Assessment of falls risk in older people (Side 1)
(Falls Risk Assessment Tool-FRAT)

Multi - professional guidance for use
by the primary health care team, hospital staff, care home staff and social care workers

This guidance has been derived from longitudinal studies of factors predicting falls in older people and randomised controlled trials that have shown a reduction in the risk of falling. (adapted for local use but originally designed by Queen Mary College, University of London)

Definition Fall- An event whereby an individual comes to rest on the ground or another lower level with or without loss of consciousness (NICE 2004)

Notes for users:

1) Complete assessment form below. The more positive factors, the higher the risk for falling.
2) If there is a **positive response to three or more of the questions on the form, then please see over** for guidance for further assessment, referral options and interventions for certain risk factors.
3) Some users of the guidance may feel able to undertake further assessment and appropriate interventions at the time of the assessment.
4) Consider which referral would be most appropriate given the patient's needs and local resources.

Name _____ Date of Birth _____

NHS Number : | | | | | | | | | | |

		YES	NO
1	Is there a history of any fall in the previous year? **How assessed?** Ask the person.		
2	Is the patient / client on four or more medications per day? **How assessed?** Identify number of prescribed medications.		
3	Does the patient / client have a diagnosis of stroke or Parkinson's Disease? **How assessed?** Ask the person.		
4	Does the patient / client report any problems with his/ her balance? **How assessed?** Ask the person.		
5	Is the patient/client **unable** to rise from a chair of knee height? **How assessed?** Ask the person to stand up from a chair of knee height without using their arms.		

Suggestions for further assessment, referral options and interventions

Assessment by nurse or doctor

Risk factor present	Further assessment	Referral Options	Interventions
1) History of falling in the previous year	♦ Review incident(s), identifying precipitating factors.	♦ Occupational Therapy ♦ Physiotherapy ♦ Falls Clinic/ICT (1)	♦ Discuss fear of falling and realistic preventative measures.
2) Four or more medications per day	♦ Identify types of medication prescribed. ♦ Ask about symptoms of dizziness.	♦ General Practitioner ♦ Falls Clinic (1)	♦ Review medications, particularly sleeping tablets (see www.bhps.org.uk/falls for more information on medication and falls ♦ Discuss changes in sleep patterns normal with ageing, and sleep promoting behavioural techniques.
3) Balance and gait problems	♦ Can they talk while walking? (2) ♦ Do they sway significantly on standing?(3) ♦ Do basic balance test such as Timed Up & Go test	♦ Occupational Therapy ♦ Physiotherapy ♦ Falls Clinic/ICT (1)	♦ Teach about risk. And how to manoeuvre safely, effectively and efficiently. ♦ Physiotherapy evaluation for range of movement, strength, balance and/or gait exercises. ♦ Transfer exercises. ♦ Evaluate for assistive devices. ♦ Consider environmental modifications (a) to compensate for disability and to maximise safety, (b) so that daily activities do not require stooping or reaching overhead.
4) Postural hypotension (low blood pressure)	Two readings taken 1. After rest five minutes supine 2. 1 minutes later standing Drop in systolic BP ≥ 20mmHg and or drop in diastolic ≥ 10mmgHg or more	♦ District Nurse ♦ Practice nurse ♦ General Practitioner ♦ Falls Clinic (1)	♦ Offer extra pillows or consider raising head of bed if severe. ♦ Review medications. ♦ Teach to stabilise self after changing position and before walking. ♦ Avoid dehydration

1. Consider Falls Clinic/ Intermediate Care Referral Form.
2. While the patient is walking ask them a question but keep walking while you do so. If the patient stops walking either immediately or as soon as they start to answer, they are at higher risk of falling.
3. The patient stands between the assessor and the examination couch (or something they can safely hold on to). First assess if the person sways significantly (raises arms or compensates foot placement) while standing freely. Then ask the person to take their weight on to one leg and try to lift the other foot off the floor by about an inch (allow a few practice attempts).