizziness, vertigo and imbalance need to be identified in the community setting. A history of vertigo or a sensation of spinning is highly characteristic of vestibular pathology.
- Trained health professionals can use the Dix–Hallpike test to diagnose benign paroxysmal positional vertigo, which is the most common cause of vertigo among older people, and which can be identified in the community setting. This is the only cause of vertigo that can be treated easily.

Interventions

- Use vestibular rehabilitation to treat dizziness and balance problems where indicated
- Use the Epley manoeuvre to manage benign paroxysmal positional vertigo
- All manoeuvres should only be done by a health care professional with the relevant training and experience.

8.5.5 Feet and footwear

Assessment

- Assessment should include screening for ill-fitting or inappropriate footwear and for foot pain, sensation deficits and other foot problems, because these are risk factors for falls.

Interventions

- Refer to a podiatrist for assessment and multifaceted intervention, where available
- Include an assessment of footwear and foot problems as part of an individualised, multifactorial intervention for preventing falls in the community
- Health care providers should provide education and information about footwear features that may reduce falls risk.

- Safe footwear characteristics include:
    - soles: shoes with thinner, firmer soles appear to improve foot position sense; a tread sole may further prevent slips on slippery surfaces
    - heels: a low, square, wide heel improves stability
    - collar: shoes with firm and supportive heel collars improve foot stability.
    - Fastening: shoes with fastening such as Velcro, laces or zips to reduce risk of trips and falls

8.5.6 Home safety

Assessment

- People considered to be at higher risk of falling should be assessed by an occupational therapist (OT) for specific environmental or equipment needs and training to maximise safety. Home safety intervention by an OT high level evidence for falls prevention high risk patients.

Intervention

- Environmental review and home hazard modification by an OT should be considered as part of a multifactorial approach in a falls prevention program for people at high risk of falls in the community
- When conducted as a single intervention, home environment interventions are effective for reducing falls in high-risk older people.

8.5.7 Medications

Assessment

- Older people living in the community and people with chronic conditions (See Section 3 for definition) should have their medications (prescribed and non-prescribed) reviewed at least yearly, and for those on four or more medications, at least six monthly.

Intervention

- Medication review and modification should be undertaken as part of a multifactorial approach to falls prevention. Clients in SESLHD can be referred for a Home Medicines Review by their General Practitioner or community health liaison pharmacist.
- For individual older people, gradual and supervised withdrawal of psychoactive medications should be considered to prevent falls
- Pharmacist-led education on medication and a program of facilitated medication review by general practitioners should be encouraged in the community setting.
- Consider likely pharmacological changes when prescribing any new medication to an older person and avoid prescribing psychoactive drugs if clinically possible.

8.5.8 Syncope

Assessment

- Older people who report unexplained falls or episodes of collapse should be assessed for the underlying cause.

Intervention

- Assessment and management of potential causes of pre-syncope and syncope should form part of a multifactorial intervention to reduce the rate of falls in older people
- Refer to the patient's General Practitioner or to a specialist for review as cardiac pacing is effective in older people who live in the community, and who have carotid sinus hypersensitivity and a history of syncope or falls, to reduce the rate of falls.

8.5.9 Vision

Assessment

- Where possible, include a test of vision as part of a falls risk assessment e.g. Melbourne Edge test
- Clients who have double vision or visual field loss (from conditions including stroke and glaucoma) are also at higher risk of falls
- Encourage older people to have regular eye examinations (every two years) to reduce the incidence of visual impairment, which is associated with an increased risk of falls.

Interventions

- Older people with visual impairment primarily related to cataracts should undergo cataract surgery as soon as practicable.
- Refer to Orthoptics (Allied Health) for a vision and visual function assessment. Referrals can be made to either Orthoptics or Ophthalmology, depending on local services, via a GP, Medical Specialist or Optometrist
- When correcting other visual impairment (e.g. prescription of new spectacles), explain to the older person and to their family and carers (where appropriate) that extra care is needed while the older person gets used to the new visual information
- Advise older people who take part in regular outdoor activities to avoid bifocals or multifocals and to use single-vision distance spectacles when walking — especially when negotiating steps or walking in unfamiliar surroundings
- People with severe visual impairment should receive a home safety assessment and modification program specifically designed to prevent falls.

8.5.10 Hearing

Assessment and interventions

- Determine if hearing impairment is present.

- Consider if patient has hearing aids and if they were wearing them.
- Consider referral to audiology service.
- Audiology testing can quantify the degree of hearing loss. The auditory and vestibular systems are closely connected, and therefore auditory symptoms (hearing loss, tinnitus) commonly occur in conjunction with symptoms of dizziness and vertigo.

8.5.11 Frailty

Assessment

- Use a validated measurement tool to identify frailty e.g. Clinical Frailty Scale, Fried's Frailty Phenotype, FRAIL Scale, Frailty Index, Edmonton Frail Scale
- Consider referral for a comprehensive Geriatric assessment if risk factors are present.

Interventions

- Prescribe physical activity programs (resistance training, aerobic training, balance training)
- Nutritional interventions (protein or protein-energy supplementation)
- Multicomponent intervention
- Individualised geriatric care targeting clinical outcomes and addressing polypharmacy.

Section 9 – Minimsing injury from falls

9.1 Osteoporosis screening and management

Patients with a history of falls should be considered for a bone health assessment. Patients (postmenopausal women and men > 70 years) who sustain a minimal trauma fracture should be assessed for their risk of falls. This should include a bone densitometry testing (DEXA) as well as pathology testing to determine serum levels of Vitamin D, Calcium and other hormonal markers.

People with diagnosed osteoporosis or with a history of a minimal trauma fracture should be offered pharmacological treatment for which there is evidence of benefit. This can be initiated in hospital, through specialist or communicated to the General Practitioner.

9.2 Calcium and Vitamin D supplementation

Consider adequacy of calcium and vitamin D as part of routine assessment of falls risk in older people living in the community.

Vitamin D should be recommended as an intervention strategy to prevent injurious falls in older people who live in the community, particularly if they are not exposed to the minimum recommended levels of sunlight. Benefits from supplementation are most likely to be seen in people who have vitamin D insufficiency [25(OH)D<25nmol/L]. Avoid high monthly dose and once year megadose of Vitamin D.

Calcium supplementation should be considered for those not able to achieve adequate levels of calcium through their diet. Encourage older people to include high calcium foods in their diet and exclude foods that limit calcium absorption.

9.3 Exercise prescription for bone health

Consider prescription of suitable exercises to address Osteoporosis including:

- Falls prevention exercise; balance challenging, core strengthening.
- Impact exercise; low, moderate, high
- Weight-bearing aerobic exercise
- Progressive resistance training; bodyweight, free weight, TheraBand or machine weight

Section 10 – Post-fall management

10.1 In-hospital (Ambulatory care,Outpatients, Cancer Care, Renal Dialysis Units, Perioperative Units and Emergency

Staff to follow local CERS policy and follow CEC Post Fall Guide and follow CEC Post Fall Assessment and Management guide.

- Undertake a rapid assessment to check for pain, bleeding, injury, possible fracture
- Ask for assistance. If the patient is able to be moved, help the patient back to a chair or bed using appropriate manual handling techniques
- Take baseline vital signs (Blood Pressure, Heart Rate, Respiratory Rate, oxygen saturation, temperature, blood sugar level, and pain score). Repeat hourly for first four hours or as clinically indicated
- Neurological Observations are mandatory post fall, regardless of whether the patient hit their head. Observations should be undertaken hourly for first four hours or as clinically indicated
- All patients must be referred for a medical review after the incident. The medical officer who reviews the patient must document an assessment and management plan in the medical record
- Check for Sepsis - follow NSW Health Adult Sepsis Pathway
- Check for Delirium - follow SESLHDPR/345 - Prevention, Assessment and Management of Delirium in older people
- **Intracranial bleeding can occur even in the absence of a direct injury to the head**. A number of patient level factors can contribute to an increased risk of intracranial bleeding. These include: use of anti-thrombotic agents (anti-coagulants and anti-platelet agents); haematological disorders; end-stage renal failure (including dialysis patients); and liver disease. Presence of these factors should lower the threshold for CT scanning of the head.
- Refer to NSW Health Initial management of closed head injury in adults.

  Strong indication for a CT scan if:

  - GCS <15 at two hours post injury
  - Deterioration in GCS
  - Focal neurological deficit
  - Clinical suspicion of skull fracture
  - Vomiting (especially if recurrent)
  - The patient is on anticoagulants, anti-platelets or has a known coagulopathy or bleeding disorder, such as haematological disease or chronic renal failure
  - Age >65 years

- Seizure
- Prolonged loss of consciousness (>5mins)
- Persistent post traumatic amnesia (A-WPTAS <18/18 at four hours post injury)
- Persistent abnormal alertness / behaviour / cognition
- Persistent severe headache.

Relative indication for a CT scan if:

- Large scalp haematoma or laceration
- Multi-system trauma
- Dangerous mechanism
- Known neurosurgery / neurological impairment.

- Immediate and ongoing prescription of anti-thrombotic agents following a fall should be considered on an individual basis by the treating clinical team. This is of particular relevance to those at increased risk of bleeding
- Inform the patient's family/carers as soon as is practicable (with consent where able) of the fall incident and the strategies put in place to prevent further falls in line with NSW Health Policy Directive PD2014_028 - Open Disclosure
- An electronic post fall management form should be completed. This can be found in Ad Hoc forms
- Repeat the fall risk screen
- Document the risk status and post fall management in the health care record
- Falls risk status, prevention strategies in place, inpatient fall incident and post fall management details should be included in clinical handover
- Record fall incident in incident management system and document the Incident ID in the medical record.
- Inform the Nursing Unit Manager
- Events with a Harm score 2 (IMS+) must be reviewed using the approved SESLHD review template which can be found on the intranet

10.2 Community care settings

- Management of fall incidents should be in line with the Clinical Excellence Commission Post Fall Guide for Community Care
- If the person requires Basic Life Support, call an ambulance (Dial 000). Commence DRSABCD (Danger, Responsive, Send for Help, Airway, Breathing, CPR, Defibrillator if available)
- Check for signs of injury. If you have concerns based on your clinical judgement, call for a clinical review/rapid response
- If the person has had a fall and is unable to get to their feet, has an injury or acute confusion and is unable to be treated and stabilised, call an ambulance. Take vital signs if able. Do not leave the client unattended
- If the person has a witnessed fall or is found on the floor but has no obvious injury and is able to get up to their feet:
  - Where required assist person into a chair using appropriate manual handling techniques
  - Discuss the incident with the person and assess for any change in function (ADL/mobility), behaviour and/or cognition
  - Contact person responsible or support person/carer - and if not available facilitate follow-up call/s to check on condition
  - Contact their GP to inform them of the fall and relay any relevant information
  - **Intracranial bleeding can occur even in the absence of a direct injury to the head**. A number of patient level factors can contribute to an increased risk of intracranial bleeding. These include: use of anti-thrombotic agents (anti-coagulants and anti-platelet agents); haematological disorders; end-stage renal failure (including dialysis patients); and liver disease
  - Warn the person/family/carer of delayed signs: dizziness, blurred vision, headaches, confusion (disorientation, agitation, restlessness and changes in behaviour - be alert for head injury), sudden onset of pain or new pain, inability to weight bear
  - Advise them to contact their GP and/or ambulance if any of these signs develop
  - Gain consent from the person to make referrals to appropriate services for falls risk assessment and management if required
  - Do not leave the person until stabilised. Where possible, await the arrival of a support person
- Record fall incident in incident management system and document the Incident ID in the medical record.
- Document the post fall actions in line with local policy and communicate fall information at clinical handover
- Consider holding an MDT post fall huddle
- Make referrals to appropriate disciplines for ongoing falls risk management

- Harm score 2 (IMS+) must be reviewed using the approved SESLHD review template which can be found on the Intranet.

Section 11 – References and Version and Approval History

References

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Version and Approval History

Date	Version	Version and approval notes
June 2017	1	Approved by Clinical and Quality Council to publish.
September 2020	2	Updates endorsed by Executive Sponsor
13 October 2023	2.1	Minor review to include CEC post fall huddle process, world guidelines, 4AT delirium screening tool. Included additional information for people over 65 years and noting mobility exercise information.
13 October 2023	2.2	Correction made to review date on cover page.

Appendix A: Falls Risk Assessment Tool (FRAT)

Health
South Eastern Sydney
Local Health District

Facility:

FAMILY NAME | MRN

GIVEN NAME | ☐ MALE ☐ FEMALE

D.O.B. ____/____/____ | M.O.

ADDRESS

LOCATION / WARD

COMPLETE ALL DETAILS OR AFFIX PATIENT LABEL HERE

SES060177

FRAT
FALLS RISK ASSESSMENT TOOL

Assessment of falls risk in older people (Part 1)

Multi - professional guidance for use by the primary health care team, hospital staff, care home staff and social care workers

This guidance has been derived from longitudinal studies of factors predicting falls in older people and randomised controlled trials that have shown a reduction in the risk of falling. (Adapted for local use but originally designed by Queen Mary College, University of London)

Definition: Fall-
An event whereby an individual comes to rest on the ground or another lower level with or without loss of consciousness (NICE 2004)

Notes for users:

1) Complete assessment form below. The more positive factors, the higher the risk for falling.
2) If there is a **positive response to three or more of the questions on the form, then please see over** for guidance for further assessment, referral options and interventions for certain risk factors.
3) Some users of the guidance may feel able to undertake further assessment and appropriate interventions at the time of the assessment.

Consider which referral would be most appropriate given the patient's needs and local resources

Please note that the use of any falls risk screening tool does not replace clinical judgement in determining falls risk status

		YES	NO
1	Is there a history of any fall in the previous year? **How assessed? Ask the person.**		
2	Is the patient / client on four or more medications per day? **How assessed? Identify number of prescribed medications.**		
3	Does the patient / client have a diagnosis of stroke or Parkinson's Disease? **How assessed? Ask the person.**		
4	Does the patient / client report any problems with his / her balance? **How assessed? Ask the person.**		
5	Is the patient / client **unable** to rise from a chair of knee height? **How assessed? Ask the person to stand up from a chair of knee height without using their arms.**		

NB: If answer **YES** to question 1 or if total score is 3 or more please provide falls prevention information

Has language specific falls prevention information been provided to the client ☐ Yes ☐ No

If yes please specify _____

Other/Comment: _____

Name _____ Designation _____

Signature _____ Date ____/____/____

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FRAT FALLS RISK ASSESSMENT TOOL SES060.177

Health
South Eastern Sydney
Local Health District

Facility:

FRAT
ACTION PLAN

FAMILY NAME | MRN

GIVEN NAME | ☐ MALE ☐ FEMALE

D.O.B. ____/____/____ | M.O.

ADDRESS

LOCATION / WARD

COMPLETE ALL DETAILS OR AFFIX PATIENT LABEL HERE

Risk factor present	Further assessment	Immediate Interventions	Referral options	Sign & Date Once actioned
1) History of falling in the previous year	a) Review incident(s), identifying precipitating factors.	☐ a) Discuss fear of falling and realistic preventative measures. ☐ b) Appropriate referral made ☐ c) Issue falls prevention information	☐ **a) Occupational Therapy** *If falls associated with home hazard or activities of daily living* ☐ **b) Physiotherapy** *If falls associated with decreased balance, strength or a general decrease in mobility* ☐ **c) Nursing** *If falls associated with continence issues* ☐ **d) Medical** *If falls associated with change in health or medical condition including dizziness*	
2) Four or more medications per day	a) Identify types of medication prescribed. b) Ask about medication side effects e.g. dizziness, drowsiness.	☐ a) Encourage client to have medications reviewed by **LMO or Pharmacist.** ☐ b) Referral to **medical registrar**	☐ **a) General Practitioner.** ☐ **b) Medical registrar** ☐ **c) Pharmacist** ☐ **d) Geriatrician/specialist** ☐ **e) CNS**	
3) Diagnosis of stroke/Parkinson's disease	a) Identify medical history b) Ask re identified/known mobility issues/concerns c) Ask re any new/recent mobility concerns	☐ a) Encourage client to have a **LMO/ specialist review** ☐ b) **Physiotherapy/ Occupational Therapy** review	☐ **a) LMO** to review if required ☐ **b) Specialist** review if required ☐ **c) Physiotherapy** ☐ **d) Occupational Therapy**	
4) Balance and gait problems	a) Can they talk while walking?" b) Do they sway significantly on standing? c) Does the client use a walking aid?	☐ Refer to **physiotherapy/ occupational therapy** and note/discuss concerns	☐ **a) Physiotherapy.** ☐ **b) Occupational Therapy** – aids & equipment	
5) Functional transfers	a) Observation of client rising from chair.	☐ Referral to **physiotherapy/ occupational therapy** and note/discuss concerns	☐ **a) Physiotherapy.** ☐ **b) Occupational Therapy** – aids & equipment/ home modifications	

* While the client is walking ask them a question but keep walking while you do so. If the patient stops walking either immediately or as soon as they start to answer, they are at higher risk of falling.

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