

Falls Risk Assessment Tool (FRAT)



Working together to prevent falls

Risk assessment tool developed by: Peninsula Health Falls Prevention Service

The Peninsula Health Falls Prevention Service developed the *Falls Risk Assessment Tool* (FRAT) for a DHS funded project in 1999, and is part of the FRAT Pack <link to FRAT Pack>. A study evaluating the reliability and validity of the FRAT has been presented at a number of conferences, and is being prepared for publication. The FRAT has been distributed to approximately 400 agencies worldwide.

The FRAT has three sections: Part 1 - falls risk status, Part 2 – risk factor checklist and Part 3 – action plan. The complete tool (including the instructions for use) is a full falls risk assessment tool. However, Part 1 can be used as a falls risk screen. An abbreviated version of the instructions for use has been included on this website. For a full copy of the instructions for use please refer to the FRAT Pack <link to FRAT Pack> or contact the Peninsula Health Falls Prevention Service.

The FRAT is a validated tool, therefore changes to Part 1 of the tool are not recommended.

Please note: The cognitive status question in Part 1 on the FRAT refers to the Abbreviated Mental Test Score (AMTS). This can be obtained by referring to the following website: http://www.nevdgp.org.au/division/mens/pdf_docs/Mini_Mental.rtf.

(Downloadable)

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<h1 style="margin: 0;"><u>FALLS RISK</u></h1> <h1 style="margin: 0;"><u>ASSESSMENT TOOL</u></h1> <h2 style="margin: 0;">(FRAT)</h2>	UR NUMBER SURNAME GIVEN NAMES..... DATE OF BIRTH <i>Please fill in if no patient/resident label available</i>
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(see instructions for completion of FRAT in the FRAT PACK-Falls Resource Manual)

PART 1: FALL RISK STATUS

RISK FACTOR	LEVEL	RISK SCORE
RECENT FALLS <i>(To score this, complete history of falls, overleaf)</i>	none in last 12 months.....	2
	one or more between 3 and 12 months ago.....	4
	one or more in last 3 months.....	6
	one or more in last 3 months whilst inpatient / resident....	8
MEDICATIONS <i>(Sedatives, Anti-Depressants Anti-Parkinson's, Diuretics Anti-hypertensives, hypnotics)</i>	not taking any of these.....	1
	taking one	2
	taking two	3
	taking more than two.....	4
PSYCHOLOGICAL <i>(Anxiety, Depression ↓Cooperation, ↓Insight or ↓Judgement esp. re mobility)</i>	does not appear to have any of these.....	1
	appears mildly affected by one or more.....	2
	appears moderately affected by one or more.....	3
	appears severely affected by one or more.....	4
COGNITIVE STATUS <i>(AMTS: Hodkinson Abbreviated Mental Test Score)</i>	AMTS 9 or 10 / 10 OR intact.....	1
	AMTS 7-8 mildly impaired.....	2
	AMTS 5-6 mod impaired.....	3
	AMTS 4 or less severely impaired	4
(Low Risk: 5-11 Medium: Risk: 12-15 High Risk: 16-20)		RISK SCORE
		/20

Automatic High Risk Status: <i>(if ticked then circle HIGH risk below)</i>
<input type="checkbox"/> Recent change in functional status and / or medications <u>affecting</u> safe mobility (or anticipated) <input type="checkbox"/> Dizziness / postural hypotension

FALL RISK STATUS: (Circle): **LOW** / **MEDIUM** / **HIGH**



List Fall Status on Care Plan/ Flow Chart

IMPORTANT: IF HIGH, COMMENCE FALL ALERT

PART 2: RISK FACTOR CHECKLIST

	Y/N
Vision	Reports / observed difficulty seeing - objects / sings / finding way around
Mobility	Mobility status unknown or appears unsafe / impulsive / forgets gait aid
Transfers	Transfer status unknown or appears unsafe ie. over-reaches, impulsive
Behaviours	Observed or reported agitation, confusion, disorientation
	Difficulty following instructions or non-compliant (observed or known)
Activities of Daily Living (A.D.L's)	Observed risk-taking behaviours, or reported from referrer / previous facility
	Observed unsafe use of equipment
	Unsafe footwear / inappropriate clothing
Environment	Difficulties with orientation to environment i.e. areas between bed / bathroom / dining room
Nutrition	Underweight / low appetite
Contenance	Reported or known urgency / nocturia / accidents
Other	

Part 2 Continued

HISTORY OF FALLS *Note: For an accurate history, consult patient/resident / family / medical records.*

Falls prior to this admission (home or referring facility) **and/or** during current stay

If ticked, detail most recent below)

CIRCUMSTANCES OF RECENT FALLS: Information obtained from _____

(Circle below) **(Where? / Comments)**

Last fall: Time ago _____ Trip Slip Lost balance Collapse Leg/s gave way Dizziness _____

Previous: Time ago _____ Trip Slip Lost balance Collapse Leg/s gave way Dizziness _____

Previous: Time ago _____ Trip Slip Lost balance Collapse Leg/s gave way Dizziness _____

→ **List History of Falls on Alert Sheet in Patient/Resident Record**

PART 3: ACTION PLAN

(for Risk factors identified in Part 1 & 2, list strategies below to manage falls risk. See tips in FRAT PACK)

PROBLEM LIST	INTERVENTION STRATEGIES / REFERRALS

→ **Transfer care strategies to Care Plan / Flow Chart**

PLANNED REVIEW _____ Date of Assessment: _____

INITIAL ASSESSMENT COMPLETED BY:

PRINT NAME _____ Signed: _____

REVIEW

(Falls Review should occur at scheduled Patient/Resident Review meetings or at intervals set by the Initial assessor)

Review Date	Risk Status	Revised Care plan (Y or N)	Signed	Review Date	Risk Status	Revised Care plan (Y or N)	Signed

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