

FRASS

T. 06a

This tool aims to identify patients at high risk of falling.

Instructions:

Assess patient's current status for each risk factor and record the relevant rating in the scoring system. Add up total scores and record in space provided.

COMPLETED BY: _____

DATE: _____

Name: _____	
UR/MR number: _____	
Ward/Unit: _____	
DOB: _____	Gender: _____
Admission Date: _____	
Place UR sticker here or add patient details:	

Risk Factor	Rating	/ / 04		
		Score	Score	Score
AGE 65 – 79 years 80 and above	(1) (2)			
MENTAL STATUS Oriented at all times or Comatose Confused at all times – poor cognition, STM, lack of insight into own safety, impulsive Intermittent confusion – as above	(0) (4) (8)			
EMOTIONAL STATUS Moderately agitated/uncooperative/anxious Severely agitated/uncooperative/anxious	(2) (4)			
TOILETING Independent and continent Catheter &/or ostomy Needs assistance with toileting Ambulatory with urge incontinence or episodes of incontinence	(0) (1) (3) (5)			
HISTORY OF FALLING WITHIN 6 MONTHS No Has fallen one or two times Multiple history of falling	(0) (2) (5)			
SENSORY IMPAIRMENT Blind/Deaf/Cataracts/Not using corrective device	(1)			
ACTIVITY Ambulates/Transfers without assistance Ambulates/Transfers with assist of one or assistive device Ambulates/Transfers with assist of two Unsteady gait/mobility affected by pain/deconditioned	(0) (2) (1) (2)			
MEDICATIONS (MEDICATION REFERENCE TABLE OVER PAGE) <input type="checkbox"/> Cardiovascular/Antihypertensives <input type="checkbox"/> Anti depressants <input type="checkbox"/> Psychotropics <input type="checkbox"/> Tranquillisers/Sedatives <input type="checkbox"/> Anti-parkinsons/Anti-Convulsives <input type="checkbox"/> Opioids <input type="checkbox"/> Diuretics None of the above listed medications One of the above listed medication Two or more of the above listed medications Add one more point if there has been a change in these medications or dosages in the past five days.	(0) (1) (2) (1)			
TOTAL SCORE				

*Level of Risk: Score of 8 - 14 patient is at high risk for falls
 Score of 15 + patient is at SUPER HIGH risk for falls*

Document each patients falls risk status in the medical history. Implement appropriate fall prevention strategies (overpage)

FRASS FALLS PREVENTATIVE STRATEGIES

T. 06b

RISK FACTOR	GOAL	INTERVENTIONS
IMPAIRED ACTIVITY OVER ACTIVITY WANDERER DECONDITIONED	Optimise mobility (Ensure safe walking)	<input type="checkbox"/> Refer for physiotherapy assessment <input type="checkbox"/> Review footwear needs <input type="checkbox"/> Keep walking aids within easy reach <input type="checkbox"/> Ensure appropriate seating <input type="checkbox"/> Document transfer/mobilisation assistance
MENTAL STATUS	Promote feeling of security (Re-orientation)	<input type="checkbox"/> Bed placed in lowest position with brakes applied <input type="checkbox"/> Talk slowly and clearly <input type="checkbox"/> Minimise number of bed location movements <input type="checkbox"/> Encourage family members to sit with patient <input type="checkbox"/> Encourage optimal hydration/nutrition
IMPAIRED VISION	Promote uncluttered environment (Prevent accidents)	<input type="checkbox"/> Remove clutter & obstacles from room <input type="checkbox"/> Orientate patient to environment <input type="checkbox"/> Ensure adequate night lighting in toilet and room <input type="checkbox"/> Wear spectacles as appropriate
INFLUENCE OF MEDICATIONS	Provide safe Environment (Prevent accidents)	<input type="checkbox"/> Liaise with Pharmacy/medical staff <input type="checkbox"/> Implement strategies to reduce effects of postural hypotension <input type="checkbox"/> Influence of opioids/sedatives
INCONTINENCE/URINARY BOWEL URGENCY	Bladder Bowel Pattern (Anticipate needs)	<input type="checkbox"/> Nurse call button handy <input type="checkbox"/> Establish toileting regime, toilet before settling <input type="checkbox"/> Commode by bed, urinal handy
MISPERCEPTION OF FUNCTIONAL ABILITIES	Reinforce limitations (Anticipate needs)	<input type="checkbox"/> Do not leave alone in bathroom/toilet <input type="checkbox"/> Assist/supervise all activities

ALWAYS ENSURE:

- o Call bell is handy
- o Remove clutter
- o Adequate night lighting

PATIENTS AT HIGH RISK OF FALLS MUST HAVE COLOURED WRIST BAND AND CHART OR RISK FLAGGED

MEDICATION REFERENCE TABLE

CARDIOVASCULAR/ ANTI-HYPERTENSIVES

- o Captopril
- o Enalapril
- o Sotalol
- o Ca channel blocker
- o ACE Inhibitors
- o GTN (oral, SL, patch)
- o Angiotensin II antagonists
- o B blockers
- o Prazosin

ANTI-DEPRESSANTS

- o Amitriptyline
- o Dothiepin
- o Imipramine
- o Mianserin
- o SSRI
- o Doxepin

NEUROLEPTICS

- o Chlorpromazine
- o Clozapine
- o Pericyazine
- o Thioridazine
- o All others

TRANQUILLISERS/SEDATIVES

- o Diazepam
- o Benzodiazepams
- o Clonazepam
- o Nitrazepam
- o Oxazepam

ANTI-PARKINSON/ANTI-CONVULSIVES

- o Bzotropine
- o Bromocriptine
- o Levodopa
- o Lamotigine
- o Carbamazepine

OPIOIDS

- o Morphine
- o MS Contin
- o Endone
- o Tramadol
- o Panadeine Forte
- o Oxycontin

DIURETICS

- o Fusedide
- o Thiazides
- o Amiloride - Moduretic

OTHERS

- o Baclofen
- o Ditropan
- o Statins
- o NSAIDS
- o Laxatives

A more extensive list of medications associated with increased falls risk is provided separately in the Tools Supplement (Minimising the risk of falls and fall-related injuries: Guidelines for acute, sub-acute and residential care settings).