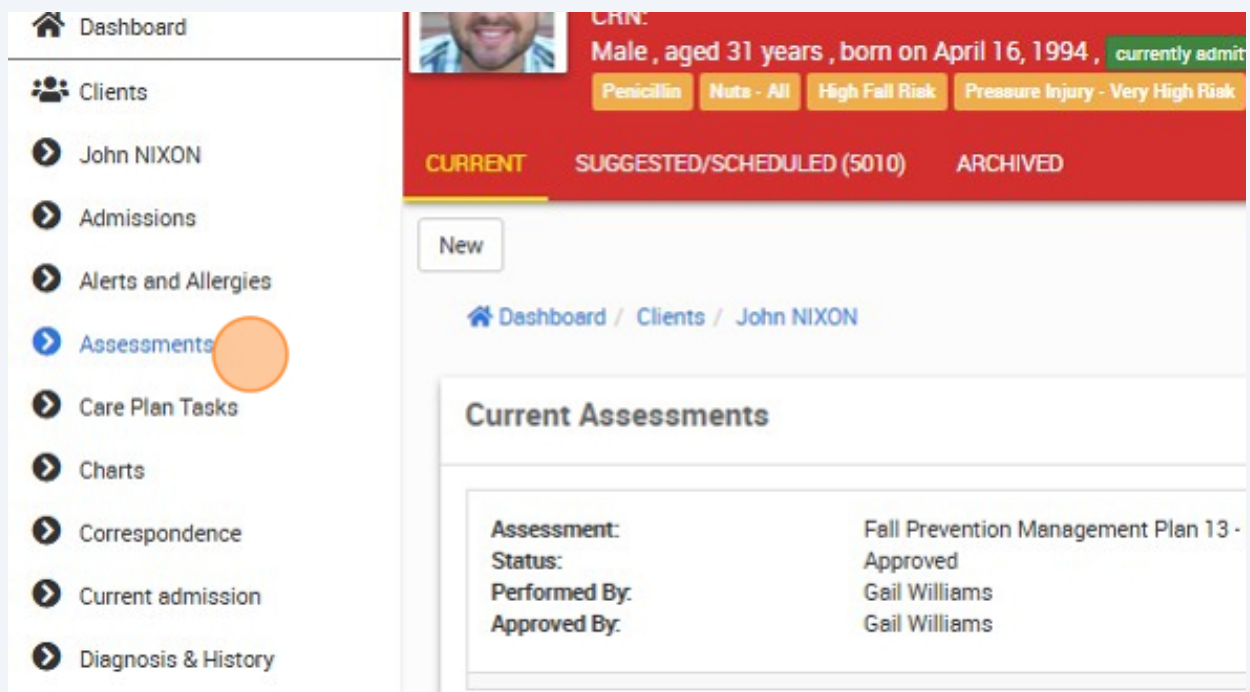


Falls Risk Assessment Tool (FRAT) and Fall Prevention Management Plan

A how to guide for completing the FRAT and fall prevention management plan in Care Right

Completing a Falls Risk Assessment Tool

- 1 Click '**assessments**' to open all current assessments



The screenshot displays the Care Right user interface. On the left is a vertical navigation menu with icons and labels for various sections: Dashboard, Clients, John NIXON, Admissions, Alerts and Allergies, Assessments (highlighted with an orange circle), Care Plan Tasks, Charts, Correspondence, Current admission, and Diagnosis & History. The main content area on the right features a red header bar with a patient profile summary: 'CRN: Male, aged 31 years, born on April 16, 1994, currently admit'. Below this are four colored tags: 'Penicillin' (yellow), 'Nuts - All' (orange), 'High Fall Risk' (yellow), and 'Pressure Injury - Very High Risk' (orange). A secondary red bar contains three tabs: 'CURRENT' (active), 'SUGGESTED/SCHEDULED (5010)', and 'ARCHIVED'. Below the tabs is a 'New' button and a breadcrumb trail: 'Dashboard / Clients / John NIXON'. The main section is titled 'Current Assessments' and contains a table with the following data:

Assessment:	Fall Prevention Management Plan 13 -
Status:	Approved
Performed By:	Gail Williams
Approved By:	Gail Williams

2 Locate the FRAT and click "Perform" from the dropdown box

s / John NIXON

nents ☐ Include chart updates Please select... Newest Created Any State Search... Q

Fall Prevention Management Plan 13 - Fall Prevention Management Plan Filter Approved Gail Williams Gail Williams	Created: 12/11/2025 at 13:24 Performed At: 12/11/2025 at 13:24 Approved At: 12/11/2025 at 13:24 Assessed At: 12/11/2025 at 13:24	Show ▾
Fall Risk Assessment Tool 18 - Fall Risk Assessment Tool Filter Approved Gail Williams Gail Williams	Created: 12/11/2025 at 13:22 Performed At: 12/11/2025 at 13:22 Approved At: 12/11/2025 at 13:22 Assessed At: 12/11/2025 at 13:22	Show ▾ Add Clinical Note Add Task Perform Strike Archive
Wound Management Plan 10 - Wound Management Plan Filter Approved Gail Williams Gail Williams	Created: 12/11/2025 at 13:03 Performed At: 12/11/2025 at 13:03 Approved At: 12/11/2025 at 13:07 Assessed At: 12/11/2025 at 13:07	
Wound Location: Right heel	Wound Status: Open	
Pressure Injury Prevention Plan 30 - Pressure Injury Prevention Plan Filter Approved Gail Williams Gail Williams	Created: 12/11/2025 at 12:23 Performed At: 12/11/2025 at 12:23 Approved At: 12/11/2025 at 12:23 Assessed At: 12/11/2025 at 12:23	Show ▾
Care Plan 23 - Care Plan Filter Approved Gail Williams Gail Williams	Created: 12/11/2025 at 09:19 Performed At: 12/11/2025 at 09:19 Approved At: 12/11/2025 at 09:19 Assessed At: 12/11/2025 at 09:19	Show ▾

3 Complete the assessment by selecting the most appropriate box to describe your client's mobility, mental state, toileting, history of falls and medication.

The total score will display at the bottom of the assessment.

Mobility: Completely Immobile / Ambulant with no gait = 0 Ambulant or transfer with assistive device / Ambulant with unsteady gait and no assistive device = 1

Mental State: Coma / unresponsive / Developmentally appropriate and alert = 0 Developmentally delayed = 1 Disorientated = 2

Toileting: Nappies / Independent = 0 Needs assistance with toileting / Independent with urinary frequency or diarrhoea = 1

History of Falls: No = 0 Yes before admission = 1 Yes during admission = 2

Medication: No medications = 0 Anticonvulsants, opioids, diuretics, sedatives, bowel prep = 1

Total_score: 3

4 Manually type in the total risk score and select the fall risk rating

displayed could be from previous entry

Fall Risk Rating

High Fall Risk

Score less than 3 = Low Falls Risk
Score equal to or greater than 3 = High Falls Risk

Use the above score and rating to complete the below fields.

You can find the Total Risk Score in the table above.

Total Risk Score: * 3

You can find the Risk Rating in the box above.
Please select either High or Low

Fall Risk Rating* High

Fall Risk Rating" fields above have been updated based on the current assessment before saving or approving.



Alert! A notice for '**High Falls Risk**' will sit on the client's banner when '**high**' has been selected for falls risk rating

 **John NIXON** ALLERGY NOTICE Medication Che

CRN:
Male, aged 31 years, born on April 16, 1994, currently admitted to

Penicillin Nuts - All High Fall Risk Pressure Injury - Very High Risk SPO

Dashboard / Clients / John NIXON

5

Click "**Click here to view Fall Prevention Management Plan**" to open a separate tab to complete a fall prevention management plan.

When Fall Risk Rating is high, please complete a Fall Prevention Management Plan

[Click here to view Fall Prevention Management Plan](#)

Approve

6

Click "**Approve**" to submit entry

When Fall Risk Rating is high, please complete a Fall Prevention Management Plan

[Click here to view Fall Prevention Management Plan](#)

Approve

Completing a Fall Prevention Management Plan

7

In assessments, locate the '**fall prevention management plan**'. If opened from the FRAT it will automatically show this assessment. Click '**perform**' from the drop down box to edit the management plan.

High Fall Risk Pressure Injury - Very High Risk SPOC 12 Years Fluid Input / Output Behaviour Chart Wound Chart Wound Chart

ED (5010) ARCHIVED

IXON

☐ Include chart updates Please select... Newest Created Any State Fall Prevent

Fall Prevention Management Plan 13 - Fall Prevention Management Plan	Approved	Created	Performed At	Approved At	Assessed At
	Gail Williams	12/11/2025 at 13:24	12/11/2025 at 13:24	12/11/2025 at 13:24	12/11/2025 at 13:24

Show

- Add Clinical Note
- Add Task
- Perform
- Strike
- Archive

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Tip! Routine fall prevention strategies for all clients will sit at the top of the plan

Routine Fall Prevention Strategies

Staff:

- Ensure appropriate bed/cot placement according to BAS and policy.
- Be aware of mobility status (and level of assistance required) prior to providing care.
- Accompany all mobilising clients unless otherwise stated.
- Assist unsteady clients with transfers and ambulation.
- Clients who have received sedation / general anaesthetic are at greater risk of falls.
- Check client regularly according to policy requirements.

Environmental Considerations:

Ensure:

- Environment is clear of clutter and trip hazards.
 - o Remove all unused equipment out of room and corridor
 - o Keep floor surfaces dry. Utilise wet floor signage where appropriate.
 - o Adequate lighting including the use of night lights.
 - o Furniture is positioned and adjusted to allow ease of access and safe use.
 - o All brakes are applied on equipment when stationary.
 - o Curtains are pulled back to enable full view of the client
 - o Room doors are kept open at all times unless specified isolation precautions are in use.
- Bed / cot rails are up except for floor line beds which must be down to reduce the risk of entrapment.
Note: Bed rails must be raised when floor line bed is elevated for transfers / personal care.
 - o If any gaps that can cause injury / entrapment, consider use of additional safety precautions e.g bolster.
 - o Placement in a bed / cot appropriate for size and development with the brakes on.
 - o Bed head and foot ends are in place as per policy.
 - o Bed height is at the lowest possible setting to the ground.
- Client dressed in appropriate footwear (non-slip) and clothing to prevent tripping.
- Clients are secured as recommended by their OT and supervised in seating equipment



Alert! The fall risk score and rating will automatically transfer across to the plan

Fall Risk Rating

**Total Risk
Score:**

3

Risk Rating:

High

8

Select boxes to indicate which strategies apply to your client's environment and supervision plan

Fall Prevention Management Plan

A Fall Prevention Management Plan is required for clients identified as High Fall Risk (≥ 3 score on the Fall Risk Assessment tool). Complete the Fall Prevention Management Plan by selecting interventions required below.

Environment:

- ☒ Place custom designed protective barriers over gaps and spaces in bed
- ☒ Refer to Occupational Therapist to review / ensure appropriate set up of bed
- ☒ Ensure that the bed is placed as close to the floor as possible

Supervision:

- ☒ Requires 1:1 staffing and supervision
- ☒ Place client in a high observation area (e.g. close to Nurse Station or a high observation area)
- ☒ Check client more frequently than specified in Allowah's Child Safety -

Enter appropriate frequency of checks

constant

Mobilisation support:

- ☒ Use appropriate mobility aids
- ☐ Accompany the client when mobilising

9

Select boxes to indicate which strategies apply to your client regarding mobilisation, other and check points.

Supervision:

- ☒ Requires 1:1 staffing and supervision
- ☒ Place client in a high observation area (e.g. close to Nurse Station or a high observation area)
- ☒ Check client more frequently than specified in Allowah's Child Safety -

Enter appropriate frequency of checks

constant

Mobilisation support:

- ☒ Use appropriate mobility aids
- ☐ Accompany the client when mobilising
- ☒ Refer to Physiotherapist for advice on safe transfer techniques and mobilisation

Other:

- ☒ Review current medication list and administration times that may contribute to falls risk (e.g. sedatives, antipsychotics, etc.)

Check points:

- ☒ Highlight "High Falls Risk" in clinical handover
- ☒ Flag "High Falls Risk" at bed side
- ☒ A scheduled plan review date

Review date: (plan will be reviewed earlier if condition changes)

12/12/2025

- 10 Add a date for review by selecting a date in the calendar.

points:

Review date: (plan will be reviewed earlier if condition changes):

☐ Accompany the client when mobilising

« December 2025 »

Su	Mo	Tu	We	Th	Fr	Sa
30	1	2	3	4	5	6
7	8	9	10	11	12	13
14	15	16	17	18	19	20
21	22	23	24	25	26	27
28	29	30	31	1	2	3
4	5	6	7	8	9	10

Today

12/12/2025

☒ Communicate and provide a copy of the Falls Risk Assessment

- 11 Click "**Communicate and provide a copy of the Falls Risk Assessment to the child's parents/carers/guardian**" if this has been attended.

☒ Highlight "High Falls Risk" in clinical handover

☒ Flag "High Falls Risk" at bed side

☒ A scheduled plan review date

er if condition changes):

16/12/2025

☒ Communicate and provide a copy of the Falls Risk Assessment to the child's parents/carers/guardian

12 Click Approve to "Submit"

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nts
s
otes

Check points:

- ☒ Highlight "High Falls Risk"
- ☒ Flag "High Falls Risk" at
- ☒ A scheduled plan review

Review date: (plan will be reviewed earlier if condition changes):

16/12/2025

- ☒ Communicate and provide

Approve