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FALLS RISK ASSESSMENT TOOL (FRAT) INSTRUCTIONS

What is the Falls Risk Assessment Tool

Falls risk assessment tools have the potential to accurately quantify falls risk and provide a sound basis for decision making regarding interventions that can be effective in reducing the likelihood of falls.

In randomised trials in residential care facilities, multiple targeted intervention programs based on comprehensive risk assessment have resulted in significant reduction in falls.

Similar results have been identified in sub-acute hospital settings.

What is the FRAT?

The FRAT is

- a validated Falls Risk Assessment Tool (FRAT) to be completed by nurses in hospital and residential care facilities.
- the outcome of a two year research project, completed in 1999, by the Falls Prevention Service, Peninsula Health. The research sample was 291 patients representing all bed types in the sub-acute and residential settings of Peninsula Health.

Why the FRAT is needed

Completing the FRAT tool achieves the following.

- Provides a focus point for the collation of falls risk relevant information.
- Predicts, with reasonable accuracy, who is most likely to fall, and who is not.
- By identifying those at most risk of falls allows the targeting of resources toward those most likely to fall.
- Identification of individual fall risk factors allows the targeting of preventative strategies.

What the FRAT does

The FRAT has two functions:

A Screening tool

- By obtaining a risk score, the assessor can screen for those patients/residents who are at highest risk of falling.

and

An Assessment tool

- To identify possible risk factors contributing to the risk of falling.
- Formulate an individual management plan for targeted residents / patients as part of care planning.

Who completes the FRAT?

The FRAT is intended as a nurse administered tool, to be completed within 24 hours of admission.

The reasons are as follows:

In sub-acute and residential care settings, the nurse is most often responsible for the overall coordination of care needs, ie screening for the presence of risks, establishing the need for allied health input. Identifying and managing falls risk is an important part of this process.

The FRAT has been designed and researched with the nurse as the reader. The questions relate to observed or reported behaviours or risk factors that can be recognized by the admitting nurse soon after admission. These act as clinical indicators for the presence of falls risk, and underlying risk factors, that can assist with formulation of an action plan. It is recognized that the admitting nurse may not have all the expertise to solve all the problems and the tool is designed with this in mind to guide decision making regarding immediate actions and referrals required.

Early identification and management of falls risk needs to occur as part of the admission process to avoid delays in meeting care needs.

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GUIDELINES FOR COMPLETING THE FRAT

ASSESSMENT PROCESS PARTS 1 & 2

Information required to complete Parts 1 and 2 of the FRAT can be obtained from:

- the patient or resident (if able),
- transfer information from donor facility
- clinical observations in the first 24 hours,
- initial nursing, medical or allied health assessment
- family, or other staff, familiar with the person's care
- and/or the medical history.

It is therefore recommended that the FRAT be completed as the final part of the initial nursing assessment, with input from the medical and allied health assessment when available. Observations during patient orientation and over the initial shift or feedback from handover will assist with accuracy of completion.

PART 1: FALL RISK STATUS

Purpose:

Completing part one will provide a Fall risk score which will categorize the individuals Fall Risk Status into low, medium or high. Each level has a corresponding protocol.

How to obtain a Score

- Circle one score ONLY in each of the 4 categories in Part 1.

  If the person's condition fluctuates you need to circle the score representing their lowest functional level.

  Determine the client's risk classification level (risk status) by adding the 4 scores from Part 1

Low risk	5–11
Medium risk	12–15
High risk	16–20

  Persons with a risk classification of 16–20 require a Fall Alert Protocol to be actioned.

- Complete the **Automatic High Risk Status** section.

  This section allows for clinical judgement of risk status, that would not otherwise be detected. These risks are often more acute in nature such as a sudden change in condition where the underlying causes are not yet known, the onset of illness or UTI, recent change in high risk medication etc. A tick in either box in this section will categorize the person at automatic high risk. Persons with automatic high-risk status should be reviewed regularly, at intervals deemed appropriate by the assessor, as the risk can change and settle quickly when issues are addressed.

  If ticked, circle high risk at the end of part 1 and list fall alert protocol in the action plan.

RISK CLASSIFICATION

Circle the appropriate level: Low, Medium or High

Low: Provide standard care and follow general patient safety principles.

Medium: Provide Standard Care but risk factors have been identified and strategies integrated in the care plan to target area of risk. See FRAT PACK, suggested strategies section for options.

High: Commence Fall Alert Protocol. Patient has a high likelihood of a fall occurring. See section in Frat Pack-Fall Alert for details of the protocol.

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PART 2: RISK FACTOR CHECKLIST & HISTORY OF FALLS

Purpose

This section includes fall risk factors that, although not found to have a high predictive value for purposes of developing the FRAT tool, are identified as major risk factors for falls in hospitals and residential care. Although Part 1 enables us to categorize an individual according to risk level, part 1 alone tells us nothing about what risk factors need targeting for management.

Instructions

Complete the risk factor checklist by placing a tick in the appropriate boxes.

Risk factors identified need targeting for management by listing in the action plan at the bottom of the page.

HISTORY AND CIRCUMSTANCES OF FALLS:

Although this section is located at the rear of the tool, it is useful to do this first before completing part 1. Information obtained by completing this section will enable accurate completion of the scored section, to establish risk status. The history of falls, particularly if occurring in the donor facility, will highlight whether the falls were associated with particular activities, problems or time of day. Information regarding strategies previously used to reduce risk can also be useful when developing an action plan.

The FRAT research indicated History of Falls as the strongest predictor that a person will fall again and is therefore weighted in the scoring. Accuracy in completing this section is therefore very important as inaccuracies can result in missing the person at high risk.

Instructions

It is recommended that this information be confirmed via a carer or family member.

Non or under-reporting by the patient / resident of falls is not uncommon and can occur for a number of reasons. This includes memory difficulties, passing off as trivial, fear that disclosure may influence staff's perception of their ability to return home).

Explore the following and list

Ask the patient and/or family.

- Were falls a problems before entering hospital and how did they occur- detail findings under this section on the FRAT?
- Seek information from the donor facility or transfer documents re falls in that facility and what seemed to work and not work with regards to risk minimization.
- Find out the circumstances of the most recent falls. Obtain information on time; activity, environment, symptoms, was gait aid used, where available.
- If available, list previous falls on a Fall or communication sheet at the front of the patient file, where history of falls can be listed. If a fall occurs during stay add subsequent falls to this list as a quick reference re falls. Remember this does not replace the need to report the fall, with or without injury, via the incident report form and to forward onto clinical risk.

Document history of falls and strategies on any transfer / discharge summary.

Use the information to appropriate score Part 1 of the FRAT.

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PART 3: ACTION PLAN

- In the left column, list problems, as identified in Part 1 and 2 of the FRAT.
- Identifies strategies to minimize the risk for each problem. (You can refer to the section "Risk Factor Checklist and Possible Interventions" in the FRAT PACK)
- >Transfer appropriate strategies to care plan.

REVIEW:

Reassessment should occur

- as part of regular team and patient review meetings
- whenever the client's condition changes.
- if a fall has occurred since the last review.

Review involves

Questioning the team whether current status and strategies, should for any reason, be altered.

Team discussion will determine appropriate changes based on the circumstances.

Note:

Review does not involve repeating the FRAT tool. The tool is for initial assessment purposes only to obtain an initial risk profile. Managing falls risk should then become a dynamic process integrated as part of ongoing care

Questions to ask as part of patient review:

Have any issues, observations of patient led to a need to alter current risk status and strategies as listed on the flow chart ?

Are there any additional strategies that need to be considered?

Note:

Decision to remove a fall alert protocol must consider risk at all times of day and therefore be a team decision ie patient may use gait aid safely but still gets confused at night.

If falls relevant information and strategies are appropriately detailed to the care plan then reassessment can be integrated as part of general review of overall care needs.

FALL ALERT PROTOCOL

WHAT IS FALL ALERT:

Fall alert is the identification of patients /residents at high risk or falls. Patients designated by this protocol are, for various reasons, those identified as being unable to manage their own safety.

Fall alert utilizes 4 strategies:

Orange alert stickers:

Orange armbands:

Specific strategies to minimize the risk or behaviors that contribute to the risk.

Communication at each handover re alert status and strategies in place.

PURPOSE

The purpose of fall alert protocol is to:

- Alert staff on each roster who is prone to falling, and
- Ensure consistency of strategies in place to reduce the risk.

CRITERIA FOR FALL ALERT PROTOCOL

Using the Falls Risk Assessment Tool, all residents/patients identified as high risk (16–20) or Automatic High Risk should be classified as Fall Alert.

PROTOCOL

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- Residents scoring high risk on the FRAT have a corresponding Fall Alert protocol listed in the action plan.
- Orange alert stickers are placed
  - on bed head
  - on the care plan
  - on the alert sheet (front page of the history)
- "Fall Alert" is documented on the handover sheet for the period the patient remains on Fall Alert protocol.
- If agreed by the team as appropriate, the resident is to wear an orange patient arm band. This assists staff to distinguish residents who are mobile and at risk.
- Notify Allied Health that resident has been classified high risk by the FRAT and is on Fall Alert Protocol (per facility protocol).

Additional strategies that may be beneficial

Select the most appropriate strategy/strategies that best meet the needs of the person and which are considered practical within the facility and transfer them to the care plan. Other strategies additional to those listed below may also be identified that are most suited to the person.

- Supervision and/or assistance for certain mobility or ADL tasks. The Occupational therapist and /or physiotherapist can give advice.
- Remove mobile equipment (ie overbed table) from areas frequently walked by the patient.
- Keep clutter around the bed clear (day and night).
- Use of bed / chair sensors, when indicated, to aid monitoring of high-risk persons with impaired cognition.
- Initiate a toileting routine including scheduled night toileting where appropriate.
- Locate person close to nurses station, if possible.
- Call button within reach at all times and ensure prompt responses to call buzzer.
- Regular supervised walking regime.
- Gait aid /mobility review.
- Individual environmental and A.D.L. assessment re additional safety precaution that may benefit.

REVIEW OF FALL ALERT PROTOCOL

Fall alert protocol can be ceased at the teams discretion.

The criteria for removing the fall Alert protocol is the agreement by the team that strategies are in place as part of routine care appear effective in minimizing falls risk.

Behaviours contributing to high risk are no longer present/or minimized.

To cease fall alert protocol

- Inform the resident and reinforce safety precautions
- Remove stickers /arm band (if used).
- Document changed status in the progress notes.
- If deemed necessary, inform the family

Note: Ceasing fall alert protocol does **not** mean ceasing strategies in place to minimize falls risk.

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DISCHARGE PLANNING

- If a person was falling prior to admission to your facility, chances are they may fall when they leave. Referral to the appropriate community follow-up would be essential.
- O.T. home assessment prior to discharge/transfer is recommended with specific focus on what may have contributed to previous falls and to assess the need for a personal alarm if returning home at risk.
- Careful consideration should be given to what type and amount of community supports is required to keep the person safe from falls on return home.
- Provide information to the patient/ resident on discharge regarding where to get help if falls continue.
- Educate the patient re safe participation in activities on return home.

place photo here

Name:

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FALLS RISK ASSESSMENT TOOL (FRAT)

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 3–12 months ago one or more in last 3 months one or more in last 3 months whilst inpatient/resident		2 4 6 8
Medication Sedatives, Anti-Depressants Anti-Parkinson's, Diuretics Anti-Hypertensives	not taking any of these taking one taking two taking more than two		1 2 3 4
Phychological 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 MMSE Hodkinson Abbreviated Mental Score or MMSE	m-m score 9 or 10/10 m-m score 7–8 m-m score 5–6 m-m score 4 or less	**OR** intact mildly impaired mod impaired 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)

Current Problems:

☐ Recent change in functional status and/or medications affecting safe mobility (or anticipated)

☐ Dizziness/postural hypotension

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

Important: If HIGH, commence fall alert

LIST FALL STATUS ON CARE PLAN/FLOW CHART

Part 2—Risk Factor Checklist

Vision	Reports/observed difficulty seeing—objects / finding way around/signs	☐
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)	☐
A.D.L's	Observed risk-taking behaviours, or reported from donor facility	☐
	Observed unsafe use of equipment	☐
	Unsafe footwear / inappropriate clothing	☐
Environment	Difficulties with orientation to environment i.e. areas b/w bed / bathroom / dining room	☐
Nutrition	Underweight / low appetite	☐
Continence	Reported or known urgency / nocturnia / accidents	☐
Other	Osteoporosis, history fractures	☐

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Part 2—Risk Factor Checklist (continued)

History of falls Note: For an accurate history, consult patient / family / medical records

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

(If ticked, detail most recent below)

Circumstances of recent falls (past residence or current)

Information obtained from .....

Last Fall: (circle below) (Where?/Comments)

When_____ Trip / Slip / Lost Balance / Collapse / leg/s gave way / dizziness .....

Previous:

When_____ Trip / Slip / Lost Balance / Collapse / leg/s gave way / dizziness .....

Previous:

When_____ Trip / Slip / Lost Balance / Collapse / leg/s gave way / dizziness .....

Previous:

When_____ Trip / Slip / Lost Balance / Collapse / leg/s gave way / dizziness .....

→ **LIST HISTORY OF FALLS ON ALERT SHEET**

Part 3—Action Plan

(For risk factors identified in Part 1 & 2, list strategies below to manage falls risk. See tips on previous pages.)

Problem list	Intervention strategies/referrals

→ **TRANSFER CARE STRATEGIES TO CARE PLAN/FLOW CHART**

Completed by:	Signature	Date
		/ /

Planned Review date: / /

Review

Falls Review should occur at scheduled Patient 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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