Falls Risk Assessment Tool (FRAT)

Developed by: Peninsula Health
Format: Assessment tool and Instructions for use
Availability: Download FRAT <PDF version> <Word version>
Download Instructions for use <PDF version> <Word version>

The Falls Risk Assessment Tool (FRAT) was developed by the Peninsula Health Falls Prevention Service for a DH funded project in 1999, and is part of the FRAT Pack. A study evaluating the reliability and validity of the FRAT has been published (Stapleton C, Hough P, Bull K, Hill K, Greenwood K, Oldmeadow L (2009). A 4-item falls-risk screening tool for sub-acute and residential care: The first step in falls prevention. *Australasian Journal on Ageing* 28(3): 139-143). The FRAT has been distributed to approximately 400 agencies world wide.

The FRAT has three sections: Part 1 - falls risk status; Part 2 – risk factor checklist; and Part 3 – action plan. The complete tool (including instructions for use) is a complete 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 complete copy of the instructions for use please refer to the FRAT Pack or contact the Peninsula Health Falls Prevention Service, telephone (61 3) 9788 1260.

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 resource is available at http://anzsgm.org/vgmtp/Dementia/cognitive_screening_tests.htm (please note: this will take you out of the Department of Health website).

In 2009 the Department of Health funded Northern Health, in conjunction with National Ageing Research Institute, to review falls prevention resources for the Department of Health's website. The materials used as the basis of this generic resource were developed by Peninsula Health under a Service Agreement with the Department of Human Services, now the Department of Health. Other resources to maintain health and wellbeing of older people are available from www.health.vic.gov.au/agedcare

# FALLS RISK ASSESSMENT TOOL (FRAT)	UR NUMBER …… SURNAME …… GIVEN NAMES…… DATE OF BIRTH …… ***Please fill in if no patient/resident label available***

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

Automatic High Risk Status: *(if ticked then circle* **HIGH** *risk below)*
☐ Recent change in functional status and / or medications affecting safe mobility (or anticipated)
☐ 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 / signs / 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	
Continence	Reported or known urgency / nocturia / accidents	
Other		

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