Winnipeg Regional Health Authority | Office régional de la santé de Winnipeg
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Community and Ambulatory Care Client Falls Risk Screening Tool

Screen at-risk clients attending community and ambulatory care settings.

A fall is defined as unintentionally coming to rest on the ground, floor or other lower surface with or without an injury.

FALLS HISTORY		SCORE
1. Number of falls in the past 12 months?	☐ None . . . . . (0) ☐ 1 fall . . . . . (1) ☐ 2 falls . . . . . (2) ☐ 3 or more falls . . . . . (3)	[ ]
FUNCTION: Instrumental Activities of Daily Living (IADL) Status		
2. Prior to this fall, how much assistance was the client requiring for instrumental activities of daily living (e.g. cooking, house and yard work)? • *If no fall in last 12 months, rate current function.* • *If receiving supportive care, client scores 3.*	☐ None (completely independent) . . . . . (0) ☐ Supervision . . . . . (1) ☐ Some assistance required . . . . . (2) ☐ Completely dependent . . . . . (3)	[ ]
BALANCE		
3. When walking and turning, does the client appear unsteady or at risk of losing their balance? • *Observe the person standing, walking a few metres, turning and sitting. If the person uses an aid observe the person with the aid. Do not base on self-report.* • *If level fluctuates, tick the most unsteady rating. If the person is unable to walk due to injury, score as 3.*	☐ No unsteadiness observed . . . . . (0) ☐ Yes, minimally unsteady . . . . . (1) ☐ Yes, moderately unsteady (needs supervision) . . . . . (2) ☐ Yes, consistently and severely unsteady (needs constant hands on assistance) . . . (3)	[ ]
	TOTAL RISK SCORE	[ ]

	Total Risk Score of 1 - 3 Low risk	Total Risk Score of 4 - 9 High risk
Immediate Required Actions	☐ Assist with transfers and mobility as needed	☐ Assist with transfers and mobility, and provide wheelchair as needed ☐ If client has recently fallen and not been assessed for injury, ensure assessment is done ☐ If client has a caregiver providing support, advise of client's fall risk and need for immediate supports ☐ Advise client to contact service providers for immediate assessment (e.g. GPAT, HC/CTS); (referral info on back page) ☐ Provide completed "Your Fall Risk Factors" Client Letter
Recommended Actions	☐ Provide copy of SOYF ☐ Provide completed "Your Fall Risk Factors" Client Letter ☐ Medication review by HCP/pharmacist ☐ If client had 3 or more falls OR a balance score of 3, alert other service providers (e.g. HC case coordinator, family physician) ☐ If client is 65 years or older AND had 3 or more falls or a balance score of 3, refer to internal program resources or Day Hospital for full fall risk assessment and management (referral info on back page)	☐ Medication review by HCP/pharmacist ☐ If client if 65 years or older AND had 3 or more falls, refer to internal program resources or Day Hospital for full fall risk assessment and management (referral info on back page) ☐ If client is involved with a specialty program (e.g. MS Clinic, Movement Disorders Clinic, ALS team) advise of screening results ☐ Provide copy of SOYF ☐ Provide completed "Your Fall Risk Factors" Client Letter

Printed Name _____ Signature and Designation _____ Date: D D M M M Y Y Y Y

The Community and Ambulatory Care Client Falls Risk Screening Tool has been developed from Russell et al's (2009) Falls Risk for Older People in the Community tool, Age and Ageing, 38(1), 40 – 46.

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Instructions for Use

Please complete this three question screening tool on all clients who attend your clinic/facility who are part of a population identified as at risk for falls. This form is to be completed before the "Your Fall Risk Factors" Client Letter.

- For at-risk clients who attend the clinic infrequently, complete this screen *every time they attend*.
- For at-risk clients who attend at least every 4 weeks, complete this screen *at least once every 6 months or each time a client presents with a change in health or functional status*.
- Do not allow the client, caregiver or family to complete the survey themselves. If the client has communication or cognitive limitations, the caregiver or family member may answer on the client's behalf.

The scoring guidelines for the screening tool are as follows:

Question 1: Falls History

Ask the client about the number of falls he or she has had over the past 12 months. The Winnipeg Regional Health Authority defines a fall as "unintentionally coming to rest on the ground, floor or other lower level with or without injury". Score as per the number of falls the client has experienced in the past 12 months with the corresponding value (i.e., "None" = 0; 1 fall = 1; 2 falls = 2; 3 or more falls = 3).

Question 2: Function: Instrumental Activities of Daily Living (IADL) Status

Ask the client about his/her ability to perform IADL *prior to the most recent fall*. Some examples are shopping, performing house or yard work, laundry, and cooking. If the client has not fallen in the past 12 months, ask about his/her current IADL status. If receiving supportive care, client receives a score of 3.

- ***"None (completely independent)" = 0***. The client plans and independently accomplishes all activities of daily living, such as shopping, doctor's appointments, housework, etc.
- ***"Supervision" = 1***. The client is able to plan and accomplish all activities of daily living but feels more comfortable when someone is present during more challenging tasks, such as having someone nearby when getting in and out of the bathtub.
- ***"Some assistance required" = 2***. The client is unable to plan and accomplish most activities of daily living and needs help with driving, shopping, and cleaning but can undertake some tasks, such as light housework, walking to the doctor's office, etc.
- ***"Completely dependent" = 3***. The client is unable to plan or accomplish any activities of daily living, ranging from challenging tasks like heavy yard work to simpler tasks such as using the bathroom.

Question 3: Balance

Observe the client standing, walking a few meters, turning, and sitting. If the client uses an aid, observe him or her using the aid. If the level fluctuates, tick the most unsteady rating. If the client is unable to walk due to injury, score as 3.

- ***"No unsteadiness observed"* = 0**. Balance/steadiness is not compromised.
- ***"Yes, minimally unsteady"* = 1**. Client appears unsteady performing any of these tasks, or is making modifications to appear steady (e.g., an increased level of effort, feet spread apart of maintain balance, or is consistently touching the walls or furniture).
- ***"Yes, moderately unsteady (needs supervision)"* = 2**. Client appears moderately unsteady walking and would require supervision to walk safely, or is making modifications and still appears unsteady.
- ***"Yes, consistently and severely unsteady" (needs constant hands on assistance)* = 3**. Client is consistently or severely unsteady when walking or turning and needs hands on assistance.

After scoring each question, add the scores to get a "Total Risk Score" then take the respective steps listed in the "Immediate Required Actions/Recommended Actions" sections. Please complete the "Your Fall Risk Factors" Client Letter for clients who score a 1 or higher. If the client receives a score of zero, provide him or her with a copy of the SOYF booklet.

Note for Antenatal Staff: Please use Antenatal specific "Your Fall Risk Factors" Client Letter.

Abbreviations and Referral Processes

CTS - Community Therapy Services: referral by HC case coordinator when client already receives services from Home Care. If client receives no services from HC contact Home Care Central Intake Line at 204-787-8330.
DH - Day Hospital: referrals made by HCP – forms available on Insite at *http://home.wrha.mb.ca/hinfo/chif/files/WCC-00017.pdf*
GPAT - Geriatric Program Assessment Team: anyone can make a referral by calling GPAT Central Intake Line at 204-982-0140 or by faxing a completed referral form.
HC - Home Care: anyone can make a referral by calling HC Central Intake Line 204-788-8330.
HCP - Health Care Provider
IADL - Instrumental Activities of Daily Living
SOYF - Staying on Your Feet: fall prevention resource series used by WRHA for clients living in the community