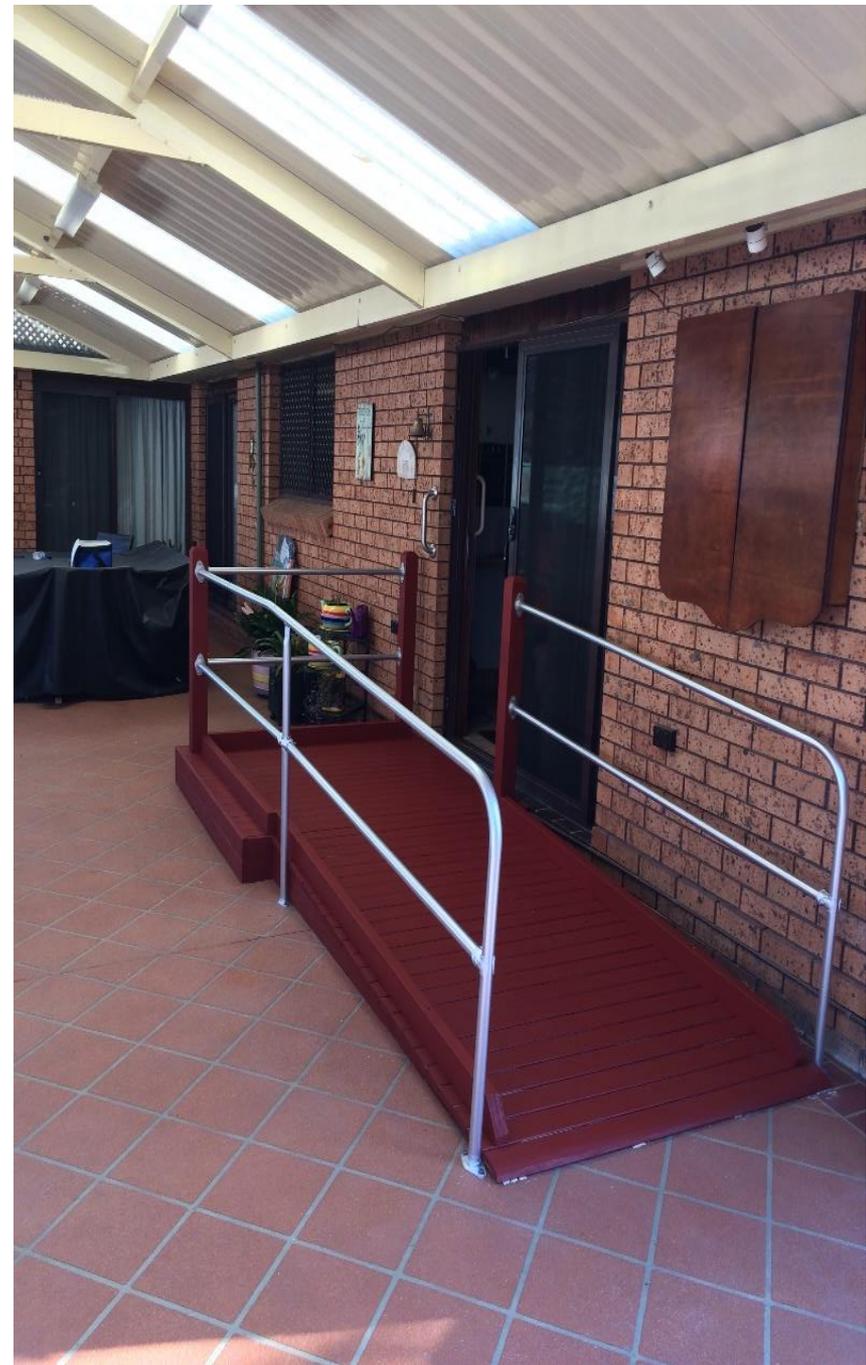
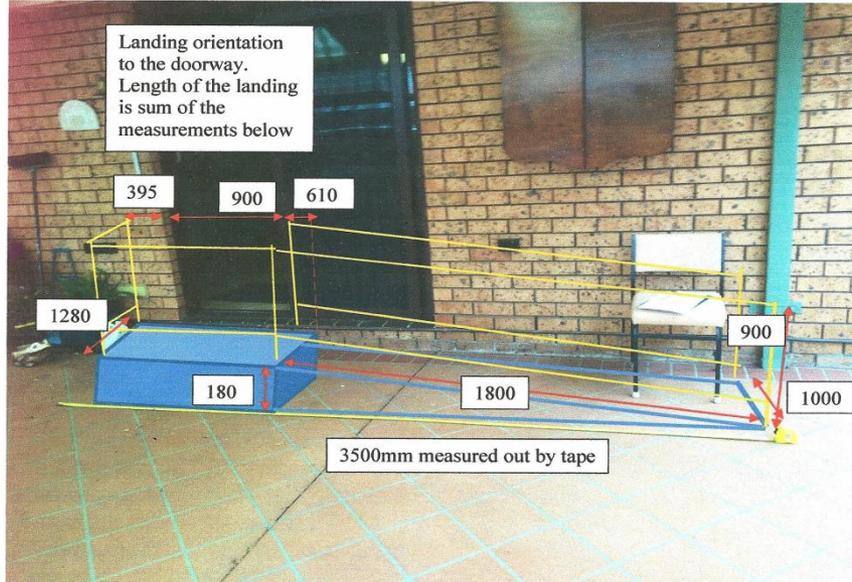


Using the FROP- Com screen

As a tool to inform and evaluate OT
intervention within a Home Modification
Service

Jo Mortimer, OT, CORE Community Services,





METHOD

- Choosing a screening tool - identify high falls risk.
- Linking the tool with an intervention checklist.
- Using the tool in reviewing decision process.

- Identifying services.
- Time efficient methods to refer clients.

- Encourage uptake of suggestions.

- Convincing the Service coordinator: minimal time and could have benefits for the Service.

- Have clients' goals of increased safety in the home been addressed?

**Falls Risk for Older People
in the Community (FROP-Com) Screen**

(Affix Patient ID Label)

UR No _____
Surname: _____
Given Name _____
DOB _____

Screen all people aged 65 years and older (50 years and older Aboriginal & Torres Strait Islander peoples)

Date of screen: / /

FALLS HISTORY		SCORE
1. Number of falls in the past 12 months?	<input type="radio"/> None (0) <input type="radio"/> 1 fall (1) <input type="radio"/> 2 falls (2) <input type="radio"/> 3 or more (3)	[]
FUNCTION: ADL status		
2. Prior to this fall, how much assistance was the individual requiring for instrumental activities of daily living (eg cooking, housework, laundry)?	<input type="radio"/> None (completely independent) (0) <input type="radio"/> Supervision (1) <input type="radio"/> Some assistance required (2) <input type="radio"/> Completely dependent (3)	[]
• If no fall in last 12 months, rate current function		
BALANCE		
3. When walking and turning, does the person appear unsteady or at risk of losing their balance?	<input type="radio"/> No unsteadiness observed (0) <input type="radio"/> Yes, minimally unsteady (1) <input type="radio"/> Yes, moderately unsteady (needs supervision) (2) <input type="radio"/> Yes, consistently and severely unsteady (needs constant hands on assistance) (3)	[]
• 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.		

Total Risk Score	[]
-------------------------	-----

Total score	0	1	2	3	4	5	6	7	8	9
Risk of being a faller	0.25		0.7		1.4		4.0		7.7	
Grading of falls risk	0 - 3 Low risk				4 - 9 High risk					
Recommended actions	Further assessment and management if functional/balance problem identified (score of one or higher)				Perform the Full FROP-Com assessment and / or corresponding management recommendations					

Date: / /

Name _____

Signature _____

Designation _____

Falls Risk for Older People in the Community (FROP-Com) Screen	(Affix Patient ID Label)
	UR No _____
	Surname: _____
	Given Name _____
	DOB _____

Screen all people aged 65 years and older (50 years and older Aboriginal & Torres Strait Islander peoples)

Date of screen: / /

FALLS HISTORY		SCORE
1. Number of falls in the past 12 months?	<input type="radio"/> None (0) <input type="radio"/> 1 fall (1) <input type="radio"/> 2 falls (2) <input type="radio"/> 3 or more (3)	[]
FUNCTION: ADL status		
2. Prior to this fall, how much assistance was the individual requiring for instrumental activities of daily living (eg cooking, housework, laundry)?	<input type="radio"/> None (completely independent) (0) <input type="radio"/> Supervision (1) <input type="radio"/> Some assistance required (2) <input type="radio"/> Completely dependent (3)	[]
<ul style="list-style-type: none"> If no fall in last 12 months, rate current function 		
BALANCE		
3. When walking and turning, does the person appear unsteady or at risk of losing their balance?	<input type="radio"/> No unsteadiness observed (0) <input type="radio"/> Yes, minimally unsteady (1) <input type="radio"/> Yes, moderately unsteady (needs supervision) (2) <input type="radio"/> Yes, consistently and severely unsteady (needs constant hands on assistance) (3)	[]
<ul style="list-style-type: none"> 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. 		

Total Risk Score	[]
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Recommended actions	Further assessment and management if functional/balance problem identified (score of one or higher)				Perform the Full FROP-Com assessment and / or corresponding management recommendations					

Intervention / Recommendations based on Score and Clinical Judgement (please circle)

Low falls risk	Education / Modifications / Equipment / Footwear / Medication packs / Eyesight review / Physio / other
High falls risk	Education / Modifications / Equipment / Footwear / Medication packs / Eyesight review / Physio / other
Comment	

OT Name: _____ Signature _____

METHOD

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I am referring this lady because of poor functional mobility and requiring assistance with walking aids... Mrs _____ has given permission for the referral.

Medical information / Physical / functional status:

Falls History:

Fell one year ago...– hit head –subsequent ongoing head pain and loss of confidence. Many near misses in past year, but has not fallen over.

Social Situation:

Issues identified

Proposed Action

- 1. Poor functional mobility*
- 2. Safety in showers*
- 3. Toilet transfers*
- 4. Safety on steps to garage*

- 1. Referral to Amb. Care Physiotherapy*
- 2. Shower chair, HSHS – Home Mod Service*
- 3. Toilet rail- Home Mod Service*
- 4. Railing on outer side- Home Mod Service*

Thanking you very much for your help

OT Home Visit

The following are the plans we agreed to together as an outcome of this visit:

1. *Discuss with your GP referral to a physiotherapist for assessment for walking aids and falls prevention exercises.*
2. *Install railing at the front steps.*
3. *Consider medication boxes.....*



Referrals to Physiotherapy

Year	Total screens	Total screened as high risk	Percentage of high risk clients Receiving/ received PT recently	Percentage of high risk clients OT referred to PT, direct or via GP	Percentage of high risk clients not referred because unsuitable	Remaining Percentage Of high risk clients Not referred reason resolved? Reason not recorded?
2016	127	77	10%	29%	38%	23%
2017	64	34	9%	21%	62%	8%

References

- Prevention of falls and harm from falls in older people: Best practice guidelines for community care, 2009
- Falls Risk for Older People in the Community (FROP-Com) Screen. National Ageing Research Institute 2008 (info available at info@nari.unimelb.edu.au).