NSW GOVERNMENT Health

Facility:

ONTARIO MODIFIED STRATIFY (SYDNEY SCORING) FALLS RISK SCREEN

FAMILY NAME	MRN
GIVEN NAME	☐ MALE ☐ FEMALE
D.O.B. _____ / _____ / _____	M.O.
ADDRESS	
LOCATION / WARD	

COMPLETE ALL DETAILS OR AFFIX PATIENT LABEL HERE

		Date / /	Date / /	Date / /
		Score	**Score**	**Score**
Complete on Admission (A), Post Fall (PF), Change of Condition (CC), or When Appropriate (W)	Value	A	PF ☐ CC ☐ W ☐	PF ☐ CC ☐ W ☐
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)	**Yes to any = 14**			
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)				
3. Vision Does the patient require eyeglasses continually?	**Yes to any = 1**			
Does the patient report blurred vision?				
Does the patient have glaucoma, cataracts or macular degeneration?				
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 **0** Minor help - one person easily or needs supervision for safety **1** Major help - one strong skilled helper or two normal people; physically can sit **2** Unable - no sitting balance, mechanical lift **3**	**Add Transfer Score (TS) and Mobility Score (MS)** **If total between 0-2, then <u>score = 0</u>** **If total between 3-6, then <u>score = 7</u>**	**Total of TS+ MS**	**Total of TS+ MS**	**Total of TS+ MS**
6. Mobility Score (MS) Independent (but may use any aid, e.g. walking stick) **0** Walks with help of one person (verbal or physical) **1** Wheelchair independent including corners, etc **2** Immobile **3**				
≥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: _____	Name: _____ Designation: _____ Signature: _____

(Papaioannou A. et al. Prediction of falls using a risk assessment tool in acute care setting BMC Medicine 2004 2:1)

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

<u>Provide patient/family/carers with information about Falls Prevention</u>

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Care actions for all patients

These care actions are relevant for all patients and are a component of ongoing clinical care <u>at all times.</u>

- 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.

Clinical Excellence Commission Falls Prevention flyers available at <u>www.cec.health.nsw.gov.au/programs/falls-prevention</u>

For further information scan this with your smart phone →