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Erratum

Nandy S, Parsons S, Cryer C, Underwood M, Rashbrook E, Carter Y, Eldridge S, Close J, Skelton D, Taylor S, Feder G on behalf of the Falls Prevention Pilot Steering Group. Development and preliminary examination of the predictive validity of the Falls Risk Assessment Tool (FRAT) for use in primary care. *J Publ Hlth Med 2004*; 26(2): 138–143

The above article published in the *Journal of Public Health Medicine*, volume 26, issue 2, stated that the Falls Risk Assessment Tools, Parts 1 and 2 were presented in the Appendix. Unfortunately the Appendix did not appear in the issue. The appendix is now presented here.

The Editors would like apologize to for this error.

Assessment of falls risk in older people

Multi-professional guidance for use by the primary health care team, hospital 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. By falling we mean 'a sudden unintentional change in position causing one to land on a lower level.'

Notes for users:

Complete assessment form below. The more positive factors, the higher the risk for falling.

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.

Some users of the guidance may feel able to undertake further assessment and appropriate interventions at the time of the assessment.

Consider which referral would be most appropriate given the patient's needs and local resources.

Name _____ Date of Birth _____

		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 their 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.		

Appendix 1. Falls risk assessment tool

Suggestions for further assessment, referral options and interventions

Assessment by nurse or doctor further referral

Risk factor present	Further assessment	Referral options	Interventions
(1) History of falling in the previous year	Review incident(s), identifying precipitating factors.	Occupational Therapy	Discuss fear of falling and realistic preventative measures
		Physiotherapy	Discuss the value of exercise for maintaining strength, mobility and balance.
(2) Four or more medications per day	Identify types of medication prescribed.	General Practitioner	Review medications, particularly sleeping tablets.
	Ask about symptoms of dizziness.		Discuss changes in sleep patterns normal with ageing, and sleep promoting behavioural techniques.

Continued

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Appendix 1. *Continued*

Risk factor present	Further assessment	Referral options	Interventions
3) Balance and gait problems	Can they talk while walking?[1]	Occupational Therapy	Teach about risk, and how to manoeuvre safely, effectively and efficiently.
	Do they sway significantly on standing?[2]	Physiotherapy	Physiotherapy evaluation for range of movement, strength balance and/or gait exercises
	Can they stand on one leg?[2]		Transfer exercises.
			Evaluate for assistive device
			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)	Three readings taken	District Nurse	Consider raising head of bed if severe.
	After rest five minutes supine	Practice nurse	Review medications.
	Immediate upon standing	General Practitioner	Teach to stabilise self after changing position and before walking.
	2 minutes later standing		
	Symptomatic or > 20mm drop systolic		
(5) Vision	Visual field test	Optician	Correct vision problems
	Snellen chart		Raise awareness regarding risks due to blurring and difficulty in judging distance
			Advise disuse of bifocals or care when first wearing them
			Advise to concentrate on walking and be deliberate/ cautious, especially in new situations and on uneven surfaces.

For frail ambulatory elderly people, consider the use of hip protectors to reduce the risk of hip fracture.

1. 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.

2. 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).

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