### Draft Falls Risk for Older People: Residential Care (FROP-Resi)

*(To be completed on resident admission and after a fall or an acute episode)*

**Date of Assessment:** / /  

#### General issues (do not score, but ensure appropriate actions)

- Has the resident been oriented to the unit & routines, and a resident information brochure/booklet provided?  
  - **Yes**  
  - **No**

- Resident’s environment assessed & safe? (seating type & height, bed height & assistive equipment)  
  - **Yes**  
  - **No**

- Is English the resident’s preferred language?  
  - **Yes**  
  - **No**

#### Recent falls (0-3)

- Has the resident fallen recently?  
  - Nil in 12 months (0)  
  - 1 in the last 12 months (1)  
  - 2-3 in the last 12 months (2)  
  - 4 or more in last 12 months (3)  

- Did they sustain an injury?  
  - No (0)  
  - Minor injury, did not require medical attention (1)  
  - Minor injury, did require medical attention (2)  
  - Severe injury (fracture, etc) (3)

#### Medications (0-3)

- Is the resident on any medication?  
  - No medication (0)  
  - 1-2 medications (1)  
  - 3 medications (2)  
  - 4 or more medications (3)

- Does the resident take any of the following type of medication?  
  - Sedative  
  - Analgesic  
  - Psychotropic  
  - Antihypertensive  
  - Vasodilator/cardiac  
  - Diuretics  
  - Antiparkinsonian  
  - Antidepressants  
  - Vestibular suppressant.  
  - Anticonvulsants

#### Medical conditions (0-3)

- Does the resident have a chronic medical condition/s affecting their balance & mobility?  
  - Arthritis  
  - Parkinson’s Disease  
  - Diabetes  
  - Dementia  
  - Peripheral neuropathy  
  - Cardiac condition  
  - Stroke/TIA  
  - Other neurological conditions  
  - Lower Limb Amputation.  
  - Vestibular Disorder (dizziness, postural dizziness, Meniere’s Disease...)

#### Sensory loss & communications

- Does the resident have an uncorrected sensory deficit/s that limits their functional ability?  
  - Vision  
  - Hearing  
  - Somato Sensory  
  - no (0)  
  - yes (1)

- Is there a problem with communication (eg Dysphasia, or CALD – speaks a language other than English)?  
  - No (0)  
  - Yes (1) – specify language…………………..?)?

#### Cognitive status: (score 0-3 points)

- AMTS score  
  - NOTE: If AMTS not used, use criteria for other tool (eg MMSE) or clinical judgement to rate level of impairment  
  - 9-10 (0 point) OR  
  - 7-8 (1 point)  
  - 5-6 (2 points)  
  - 4 or less (3 points)

**Sub total for this page**

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**Falls Risk Classification** (please circle): **Low / Medium /**
# Resident Information

<table>
<thead>
<tr>
<th>Resident Name:</th>
<th>ID Number:</th>
</tr>
</thead>
</table>

| Sub total from previous page | [ ] |

## Continence

- Is the resident incontinent?  
  - No (0)  
  - Yes (1)  

- Do they require frequent toileting or prompting to toilet?  
  - No (0)  
  - Yes (1)  

- Do they require nocturnal toileting?  
  - No (0)  
  - Yes (1)  

## Nutritional conditions (score 0-3 points)

- Has the resident’s food intake declined in the past three months due to a loss of appetite, digestive problems, chewing or swallowing difficulties?  
  - No (0)  
  - Small change, but intake remains good (1)  
  - Moderate loss of appetite (2)  
  - Severe loss of appetite / poor oral intake (3)  

- Weight loss during the last 3-12 months.  
  - Nil (0)  
  - Minimal (<1 kg) (1)  
  - Moderate (1-3kg) (2)  
  - Marked (>3kg) (3)  

## Functional behaviour and agitation (score 0-3)

- Observed behaviours in Activities of Daily Living & Mobility indicate:  
  - Consistently aware of current abilities/seeks appropriate assistance as required (0)  
  - Generally aware of current abilities/occasional risk-taking behaviour or agitation (1)  
  - Under-estimates abilities/inappropriately fearful of activity or moderate agitation (2)  
  - Over-estimates abilities/frequent risk-taking behaviour or severe agitation (3)  

## Feet & footwear and clothing

- Does the resident have foot problems, e.g. corns, bunions etc.  
  - No (0)  
  - Yes (1) (specify):  

- The resident’s main footwear are/have:-  
  - an inaccurate fit  
  - poor grip on soles  
  - in-flexible soles across the ball of foot  
  - heels greater than 2cm high/less than 3 cm wide  
  - flexible heel counter**  
  - without fastening mechanism (ie lace, velcro or buckle.  
  - slippers or other inappropriate footwear?  
  - none apply (0)  
  - one applies (1)  
  - 2 apply (2)  
  - 3 or more apply (3)  

- Does the resident’s clothing fit well (not too long or loose fitting)?  
  - Yes (0)  
  - No (1)  

## Balance (score 0-3 points) – Rate for walking if resident ambulant. If not ambulant, rate balance in sitting. ONLY RATE ONE OF THESE.

- IF AMBULANT: Does the resident, upon observation of walking and turning, appear unsteady or at risk of losing their balance? (NOTE: Rate with usual walking aid. Tick I only, if level fluctuates, tick the most unsteady rating)  
  - No unsteadiness observed (0)  
  - Yes, minimally unsteady on walking or turning (1)  
  - Yes, moderately unsteady on walking or turning (needs supervision) (2)  
  - Yes, consistently and severely unsteady on walking or turning (needs constant hands on assistance) (3)  

- IF NON-AMBULANT: Is the resident unsteady while sitting unsupported?  
  - Sitting slightly forwards in chair, so that back and arms are not supported (close supervision)  
  - No unsteadiness observed (0)  
  - Minimal unsteadiness when reaching, needs to support self (1)  
  - Yes, moderate unsteadiness on minimal reach, (needs supervision) (2)  
  - Yes, unable to maintain sitting balance without support(3)  

## Transfers (score 0-3 points)

- Is the resident independent in transferring? (Includes wheelchair mobility)  
  - Independent, no gait aid needed OR Fully dependent, needs hoist (0)  
  - Independent with a gait aid or in wheelchair (1)  
  - Supervision needed (2)  
  - Physical assistance needed (3)  

## Score Legend:

- 0 to 14 = Low risk;  
- 15 to 22 = medium risk;  
- 23+ = high risk  

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**Grading of falls risk:**

<table>
<thead>
<tr>
<th>Grade</th>
<th>Score</th>
<th>Actions</th>
</tr>
</thead>
<tbody>
<tr>
<td>Low falls risk (0)</td>
<td>0 – 14</td>
<td>Implement actions for identified individual risk factors, &amp; recommend health promotion behaviour to minimise future ongoing risk (eg – increased physical activity, good nutrition)</td>
</tr>
<tr>
<td>Mild to moderate falls risk (1)</td>
<td>15 – 22</td>
<td>Implement actions for identified individual risk factors</td>
</tr>
<tr>
<td>High falls risk (2)</td>
<td>23+</td>
<td>Implement actions for identified individual risk factors, and implement additional actions for high falls risk</td>
</tr>
</tbody>
</table>

(maximum =45)

**NOTE:** Guidelines to assist with use of the FROP-RC and management options if a risk factor is identified are also available (eg Victorian Quality Council Guidelines Quick Reference Guide).