

Falls Prevention Assessment Tool

Part 1: Fall risk status | FRAT-based screening

Resident / patient name		Date of birth	
Room / unit		ID / NHS no.	
Date of assessment		Completed by	

PART 1: FALL RISK STATUS - tick ONE option in each row

Recent falls Complete the falls history on page 2 to score this.	☐ None in last 12 months	2	Score
	☐ 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 Sedatives, anti-depressants, anti-hypertensives, anti-Parkinson's, diuretics or hypnotics.	☐ Not taking any of these	1	Score
	☐ Taking one	2	
	☐ Taking two	3	
	☐ Taking more than two	4	
Psychological Anxiety, depression, poor cooperation, poor insight or poor judgement, particularly regarding mobility.	☐ Not apparent	1	Score
	☐ Mildly affected by one or more of these	2	
	☐ Moderately affected by one or more of these	3	
	☐ Severely affected by one or more of these	4	
Cognitive status Use the Hodkinson Abbreviated Mental Test Score (AMTS), 10 questions.	☐ AMTS 9-10 / intact	1	Score
	☐ AMTS 7-8 / mildly impaired	2	
	☐ AMTS 5-6 / moderately impaired	3	
	☐ AMTS 4 or less / severely impaired	4	

TOTAL RISK SCORE / 20

Low risk: 5-11

Medium risk: 12-15

High risk: 16-20

Automatic HIGH risk status (tick if present, then mark HIGH):

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

FALL RISK STATUS

☐ LOW

☐ MEDIUM

☐ HIGH

Note: if any automatic high-risk factor is present, the overall status is HIGH whatever the score. Part 1 is a validated screen, so do not alter its wording or scoring. Cognitive status should be scored using the AMTS, administered by a trained member of staff.

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Part 2: Risk factor checklist and falls history

PART 2: RISK FACTOR CHECKLIST - tick Yes or No for each

	YES	NO	DETAIL
Vision Reports or has been observed having difficulty seeing; glasses not worn or out of date; difficulty seeing obstacles or finding the way around.	☐	☐	
Mobility Unsteady or reduced strength; difficulty walking; walking aid not used correctly or in poor condition; reduced balance.	☐	☐	
Transfers Needs help or supervision to get in or out of bed, a chair or the toilet; unsafe transfer technique.	☐	☐	
Behaviours Overestimates own ability; restless, agitated or wandering; does not use call bell or walking aid; impulsive.	☐	☐	
Activities of daily living Needs help with dressing, washing, toileting or eating; unsafe footwear or clothing.	☐	☐	
Environment Poor lighting; clutter or trip hazards; wet floors; unsuitable bed or chair height; unfamiliar surroundings.	☐	☐	
Nutrition Underweight, low appetite or poor fluid intake.	☐	☐	
Continence Urgency, frequency, nocturia or incontinence; needs help to reach the toilet quickly.	☐	☐	

CIRCUMSTANCES OF RECENT FALLS

Information obtained from

Date	Time	Location	Activity at the time	Injury / outcome

Falls history prompts: What was the person doing? Was anyone with them? Were there signs of dizziness, illness, or a change in medication beforehand? Was the area clear and well lit? Was the person wearing suitable footwear and their glasses or hearing aids?

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Part 3: Action plan and review

PART 3: ACTION PLAN - strategies for risk factors identified in Parts 1 and 2

Risk factor	Strategy / action	Who	By when	Done
				☐
				☐
				☐
				☐
				☐
				☐
				☐
				☐

Prompt ideas for the action plan

- **Vision:** arrange an eye test; make sure glasses are clean, worn and in date.
- **Mobility and transfers:** check walking aids; consider a physiotherapy or occupational therapy referral; agree the level of help needed.
- **Medications and dizziness:** ask the GP or pharmacist for a medication review; consider lying and standing blood pressure checks.
- **Behaviours and cognition:** use more frequent checks, familiar routines, clear prompts and call bell reminders.
- **Environment and footwear:** improve lighting, clear clutter, check bed and chair height, provide well-fitting non-slip footwear.
- **Nutrition and hydration:** monitor intake and weight; consider a dietitian referral.
- **Continence:** agree a toileting plan, keep a clear route to the toilet, and consider a night light.

REVIEW AND SIGN-OFF

Assessed by (name / role)		Signature	
Date		Next review due	

When to reassess: on admission or at first assessment; after any fall; after a change in condition, medication or mobility; on moving room or unit; and at regular intervals set by your service policy. If risk is HIGH or MEDIUM, share the action plan with the care team and update the care plan.

About this tool: Part 1 reproduces the structure and scoring of the Falls Risk Assessment Tool (FRAT), developed by the Peninsula Health Falls Prevention Service, Victoria, Australia, as part of the FRAT Pack. Parts 2 and 3 are adapted from the FRAT structure for use in care settings. This is a screening aid and does not replace clinical judgement or your organisation's falls policy.