ADDRESSOGRAPH/LABEL

Falls Prevention and Management in Personal Care Home

FALL RISK SCREENING TOOL*

Complete within 24 hours of admission, quarterly, annually, when there is a significant change in medical status or when the resident has had a fall resulting in injury or multiple falls.

Date				
Risk Factors *(see reverse for instructions on how to complete each item)*	**Circle**	**Circle**	**Circle**	**Circle**
1. More than 2 falls in previous 6 months (review Falls Log or pre-admission information).	6	6	6	6
2. Impaired mobility, balance or gait.	2	2	2	2
3. Altered mental state (e.g. delirium, brain injury, dementia, depression).	2	2	2	2
4. Attempts to unsafely get out of bed due to lack of understanding, agitation or restlessness.	3	3	3	3
5. Move to facility in past month.	1	1	1	1
6. Dizziness or vertigo.	1	1	1	1
7. Generalized weakness.	1	1	1	1
8. Alterations in urinary and bowel elimination.	1	1	1	1
9. Greater than 7 medications, especially narcotics, anti-depressants, anti-psychotics, diuretics.	1	1	1	1
10. Any prescribed benzodiazepine or psychotropic medication.	1	1	1	1
11. Immobile (unable to walk or stand unaided).	-5	-5	-5	-5
Total (Fall Risk Score)				
Contributing Factors (check if present)				
➢ Vision deficit				
➢ Neuropathy				
➢ Difficulty perceiving elements of the environment				
➢ Underweight or low appetite				
➢ Fear of falling				
➢ Other:				
Initials				

Score less than 7 *At risk for falls.* Score equal to or greater than 7 *Deemed to be at high risk for falls.*

Score greater than 12 *Deemed to be at high risk for falls and unsafe ambulation.*

* Numbers 1 – 11 comprise the *Scott Fall Risk Screen*, a validated tool developed by Dr. Vicki Scott

Guidelines for Completion of the Fall Risk Screening Tool

- The Fall Risk Screening Tool may be used up to four times.
- Enter the date screening is conducted in one of the top right hand columns.
- If a risk factor is true for the resident, circle the corresponding number to the date of the screen.
- If a risk factor is not true, do not circle the corresponding number to the date of the screen.
- Calculate the total of the numbers circled to arrive at the Falls Risk Score.
- Check any Contributing Factors which may be true for the resident. These are not scored.

- Proceed to the Falls Preventions/Interventions Checklist to determine which preventative measures or interventions to implement to best address the identified risk factors true for the resident.

Risk Factor Item Completion

1. More than 2 falls in previous 6 months (review Falls Log or pre-admission information).
   - Prior falls are the greatest predictor of future falls.
2. Impaired mobility, balance or gait.
   - Impaired gait: shuffling, small steps, slow pace, hangs onto walls or furniture.
   - Impaired balance: unsteadiness while standing.
3. Altered mental state (e.g. delirium, brain injury, dementia, depression).
   - Unable to follow instructions, impaired short-term memory, impaired thought processes (psychosis) or conditions which increase agitation and aggression.
4. Attempts to unsafely get out of bed due to lack of understanding, agitation or restlessness.
   - Poor judgment and safety awareness.
   - Attempts to get out of bed could be related to dementia, poor pain control, language barrier, need to toilet, alcohol or cognitive deficits.
5. Move to facility in past month.
   - Score only if the resident has moved in within the past month.
6. Dizziness or vertigo.
   - Unsteady on feet, particularly when rising from a lying or sitting position.
7. Generalized weakness.
   - Resident verbalizes that he/she feels weak.
   - If unable to stand unassisted by side of bed for 2-3 minutes, or unable to do 2 or more of the following:
     - Get up and go to the bathroom independently
     - Sit to stand and back to sit without assistance
     - Able to dress and groom independently
     - Walk across room (20 ft), turn and walk back without assistance (may use mobility aide)
     - Transfer/move in bed
8. Alterations in urinary and bowel elimination.
   - Frequency, urgency, nocturia, occasional or regular incontinence, constipation.
9. Greater than 7 medications, especially narcotics, anti-depressants, anti-psychotics, diuretics.
   - Do not include vitamins, herbal pills, eye ointments, skin creams.
10. Any prescribed benzodiazepine or psychotropic medication.
    - Score this item if the resident is taking any regularly scheduled or as needed benzodiazepines or psychotropic medications.
11. Immobile (unable to walk or stand unaided).
    - Unable to initiate movement.
    - May use a wheelchair, but cannot transfer without assistance.
    - If resident is immobile do not score as “impaired mobility”.