## ONTARIO MODIFIED STRATIFY (SYDNEY SCORING)

### FALLS RISK SCREEN

**COMPLETE ALL DETAILS OR AFFIX PATIENT LABEL HERE**

<table>
<thead>
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<th>Facility:</th>
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### COMPLETE ON ADMISSION (A), POST FALL (PF), CHANGE OF CONDITION (CC), OR WHEN APPROPRIATE (W)

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<tr>
<th>Date</th>
<th>Score</th>
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<tr>
<th>Value</th>
<th>A</th>
<th>PF</th>
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### 1. History of Falls
Did the patient present to hospital with a fall or have they had a fall since admission?
- Yes to any = 6

If not, has the patient fallen within the last 6 months?

### 2. Mental Status
Is the patient confused? (i.e. unable to make purposeful decisions, disorganised thinking and/or memory impairment)
- Is the patient disorientated? (i.e. lacking awareness, being mistaken about time, place or person)
- Is the patient agitated? (i.e. fearful affect, frequent movements and/or anxious)
  - Yes to any = 14

### 3. Vision
- Does the patient require eyeglasses continually?
- Does the patient report blurred vision?
- Does the patient have glaucoma, cataracts or macular degeneration?
  - Yes to any = 1

### 4. Toileting
Are there any alterations in urination? (i.e. frequency, urgency, incontinence, nocturia)
- Yes = 2

### 5. Transfer Score (TS) [means from bed to chair and back]
Independent - use of aids to be independent is allowed
Minor help - one person easily or needs supervision for safety
Major help - one strong skilled helper or two normal people; physically can sit
Unable - no sitting balance, mechanical lift
- Add Transfer Score (TS) and Mobility Score (MS)
  - If total between 0-2, then score = 0
  - If total between 3-6, then score = 7

### 6. Mobility Score (MS)
Independent (but may use any aid; e.g. walking stick)
Walks with help of one person (verbal or physical)
Wheelchair independent including corners, etc
Immobile
- ≥9 = HIGH RISK OF FALLS

**TOTAL SCORE**

If a patient scores <9, a clinician using clinical judgment can determine a high level of risk risk for that patient.

- Clinical Judgement
- High Risk Reason:

If any falls risk factors are identified, complete the relevant section on the Falls Risk Assessment and Management Plan (FRAMP) and implement actions.

*Name: ____________________________*
*Designation: ____________________________*
*Signature: ____________________________*

(Name: ____________________________ Designation: ____________________________ Signature: ____________________________)

*Medications: Is the patient on antipsychotics, antidepressants, sedatives/hypnotics, or opioids?*
- YES ☐ Complete medication section on Falls Risk Assessment and Management Plan.

*Provide patient/family/carers with information about Falls Prevention*
Care actions for all patients

*These care actions are relevant for all patients and are a component of ongoing clinical care at all times.*

- Orientate patient to bed area, toilet and ward
- Educate patient and family, providing culturally appropriate information about the risk of falling and safety issues
- Instruct patient 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, on appropriate side of the bed, in good working order and are adjusted for the patient
- Bed and chair are at appropriate height for the patient – instruct patient on use of bed control (if appropriate)
- Ensure bed brakes are on at all times and chair brakes are on when not mobilising
- Position over-bed table on the non exit side of the bed
- Place IV pole and all other devices/attachments (as appropriate) on the exit side of bed
- Ensure attachments (such as catheters, wound drainage, IVs) are secured
- Remove clutter and obstacles from room
- Ensure patient is using appropriate personal aids such as eyeglasses (that are clean) and/or working hearing aid
- Ensure patient wears appropriate footwear when ambulant
- Establish patient’s level of personal care need
- Ensure adequate night lighting

Provide patient/family/carers with falls prevention information.


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